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Aligning Public Health, Health Care, Law and Policy: Medical-Legal Partnership as a Multilevel Response to the Social Determinants of Health

Elizabeth Tobin Tyler*

Health, among all the other forms of disadvantage, is special and foundational in that its effects on human capacities impact one's opportunities in the world and, therefore, health must be preserved to ensure equality of opportunity.

Lawrence O. Gostin¹

I. Introduction

In the United States, the intersection between health and equal opportunity is most often framed around access to health care. As compared to other countries, health is generally understood through the lens of American ideals of individualism.² Each individual bears personal responsibility for his or her own health.³ Unavoidable disease and illness should be treated medically by providing access to a high quality health care system; the burden of disease and illness brought on by poor lifestyle choices should be borne by the individual. The concept of justice as it relates to health stems from notions

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¹ Lawrence O. Gostin, *Meeting Basic Survival Needs of the World's Least Healthy People: Toward a Framework Convention on Global Health*, 96 *GEO. L.J.* 331, 344 (2008).

² See Meredith Minkler, *Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End*, 26 *HEALTH EDUC. & BEHAV.* 121, 123 (1999) (discussing the role of individualism in American health care).

³ See *infra* notes 28-34 and accompanying text.

of individual rather than social responsibility for individual, community or even population health.

As an indicator of our national priorities related to health, the Patient Protection and Affordable Care Act (“ACA”) symbolizes this focus on access to the health care system, rather than a broader vision of the connections between social context and communal responsibility for health. As critically important as expansion of access to health care is, a fuller understanding of the role of social justice in health is needed, particularly as mounting evidence points to the role of social conditions in health outcomes. As public health researchers continue to document the role of the social determinants of health (“SDH”) – “where we live, learn, work and play” – in racial, ethnic and economic health disparities in the U.S., discussion of the intersection between health and social justice is unavoidable.⁴ Yet, shifting focus to legal and policy changes that may address SDH has been difficult.

The role that law plays in SDH is a relatively new area of concern for both health law scholars and lawyers who serve vulnerable populations. Recently, however, the role of law in SDH has garnered significant attention. A 2011 report by the Institute of Medicine, *For the Public’s Health: Revitalizing Law and Policy to Meet New Challenges*, highlights this heightened attention and inquiry.⁵ Similarly, health policy experts are increasingly noting that to improve population health outcomes and reduce disparities, a “health in all policies” approach is fundamental to addressing SDH.⁶ Nonetheless, as researchers, practitioners, and policymakers more directly acknowledge and articulate the connections between social justice and health, they all face the challenge of identifying and then acting to change laws and policies that harm the health of vulnerable populations or develop ones that improve health outcomes.

Typically, models of prevention in the health care and public health sectors have been viewed as discrete, with public health focusing on primary prevention (“upstream” interventions) and health care offering secondary or tertiary prevention once a patient is ill. Health care providers are not viewed as active or even relevant to addressing SDH.⁷

⁴ See *infra* notes 13-16 and accompanying text.

⁵ COMM. ON PUB. HEALTH STRATEGIES TO IMPROVE HEALTH, INST. OF MED., FOR THE PUBLIC’S HEALTH: REVITALIZING LAW AND POLICY TO MEET NEW CHALLENGES 1-2 (2011) [hereinafter *INST. OF MED.*], available at http://www.nap.edu/catalog.php?record_id=13093.

⁶ *Id.* at 79. A health in all policies approach is “an approach to policymaking in which decision-makers outside the health sector routinely consider health outcomes: benefits, harms, and health-related costs.” *Id.*

⁷ See *infra* notes 79-82 and accompanying text.

With passage of the ACA, several public health law scholars have assessed the law's attention to public health goals of primary prevention, and have come to different conclusions regarding the strength of the law's provisions.⁸ Professor Lawrence Gostin argues that what is needed is a more "integrated" approach to what has been a fairly incongruous approach to SDH through the health care and public health sectors.⁹ Using the concept of integration, I explore here the importance of addressing SDH in both the health care setting and through public health policy. Furthermore, I discuss the role of law in shaping SDH and the role of lawyers in addressing SDH through partnering with health care providers, public health workers, and policymakers through Medical-Legal Partnerships ("MLPs"). In MLPs, lawyers are part of the health care team, training health care providers to identify unmet legal needs and enforcing legal rights as a targeted intervention directed at SDH. MLP represents a public health intervention that addresses SDH both within and outside the health care system.

In Part II, I present briefly how SDH are the primary factor in creating health disparities. In Part III, I discuss the current responses to SDH. Specifically, I highlight how the U.S. trails other developed countries in its approach to SDH, in large part because of policymakers' framing of health as an individual, personal responsibility. I then explore the role of public policy and law in addressing SDH. In Part IV, I assess the potential for the ACA to provide mechanisms for reducing health disparities by addressing SDH. With its primary focus on reforming the health care system and expanding health insurance to the uninsured, is it likely to help to reduce health disparities? In Part V, I explore the importance of integrating public health goals into primary health care by describing the vital role of health care providers in identifying and addressing SDH. Finally, Part VI argues that MLPs achieve the dual goals of screening for and addressing SDH for individual patients and families by enforcing legal rights, while also identifying systemic and policy issues at the community level that must be addressed to improve population health and reduce health disparities. Furthermore, I argue that the enforcement of legal rights by integrating legal services into primary care health settings serving vulnerable patients benefits health, not just by addressing SDH, but also through empowering individuals, families, and communities to challenge unresponsive systems (i.e. the health care system, the education system, and government assistance programs) that affect their health.

⁸ See *infra* notes 56-66 and accompanying text.

⁹ See *infra* notes 67-71 and accompanying text.

II. Social Determinants of Health as the Primary Factor in Health Disparities

Racial, ethnic, and socioeconomic health disparities have proven to be a persistent, if not intractable problem in the U.S.¹⁰ Despite recent attention from public health researchers, health policy experts and foundations, improvements have been slow. Because equity in health plays a significant role in human opportunity, it is of great importance for policymakers concerned not only with individual health,¹¹ but also with the functioning and productivity of populations.¹²

Some of the difficulty of addressing health disparities lies in the complexity of identifying their root causes.¹³ Increasingly, researchers and policymakers are focusing on the social determinants of health—"the conditions in which people are born, grow, live, work and age."¹⁴—rather than just the health care system to understand and address

¹⁰ See David R. Williams, *Patterns and Causes of Disparities in Health*, in POLICY CHALLENGES IN MODERN HEALTH CARE 115, 129-30 (David Mechanic et al. ed., 2006); see also COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 35-36 (Brian D. Smedley et al. eds., 2003) (discussing the health gap between minority and non-minority groups); Paula A. Braveman et al., *Broadening the Focus: The Need to Address the Social Determinants of Health*, 40 AM. J. PREVENTATIVE MED. S4, S14-S15 (2011).

¹¹ Mutamad Amin et al., *EquiFrame: A Framework for Analysis of the Inclusion of Human Rights and Vulnerable Groups in Health Policies*, HEALTH & HUM. RTS., Dec. 2011, at 1, 3 available at <http://www.hhrjournal.org/index.php/hhr/article/view/430/646>. "Equity in health 'implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided.'" *Id.* (quoting M. Whitehead, *The Concepts and Principles of Equity and Health*, 22 INT'L J. HEALTH SERVICES 429 (1992)).

¹² INST. OF MED., *supra* note 5, at 24-25 ("Health is a foundational requirement for the social, economic, and political activities critical to the public's welfare and to the strength of a nation (its governmental structure, civil society organizations, cultural life, economic prosperity, and national security)" (citing Gostin, 2006)); see also Gostin, *supra* note 1, at 7.

¹³ See THOMAS A. LAVEIST, *MINORITY POPULATIONS AND HEALTH: AN INTRODUCTION TO HEALTH DISPARITIES IN THE UNITED STATES* 283-85 (2005); Wendy E. Parmet et al., *Social Determinants, Health Disparities and the Role of Law*, in POVERTY, HEALTH AND LAW 3, 3 (Elizabeth Tobin Tyler et al. eds., 2011).

¹⁴ COMM'N ON SOCIAL DETERMINANTS OF HEALTH, WORLD HEALTH ORG., *CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH* 1 (2008), available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf. There is extensive literature on research documenting the significance of social determinants in affecting health outcomes and disparities. See e.g., INST. OF MED., *supra* note 5, at 57; Bruce G. Link & Jo C. Phelan, *Fundamental Sources of Health Inequalities*, in POLICY CHALLENGES IN MODERN HEALTH CARE 71, 71 (David Mechanic et al. eds., 2006); Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099, 1103 (2005).

disparities: “Practical experience suggests that eliminating systematic health disparities between social groups requires correcting their fundamental causes, at least to some extent, as well as cushioning their health-damaging effects.”¹⁵ Yet, addressing SDH as a means to health equity is not only complex, but may also be controversial, as it raises critical questions about poverty and income inequality in the U.S.¹⁶

Nonetheless, evidence shows that improvement in individual and population health and reduction of disparities will only occur with recognition that access to health care alone is insufficient:

Evidence indicates that preventative interventions targeting behavior, the environment, and socioeconomic factors (including education, economic security, social support, and community safety) account for approximately 80% of the reduction in morbidity and mortality, whereas clinical care only accounts for 20%.¹⁷

At the global level, the World Health Organization established the Commission on the Social Determinants of Health in 2005, recognizing that improving public health requires a shift from a “biomedical model to a social model: to put on the agenda the social and political conditions that create health inequity, and policies to deal with them.”¹⁸ In the U.S., policy responses have primarily focused on changes in the health

¹⁵ Paula Braveman & Sofia Gruskin, *Poverty, Equity, Human Rights and Health*, 81 BULL. WORLD HEALTH ORG. 539, 540 (2003), available at <http://www.who.int/bulletin/volumes/81/7/Braveman0703.pdf>.

¹⁶ *INST. OF MED.*, *supra* note 5, at 23.

[P]ublic health attention to the more distal social and environmental determinants of health is often controversial in that it occurs against the interplay between the values of society and elected officials, and among disagreements about the ascendance of particular values. Moreover, these determinants have the longest time line and most complex—and often poorly elucidated—pathways (i.e., pathophysiologic links) from cause to effect.

Id.

¹⁷ Lawrence O. Gostin et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1792 (2011).

¹⁸ Ruth Bell et al., *Global Health Governance: Commission on Social Determinants of Health and the Imperative for Change*, 38 J.L. MED. & ETHICS 470, 475 (2010). The Commission's Interim Statement articulates the focus on root causes of ill-health:

Strengthening health equity – globally and within countries – means going beyond contemporary concentration on the immediate causes of disease. More than any other global health endeavor the Commission focuses on the “causes

care system rather than public health approaches focused on preventive interventions. As discussed in Part IV, the most consequential federal law affecting health and health care, the ACA, incorporates some provisions that may serve to address SDH and promote preventive public health goals, but is primarily geared toward reforming the health care delivery system and expanding access to health insurance.

III. Responses to SDH: Public Health versus Health Care Paradigms

Public health strategies focus not on health care interventions to improve individual health outcomes, but rather on “upstream” preventive interventions that improve health outcomes at the population level. Thus,

[b]y looking at multiple populations, public health researchers have observed the so-called prevention paradox: interventions (including legal interventions) that operate even slightly upon larger populations can, at times, reduce the overall incidence of disease more significantly than those that act more robustly upon high-risk individuals or narrowly defined groups.¹⁹

In designing interventions that may address SDH, the public health approach uses social epidemiology to understand the influence of social conditions that affect health and health behaviors, rather than employing a biomedical or individual approach.²⁰ Furthermore, public health assesses interventions as primary, secondary, and tertiary levels of prevention, focusing on primary prevention to prevent illness altogether.²¹

of the causes” – the fundamental structures of social hierarchy and the socially determined conditions these structures create in which people grow, live, work and age – the social determinants of health.

Id.

¹⁹ WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH AND THE LAW 21 (2009).

²⁰ Micah L. Berman, *A Public Health Perspective on Health Care Reform*, 21 HEALTH MATRIX 353, 355 (2011).

²¹ *See id.* at 361. These are defined as:

Primary prevention prevents an illness or injury from occurring at all, by preventing exposure to risk factors. *Secondary prevention* detects disease at an early stage, before the disease has become symptomatic, using medical testing and screening. *Tertiary prevention* seeks to prevent a worsening of symptoms in an individual already suffering from an ailment or disorder.

Id.

Childhood lead poisoning provides a good example. A primary prevention approach would ensure through law and policy that housing is free from lead hazards that may poison a child. A secondary approach would ensure that all children are screened in the health care setting for elevated lead levels in order to detect initial exposure. This screening would be an attempt to remedy the hazardous conditions before a child is harmed or in order to reduce potential further harm. Tertiary prevention would provide medical intervention to address the damage caused by poisoning and seek to prevent continued exposure and damage. Unfortunately, in the case of childhood lead poisoning, many state approaches focus on secondary and tertiary prevention, thus adopting a reactive rather than a truly preventive strategy.²² Addressing the social conditions (in this case unsafe housing) that lead to illness, is in fact, the only way to ensure that a childhood lead poisoning can be prevented. A public health approach to SDH “seeks to uncover the social and environmental factors that lead to health disparities (whether along socioeconomic, racial, gender, or other lines).”²³ Yet, as discussed below, the approach to health disparities in the U.S. remains focused on individual responsibility for health and clinical interventions rather than contributing social structures and conditions that may be addressed through preventive interventions.

Similarly, public health scholars have been frustrated by the failure of policymakers to acknowledge the role of prevention in attacking the root causes of chronic disease, including SDH.²⁴ Instead of employing a public health approach which is “better situated than medical care” to address chronic disease, policymakers have failed to adopt such an approach.²⁵

A. The Role of Public Policy and Law in Addressing SDH

As noted earlier, the U.S. has trailed other developed countries in its attention to the role of SDH in health disparities. Sweden and the U.K., for example, have integrated SDH into public health policies designed to reduce socioeconomic health

²² See Doug Farquhar, *State Lead Poisoning Prevention Statutes*, NAT'L CONFERENCE OF STATE LEGISLATURES, (Nov. 15, 2007), <http://www.cdc.gov/nceh/lead/Legislation%20&%20Policy/StateLeadStatutes2007.pdf> (detailing each state's statutory provisions regarding lead poisoning prevention).

²³ See Berman, *supra* note 20, at 360-61.

²⁴ See *id.* at 353.

²⁵ Gostin et al., *supra* note 17, at 1795. One of the reasons that policymakers do not always fund prevention oriented efforts is that evidence of cost savings may take several years to manifest. See MICHAEL J. O'GRADY & JAMES C. CAPRETTA, CAMPAIGN TO END OBESITY: ASSESSING THE ECONOMICS OF OBESITY AND OBESITY INTERVENTIONS 7 (2012), available at <http://obesitycampaign.org/documents/StudyAssessingtheEconomicsOfObesityandObesityIntervention.pdf>.

disparities.²⁶ Recent studies show that, despite spending two to three times more per capita for health care than countries in Europe, the U.S. has significantly worse health outcomes than Europe, particularly for its poorest residents.²⁷ The primary reason given by scholars for the reluctance in the U.S. to embrace the role of SDH in health disparities is policymakers' conceptualization of health as primarily a matter of personal responsibility and individual choice. Meredith Minkler, Professor of Health and Social Development at the University of California – Berkeley, argues that this view of health has been prevalent in the U.S. for many years:

The dominant view of health promotion in the United States today emerged in the 1970s in response to a growing disillusionment with the limits of medicine, pressures to contain health care costs, and a social and political climate emphasizing self-help and individual control over health. It is a vision that sees individual behavior as in large part responsible for the health problems we face as a society. In the words of J. K. Iglehart, editor of the journal *Health Affairs*, this vision that “most illnesses and premature death are caused by human habits of living *that people choose for themselves*.”²⁸

Furthermore, policy in the U.S. has been directed at health promotion focused on individual behavior change, rather than health protection, focused on social and environmental factors.²⁹ As Minkler further explains, “The programmatic emphasis on

²⁶ See Marmot, *supra* note 14, at 1103.

In Sweden, the new strategy for public health is ‘to create social conditions that will ensure good health for the entire population’. Of 11 policy domains, five relate to social determinants: participation in society, economic and social security, conditions in childhood and adolescence, healthier working life, and environment and products. These are in addition to health promoting medical care and the usual health behaviours. The UK set reduction of health inequalities as a key aim of health policy. It assembled evidence and expert judgments on areas suitable for policy development. These then formed the basis of a plan of action to reduce health inequalities.

Id. However, Britain’s policy efforts to reduce disparities have been criticized as ineffective. See RICHARD WILKINSON & KATE PICKETT, *THE SPIRIT LEVEL: WHY GREATER EQUALITY MAKES SOCIETIES STRONGER* 233-34 (2009). “[A] Dutch expert said Britain was ahead of other countries in implementing policies to reduce health inequalities. However, health inequalities in Britain have shown little or no tendency to decline.” *Id.* at 234.

²⁷ Bell et al., *supra* note 18, at 472-73.

²⁸ Minkler, *supra* note 2, at 123.

²⁹ *Id.* at 124.

individual *responsibility* for health, in short, frequently was not accompanied by attention to individual and community *response-ability*, or the capacity of individuals and communities to build on their strengths and respond to their personal needs and the challenges posed by the environment.”³⁰ That health policy has been primarily constructed around the notion that personal responsibility is at the root of health disparities is hardly surprising given that much of the social policy in the U.S. stems from the principle that poverty is at root caused by individual failure.³¹ Health, therefore, is most often framed in the U.S. in terms of individual choice and the failure to make healthy choices. Fundamental to this view is the uniquely American perspective on autonomous decision-making as a fundamental right and with that right, the responsibility to make good choices.³² Inherent in this notion is that an individual can make decisions in isolation of his or her social environment.³³

Health scholars suggest that this view ignores the importance of social conditions in constructing healthy choices: “. . . people frequently encounter barriers that block their capacity to maximize health. For people at lower socioeconomic levels, lack of money, awareness, understanding, time, social support for health-enhancing behavior, and optimism that adopting certain behaviors will result in a long and satisfying life can be obstacles.”³⁴ Recognizing the impact of social environment on health and health behavior, does not presume that people of low socioeconomic status, for example, cannot and do not make autonomous choices, but rather acknowledges the importance of social environment in shaping those choices.³⁵

³⁰ *Id.*

³¹ The 1996 welfare reform law is titled, “The Personal Responsibility and Work Opportunity Reconciliation Act.” *See* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (codified in scattered sections of 7, 8, 21, 25, and 42 U.S.C.).

³² Minkler, *supra* note 2, at 126.

³³ *Id.*

³⁴ Link & Phelan, *supra* note 14, at 78.

³⁵ Erika Blacksher, *On Being Poor and Feeling Poor: Low Socioeconomic Status and the Moral Self*, 23 THEORETICAL MED. & BIOETHICS 455, 460 (2002). As health ethicist, Erika Blacksher, explains:

Analyses of autonomy have implications for the principle of respect for autonomy. An argument that makes the case that chronic socioeconomic deprivation can thwart the autonomous agency of low SES selves may seem to suggest that their decisions and actions ought not to be respected as autonomous. No such implication is intended. This analysis does raise questions about when and under which circumstances individuals and their decisions can be considered autonomous. But the overarching goal of the analysis is to illuminate the degree to which “we” – as individuals, families,

Given the focus on personal responsibility, it is not surprising that the U.S has focused primarily on health education in the clinical context as a means to change health behavior. But these approaches have relied on efforts “to change behaviors and lifestyles that are ‘too embedded in organizational, socioeconomic, and environmental circumstances for people to be able to change their own behavior without concomitant changes in these circumstances.’”³⁶

Focusing on personal responsibility without recognition of the role of social conditions in health also ignores mounting evidence about the role that stress, racial segregation and discrimination, and social status play in health. Studies of the biology of stress demonstrate that an individual’s response to a stressful environment can literally translate the “social into the biologic.”³⁷ Individuals from lower socioeconomic status have been shown to experience elevated levels of stress in both childhood and adulthood.³⁸ Public health researcher, Nancy Krieger, has also documented a connection between the experience of racial discrimination and poor health outcomes.³⁹ Thus, socioeconomic deprivation affects not just physical health, but also psychosocial health, and as some would argue, the “moral self”– a faith in one’s self-efficacy and agency.⁴⁰

B. Redefining Health Policy to Focus on SDH

Based on the recognition that “policies in societal domains far removed from traditional health policy can have decisive consequences for individual and population health,” public health scholars and some policymakers are promoting policies that take health outcomes into account. Public health researchers use health impact assessments (“HIA”) to illustrate how policies outside of traditional health policy influence health. Specifically,

These assessments offer an objective, evidence- and experience-based

communities, and the larger society – are responsible for fostering and enabling the agency of others.

Id.

³⁶ *INST. OF MED.*, *supra* note 5, at 19.

³⁷ Parmet et al., *supra* note 13, at 12.

³⁸ *Id.* at 13.

³⁹ See generally Nancy Krieger, *Discrimination and Health*, in *SOCIAL EPIDEMIOLOGY* 36-75 (Lisa F. Berkman & Ichiro Kawachi eds., 2000).

⁴⁰ See Blacksher, *supra* note 35, at 455-70 (providing an excellent discussion of the multiple ways in which socioeconomic deprivation assaults “the self”).

method through which to evaluate the implications of policy, regulations and legislation for health and well-being. These focus on policy arenas outside the traditional realm of health care, public health, and health policy, such as education, housing and landlord/tenant laws, immigration and naturalization, criminal justice and employment and income supports.⁴¹

Drawing on research from HIA, the “health in all policies” (“HIAP”) movement seeks to engage government and non-governmental organization in cross-sector activities that “routinely consider health outcomes: benefits, harms, and health-related costs.”⁴² HIAP has been described as “public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal or informal, and can focus on policy development, program management and service delivery.”⁴³

While HIAP is critical to addressing SDH, it is not easily accomplished. As the Institute of Medicine Committee acknowledges in *For the Public's Health*:

Apart from politics and philosophical questions, the fragmented structure of government is itself an obstacle to the HIAP approach. Federal, state, and local governments are often balkanized in silos—agencies with discrete policy interests and regulatory concerns that lack the culture, tools, and language to cross boundaries and coordinate with counterparts in other agencies. An infrastructure that supports such collaboration, such as an interagency task force, cannot be formed or operate effectively without hard work to build relationships and solve interagency barriers that impede communication, collaboration, and the sharing of resources.⁴⁴

Nonetheless, HIAP is a step toward acknowledging that health policy must move beyond a focus on individual personal responsibility and biomedical interventions toward one that incorporates understanding of SDH. As will be discussed in greater detail below, while policies impacting health may or may not be associated with law or

⁴¹ Parmet et al., *supra* note 13, at 21.

⁴² *INST. OF MED.*, *supra* note 5, at 79.

⁴³ *Id.* at 79 (citing GOV'T OF S. AUSTL., IMPLEMENTING HEALTH IN ALL POLICIES, (Ilona Kickbusch, & Kevin Buckett eds., 2010), available at <http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf>).

⁴⁴ *INST. OF MED.*, *supra* note 5, at 89.

legal rights, law plays a pivotal role in the social determinants of health.

C. Law and the Social Determinants of Health

Public health law scholar, Professor Scott Burris, has described “two important ways that law interacts with social determinants: (1) law helps structure and perpetuate the social conditions that we describe as ‘social determinants,’ and (2) it acts as a mechanism or mediator through which social structures are transformed into levels and distributions of health.”⁴⁵ Furthermore, Professor Wendy Parmet provides a useful example of how a law that may seem distal to health may, itself, be understood as a social determinant of health:

Consider the laws that exist in every state requiring children to be schooled. These laws were presumably enacted to educate the next generation of workers and citizens. They are not generally thought of as health laws. Nevertheless, once we recall the well-established connection between education level and health, we may begin to suspect that public education laws may have a profound (albeit perhaps incidental) effect on a population’s health. Importantly, because education may be associated with numerous other social determinants, such as income and health literacy, public education laws may influence health through multiple pathways.⁴⁶

In *For the Public’s Health*, the committee argues that the time is particularly ripe for understanding the importance of law in addressing the social determinants of health.⁴⁷ Public health laws, the committee asserts, are antiquated, focus on infectious rather than chronic disease, and predate current knowledge about the role of social determinants.⁴⁸

In seeking to understand the role of law in SDH, public health law researchers have primarily focused on studying the structural role of law in health outcomes and health disparities. As Professor Burris describes it, the field of public health law research “‘defined as the scientific study of the relation of law and legal practices,’ makes

⁴⁵ Scott Burris, *Law in a Social Determinants Strategy: A Public Health Law Research Perspective*, 126 PUB. HEALTH REP. 22, 23 (Supp. 3 2011), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150125/pdf/phr126s30022.pdf>.

⁴⁶ Parmet et al., *supra* note 13, at 23.

⁴⁷ INST. OF MED., *supra* note 5, at 33.

⁴⁸ *Id.* at 33.

its contribution to the effort to address social determinants by empirically studying both of the ways in which law interacts with social conditions.”⁴⁹ This includes documenting the difference between “the law on the streets” and “the law on the books,” including who is targeted for enforcement and who is not.⁵⁰

Public health law research is an exciting expansion of the framework for understanding “health law” and will undoubtedly make a significant contribution to discussion of how to effectively structure meaningful interventions in law and policy to address SDH. As I will argue in Part VI, another critical strategy for using the law as a tool to address SDH and reduce health disparities is MLP. MLP is, in fact, complementary to public health law research, as it plays a critical role in both addressing SDH in the health care context and serving as a forum for identifying structural legal issues affecting health that are the focus of public health law research.

The discussion of the role of law in SDH is particularly important at this moment in time. As the Institute of Medicine (“IOM”) committee reported,

Law has been and will remain critical for creating the infrastructure that supports directed and accountable action, as well as for limiting some actions that diminish health, or requiring actions that enhance it. As the nation looks to true reform in its health system, and the ultimate goal of optimizing the health of the public, challenges, but also opportunities, exist in revisiting, refashioning, and applying laws to improve the health of Americans. The challenges are by no means minimal.⁵¹

Before turning to medical-legal partnership as a public health intervention to address SDH, it is important to first explore what passage of the ACA indicates about U.S. policymakers’ view of and approach to SDH and health disparities.

IV. The Affordable Care Act: Will It Help to Reduce Health Disparities?

The most consequential health law ever passed in the U.S., the ACA attempts to make dramatic changes in the private health insurance and health care delivery systems.⁵² Because of its expanse, deciphering its impact on the health of vulnerable populations is

⁴⁹ Burris, *supra* note 45, at 24.

⁵⁰ *Id.* at 23.

⁵¹ *INST. OF MED.*, *supra* note 5, at 103.

⁵² *See infra* notes 54-58 and accompanying text.

complex. For example, there are key provisions in the law that clearly seek to reduce health disparities.⁵³ While these provisions primarily focus on expanding access to health insurance and health care and not on addressing SDH, they will, nonetheless, contribute to reducing health disparities.

A. Health Care Coverage Expansions under the ACA

The ACA changes some fundamental relationships governing the health insurance market. Its expansions in health care coverage to the uninsured indicate a major shift toward redistribution of health care coverage.⁵⁴ Health policy expert, Professor Sara Rosenbaum, notes:

Soaring beyond its predecessors, the Affordable Care Act reflects an ambitious and unique legal construct that combines an approach to law in which social contract principles of universality and mutual dependence are linked to a market-based solution to the problem of health insurance.⁵⁵

Through the individual mandate, establishment of state health care exchanges and Medicaid expansion to individuals with incomes below 133 percent of the federal poverty level, it is projected that the ACA will extend health insurance to an additional 32 million uninsured by 2019.⁵⁶ The Medicaid expansion represents a momentous shift in federal health policy, for the first time extending coverage to non-elderly low-income adults.⁵⁷

In addition to health care coverage expansions, the ACA contains provisions that affect virtually every aspect of the health care delivery system. These include provisions, among many more, that affect: Medicare, CHIP, health care quality,

⁵³ See *infra* notes 59-74 and accompanying text.

⁵⁴ Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 2 (2011); see also Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

⁵⁵ Rosenbaum, *supra* note 54, at 10.

⁵⁶ Gostin et al., *supra* note 17, at 1780.

⁵⁷ Rosenbaum, *supra* note 54, at 16; see also Patient Protection and Affordable Care Act of 2010 § 1331 (codified as amended at 42 U.S.C. § 18051); Andrea Kovach & Rachel Gielau, *The Great Medicaid Expansion of 2014: What it is and How to Make it Succeed*, 45 CLEARINGHOUSE REV. 388, 388 (2012). It remains to be seen if any states opt out of the Medicaid program altogether rather than abide by the federal requirements.

community health centers, the health workforce, health information technology.⁵⁸ As discussed below, there are also provisions focused on public health, prevention and health disparities.

B. Public Health: The ACA's Potential for Addressing SDH and Health Disparities

As a representation of lawmakers' understanding of the social determinants of health and a statement of public health priorities, the ACA is a mixed-bag. The IOM's committee's assessment is as follows:

The 2010 *Affordable Care Act*, intended to make quality clinical care services available to all Americans, also includes provisions related to prevention and population health. These components of the law are in some ways peripheral to the law's central purpose, but they reflect the fact that some of the discussions that led to the writing of the law revolved around health, not merely health care. This represents recognition on the part of some lawmakers, advocates, and health professionals that the nation's health problems are not just lack of access or less than optimal quality, but include far more complex challenges that explain the nation's poor return on investment.⁵⁹

Health law scholars have variously depicted the law as fulfilling important public health goals and falling far short of addressing key goals of prevention and attention to SDH. Those who see the ACA as making major strides in public health policy suggest that all of the provisions of the Act taken together have the potential to substantially improve population health.⁶⁰ Some point to the importance of specific provisions in the Act focused on public health and prevention, such as the Prevention and Public Health Fund, which expands funding of preventive services through a range of public health activities, including Community Transformation Grants and wellness programs.⁶¹ Others view the provisions that expand the role of safety net providers in

⁵⁸ Joshua Greenberg & Joel Teitelbaum, *Looking Ahead: Opportunities for Medical-Legal Partnership in the Era of Healthcare Reform*, in POVERTY, HEALTH AND LAW 665, 666 (Elizabeth Tobin Tyler et al. eds., 2011).

⁵⁹ INST. OF MED., *supra* note 5, at 19-20 (citation omitted).

⁶⁰ See Lance Gable, *The Patient Protection and Affordable Care Act, Public Health, and the Elusive Target of Human Rights*, 39 J.L. MED. & ETHICS 340, 340-41 (2011).

⁶¹ Gwendolyn Roberts Majette, *PPACA and Public Health: Creating a Framework to Focus on Prevention and Wellness and Improve the Public's Health*, 39 J.L. MED. & ETHICS 366, 373-75 (2011); see also Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 4002, 4201, 124

the delivery of health care to vulnerable populations as furthering public health goals.⁶² These include outreach, education and enrollment of diverse patient populations through support of patient navigators, and support for community-based primary care such as rural and school-based clinics.⁶³ A major priority of the Obama Administration has been on increasing primary care providers.⁶⁴ Finally, some cite the Act's promotion of integrated models of care, including medical homes⁶⁵ and accountable care organizations⁶⁶ as having the potential to reduce health disparities, particularly through

Stat.119, 541, 564 (2010) (codified at 42 U.S.C. §§ 300u-11, 300u-13) (detailing Prevention and Public Health Fund and community transformation grants). Community transformation grants are competitive grants to be awarded by the Secretary of Health and Human Services through the Director of the Centers for Disease Control and Prevention "to State and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming." Patient Protection and Affordable Care Act § 4201.

⁶² See Dennis P. Andrulis & Nadia J. Siddiqui, *Health Reform Holds Both Risks and Rewards for Safety-Net Providers and Racially and Ethnically Diverse Patients*, 30 HEALTH AFF. 1830, 1830-31 (2011).

⁶³ *Id.* at 1830.

⁶⁴ Berman, *supra* note 20, at 379.

⁶⁵ Greenberg & Teitelbaum, *supra* note 58, at 669.

⁶⁶ Robert A. Berenson & Rachel A. Burton, *Next Steps for ACOs*, HEALTH AFF. HEALTH POLICY BRIEF, Jan. 31, 2012, at 1, available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_61.pdf. The Accountable Care Organization ("ACO") model is intended to improve quality of care through agreed upon quality measures, increase efficiency in health care delivery and reduce costs through shared risk by creating providers that share in the costs of care. See *id.* at 2 (explaining that "shared risk" models allow providers to be eligible for bonuses only if they keep spending to a certain minimum). It remains to be seen whether the ACA's provisions regarding the development of ACOs are likely to reduce health disparities. See *id.* at 5 (outlining the potential improvements and concerns regarding certain racial and socioeconomic groups). While ACOs may improve the quality of care of vulnerable patient populations, Berenson and Burton argue that:

[I]t is unclear whether this focus will improve or worsen health disparities among racial and socioeconomic subgroups. On the one hand, minorities may benefit from ACOs' increased attention to keeping patients in good health, which could "raise all boats" and thus shrink the current disparities in care delivery. On the other hand, ACOs may end up primarily forming in geographic areas where a higher proportion of the population has private insurance, and providers are therefore reimbursed more generously. This could inadvertently worsen health disparities if racial subgroups are left behind as other populations are targeted by ACOs.

Id.

management of chronic diseases, which disproportionately affect low-income and minority populations.

Despite the provisions of the ACA that focus on prevention and promotion of more integrated models of health care delivery, many view the Act as failing to incorporate public health interventions that will reduce health disparities. As Professor Lawrence Gostin and colleagues note:

Aside from increasing health care access and surveillance, PPACA does little to fund or mandate decisive interventions to reduce health inequalities based on race, income, or other factors. Further action will be necessary to develop disparity-reduction initiatives, both in the health sector and in government activities that address the socioeconomic root causes of ill health, such as housing, education, employment, and welfare.⁶⁷

Among public health law scholars, the primary criticism of the ACA is its focus on the individual patient/biomedical approach to prevention rather than public health interventions. Thus, it reflects a secondary, rather than primary prevention approach.⁶⁸ The Act includes provisions such as clinical screening and preventive services, but leaves out broader policy interventions that would address SDH.⁶⁹ In essence, the ACA is a

⁶⁷ Gostin et al., *supra* note 17, at 1814.

⁶⁸ Berman, *supra* note 20, at 363-64 (stating provisions of ACA reflect an individualist paradigm by encouraging personal responsibility). It is important to note, however, that despite these criticisms of the ACA, the Obama Administration has promoted a broader vision of prevention. See Press Release, U.S. Dept. of Health & Human Services, Obama Admin. Releases Nat'l Prevention Strategy (June 16, 2011), available at <http://www.hhs.gov/news/press/2011pres/06/20110616a.html>. In June 2011, the administration announced the National Prevention Strategy, which is "a comprehensive plan that will help increase the number of Americans who are healthy at every stage of life. The National Prevention Strategy recognizes that good health comes not just from receiving quality medical care, but also from clean air and water, safe worksites and healthy foods." *Id.*

⁶⁹ Berman, *supra* note 20, at 371. Professor Berman points out that the law's drafters included recommendation from the Task Force on Community Preventive Services focused on clinical preventions strategies, but left out "a variety of policy and programmatic interventions that reflect a broader understanding of preventive health." *Id.* These include earlier recommendations from the Task Force, such as:

- Comprehensive early childhood development programs for low-income children, "on the basis of strong evidence that they improve intermediate cognitive and social outcomes, which in some cases are markers of improved long-term health outcomes,"

collection of programs and policies, without a coherent public health strategy.⁷⁰ Instead of the primarily individual/biomedical approach taken by the drafters to the ACA, critics argue that a more public health focused approach would have incorporated an understanding of SDH. Professor Gostin and colleagues suggest this different focus:

We applaud the increased access to health insurance and emphasis on prevention, but our approach would substantially alter PPACA's funding allocation, its focus on health insurance markets, and its emphasis on individual health care. To illustrate how our approach to health reform differs from PPACA, we propose three major policy reforms: (1) changing the environment to make healthy behaviors the more likely choice; (2) strengthening the public health infrastructure at the state and local levels; and (3) developing a Health-in-All-Policies strategy that would engage all government agencies in improving health outcomes.⁷¹

Ultimately, Professor Gostin and his colleagues argue that to improve health and reduce health disparities, an "integrated system" that recognizes the importance of both public health (population) and health care (individual patient) perspectives is needed.⁷² Viewing public health and health care as distinct and separate, policy

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- Rental assistance programs to subsidize low-income housing, "on the basis of sufficient evidence of effectiveness in reducing exposure to crimes . . . and decreasing neighborhood social disorder,"
 - Smoke-free laws that prohibit smoking in public places, because such laws not only reduce exposure to secondhand smoke but reduce cigarette consumption as well; and
 - Programs that create places where the public can exercise or that otherwise expand access to fitness equipment.

Id.

⁷⁰ *Id.* at 377. The Affordable Care Act provisions "create a hodge-podge of grant programs, demonstration projects, and research initiatives." *Id.* "Given the sometimes ugly, 'sausage making' process that produced the Affordable Care Act, it is perhaps not surprising that the public health provisions do not reflect any coherent, sustained vision, and many of them look like sweeteners intended to win over particular constituencies." *Id.* at 378.

⁷¹ Gostin et al., *supra* note 17, at 1782-83.

⁷² *See id.*; *see also* Lorian E. Hardcastle et al., *Improving the Population's Health: The Affordable Care Act and the Importance of Integration*, 39 J.L. MED. & ETHICS 317, 318-19 (2011) (stating the importance of integration).

formation often reflects an “either-or” approach, rather than an integrated strategy.⁷³ “Our premise is that public health and personal health care are interactive fields that can, and should, be integrated into one health system. Standing alone, each sphere is necessary but not sufficient. An integrated health system will more effectively prevent and ameliorate injuries and diseases in individuals and the population.”⁷⁴

The move toward integration of public health and health care is also a focus of the IOM. In 2012, the Health Resources and Services Administration (“HRSA”) and the Centers for Disease Control and Prevention (“CDC”) requested that the IOM convene a committee of experts to examine the integration of primary care and public health. The committee’s report, *Primary Care and Public Health: Exploring Integration to Improve Population Health*, suggests that “a number of relatively new developments have converged” that create the opportunity for integration. These opportunities include: the recognized need for innovation to address rising health care costs, growing research on the social determinants of health and importance of primary prevention, new data that help to “understand and address community-level health concerns,” and, most importantly, passage of the ACA.⁷⁵

Embracing the premise that more integration of public health and health care is needed, I now turn to discussion of the inadequacy of *either* a public health approach *or* a health care approach to addressing health disparities and SDH. I then describe how MLP represents *both* a health care *and* a public health intervention that effectively addresses SDH and has the potential to reduce health disparities.

⁷³ Gostin et al., *supra* note 17, at 1783-84 (“Reflecting this functional and conceptual divide, policymakers conceptualize two discrete spheres for policy formulation and implementation. We take a different approach, believing that the separation between health care and public health is exaggerated and that personal and population-based services are interconnected. We prefer to think of a single integrated “health system,” which demonstrates the importance of both perspectives, as well as the synergies between them. Because there is already an emerging, if inchoate, convergence between the two spheres, treating them as two separate systems is increasingly untenable. The future will be an integrated health system, and the more quickly policymakers make this conceptual and functional shift, the better the health outcomes will be for individuals and the population as a whole.”).

⁷⁴ Gostin et al., *supra* note 17, at 1784.

⁷⁵ INST. OF MEDICINE, PRIMARY CARE AND PUBLIC HEALTH: EXPLORING INTEGRATION TO IMPROVE POPULATION HEALTH 1-2 (2012), available at http://www.nap.edu/openbook.php?record_id=13381&page=R1.

V. Integrating Public Health and Health Care to Address Disparities: What Does it Mean in Practice?

A. Understanding SDH: The Role of Health Care Providers

As discussed above, public health law scholars concerned with SDH have focused primarily on identifying how laws and policies impact population health and on promoting a “health in all policies” approach to address SDH.⁷⁶ While studying the effects of particular laws on the health of vulnerable populations and developing multi-sector policies targeted at reducing health disparities is critical, there is also a danger that these efforts may become so remote that they lose sight of the impact on individual and community health and well-being. Professor Burris notes the challenges involved in identifying the most effective site for intervention, particularly when attempting to target specific diseases: “Even when the interventions are truly structural, they may be acting at points in the causal chain so remote from fundamental causes that the interventions cannot reduce overall health inequality, which simply finds a new path to the same inequitable results.”⁷⁷

The distance between policy development and the “effects on the ground” is not specific to public health and health care. There are many contexts in which policy interventions do not render the intended results for individuals and communities.⁷⁸ Nonetheless, there is a particular danger in the “health in all policies” approach that policy analysis and development will become so far removed from patient health that it will be ineffective.⁷⁹ Ultimately, SDH “come together at the individual level.”⁸⁰ Of

⁷⁶ See *supra* Section III.B.

⁷⁷ Burris, *supra* note 45, at 25.

⁷⁸ See, e.g., U.S. DEPT. OF HOUSING AND URBAN DEVELOPMENT MOVING TO OPPORTUNITY FOR FAIR HOUSING DEMONSTRATION PROJECT: FINAL IMPACTS EVALUATION SUMMARY 7-8 (2011). The U.S. Department of Housing and Urban Development’s *Moving to Opportunity* demonstration project rendered mixed results. See *id.* The project provided an experimental group of very low-income residents of public housing with Section 8 vouchers allowing them to move to low-poverty areas. *Id.* at 3-4. While the program showed some health and safety benefits, it did not render the anticipated educational and employment outcomes for the families that received the vouchers. *Id.* at 7-8.

⁷⁹ Scott Burris & Evan D. Anderson, *A Framework Convention on Global Health: Social Justice Lite, or a Light on Social Justice?*, 38 J.L. MED. & ETHICS 580, 581 (2010) (citing concern expressed by Paul Farmer).

⁸⁰ JENNIFER PRAH RUGER, HEALTH AND SOCIAL JUSTICE 103 (2009) (“Without full analysis of the multiple and leveled factors affecting any given person at the individual level, it is impossible to say with certainty and exactitude that some social determinants are more important than others at the supra-individual level.”).

course, this reinforces the need for high quality research to document the pathways between particular interventions and health. But it also signals another principal issue: What is the role of the health care setting (where patients' health is assessed) in identifying the impact of laws and policies intended (or not intended) to affect health outcomes?

While “[g]overnment policy interventions work at a level far above the individual to transform the conditions for health and can achieve efficiencies and economies of scale that are not possible with one-on-one health education or clinical encounters,” frontline health care providers are perhaps best able to identify the role of SDH in patient health, not just at the individual level, but also at the community level.⁸¹ Megan Sandel, a pediatrician and social determinants expert, asserts that physicians and other health care providers “witness the effects of policies on their patients’ bodies.”⁸² In fact, a recent survey of primary care physicians conducted by the Robert Wood Johnson Foundation found that eighty-five percent of the physicians indicated that “unmet social needs are directly leading to worse health for all Americans” and ninety-five percent of physicians serving patients in low-income, urban communities said that “patients’ social needs are as important to address as their medical conditions.”⁸³

In describing the potential partnership between the public health and health care sectors in addressing SDH, public health law scholars have primarily focused on the role of health care providers in tracking outcomes for purposes of evaluating public health interventions.⁸⁴ Integrating public health and health care also requires training of primary care physicians in population health to understand the role of SDH in health. To effectively treat disease, providers must have a comprehensive understanding of environmental, social and community context as well as apply medical interventions.⁸⁵

⁸¹ INST. OF MED., *supra* note 5, at 57.

⁸² Dr. Megan Sandel, Lecture at Brown University’s Seminar Series: *Law and Social Determinants: Legal Interventions to Address Health Disparities* (March 13, 2012), available at <http://www.brown.edu/academics/taubman-center/events/social-determinants-health-law-and-public-policy-part-2>.

⁸³ 2011 *Physicians’ Daily Life Report*, ROBERT WOOD JOHNSON FOUNDATION (Nov. 15, 2011) <http://www.rwjf.org/files/research/73646rwjfpphysicianssurveyrev.pdf>.

⁸⁴ Gostin, *supra* note 17, at 14. For example, Gostin and colleagues describe this kind of collaboration between the public health and health care sectors this way: “[m]easuring public health performance requires integration and active collaboration with the health care sector, as primary care physicians provide preventive services that affect health outcomes at the population level. Partnership with the health care industry is not only necessary, but also highly informative.” *Id.*

⁸⁵ *Id.* at 13.

While training physicians to understand the role of SDH and to identify SDH for purposes of evaluation are critical to public health, these means to integrating public health and health care beg the question of the primary care provider's role in addressing SDH in the patient population that he or she treats. In the Robert Wood Johnson survey, only twenty percent of physicians said that they "feel confident or very confident in their ability to address their patients' unmet social needs."⁸⁶ The survey indicates that many physicians are fully aware of how unmet social needs impact their patients' health but may feel that their training has not prepared them to access the resources needed to address those needs.

B. Health Care Providers as Advocates for Addressing SDH

The divide between health care and public health in addressing SDH is most often described with a narrow conception of the role of health care providers: "Actions may be palliative or responsive (like health care), in that they may (often effectively) moderate the impact of social determinants they do not alter, or they may take the form of 'structural interventions' aimed at changing determinants or their more distal mechanisms themselves."⁸⁷ The problem with this construction of the role of health care providers is that it assumes that addressing social determinants must be left to public health, social and legal services agencies outside the health care setting. But who is better situated to identify the "causal pathways"⁸⁸ of social conditions affecting the health of a patient population than a health care provider? Who is better positioned than the health care provider to advocate for the necessary structural changes that need to occur to reduce or eliminate the impact of those social conditions?

For example, a physician serving low-income patients in a community health center sees multiple patients who reside in a local public housing complex. The physician notices that several of his or her patients with asthma are experiencing an exacerbation of symptoms. After talking with her patients, she learns that the public housing complex has a severe mold problem that housing authority officials have

⁸⁶ 2011 *Physicians' Daily Life Report*, *supra* note 83.

⁸⁷ Burris & Anderson, *supra* note 79, at 582.

⁸⁸ The term, "causal pathway" is defined by the National Institutes of Health as an "'analytical framework,' a depiction (e.g., in a schematic) of direct and indirect linkages between interventions and outcomes. For a clinical problem, a causal pathway typically includes a patient population, one or more alternative interventions (e.g., screening, diagnosis, and/or treatment), intermediate outcomes (e.g., biological markers), and health outcomes." HTA 101 Glossary, THE NAT'L LIBRARY OF MED., <http://www.nlm.nih.gov/nichsr/hta101/ta101014.html> (last updated Sept. 8, 2008). Social epidemiologists focus on the pathways between social conditions and health outcomes. *See generally* SOCIAL EPIDEMIOLOGY (Lisa F. Berkman & Ichiro Kawachi eds., 2000).

refused to address, despite complaints from residents. The physician is in the best position to not only identify social conditions impacting individual and community health, but also to advocate for alteration of those conditions.

Medical education is increasingly incorporating “advocacy training,” for medical students headed into primary care.⁸⁹ With the passage of the ACA and the attention to primary care medical homes as instrumental in reducing health disparities, the role of physicians in not only treating disease but also advocating for policy changes on behalf of their vulnerable patients may have renewed meaning.⁹⁰ As discussed below, health care providers should not be expected to act alone in addressing SDH,⁹¹ but rather should be viewed as critical members of a team that partners them with legal and public health professionals.⁹²

VI. Medical-Legal Partnership: Partnering Health, Law and Public Health Professionals to Address SDH

A Medical-Legal Partnership (“MLP”) is a health care delivery model that integrates legal assistance into health care institutions serving the most vulnerable patient

⁸⁹ See, e.g., Jeremy A. Long et al., *Developing Leadership and Advocacy Skills in Medical Students Through Service Learning*, 17 J. PUB. HEALTH MGMT. & PRAC. 369, 369-72 (2011).

⁹⁰ Peter D. Jacobson & Shelley A. Jazowski, *Physicians, the Affordable Care Act, and Primary Care: Disruptive Change or Business as Usual?*, 26 J. GEN. INTERNAL MED. 934, 936 (2011).

[T]he ACA’s focus on wellness and prevention opens opportunities for physicians to integrate population health into primary care practice. Through every day encounters with patients, physicians see the impact of illness and injury on individuals, as well as the effects of population health factors on individual patients. Physicians seeking to improve their patients’ health must be concerned with both treating disease and preventing illness through education and supportive programs and policies. As a result, a core purpose of primary care should be improving population health.

Id. An SDH framework also needs to be “built on a Primary Health Care platform that balances treatment, prevention, and health promotion” Bell et al., *supra* note 18, at 480.

⁹¹ In fact, anticipated shortages of primary care physicians not only highlight the need for interdisciplinary teams, but also the importance of leveraging physicians as advocates for policy changes that may benefit larger patient populations. For discussion of the impending primary care provider shortage, see generally Thomas Bodenheimer et al., *Confronting the Growing Burden of Chronic Disease: Can the U.S. Health Care Workforce Do The Job?*, 28 HEALTH AFFAIRS 64 (2009).

⁹² This is not to diminish the critical importance of social epidemiological research or the role of public health officials in addressing SDH through broad “health in all policy” initiatives. It is, instead, to suggest a broader vision of the ways in which health care and public health should be integrated to address SDH.

populations to address the social determinants of health. The premise of MLP is that unmet legal needs are social determinants of health: “A legal need is an adverse social condition with a legal remedy—that is, an unmet basic need that can be satisfied via laws, regulations, and policies. Unmet legal needs, which can lead to poor health outcomes, are critical social determinants of health.”⁹³

Since the early 1990’s, when the first MLP was created in Boston, the model has caught fire across the U.S. as an effective strategy for addressing SDH in the health care setting. There are now MLP programs in over 235 health care institutions in the U.S.⁹⁴ The model is being studied and adopted in other countries such as Canada and Australia.⁹⁵ While MLPs vary in structure based on the local health care and legal institutions involved, MLPs share three core components: Legal Assistance, Transforming Health and Legal Institutions and Practices, and Policy Change.

A. The Core Components of MLP

1. *Legal Assistance*

MLP integrates legal professionals into the health care setting to address the complex legal needs of low-income patients. “With a focus on early detection of legal problems and prevention of legal and health crises, MLP legal practice is frequently understood as analogous to primary care.”⁹⁶ Frontline clinicians, who are trained to screen for and identify social determinants of health that may reflect unmet legal needs,

⁹³ Ellen Lawton et al., *Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations*, in *POVERTY, HEALTH AND LAW* 71, 72 (Elizabeth Tobin Tyler et al. eds., 2011). One example of a social need that can translate as a legal need is hunger resulting from wrongful denial of government-funded nutrition assistance. “A patient might not have enough food, which is frequently seen as a ‘social’ need. But when that patient is wrongly denied Supplemental Nutrition Assistance Program (SNAP) benefits—formerly known as food stamps—what was a social need becomes a legal need, because access to the benefit is prescribed by law.” *Id.*

⁹⁴ *MLP Network*, NAT’L CTR. FOR MED.-LEGAL P’SHP, <http://www.medical-legalpartnership.org/mlp-network> (last visited April 25, 2012).

⁹⁵ In 2012, the Hospital For Sick Children and Pro Bono Law Ontario partnered to create Canada’s first medical-legal partnership, modeled after U.S. programs. *Canada Embraces Medical-Legal Partnerships*, THE PBEYE (Jan. 23, 2012), <http://thepbeye.probonoinst.org/2012/01/23/canada-embraces-medical-legal-partnerships>. The MLP model is being studied and adopted in Australia as “advocacy health alliances.” In person conversation with Peter Noble, Coordinator, Legal Practitioner and Migration Agent, Community Legal Centre, in Bendigo, Austl. (April 6, 2012).

⁹⁶ Lawton et al., *supra* note 93, at 74.

refer patients to MLP attorneys for assistance.⁹⁷ On-site legal assistance includes consultation and advice as well as direct representation.⁹⁸ Because MLP attorneys partner directly with the health care team, MLP is not simply a referral service—“it is an integrated approach to health and legal services that facilitates critical, efficient, shared problem solving among health and legal teams who care for patients with complex health and legal needs.”⁹⁹

Through enforcement of legal rights, MLPs address key social determinants of health centered on meeting basic social needs. Health care providers often identify these needs through use of the assessment tool IHELP (Income Supports, Housing and Utilities, Education, Legal Status/Immigration, and Personal and Family Stability and Safety).¹⁰⁰ In this way, MLP illuminates “how injustice is bad for health and therefore what we can do about it . . .”¹⁰¹ by exposing not just how written laws impact health, but also how the implementation and enforcement (or the lack thereof) of laws, regulations and policies on behalf of vulnerable populations determines health outcomes.

2. Transforming Health and Legal Institutions and Practices

MLP also represents a significant reform to the health care and legal systems. MLPs transform health care practice by “training frontline providers to screen for, identify and refer patients with potential legal needs.”¹⁰² This training and the partnership with on-site attorneys not only increases provider understanding of SDH in patient health, it engages those providers in an active role in addressing unmet legal needs that manifest as SDH.

A critical component of MLP is enhancing a health care provider’s ability to identify legal needs early and help address them through improved frontline advocacy, since health care teams have frequent access to vulnerable populations. Along these lines, MLPs develop and disseminate tools and resources to help providers identify and “treat” legal needs that impact health.¹⁰³

⁹⁷ *Id.* at 75.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ See *Legal Issue Areas*, NAT’L CTR FOR MED.-LEGAL P’SHP, <http://www.medical-legal-partnership.org/mlp-network/legal-issue-areas> (last visited April 25, 2012).

¹⁰¹ Burris & Anderson, *supra* note 79, at 581.

¹⁰² Lawton et al., *supra* note 93, at 75.

¹⁰³ *Id.*

MLPs also transform the way that legal services are delivered to vulnerable populations by identifying legal needs within a trusted health care setting, rather than waiting for potential clients to seek out assistance at a local legal aid office. Because legal needs are identified through health care screening, legal problems that may translate into SDH can be addressed preventively before a legal or health crisis arises.¹⁰⁴ Given that it is estimated that only twenty percent of legal needs of low-income individuals are currently being met by traditional legal services programs,¹⁰⁵ there is little question that prevention of legal crises (such as preventable eviction or failure to file an appeal of denial of food stamps in a timely manner) benefits not just the patient/client but also legal services providers addressing basic needs.

Finally, MLPs position health care and legal service providers to address systemic barriers affecting patient health:

[T]hrough frequent interaction with patients, clinicians and the health care system, MLP staff members are in a unique position to identify patterns of unmet need among patient populations, as well as opportunities for institutional and systemic improvement to better address those needs. A core MLP activity is providing evidence-based recommendations to improve the programs and policies within health and legal institutions.¹⁰⁶

3. Policy Change

While MLP makes sense as a service delivery model for addressing the SDH affecting individual health, and helps to transform health care and legal practice, its reach would be limited if it did not also impact population health through policy change. As discussed earlier, identification of SDH at the patient and clinical level is key to driving an understanding of how laws and policy impact both individual and population health. MLP plays a critical role in generating the “patient to policy” perspective that may be missed in public health approaches more divorced from the clinical setting. By

¹⁰⁴ See Samantha Morton et al., *Advancing the Integrated Practice of Preventive Law and Preventive Medicine*, in PREVENTIVE LAW AND PROBLEM SOLVING: LAWYERING FOR THE FUTURE 343 (Thomas Barton, ed., 2009).

¹⁰⁵ LEGAL SERVICES CORPORATION, DOCUMENTING THE JUSTICE GAP IN AMERICA: THE CURRENT UNMET CIVIL LEGAL NEEDS OF LOW-INCOME AMERICANS 16 (2009), available at http://www.lsc.gov/sites/default/files/LSC/pdfs/documenting_the_justice_gap_in_america_2009.pdf (noting that less than one in five legal problems experienced by low-income people are addressed with the assistance of a private attorney or legal aid lawyer).

¹⁰⁶ Lawton, et al., *supra* note 93, at 75-76.

functioning at the health care and community levels, and by partnering health care providers and lawyers to address SDH, MLP shines a spotlight on policy failures that otherwise may go undetected. It provides critical insight into problems of implementation and enforcement—the difference between “laws on the books” and “laws on the streets”—through daily interaction with the unmet legal needs of low-income and vulnerable patient communities.

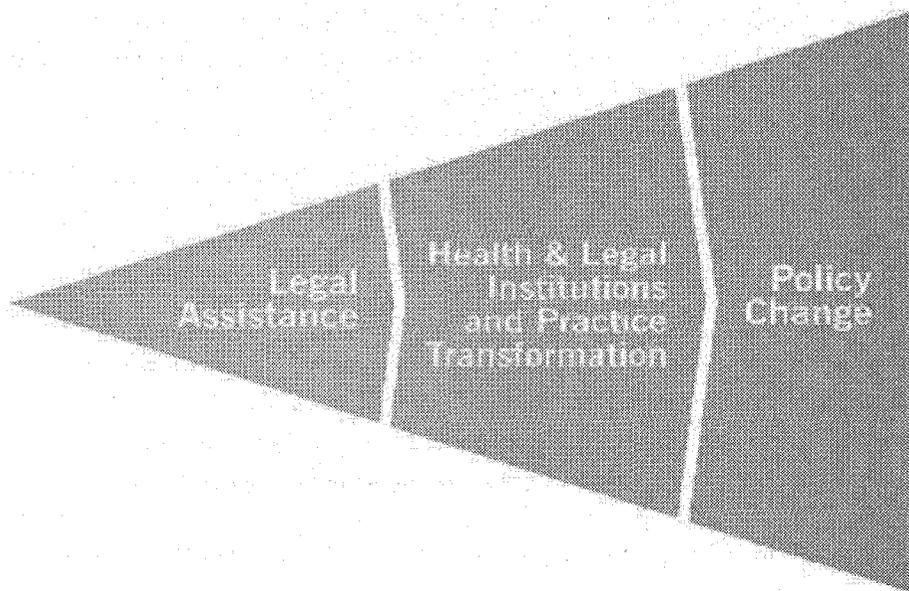


Figure 1: Medical-Legal Partnership: From Patient to Policy. Source: National Center for Medical-Legal Partnership, www.medical-legalpartnership.org

Apart from identifying implementation and enforcement problems, MLPs provide a powerful voice for change. As advocates, health care providers are armed with clinical stories and medical evidence of the impact of SDH on patient health. Their voice in policy debates may be critical to convincing policymakers that change is needed. Partnering health care providers with lawyers who are well-trained in legal and policy analysis leverages the expertise of both professions to present compelling arguments for how laws, regulations and practices impact the health and well-being of vulnerable patient populations. Figure 1 shows the relationship between the core components of MLP and how MLP practitioners’ interactions with individual patients and families shape institutional and policy change.

For example, the Rhode Island MLP in partnership with community health and

housing advocates, identified the failure of city housing inspectional services to carry out its duty to cite lead paint violations as part of housing code enforcement and advocated for policy changes requiring inspectors to cite any property it inspected that did not have a lead-safe certificate.¹⁰⁷ The Boston MLP documented the health impacts of utility shut-offs on its patient population and successfully advocated for changes to the state regulations governing shutoffs.¹⁰⁸ Beyond influencing community-level policies affecting health, MLPs also have the potential to support broader public health policy initiatives, such as those addressing the childhood obesity crisis:

Individual cases develop a practitioner's sense of broader concerns or trends in a community. It is often a recurrent problem seen as a pattern across many patients that triggers the need for policy action rather than individual attention. MLP develops both perspective and relationships that can facilitate the steps to influencing policy.

With respect to obesity prevention, health care providers have observed the trends for decades. They have tackled problems independently and are well versed in the statistics and the reality of this epidemic. . . . Armed with this knowledge and perspective, MLPs are poised to help inform and affect policy in this area as well as develop coalitions.¹⁰⁹

In their ground-up approach to identifying SDH and health disparities, MLPs shift the paradigm for public health and policy change from one that identifies broad policies changes and then studies their effects to one that identifies systems and policy failures through patient and community-based interactions and then advocates for policy change. See Figure 2.

¹⁰⁷ Advocacy by the "Get the Lead Out Coalition" which is facilitated by the Childhood Lead Action Project in Providence, RI and included the RI Medical-Legal Partnership for Children, convinced city officials to make this policy change. Conversation with Laura Brion, Community Organizer, Childhood Lead Action Project, in Providence, RI.

¹⁰⁸ Megan Sandel, et al., *Medical-Legal Partnership: Strategies for Policy Change*, in POVERTY, HEALTH AND LAW 581, 597 (Elizabeth Tobin Tyler et al. eds., 2011).

¹⁰⁹ Manel Kappagoda et al., *Public Health Crisis: Medical-Legal Partnership Approaches to Obesity Prevention*, in POVERTY, HEALTH AND LAW 601, 636 (Elizabeth Tobin Tyler et al. ed., 2011).

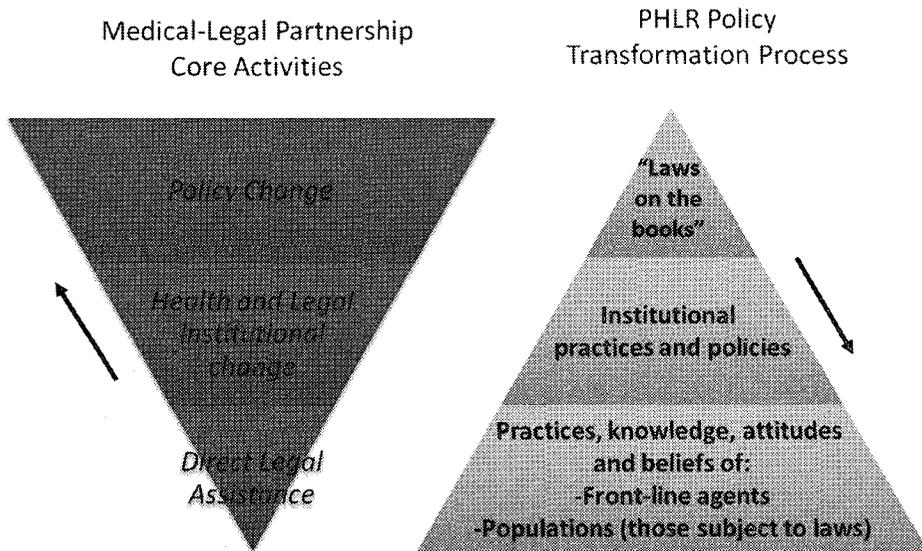


Figure 2: Comparing Medical-Legal Partnership to Public Health Law Research Policy Transformation. Source: Medical-Legal Partnership Core Activities (National Center for Medical-Legal Partnership, www.medical-legal-partnership.org); PHLR Policy Transformation Process (adapted from Scott Burris, *Law in a Social Determinants Strategy: A Public Health Law Research Perspective*, available at <http://www.cdc.gov/socialdeterminants/docs/Burris-SDOH-Symposium-101910-508.pdf>.)

B. Linking Enforcement of Individual Legal Rights to Systems Change

There has long been a tension in legal services programs for the poor between prioritizing individual legal representation and social change advocacy.¹¹⁰ As one

¹¹⁰ COREY S. SHDAIMAH, *NEGOTIATING JUSTICE* 58 (2009). Corey Shdaimah describes this tension:

Individual or incremental work is viewed as a means of alleviating immediate suffering and is sensitive to individual clients. But it has also been criticized as insufficient and possibly dangerous. It is insufficient because the limited resources available to the marginalized have never been, and probably never will be, enough to meet all the needs of low-income clients. It is inefficient because it addresses only symptoms, so the problems recur not only for the client served, but for others. Individual work can be dangerous because it fails to mount challenges to the status quo – it works within systems rather than against them.

commentator notes, “[a]n almost universally accepted and cherished idea in law practice for the poor is the dichotomy between service and impact. Rarely do Legal Services lawyers imagine the possibility of abandoning the distinction of ‘service versus impact.’”¹¹¹ Because of Legal Services Corporation (“LSC”) funding restrictions on certain activities that focus on systemic change (including prohibitions against class action lawsuits and legislative lobbying), some programs that accept LSC funding may not engage in social change advocacy at all.¹¹²

Yet, like the need for more integrated strategies for addressing SDH through both health care (service) and public health (impact), legal services for the poor need to embrace a more integrated model of service delivery and social change advocacy.¹¹³ As with the need to identify and address SDH at both the health care and the public health levels, lawyers for the poor should track unmet legal needs for purposes of developing advocacy strategies to effect systems change. The day-to-day experiences of individual clients should inform these strategies.

C. The Importance of Enforcement of Legal Rights for the Health of Individuals and Populations

One of the most fascinating health-related scientific findings in recent years is the role of stress in health outcomes. As discussed earlier, higher levels of stress among people of marginalized groups may be at least a partial explanation for health disparities. Scott Burris describes the importance of stress and “allostatic load” in health outcomes among disadvantaged groups: “research is describing how an elaborate chemical reaction unfolds when humans are faced with threats . . . when experienced too often . . . this

Id.

¹¹¹ *Id.* at 59 (citing Marc Feldman).

¹¹² See *Legal Services Corp. v. Velazquez*, 531 U.S. 533, 537-38 (2001) (discussing restrictions on LSC cases and activities). Medical-legal partnerships that are affiliated with LSC funded legal services providers, however, engage in systemic change activities. In fact, MLPs enhance the capacity for systemic work by, for example, training physicians to testify in support of legislation benefiting vulnerable populations. Megan Sandel, et al., *Medical-Legal Partnerships: Transforming Primary Care By Addressing The Legal Needs Of Vulnerable Populations*, 9 HEALTH AFF. 1697, 1702 (2010) (discussing regulatory changes assisted by partnership testimony).

¹¹³ See *supra* note 74 and accompanying text; Gostin, *supra* note 17, at 6. While the LSC restrictions create a barrier to doing so, some state legal services programs have been extremely creative in finding ways to continue to do social change advocacy. Andrew Haber, Note, *Rethinking the Legal Services Corporation's Program Integrity Rules*, 17 VA. J. SOC. POLY & L. 404 (2010) (noting that some LSCs have split into separate federally funded organizations and independently funded organizations). Nonetheless, a truly integrated approach is, no doubt, more difficult under the current restrictions.

process can have a corrosive impact on health, and when exposure to stress differs across populations, distinct inequalities in outcomes will develop over time.”¹¹⁴

Just how “epidemiology anatomizes injustice”¹¹⁵ is quite complex, but nonetheless, should not be ignored in designing clinical, legal, and public health responses to SDH. One of the key findings in stress research focused on marginalized groups is the importance of a sense of control over one’s destiny.¹¹⁶ There is a developing base of related research which attempts to understand the link between notions of human agency and autonomy and SDH. The daily insults of poverty and deprivation may not only increase stress, but may also affect an individual’s belief in his or her own self-efficacy.¹¹⁷ In *On Being Poor and Feeling Poor*, health ethicist, Erika Blacksher, explains:

The social determinants of health data point not only to disparities in biological health but to psychosocial health. Persons of lower SES more commonly have low self-esteem, self-mastery and self-efficacy; increased levels of hostility and anger; and are more likely to commit suicide. These clinical-sounding phrases mask sufferers’ harsher self-descriptions: “foolish, stupid, ridiculous, inadequate, defective, incompetent, awkward, exposed, vulnerable, insecure, helpless.”¹¹⁸

Blacksher is careful to caution that in asserting that SES affects self-efficacy, she is not suggesting that poor people are incapable of making autonomous choices, but that inequality and injustice may take a toll on the ability to make healthy decisions and to control one’s destiny.¹¹⁹ She describes how a study of blue collar workers illuminates a diminished sense of self based on their experience of low-SES:

Their educational deficits and occupational status were interpreted by them as a lack of freedom, which in turn symbolized for them a lack of dignity. They described the causal connection between their self-worth and social status as the lack of opportunity to develop “powers inside

¹¹⁴ Burris & Anderson, *supra* note 79, at 583-584.

¹¹⁵ *Id.* at 584.

¹¹⁶ This research is eloquently presented in a seven-part PBS documentary. *Unnatural Causes: How Inequality is Making Us Sick* (PBS television broadcasts Mar. 27–Apr. 17, 2008); see also *Unnatural causes – About the Series*, UNNATURAL CAUSES, http://www.unnaturalcauses.org/about_the_series.php (last visited April 25, 2012).

¹¹⁷ See Blacksher, *supra* note 35, at 458.

¹¹⁸ *Id.*

¹¹⁹ *Id.* at 459-60.

themselves,” powers that would enable them to express themselves in rational and controlled ways, powers that would enable them to win the respect of others.¹²⁰

The relationships among stress generated by lower-SES, a diminished sense of self-efficacy and health are extremely complex. But this fascinating research indicates the vital role that enforcement of legal rights may play in the “control factor.” Epidemiologist Leonard Syme coined the term “control factor” – “the capacity of individuals to deal with day-to-day challenges and stresses of life without becoming overwhelmed by them.”¹²¹ Some argue that the “control factor” is an often overlooked social determinant of health resulting from “unhelpful binary approaches to the relative importance of individual agency versus systemic structures in reducing health disparity.¹²² However, unless individuals have the capacity and the reason to do something about their situation, healthy policies by themselves are less likely to achieve their desired effects.”¹²³ Others have also argued that policies addressing SDH without participation and empowerment of individuals and communities will be ineffective.¹²⁴ The World Health Organization (“WHO”) Commission on Social Determinants articulate “three dimensions of empowerment that underpin the social determinants of health approach: material, psychosocial, and political empowerment.”¹²⁵

Whether one defines it as “control,” “agency,” “empowerment,” or “resistance” it is clear that individuals and communities must play a role in addressing, and ultimately changing the social conditions that harm their and their family’s health and well-being. A key tool in resistance against oppressive and unresponsive systems is the ability to exercise one’s legal rights and to have a voice in the legal system. A critical role that lawyers play in the lives of their clients is treating them with respect and dignity and counteracting the demeaning experiences that so many poor people endure on a daily basis. “Lawyer-client interactions can be a significant counter-action to the demeaning experiences that clients have with bureaucracies.”¹²⁶ Furthermore, translating what an individual understands to be a common affront on his or her dignity into a legal problem

¹²⁰ *Id.* at 464.

¹²¹ Komla Tsey, *The Control Factor: A Neglected Social Determinant of Health*, 372 LANCET 1629, 1629 (2008).

¹²² *Id.*

¹²³ *Id.*

¹²⁴ WORLD HEALTH ORG., A CONCEPTUAL FRAMEWORK FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH § 6.3.3 (2010), available at http://www.who.int/sdh_conference/resources/ConceptualframeworkforactiononSDH_eng.pdf/

¹²⁵ Bell et al., *supra* note 18, at 479.

¹²⁶ SHDAIMAH, *supra* note 110, at 117.

is central to “naming, blaming and claiming.”¹²⁷ The process of taking action and discovering that a legal remedy may exist can be critical to giving clients a sense of control over their lives as well as a sense of empowerment.

By integrating legal assistance into primary health care, MLP serves clients who might otherwise never know that their rights have been violated or that their “problem” is even a legal one. Through identifying potential unmet legal needs in the health care setting, clients have the opportunity to “name, blame and claim” a problem as unjust because it is a violation of their legal rights. While studies of causal links between enforcement of legal rights and improved health outcomes are complex to design and are in very preliminary stages, a qualitative study on the impact of MLP on patient/client perceptions of the beneficial impact of legal assistance on their well-being suggests that the ability to exercise legal rights may have a positive effect on sense of agency.¹²⁸

D. MLP as Community Lawyering and Community Health Promotion

Individual empowerment gained through the knowledge of and enforcement of legal rights may benefit not just individual but also community health. In the health care context, community health workers (“CHWs”) have long been a vital clinic to community link. As members of the communities they serve, CHWs empower individuals and communities to improve their health by helping them to navigate obstacles in the health care and other systems.¹²⁹ Community health promotion programs help to facilitate organized action to change the social conditions that harm their community’s health.¹³⁰

Community lawyering is built on a similar premise – that lawyers should collaborate *with* clients to work together for social change.¹³¹ Partnering lawyers with

¹²⁷ *Id.* at 119 (quoting William L. F. Felstiner et al., *The Emergence and Transformation of Disputes: Naming, Blaming, and Claiming . . .*, 15 LAW & SOCIETY REVIEW 631 (1980-81)).

¹²⁸ DIANA HERNANDEZ, NAT’L CTR. FOR MED.-LEGAL P’SHIP & CORNELL UNIV., QUALITATIVE LEGAL NEEDS STUDY, EXECUTIVE SUMMARY (Feb. 2008), [http://www.medical-legal-partnership.org/sites/default/files/page/Diana%20Hernandez%20Qualitative%20Summary\(2\).pdf](http://www.medical-legal-partnership.org/sites/default/files/page/Diana%20Hernandez%20Qualitative%20Summary(2).pdf).

¹²⁹ For discussion of the role of community health workers, see generally UTA LEHMANN & DAVID SANDERS, WORLD HEALTH ORGANIZATION, COMMUNITY HEALTH WORKERS: WHAT DO WE KNOW ABOUT THEM? THE STATE OF THE EVIDENCE ON PROGRAMMES, ACTIVITIES, COSTS AND IMPACT ON HEALTH OUTCOMES OF USING COMMUNITY HEALTH WORKERS (2007), available at http://www.who.int/hrh/documents/community_health_workers.pdf.

¹³⁰ See Minkler, *supra* note 2, at 131.

¹³¹ See Karen Tokarz et al., *Conversations on “Community Lawyering”: The Newest (Oldest) Wave in*

health care teams, including CHWs, has enormous potential to drive community-based changes that promote health. This team approach fits squarely with integrated care models encouraged under the ACA that emphasize community to health care system linkages. Finally, because MLPs are integrated into community health settings and partner with multiple constituencies (see figure 3), they are uniquely situated to facilitate community-wide dialogue about the role of SDH in health and to engage stakeholders, including patients themselves, in systems change. MLPs build on models of community lawyering¹³² and community health advocacy¹³³ which facilitate the community networks needed to effect change.

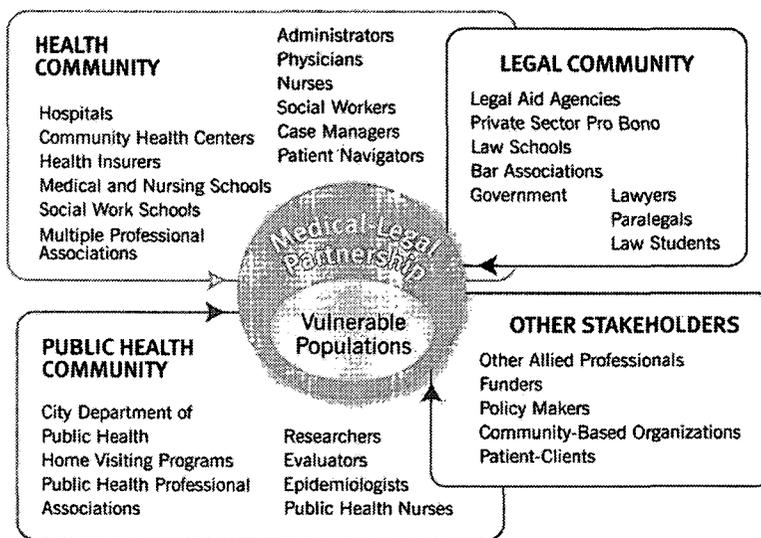


Figure 3: MLP in Community Context. Source: National Center for Medical-Legal Partnership, www.medical-legalpartnership.org.

Clinical Legal Education, 28 WASH. U. J.L. & POL'Y 359, 362-365 (2008).

¹³² Community lawyering has been defined as "a mode of lawyering that envisions communities and not merely individuals as vital in problem-solving for poor people, and that is committed to partnerships between lawyers, clients, and communities as a means of transcending individualized claims and achieving structural change." See Muneer Ahmad, *Interpreting Communities: Lawyering Across Language Difference*, 54 UCLA L. REV. 999, 1079 (2007); see also Tokarz et al., *supra* note 131; see also Michael Diamond, *Community Lawyering: Revisiting the Old Neighborhood*, 32 COLUM. HUM. RTS. L. REV. 67 (2000).

¹³³ Maia Ingram et al., *Community Health Workers and Community Advocacy: Addressing Health Disparities*, 33 J. COMM. HEALTH 417, 420 (2008).

E. MLP as a Forum for Research and Evaluation

As public health law researchers increase their focus on studying the impact of laws and policies on the social determinants of health, MLP provides a unique environment in which to study these impacts on community health. As the IOM committee noted:

Accurate and complete assessment of the outcomes and benefits of laws, in public health or other arenas, is complicated by the fact that the effects are often distributed across multiple segments within the population, across multiple health and social endpoints, and across long time horizons.¹³⁴

Because MLPs are inherently structured to identify through patient experience both failures in enforcement of existing laws but also potential benefits of legal or regulatory changes, they are naturally situated to provide valuable evidence for researchers. In particular, MLPs can contribute to research at the community level, often missed by large epidemiological studies focused on broad scale policies.

An excellent example of how MLPs can connect community-level health data to the failure to enforce laws is demonstrated through the work of the Cincinnati Health-Law Partnership.¹³⁵ The medical partners have mapped the homes of patients admitted at Cincinnati Children's Hospital for asthma.¹³⁶ The hospital has more than 3,000 asthma related admissions per year.¹³⁷ Simultaneously, the legal partners at the Legal Aid of Cincinnati have mapped housing conditions cases.¹³⁸ Not surprisingly, when the maps are overlaid, the neighborhoods with high asthma admission rates mapped neatly onto the housing case maps.¹³⁹ The MLP is now directing targeted legal interventions in those neighborhoods and tracking medical and legal outcomes.¹⁴⁰

Again, the IOM suggests that patient-centered research is just as important for

¹³⁴ Inst. of Med., *supra* note 5, at 99.

¹³⁵ Dr. Robert S. Kahn, Dir. of Research Section, Cincinnati Children's Hosp. and Assoc. Professor, Univ. of Cincinnati Dep't. of Pediatrics, and Elaine Fink, Esq., Managing Attorney, Legal Aid Society of Southwest Ohio, Presentation at National Medical-Legal Partnership Summit (March 26, 2012).

¹³⁶ *Id.*

¹³⁷ *Id.*

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

understanding the impact of laws and policies as are large-scale longitudinal studies:

Ideally, outcome measures for public health laws should consider not only epidemiological measures of mortality and morbidity but also measures of population preferences, well-being, and quality of life. Just as the development of patient-centered outcome measures has become a priority for comparative effectiveness research and evaluation under health reform . . . community-centered outcome measures, together with distal outcomes such as health-adjusted life expectancy, are needed to evaluate the full impact of laws on outcomes of importance to the public.¹⁴¹

Since enforcement of laws and implementation of agency policies on behalf of vulnerable populations directly affect the health and well-being of a particular patient population, MLPs provide critical evidence about community-level health outcomes.¹⁴² Because they are integrated into community health care settings serving the most vulnerable populations, they connect the dots – from patient health to family well-being in social context to community-wide systems to broad scale legal and policy changes.

VII. Conclusion

In the wake of health care reform and an increasing focus on SDH by health care providers, lawyers, public health workers, and policymakers, identifying and evaluating targeted interventions to improve health outcomes of vulnerable populations is critical. There is always a danger that professionals will remain in their siloes rather than working together, even as they labor to solve the same problems. The health care system will change significantly over the next decade as provisions of the ACA are implemented,¹⁴³ and particularly with enormous pressures to reduce costs. While the health care delivery system cannot be the forum for addressing all of the social ills that lead to health disparities, it must play a key role in the strategy. Frontline primary health care providers see firsthand the effects of SDH on their patients' bodies and thus may be the first to detect the unmet legal needs and policy failures that harm health. Similarly, lawyers are essential to addressing SDH; they not only enforce legal rights to

¹⁴¹ INST. OF MED., *supra* note 5, at 99-100.

¹⁴² See Rebecca Lawrence et al., *Evaluating Medical-Legal Partnership: Approaches and Challenges, in POVERTY, HEALTH AND LAW* 643-664 (Elizabeth Tobin Tyler et al. ed., 2011) (discussing in detail the evaluation of MLP as an intervention).

¹⁴³ This is, of course, assuming that the U.S. Supreme Court does not strike down some or all of the Act.

protect individual and family health, but they also work in tandem with community health care providers and patient communities to bring about systems changes that will benefit population health.

Medical-legal partnerships are strategically placed to effect change at multiple levels. By working within the health care system, they focus attention on SDH, and the role of justice in health. By working in collaboration with the community, public health workers, local and state officials, and policymakers, they offer compelling evidence of the role of law and policy in SDH and, at the same time, create coalitions for change.

