

Tackling systemic racism requires the system of science to change

In response to the global Black Lives Matter protests, many institutions pledged actions to combat racism. That's not enough.

Next week marks a year since the murder of George Floyd, and nearly a year since the Black Lives Matter protests compelled numerous institutions – including many in research – to acknowledge systemic racism. These events made universities, institutes, corporations, museums, societies, publishers and funders confront racial injustice in a way that had never happened before.

As part of that response, *Nature* recognized systemic racism in science and our part in it, and committed to stand against it.

We know that such statements must be followed by actions. At *Nature*, we have made it an editorial priority to expose and tackle racism in science by publishing more research, commentary and journalism about racism and racial injustice. Next year, we will produce a special issue, under the guidance of a group of external editors, that examines systemic racism in research. We will be launching a news internship for Black journalists later this year. We are taking further steps to diversify our authors, reviewers and contributors. And we know that too few of our editorial staff are people of colour, so we are working to change this.

The other journals and teams in the Nature Portfolio are also forging stronger connections with communities of Black researchers; and our publisher, Springer Nature, has made commitments to champion diversity internally and in the communities it serves. Its Black Employee Network, formed in August 2020, has made valuable contributions to editorial policy and to elevating Black voices in science, technology, engineering and mathematics (STEM). Many other journals and science publishers have also made welcome changes.

But we know we are only at the foothills; there is a mountain ahead. We need to do much more, and are determined to do so. At the same time, we recognize that such pledges and actions, by themselves, do not constitute systemic change.

Racism in science is endemic because the systems that produce and teach scientific knowledge have, for centuries, misrepresented, marginalized and mistreated people of colour and under-represented communities. The research system has justified racism – and, too often,

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scientists in positions of power have benefited from it. That system includes the organization of research: how it is funded, published and evaluated.

Ending systemic racism will therefore require those in the system, including *Nature*, to collectively acknowledge and study these facts, and to ask: how and why did this happen? We need to thoroughly understand the root causes, even as we seek energetically to remedy the ongoing damage. Some have already started down this road. Projects at the Massachusetts Institute of Technology in Cambridge and the University of Glasgow, UK, have investigated these institutions' past ties to the slave trade and how they prospered from it, helping to build a more accurate and complete account of science history.

Hundreds of individual organizations have pledged actions to combat racism. All of these are important, but on their own they will not bring about the systemic change that is required. One essential change all institutions can make today is to put the right incentives in place. They must ensure that anti-racism is embedded in their organization's objectives and that such work wins recognition and promotion. Too often, conventional metrics – citations, publication, profits – reward those in positions of power, rather than helping to shift the balance of power.

A second change institutions should make is to come together to tackle racism, as some already are. At the very least, this means talking to and learning from a wide range of communities, and transcending conventional boundaries to team up. Funders, research institutions and publishers must work together to ensure that research from diverse scientists is funded and published. As part of the system of science, *Nature* is starting to develop such partnerships, and we look forward to doing more. Together, we will move further, faster.

Universal health care is a priority – even amid COVID

A focus on specific diseases has derailed efforts to achieve health care for all before. The world must not repeat that mistake with COVID-19.

Vaccinating the world's population against COVID-19 remains a global health priority. But it is vital that this effort does not overshadow the need to ensure that everyone, everywhere has access to basic health care.

Despite the urgency of the current crisis, the provision of universal health care remains a priority for Tedros Adhanom Ghebreyesus, the director-general of the World Health Organization (WHO). It is also enshrined in the

United Nations Sustainable Development Goals on the basis that health is a prerequisite for economic growth. Governments, scientists and the public should support this goal, because it's in everyone's best interests. And they will have an opportunity next week, when the World Health Assembly convenes online.

The pandemic has amply demonstrated how a lack of reliable health care can render communities vulnerable. Although access to health care isn't the sole factor that determined how well countries fared, its absence clearly fuelled the flames. Many lives have been lost in India because hospitals have been overwhelmed. In the United States, COVID-19 deaths have been higher among people on low incomes, who are less likely to have health insurance and therefore less likely to seek medical care promptly. A similar pattern has been seen elsewhere: one study found that in the poorer neighbourhoods of Santiago, more than 90% of people whose deaths were attributed to COVID-19 died outside health-care facilities (G. E. Mena *et al. Science* <https://doi.org/f9b4>; 2021). Moreover, people without reliable health care might be more vulnerable to complications of COVID-19 because of poorly controlled chronic diseases.

A lack of easily accessible health care – and of health systems for sharing information – has impeded the detection and monitoring of COVID-19 infections. Should another deadly virus emerge in a region with inadequate health care, the world could lose valuable time to contain the outbreak. The two largest Ebola outbreaks so far – in West Africa and the Democratic Republic of the Congo – spread for weeks to months before they were identified.

Despite almost a century of calls to provide all people with health care, attempts have been stymied by crises and disease-specific interventions. After the economic depression of the 1930s, international health officials working for the League of Nations touted the need for the provision of basic health services by country-wide networks of clinics. This vision was interrupted by the Second World War, but was revived in 1946, when the newly formed United Nations met to write a constitution for the WHO. The constitution stated that health is a human right, and that governments are responsible for the health of their people.

But the United States nearly rejected the WHO and its constitution outright. At the time, opponents of national health-care provision in the country connected the measure to socialism and communism. The United States eventually signed on, but inserted a clause stating that it could withdraw from the WHO at any time – meaning that the country donating the most money (dues are based on the size of economies) could walk away if it opposed the organization's ideology.

The next 20 years of single-disease programmes driven by the WHO and global health funders wasn't ideological, however. Ironically, they were also driven by a wave of scientific advances that offered simple, technological fixes to specific health problems, such as the use of the insecticide DDT to fight malaria and antibiotics to fight infections.

But, in 1978, the push to build up health systems was revived at an international conference on providing

everyone with primary health care, held in Alma-Ata in what was then the Soviet Union. The resulting WHO-sponsored Alma-Ata declaration vowed to provide essential care, at the level of neighbourhoods, by the year 2000.

But according to Tedros and health-policy experts, the Alma-Ata declaration was undermined by factors including inadequate political leadership, economic crises, political instability and an over-investment in treating individual diseases (T. A. Ghebreyesus *et al. Lancet* **392**, P1371–P1372; 2018). Others have suggested that the movement lacked defined steps backed by evidence, as well as cost-effectiveness assessments. Compare this with the UN children's charity, UNICEF, which in the 1980s vowed to save the lives of four million to five million children a year through well-defined and budgeted programmes to deliver vaccines for diseases including measles, tetanus and polio. Government and philanthropic donors grasped the concept immediately, and UNICEF quickly became one of the larger UN agencies. In 2019, its budget was nearly three times that of the WHO.

Childhood immunization programmes save lives, but the lack of investment in strengthening countries' health systems has led to untold deaths. The answer isn't to stop vaccinations, of course, but to take cues from the success of UNICEF's campaign and the failures of Alma-Ata.

In 2019, the WHO once again turned the focus on health care for all, this time at the first UN high-level meeting on universal health care. A corresponding report stated that to provide all people with primary health care, countries, on average, must increase their spending in this area by 1% of their gross domestic product. And world leaders signed a declaration promising to pursue universal health care – in their national context – and provide basic, affordable health services to everyone in the country. To hold them accountable, global-health researchers have created an online portal to track progress towards the attainment of this goal by 2030. For example, the tracker says that about 15% of the populations of the United States and Cuba lack access to essential health services. The rate grows to 20% in China and 45% in India and Kenya.

The WHO has placed 'health for all' high on the agenda of next week's meeting, hoping to drive political and financial commitments from governments. Perhaps mindful of the vagueness that doomed past efforts, Tedros has created a new council of economists, health and development experts to advise on the economics of providing everyone with basic health care, including ways to quantify its value.

Universal health care might seem a lofty goal amid a crisis, but if we do not push for change now, we will regret it. The pandemic has increased the number of people living in extreme poverty, making them more vulnerable to disease. It's infected, killed and traumatized health-care workers everywhere, most devastatingly in places that had too few already. "Our failure to invest in health systems doesn't only leave individuals, families and communities at risk, it also leaves the world vulnerable to outbreaks and other health emergencies," Tedros said in October 2019. "A pandemic could bring economies and nations to their knees." A few months later, it did. We must not let that happen again.

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