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Viewpoints

The Global Society on Migration, Ethnicity, Race and Health: why race can't be ignored even if it causes discomfort

The first World Congress on Migration, Ethnicity, Race and Health took place in Edinburgh, Scotland in 2018, jointly hosted by the European Public Health Association (EUPHA) with the scientific abstracts published by the *EJPH*.[1] Migration, ethnicity and race are sensitive yet unavoidable topics in today's globalized, multicultural societies.[2] Their impact on health and well-being is beyond doubt, but understanding how and why and addressing the consequent disparities and injustices are huge global challenges. The aim of the Congress was to bring together researchers, practitioners, community members, activists and policymakers from across the world who were working on at least one of these three intersecting health-related topics. It was driven by a vision that much would be gained by sharing information, insights and concerns and working together to improve the health of all. At the outset, there was a fierce debate about its name, in particular about whether to include the word race. Some argued it was a discredited concept. It was decided to retain it while providing Congress participants with a glossary of definitions for migration, ethnicity, race and other related words, aimed at creating a shared vocabulary and enhancing mutual understanding.[3]

The Congress was highly successful. One outcome was a decision to set up a Global Society to further the aims of the Congress by stimulating research and debate and promoting positive change. However, the controversy about race was reignited during the Working Committee's preparations for launching the Global Society, leading to a series of deep and heartfelt discussions. Many alternatives titles were considered including placing inverted commas around race, switching it to racism or race relations and removing it from the title. The latter was probably the easiest way to smooth our path. After long deliberation, however, a near unanimous consensus was reached to retain the original title. Here, we explain why.

Migration is, 'the movement of people either across an international border or within a country'.[3] It is arguably the most important factor in the success of humanity and will continue to shape human history. It accelerates change through the intermingling of peoples, leading to cultural and genetic vigour, economic innovation and progress. However, the flight of refugees from Syria and Myanmar and the ongoing tensions at the US-Mexican border are just three recent examples of the human suffering and political turmoil that migration can produce, endangering health and well-being in numerous ways. The coronavirus pandemic has jeopardized millions of migrant workers, asylum seekers or undocumented migrants across the world, because of COVID-19 itself or unemployment and social exclusion due to lockdowns and border closures.[4]

Ethnicity or ethnic group refers to 'the social group a person belongs to and either identifies with or is identified with by others as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features'.[3] Everyone has an ethnicity, albeit often complex, multi-faceted and subject to change over time and from one generation to another. Categories can be broad-brush such as South Asian or African, or fine-grained, such as Māori, Hasidic Jew or Roma. In some countries, a high proportion of the population are willing to self-report their ethnicity using a classification developed with community participation.[5] Recording self-identified ethnic group during a census or hospital admission has revealed a wide range of important health differences between ethnic groups.[1] Information has recently emerged in the UK and elsewhere that some ethnic groups are more likely to become infected with SARS-CoV-2 or develop severe forms of COVID-19.[6] However, as societies become ever more diverse and cultures adapt and converge, the usefulness of such categorizations may diminish. There is also the danger of an ethnocentric view—seeing the world from the standpoint of one ethnic group, typically by using the White or another majority ethnic group as the norm or standard.

Race is 'the group a person belongs to as a result of a mix of physical features such as skin colour and hair texture, which reflect ancestry and geographical origins'.[3] With economic and scientific advances in Europe, the self-serving idea of White superiority was legitimized by leading scientists who used physical characteristics to classify people into a racial hierarchy, even if not the intention of Blumenbach, one of the most influential.[7] This lethal concept helped justify foreign conquests, empire-building, slavery, the annihilation of Indigenous peoples, forcing entire populations into servitude and the Holocaust.

After the Second World War, the United Nations meticulously examined the concept of race and concluded without reservation that the biological classification of human populations by race has no scientific basis.[8] Nevertheless, race remains a pervasive idea in many societies, most often based on skin colour. Racial categorization may, sometimes inadvertently, contribute to racism, 'the belief that some races are superior to others, used to devise and justify individual and collective actions which create and sustain inequality among racial/ethnic groups',[3] an idea we wholly repudiate. Structural or systemic racism remains deeply embedded in the culture, legislation, policies and organizational practices of many countries. The health professions are no exception, as a special issue of the *British Medical Journal* recently demonstrated. The killing of the African American, George Floyd, by a White policeman in Minneapolis and the subsequent global upsurge in support for the Black Lives Matter movement have highlighted the continuing daily impact of racism on millions of people in the USA and elsewhere. Racism is a potent driver of health inequalities in numerous ways, exacerbated by its intersectionality with other determinants of health such as low socio-economic status and gender-based violence.[9]

Most English-speaking and many other countries have human rights and anti-discrimination laws which explicitly refer to race or the equivalent word. The US Government has been collecting data on race in its census since 1790.[1] Since 1997, it has identified five minimum categories for race and two for ethnicity in its census and other surveys.[1] While both race and ethnicity are routinely used terms of classification in the health and social sciences in the USA, ethnicity (or country of birth) is favoured in Europe. In a recent analysis, about half of all relevant scientific papers listed in Medline referred to race and half to ethnicity, with some using both e.g. race/ethnicity.[10] Thus, as race and ethnicity are often used synonymously, only using ethnicity does not banish race from our thinking but renames it.

We have therefore concluded that migration, ethnicity and race are interrelated terms that are all essential for understanding global health and confronting health inequities. Rather than rejecting race because it makes us uncomfortable or reminds us of some of the gravest crimes recorded in human history, we should openly discuss its meaning and contemporary relevance, and strive to prevent its abuse. The Global Society on Migration, Ethnicity, Race and Health will uphold the principle that we all have an equal right to health

and access to health care regardless of our appearance, heritage, place of origin, gender, religion, disability or sexual orientation.

For more information about the Global Society, visit www.gsmerh.org. A full list of references is available from the corresponding author.

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'Race' causes discomfort? Worse: it misleads

In their viewpoint, the Global Society on Migration, Ethnicity, Race and Health pen a cogent call to move beyond the discomfort and embrace the construct of 'race' in research on migration and health.[1] They recognize the sources of this discomfort: race was utilized to create hierarchies in and across societies, which gave rise to unspeakable atrocities, from slavery to genocide and the Shoah. In many societies, these atrocities are still very recent, restorative justice or reparations have not materialized, and privileges earned from being placed higher in the hierarchy have had enduring legacy, generating multi-layered and multi-generational inequalities.

It is (systemic) racism that leads to persistent (health) inequalities, however, not people's (perceived) race. Racism needs race to prevail; as Jean-Paul Sartre put it: 'If the Jew did not exist, the anti-Semite would invent him'.[2] We believe that even today the scientific community fails to critically engage with, and ultimately reject, the construct of race. For example, we find the definition of race proposed by the authors, with its focus on 'skin colour and hair texture', allegedly reflecting 'ancestry and geographical origins'[3] to be misleading and untenable. It legitimates a biological understanding of race, which the authors say they reject. Humanity is the result of migration and admixture and should be framed as such. In the past 100 000 years, culture predominated in generating group differences, not biology.[4]

As many have argued, today we are seeing less (openly) of the type of racism as ideology of human races, which postulates intrinsic biological differences between particular groups. It is argued, however, that biological superiority, as implied by the construct of race, has now been replaced by alleged cultural superiority,[5] which is often difficult or impossible to align with bodily differences, as can be seen in the case of anti-Muslim racism. Underlying cultural racism is less the superiority of certain groups but rather the perceived perils of crossing of boundaries and the incompatibility of different ways of living.[6] Upholding cultural superiority can also lead to exploitation, oppression, exclusion and extermination, just as well as upholding biological superiority.[7] These views support a 'racism-without-race' approach: we can only speak of anti-migrant or anti-Muslim racism when 'migrants' or 'Muslims' are regarded as uniform groups with shared cultural traits. Following Sartre, there may not be a need to recreate the targets of racism to dismantle racism. Cultural racism, we believe, makes race, as defined in the commentary[3] unhelpful for its analysis.

One approach to critically engage with race is to study 'racialization' rather than race. Racialization was defined as 'the extension of racial meaning to a previously racially unclassified relationship, social practice, or group'[8] the initial extension being assignment at birth.[9] Racialization as a process has such temporality that it can appear permanent and become institutionalized as 'all members of the racialized group are treated as if all they do, feel and think is caused by their race as it is conceived by the racially dominant

population'.[9] The racialized people are (mis)treated in three ways (in their many forms) according to Gans: (i) stigmatization (e.g. demonizing), (ii) exclusion (e.g. segregation) and (iii) punishment (e.g. incarceration).[9]

If racialization replaces race as a point of explanation, structural and institutional racism becomes the major issue to address. Racism as a hegemonic structure racializes and reproduces the different groups and solidifies hierarchies, maintaining the privileges of the privileged. It can pervade a society and results in health inequities, even when individual bigotries towards race (also of scientists) are seemingly absent. Singh explains how the racialization of diseases (e.g. sickle cell anaemia) is detrimental to health care and articulates a warning against racialization of other illnesses and treatment approaches as race data become more available. He further warns that race data in relation to Covid-19, with the premise of better understanding how it affects different communities, become its own form of racialized surveillance.[10] Racialization as a lens in relation to health leaves race with little explanatory value and may show how race data lead to racialization by itself.

Our call, contiguous to the Global Society on Migration, Ethnicity, Race and Health, is to recognize the forms of racism in society and in public health, move away from the construct of race to critically engage with it, and embrace racialization as a focus of study. We believe that we can begin to dismantle structures of racism and health inequalities they create by putting the spotlight on racism, not race. We recognize public health science as an important contributor to the efforts of deracialization and 'reversal of racialization'[9] in its fights against racism.

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Considering racial terminology in public health research

The concept of race has a troubled history in public health. From the infamous Tuskegee Study in the USA to the Nazi's Final Solution, racial ideologies have long been utilized in public health, causing grievous harm to people and populations.[1,2]

Yet, racial measures—descriptors of difference generally rooted in continental ancestry and skin color—continue to be used in public health, genetics and medicine to characterize human population differences (and similarities) in pursuit of a wide array of scientific questions. Prominent among these questions is the use of racial variables in the study of health disparities and other poor health outcomes, which remains a significant and stubborn challenge to public health authorities and policy makers. Recent scientific and popular articles claiming connections between race, genes and morbidity and mortality rates for COVID-19 are an example of how the race concept can be dangerously misused in health disparities research and in popular explanations for such disparities.[3]

In the pages of this issue of the *European Journal of Public Health*, the Global Society on Migration, Ethnicity, Race and Health describe their own struggle with use of 'race' in the title of their group.[4] This struggle, they say, was driven by a tension between the discomfort of using a 'discredited concept' that 'may, sometimes inadvertently, contribute to racism' and a belief that race and related terms are 'all essential for understanding global health and confronting health inequities'. Nevertheless, the group concluded that they should not reject race because 'it makes us uncomfortable or reminds us of some of the gravest crimes recorded in human history', but should instead be openly discussing the meaning and relevance of race so that we can 'strive to prevent its abuse'.

I empathize with the Society's plight. Whether we reject the historical meaning of racial terminology in research, it is both a signifier of one's lived experience and a common language globally used to describe differences (and similarities) between peoples. In my own work, I have called on the biological sciences to abandon racial terminology, but at the same time also recognize how racial terminology can be essential to the study of racism and other forms of discrimination. After all, race is also a social determinant of health that can give researchers insight into a wide array of social, structural and environmental determinants.

While most public health scientists acknowledge the fact that racial differences and disparities between groups are not rooted in

biological difference (because race is too crude a biological measure to capture genetic diversity and because human races are too genetically heterogenous), decades of public health science have shown how race and other determinants of health shape population and individual health. Another way to put this is that race as a biological measure tells us very little about differences between people, while race as a social determinant can tell us a lot. It can offer insights into the lived experiences of people, the nature of the groups to which they belong and how societies limit (or open) opportunities for people and populations to be healthy.

The use of race as a population descriptor has also found criticism from across academic disciplines. Social scientists and scholars in the humanities have expressed concern over how race, even when used as a proxy for someone's lived experience or when used to understand the impact of racism on individuals and populations, is still a variable rooted in historical notions of hierarchical difference between human populations, and thus can reinforce dangerous ideas in both scientific and popular thought about the nature of human difference.[5]

Racial measures have also been criticized for the way they have distracted both natural and social scientists from characterizing other social, structural and environmental determinants in the context of health disparities. Race is too often a reductive lens to view disparities at the expense of other health determinants.

Meanwhile, geneticists, anthropologists and other scientists working in the biological sciences have criticized the use of racial categories as too crude to help characterize the relationship between an individual and their genes.[6] Thus, some studies trying, for example, to understand the nature of asthma disparities, may look to genetic distribution by race as a key factor for understanding the distribution of asthma disparities between groups. Instead, studies can look to a host of other health determinants to make sense of a distribution that may look racial in nature, but in fact may be rooted in a more complex web of determinants.

Finally, a growing number of clinicians have called attention to the misuse of racial descriptors in medical practice, including the way some diagnostic algorithms and practice guidelines use racial or ethnic 'corrections' in their analyses.[7,8] Such corrections can be dangerous to patients, promoting ideas of biological racial difference and guiding physician decisions in a way that can reinforce health disparities.

The fundamental challenge that exists for social science researchers utilizing racial descriptors in their work is that it is very difficult, if not impossible, to distinguish between the social and scientific meanings of race. We have learned from decades of research that the social and scientific meanings of race are inseparable. How to resolve this issue should be a priority for public health.

This is not to suggest that the Global Society on Migration, Ethnicity, Race and Health should not use race in their title. They should. But their rationale for doing so is problematic. There is no evidence that discussing race somehow prevents its abuse. European countries, for example, handle race and population measures differently than the USA, but racism and other forms of tribalism and discrimination are no less relevant or impactful there. In fact, there is compelling evidence from scholars, scientists and clinicians that racial categories themselves can foster reductive views of the very public health problems our field seeks to redress. Race remains a relevant marker of lived experience, but if we fail to acknowledge the consequences of using racial categories in public health research, we may be harming the very populations we seek to protect.

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