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LEGAL DETERMINANTS OF HEALTH

ABSTRACT

Social determinants of health are the social and economic conditions that have a determining impact on health at an individual and population level. Working within this framework, in 2019 the O'Neill Institute for National and Global Health Law at Georgetown University and *The Lancet* published *The Legal Determinants of Health*. This report identifies and promotes four legal determinants: provision of universal health coverage under the Sustainable Development Goals; governance of national and global health institutions; implementation of evidence-based health interventions; and building legal capacity. These determinants are dominated by the role of law in founding and governing health institutions and regulating their interventions. Such work is essential. However, the relationship between law, health improvement, and health equity articulated through these four determinants risks marginalising questions of disadvantage and inequality that social determinants of health research – and the report itself - mandates we attend to. Addressing the UK experience of COVID-19, and how social inequalities profoundly impacted experiences and outcomes in the first year of the pandemic, this article builds on the *Lancet*-O'Neill Commission's important work to argue that any articulation of legal determinants of health must foreground law's role in improving fairness in social arrangements and the distribution of resources.

Keywords: COVID-19, Health equity, Health inequalities, Inequality, Legal Determinants of Health, Social Determinants of Health.

I. INTRODUCTION

> [The] unequal distribution of health-damaging experiences is not in any sense a natural phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.[1]

Health has a special status.[2] It is foundational to well-being, and underpins social and political participation.[3] Understood in this way, the primary function of states should be to promote health,[4] including by addressing health inequalities that result from the unequal distribution of resources and opportunity.[5] As the World Health Organization (WHO) Commission on the Social Determinants of Health stated as the banking crisis in the late 2000s was unfolding, 'Social and economic policies have a determining impact on whether a

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[1] WHO Commission on the Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health: Final report of the Commission on Social Determinants of Health* (WHO: Geneva, 2008) 1.

[2] R Ruger, *Health and Social Justice* (Oxford University Press, 2009).

[3] J Coggon, 'Global health, law, and ethics: Fragmented sovereignty and the limits of universal theory' in M Freeman, S Hawkes, B Bennett, *Law and Global Health: Current Legal Issues* (Oxford University Press, 2014) 369, 372.

[4] *Ibid*.

[5] M Powers and R Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (OUP 2006), 246.

child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted'.[6] In countries like the UK, a decade of austerity policies in response to the financial crisis have adversely effected the health of the already most disadvantaged.[7] This has been compounded by the impact of COVID-19 and some of the policies introduced in response to the pandemic.[8]

Social justice has long been identified as providing the normative foundations for public health.[9] The emergence of work addressing Social Determinants of Health (SDH) has strengthened this association. While the relationship between the social environment and health status has long been recognised, embedded in the history of public health and the disciplines it draws upon, reference to SDH came to prominence at the end of the 1990s and early 2000s.[10] Most notably, the Commission on the Social Determinants of Health was set up by WHO in 2005 to 'marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it'.[11] By the second decade of the twenty-first century, it can be stated with confidence that WHO and others have been successful in mapping the relationship between health outcomes and the social 'contexts in which people live, learn, work, and play'.[12] This interdisciplinary field has generated a compelling body of research and the global movement that was intended. At the same time, state action and supra-national co-ordination remains inadequate with the research failing to penetrate common knowledge or, it is claimed, the realm of 'opinion elites'.[13] If these failings persist, health inequality may become the 'defining narrative of the 21st century'.[14]

In response to SDH data and the limited response it had generated, in 2019 the O'Neill Institute for National and Global Health Law at Georgetown University and *The Lancet* published *The legal determinants of health: Harnessing the power of law for global health and sustainable development*.[15] The *Lancet*-O'Neill Commission Report acknowledges the relationship between law and SDH, stating that law affects health 'in multiple ways, by structuring, perpetuating, and mediating the social determinants of health.'[16] The Report brings within its remit domestic and international law, as well as 'soft' law acting across these jurisdictional scales. It defines law to mean 'the statutes, regulations, and rules that

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[6] WHO Commission on the Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health: Final report of the commission on social determinants of health* (WHO: Geneva, 2008) 3.

[7] M Marmot, 'Health equity in England: The Marmot Review 10 years on' (2020) 368 BMJ 1.

[8] See below, Section V. COVID-19 AND INEQUALITIES, pp. 21-33.

[9] M Fox and M Thomson, 'Realising social justice in public health law' (2013) 21(2) Medical Law Review 278; S Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Polity Press: Cambridge, 2011); LO Gostin and M Powers, 'What does social justice require for the public health? Public health ethics and policy imperatives' (2006) 25(4) Health Affairs 1053; DE Beauchamp, 'Public health as social justice' in DE Beauchamp and B Steinbock (eds), *New Ethics for the Public's Health* (Oxford University Press, 1999) 101.

[10] See, for example, R Wilkinson and M Marmot, *Social Determinants of Health: The Solid Facts* (World Health Organisation: Geneva, 2nd edn, 2003); R Wilkinson and M Marmot, *The Social Determinants of Health* (Oxford University Press: Oxford, 1999).

[11] WHO Commission on the Social Determinants of Health (n 6) 3.

[12] P.A. Braveman et al., 'Broadening the focus: The need to address the social determinants of health' (2011) 40 American Journal of Preventive Medicine S1, S5.

[13] Robert Wood Johnson Foundation, 'A New Way to Talk about the Social Determinants of Health' (2010) <www.rwjf.org/files/research/vpmessageguide20101029.pdf> accessed 7 July 2021.

[14] JC Kaldor et al, 'The Lancet-O'Neill/Georgetown University Commission on Global Health and Law: The Power of Law to Advance the Right to Health' (2020) 13(1) Public Health Ethics 9, 14.

[15] LO Gostin et al, 'The legal determinants of health: harnessing the power of law for global health and sustainable development' (2019) 393 The Lancet 1857.

[16] *Ibid* 1857.

express public policy' and 'the public institutions such as legislatures, agencies, and courts … which are responsible for creating, and interpreting the law'.[17] It identifies law's ability to protect health, promote well-being, and reduce health inequalities, arguing that law can be a powerful means for advancing health, yet 'it remains substantially underutilised and poorly understood'.[18]

In response to the underutilisation of law in the broader public health enterprise, the Report aims to educate public health professionals of law's potential and provide a 'blueprint' for action.[19] In addressing the many and complex ways law can protect and promote health, and reduce health inequalities, the Report proposes four legal determinants of health (LDH): (i) giving effect to the Sustainable Development Goals, in particular the provision of Universal Health Coverage (UHC); (ii) governance of national and global health institutions; (iii) implementation of evidence-based health interventions; (iv) and building legal capacity. These are promoted as examples of the 'power of law'[20] to address the social and economic causes of ill-health, but also reflect 'the Commission's views of what constitutes the major dimensions of law in global health, in the common era'.[21] These determinants are dominated by the role of law in founding and governing national and international health institutions and regulating their interventions.

Law has an essential and important role in constituting and enabling these institutions and regulating health services and interventions. Furthermore, building personnel numbers who are appropriately skilled and trained to mobilise law will improve individual and population health.[22] However, I argue that to affect significant improvements in health we need to build upon the *Lancet*-O'Neill Commission's important intervention to foreground the key findings of work on SDH. Specifically, I argue that in articulating legal determinants we must centre the role of law in addressing inequalities in social determinants; that is, the conditions in which people 'live, learn, work, and play'.[23] While the Report provides a detailed understanding of the importance of disadvantage and inequality, this does not translate to the four identified legal determinants of health, which, as noted, address health *care*. That is to say, the Report focuses on law's role in establishing health care infrastructure, and regulating services and interventions. This narrowing to infrastructure and service delivery leaves the Report in danger of inadvertently reinforcing the erroneous and limiting idea that health improvement and promotion is primarily about health care. This may divert attention from more challenging questions about inequalities and the legal interventions required to promote greater health equity and social justice.

The *Lancet*-O'Neill Commission's report addresses global health, 'an area for study, research and practice that places a priority on improving health and achieving health equity for all people worldwide'.[24] While the outlook and ambitions are global, population health is largely determined by action or inaction at national level. So, the social and economic policies that

[17] *Ibid* 1859.
[18] *Ibid*.
[19] Kaldor et al (n 14) 9.
[20] Gostin et al (n 15) 1857.
[21] *Ibid* 1860.
[22] In this regard, see the discussion of health justice partnerships in A. Schram, T. Boyd-Caine, S. Forell, F. Baum, and S. Friel, 'Advancing action on health equity through a sociolegal model of health' (2021) 99(4) *Millbank Quarterly* 904.
[23] Braveman et al (n 12).
[24] JP Koplan, TC Bond, MH Merson, KS Reddy, MH Rodriguez, NK Sewankambo et al., 'Towards a common definition of global health' (2009) 373(9679) The Lancet 1993.

have a determining impact on health – for good or ill – are primarily generated at the domestic level, albeit that this may happen in the context of international legal frameworks. The four legal determinants of health singled out in the Report's blueprint for action are, for example, primarily implemented through domestic law. Acknowledging this, this article addresses the first year of the UK's experience of the COVID-19 pandemic. Here, as in other jurisdictions, social inequalities profoundly shaped experiences and outcomes. Stark inequalities in the impact of the virus manifested notwithstanding the National Health Service (NHS) - a legally constituted and governed health system - a commitment to evidence-based interventions, and very high levels of relevant legal expertise. This supports the argument that in articulating LDH we must foreground law's role in improving fairness in social arrangements and the distribution of resources. The pandemic has demonstrated once again the impact on health outcomes of inequalities in social determinants, including education, income, housing, and employment conditions. Laws that can improve these determinants should be the focus of our attention. This is one of the lessons from the experience of COVID-19 in the UK and other high income countries with similarly developed health and legal systems.

Law has an important role to play in health improvement, both nationally and globally. Yet, the reach and power of law in this context is deeply circumscribed by many factors, ranging from discriminatory practices that impact on health inequalities experienced by women and girls, to global inequalities in access to resources for health improvement measures. COVID-19 has underscored a number of challenges, not just for law but also health equity research. This is perhaps most notable in the context of race. Here, COVID-19 has highlighted the racialised experience of health inequalities, intersectional effects, and the failure of SDH research to fully address the 'causes of the causes' of health inequalities; that is, to address why, for example, Black, Asian and minority ethnic (BAME) populations are overrepresented at the bottom of all measures of disadvantage.[25] While these challenges exist for law and public health, it is nevertheless important to articulate what law has the potential to achieve.

The argument develops as follows. Acknowledging that the *Lancet*-O'Neill Commission Report is articulated in direct relation to SDH, the next section provides a brief outline of this field. I then summarise the *Lancet*-O'Neill model of LDH. A number of criticisms are outlined in section IV; in particular, the need to engage core findings of work on SDH and, in so doing, foreground law's role in addressing inequalities. To re-emphasise this, section V considers the way that inequalities profoundly impacted experiences and outcomes in the first year of the COVID-19 pandemic in the UK, a country with a developed and legally regulated health system. In response, in the final section I argue for an articulation of LDH that leads with law's role in improving fairness in social arrangements and the distribution of resources.

II. SOCIAL DETERMINANTS OF HEALTH

Significant health inequalities are experienced both between and within nations. In terms of inter-country comparisons, in 2016 there was a more than three-decade difference in life expectancy between the wealthiest (for example, Japan and Switzerland) and the poorest

[25] M Marmot, J Allen, P Goldblatt, E Herd, and J Morrison, *Build Back Fairer: The COVID-19 Marmot Review. The Pandemic, Socioeconomic and Health Inequalities in England* (London: Institute of Health Equity, 2020), 7.

countries (for example, Lesotho and Central African Republic).[26] Within countries, health inequalities are experienced regardless of the level of national wealth. They vary in magnitude and correlate with social inequality. Countries with greater degrees of economic and social inequalities have greater health disparities. This results in 'staggering and avoidable' differences in experiences of disease and disability,[27] and also average life expectancy:

> The poor health of the poor … [is] caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people's lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns or cities – and their chances of leading a flourishing life.[28]

Health inequalities occur on a social gradient.[29] As Scott Burris explains, there is a 'tendency of health outcomes to line up on a steady slope from the have-leasts to the have-mosts'.[30] In addressing SDH and the health gradient, there have been a number of attempts to articulate the social determinants by way of both the social institutions or structures that appear determinative, and the causal mechanisms that then tie disadvantage to poor health. In terms of the first of these, Richard Wilkinson and Michael Marmot's *The Social Determinants of Health: The Solid Facts* for WHO in 1999, listed ten determinants: socio-economic status, stress, early life, social exclusion, work, unemployment, social support, addiction, and transport.[31] In the landmark *Closing the Gap* in 2008, the WHO Commission on the Social Determinants of Health organised determinants under two broad areas: 'Daily Living Conditions', and 'Power, Money and Resources'. Daily Living Conditions included healthy physical environments, fair employment and decent work, social protection, and access to health care. Power, Money, and Resources included health equity as a goal, fair public financing, market responsibility, gender equity, political empowerment, and good global governance.[32]

In terms of identifying causal mechanisms, the early and formative Whitehall studies hypothesised possible effects of early-life environment, notably in underlying health status and educational achievements which then impact on employment and income in later life.[33] This has been supported by others who take a life course approach and point to the effect of early childhood deprivation on health later in life.[34] This has extended to a more general consideration of access to the basic resources that we need to thrive.[35] Others have directed

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[26] World Health Organization (WHO), *World Health Statistics 2020: Monitoring Health for the SDGs* (WHO: Geneva, 2020) Annex 2 <https://www.who.int/gho/publications/world_health_statistics/2020/en/> accessed 7 July 2021.
[27] Coggon (n 3) 376.
[28] WHO Commission on the Social Determinants of Health (n 6) 1.
[29] J Wilson, 'Justice and the Social Determinants of Health: An Overview' (2009) 2(3) Public Heath Ethics 210, 210.
[30] S Burris, 'From health care law to the social determinants of health: A public health law research perspective' (2011) 159(6) University of Pennsylvania Law Review 1649, 1652.
[31] R Wilkinson and M.Marmot, *The Social Determinants of Health: The Solid Facts* (WHO: Geneva, 1999).
[32] WHO Commission on the Social Determinants of Health (n 6).
[33] See M Marmot et al, 'Health inequalities among British civil servants: the Whitehall II study' (1991) 337(8754) The Lancet 1387.
[34] See, for example, J Lynch and GD Smith, 'A life course approach to chronic disease epidemiology' (2005) 26(1) Annual Review of Public Health 1, 5.
[35] BG link and J Phelan, 'Social conditions as fundamental causes of disease' (1995) Journal of Health & Social Behavior (Extra Issue) 35.

attention to the health impacts of psychosocial stress experienced across the life course.[36] While determining causal pathways is undoubtedly important, this should not detract from the fact that 'consistent correlations across populations between health and various forms of social and economic inequality leave little room for doubt that social arrangements account for an important fraction of population health'.[37]

III. LEGAL DETERMINANTS OF HEALTH: THE *LANCET*-O'NEILL REPORT

The role of law in driving population level health improvements 'remains relatively underutilised, and less well understood, compared to other public health disciplines such as medicine and epidemiology'.[38] The *Lancet*-O'Neill Commission's articulation of the role of law in population level health improvement is an important step in addressing this significant omission. The Report is located at the intersection of public health law and the related field of global health law. If public health law concerns the legal powers and duties to create the conditions to promote health, and defines the limits of state action in the name of public health and the common good,[39] then global health law addresses this with reference to international law. The Commission brings these disciplines to SDH, arguing that law has the potential to 'exert a powerful force' on health improvement:

> [B]y embracing the concept of 'determinants', the Commission sought to situate law within the larger social determinants of health movement. An SDH lens draws attention to the myriad influences on health outcomes: not just the proximal causes of injury and disease, but also the more distal ones, which include economic, social and environmental factors shaped powerfully by law.[40]

The Commission identified their mandate as examining 'the vital role of law' in responding to 'health challenges and to make recommendations to improve health outcomes'.[41] They aim to inform the international health community of the utility of law for securing health improvement; thereby, enhancing the 'global health community's understanding of law, regulation, and the rule of law as effective tools to advance population health and equity'.[42] The Commission narrates a diffuse and expansive understanding of law without inviting 'uncritical reverence' to it.[43] It acknowledges that laws may harm and undermine health, both individually and at the population level: 'laws that are poorly designed, implemented, or

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[36] CM Worthman and EJ Costello, 'Tracking biocultural pathways in population health: The value of biomarkers' (2009) 36(3) Annals of Human Biology 281.
[37] Burris (n 30) 1653.
[38] JC Kaldor et al, 'The Lancet-O'Neill/Georgetown University Commission on Global Health and Law: The Power of Law to Advance the Right to Health' (2020) 13(1) *Public Health Ethics* 9, 9. This mirrors a somewhat limited engagement with the important role of law in public health, particularly in terms of promoting non-discrimination and equality norms, see Fox and Thomson (n 8).
[39] LO Gostin and L Wiley, *Public Health Law: Duty, Power, Restraint* (University of California Press: Oakland, 3rd edn, 2016). J Coggon et al, provide the following definition, 'A field of study and practice that concerns those aspects of law, policy and regulation that advance or place constraints upon the protection and promotion of health (howsoever understood) within, between, and across populations': J Coggon et al, *Public Health Law – Ethics, Governance, and Regulation* (Routledge: Abingdon, 2017) 72.
[40] Kaldor et al (n 14) 10-11.
[41] *Ibid* 9.
[42] Gostin et al (n 15) 1857.
[43] J Coggon and LO Gostin, 'Postscript: COVID-19 and the Legal Determinants of Health' (2020) 13(1) Public Health Ethics 48, 52.

enforced can harm marginalised populations and entrench stigma and discrimination'.[44] They draw particular attention to discriminatory laws directed at sexual minorities and the regulation of reproduction.[45] It is also important to note that the Commission build on the *Lancet*-University of Oslo Commission on Global Governance for Health, which located law as part of broader global governance structures, and acknowledged the need for 'global cross-sectoral action and justice in our efforts to address health inequality'.[46]

In order to achieve their aims, and to provide a framework for action, the *Lancet*-O'Neill Commission's Report is structured around four legal determinants of health. Legal determinant 1 recognises that law can 'translate vision into action' with the Sustainable Development Goals (SDG).[47] According to the Commission, law can provide the 'mechanisms, frameworks, and accountability measures' to achieve the SDGs unifying vision of global health and development.[48] Within the broader SDG framework, the Commission singles out Universal Health Coverage (UHC) as a case study and exclusive focus.[49] Legal determinant 2 acknowledges that law can 'strengthen the governance of national and global health institutions'. In this, law is a tool to 'structure and clarify', 'harmonise mandates', 'foster state compliance', and 'increase transparency, openness, inclusiveness, and accountability'.[50] Legal determinant 3 focuses on the role of law in implementing 'fair, evidence-based health interventions' to create 'the conditions for good health'.[51] The Commission highlights important work across infectious diseases, non-communicable diseases, and injuries, and demonstrate the value of such legal interventions and how they interrelate and inform one another. Legal determinant 4 supports the first three determinants by asserting the need to build legal capacities for health:

> Strong legal capacities are a key determinant of progress towards global health and sustainable development. Yet, too often, countries lack either the basic legal infrastructure or the capacity to build it.[52]

The Report is dominated by the role of law in founding and governing health institutions and regulating their interventions. This might be referred to as 'infrastructure health law'.[53] The four determinants represent areas where it is believed 'stronger, more strategic linkages between health and law could substantially strengthen the overall global health agenda'.[54]

IV. DEVELOPING OUR UNDERSTANDING OF LEGAL DETERMINANTS OF HEALTH

[44] Gostin et al (n 15) 1857.
[45] For an expansion of this point, see S McGuinness and J Montgomery, 'Legal determinants of health: Regulating abortion care' (2020) 13(1) Public Health Ethics 34, 38.
[46] OP Ottersen et al, 'The political origins of health inequity: prospects for change' (2014) 383(9917) The Lancet 630.
[47] Gostin et al (n 15) 1857.
[48] *Ibid*.
[49] Indeed, reference to the wider SDGs is at one point dropped as the 4 legal determinants are outlined as: 'rights based UHC, good governance standards, fair and evidence-based interventions, and building legal capacity'. See Gostin et al (n 15) 1860.
[50] *Ibid* 1858.
[51] *Ibid*.
[52] *Ibid*.
[53] Burris (n 30) 1661.
[54] Gostin et al (n 15) 1860.

The *Lancet*-O'Neill Commission launches the concept of LDH and invites dialogue. This is to be welcomed and the potential of this concept should be explored as a priority. As Belinda Bennett writes, conceptualising law as a determinant of health creates the 'opportunity to reflect upon the discipline of law and its role in supporting healthy outcomes for individuals and communities'.[55] A number of scholars have begun to engage in this debate, highlighting areas where further work may be beneficial. Carmel Williams and Paul Hunt have, for example, highlighted the need for a greater engagement with human rights literatures.[56] Similarly, John Coggon has argued that the aspiration of achieving health with justice requires rigorous ethical justification if it is to challenge current harmful practices and support their replacement with more socially just interventions.[57] Coggon argues for more prominent engagement with ethics and political philosophy to rigorously underpin the obligations to improve health.[58]

Building on the *Lancet*-O'Neill Commission's work and participating in this debate, I argue here that in articulating LDH we must emphasise law's role in addressing social inequalities if it is to affect improvements in health equity of the order needed. Acknowledging Coggon's argument, political philosophers have worked to direct us beyond health care, to more fundamental and challenging questions of inequality and social justice. Work on SDH, and deepening recognition of the indivisibility of health inequalities from broader structural inequalities, has heightened interest in social justice and generated important concepts such as health justice[59] and health equity.[60] For the growing number who articulate health in these terms, inequalities in health are inequalities in freedom, and improved population level health and health equity are essential for greater social justice.[61] It has been argued that this demands that health policy be developed within a broader understanding of social justice, rather than isolated to narrower biomedical conceptions of health and a concomitant focus on health care. Madison Powers and Ruth Faden, for example, argue that public health policy should be grounded in a commitment to social justice.[62] In their model, which draws on the work of Amartya Sen, health is one of six core dimensions of social justice, along with personal security, reasoning, respect, attachment and self-determination. Françoise Baylis, Nuala Kenny, and Susan Sherwin develop this model to offer an important account that emphasises the social nature of life and the moral significance of social patterns of discrimination and privilege.[63] They argue that because inequalities are socially constructed and the unequal distribution of (ill-)health is inextricable from other social inequalities, public health must be addressed in the context of the structural causes of inequality:

> Social justice directs us to explore the context in which certain political and social structures are created and maintained, and in which certain policy decisions are made and implemented. It asks us to look beyond effects on individuals and to see how

[55] B Bennett, 'Law, Global health, and sustainable development: The Lancet Commission on the Legal Determinants of Health' (2020) 27(3) Journal of Law and Medicine 505.
[56] C Williams and P Hunt, 'Health rights are the bridge between law and health' (2019) The Lancet 1782, 1783.
[57] J Coggon, 'Legal, moral and political determinants within the social determinants of health: Approaching transdisciplinary challenges through intradisciplinary reflection' (2020) 13(1) Public Health Ethics 41.
[58] *Ibid* 44-5.
[59] Ruger (n 2); Venkatapuram (n 9).
[60] A Ruckert and RN Labonte, *Health Equity in a Globalizing Era: Past Challenges, Future Prospects* (Oxford University Press, 2019).
[61] S Anand et al, *Public Health, Ethics and Equity* (Oxford: Oxford University Press, 2004) 17-8; Fox and Thomson (n 9); Powers and Faden (n 5); Gostin and Powers (n 9); Beauchamp (n 9).
[62] Powers and Faden (n 5) 15.
[63] F Baylis et al, 'A relational account of public health ethics' (2008) 1(3) Public Health Ethics 196.

> members of different social groups may be collectively affected by private and public practices that create inequalities in access and opportunity. … Social justice further enjoins us to correct rather than worsen systemic disadvantages in society.[64]

Within this framework, health is indivisible from other rights and freedoms. This leads to an important observation that not only should we be concerned by health inequalities for the intrinsic harms these cause, but we can also take these as an indication of other inequalities and social injustices.[65] As Michael Marmot writes, health can provide a measure of social and economic progress: 'When a society is flourishing, health tends to flourish. When a society has large social and economic inequalities, it also has large inequalities in health'.[66] And as he concludes, health is not just a matter of how well health services function, 'but also the conditions in which people are born, grow, live, work, and age, and the inequities in power, money, and resources'.[67] This is supported by Amartya Sen's work on health equity which can help to justify a central place for law's role in addressing social inequalities in any statement of LDH. In defining the health equity concept as 'immense' and explaining its broad parameters, Sen directs us to the necessity of reaching far beyond health care systems to broader questions of how society is organised:

> Health equity cannot just be concerned only with health, seen in isolation. Rather it must come to grips with the larger issue of fairness and justice in social arrangements, including economic allocations, paying appropriate attention to the role of health in human life and freedom. Health equity is most certainly not just about the distribution of health, not to mention the even narrower focus on the distribution of health care. Indeed, health equity as a consideration has an enormously wide reach and relevance.[68]

These observations are substantiated by SDH data, and, as already noted, the *Lancet*-O'Neill Commission Report is directly linked to this. Indeed, the Report states that 'Law exerts a powerful influence on health by structuring, perpetuating, and mediating … the social determinants of health: education, food, housing, income, employment, sanitation, and health care'.[69] Yet the identified determinants are, nevertheless, focused on the role of law in establishing and regulating health systems. Here, there is a danger that the Commission's work may inadvertently reinforce the damaging assumption that health improvement and addressing health inequalities is primarily about health *care*. This is the case regardless of the wider framing and context, or the fact that mobilising 'health care' may well be a strategy designed to have more leverage in political domains.[70]

While this may be far from the Commission's intentions, there is a responsibility to consider the social life of such reports and documents. Indeed, Ludwig Fleck famously argued that the further scientific findings travel from their sites of production, the more they lose their contingency and specificity.[71] In Fleck's terms, 'journal science' is tentative and contingent.

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[64] *Ibid* 203.
[65] F Peter, 'Health equity and social justice' (2001) 18(2) Journal of Applied Philosophy 159.
[66] Marmot (n 7).
[67] *Ibid*.
[68] A Sen, 'Why Health Equity?' (2002) 11(8) Health Economics 659, 659.
[69] Gostin et al (n 15) 1859.
[70] On this, see John Coggon's analysis of the political realism of Lawrence Gostin's broader method: J Coggon, 'Global health, law, and ethics: Fragmented sovereignty and the limits of universal theory' in M Freeman, S Hawkes and B Bennett, *Law and Global Health: Current Legal Issues* (Oxford University Press, 2014) 369.
[71] L Fleck, *Genesis and the development of scientific fact* (University of Chicago Press, 1979).

Over time, this science becomes more certain - 'simplified, lucid, and apodictic'.[72] It gets refracted through other research and citations, interpreted for particular purposes, simplified, and translated for broader consumption, including in policy spheres. As David Wastell and Sue White argue, 'Once assembled, this new, more certain science appears to be self-evidently right, it is characterised by orderliness, consistency and certainty'.[73] This can come to limit both what is likely to be claimed as well as what can plausibly be claimed.[74] While the *Lancet*-O'Neill Commission Report is careful to map a complex understanding of the potential role of law in addressing the inequalities and disadvantages that shape the distribution of ill-health, it may be reduced to the four LDH with their focus on health care, rather than on the inequalities that determine poor health outcomes. Indeed, aspects of this process are already being witnessed.[75] My concern with an impoverished afterlife for the Commission's important work, and for our understanding of law's role in addressing health inequalities, motivates this article.

The *Lancet*-O'Neill Commission's model of LDH was published at a time when pre-pandemic, health improvements in a number of countries were faltering. For example, the 10 year follow up to the important *Marmot Review of Health in England,* published at the beginning of 2020, recorded declining health outcomes in England.[76] This includes stagnating, and in some instances declining, life expectancy, with the most marked declines experienced by women in deprived communities in the North of England. During the decade between reviews, health inequalities grew wider, and the years spent in ill-health increased:[77]

> [A]usterity has taken its toll in almost all areas identified as important for health inequalities. Child poverty has increased. Children's centres have closed. Funding for education is down. There is a housing crisis and a rise in homelessness. Growing numbers of people have insufficient money to lead a healthy life and now resort to food banks. There are more left-behind communities living in poor conditions with little reason for hope.[78]

This situation is forecast to worsen. The Institute for Fiscal Studies (IFS), for example, predicts a 7% rise in child poverty between 2015 and 2022, and others predict a child poverty rate as high as 40%.[79] Addressing these wider social arrangements is essential, and, as Isabel Karpin and Karen O'Connell argue, law has an important role in redressing 'disparities in the distribution of the social goods that lead to poor health'.[80] To illustrate this further, I now turn to map how inequalities in the UK directly affected the pattern of infection and death during the first year of the COVID-19 pandemic. Initially imagined as a 'great leveller' - affecting

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[72] *Ibid* 112.
[73] D Wastell and S White, *Blinded by Science: The social implications of epigenetics and neuroscience* (Policy Press, 2017) 27.
[74] *Ibid*.
[75] In their engagement with the *Lancet*-O'Neill Commission's work, Ashley Schram and colleagues, for example, characterise the Report as focused on 'the naming of three functions of law and four legal determinants.' Schram et al (n. 22).
[76] Marmot (n 7) 1.
[77] With respect to addressing the UK as a whole, Marmot stated: 'Bad as health is in England, the damage to the health of people in Scotland, Wales, and Northern Ireland has been worse'. *Ibid*.
[78] *Ibid*.
[79] Office of the High Commissioner, 'Statement on visit to the United Kingdom, by Professor Philip Alston, United Nations Special Rapporteur on extreme poverty and human rights' (2018) <www.ohchr.org/en/newsevents/pages/displaynews.aspx?NewsID=23881> accessed 7 July 2021.
[80] I Karpin and K O'Connell, 'Social Determinants of Health and the Role of Law' in A Farrell and others (eds), *Health Law: Frameworks and Context* (Cambridge University Press, 2017) 34, 47.

rich and poor alike - it soon became apparent that inequalities were going to be determinative in this health context. As Frank Snowdon argues, such health emergencies do not 'afflict societies capriciously and without warning. On the contrary, every society produces its own specific vulnerabilities'.[81] While no one would dispute that robust health systems are essential, the UK experience of COVID-19 directs us again to the need to address social inequalities and promote fairness in social arrangements if population health and health inequalities are to be significantly improved. This is central to law's role in health improvement and must be clearly articulated as the Commission's work is promoted and debated.

V. COVID-19 AND INEQUALITIES

This section addresses how COVID-19 impacted differentially according to socio-economic status, race, and gender. As the analysis demonstrates, it is, of course, difficult to disaggregate these. The devastating impact the virus has had in institutional facilities and care homes is also addressed. This context again demonstrates how inequality, disadvantage, and discrimination are intersectional and exacerbated the impacts of the virus. The analysis here is neither comprehensive nor complete, yet it provides a timely and arresting account of the importance of addressing inequalities if we are to effectively improve health and health equity.

A. Socio-Economic Status

Analysis of COVID-19 related deaths in the UK by the Office of National Statistics (ONS) found 'sharp differences' in infection and outcomes of COVID-19 depending on the deprivation level of geographic areas.[82] For example, death rates from COVID-19 in the most deprived areas were more than twice the rate in the least deprived areas when comparing top and bottom deciles of deprivation.[83] As the Institute for Fiscal Studies (IFS) suggest, this is likely to reflect:

> a combination of heightened vulnerability to the virus if you get it, and higher exposure to getting it in the first place: underlying heath conditions that put more deprived people at a higher medical risk to the virus, as well as differences in occupations and working conditions …, modes of transport and living environment that increase their risk of infection.[84]

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[81] F Snowden, *Epidemics and Society* (Yale University Press, 2019).

[82] Office for National Statistics (ONS), 'Deaths involving COVID-19 by local area and socioeconomic deprivation' (2020). <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31may2020> accessed 7 July 2021. See also, R Blundell et al, 'COVID-19 and inequalities' (The Institute for Fiscal Studies, 2020). <https://www.ifs.org.uk/inequality/covid-19-and-inequalities/> accessed 7 July 2021.

[83] ONS, ibid ; Blundell et al, ibid. See also C Niedzwiedz et al, 'Ethnic and socioeconomic differences in SARS-CoV-2 infection: Prospective cohort study using UK Biobank' (2020) 18(1) BMC Medicine 160 <https://doi.org/10.1186/s12916-020-01640-8> accessed 7 July 2021; TC Rose et al, 'Inequalities in COVID19 mortality related to ethnicity and socioeconomic deprivation' (2020) MedRxiv [preprint] <https://doi.org/10.1101/2020.04.25.20079491> accessed 7 July 2020; and S Lusignan et al, 'Risk factors for SARS-CoV-2 among patients in the Oxford Royal College of General Practitioners Research and Surveillance Centre primary care network: A cross-sectional study' (2020) 20(9) The Lancet Infectious Diseases 1034 <https://doi.org/10.1016/S1473-3099(20)30371-6> accessed 7 July 2021.

[84] Blundell et al (n 82).

With regard to underlying health conditions, 'rather than being a "great leveller"', the pandemic once again highlighted the 'potential consequences of existing health inequalities and uneven distribution of underlying health conditions'.[85] In addition to the frequently cited association between severity of COVID-19 outcomes and respiratory diseases, research also points to links with obesity and related conditions such as cardiovascular disease, hypertension, diabetes; all of which are more prevalent among lower socioeconomic groups and those from BAME backgrounds.[86] As Matthew Belanger and colleagues, remark of the United States of America, 'long-standing disparities in nutrition and obesity play a crucial role in the health inequities unfolding during the pandemic'.[87] Indeed, Public Health England reported that among COVID-19 deaths, hypertensive disease was mentioned in 40% of deaths in the Black group, compared with only 17% of the White British group.[88] Similarly, diabetes was more often mentioned among those living in the most deprived areas (26%) compared with the least (16%), and more often among Asian and Black groups (43% and 45% respectively compared to 18% for White British).

Returning to socio-economic status and the risk of exposure to the virus, people in key worker occupations experienced greater exposure to COVID-19 and were twice to 3.9 times as likely to have died from COVID-19 in the UK.[89] This vulnerability was disproportionately distributed across the population, in line with longstanding patterns of disadvantage. Key workers – including health and social care workers, taxi drivers, public transport drivers, and retail assistants – were more likely to be from ethnic minorities and in the bottom income group.[90] Women who continued to work during lockdown were more likely than men to be key workers, in particular in the health and social care sector.[91] Outside of the key worker population, only a small proportion of people in the lowest income group were able to work from home, only 20%, compared to 75% in the highest income group.[92] This meant that lower income groups were typically exposed to either greater risk of infection or unemployment.[93]

B. Race

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[85] KE Mason et al, 'Age-adjusted associations between comorbidity and outcomes of COVID-19: A review of the evidence' (2020) MedRxiv <https://doi.org/10.1101/2020.05.06.20093351> accessed 7 July 2021.

[86] MJ Belanger et al, 'Covid-19 and Disparities in Nutrition and Obesity' (2020) 383(11) New England Journal of Medicine <https://doi.org/10.1056/NEJMp2021264> accessed 7 July 2021; Public Health England, 'Excess weight can increase risk of serious illness and death from COVID-19' (2020) <https://www.gov.uk/government/news/excess-weight-can-increase-risk-of-serious-illness-and-death-from-covid-19> accessed 7 July 2021; Mason et al (n 85) Lusignan et al (n 83).

[87] Belanger et al, ibid.

[88] Public Health England, 'Disparities in the risk and outcomes of COVID-19' (2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf> 63 accessed 7 July 2020.

[89] ONS, 'Coronavirus (COVID-19) related deaths by occupation, England and Wales: deaths registered between 9 March and 25 May 2020' (2020) <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand25may2020> accessed 7 July 2021.

[90] Blundell et al (n 82)

[91] *Ibid*.

[92] *Ibid*.

[93] *Ibid*.

In the UK, people identifying as BAME have experienced greater case numbers and deaths from COVID-19 than would be expected given their age profile in the population (that is, given that age within these subpopulations tend to be younger overall than White British populations). A review of NHS electronic health records, for example, found that among case numbers, people identifying as south Asian and black African had positive test rates respectively at 2 and 1.7 times the rates of white British (after adjusting for socio-demographic factors, clinical co-morbidities, geographic region, care home residency, and household size).[94] After adjusting for age and care home status, the ONS identified that:

> the rate of death for Black males was 3.8 times greater than that for White males of the same age, while the rate for Black females was 2.9 times greater than for White females.[95]

According to the ONS and Robert Aldridge and colleagues, these are statistically significant differences in mortality rates across these groups.[96] Tanith Rose and colleagues point to the complex socio-economic and historical reasons why these groups are at greater risk:

> BAME groups may be at greater risk of infection, severe disease and poor outcomes for multiple reasons. These include socioeconomic conditions that increase risk of transmission and vulnerability (e.g. overcrowded housing, employment in essential occupations, poverty and reliance on public transport), unequal access to effective healthcare and higher rates of comorbidities, such as diabetes, hypertension, and cardiovascular diseases. These comorbidities have all been associated with COVID19 mortality and are also more common in BAME groups.[97]

The IFS argues that some of the disproportional impact on these minority groups is likely to be due to greater exposure in employment, given that people in these groups are more likely to be 'key workers'; for example, more than 20% of black African women work in health and social care roles.[98] Additionally, Public Health England report that institutional racism within the work place may have made it less likely that BAME staff raised concerns about lack of Personal Protective Equipment or risk.[99] And Tim Cook and colleagues suggest that even among NHS staff, people from BAME backgrounds are overrepresented in deaths from COVID-19.[100] While making up 20% of nursing staff, people from BAME backgrounds

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[94] R Mathur et al, 'Ethnic differences in COVID-19 infection, hospitalisation, and mortality: an OpenSAFELY analysis of 17 million adults in England' (2020) MedRxiv [preprint] <https://doi.org/10.1101/2020.09.22.20198754> accessed 7 July 2021.

[95] ONS, .'Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020' (2020) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/deathsoccurring2marchto28july2020> accessed 7 July 2021.

[96] RW Aldridge et al, 'Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: Indirect standardisation of NHS mortality data' (2020) 5 Wellcome Open Research 88 <https://doi.org/10.12688/wellcomeopenres.15922.2> accessed 7 July 2021.

[97] Rose et a (n 83).

[98] *Ibid*.

[99] Public Health England, 'Beyond the Data: Understanding the impact of COVID-19 on BAME groups' (2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf> accessed 7 July 2021.

[100] T Cook et al, 'Exclusive: Deaths of NHS staff from covid-19 analysed' (2020) Health Service Journal <https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article> accessed 7 July 2021.

accounted for 64% of deaths, and although 44% of medical staff are from BAME groups, they made up 95% of deaths. In analysing the deaths of bus drivers in London, Peter Goldblatt and Joana Morrison produced similar findings which suggested that Black drivers were more likely to die of COVID-19 independently of whether they had pre-existing health conditions.[101]

The IFS also highlights that older BAME people in are more likely to have long-term health conditions; for example 'Bangladeshis are more than 60% more likely to have a long-term health condition that makes them particularly vulnerable to infection, which may explain excess fatalities in this group'.[102] According to Public Health England, hypertension is more common among people of Caribbean and Black African ethnicity, and type II diabetes is more common among people from BAME communities.[103] Similarly, Abhinav Vepa and colleagues argue that 'obesity, insulin resistance, cardiovascular disease, psychological stress, chronic infections and genetic predispositions' are more prevalent among BAME populations and may lead to chronic inflammation, which in turn is exacerbated by COVID-19 infection.[104]

BAME populations in the UK are consistently reported as having levels of higher material deprivation.[105] The ONS point out that data indicates that Bangladeshi and Pakistani and Black ethnicities are more likely than white British residents to live in larger, overcrowded households, with multiple generations, in rental properties, and in deprived areas.[106] Bangladeshi and Pakistani, Chinese, and Black ethnicities are approximately twice as likely to experience poverty as children and subsist on a low income. Rose and colleagues also emphasise that immune responses are impaired by chronic stress, such as that caused by systemic racism and discrimination.[107]

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[101] P Goldblatt P and J Morrison, 'Initial Assessment of London Bus Driver Mortality from COVID-19. Report for Transport for London' (Institute of Health Equity, 2020) <http://content.tfl.gov.uk/initial-assessment-of-london-bus-driver-mortality-from-covid-19.pdf> accessed 7 July 2020.

[102] Blundell et al (n 82). See also Z Raisi-Estabragh et al, 'Greater risk of severe COVID-19 in Black, Asian and Minority Ethnic populations is not explained by cardiometabolic, socioeconomic or behavioural factors, or by 25(OH)-vitamin D status: Study of 1326 cases from the UK Biobank' (2020) 42(3) Journal of Public Health 451 <https://doi.org/10.1093/pubmed/fdaa095> accessed 7 July 2021; PC Balfour et al, 'The role of hypertension in raceethnic disparities in cardiovascular disease' (2015) 9(4) Current Cardiovascular Risk Reports 18 <https://doi.org/10.1007/s12170-015-0446-5> accessed 7 July 2021; DT Lackland, 'Racial differences in hypertension: implications for high blood pressure management' (2014) 348(2) American Journal of Medical Science 135 <https://doi.org/10.1097/MAJ.0000000000000308> accessed 7 July 2021; GY Lip et al, 'Ethnicity and cardiovascular disease prevention in the United Kingdom: a practical approach to management' (2007) 21(3) Journal of Human Hypertension 183 <https://pubmed.ncbi.nlm.nih.gov/17301805/> accessed 7 July 2021.

[103] Public Health England, 'Beyond the Data'

[104] A Vepa et al, 'COVID-19 and ethnicity: A novel pathophysiological role for inflammation' (2020) 14(5) Diabetes & Metabolic Syndrome: Clinical Research & Reviews 1043 <https://doi.org/10.1016/j.dsx.2020.06.056> accessed 7 July 2021.

[105] Raisi-Estabragh et al (n 102).

[106] ONS, 'Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020' (2020) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020> accessed 7 July 2021.

[107] Rose et al (n 83).

The ONS also found that people in BAME communities have been more vulnerable to COVID-19 because of pre-existing socio-economic inequalities.[108] As Zahra Raisi-Estrabragh and colleagues point out, while some have argued that attitude or behaviour may be responsible for increased rates among this group (specifically, lack of compliance with lockdown rules) this did not bear out in the data they analysed.[109] They also note that among global deprivation factors, higher rates of infection were related strongly to the more specific issue of overcrowding in households.[110] They thus suggest that in addition to potential biological factors, the unexplained disproportionate impact on BAME communities demands that a 'more comprehensive assessment of the complex economic, social and behavioural differences should be prioritised'.[111]

C. Institutions

The disproportionate impact of COVID-19 on residents of long term care facilities has been observed in many countries. This includes countries that were acknowledged as having done well to tackle the spread of the virus in the early stages of the pandemic. In early research considering international data, many countries reported rates of deaths of long term care residents at between 20-50% of all COVID-19 deaths. While some countries reported a low proportion of deaths in aged care – Singapore, for example, recorded a rate of 11% - others, such as Slovenia, were as high as 81%.[112]

In terms of UK specific data, analysis from the International Long-Term Care Policy Network found that in England and Wales up to 12 June 2020, there were 19,700 deaths of care home residents related to COVID-19 (not all occurring in the actual care home), which was 41% of all COVID-19 related deaths in England and Wales.[113] This meant that from March-June 2020, 5.3% of all home care residents in England and Wales died in relation to COVID-19.[114] Of these, almost half had an underlying condition of Alzheimer's or dementia (49.5%).[115] In both England and Wales, the rate of death for residents over 85 in care was higher than for the same age group outside of care homes; in England it was 6.2 times higher and in Wales 4.7 times higher.[116] In another study by the ONS, care residents in London were the most impacted by COVID-19, with higher case rates than other areas; whereas residential care *staff* were more impacted in regions outside London, particularly North East, Yorkshire

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[108] Noting this, see S Yaya et al, 'Ethnic and racial disparities in COVID-19-related deaths: Counting the trees, hiding the forest' (2020) 5(6) BMJ Global Health e002913 <https://doi.org/10.1136/bmjgh-2020-002913> accessed 7 July 2021.

[109] Raisi-Estabragh et al (n 102).

[110] See also CA Martin et al, 'Socio-demographic heterogeneity in the prevalence of COVID-19 during lockdown is associated with ethnicity and household size: Results from an observational cohort study' (2020) 25 EClinicalMedicine 100466 <https://doi.org/10.1016/j.eclinm.2020.100466> accessed 7 July 2021.

[111] Raisi-Estabragh et al (n 102).

[112] A Comas-Herrera et al, 'Mortality associated with COVID-19 outbreaks in care homes: Early international evidence' (International Long-Term Care Policy Network, 2020) 1.

[113] *Ibid* 15.

[114] *Ibid* 21.

[115] ONS, 'Deaths involving COVID-19 in the care sector, England and Wales: deaths occurring up to 12 June 2020 and registered up to 20 June 2020 (provisional)' (2020) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/deathsinvolvingcovid19inthecaresectorenglandandwales/deathsoccurringupto12june2020andregisteredupto20june2020provisional> accessed 7 July 2021. In contrast, the most common underlying condition for males not in residential care was Ischemic heart disease.

[116] *Ibid*.

and the Humber.[117] Among the 9,081 care homes studied, it was estimated that 10.7% of care home residents and 6.7% of care home staff had tested positive for COVID-19. While much attention has been focused on the fact care home residents are generally older members of the population, it should be acknowledged that disability was also a risk factor for the worst outcomes from infection. People with intellectual disabilities in long term care had a higher risk of death that residents without disabilities.[118] Janet Anand and colleagues argue that the most damaging consequences of the pandemic have fallen disproportionately on people living in care homes, reflecting a number of systemic human rights failings.[119]

D. *Gender*

In coming to gender as the fourth category in this account of how inequality shaped the trajectory of the virus and its impacts in the first year of the pandemic (2020-21), the intention is to highlight how gender is a risk factor in the experience of health inequalities and how it intersects with socio-economic class and race to amplify inequalities. As Sarah Hawkes and colleagues note on the launch of the *Lancet* Commission on Gender and Global Health in 2020:

> Gender inequalities drive inequities in health and well-being…. [G]ender interacts with, and frequently amplifies, other inequalities such as race or poverty in shaping our entire life experience. The global goal of equality on the basis of gender is an integral part of other global struggles for inclusive, rights-based, respectful, equitable systems, structures, and communities.[120]

Focusing on the question of how gender intersects with other factors and returning to the analysis in the preceding sections, women constitute a higher proportion of care home residents.[121] Care home residents are a population with high levels of chronic conditions, which were implicated in higher mortality rates from the virus.[122] Not only do women constitute a higher proportion of aged care residents – and indeed users of care services more generally – they also dominate the workforce across care services, particularly in lower paid sectors. Women represent nearly three-fifths of all key workers and are employed in

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[117] Office for National Statistics, 'Impact of coronavirus in Care Homes in England (Vivaldi): 26 May to 19 June 2020' (2020) <https://www.ons.gov.uk/releases/impactofcoronavirusincarehomesinenglandvivaldi26mayto19june2020> accessed 7 July 2021.

[118] JR Glynn, K Fielding, and T Shakespeare, 'COVID-19: excess all-cause mortality in domiciliary care' (2020) 370 BMJ: m2751. It is also worth noting that people with disabilities also experienced a higher risk of death outside of care homes. Learning Disabilities Mortality Review (LeDeR) Programme. Deaths of people with learning disabilities from COVID-19 (Bristol: University of Bristol, 2020). See, more generally, T Shakespeare, F Ndagire, and QE Seketi, 'Triple jeopardy: Disabled people and the COVID-19 pandemic' (2021) 397 The Lancet 1331.

[119] JC Anand, S Donnelly, A Milne, H Nelson-Becker, E-L Vingare, B Deusdad, G Cellini, R-L Kinni and C Pregno 'The covid-19 pandemic and care homes for older people in Europe - deaths, damage and violations of human rights' (2021) *European Journal of Social Work*, DOI: 10.1080/13691457.2021.1954886

[120] S Hawkes et al, 'The *Lancet* Commission on Gender and Global Health' (2020) 396 The Lancet 521.

[121] *Ibid* 522.

[122] WHO, 'Preventing and managing COVID-19 across long-term care services' (WHO, 2020) 4 <https://www.who.int/publications/i/item/WHO-2019-nCoV-Policy_Brief-Long-term_Care-2020.1> accessed 7 July 2021.

particularly high proportions in education and childcare (81% in both).[123] Women are also 126% more likely to work for the NHS than men, and, across all fields, report that their work involves 'very close' physical contact with other people - 13% more often than men.[124] Thus, women were more readily exposed to the virus - as residents, or service users, or as key workers in high risk environments. This may also intersect with race as a risk factor for the virus. As WHO summarised in terms of women's precarious position as the virus spread:

> [W]omen, especially older women, represent the highest share of people who use care services, dominate the long-term care workforce, and are the main providers of family care. In addition, long-term care services often depend heavily on migrant workers and workers from ethnic groups, who may be at higher risk.[125]

It should also be noted that disability was an increased risk factor for death from COVID-19 with women with disabilities having a higher mortality rate than men. In 2020, risk of death in England was 3.1 times greater for men with disabilities and 3.5 times higher for women with disabilities.[126] Moving beyond the question of gendered risks and COVID-19, Alicia Ely Yamin directs attention to the disproportionate impacts of government policy in response to the pandemic:

> [T]he impacts of government responses are not equally distributed. Women suffer disproportionately from displacement of other services, such as reproductive health care, as well as from indirect effects. They bear the greatest burden of care in most societies, both within families and in wider society, and are disproportionately affected when serious social disruption occurs. And women are overwhelmingly the victims of the 'shadow pandemic' of domestic violence, as millions find themselves confined with their abusers.[127]

Substantiating Yamin's claims, 36% of women reported feeling 'unsure' as to how to access contraception during the first year of the pandemic and 14% of those who tried to access contraception said that there were no appointments available in their area, as general practitioners cancelled 'non-urgent' appointments.[128] And in a different context, the unprecedented labour market disruptions have resulted in the rearrangement of domestic labour amongst household members. In mixed gender households, women have been one and half times more likely to lose their jobs than men and this has caused their absolute time

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[123] ONS, 'Coronavirus and key workers in the UK' (2020) <https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/coronavirusandkeyworkersintheuk/2020-05-15> accessed 7 July 2021.

[124] S Oreffice and C Quintana-Domeque, 'Gender Inequality in COVID-19 Times: Evidence from UK Prolific Participants' (Institute of Labor Economics: Bonn, Germany, 2020).

[125] *Ibid.*

[126] ONS, Updated estimates of coronavirus (COVID-19) related deaths by disability status January to 20 November 2020 (London: Office for National Statistics, 2021).

[127] AE Yamin, 'A wake-up call in our upside-down world: Three starting-points for advancing health rights and social justice in a post-pandemic future' (2020) 12 Journal of Human Rights Practice 1, 2.

[128] Marie Stopes International, 'More than a third of UK women unsure how to access contraception during COVID-19' (2020) <https://www.msichoices.org.uk/news/press-release-more-than-a-third-of-uk-women-unsure-how-to-access-contraception-during-covid-19/#_edn8> accessed 21 December 2020.

spent on caring and domestic labour to increase.[129] Finally, during the first week of lockdown, calls to a national domestic violence helpline rose by 25%.[130]

VI. LEGAL DETERMINANTS OF HEALTH: FAIRNESS AND SOCIAL JUSTICE

The differential impacts of COVID-19 should focus attention on health inequalities and their origins in compounded social injustices: 'COVID-19 is in reality a social x-ray that illuminates the fragmentation and social inequalities within and between societies'.[131] The trajectory of the pandemic in 2020 and since, adds acutely to calls to address the inequalities that shape the social injustice of health inequality. As Coggon notes, 'health inequalities serve as indicators of points of deep social injustice through compounded, socially determined disadvantage'.[132] In this context, it is useful to return to Sen and his injunction that we should not seek an absolute and hermetic definition of justice or injustice; rather, 'the idea of justice' should be sufficient and our efforts should be expended on addressing injustices that we are readily able to identify without complex theoretical or procedural scaffolding.[133] Thus, Sen cautions against 'transcendental institutionalism'; that is, the pursuit of perfection in the theoretical and political architecture we may seek to instantiate to address social justice.[134] In the current context, this can translate to the argument that rather than debating the exact configuration and emphasis of LDH, we should look to mobilise law to most effectively address social inequalities. Such an approach was adopted by the *Lancet* Commission on Gender and Global Health that directly followed the *Lancet*-O'Neill Commission's report. Here, the *Lancet* Commission made the important observation that: 'For change to happen, academic evidence is necessary but insufficient: the world does not need another report on the evidence and extent of a so-called gender problem in health'.[135]

Recognising that the reach of global health and law is 'potentially vast', the *Lancet*-O'Neill Commission aim to 'enunciate core legal concepts, building the case for the value of law in global health'.[136] Here, the Commission acknowledges that to address health equity we must move beyond traditional biomedical definitions and approaches to health and health care. Yet, the Report's strong focus on the legal mechanisms necessary to establish health infrastructure, regulate services and evidence-based interventions, nevertheless steers the focus back to biomedical approaches and the health care systems they are delivered through. This focus also sits uneasily with the long standing claim that population level health improvements have been driven less by clinical medicine than by factors such as improvements in sanitation, housing, environmental safety, and nutrition; that is, the domains of public health.[137] Thus, while it is stated that the *Lancet*-O'Neill Commission's four legal determinants 'show the key pathways through which law can powerfully influence global

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[129] A Andrew et al, 'How are mothers and fathers balancing work and family under lockdown?' (Institute for Fiscal Studies, Briefing Note BN290, 2020) <https://ifs.org.uk/publications/14860> accessed 7 July 2021.
[130] J Kelly and T Morgan, 'Coronavirus: Domestic Abuse Calls up 25% Since Lockdown, Charity Says' (BBC News, 2020) <https://www.bbc.co.uk/news/uk-52157620> accessed 21 December 2020.
[131] *Ibid*.
[132] Coggon (n 3) 36.
[133] A Sen, *The Idea of Justice* (Harvard University Press, 2009).
[134] *Ibid*. 5.
[135] Hawkes et al (n 120) 522.
[136] *Ibid*.
[137] T McKeown, *The Role of Medicine: Drama, Mirage or Nemesis?* (Blackwell: Oxford, 1979); A Ostry and J Frank, 'Was Thomas McKeown right for the wrong reasons?' (2010) 20(2) Critical Public Health 233.

health',[138] it is unclear that the wider SDH data supports this assertion. Rather, such work emphatically directs us to consider the role of law in improving the broader societal conditions for good health.

In their response to the *Lancet*-O'Neill Commission, Ashley Schram and colleagues note that at the core of the Report is the 'naming of three functions of law and four legal determinants'.[139] While they provide a compelling account of the importance of legal capacity through the example of health justice partnerships, they otherwise sidestep the other identified legal determinants. Rather, their focus is on the functions of law and the need for a greater integration of law into the existing SDH framework. The three functions of law they identify as articulated in the Commission's work are (i) governing public and private institutions, (ii) establishing norms and standards that guide conduct, and (iii) resolving disputes. The first and last of these are the technocratic functions that are most commonly associated with law and feature in the 'infrastructure health law'[140] centred through the identified determinants. It is, however, the second function that enables law to most directly respond to SDH findings and so address inequalities in social determinants. This is acknowledged when the *Lancet*-O'Neill Commission state that by 'creating and implementing social norms and redistributing resources',[141] law can tackle health inequalities and create the conditions to improve the public's health. In bringing together social norms and redistribution, the Commission emphasises the central place of realising equality norms in addressing health inequalities. Here, it is worth drawing attention to the weight that is placed on redistribution and income in the Commission's articulation of the possibilities of law:

> Examples of the power of law to affect the social determinants of health include social welfare and income support programmes; market regulations that enhance income and agency for workers (minimum wages, paid sick leave or family leave); protection of union and labour rights; redistribution policies, such as pre-tax limits on compensation levels, progressive taxation, and negative income taxes; nutrition policies, such as subsidising healthy foods and restricting unhealthy foods in school lunches; consumer protection; and occupational health and safety regulations.[142]

As such, while the importance of income and socio-economic factors are acknowledged, and the many ways law can be employed to address aspects of inequality through improving income and redistribution is highlighted, this does not follow through to the four determinants that are identified as a blueprint for action. This happens notwithstanding the fact that income is the single best indicator of living conditions and directly impacts health via 'the conversion of money and assets into health enhancing commodities and services.'[143] Returning to the considerations in the preceding section, income has clearly had a determining effect on the differential impacts of COVID-19. Those on the lowest incomes faced the highest risk of transmission through overcrowded housing, employment in essential occupations, and reliance on public transport. At the same time, those on the lowest incomes had higher rates

[138] Kaldor et al (n 14) 10.
[139] Schram et al (n 22) 906-7.
[140] Burris (n 30) 1661.
[141] Gostin et al (n 15) 1883.
[142] *Ibid*.
[143] O Solar and A Irwin, 'A conceptual framework for action on the social determinants of health' (2010) Social Determinants of Health Discussion Paper 2 (Policy and Practice) 1, 30.

of comorbidities, such as diabetes, obesity, hypertension, and cardiovascular diseases, which are risk factors for hospitalisation and death.[144]

Several methods for income redistribution and support are highlighted in the *Lancet*-O'Neill Commission Report. Here, it is worth briefly considering the most basic forms and how they have been adopted in health equity strategies. Unconditional Cash Transfers (UCT) and Universal Basic Income (UBI) have both been identified as generating significant public health gains. UCT are directed at reducing poverty, primarily in low and middle income countries, and come without the conditions that are sometimes imposed on recipients of other interventions (for example, school attendance). UCT and UBI can be characterised as a form of social protection intervention that addresses income as a key social determinant of health. A systematic review of the health impact of UCT found that transfers lead to a significant and clinically meaningful reduction in the likelihood of being sick by an estimated 27%.[145] UCT may also improve food security and nutrition.[146] Additionally, children in recipient families attend school at higher rates, and these families may spend more on health care.[147]

UBI is a form of unconditional transfer, but, as the name indicates, it is universal in its design. While basic income measures have long been advocated as an important potential policy intervention,[148] austerity policies and changing global work patterns (particularly increasing employment precarity) have strengthened justifications for this intervention. As WHO noted at its 2019 Strategic Meeting on Social Determinants of Health, health equity is supported by 'good design and high coverage' of welfare, economic security, and social protection policies.[149] Changing conditions have undermined existing designs – exacerbating old flaws and introducing new ones.[150] UBI presents a possible solution: 'Evidence shows positive impacts of UBI on fertility, nutrition, and school enrolment, and mental health and well-being'.[151] Given these impacts, UBI - along with other unconditional measures and access to services - is interpreted as an opportunity to reinvent health policy with a focus on the design of policy that advances health equity.[152]

These relatively simple examples bring together the key lessons learnt from work on SDH that are further substantiated by data from COVID-19. They also highlight the importance of a public health rather than health care approach to health inequalities. In turning to UCT and UBI, the suggestion is not that these are the most appropriate or sole focus as we consider the need to orientate LDH in the most effective direction. Rather, they are examples of how law and policy can address fairness in social arrangements and the distribution of resources with positive health impacts.[153] Here, these illustrative examples highlight the importance of

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[144] Rose et al (n 83).

[145] F Pega et al, 'Unconditional cash transfers for reducing poverty and vulnerabilities: effect on use of health services and health outcomes in low- and middle-income countries' (2017) 11(4) Cochrane Database of Systematic Reviews CD011135.

[146] Ibid

[147] Ibid.

[148] See Basic Income Earth Network (BIEN) <www.basicincome.org> accessed 7 July 2021.

[149] WHO, 'WHO Strategic Meeting on Social Determinants of Health: Final Meeting Summary' (WHO: Geneva, 2020). See also presentation slides by L Haagh, 'Basic income, health constitution and governance coherence for human development' (2019) <https://www.who.int/social_determinants/6_Haagh_Basic-income-health-constitution-governance-coherence.pdf?ua=1> accessed 7 July 2021.

[150] See L Haagh and Rohregger, 'Universal Basic Income Policies and their Potential for Addressing Health Inequities' (WHO: Geneva, 2019); L Haagh, 'The Case for Universal Basic Income' (Polity: Cambridge, 2019).

[151] WHO (n 149).

[152] Haagh (n 149).

[153] See also Karpin and O'Connell (n 80).

income and how law and policy may support this. There are, however, a number of points to make in this context. First, it is worth remembering that the SDH research points not just to the impact of poverty and low income on health, but to wealth inequality more generally. This supports calls for legal interventions to limit income inequalities and the accumulation of wealth, including proposals for a maximum wage,[154] or for limiting relative earnings.[155] Furthermore, while redistributive policies are undoubtedly important, and have clear benefits in terms of what is political achievable, others argue that such policies will have limited impact on population level health improvement and health equity without addressing the national and global economic systems that enable poverty and inequalities.[156] On both of these points, it should be noted that between March and September 2020 – at the height of the first wave of the virus - the wealth of the United States 643 billionaires increased by 29%[157] At the same time, the hourly pay of the bottom 80% reduced by 4%. While it is important to be cognisant of these factors, we must also acknowledge the role that addressing poverty has in health improvement, and the legal mechanisms that can be mobilised to this end.

It would, however, be a mistake to promote law as a panacea. In this section I have provided some examples of legal interventions that could address socio-economic disadvantage. In the context of COVID-19, this has been a risk factor for exposure to the virus, severity of disease, and the poorest outcomes. Policies to tackle socio-economic disadvantage will also benefit BAME populations and women who are overrepresented at the lowest income levels. Some of the issues around care homes and other institutions can also be addressed by redistributive policies. Yet, the groups that have provided the focus for this analysis are also disadvantaged by practices that are less easily reached by law when we acknowledge the multi-dimensional nature of inequality.[158] The health inequalities experienced globally by women and girls, for example, are often the result of cultural practices and norms (feeding male children first, removal of girls from education, gendered violence, and so forth). Similarly, the pandemic has drawn attention to health inequalities experienced by people of colour. As Sanni Yaya and colleagues observe, the pandemic has 'illuminated a disturbing and inconvenient truth: the "colour of health" and how ethnoracialised differences in health outcomes have become the new normal across the world'.[159] While income is implicated in this, we must also ask *why* BAME groups are overrepresented in the lowest income groups and every other measurement of disadvantage.

In 2020, the Institute of Health Equity published, *Build Back Fairer: The COVID-19 Marmot Review. The Pandemic, Socioeconomic and Health Inequalities in England*.[160] This report

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[154] Oxfam Australia, 'When is enough enough? The question of a maximum wage' (2012) <https://www.oxfam.org.au/2012/03/when-is-enough-enough-the-question-of-a-maximum-wage/> accessed 7 July 2021.

[155] G Monbiot, 'Only a maximum wage can end the great pay robbery' (The Guardian, 2012) <https://www.theguardian.com/commentisfree/2012/jan/23/george-monbiot-executive-pay-robbery> accessed 7 July 2021.

[156] G MacNaughton, 'Is economic inequality a violation of human rights?' in M Davis and others (eds), *Research handbook on human rights and poverty* (Edward Elgar Press, 2021) 53; G MacNaughton, 'Equality rights beyond neoliberal constraints' in G MacNaughton and DF Frey (eds), *Economic and social rights in a neoliberal world* (Cambridge University Press, 2018) 103.

[157] Marmot et al (n 25), 196.

[158] See S Fredman, 'Substantive equality revisited' (2016) 14(3) International Journal of Constitutional Law 712.

[159] S. Yaya, H. Yeboah, C.H. Charles, A. Out, and R. Labonte, 'Ethnic and racial disparities in COVID-19 deaths: Counting the trees, hiding the forest' *BMJ Global Health* 2020 5(6) https://gh.bmj.com/content/5/6/e002913.full

[160] Marmot et al (n 25).

provides a detailed analysis of the impact of the pandemic across the social determinants of health, and health. This is done as 'a first step to achieving a more important goal: to build back fairer'.[161] In responding to the 'shockingly' disproportionate burden of COVID-19 on BAME groups,[162] the Report directs us to consider the 'causes of the causes'.[163] As it states, it is 'structural racism that means minority ethnic groups suffer from disadvantage in each of the social determinants'.[164] This highlights 'the overwhelming need to deal with … racism in combatting the social determinants of health inequalities'.[165] While race is often a focus for SDH research, racism has not been a central concern.[166] This may reflect the tendency whereby, '"social determinants" almost always turns out to mean "socioeconomic determinants"'.[167] Addressing the 'causes of the causes' is a challenge to both SDH researchers and law. While law can attempt to address discrimination on the grounds of race and ethnicity, it is clear that this has had limited impact, and, indeed, law and its institutions can be the sites of the most damaging experiences of racism. Addressing structural racism demands a broader and shared reparatory politics.[168] Law is a key mechanism in addressing SDH, but a more fundamental commitment to fairness and social justice - a responsibility of all to all - is needed.

VII. CONCLUSIONS

The *Lancet*-O'Neill Commission is an important intervention in debates around health inequalities. As the Commission states, law is a 'key determinant of health',[169] as well as at times a 'formidable barrier' to health, health justice and health equity.[170] Employing the language of determinants, the Commission positions its work as emerging from scholarship on SDH, a concept and political movement that is supported by a compelling and growing body of empirical and theoretical research. As the Commission acknowledges, however, 'Despite this, international institutions … and governments have not devoted the attention and resources needed to address the social determinants of health'.[171] In response, they claim that law is a tool that is well placed to provoke change. It is 'highly effective in defining and operationalising government action. By creating and implementing social norms and redistributing resources, law can create the conditions for the public's health'.[172] The Report does the important work of moving debate 'beyond a narrow concept of "law as umpire", to understand how law affects health in multiple ways'.[173]

Members of the Commission have argued that the challenge for public health lawyers is to 'articulate a coherent and, importantly, *actionable* vision of how law can advance the vision

[161] Ibid., at 195.
[162] Ibid., at 7.
[163] Ibid.
[164] Ibid.
[165] Ibid.
[166] R, Yearby, 'Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause' (2020) 48(3) *Journal of Law, Medicine & Ethics* 518.
[167] D. Ingleby, 'Ethnicity, Migration and the "Social Determinants of Health" Agenda' (2012) 21 *Psychosocial Intervention* 331, 332.
[168] J Torpey, *Making Whole What Has Been Smashed: On Reparations Politics* (Harvard University Press, 2006).
[169] Gostin et al (n 15) 1859.
[170] *Ibid.*
[171] *Ibid.*, 1884.
[172] *Ibid.*
[173] Kaldor et al (n 14) 11.

of global public health with justice'.[174] In this article I have addressed the concern that the four determinants identified in the Report will become the focus for subsequent discussion of the authoritative Report and, therefore, perhaps what is more widely understood as the appropriate parameters of law in this context. The focus on health care provision and governance will do less to advance health with justice than a focus on underlying inequalities. While the identified LDH are without doubt important, I argue that we need a focus on legal determinants that more directly address inequalities and challenge the 'power asymmetries that cause patterns of ill health and health inequities'.[175] Health outcomes are determined by the 'conditions in which people are born, grow, live, work, and age, and the inequities in power, money, and resources'.[176] The more control people are able to exercise over their lives - the more meaningful opportunities that exist - the better the health of individuals and groups.[177] I argue that laws and policies that extend control and choice, such as those that secure rights to education, income, affiliation and so forth, are the LDH that we must promote as a priority.

COVID-19 continues to have a disproportionate impact on the most disadvantaged globally, including in jurisdictions with established health and legal systems. As *The COVID-19 Marmot Review* stated, 'this pandemic exposes the underlying inequalities in society and amplifies them'.[178] Philip Alston, the former UN Special Rapporteur on Extreme Poverty and Human Rights, cautions that inadequate responses to the pandemic are likely to push more than half a billion into poverty and potentially starvation globally.[179] Sarah Hawkes and colleagues note that 'The world's community is not on track to meet the Sustainable Development Goals for health and for gender equality' and that COVID-19 could 'widen the gaps'.[180] As we have seen, pandemics are 'amplifiers, not levellers'.[181] While the pandemic has amplified disadvantages, it may also amplify calls for change, focusing attention on the link between social and health inequalities. It can also help us to imagine and articulate a fairer post-pandemic world. Law has an essential role in helping to delivering that fairer future, nationally and globally. This must include mobilising law to address inequalities in social determinants, including income, education, and housing. Nevertheless, it is only one aspect of the change needed for greater health equity and social justice.

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[174] *Ibid* 10.
[175] Williams and Hunt (n 56) 1784.
[176] Marmot (n 7).
[177] Marmot (n 25).
[178] *Ibid*. at 5.
[179] P Alston, 'Responses to COVID-19 are failing people in poverty worldwide' (United Nations Human Rights, Office of the High Commissioner: Geneva, 2020) <www.ohchr.org/en/newsevents/pages/displaynews.aspx?NewsID=25815> accessed 7 July 2021.
[180] *Ibid*.
[181] L Clements, *Clustered Injustice and the Level Green* (Legal Action Group, 2020) 8.