

CHAPTER 7

# Social Determinants of Health and the Role of Law in Optimizing Health

**Learning Objectives**

**By the end of this chapter, you will be able to:**

- Describe the meaning of *social determinants of health* and the significance of social factors on individual and population health
- Describe how law can create or perpetuate health-harming social conditions
- Explain how law can be used to ameliorate health-harming social conditions
- Understand how innovative interventions to improve health, such as Medical-Legal Partnership, can help address health-harming social conditions at the individual and population levels

## BOX 7-1 VIGNETTE

**Living through brief periods without heat or electricity is a fact of life for most of us, perhaps as a result of a powerful weather system or a blown generator. But have you thought about what it would be like to be without heat or electricity more chronically, due to homelessness, inadequate housing, or an unscrupulous landlord who neglects a property without concern for tenants? Even for the healthiest among us, this social factor would be incredibly challenging; for those with chronic illness, it can mean increased asthma attacks, severe pain associated with sickle cell disease, an inability to refrigerate needed medicine, and much more, including death. The social factors noted above—homelessness, dilapidated homes, slum landlords—and many others have nothing to do with biology, genetics, personal choice, or access to healthcare services, but have a great deal to do with individual and public health.**

## INTRODUCTION

Disparities in health and health care are a systemic and deeply challenging problem in the United States.[1] While related, the two terms have different meanings. A *health disparity* exists when one population group experiences a higher burden of disability or illness relative to another group; a *healthcare disparity*, by contrast, tends to denote differences in access to healthcare services or health insurance, or in the quality of care actually received.[2] What makes both types of disparities so invidious—and a major social justice concern—is that they can exist even when patient needs or treatment recommendations do not differ across populations.[3] As long as these disparities exist, a society cannot achieve what is known as *health equity*—a situation in which everyone has the opportunity to attain his or her full health potential.

Many different factors can contribute to health and healthcare disparities. Individual behaviors, healthcare provider bias, cultural expectations and differences, the location and financing of healthcare systems, social factors, and more can all be contributors. Furthermore, health and healthcare disparities appear through many different lenses—researchers have documented disparities based on race, ethnicity, socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation.[4]

In 2010 the U.S. Department of Health and Human Services developed a series of strategies and goals for eliminating health disparities based on race and ethnicity[5] and, as described most prominently in the chapter on health reform, the Affordable Care Act includes many provisions aimed at improving the health of vulnerable individuals and populations, including several programs specifically directed at reducing health disparities. In addition, many states, localities, and private organizations have agendas for combating and eliminating various types of health and healthcare disparities.

Too often overlooked in discussions about health and health disparities, however, is a striking fact about American society that both differentiates it from other developed countries and appears to deeply affect individual and population health: aside from expenditures related to the direct provision of individual healthcare services, the United States spends far less on social services (housing and food programs, support services for older adults, disability and sickness benefits, employment programs, unemployment benefits, homeless shelters, utility assistance programs, etc.) than do other first-world countries. For every $1 spent on health care, the United States dedicates approximately $0.90 to other social services; in the 33 other Organisation for Economic Co-operation and Development countries (a multinational organization, of which the United States is a member, that strives to fight poverty and achieve economic growth and employment in member countries), the typical spending ratio is $1 on health care to $2 on other social services. As it turns out, the latter ratio is significantly associated with better health outcomes, including less infant mortality, less premature death, longer life expectancy, and fewer low-birth-weight babies.[6] At the same time, despite spending two to three times more *per capita* on direct healthcare services than nearly all of our European counterparts, the United States has significantly worse health outcomes in many respects than Europe, particularly among the poorest individuals and families.[7]

As evidence mounts that interventions targeting social, economic, and environmental factors can account for sizable reductions in morbidity and mortality,[8] healthcare payers and policymakers are increasingly aiming to tie these non-medical interventions to new models of healthcare delivery that create economic incentives for providers to incorporate social interventions into their approach to care by linking payments to overall health outcomes (e.g., "accountable care organizations," or ACOs, are an evolving concept in which various types of healthcare providers collaborate in the provision of care and accept collective accountability for the cost and quality of care delivered to a population of patients).[9] While it will take time to implement and test these new models, early results indicate that these multi-faceted approaches to health and health care can result in cost savings, higher patient satisfaction, more provider productivity, and improved employee satisfaction.[10]

## BOX 7-2 Discussion Questions

Do you think trying to achieve wide-scale health equity is a laudable goal? Why or why not? If yes, what do you think are the keys to achieving it? And what about people who are given the opportunity to achieve optimal health but do not take advantage of it; should they face consequences of some sort?

## SOCIAL DETERMINANTS OF HEALTH

### Defining Social Determinants of Health

According to the federal Centers for Disease Control and Prevention (CDC), determinants of health are "factors that contribute to a person's current state of health." Included within this broad category are biological factors (e.g., carrying a genetic mutation that could increase one's chances of developing a particular disease, such as sickle cell anemia), psychosocial factors (e.g., conflicts within one's family that may lead to stress, anger, and/or depression), behavioral factors (e.g., alcohol/drug use, smoking, unprotected sex), and finally, social factors. Social determinants of health (SDH), broadly speaking, are the social conditions into which people are born and that affect their daily lives and overall well-being as they move through the various stages of life. The World Health Organization (WHO) defines SDH as "the conditions in which people are born, grow, live, work and age"[11] and the CDC notes that SDH are shaped by the distribution of money, power, and resources at both local and national levels.

Resources that enhance the quality of one's life—such as the availability of healthy foods, access to education, and an environment free of toxins—all shape individual and population health. These and many other SDH are transient across the life cycle, with some social determinants becoming more pertinent depending on one's stage of life. For example, proximity to a high-quality school would be more meaningful for

a child, while one's actual education level would be more significant to an adult who is either seeking work or to increase her income to better support her family. Social determinants include factors that may have led to an individual's disadvantaged state to begin with—institutional racism, exposure to crime and violence, a lack of available community-based resources, and many other factors can all be health harming.

As you have likely gleaned already, social factors that influence health cover a wide swath of topics and life events, many of which remain outside the control of individuals and populations affected by them. As a result, it is not always easy to specifically define exactly what role SDH—whether one individual social factor, or many at once—play in shaping health. Researchers have for decades explored such questions as these: Why are some populations more predisposed than others to develop and suffer from certain ailments? Why do differences persist in healthcare quality among racial and ethnic groups? Why do people in low-income families sometimes experience lower quality care compared to high-income families? Why do studies show incremental improvements in health as one rises in social status? In some capacity, it is likely that social factors are at play in all of these situations, but defining their role is a challenge. Before delving into some of the more specific research findings concerning the health effects of certain social factors, let's take a more detailed look at some different types of SDH.

## Types of Social Determinants of Health

The Healthy People 2020 Initiative[12] lists many different examples of SDH. We summarize several of them here to provide context for the discussion that follows.

- **Access to high quality educational opportunities**: Individuals with access to consistent, high-quality educational opportunities are more likely to obtain higher-income jobs, and completion of undergraduate and graduate studies affords a sheer greater number of these higher-paying opportunities. Many middle and high schools in low-income areas, however, have high dropout rates or do not adequately prepare students for higher education, and many of these areas do not have adequate access to job training resources for those seeking training in a vocation, which can provide a path to a well-paying career in the absence of a four-year college degree. Furthermore, many low-paying positions do not offer health insurance as a job benefit, making it all the more difficult for individuals in these positions to access routine and specialty physician services. Overall, educational attainment and corresponding income levels tend to be strong predictors of individual and population health. From an early age, educational attainment and income provide valuable resources that protect individuals against stressors that tend to lead to health complications later in life.
- **Access to medical care services**: Individuals who do not live close to medical care providers (primary care doctors, clinics, hospitals, etc.) are less likely to see a physician regularly and will often only seek care in emergencies, eschewing preventive care. Access is also not just about geography—it entails affordability as well. People who do not receive health insurance coverage as a job-related benefit and cannot purchase it on their own can forgo seeing a doctor for several years before presenting to the emergency room for an acute problem, which can possibly lead to a lengthy hospitalization and/or decreased quality of life.
- **Access to social media and other technologies (e.g., the Internet, cell phones)**: The Internet and cell phones are becoming increasingly useful in individual and population health, from appointment time reminders, to learning more about one's symptoms and diagnoses, to buying insurance through state exchanges established under the ACA, to finding providers who are accepting new patients. In addition, many people connect to support groups or other valuable health-related resources through the Internet, and providers are increasingly making health records available via Internet portals.
- **Availability of community-based resources and opportunities for recreational activities**: Community-based resources can connect residents to local health providers and recreational/physical activities, both of which increase the likelihood that people will lead healthier lives overall. The absence of leisurely activities in one's life can lead to increased stress, which in turn is associated with poorer health outcomes overall.
- **Availability of resources to meet daily needs (e.g., access to local food markets)**: The further an individual lives from a grocery store that offers healthy food options, like fruits and vegetables, the more likely it is that the individual will consume fast foods or other relatively unhealthy options. Geographic areas that have no or few healthy food options are referred to as "food deserts." Food deserts tend to be identified based on their shortages of whole food providers and their abundance of "quick marts" and fast food

establishments that stock processed, sugar-heavy, and fat-laden foods that contribute to a poor diet and can lead to higher levels of obesity and other diet-related diseases, such as diabetes and heart disease. Due to the enormous individual and public health effects of food deserts, the U.S. Department of Agriculture has developed a map of the nation's food deserts[13] and many resources aimed at reducing their number.

- **Culture**: By way of example, some cultures rely heavily on time-honored approaches to illness, such as teas and other homemade remedies. While these can be effective, some commonly ingested herbals can in fact be quite dangerous when taken in conjunction with other regularly prescribed medications; for example, St. John's Wort—a plant that is used for medicinal purposes in this country and many others—can have drastic effects when taken alongside certain antidepressant medications. So while traditions can have important positive effects in treating illness, cultural norms can also impact health in unseen ways.
- **Language/literacy**: If adequate translation and interpretation services are not in place in healthcare facilities, foreign language-speaking patients may be discouraged from seeking out care. Even when they do, many patients struggle to understand clinicians and medication or other treatment protocols.
- **Public safety**: Individuals who live in dangerous neighborhoods tend to remain indoors, which can close off opportunities for exercise and social interaction. People who must pass through a dangerous neighborhood in order to reach public transportation often have to make a choice between their own safety and attending work or a doctor's appointment. Furthermore, alcohol, drugs, violence, and the adverse health outcomes associated with them tend to be more prevalent in relatively unsafe neighborhoods.
- **Residential segregation**: Physicians may preferentially set up their practices in locations dominated by certain demographics. As a result, some patient populations—often minority and low-income populations—suffer from a lack of healthcare facilities and resources in their neighborhoods, a particularly strident problem in rural areas.
- **Social norms and attitudes (e.g., discrimination, racism, and distrust of government)**: Discriminatory attitudes remain a cause of health disparities. Multiple studies have shown that physicians are more likely to recommend medical best practices based on race, gender, and age.[14] These studies demonstrate that bias (unconscious or otherwise) in physicians and other health professionals still plays a significant role in how patients of certain races, ethnicities, social statuses, and education levels are treated. Patient attitudes about the medical professions can also affect health. The most infamous example of this stems from the Tuskegee syphilis *experiment*, in which hundreds of syphilis-infected, African American men in rural Alabama were used as unwitting research subjects by the U.S. Public Health Service, which wanted to study untreated syphilis in humans. The men were given free medical care but were never told they had the disease, nor were any of them treated with penicillin once it became the accepted course of treatment for syphilis. The study lasted a stunning 40 years, from 1932–1972, and has affected the attitudes and healthcare decisions of many African Americans ever since. In 1997 President Bill Clinton issued a formal apology for the Tuskegee Study, but government healthcare programs have been hard-pressed to earn back the trust of millions of patients that was shattered once the study was revealed.[15]
- **Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)**: While the link between poverty and poor health is discussed below, suffice it to say here that the connection between the two is well-documented and undeniable, and the health effects of extreme financial hardship in childhood can be lifelong even in the event that people eventually escape poverty. A similar phenomenon, though with far different health effects, can be seen at the other end of the socioeconomic spectrum: greater wealth correlates with lower rates of morbidity and longer life spans.

## BOX 7-3 Group Activity

Each student should begin by rank-ordering a list of the half-dozen social determinants (from those listed in this chapter or otherwise; broad or specific) that she/he believes most significantly affects individual health. Then get together in groups of three or four people to compare lists, discussing disagreements and making the case for some determinants over others.

- **Transportation options**: Many individuals miss medical appointments because they cannot afford private transportation and live long distances from reliable public transportation. It is common for patients without their own cars to spend hours on buses in an effort to reach medical appointments.

### The Link Between Social Determinants and Health Outcomes

While it is well beyond the scope of this chapter to provide a full discussion of the myriad ways in which social factors play important roles in individual and population health, we provide in this section a flavor of the types of links that researchers have drawn in this respect. We note at the outset that these links are not usually linear and directly causative: social determinants do not usually act alone or in "simple additive fashion, but rather in concert with one another [and with other types of determinants] in complex, interdependent, bidirectional relationships."[16] Indeed, "most diseases and injuries have multiple potential causes and several factors and conditions may contribute to a single death. Therefore, it is a challenge to estimate the contribution of each factor to mortality."[17] That said, "the overwhelming weight of evidence demonstrates the powerful effects of socioeconomic and related social factors on health, even when definitive knowledge of specific mechanisms and effective interventions is limited."[18]

Links can be drawn between social determinants and both physical and mental health. Among many examples on the physical health front, research indicates that while half of all deaths in the United States involve behavioral causes,[19] evidence shows that health-related behaviors are strongly shaped by three important social factors: income, education level, and employment.[20] Another study concluded that the number of U.S. deaths in 2000 attributable to low education, racial segregation, and low social support was comparable with the number of deaths attributable to heart attack, cerebrovascular disease, and lung cancer, respectively.[21] The CDC has regularly found that individuals among the lowest levels of income and education suffered the greatest age-adjusted prevalence and incidence rate of diagnosed diabetes.[22] Similarly, associations have been demonstrated between lower socioeconomic status and increased prevalence of disease, morbidity, and mortality in persons with arthritis and rheumatic conditions.[23]

Access to safe, quality, affordable housing represents one of the most influential social determinants of health. Indeed, for individuals and families trapped in a cycle of housing instability, this determinant can almost completely dictate their ability to achieve and maintain a healthful state.[24] Several studies demonstrate that linking healthcare management to supportive housing—an evidence-based practice that combines permanent affordable housing with relevant support services—leads to improved health outcomes. For example, a study out of Denver found that 50% of supportive housing residents experienced improved health status, 43% had better mental health outcomes, and 15% reduced substance use.[25]

Regardless of income or housing cost, living in a predominately minority neighborhood increases the likelihood of having poor access to healthy food choices.[26] For example, one study found that African American urban neighborhoods have only 41% of the chain supermarkets found in comparable white neighborhoods,[27] and minority neighborhoods have an overabundance of fast-food restaurants known for relatively inexpensive but unhealthful food options.[28]

As noted, social determinants play a significant role in mental health outcomes, as well. Emotional stressors—such as neighborhood violence, poverty, or familial abuse—during key developmental years in childhood can lead to severe consequences later in life. For example, several studies have been conducted regarding the mental health outcomes of children who have been subject to abuse, including one showing that survivors of childhood sexual abuse have higher levels of both general distress and major psychological disturbances, including personality disorders.[29] One recent and fascinating study demonstrated that the brains of children in low-income families actually had less surface area than children from families who were wealthier—specifically, 6% less surface area in children whose families made less than $25,000 a year compared with children whose families made more than $150,000.[30] One theory behind this finding was that children from poor families tend to be malnourished and have less access to high-quality education than their richer peers. Another theory proposed that poorer families tend to lead more chaotic lives, which can inhibit brain development in children.

## LAW AS A SOCIAL DETERMINANT OF HEALTH

Up to this point, we've described generally various types of social determinants of health and some correlations between those determinants and the health of people who live in communities in which SDH may be relatively more compromised. We turn now to a more nuanced discussion of one very influential social determinant of health: the law. Throughout the nation's history, law has played an integral role in causing, exacerbating, and alleviating health-harming social conditions,

from the legally sanctioned, racially segregated—and horribly unequal—medical care systems used during slavery time, to the expansion of building codes in the 1920s, to the War on Poverty legislation of the 1960s, to the Affordable Care Act's focus on health equity. Because the law's reach in this regard is so expansive, we only provide an overview for purposes of this chapter.

Whether embodied in constitutions, statutes, regulations, executive orders, administrative agency decisions, or court decisions, the law plays a profound role in shaping life circumstances and, in turn, health. The ways in which this occurs can be broken down into four categories.

1. **The law can be used to design and perpetuate social conditions that can have terrible physical, mental, and emotional effects on individuals and populations**. One obvious example in this category is the "separate but equal" constitutional doctrine that allowed racial segregation in housing, health care, education, employment, transportation, and more. Indeed, injustices in healthcare access and quality were commonplace in the United States prior to the Civil Rights Movement. Racially segregated health care dates to slavery times, when plantations had on-site facilities to care for slave laborers. After the slaves were freed but also after the First Reconstruction ended in the late 1870s, Jim Crow laws ushered in a new era of discriminatory healthcare access and delivery through separate hospitals and physician practices, separate medical, nursing, and dental schools, and separate professional medical societies (for example, Alabama once had a law that stated: "No person or corporation shall require any White female nurse to nurse in wards or rooms in hospitals, either public or private, in which Negro men are placed."[31]
2. **The law can be utilized as a mechanism through which behaviors and prejudices are transformed into distributions of well-being among populations**. By way of example, although black and white people use illicit drugs at approximately the same rate, drug crime incarceration rates are far higher for black people. Thus, who is chosen for surveillance and arrest, and how the arrested are selected for either punishment or treatment, turns out to be an important driver of how a supposedly neutral law differentially impacts people and communities, and in turn their health.[32] Healthcare provider discrimination and bias reside in this category, as well. Healthcare discrimination and bias can take many forms: it can be based on race, ethnicity, disability, age, gender, and class (or socioeconomic status). Class-related healthcare discrimination alone can take multiple forms. For example, some healthcare providers might refuse to accept as patients individuals who are covered under Medicaid (because the Medicaid population tends to be disproportionately poor and of color), or low-income individuals might fall victim to the practice of redlining, which refers to situations in which healthcare entities relocate from poor neighborhoods to wealthier ones.[33]
3. **Laws can be determinative of health through their under-enforcement**. For example, a perfectly good set of housing regulations aimed at keeping housing units safe, clean, and quiet are of little value to individual and group health if there is neither the will, nor the resources, to enforce them. Substandard housing conditions, including the presence of rodents, mold, peeling lead paint, exposed wires, and insufficient heat—all of which are common among low-income housing units—can cause or exacerbate asthma, skin rashes, lead poisoning, fires, and common illnesses, yet none of these housing problems can be "cured" by a clinical encounter. While their consequences can be treated medically, the causes require robust enforcement of existing laws.[34]
4. **Finally, the law can be used to structure direct responses to health-harming social needs that result from things like impoverishment, illness, market failure, and individual behavior that harms others**. For example, the Emergency Medical Treatment and Active Labor Act (EMTALA) requires Medicare-participating hospitals to provide needed stabilization services to individuals who have an emergent condition. Notably, EMTALA's requirements are universal—meaning they have to be fulfilled by hospitals irrespective of the presenting patient's socioeconomic or insurance status—and were written into law because many private hospitals had long turned away emergent patients who were uninsured and could not pay out-of-pocket for their care.

   Many financing laws that subsidize healthcare services for vulnerable populations also fit into this category. Medicaid is an obvious example, and the Public Health Service Act includes funding for community health centers, persons with HIV/AIDS, persons with mental illness or substance abuse disorders, and project grants to provide preventive and immunization services, and breast and cervical cancer screening and detection. Title VI of the 1964 Civil Rights Act prohibits discrimination on the basis of race, color, or national origin by any recipient of federal financing, including healthcare providers and facilities. Finally, public health departments funded under state and local legal authority provide primary and preventive healthcare services, such as childhood immunizations, to underserved populations.

Programs such as the National Health Service Corps (NHSC) and the Indian Health Service (IHS) were established under federal law to address the lack of providers in rural and other underserved areas. The NHSC was founded in order to incentivize graduates of medical school and other health professions programs to practice primary care in underserved areas, because starting in the 1950's many medical graduates began gravitating in large numbers to large cities to practice a medical specialty. The IHS is the principal federal healthcare provider and health advocate for Indian people, providing comprehensive health services to approximately 1.9 million American Indians and Alaska Natives.

Furthermore, through their police powers, states directly regulate individual and corporate behavior in order to protect and promote the public's health. For example, states regulate the food supply and food establishments, enforce occupational safety rules, curb pollution, control the sale of firearms, restrict the marketing of tobacco products, and accredit healthcare professionals and facilities. Indeed, at the local, state, and federal levels, the law has played important roles in all of the 10 most noteworthy public health achievements of the 20th century, as selected by the federal Centers for Disease Control and Prevention: control of infectious diseases, motor vehicle safety, fluoridation of drinking water, tobacco use control, vaccinations, decline in deaths due to coronary heart disease and stroke, food safety, improvements in maternal and child health, family planning, and safer work places.[35]

Taken together, the above discussion illustrates how using law to achieve better health is well-suited to what is called a "health in all policies" (HIAP) strategy. This strategy is based on the recognition that several pressing health-related challenges—inequities, chronic disease, skyrocketing costs, the need for insurance reform, and so on—are often complex, multi-dimensional, and linked to one another. As a result, HIAP relies on a collaborative governmental (and sometimes nongovernmental) approach to health improvement by incorporating health considerations into an array of policy decisions, and by engaging governments and other stakeholders in a multi-sector approach to shaping the economic, physical, and social environments in which people live, work, and play.

In thinking about how law could be used to foster a HIAP approach, consider the number of rule-making departments and agencies at just the federal level that can (and do) serve health care and public health functions even though they are not commonly identified as health agencies. The Environmental Protection Agency (EPA) plays an obviously important role in environmental health. Reducing injuries and hazards in the workplace are key goals of the Occupational Safety and Health Administration (OSHA), which is part of the Department of Labor. The Department of Homeland Security protects health when it prepares for and responds to disasters and terrorism. The Department of Agriculture (along with the Food and Drug Administration) plays an important role in the protection of the nation's food supply. The Department of Housing and Urban Development influences the built environment, which in turn influences health. The Department of Energy sets radiation safety standards for nuclear power plants and other sources of energy. Again, these are just federal agencies, and they are all part of the Executive Branch of government; Legislative Branch committees at the federal, state, and local levels that are also not typically considered "health" committees could also craft legislation with a HIAP approach in mind. The multiple branches and agencies involved in health-related matters plainly shows that the variety of influences impacting individual and population health are outside the control of the health sector alone.

## BOX 7-4 Group Activity

Get together in groups of three or four people. As a group, take 20 minutes to make a list of all the specific ways you can think of that the law has been used to directly respond to health-harming social needs (examples exist in category #4 in this section). When time is up, compare lists across groups, discuss disagreements, and see which group thought of the greatest number of legal interventions.

### Right to Criminal Legal Representation vs. Civil Legal Assistance

Appreciating the law's power to ameliorate social conditions that negatively affect health requires an understanding of the difference between using law to design broad policies (e.g., Title VI of the Civil Rights Act, firearm regulations, federal housing policy, the Affordable Care Act) and leveraging the

legal system as an individual who is aiming to redress his or her own hardship. In the case of the latter, it helps to understand the difference between rights that attach in the area of criminal legal representation versus those that exist in the realm of civil legal assistance, because it is through civil legal assistance that many types of SDH can been ameliorated.

### Criminal Legal Representation

The government is required to provide legal counsel to all federal defendants who are unable to afford their own attorneys; this right is explicit in the Sixth Amendment to the U.S. Constitution. The right to counsel in state criminal prosecutions was established by the U.S. Supreme Court (though only for serious offences) in the famous 1963 case of *Gideon v. Wainwright*.[36] The case arose out of an everyday burglary at a Florida pool hall, for which Clarence Earl Gideon was arrested notwithstanding the flimsy evidence against him. Because Gideon was indigent and could not afford private counsel, he appeared in court alone. He requested counsel but was denied, and as a result acted as his own lawyer at trial. A jury found him guilty and the Florida trial court sentenced Gideon to serve five years in state prison.

From prison, Gideon appealed his conviction to the U.S. Supreme Court, arguing that his constitutional rights had been violated when he was denied counsel. The Supreme Court agreed to hear Gideon's constitutional claim and assigned him a well-known lawyer, Abe Fortas, who himself would one day become a U.S. Supreme Court Justice. Building on previous right to counsel cases (for example, in the event of a state prosecution where the death penalty was sought), the court ruled that the assistance of counsel, if desired by an indigent defendant, was a fundamental right under the U.S. Constitution that was required in state prosecutions of serious crimes. Gideon received a new trial and—with the assistance of a lawyer supplied at government expense—was acquitted of all charges just five months after the Supreme Court's ruling.

The decision in *Gideon v. Wainwright* spawned many changes in the representation of indigent criminal defendants, including in misdemeanor and juvenile proceedings. The decision effectively created the need for public defenders (lawyers employed at public expense in criminal trials), and it lies at the heart of a series of cases dealing not only with legal representation at trial and on appeal, but with police interrogation tactics and the right to remain silent, as well.

### Civil Legal Assistance

While the right to legal representation exists in criminal matters, no such right exists on the other side of the legal ledger: there is no right to the assistance of a lawyer in civil matters, even when the most basic human needs are at stake. Common civil legal matters involve immigration status, domestic violence, disability law, family law (e.g., child custody cases), housing needs, public benefits (e.g., Medicaid, food stamps, Social Security), employment disputes, and special education needs. In all of these types of disputes—which can be incredibly complex from a legal perspective and which can have life-altering consequences—low-income individuals and families can have no expectation that an attorney will provide them with assistance. (We should note, however, that under some state laws individuals have a right to counsel in limited civil situations, such as with the termination of parental rights or involuntary commitments to mental health facilities.) In civil matters, indigent people (and, increasingly, more members of the middle class and a rising number of small businesses who cannot afford legal fees[37] can apply for what is known as civil legal aid or civil legal services, which are provided by a network of publicly funded legal aid agencies, private lawyers and law firms practicing on a *pro bono* basis, law school clinics and professional organizations (the latter group includes organizations such as the American Bar Association, the National Legal Aid & Defender Association, and the American Bar Foundation).

This network is the heart and soul of what is termed the *access to justice* movement, which promotes strategies to address the severe gap in access to both criminal and civil justice for low-income and other vulnerable populations.[38] One of the goals of this movement is to establish a "civil *Gideon*"—in other words, to create a mandate for legal representation of the poor in civil lawsuits. For example, the American Bar Association's House of Delegates passed in 2006 a resolution backing the concept of "civil *Gideon*":

> **RESOLVED**, That the American Bar Association urges state, territorial and federal jurisdictions to provide counsel as a matter of right at public expense to low-income persons in those categories of adversarial proceedings where basic human needs are at stake, such as those involving shelter, sustenance, safety, health or child custody, as determined by each jurisdiction.[39]

Because the combined resources of the civil legal services community are very limited, services are approved on the basis of financial need, meaning that only those individuals with very low incomes receive assistance. Indeed, reports on the legal aid community routinely describe situations

in which 80% of civil legal needs for low-income families were not being met, and legal services programs typically turn away over half of the low-income individuals that seek assistance. Congress is most to blame for legal aid's financial predicament; it provides the vast majority of the budget for the Legal Services Corporation (LSC), a not-for-profit corporation established by federal law in 1974 as the single largest funder of civil legal aid for low-income Americans. Considering LSC's annual appropriations from Congress in constant 2015 dollars, its appropriation in 1976 was approximately $386,000,000; in 2015, its appropriation was $375,000,000.[40] So even as need has soared over time—the U.S. Census Bureau's 2012 statistics on poverty show that over 63 million Americans could qualify for civil legal assistance funded by LSC[41]—the key element of legal aid funding has been treated as an afterthought.

The link between civil legal assistance and individual and population health is exemplified by a study of the civil justice experiences of the American public, called the Community Needs and Services Study.[42] The study uncovers widespread incidence of events and situations that have civil legal aspects and for which people receive no formal or expert legal assistance: fully two-thirds of a random sample of adults in a middle-sized American city reported experiencing at least one of 12 different categories of civil justice situations in the previous 18 months (the average number of situations reported was 3.3, and poor people, African Americans, and Hispanics were more likely to report civil justice situations than were middle- or high-income earners and white people).[43] Unsurprisingly, the most commonly reported situations concerned problems with employment, finances and government benefits, health insurance, and housing. Importantly, respondents indicated that almost half of the civil justice situations they experienced resulted in a significant negative consequence such as feelings of fear, a loss of confidence, damage to physical or mental health, or verbal or physical violence or threats of violence.[44] In fact, adverse impacts on health were the most common negative consequence, reported for 27% of situations. Also important is the fact many of those who responded indicated that they didn't even know that the problems they were experiencing were rightly considered "legal" in nature.[45]

For all of the reasons just discussed—the lack of a right to needed civil legal services, the misunderstandings among those most in need, and the lack of resources in the civil legal aid community—it is paramount that the nation develop and implement innovative, upstream approaches to addressing social conditions that harm health. One such innovation that has taken root is medical-legal partnership.

## BOX 7-5 Discussion Questions

What do you think about the differences that exist between rights that attach in the area of criminal legal representation versus those that exist in the realm of civil legal assistance? Does it seem fair to you? Why or why not? Even if you believe it is fair, do you think all individuals should have access to at least a baseline level of civil legal assistance?

## COMBATING HEALTH-HARMING SOCIAL CONDITIONS THROUGH MEDICAL-LEGAL PARTNERSHIP[46]

"Do you have any concerns about your housing conditions? Are you concerned about having enough food to eat? Is your child receiving proper supports at school? Do you feel safe at home?" These types of questions are asked of low-income patients with regularity, and their medical care providers know well that the answers speak volumes about patients' health. When the answers come back, however, healthcare providers are too often powerless to do as much as they would like to help remedy these "life circumstances."

Training doctors, nurses, and allied health professionals to reframe these circumstances can help. By now, you probably recognize many of these types of determinants of health for what they are: social conditions whose improvement would benefit from civil legal assistance. Yet despite the connection between poverty, health, and legal needs, and despite the fact that healthcare and civil legal aid professionals commonly provide services to overlapping vulnerable populations, the professions too infrequently attempt to address their populations' needs in a coordinated fashion.

Medical-legal partnership (MLP) aim to bridge this divide. At a practical level, MLPs function as a patient care team that includes both medical and legal professionals; a legal services attorney is literally embedded in a medical care setting (a hospital, community health center, etc.) to address underlying social conditions that negatively affect patient health but whose remediation is outside the expertise of traditional healthcare providers. At a more fundamental level, the goal of the MLP movement is to help create an interconnected care system that focuses on the whole patient (rather than just on biology and behavior), including the ways in

which myriad social conditions factor into individual and population health. Thus, the work of MLP lawyers is quite different from that of a general counsel or compliance officer who normally inhabits hospitals and clinics; a general counsel typically provides legal advice to clinicians on matters of medical liability and informed consent, and represents them in insurance and disciplinary matters; corporate compliance officers are responsible for ensuring that the facility meets all governmental, environmental, and licensing regulations.

## The Evolution of an "Upstream" Innovation

The modern MLP movement has its roots in the late 1960s, when visionary physicians H. Jack Geiger and Count Gibson were funded by the federal government to form the nation's first community health centers in Mississippi and Massachusetts. The government's community health center program grew out of the civil rights movement, when the federal Office of Economic Opportunity (the agency created to administer many of President Lyndon Johnson's War on Poverty programs, and whose programs continue in large part to this day under the auspices of the U.S. Department of Health and Human Services) established "neighborhood health centers" to provide health and social services to medically underserved populations. In designing the earliest centers, Drs. Geiger and Gibson recognized the importance of spending some of their federal funding on lawyers, who assisted African American health center patients battling housing discrimination.

The second prominent instance of the blending of medical and legal services for low-income populations occurred in the early 1980s when, faced with devastating death tolls from HIV/AIDS, some health clinics began providing on-site legal assistance to patients who needed to quickly grapple with end-of-life issues (medical decision-making, asset distribution, family and custody matters, etc.). A few pioneering clinics held on to this blended model even after the national AIDS crisis abated, offering comprehensive legal services to all patients in need.

Building on these examples, the first formal MLP was created in the early 1990s in a Boston hospital to intervene on behalf of pediatric patients with chronic conditions who were suffering the consequences of inadequate housing. From that point through 2006, medical-legal partnerships sprouted up a few at a time, mainly in pediatric healthcare settings, where the model had proven effective in Boston. Since 2006, however, use of the MLP model has expanded considerably. Fueled by the creation of the National Center for Medical-Legal Partnership (NCMLP), the focus by social scientists on the importance of social factors in determining health, and the Affordable Care Act's focus on disease prevention and professional collaboration, MLP is now practiced in 36 states by nearly 300 hospitals and health centers, in settings as diverse as veteran care facilities, American Indian reservations, and correction facilities.[47]

Under the MLP model, public interest lawyers work with health care workers to screen for health-related legal problems, often encompassing family matters (divorce, domestic violence), housing problems (eviction, habitability, utility advocacy), special education advocacy, immigration issues, disability issues, employment instability, receipt of public benefits (health insurance, Social Security Income), food security concerns, and additional problems that can lead to stress or injury or that can exacerbate existing health problems. **Figure 7-1** lays out the key types of patient problems that make up the practice of a typical, comprehensive MLP, using the mnemonic "I-HELP": **I**ncome, **H**ousing and utilities, **E**ducation and employment, **L**egal status, and **P**ersonal and family stability. [48]

The MLP approach is built on the understanding not only that many social determinants of health require legal interventions, but that moving "upstream" to assist vulnerable populations with legal needs is preferable to waiting until a legal crisis erupts (for example, remediating a housing problem prior to the receipt of an eviction notice). It is similar to preventive health care: it is often more cost effective—and of course more beneficial to the patient, both physically and emotionally—to help a patient remain healthy, rather than treat the patient post-illness. At medical-legal partnerships, healthcare and legal professionals are trained side-by-side about the intersection of health and legal needs and ways to screen for health-harming legal needs. Because MLPs recognize that social determinants contributing to poor health require both health system and public policy change, MLP lawyers utilize on-site legal assistance provided to patients to identify patterns of systemic need, transform institutional practices, and advocate for improved population health policies. **Figure 7-2** portrays this upstream MLP approach. Similar to the movement to integrate behavioral healthcare services into primary care, the integration of civil legal aid with healthcare delivery can improve access to services, build team capacity, and promote patient-centered care.

Medical-legal partnerships have become more integrated over time, with healthcare and legal partners sharing patient and institutional data, jointly developing service and training priorities, and establishing cross-sector communication processes. The more collaboration and integration

**FIGURE 7-1** Framing Legal Care as Health Care

| I-HELP ® Issue | Common Social Determinant of Health | Civil Legal Aid Interventions That Help | Impact of Civil Legal Aid Intervention on Health /Health Care |
|---|---|---|---|
| **Income**  | Availability of resource to meet daily basic needs | **Benefits Unit:** Appeal denials of food stamps, health insurance, cash benefits, and disability benefits | 1. Increasing someone's income means s/he makes fewer trade-offs between affording food and health care, including medications.<br>2. Being able to afford enough healthy food helps people manage chronic diseases and helps children grow and develop. |
| **Housing & Utilities**  | Healthy physical environments | **Housing Unit:** Secure housing subsidies; Improve substandard conditions; Prevent eviction; Protect against utility shut-off | 1. A stable, decent, affordable home helps a person avoid costly emergency room visits related to homelessness.<br>2. Consistent housing, heat and electricity helps people follow their medical treatment plans. |
| **Education & Employment**   | Access to the opportunity to learn and work | **Education & Employment Units:** Secure specialized education services; Prevent and remedy employment discrimination and enforce workplace rights | 1. A quality education is the single greatest predicator of a person's adult health.<br>2. Consistent employment helps provide money for food and safe housing, which also helps avoid costly emergency health care services.<br>3. Access to health insurance is often linked to employment. |
| **Legal Status**  | Access to the opportunity to work | **Veterans & Immigration Units:** Resolve veteran discharge status; Clear criminal/credit histories; Assist with asylum applications | 1. Clearing a person's criminal history or helping a veteran change their discharge status helps make consistent employment and access to public benefits possible.<br>2. Consistent employment provides money for food and safe housing, which helps people avoid costly emergency health care services. |
| **Personal & Family Stability**  | Expose to violence | **Family Law Unit:** Secure restraining order for domestic violence; Secure adoption, custody and guardianship for children | 1. Less violence at home means less need for costly emergency health care services.<br>2. Stable family relationship significantly reduce stress and allow for better decision-making, including decisions related to health care. |

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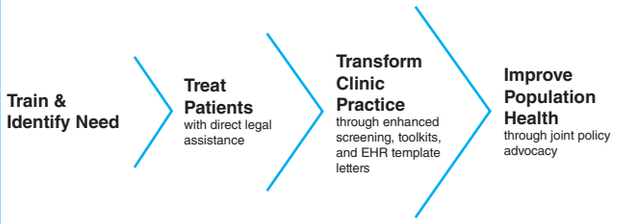
**FIGURE 7-2** The MLP Approach to the Social Determinants of Health

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that occurs, the more likely it is that upstream detection of the social conditions that lead to poor health can occur. Deep collaboration and integration also presents an opportunity for healthcare providers and lawyers—two learned professions that, historically, have not been the closest of colleagues—to work together when policymakers design fixes for health-harming social and legal problems.

## The Benefits of Medical-Legal Partnership

Due to the relatively recent growth of medical-legal partnership, the effects of the MLP model have been relatively untested in formal, large-scale studies. At the same time, several small-scale studies have been conducted[49] and offer preliminary evidence of the benefits of the model in three areas: impact on patient health and wellbeing, financial impact on partners and patients, and impact on knowledge and training of health providers.

A handful of studies make the case for MLPs by demonstrating the positive impact they can have on patient health and wellbeing. One such study, focused on home visit/nurse-based interventions for prenatal and postpartum patients, demonstrated better prenatal health behaviors, better pregnancy outcomes, lower rates of child abuse and neglect, and higher rates of maternal employment among participants as a result of MLP services.[50] A second study indicated that a 91% reduction in emergency department visits and hospital admissions of inner-city asthmatic adults took place after a medical-legal intervention. In the same study, over 91% of patients also dropped two or more classes in asthma severity.[51] Another study focused on cancer patients in an MLP showed a reduction in stress for 75% of the patients, an increase in treatment adherence for 30% of them, and greater ease in keeping appointments for 25% of patients.[52] Yet another study showed that by redressing complex social issues through legal advocacy, patients benefitted by suffering less stress, increasing their access to preventive health care, and a greater feeling of general well-being.[53]

Several MLP studies have focused on the financial benefits of the model—in other words, on the "return on investment" that accrues to institutions that invest in a medical-legal partnership. One such study found that an MLP targeting the needs of cancer patients generated nearly $1 million by resolving previously denied health insurance benefit claims.[54] Similarly, a separate study highlighted four MLP programs, each of which demonstrated successful recovery of previously unreimbursed funds as a result of improperly denied Medicaid or Social Security Disability claims.[55] More striking still is evidence of the financial impact that MLPs could have on patients: an MLP in Illinois helped to relieve $4,000,000 in patients' healthcare debt, and claimed $2,000,000 in additional awarded Social Security benefits for patients.[56]

Finally, multiple articles have addressed how MLPs can benefit practitioners and patients alike through interdisciplinary training and education. One article, focused on strategies for teaching cultural competence, interdisciplinary practice, and holistic problem solving in legal and medical curricula, describes a legal clinic that increased knowledge about avenues of legal assistance among doctors and of the clinical impact of social determinants of health among lawyers.[57] A second paper describes how medical residents working in clinics with social/legal resources were more confident in their knowledge regarding public benefits, and how these same residents were more likely than residents without these resources to ask patients about their social history, use of public benefits, and housing situation.[58] Finally, medical residents who had social work or MLP resources on-site were more confident regarding their personal knowledge of social determinants of health, and as a result were found to screen for them more frequently than other residents.[59]

## CONCLUSION

Recall from the start of this chapter the concept of health equity—essentially, an environment in which all people have an opportunity to attain their full health potential. While the nation is far from achieving a state of health equity, it does appear that society is reorienting itself in the direction of this goal, if incrementally. More evidence of whether this is in fact the case will come in a few years, when it will be clearer as

to whether most Americans accept the Affordable Care Act's main goals as ones worth striving for. (Note one final time the law's role as social determinant of health: should the ACA achieve near-complete implementation—and public acceptance along the lines of, say, the Medicare program—the nation, in our view, will be healthier than if it continues to be subjected to political and legal attacks, and to implementation battles in nearly half the states.)

Whether the nation strives for full health equity aggressively or half-heartedly, there is little doubt that increasing our collective focus on the link between social factors and health would benefit millions of individuals and, in turn, the public more generally. Considering that American children, in particular, experience a high prevalence of social conditions that compromise their care and development—including insufficient family income to meet basic living needs, food insecurity, unstable housing, environmental toxins, and a lack of high-quality child care[60]—this type of reorientation is nothing less than a moral imperative.

One facet of this transformation is reframing civil legal services for vulnerable populations as a critical component of health care. Civil legal aid, after all, is first and foremost about promoting the enforcement of existing laws that protect vulnerable populations.[61] If health is at the core of well-being for all people, then reducing barriers to good health should be an obvious societal goal, and for low-income and other vulnerable populations this means reducing the health-harming effects of social conditions that they struggle with disproportionately. To address this inequality, the civil legal community should closely align its activities and priorities with healthcare and public health partners.

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