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A reparatory account of health inequities

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ABSTRACT

Colonialism has left biological and social legacies that damage health. The resulting racialized health inequities re-enact past harms and are a profound social injustice. In response, this article brings together reparatory justice and health equity. Understandings of reparatory justice have evolved from a focus on compensation for past wrongs to the need for a more sustained and expansive politics of repair. This seeks to recognize the history and legacies of harm while diminishing the likelihood that such harms are repeated. Addressing racialized health inequities in the UK, and working with this articulation of reparatory justice, this article argues for the repair of bodies that continue to be damaged by historically rooted harms. Social determinants of health research has long linked socioeconomic inequalities to poor health outcomes, and promoting health equity by addressing these inequalities can be an important element of the work to repair the past. This response acknowledges the moral case for both reparatory justice and health equity, while potentially addressing problems faced by traditionally articulated reparatory claims. Finally, exploring law's role in addressing racialized health inequities can help us better understand how law is a determinant of health and its role in advancing health equity.

KEYWORDS: colonialism; health inequities; health equity; legal determinants of health; racism; reparations

I. INTRODUCTION

Calls for reparations for historic abuses have grown globally over the last two decades as the need to come to terms with the past and address its enduring legacies has become more urgent.[1] This renewed interest has been strengthened by the unmet promise of racial and gender equality,[2] as well as the success of key interventions by academics and activists.[3] The UK has a long and particular history of reparatory discourses, particularly in the context of

[1] Catherine Hall, 'Doing Reparatory History: Bringing "Race" and Slavery Home' (2018) 60 Race & Class 3, 7–8.
[2] John Torpey, *Making Whole What Has Been Smashed: On Reparations Politics* (Rutgers University Press 2017).
[3] See, eg, Ta-Nehisi Coates, 'The Case for Reparations' *The Atlantic* (Washington DC, June 2014) and the global impact of the Black Lives Matter movement.

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slavery, the paradigm issue within reparation debates. Here reparations were first considered at a national level in the 1820s when the British Parliament debated and rejected a proposal calling for Caribbean colonies to receive compensation for the enslavement of their peoples.[4] A decade later, however, reparations were a successful part of the Slavery Abolition Act 1833, although it was slave owners who were compensated. Payments were made according to the productivity and perceived value of enslaved people.[5] This was combined with 'apprenticeships' that tied freed men and women to work unpaid for their former owners for between 4 and 6 years.[6] The final cost of the compensation was £20 million—equivalent to approximately £16 billion in 2024—and was an estimated 40 per cent of the national budget at the time.[7] It was only repaid in full by the UK government in 2015.[8]

Modern Britain is founded upon, and shaped by, slave ownership.[9] This is through the wealth accumulated by virtue of slave labour, as well as the reparations paid under Lord Wilberforce's Act.[10] This compensation was dispersed by its many recipients across economic, political, and cultural activities.[11] It was also deployed in the colonization of new territories,[12] deepening the relationship between slavery and the wider projects of colonialism and Empire. In tracing the monies paid, the Centre for the Study of the Legacies of British Slavery has created a contemporary census of approximately 61,000 individuals whose financial legacies can be traced throughout Britain's modern history.[13] This work to make visible again slave ownership attempts to address the erasure of Britain's historical—and modern—reliance on slavery.[14] Importantly, uncovering the contemporary legacies of wealth generated by slave ownership directs attention to the very different legacies experienced by the descendants of those who experienced enslavement and other practices of colonialism. In contrast to the immediate payments to slave owners, the question of reparations for the harms caused and entrenched by these historic abuses has been less easily resolved.[15] Indeed, state-based reparations continue to be fiercely contested, even as the idea of what reparations might look like in the twenty-first century evolves. This article responds to the need for reparations and argues for action to address racialized health inequities, which are identified as an enduring legacy of British colonial history and one of the means by which the UK may start to address the past.

Chattel slavery was a distinct economic and political practice and has been recognized as a crime against humanity.[16] While it is essential to acknowledge this, slavery was a stage of

4 Hillary Beckles, 'The Reparation Movement: Greatest Political Tide of the Twenty-first Century' (2019) 68 Social and Economic Studies 11, 18.

5 Hall (n 1); Catherine Hall, 'Britain's Massive Debt to Slavery' *The Guardian* (London, 27 February 2013) <https://www.theguardian.com/commentisfree/2013/feb/27/britain-debt-slavery-made-public> accessed 14 July 2024.

6 This was designed to account for the difference between the £20 million that the British Government was willing to pay and the estimated £47 million replacement value of the 600,000 Black slaves in the British Caribbean: Beckles (n 4) 24.

7 Jo Harper, 'Britain, Slavery and Unfinished Business' *DW* (Berlin,17 June 2020).

8 Emma Christopher and others, 'No Slavery in Australia? The Dark Legacies of Slave Ownership Persist Long After Abolition' *ABC Religion & Ethics* (Sydney, 8 October 2020) <https://www.abc.net.au/religion/australia-and-the-dark-legacy-of-slave-ownership/12744288> accessed 14 July 2024.

9 Hall (n 1); Catherine Hall, 'The Racist Ideas of Slave Owners are Still With Us Today' *The Guardian* (London, 27 September 2016).

10 Peter Fryer, *Staying Power: The History of Black People in Britain* (Pluto Press 2018).

11 Catherine Hall, 'The Slavery Business and the Making of "Race" in Britain and the Caribbean' (2020) 61 Current Anthropology S172, S172.

12 ibid.

13 University College London Department of History, *The Centre for the Study of the Legacies of British Slavery* (University College London 2024) <www.ucl.ac.uk/lbs> accessed 14 July 2024.

14 Harper (n 7); Hall (n 5).

15 Hilary Beckles, *Britain's Black Debt: Reparations for Caribbean Slavery and Native Genocide* (University of the West Indies Press 2013).

16 As Beckles (n 4) 17 argues: 'For centuries, enslaved Africans were denied their right to be human. There has been no greater crime. The chattel model began as a calculated business proposition. Profit maximization was its financial calculation.

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colonialism, allowing colonizers to address labour shortages as well as simultaneously extending markets for products.[17] Western Europe's historically unprecedented growth between 1500 and 1800 can be 'almost entirely' explained by access to the Atlantic economy, which was enabled by both the trafficking of enslaved Africans and participation in markets sustained by colonial conquest.[18] These economic and political processes cannot be separated from each other or divorced from the present. As Olúfẹ́mi Táíwò notes, 'slavery and colonialism built the world we live in',[19] and 'the patterns in how advantage and disadvantage flow have changed very little'.[20] This understanding has seen calls for reparatory action increasingly bring together slavery and colonialism. This responds not just to their interrelationship, shared logics, and how capital, people, and technologies moved across the geographies of colonialism,[21] but also how they have been instrumental in the formation of the modern world order,[22] and, to return to Táíwò, the 'global racial empire'.[23] As he writes, this is a 'system of distribution, explaining where social advantages and disadvantages are made and how much of those social advantages and disadvantages different people and places get'.[24] In the UK, as elsewhere, this has created enduring racially codified economic and social inequalities.[25] These, in turn, have resulted in enduring racialized health inequities. While our knowledge of such inequities is longstanding, COVID-19 brought them to the fore and into wider public knowledge. As Yaya and others observe, the pandemic has 'illuminated a disturbing and inconvenient truth: the "colour of health" and how ethnoracialized differences in health outcomes have become the new normal across the world'.[26] It is addressing the 'colour of health' inequities in the UK as part of a process of reparation for colonialism that is the focus of this article.

While calls for state-based reparations grow, reparatory discourses have—for some—moved from a focus on a singular payment in compensation for a past wrong to the need for a more sustained and expansive politics of repair. Acknowledging this, I argue that addressing racialized health inequities can be an important element of the work to repair past wrongs. Early abolitionists focused on undoing the harms inflicted on the bodies of enslaved people.[27] Prefiguring embodied accounts of justice that emerged towards the end of the twentieth century,[28] many abolitionists articulated and campaigned for liberty in embodied

The denial of African human identity was unique, a unique and seminal development. The consequences of this denial was race hatred and brutality, as well as genocidal attitudes about enslavement. No other race has ever been subjected and degraded to the non-human form of chattel.'

[17] Olúfẹ́mi Táíwò, *Reconsidering Reparations* (Oxford University Press 2022) 44–49.

[18] Daron Acemoglu, Simon Johnson, and James Robinson, 'The Rise of Europe: Atlantic Trade, Institutional Change, and Economic Growth' (2005) 95 The American Economic Review 546, 546–579.

[19] Táíwò (n 17) 1.

[20] ibid 75.

[21] Anaïs EA Goubert, 'Slavery, Colonialism, and Ecological Imperialism: Insights from Stratification Economics' (2022) 81 American Journal of Economics and Sociology 537.

[22] Amitav Acharya, 'Race and Racism in the Founding of the Modern World Order' (2022) 98 International Affairs 23.

[23] Táíwò (n 17) 10.

[24] ibid.

[25] David Wilkins, 'Understanding Historical Slavery, its Legacies, and its Lessons for Combating Modern-day Slavery and Human Trafficking' in John Winterdyk and Jackie Jones (eds), *The Palgrave International Handbook of Human Trafficking* (Palgrave Macmillan 2019) 8.

[26] Sanni Yaya and others, 'Ethnic and Racial Disparities in COVID-19 Deaths: Counting the Trees, Hiding the Forest' (2020) 5 BMJ Global Health <https://gh.bmj.com/content/5/6/e002913.full> accessed 14 July 2024. This was also acknowledged in Michael Marmot and others, *Build Back Fairer: The COVID-19 Marmot Review. The Pandemic, Socioeconomic and Health Inequalities in England* (Institute of Health Equity 2020) 7: '[P]ersistent ethnic health disparities have been well known for many decades, but often systematically ignored … . COVID-19 exposes, once more, the racial fault lines that have been the norm in many countries' health systems, and social and economic policies.'

[27] Kathleen Brown, *Undoing Slavery: Bodies, Race, and Rights in the Age of Abolition* (University of Pennsylvania Press 2023).

[28] Sam Lewis and Michael Thomson, 'Social Bodies and Social Justice' (2019) 15 International Journal of Law in Context 344.

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terms.[29] Contemporary racialized health inequities demonstrate both the importance of this focus and how the need to repair the body endures. It is argued that this reparatory work can be done by mobilizing social determinants of health (SDH) research, which has long linked social disadvantage to poor health and other outcomes.[30] As the World Health Organisation (WHO) explains, health is determined by 'the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life'.[31] The conditions of daily life create a health gradient that tracks improving health outcomes on a consistent and predictable slope, from those who have the least to those who have the most.[32] This gradient is raced, and an increasing body of work addresses the role of racism in driving inequalities in determinants of health.[33] Indeed, structural racism has been identified as a 'long-standing public health emergency',[34] and as the United Nations Secretary-General restated in 2023, slavery and colonialism 'are among the major sources of contemporary racism, racial discrimination, xenophobia and related intolerances'.[35]

This article provides a reparatory account of racialized health inequities in the UK in order to help 'address the ways in which injustices may be acknowledged and put right'.[36] SDH research highlights how addressing the conditions and inequalities of daily life promotes greater health and social justice. Universally available improvements in the determinants of health (in education, housing, nutrition, income, and so forth) acknowledge the complex histories and patterning of abuse, disadvantage, and need across different communities. It also recognizes the wider demands of reparation: 'If slavery and colonialism built the world and its current basic scheme of social injustice, the proper task of social justice is no smaller: it is, quite literally, to remake the world'.[37] In making the case for addressing health inequities as part of a reparatory programme, this article provides a framework for understanding and responding to racialized health inequities, creating a research agenda for public health disciplines in terms of designing effective and equitable implementation. Law is a key public health discipline, although it remains 'underutilised and poorly understood'.[38] This article joins a growing body of literature that responds to this, drawing law into the SDH framework. [39] In doing so, it clarifies our understanding of law as a determinant of health.

[29] Brown (n 27).

[30] Richard Wilkinson and Michael Marmot, *Social Determinants of Health: The Solid Facts* (2nd edn, World Health Organisation 2003); Michael Marmot, *The Status Syndrome: How Social Standing Affects Our Health and Longevity* (Owl Books 2004); World Health Organisation Commission on the Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (World Health Organisation 2008); Richard Wilkinson and Kate Pickett, *The Spirit Level* (Bloomsbury Publishing 2010).

[31] World Health Organisation ibid.

[32] Scott Burris, 'From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective' (2011) 159 University of Pennsylvania Law Review 1649, 1652.

[33] Ruqaiijah Yearby, 'Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause' (2020) 48 Journal of Law, Medicine & Ethics 518; David R Williams, Jourdyn A Lawrence, and Brigette A Davis, 'Racism and Health: Evidence and Needed Research' (2019) 40 Annual Review of Public Health 105.

[34] Naomi Priest and David R Williams, 'Structural Racism: A Call to Action for Health and Health Disparities Research' (2021) 31 Ethnicity & Disease 285, 286.

[35] Report of the Secretary-General, 'Implementation of the International Decade for People of African Descent' (18 August 2023) UNGA 78th Session (2023) UN Doc A/78/317, 3.

[36] Catherine Hall, 'There are British Businesses Built on Slavery: This is How we Make Amends' *The Guardian* (London, 23 June 2020) <https://www.theguardian.com/commentisfree/2020/jun/23/british-business-slave-trade-university-college-london-slave-owners> accessed 14 July 2024.

[37] Táíwò (n 17) 67.

[38] Lawrence O Gostin and others, 'The Legal Determinants of Health: Harnessing the Power of Law for Global Health and Sustainable Development' (2019) 393 Lancet 1857, 1857.

[39] Burris (n 32); Jenny C Kaldor and others, 'The Lancet-O'Neill/Georgetown University Commission on Global Health and Law: The Power of Law to Advance the Right to Health' (2020) 13 Public Health Ethics 9; Ashley Schram and others, 'Advancing Action on Health Equity Through a Sociolegal Model of Health' (2021) 99 Milbank Quarterly 904; Michael

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This reparatory account starts by providing a brief history of reparations, acknowledging that this is, in general, a history of failure.[40] It then addresses how reparations have come to be articulated differently, with the debate moving from a narrow focus on compensation to questions of repair and a broader reparatory politics.[41] Acknowledging early abolitionists' focus on the body and emergent ideas of embodied justice, the concept of health equity and the SDH research that links disadvantages experienced by different racial and ethnic populations to poor health outcomes are then introduced. This includes groups that have experienced different colonial practices, but where enduring poor health is a common legacy. The final section considers law and the work of repair. It addresses how a focus on racialized health inequities can add to conceptualizations of reparatory justice, as well as to our understanding of what is demanded when we articulate law as a determinant of health.

II. A HISTORY OF REPARATIONS

The question of reparations in the UK has been obscured by the Abolition of the Slave Trade Act 1807 and the Slavery Abolition Act 1833, which have allowed the country to focus on its role in ending slavery.[42] This has deflected attention from the nation's 250 years of slaving, its position as the largest slaving nation during this time, and the fact that it was responsible for the introduction of chattel slavery; that is, the denial of humanity to enslaved Black people.[43] While the focus of this article is the UK, this section—and indeed the argument more generally—draws on the development of calls for reparations and understandings of reparatory justice from across jurisdictions, most notably the USA. This recognizes not only the historical particularity of the UK and how this has limited engagement with reparatory discourses, but also the fact that 'slavery, colonialism, and the political structures they produced were and are global phenomena'.[44] As such, while jurisdictional particularities are important, they do not negate the relevance of reparatory work from elsewhere. Indeed, the interconnected global legacies of disadvantage have rightly provoked global visions of repair.[45]

In jurisdictions around the world, reparation campaigns have emerged within a variety of contexts, including slavery,[46] mistreatment of people with disabilities,[47] land rights,[48] wage

Thomson, 'Legal Determinants of Health' (2022) 30 Medical Law Review 610; John Coggon and Beth Kamunge-Kpodo, 'The Legal Determinants of Health (In)justice' (2022) 30 Medical Law Review 705; Lisa Montel, 'Social Determinants of Health, Human Rights, Law, and Urban Development' (2022) 30 Medical Law Review 680; Gostin and others (n 38); Michael Thomson, 'Law as a Determinant of Health: COVID-19 and Gender' in Linda McClain and Aziza Ahmed (eds), *Routledge Companion to Gender and COVID-19* (Routledge 2024).

[40] Kaimipono David Wenger, 'The Unconscionable Impossibility of Reparations for Slavery; or, Why the Master's Mules Will Never Dismantle the Master's House' in Anne Bloom, David Engel, and Michael McCann (eds), *Injury and Injustice: The Cultural Politics of Harm and Redress* (Cambridge University Press 2018) 249.

[41] Hall (n 1) 9.

[42] John Richard Oldfield, 'Repairing Historical Wrongs: Public History and Transatlantic Slavery' (2012) 21 Social & Legal Studies 243.

[43] ibid.

[44] Táíwò (n 17) 9–10.

[45] ibid.

[46] José Atiles-Osoria, 'Colonial State Crimes and the CARICOM Mobilizations for Reparation and Justice' (2018) 7 State Crime Journal 349; Max du Plessis, 'Historical Injustice and International Law: An Exploratory Discussion of Reparation for Slavery' (2003) 25 Human Rights Quarterly 624.

[47] Linda Steele and Kate Swaffer, 'Reparations for Harms Experienced in Residential Care' (2022) 24 Health and Human Rights Journal 71.

[48] Sangeetha Chandrashekeran, 'Rent and Reparation: How the Law Shapes Indigenous Opportunities from Large Renewable Energy Projects' (2021) 26 Local Environment 379; Arturo Arias, 'The Ghosts of the Past, Human Dignity, and the Collective Need for Reparation' (2010) 5 Latin American and Caribbean Ethnic Studies 207.

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control,[49] genocide,[50] sexual enslavement,[51] and acts of war.[52] In Europe, reparations are most commonly associated with the financial settlements paid by Germany, first in 1921 following World War I, and then the sum Germany agreed to pay at the World Jewish Congress in Israel in 1952. Successful examples have also arisen in postcolonial contexts. Reparations were made by the UK government in 2011, for example, to the families of individuals who had been murdered or detained following accusations of membership in the Mau Mau resistance in Kenya between 1952 and 1960.[53] While these provide examples of successful claims, they are far outweighed by those that have failed. In this vein, the attitude of successive UK governments towards the question of reparations for slavery has been characterized as dismissive.[54] As already noted, the earliest unsuccessful attempt at national-level reparations was in the 1820s.[55] The UK also debated and rejected various calls for reparations that formed part of the wave of independence campaigns from former colonized nations that marked the mid-twentieth century.[56]

In the last decade, calls for reparations have been buttressed by unrest and condemnation following a number of high-profile police killings of Black people in the USA, mobilization of publics around the world by the Black Lives Matter movement, and the racialized impacts of COVID-19[57]—that is, the ‘color of COVID’.[58] The effects have been felt globally, including the UK. In July 2020, Lambeth Council in London passed the first successful motion of its kind to formally demand reparations for slavery, calling on the UK government ‘to establish a commission to study the impact of UK involvement in the transatlantic trafficking of enslaved Africans and to make reparations’.[59] This commission would be an All-Party Parliamentary Commission of Inquiry for Truth and Reparatory Justice.[60] In March 2021, Bristol Council supported establishing such a commission, as well as advocating for the development of a reparations plan.[61]

While reparations for slavery have not been forthcoming at national level, some indirect and local initiatives can be identified. For instance, calls for the British Government to pay

49 Andrew Gunstone, ‘Indigenous Stolen Wages and Campaigns for Reparations in Victoria’ (2014) 8 Indigenous Law Bulletin 3.

50 Allan Cooper, ‘Reparations for the Herero Genocide: Defining the Limits of International Litigation’ (2007) 106 African Affairs 113.

51 E. Tammy Kim, ‘Performing Social Reparation: “Comfort Women” and the Path to Political Forgiveness’ (2006) 16 Women & Performance: A Journal of Feminist Theory 221.

52 Karl Keinz Roth, ‘German Reparation Debts after the Second World War—A Research Summary’ (2020) 48 Critique 133; Richard Buxbaum, ‘From Paris to London: The Legal History of European Reparation Claims: 1946-1953’ (2013) 31 Berkeley Journal of International Law 323.

53 For a critical response to the settlement, see Andrew Songa, ‘Reparations for Colonial Atrocities: The Case of the Mau Mau in Kenya’ (2014) 2 Pan-African Reparation Perspectives 2, 2–3.

54 Kuba Shand-Baptiste, ‘While the US Debate Heats Up, Why Won’t the UK Even Talk About Reparations for Slavery?’ *Independent* (London, 20 July 2019) <https://www.independent.co.uk/voices/reparations-us-slavery-african-americans-chuck-schumer-uk-david-cameron-a9008761.html> accessed 14 July 2024.

55 Beckles (n 4) 18.

56 ibid 21. The USA has a similarly long history of failed reparation claims. This started in 1865 when former slaves were initially promised 40 acres of land and a mule. Following the assassination of President Lincoln, this scheme was swiftly overturned by Andrew Johnson within months of its commencement. The sum of unpaid promises under this reparations scheme is now estimated to be $1.3 trillion USD: Kaimipono David Wenger, ‘1200 Dollars and a Mule: COVID-19, the CARES Act, and Reparations for Slavery’ (2020) 68 UCLA Law Review Discourse 204.

57 See, Audrey Chapman, ‘Rethinking the Issue of Reparations for Black Americans’ (2022) 36 Bioethics 235; Patricia Muhammad, ‘The U.S. Reparations Debate: Where Do We Go from Here?’ (2020) 44 Harbinger 43.

58 Catherine Powell, ‘Color of Covid and Gender of Covid: Essential Workers, Not Disposable People’ (2021) 33 Yale Journal of Law and Feminism 1.

59 Green Party, ‘Greens Lead on First Successful Motion to Demand Government Reparations for Slavery’ (15 July 2020) <https://web.archive.org/web/20230330142841/https://www.greenparty.org.uk/news/2020/07/15/greens-lead-on-first-successful-motion-to-demand-government-reparations-for-slavery/> accessed 14 July 2024.

60 ibid.

61 Steven Morris, ‘Bristol Council Calls for Parliamentary Inquiry on Slavery Reparations’ *The Guardian* (London, 3 March 2021).

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reparations to Caribbean countries have recirculated since 2002.[62] While the payment of formal reparations continues to be rejected, UK investment in many Caribbean countries has increased, helping to improve infrastructure including, health care.[63] The legacies of slavery are also increasingly acknowledged by institutions, including companies, banks, and universities. Some organizations who received compensation for their historic ownership of enslaved people, or who otherwise benefitted from wealth generated from slave labour, are now undertaking to make payments to Black communities.[64] Individuals are also coming together to consider their obligations.[65] While these and other initiatives—or micro-reparations[66]—are welcome, they fall short of the coordinated national approaches needed. At the same time, such national approaches have provoked a number of objections.

In the context of the paradigm question of reparations for slavery, objections have included: 'that the victims of the direct harm are dead, that the perpetrators are diffuse, and that some of the actual harms were legal at the time they were committed'.[67] Such identified difficulties generally have a legalistic hue, with law painted as natural or apolitical,[68] and a transhistorical determinant of the possible. Having said that, current legal rules do create significant obstacles for those seeking reparations through the courts in advance of any legislative intervention.[69] As Johnstone and Quirk note: '[i]n the absence of a clear-cut legal relationship between a set of identifiable plaintiffs and identifiable defendants, existing laws frequently have little to offer reparations campaigners'.[70] At the same time, as these obstacles have been acknowledged, the nature of the reparation debates has shifted. Calls for reparations have moved to include more than financial compensation and an admission of past wrongs. They now often seek to address the trauma that has folded out from these past wrongs to create centuries of social injustice.[71] This requires reparations to include not only compensatory and restitutionary purposes, but also the aim of building a more just future.[72] These purposes and ambitions inform articulations of reparatory justice.

A. Reparatory justice

A distinction is increasingly made between *reparations*—generally denoting compensation—and *reparation*, which has come to mean repair and engages a broader reparatory politics directed at justice.[73] It moves the debate beyond a narrow focus on the payment of a compensatory sum and invokes the need for a broader response to obligations owed. This follows, in part, from a more appropriate temporal frame: looking beyond an act to which compensation attaches, to the wider context, history, and legacies of harm. Thus, it acknowledges the 'government policies and decades of indifference' that followed the legal end of slavery and

[62] BBC, 'Slavery: What are Reparations and Should They be Paid?' *BBC Newsround* (London, 21 August 2020) <https://www.bbc.co.uk/newsround/53531055> accessed 14 July 2024.

[63] ibid.

[64] Hall (n 36).

[65] See, eg, Heirs of Slavery set up in April 2023 that represents a number of descendants of slave owners who were paid compensation under the Slavery Abolition Act 1833: Heirs of Slavery, 'Home' (*Heirs of Slavery*) <www.heirsofslavery.org> accessed 14 July 2024.

[66] Kaimipono David Wenger, '"Too Big to Remedy?": Rethinking Mass Restitution for Slavery and Jim Crow' (2010) 44 Loyola Los Angeles Law Review 177.

[67] Adeel Hassan, 'No Easy Answers on Reparations' *New York Times* (New York, 21 June 2019).

[68] Mari J Matsuda, 'Looking to the Bottom: Critical Legal Studies and Reparations' (1987) 22 Harvard Civil Rights-Civil Liberties Law Review 323.

[69] Alfred Brophy, 'Some Conceptual and Legal Problems in Reparations for Slavery' (2003) 58 New York University Annual Survey of American Law 497.

[70] Gerry Johnstone and Joel Quirk, 'Repairing Historical Wrongs' (2012) 21 Social & Legal Studies 155, 157.

[71] John Torpey, '"Making Whole What has been Smashed": Reflections on Reparations' 73 Journal of Modern History 333.

[72] Buxbaum (n 52) 323.

[73] See Torpey (n 71); Hall (n 5).

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processes of decolonization to produce ongoing 'racial disparities in wealth, health and criminal justice'.[74] In terms of the temporal frame, it is also forward-oriented, aiming 'to achieve cultural changes that diminish the likelihood that these things will take place again'.[75]

Different approaches to reparatory justice have evolved. These recognize the need not just for material restitution, but also apology, public memorialization, and accurate historical education.[76] As Rhoda Howard-Hassmann states: 'Accurate acknowledgement would be a first step in reparations. Apology is a second step.'[77] Memorials and financial reparations then follow.[78] These elements are essential, yet they must be joined by interventions that address the material conditions of communities living with the legacies of colonial abuses. This is addressed, for example, with the CARICOM Ten Point Plan for Reparatory Justice, which addresses both slavery and the related colonial abuses of indigenous Caribbean peoples. The plan demands: (i) Full Formal Apology, (ii) An Indigenous Peoples Development Programme; (iii) Repatriation for those who desire it; (iv) Cultural Institutions; (v) Attention to the Public Health Crisis in the Caribbean; (vi) Illiteracy Eradication; (vii) African Knowledge Programme to rebuild ruptured relationships; (viii) Psychological Rehabilitation; (ix) Technological Transfer, and (x) Debt Cancellation.[79] The CARICOM Plan aligns with Táíwò's model of reparation, which demands not only compensation, but also the structural change necessary for social justice[80]:

> This is the constructive view of reparation: a historically informed view of distributive justice, serving a larger and broader worldmaking project. Reparation, like the broader struggle for social justice, is concerned with building the just world to come.[81]

Focusing on reparation as repair, the argument developed here centres the ongoing need to repair the body as an essential element of reparatory justice and the worldmaking Táíwò envisages. This directs attention not to the 'racial wealth gap' but the 'health gap' with which it correlates. This health gap is a social injustice arising from the disadvantages that historic wrongs have caused and entrenched. The argument draws on SDH research to link contemporary health inequities to the historic and ongoing disadvantages experienced by racial and ethnic minorities. This research also provides a solution: mandating investment in social determinants to address health and other inequities. The next section outlines the health equity concept. It then illustrates how racism intersects with social determinants before the health impacts of this are then addressed in the section that follows it.

III. HEALTH EQUITY, SOCIAL DETERMINANTS, AND RACE

In *Undoing Slavery: Bodies, Race, and Rights in the Age of Abolition*, Kathleen Brown reveals an 'abolitionist body politics' whereby early abolitionists centred the body in the pursuit of liberty for the enslaved.[82] Dominant historical accounts argue that abolitionists campaigned

74 Hassan (n 67).

75 Eva Knaggs, 'Global Models for Questions of Reparations' (Yale University Gilder Lehrman Center for the Study of Slavery, Resistance, and Abolition 12 May 2021) <https://glc.yale.edu/news/global-models-questions-reparations> accessed 14 July 2024.

76 See Kim (n 51) 237.

77 Rhoda Howard-Hassman, *Reparations to Africa* (University of Pennsylvania Press 2008) 178.

78 ibid.

79 CARICOM Caribbean Community, 'CARICOM Ten Point Plan for Reparatory Justice' (*CARICOM,* 2014) <https://caricom.org/caricom-ten-point-plan-for-reparatory-justice/> accessed 14 July 2024.

80 Táíwò (n 17) 4.

81 ibid 74.

82 Brown (n 27) 1.

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for recognition of the human rights of enslaved peoples as a means of securing a future free from harm. Contrary to this, Brown argues that these abolitionists understood that bodily integrity—and a body free from the brutal bodily harms of slavery—was a necessary precondition for achieving rights and liberty. As she notes, this focus on bodily or embodied integrity as necessary for the realization of human rights and flourishing had to wait until the twentieth century to be engaged by human rights academics, activists, and others.[83] In this, the abolitionists foreshadow work that has come to identify bodily integrity as the fundamental value and a cornerstone of all other rights.[84] They also prefigure the embodied theories of justice that have featured prominently in feminist and other critical fields in the last 30 years.[85]

Contemporary work on health equity centres the body in an echo of this abolitionist body politics, providing an account of why health should be the focus of our ethical and political concerns, as well as our legal action. Health equity has its foundations in the special status of health,[86] which is necessary not just for well-being, but also for social and political existence.[87] Inequities in health are therefore inequities in opportunity and the freedoms this creates. In other words, health inequities can significantly diminish the life choices of different groups within a population and are therefore a profound social injustice.[88] In response, health equity has come to mean a state where everyone has a fair and just opportunity to be as healthy as possible.[89]

While this understanding of health and health inequity mandates that improving population-level health should be a primary goal of states,[90] governments nevertheless often accept or promote situations that create or exacerbate health inequities. As the WHO asserts, the conditions that determine the unequal distribution of poor health are not natural, rather they are 'the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics'.[91] Importantly, inequalities in social determinants—that is, inequalities in the distribution of power, income, goods, and services, and the conditions of work, leisure, and home life—are 'responsible for a major part of health inequities between and within countries'.[92] Given this relationship between social and health inequities, health disparities demand our attention not just because of the direct and indirect harms they cause, but also because they highlight structural inequalities. Social and economic inequalities correlate to inequities in health. Conversely, when societies are fairer, a population's health outcomes are better.[93] Health inequities therefore highlight fault lines of inequality, discrimination, and deprivation. Without concerted global action, it has been observed that health inequity may become the 'defining narrative of the 21st century'.[94]

[83] ibid.

[84] Marie Fox and Michael Thomson, 'Bodily Integrity, Embodiment, and the Regulation of Parental Choice' (2017) 44 Journal of Law and Society 501.

[85] Lewis (n 28).

[86] Amartya Sen, 'Why Health Equity' (2002) 11 Health Economics 659; Jeniffer Prah Ruger, *Health and Social Justice* (Oxford University Press 2009).

[87] John Coggon, 'Global Health, Law, and Ethics: Fragmented Sovereignty and the Limits of Universal Theory' in Michael Freeman, Sarah Hawkes, and Belinda Bennett (eds), *Law and Global Health: Current Legal Issues* (Oxford University Press 2014) 369, 372.

[88] Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Polity Press 2011); Madison Powers and Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (Oxford University Press 2006).

[89] Paula Braveman and others, *What Is Health Equity? And What Difference Does a Definition Make?* (Robert Wood Johnson Foundation 2017) 2

[90] Coggon (n 87) 372.

[91] WHO Commission on the Social Determinants of Health (n 30) 1.

[92] ibid.

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

[94] Kaldor (n 39) 14.

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In the UK, a growing body of work focuses on the impact of racism on the distribution of social determinants and identifies racism as a legacy of colonialism.[95] As Nazroo and Williams write: 'the socio-economic disadvantage faced by ethnic minority migrants in the UK, was, and continues to be, structured by racism that has its roots in colonial history'.[96] Colonialism created 'race',[97] a socially constructed taxonomy reflecting the 'intersection of particular historical conditions with economic, political, legal, social, and cultural factors, as well as racism'.[98] Racist scientific and political theories then emerged to justify colonialism, with these becoming embedded in the social, political, and legal structures of slaving nations.[99] The end of slavery and the processes of decolonization did not challenge these embedded values. Rather, notions of racial hierarchy were amplified and have endured.[100] As the United Nations Secretary General recently reported:

> United Nations experts have documented the linkages between the past and the present, shedding light on the economic, psychological, social, political, cultural, educational and intergenerational dimensions of the lasting and structuring impact of past tragedies and crimes in past societies. They have shown that the formal abolition of enslavement and colonialism was insufficient to dismantle the racially discriminatory structures built by those practices. Instead, it often gave way to racially discriminatory policies and systems, including segregation … that perpetuated racial discrimination, oppression and inequalities.[101]

This captures the experience of racial and ethnic minorities in the UK, seen particularly graphically with mass migration from colonial territories in the Caribbean, Africa, and the Indian subcontinent following the end of World War II. These migrants travelled to escape poverty and economic decline in the colonies and to address labour shortages in the UK.[102] Nevertheless, they were met with 'hostility bred from the attitudes of racial supremacy fostered by centuries of imperial power'.[103] This was witnessed at every level of society, from the actions of the British state and its elites, to interpersonal racism and violence on the streets.[104] Such racism has been a 'defining feature' of post-war Britain,[105] where it is 'deeply sedimented' in all layers of society.[106] This has resulted in social and economic segregation and the consequent uneven distribution of the determinants of health:

[95] Angus Nurse, *Reparations and Anti-Black Racism: A Criminological Exploration of the Harms of Slavery and Racialized Injustice* (Bristol University Press 2021).

[96] James Nazroo and David Williams, 'The Social Determination of Ethnic/racial Inequalities in Health' in Michael Marmot and Richard Wilkinson (eds), *Social Determinants of Health* (2nd edn, World Health Organisation 2003) 238–266, 260.

[97] Ishita Pande, *Medicine, Race and Liberalism in British Bengal: Symptoms of Empire* (Routledge 2009).

[98] David R Williams, Risa Lavizzo-Mourey, and Rueben C Warren, 'The Concept of Race and Health Status in America' (1994) 109 Public Health Reports 26, 28.

[99] Paul Finkelman, *Slavery and the Law* (Rowman and Littlefield 1997).

[100] See Centers for Disease Control and Prevention, *Health Equity: Impact of Racism on our Nation's Health* (Centers for Disease Control and Prevention, 2021) <https://web.archive.org/web/20221208231049/https://www.cdc.gov/minorityhealth/racism-disparities/impact-of-racism.html> accessed 14 July 2024.

[101] Report of the Secretary-General (n 35) 3.

[102] Ashley Dawson, *Mongrel Nation: Diasporic Culture and the Making of Postcolonial Britain* (University of Michigan Press 2007).

[103] ibid 9.

[104] Marcia Sutherland, 'African Caribbean Immigrants in the United Kingdom: The Legacy of Racial Disadvantages' (2006) 52 Caribbean Quarterly 26.

[105] William Shankley and James Rhodes, 'Racisms in contemporary Britain' in Bridget Byrne and others (eds), *Ethnicity and Race in the UK: State of the Nation* (Bristol University Press 2020) 203, 206–207.

[106] Paul Miller, '"System Conditions", System Failure, Structural Racism and Anti-Racism in the United Kingdom: Evidence from Education and Beyond' (2021) 11 Societies 42.

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> Shaped by ideas of Empire and Britain's colonial history, … discriminatory practices in areas such as housing, employment and criminal justice produced a deeply unequal society, in which black and minority communities have been disproportionately concentrated in more deprived areas, in poorer quality housing, and within low-wage and insecure employment.[107]

While discriminatory practices happened across sectors or determinants—such as education and employment—housing has a particular importance in terms of its place within the dynamics and longevity of segregation and stratification. Racism shaped access to private and public housing for migrants.[108] In the public sector, racism by local authorities saw racial and ethnic minorities allocated the least desirable housing in the least favourable estates.[109] Susan Smith identifies housing as a lynchpin, whereby it is fundamental in constituting citizenship, and creating and sustaining racial inequalities:

> As a residential pattern … , *racial* segregation reflects and structures enduring inequalities in access to employment opportunities, wealth, services and amenities, and to the package of civil and political rights associated with citizenship. As an ideology … , segregation builds from the objective deprivation of black people to a subjective acceptance that racial differentiation has a logic of its own; it provides a reservoir of common sense justifications for discriminatory policy and separatist practice.[110]

Housing disadvantage became entrenched in the decades that followed post-war migration and has been exacerbated by changes in the housing landscape in more recent decades. The UK now experiences 'stark and persistent ethnic inequalities in housing', with at least a third of Bangladeshi, Pakistani, and Black African people living in overcrowded conditions. This compares to 1 in 20 white households.[111] Housing for racial and ethnic minorities is also more precarious, with these households significantly over-represented as statutory homeless.[112] Within this context of entrenched and intergenerational housing inequality, and echoing Smith's earlier observations, housing retains its influence on experiences of other determinants of health.

The next section addresses how inequalities in access to social determinants translate to health inequities experienced by racial and ethnic minorities in the UK. Findings across different populations are provided, acknowledging that contemporary experiences of health inequities are raced, with their origins in the complex and interrelated histories of colonialism. In this, racism is revisited and acknowledged as a complex and 'fundamental' determinant of health.[113]

[107] Shankley (n 105) 206–207.

[108] William Shankley and Nissa Finney, 'Ethnic Minorities and Housing in Britain' in Bridget Byrne and others (eds), *Ethnicity and Race in the UK: State of the Nation* (Bristol University Press 2020) 149.

[109] Sue Lukes, Nigel de Noronha, and Nissa Finney, 'Slippery Discrimination: A Review of the Drivers of Migrant and Minority Housing Disadvantage' (2018) 45 Journal of Ethnic and Migration Studies 1.

[110] Susan J Smith, *The Politics of 'Race' and Residence: Citizenship, Segregation and White Supremacy in Britain* (Polity 1989) 170.

[111] Shankley and Finney (n 108) 149.

[112] ibid 149.

[113] Gilbert C Gee and Chandra L Ford (2011) 'Structural Racism and Health Inequities: Old Issues, New Directions' (2011) 8 Du Bois Review 115, 128.

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IV. THE COLOUR OF HEALTH INEQUITIES IN THE UK

Racialized inequities in health outcomes are substantial and have generally not changed over time.[114] Within this overall context, health inequities are uneven across racial and ethnic minorities and health conditions. As the UK Parliamentary Office of Science and Technology summarized, racial and ethnic minorities 'generally have worse health than the overall population, although some … groups fare worse than others, and patterns vary from one health condition to the next'.[115] Thus, it should be noted that while some groups have the poorest health outcomes across a range of indicators,[116] it is more common to see high levels of variance across indicators. To provide a brief and incomplete illustration of the complexity of the patterning and experience of racialized health inequities in the UK, it can be noted that there are higher rates of heart disease among 'South Asian' people, but particularly among Bangladeshi and Pakistani people.[117] Hypertension and stroke are experienced more frequently by Caribbean and African people than other groups, and these populations also experience higher rates of admission to psychiatric hospitals with a diagnosis of psychotic illness.[118] While rates of maternal mortality are generally low in the UK, poor outcomes are higher for mothers and babies from Black and Asian groups.[119] Compared to white groups, the rate of women dying in the UK in 2016–2018 during and up to 1 year after pregnancy was more than four times higher in the Black group.[120] Obesity is also experienced by a significantly higher number of Black adults,[121] and childhood obesity has a higher prevalence among Black and Asian children.[122] It is associated with higher levels of deprivation and has a significant bearing on immediate and future health. Children in Asian and Black households are twice as likely to live in persistent low-income households than children from white households.[123] Such deprivation is a risk factor in infant mortality, which is experienced at higher levels in racial and ethnic minorities.[124] Thus, while for many conditions and outcomes, there are differences between groups, infant mortality is a health inequity shared across all racial and ethnic minorities. This is also seen with Type 2 Diabetes and associated complications.[125]

The picture is therefore complex and identifying causation is difficult. It is suggested that the experience of health inequities is driven by the interplay of deprivation, environmental factors, and health-related behaviours.[126] The Parliamentary Office of Science and

[114] Karen Chouhan and James Nazroo, 'Health Inequalities' in Bridget Byrne and others (eds), *Ethnicity and Race in the UK: State of the Nation* (Bristol University Press 2020) 73.

[115] Parliamentary Office of Science and Technology, 'Ethnicity and Health' (Postnote No 276, January 2007) 1.

[116] Veena Raleigh and Jonathon Holmes, 'The Health of People from Ethnic Minority Groups in England' (The King's Fund 17 February 2021) <https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england> accessed 14 July 2024.

[117] Chouhan (n 114) 76–78.

[118] ibid.

[119] Commission on Race and Ethnic Disparities: The Report (March 2021) https://assets.publishing.service.gov.uk/media/6062ddb1d3bf7f5ce1060aa4/20210331_-_CRED_Report_-_FINAL_-_Web_Accessible.pdf accessed 14 July 2024.

[120] It should be noted that the numbers remain relatively low, at under 10 a year in the Black group. MBRRACE-UK, 'Saving lives, improving mothers' care: lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2016-18' (December 2020) <https://www.npeu.ox.ac.uk/mbrrace-uk/presentations/saving-lives-improving-mothers-care> accessed 14 July 2024.

[121] ibid.

[122] National Audit Office, *Childhood Obesity* (September 2020) <www.nao.org.uk/report/childhood-obesity> accessed 14 July 2024.

[123] Department for Work and Pensions, *Persistent Low Income* (*GOV.UK* 2020) <www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/pay-and-income/low-income/latest> accessed 14 July 2024.

[124] Mary E Kroll and others, 'Ethnic Variation in Unexplained Deaths in Infancy, Including Sudden Infant Death Syndrome (SIDS), England and Wales 2006-2012: National Birth Cohort Study Using Routine Data' (2018) 72 Journal of Epidemiology and Community Health 911.

[125] Commission on Race and Ethnic Disparities (n 119).

[126] Raleigh and Holmes (n 116).

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Technology concluded: 'Ethnic health inequalities result from many inter-linking factors, of which the relative poverty of [racial and ethnic minorities] is probably the most important'.[127] Returning to the importance and influence of housing, Public Health England have stated that 'ethnic minority people reside disproportionately in areas of high deprivation with poor environmental conditions, with concomitant negative impacts on health'.[128] Importantly, racism is increasingly identified as a significant contributor to these socio-economic factors and therefore to the health disparities that follow. Public Health England, for example, go on to highlight the role of racial discrimination in housing, education, employment, and other determinants.[129] Increasingly, work on racialized health inequities has developed to identify the importance and interaction of structural, institutional, and interpersonal forms of racism.[130] As Gee and Ford argue, to understand racism as a 'fundamental determinant of health disparities requires attending to the multiple manifestations of racism'.[131]

This can be illustrated through the example of racialized inequities in severe mental health, which have been reported consistently for more than 60 years.[132] At the macro level, structural racism leading to socio-economic disadvantage creates an increased risk of severe mental illness.[133] At the same time, such socio-economic disadvantage increases the likelihood of interactions in health and criminal justice domains where institutional racism can lead to unequal health outcomes.[134] Black Caribbean and Black African patients, for example, are at least three times more likely than white patients to experience compulsory admission under the powers of the Mental Health Act.[135] This follows similar disparities in police contact before admission, where Black Caribbean patients are at least 2.5 times more likely, and Black African patients are at least 3.5 times more likely, than white patients to have had contact with the police prior to admission.[136] At the same time, Black Caribbean and Black African patients are almost half as likely to have seen a general practitioner before admission compared to white patients.[137] Once admitted, these groups are more likely to be in psychiatric intensive care units and medium secure units, more likely to be secluded or physically restrained, spend longer in acute hospital care, and subsequently experience more frequent compulsory readmissions.[138] During this time, they can receive non-standard pharmacological treatment.[139] This reflects the broader picture whereby racial and ethnic minorities are more likely to experience negative pathways through care, poorer access to effective interventions,

[127] Parliamentary Office of Science and Technology (n 115) 4.

[128] Public Health England, *Local Action on Health Inequalities: Understanding and Reducing Ethnic Inequalities in Health* (August 2018) 57.

[129] ibid.

[130] David R Williams, 'Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination' (1999) 896 Annals of the New York Academy of Science 175; David R Williams and Selina A Mohammed, 'Discrimination and Racial Disparities in Health: Evidence and Needed Research' (2009) 32 Journal of Behavioural Medicine 20; David R Williams and others, 'Understanding how Discrimination Can Affect Health' (2019) 54 Health Services Research 1374.

[131] Gee and Ford (n 113) 128.

[132] Kristoffer Halvorsrud and others, 'Ethnic Inequalities in the Incidence of Diagnosis of Severe Mental Illness in England: A Review of Reviews and New Meta-analyses for Non-affective and Affective Psychoses' (2019) 54 Social Psychiatry and Psychiatric Epidemiology 1311.

[133] James Y Nazroo, Kamaldeep S Bhui, and James Rhodes, 'Where Next for Understanding Race/ethnic Inequalities in Severe Mental Illness? Structural, Interpersonal and Institutional Racism' (2020) 42 Sociology of Health & Illness 262, 270. See also, Suman Fernando, *Cultural Diversity, Mental Health and Psychiatry: The Struggle Against Racism* (Routledge 2004).

[134] ibid 271.

[135] Halvorsrud and others (n 132).

[136] ibid.

[137] ibid.

[138] Nazroo and others (n 133).

[139] ibid.

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and poorer outcomes.[140] Finally, it should be noted that the incidence of severe mental illness is significantly increased for people reporting verbal or physical racist abuse.[141]

The data on mental health disparities demonstrate how structural, institutional, and interpersonal racism across domains can compound disadvantage. Stressing the interaction of different forms of racism, Nazroo and colleagues nevertheless single out the importance of institutional racism:

> Institutions are sites crucially situated in and shaped by both wider forms of structural racism and inequality, and spaces within which forms of interpersonal racism and micro-forms of racialisation operate, and can sediment and acquire greater salience through their institutionalisation.[142]

It is against this backdrop of health inequities shaped by interrelated racism that the COVID-19 pandemic unfolded. As Yaya and colleagues note, it aggravated 'an already very fragile situation' characterized by 'grave inequalities'.[143] The statistics detailing ethnic disparities in the impact of the pandemic in the UK are stark. Racial and ethnic minorities together are 13 per cent of the UK population and yet accounted for one-third of those with the virus who were admitted to intensive care units in the first months of the pandemic.[144] A review of National Health Service (NHS) data found that people identifying as South Asian and Black African had positive test rates, respectively, at 2 and 1.7 times the rates of white British.[145] The Office of National Statistics (ONS) found that in the early months of the pandemic, the rate of death for Black males was 3.8 times greater than that for white males, while the rate for Black females was 2.9 times greater than for white females.[146] Statistics to 31 March 2021 confirmed that mortality rates remained higher for Black Caribbean males and Bangladeshi and Pakistani males and females.[147]

COVID-19 has shone a light on the relationship between race and ethnicity, deprivation, and poor health. The ONS found that people from racial and ethnic minorities were more vulnerable to COVID-19 because of pre-existing socio-economic inequalities.[148] As already noted, minoritized ethnic populations in the UK experience higher levels of material deprivation and are more likely than white British residents to live in larger, overcrowded households, with multiple generations, in rental properties, and in deprived areas. The Institute for Fiscal Studies argued that some of the disproportionate impact was likely to be due to greater exposure in employment, given that people in these groups are more likely to be key

[140] ibid.

[141] Saffron Karlsen and others, 'Racism, Psychosis and Common Mental Disorder Among Ethnic Minority Groups in England' (2005) 35 Psychological Medicine 1795.

[142] Nazroo and others (n 133) 272.

[143] Yaya (n 26).

[144] Richard Milne and Clive Cookson, 'Nations Look into Why Coronavirus Hits Ethnic Minorities so Hard' *Financial Times* (London, 29 April 2020) <https://www.ft.com/content/5fd6ab18-be4a-48de-b887-8478a391dd72> accessed 14 July 2024.

[145] Rohini Mathur and others, 'Ethnic Differences in SARS-CoV-2 Infection and COVID-19-related Hospitalisation, Intensive Care Unit Admission, and Death in 17 Million Adults in England: An Observational Cohort Study Using the OpenSAFELY Platform' (2020) 397 Lancet 1711.

[146] Office for National Statistics, *Updating Ethnic Contrasts in Deaths Involving the Coronavirus (COVID-19), England and Wales: Deaths Occurring 2 March to 28 July 2020* (Office for National Statistics 16 October 2020) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/deathsoccurring2marchto28july2020> accessed 14 July 2024.

[147] Office for National Statistics, *Updating Ethnic Contrasts in Deaths Involving the Coronavirus (Covid-19) England: 24 January 2020 to 31 March 2021* (Office for National Statistics 26 May 2021) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/24january2020to31march2021> accessed 14 July 2024.

[148] ibid.

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workers.[149] All of these factors add to the likelihood of contracting the virus, as does the dependency on public transport and the reduced capacity to work from home. This increased risk of exposure is coupled with a higher likelihood of underlying health conditions that exacerbate the impact of infection.[150]

Structural racism leading to inequalities in social determinants therefore amplified the effects of COVID-19 amongst racial and ethnic minorities in two ways that compound each other. First, key determinants (including poverty, housing, and employment) increased the risk of contracting the virus. Secondly, longstanding inequalities led to higher levels of pre-existing co-morbidities, increasing the impact of the virus in its severity and mortality. Returning to institutional racism, the pandemic exposed racism in the healthcare system. At its starkest, Black women reported receiving substandard care and being sent home after presenting to hospital with COVID-19.[151] Public Health England also reported that institutional racism within the workplace may have made it less likely that minority ethnic staff raised concerns about risk levels or lack of personal protective equipment.[152] As Marmot and colleagues concluded: 'The implication is clear: dealing with this higher risk entails not just healthy practices, handwashing and social distancing, but also recognizing and dealing with structural racism.'[153]

It is important to note that the disproportionate impact of the pandemic was as sharply experienced by racial and ethnic minorities in many jurisdictions. The racial impact in the USA is well known. States with larger African American communities demonstrated pronounced inequalities in the impact of the pandemic. In Illinois in 2020, for example, while African Americans constitute 16 per cent of the State's population, 37 per cent of the total confirmed cases and 45 per cent of COVID-19 deaths were amongst the Black population. Similar statistics are available for Michigan, Missouri, North, and South Carolina.[154] To give a very different example, these inequities were also evident in Scandinavian countries. Somalians in both Sweden and Norway, for example, had higher infection rates than the white populations. In Norway, Somalians had an infection rate 10 times higher than the national average.[155] As Priest and Williams note, 'Since colonization, racism has been deeply embedded in the structures, systems and institutions of society … with vast and severe consequences for health and health disparities.'[156]

Returning to the special status of health, contemporary racialized health inequities can be understood as continuing the injustices of historic colonial abuses as these pasts shape inequities in the present. These continuities give added weight to arguments that the failure to meet rectificatory duties and the subsequent passing of time does not nullify obligations to make reparation. Indeed, as Daniel Butt has argued, such 'failure to rectify injustice counts as an act of injustice. The passage of time does not mean that a particular set of reparative

[149] Eg, more than 20 per cent of Black African women work in health and social care roles: Richard Blundell and others, *COVID-19 and Inequalities* (The Institute for Fiscal Studies, June 2020) <https://www.ifs.org.uk/inequality/covid-19-and-inequalities/> accessed 14 July 2024.

[150] Tanith C Rose and others, 'Inequalities in COVID19 Mortality Related to Ethnicity and Socioeconomic Deprivation' [Preprint] (2020) *medRxiv Infectious Diseases* (except HIV/AIDS) <https://doi.org/10.1101/2020.04.25.20079491> accessed 14 July 2024.

[151] Whitney N Laster Pirtle and Tashelle Wright, 'Structural Gendered Racism Revealed in Pandemic Times: Intersectional Approaches to Understanding Race and Gender Health Inequalities in COVID-19' (2021) 35 Gender & Society 168, 175.

[152] Public Health England, *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups*' (Public Health England 2020).

[153] Marmot (n 26) 7.

[154] Black Demographics, 'COVID-19: Why Data Shows African Americans Might be Affected at Higher Rates' (*Black Demographics*, 4 April 2020) <https://blackdemographics.com/alarming-new-covid-19-data-shows-african-americans-might-be-affected-at-higher-rates/> accessed 14 July 2024.

[155] Milne and Cookson (n 144).

[156] Priest (n 34) 285.

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obligations ... lapses'.[157] This argument has increased significance when a failure to meet an initial obligation can lead to a compounding of harm. This is illustrated with health inequities, with COVID-19 providing a particularly stark example of this effect.[158] The issue of racialized health inequities also illustrates how reparations in the form of a single compensatory payment are likely to be inadequate:

> [I]nstead, what is indicated is the need for an on-going commitment on the part of the advantaged community to correct the distributive distortion caused by both the initial wrongdoing and the subsequent failure to fulfil rectificatory obligations.[159]

V. LAW AND THE WORK OF REPAIR

It has been noted that the history of reparation campaigns is, in general, a history of failure.[160] In response, some have argued that advocates must expand the concept of reparations, whereby any legal steps that address the legacies of slavery and colonialism (including racism, disadvantage, or health inequities) can be understood as a type of reparatory action.[161] This can allow majority citizens to identify with and support reparatory interventions, potentially countering low public support for more traditionally articulated programmes.[162] This can strengthen attempts at building shared, or at least overlapping, interests. Derek Bell famously argued that reparations would fail because of white self-interest.[163] Nevertheless, he noted that advances—like desegregation—happen when interests converged; specifically, when white political elites believed they were necessary to achieve economic and political advances.[164] Bell argued that distinct but overlapping interests can enable change. A focus on achieving health equity through improved social determinants—that is, greater fairness in social arrangements and the distribution of resources[165]—has the potential to generate some degree of convergence in both political and public realms.

The need to build alliances draws attention to the precarity of the politics of repair. While some document a changing appetite to repair the injustices of the past, others caution that significant state-based responses remain unlikely. This has provoked warnings that energy expended on such campaigns is misdirected. Johnson and Quirk, for example, observe that, if 'claims for historical restitution are likely to have limited political prospects, then perhaps other forms of political argument might be more successful in achieving comparable or equivalent goals?'[166] Such arguments can direct us to consider the effects of historic injustices on contemporary lives and rights. Torpey makes such a point, arguing that the new 'forward-looking' reparations seek to 'harness the prevalence of "human rights" to political projects oriented both to coming to terms with brutal pasts *and* to equalizing the imbalance between rich and poor'.[167] Torpey's characterization supports bringing together reparatory justice and health equity. Addressing the 'imbalances between rich and poor' means

157 Daniel Butt, 'Repairing Historical Wrongs and the End of Empire' (2012) 21 Social & Legal Studies 227, 239.
158 Powell (n 58).
159 Butt (n 157) 239.
160 Wenger (n 40).
161 John Conyers, 'Reparations: The legislative agenda' (2007) 29 Thomas Jefferson Law Review 151.
162 Wenger (n 66) 225.
163 Derrick Bell, 'Dissection of a Dream' (1974) 9 Harvard Civil Rights-Civil Liberties Law Review 156.
164 Derrick Bell, '*Brown v Board of Education* and the Interest-Convergence Dilemma' (1980) 93 Harvard Law Review 518.
165 Thomson (n 39).
166 Johnson (n 70) 166.
167 Torpey (n 71) 355.

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addressing not just the 'wealth gap' but also the 'health gap'. This also aligns with Táíwò's capabilities-informed account of the worldbuilding needed for repair. As he argues: 'Everyone in the world order should have capabilities that grant effective access to the means of maintaining their biological existence, economic power, and political agency.'[168]

Reference to human rights raises questions about the role of law in this context. The primary focus of this analysis has been racialized health inequities in the UK and their origins in colonialism. Focusing on UK domestic law, health inequities engage existing legal obligations. So, for example, racialized health inequities breach duties that exist under UK equality legislation. As Public Health England has acknowledged, action on such inequities is needed to meet the legal duty on the Secretary of State for Health, NHS England, and Clinical Commissioning Groups to have regard to the need to reduce health inequities and to comply with the Equality Act 2010.[169] There are also domestic obligations created by international law in the context of the right to health, particularly when read together with non-discrimination obligations.

The relationship between law and health is, however, more complex, and this article contributes to the developing literature that locates law within the social determinants framework, where health outcomes and inequities are understood as determined by the 'conditions in which people are born, grow, live, work, and age, and the inequities in power, money, and resources'.[170] This requires that we address the different ways in which law shapes health, where it can be helpful to think of this in terms of scale—working from the highest level of governance to the most individualized. At a macro level, law impacts health through the organization of political and economic systems that can result in greater or lesser inequality within a population.[171] Again, the more equal a society is, the better its overall health outcomes. In other words, justice is good for health.[172] At the intermediate scale, law works at a structural level within SDH,[173] influencing equity and justice within the distribution of determinants such as education, housing, transport, and income.[174] Finally, specific laws and their enforcement act to 'sort' individual people—and populations when the effect is aggregated—into more or less healthy environments.[175]

These elements are not neatly disaggregated, but approached in this way we may better understand the relationship between law and health, and what is demanded as we address racialized health inequities as an act of reparatory justice. In terms of the macro level, slavery and other colonial practices were economic and political projects enabled and secured by law.[176] Colonialism relied on administrative provisions that determined the shape and governance of Empire. This authorized systems that damaged the health of millions, with harms experienced intergenerationally.[177] In turn, the economic and political relations instantiated under colonial governance continue to shape contemporary global economic and political

[168] Táíwò (n 17) 102.
[169] Public Health England (n 128) 5.
[170] Marmot (n 93).
[171] Montel (n 39).
[172] Norman Daniels, Bruce P Kennedy, and Ichiro Kawachi, 'Why Justice is Good for our Health: The Social Determinants of Health Inequalities' (1999) 128 Daedalus 215.
[173] Coggon (n 39) 722.
[174] Kaldor (n 39); Gostin (n 38).
[175] Scott Burris, Ichiro Kawachi, and Austin Sarat, 'Integrating Law and Social Epidemiology' (2002) 30 Journal of Law, Medicine & Ethics 510.
[176] Finkelman (n 99).
[177] Jonathan Wells, 'Maternal Capital and the Metabolic Ghetto: An Evolutionary Perspective on the Transgenerational Basis of Health Inequalities' (2020) 22 American Journal of Human Biology 1.

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systems to the detriment of the Global South, including the health of its populations.[178] This is a foundation of Táíwò's global racial empire, the global system that continues to distribute advantage and disadvantage.[179]

In terms of the intermediate scale, and as already noted, colonialism has resulted in ongoing social and economic stratification. One result of this, is that in the UK some racial and ethnic minorities experience disadvantage in each of the social determinants.[180] This is an issue for law. As McGowan and colleagues note, 'many structural and social factors that negatively influence health and well-being are not "natural" - they are human made, often through the creation, revision, repeal, or lack of law and legal policy'.[181] Here, it is argued that failure to meet reparatory obligations and to introduce laws that effectively address social inequalities is a cause of ongoing racialized health inequities. This can be illustrated with COVID-19. As the Institute for Fiscal Studies noted, racial and ethnic minorities had a disproportionate experience of the worst outcomes because of inequalities that increased the risk of transmission and the incidence of pre-existing comorbidities that amplified the chances of a poor outcome.[182] Both are the product of social inequalities that law has failed to remedy. This argument is supported by a study that examined the impact of COVID-19 on African Americans, comparing data from Louisiana to that of South Korea, a more 'egalitarian polity'.[183] The authors' analysis demonstrates how a programme of reparations would have potentially reduced several variables that determined the reproductive ratio of the virus.[184] Provided prior to the pandemic, reparations may have suppressed the negative effects of COVID-19 on African Americans by narrowing the racial wealth divide, creating changes in the built environment, fostering the ability to social distance, ensuring that frontline work was spread across racial and ethnic groups, and decreasing race-based allostatic load; that is, the cumulative burden of chronic stress and adverse life events on the body. While the study focuses on the USA, the lessons are applicable to the UK.

Finally, the impact on health outcomes through law's more individualized work of 'sorting' people into more or less healthy environments is seen in the long history of racially discriminatory legislation after the abolition of slavery. While legislation that is directly discriminatory has disappeared, indirect forms of discrimination persist. Furthermore, the discriminatory implementation or enforcement of laws can also 'sort' people into health-damaging environments, such as prisons.[185] This is seen with the racially discriminatory implementation of drug and stop-and-search laws, for example.[186] This discriminatory enforcement is a product of the racism and racial hierarchy that was created and embedded by colonialism and survived its end.

Repair will require work at each of these scales. The argument developed in this article has focused on the intermediate scale; that is, the distribution of social determinants. Here, law has a key role in securing the equitable distribution of determinants of health. As already noted, health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires 'removing obstacles to health such as poverty, discrimination, and

[178] Acharya (n 22).
[179] Táíwò (n 17).
[180] Marmot (n 30) 7.
[181] Angela K McGowan, KT Kramer and Joel B Teitelbaum, 'Healthy People: The Role of Law and Policy in the Nation's Public Health Agenda' (2019) 47 Journal of Law, Medicine & Ethics 63, 66.
[182] Blundell (n 149).
[183] Eugene T Richardson and others, 'Reparations for Black American Descendants of Persons Enslaved in the U.S. and their Potential Impact on SARS-CoV-2 Transmission' (2021) 276 Social Science & Medicine 1.
[184] ibid 3.
[185] Burris (n 175)
[186] ibid.

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their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care'.[187] Law can effect change in each of these areas, ensuring, for example, basic income and minimum wages, housing standards, and environmental safety. In this, law must work with other public health disciplines to ensure that improvements are applied universally 'but with a scale/intensity proportionate to the level of disadvantage'.[188]

A necessary part of the work towards health equity is addressing racism. In 2018, the United Nations Special Rapporteur on Contemporary Forms of Racism visited the UK in order to 'assess the situation of racism, racial discrimination, xenophobia, and related intolerance'.[189] In her End of Mission Statement, Tendayi Achiume highlighted the pervasiveness of racism in contemporary Britain. The Report identifies the 'striking' levels of 'structural socio-economic exclusion of racial and ethnic communities in the UK' in areas such as housing, employment, policing, and health. She concluded that race and ethnicity, 'continue to determine life chances in ways that are unacceptable, and in many cases, unlawful'.[190] Achiume's report provides an important account of the prevalence of structural racism in the UK. While structural racism is frequently identified as the 'root cause' of racialized health disparities,[191] the examples of inequities in severe mental health and the impacts of COVID-19 illustrate the complex ways in which structural, institutional, and interpersonal racism interrelate. As Nazroo and colleagues write, an integrated account of racism working at these different levels 'provides a more comprehensive identification of how racisms operate to shape opportunities, and a powerful and fundamental framework for understanding race/ethnic inequalities more generally'.[192]

Emphasizing the role of law in promoting equality and non-discrimination is important as increasing attention is paid to law as a determinant of health. As already noted, the role of law in public health is 'underutilised and poorly understood',[193] and there can be a tendency to focus on the role of law in building and regulating healthcare systems and interventions. In other words, as we continue to develop an understanding of law as a determinant of health, we should not lose sight of the key lessons from SDH research that health inequities are driven by inequalities in the conditions of everyday life.[194] Returning to race, Zinzi Bailey, Justin Feldman, and Mary Bassett argue that combatting racialized health inequities will 'require policies that restructure the chances for a healthy life for people of color, righting the wrongs of everyday life'.[195] This includes the need for law to articulate and develop the instruments through which it can better address the racisms that drive racialized health inequities.[196] This work can also help to strengthen the understanding of law as an essential public health discipline and a mechanism to achieve justice.

[187] Braveman (n 89) 2.

[188] Michael Marmot and others, *Fair Society, Healthy Lives (The Marmot Review)* (University College London 2010) 15.

[189] E Tendayi Achiume, *End of Mission Statement of the Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance at the Conclusion of her Mission to the United Kingdom of Great Britain and Northern Ireland* (Geneva, UN Office of the High Commissioner on Human Rights 11 May 2018) <https://www.ohchr.org/en/statements/2018/05/end-mission-statement-special-rapporteur-contemporary-forms-racism-racial> accessed 14 July 2024.

[190] ibid [19].

[191] Yearby (n 33) 518.

[192] Nazroo (n 133) 271

[193] Gostin (n 38).

[194] Thomson (n 39).

[195] Zinzi D Bailey, Justin M Feldman, and Mary T Bassett, 'How Structural Racism Works—Racist Policies and a Root Cause of US Racial Health Inequities' (2021) 384 The New England Journal of Medicine 773.

[196] Leonard E Egede and Rebekah J Walker, 'Structural Racism, Social Risk Factors, and COVID-19: A Dangerous Convergence for Black Americans' (2020) 383 New England Journal of Medicine e77; Pirtle and Wright (n 151).

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VI. CONCLUSIONS

Social stratification is intimately linked to ethnic and racial diversity and, in particular, histories of large-scale migration, oppression of indigenous groups by settlers, and slavery. In each instance, colonialism shapes the contemporary social inequalities that drive persistent racialized health inequities.[197] In this regard, and as Táíwò notes, '[h]istory is not merely an interesting point of comparison for our contemporary problems. Everything we experience happens in the flow of time from past to present to future.'[198] This stratification and social inequality cannot, however, be addressed without confronting racism, and this must be engaged in SDH research.[199] As Williams and Cooper acknowledge, in determining unequal access to resources and opportunity, racism is a 'fundamental cause' of racialized health inequities. As they conclude: 'The bottom-line is that the system of racism has created reduced access for stigmatized groups to the many opportunities that facilitate socio-economic attainment, quality of life and health.'[200]

The global pandemic brought many of these issues to wider attention. It highlighted how historically determined racism, segregation, and inequality have a direct impact on the health outcomes and lifespan of racial and ethnic minorities today. In this, COVID-19 has underscored the importance of Daniel Butt's pre-pandemic assertion that, in a world where the distribution of resources is 'literally of vital importance, the failure of colonial powers to fulfil their reparative duties to the people they have wronged is a continuing injustice, which cries out for rectification'.[201] Butt's reference to vitality highlights the importance of health equity as a focus for reparatory action. Addressing the need to repair the body that continues to be harmed by the legacies of colonialism engages the changing nature of reparatory discourses and the need for a broader politics of repair. This articulation of reparation through health equity is also a means of addressing the frequently cited objections to the way reparations are traditionally framed. As Kevin Outterson states: 'Disparities in Black health may provide a better foundation for successful [reparations] litigation, resolving major issues in standing, statutes of limitations, and sovereign immunity'.[202] Perhaps most importantly, in the face of entrenched and life-limiting inequalities, new ways to articulate and achieve repair are essential. As Johnson and Quirk write, in these circumstances 'it becomes necessary to find a way of combining both ethical ideals and practical calculations'.[203]

While this article argues for a focus on health inequities—that is, the ongoing embodied effects of the structural disadvantages wrought by colonialism—this strategy is not without risks. In this regard, it is important to state that centring the body and health is not a proxy or substitute for the other essential reparative acts which must happen alongside. It is notable that in some contexts health has become a substitute for such action. As already noted, while the UK Government has continued to refuse to apologize for slavery in the Caribbean, or directly address reparatory claims, it has increased its investment in Caribbean nations, including in healthcare infrastructure.[204] While such investment is important and can address the lived legacies of slavery and colonization, it leaves central reparative obligations unmet.

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[197] David Ingleby, 'Ethnicity, Migration and the "Social Determinants of Health"' (2012) 21 Agenda Psychosocial Intervention 331, 333.

[198] Táíwò (n 17) 24. See also, Michael Thomson and Beth Goldblatt, 'Legislating for the Future: Situated Health and Embodied Justice' (2024) International Journal of Law in Context 1.

[199] Ingleby (n 197).

[200] David R Williams and Lisa A Cooper, 'Reducing Racial Inequities in Health: Using What we Already Know to Take Action' (2019) 16 International Journal of Environmental Research and Public Health 606, 607.

[201] Butt (n 157) 239.

[202] Kevin Outterson, 'Tragedy & Remedy: Reparations for Disparities in Black Health' (2005) 9 DePaul Journal of Health Care Law 735, 781.

[203] Johnson and Quirk (n 70) 166.

[204] See (n 63).

A similar picture is seen in Australia. *Closing the Gap* is a longstanding national initiative to address the significant inequities in health and life expectancy that are experienced by Australia's First Nations people.[205] While the programme is important and aims to address the intergenerational harms experienced by many communities, it has had a limited impact and has, for some, replaced the national action that is still needed to address Australia's brutal past and the unmet obligations of repair.[206]

The abolition of slavery through legislation in 1807 and 1833 has shaped the UK's collective memory of slavery and the wider histories of colonialism and Empire. This has left the country's colonial pasts unresolved, both in terms of the need to make reparation and the wider accounting for the harms caused. Contemporary racialized health inequities are a legacy that continues to re-enact the harms and injuries of the past. Directing reparatory attention towards health inequities should not distract from the wider demands of reparatory justice. Rather, this account of the ongoing embodied legacies experienced by racial and ethnic minority populations should act to underscore the issue of our unresolved past and the continuing need for repair.

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CONFLICT OF INTEREST

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[205] Australian Government, *Closing the Gap on Indigenous Disadvantage: the Challenge for Australia* (February 2009) <https://www.dss.gov.au/sites/default/files/documents/05_2012/closing_the_gap.pdf> accessed 14 July 2024.

[206] Megan Davis, 'Closing the Gap in Indigenous Disadvantage: A Trajectory of Indigenous Inequality in Australia' (2015) 16 Georgetown Journal of International Affairs 34; Chelsea J Bond and David Singh, 'More than a Refresh Required for Closing the Gap of Indigenous Health Inequality' (2020) 212 Medical Journal of Australia 198.

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