Essentials of HEALTH JUSTICE

A PRIMER

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Introduction

Most population health experts would tell you that the global community lives in perilous times. Each of the following threatens the well-being of civilization, either in the here and now or in the not-too-distant future: climate change, food underproduction, overpopulation, epidemic disease (including multidrug-resistant "superbugs"), and emerging technologies such as biotechnology, nanotechnology, and artificial intelligence, all of which are becoming increasingly powerful and increasingly accessible to rogue governments and individuals alike. None of these threats can be addressed by any single nation or even by any particular region of the world. In our increasingly globalized existence—in which financial markets, labor, and other forms of migration, technology, and travel are becoming increasingly intertwined around the globe—most nations would need to embark on a truly concerted effort to prevent or reduce the major risks posed by these population health hazards. Even the United States, a world power by virtue of its military and economic clout, could do very little on its own to wipe out even one of the threats noted above, or to shield itself completely from their effects.

There is one invidious population health affliction, however, from which the U.S. already suffers and which actually is within the nation's power to control and remedy: health inequity. (This is not to say that health inequity is not a significant population health problem in other countries—it is, and its reduction is a priority in many countries. Our point is that here in the U.S., health inequity is neither a problem on the horizon nor one that requires a multinational response—it is an existing problem of our own making and one which we could solve independently.) One can find many definitions of *health equity*, but for purposes of this text we offer the following one: "Health equity means that everyone has a fair and just opportunity to be healthy. This requires removing obstacles to health, such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."[1] We selected this definition because we believe it succinctly encompasses many of the things discussed throughout this text: acknowledging historical and contemporary discrimination, valuing all people equally, focusing societal efforts on addressing avoidable injustices, and eliminating health and health care disparities. To get a sense of just how long health inequities have plagued our society, consider what you know about the colonists' treatment of Native Americans and about the enslavement of the millions of African people who were kidnapped and shipped to the Americas; do you think those Native Americans and Africans were given "a fair and just opportunity to be healthy"?

Before contextualizing and describing more fully the contents of this text, it is instructive to define and distinguish three other terms: *health equality, health disparity,* and *health care disparity.* Health equality is the absence of avoidable or

remediable differences in health and health care among groups of people. To put it differently, health *in*equalities are "differences in health status or in the distribution of health determinants between different population groups."[2] The important difference between health equity and health equality is summed up nicely this way: "The nation's focus should be on achieving equity, not equality. One is a moral and fiscal imperative; the other is impossible. Because life choices, chance, and providence bring fortune and misfortune, no society can promise equal outcomes, and inequalities are inevitable. Furthermore, unequal health outcomes are not inherently unjust: They can arise from biology, personal choices, or chance."[3]

Separate from, but related to, health inequities and inequalities are health and health care disparities. A health disparity is a difference in health status that is closely linked with social, economic, and/or environmental disadvantage. In other words, these are health differences that exist between groups of people who have systematically experienced greater obstacles to health based on their race, ethnicity, religion, socioeconomic status, gender, age, mental or physical disability, sexual orientation or gender identity, or geographic location when compared with majority populations.[4] Health care disparities, on the other hand, refer to "differences in the *quality* of health care provided that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions. These differences would include the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels."[5]

Finally, recognize that we use yet another term—*health justice*—for the title of this text. "Justice" is defined by a typical dictionary as "just behavior or treatment," and as having "a concern for justice, peace, and genuine respect for people." Typical synonyms include fairness, evenhandedness, impartiality, and morality. While we could easily have used *health equity* in the book title, we settled on *health justice* because it tends to be relatively more recognized and understood by a greater number of people. For example, complete the following sentence in your mind: "I appealed to his sense of _____." Chances are you completed that sentence with either "justice" or "fairness", but not with "equity." Furthermore, "justice" is often linked in people's minds to the legal system, and we discuss at many points in this text the role of law in both creating and remediating health injustices. Thus, because we wanted this text to be as relatable as possible across a range of fields and disciplines, and because of the link between justice and legal recourse, we selected *health justice* for the title. If you're looking for a definition of health justice to hold onto as you read further, think of it simply as laws, policies, systems, and behaviors that are evenhanded with regard to and display genuine respect for *everyone's* health and well-being.

This Introduction contextualizes the concept of health justice by touching briefly on four overarching topics, all of which are more fully discussed at later points:

1. There is no across-the-board right to health, health care services, or health insurance in the U.S.
2. Social factors play a critical role in individual and population health.
3. Wealth equals health—and the U.S. currently faces historically high levels of economic inequality.
4. Society is too willing to medicalize social needs and criminalize social deficiencies.

After providing a summary of each of these topics, this Introduction concludes by describing the rationale for and structure of *Essentials of Health Justice: A Primer*.

No Generalized Right to Health, Health Care, or Health Insurance

An obvious starting point for an introductory section on health justice is the fact that in the U.S., there is no universal right to health, to health care services, or even to insurance coverage of health care expenses. This sets the U.S. apart from every other highly developed nation, and from some less-developed countries, as well. The key distinction is that in this country we generally treat access to health services like we treat access to food, shelter, automobiles, and vacuum cleaners, which is to say you are welcome to them if you can afford them; in other developed countries, there is a sense that basic human rights standards include a distinct right to health care services. In the former instance health care services are viewed as a commodity, whereas in the latter case health care is seen as a public good worthy of promoting through wealth redistribution.

The choice to commodify health care services—and therefore exclude tens of millions of people from being able to afford it—comes with significant costs to society, and many of the more obvious costs are discussed at points throughout this text. At the same time, there are less obvious ways in which our for-profit health care system harms people. For example, one consequence of the nation's failure to grant equal access to health care services is to actually make people *feel* excluded. Indeed, access to health insurance and health care services functions as a type of social institution, in that having access to these goods shapes behaviors, offers the potential for upward mobility, and fosters feelings of belonging and dignity. The reverse is also true: "In addition to the stress, powerlessness and social disrespect that have been shown to be associated with poorer health status, [uninsured individuals'] awareness of their disadvantaged social status has the potential to undermine self-respect and their sense of themselves as the moral equals of the more fortunate members of society."[6] Furthermore, "where state and local governments have made a concerted effort to integrate marginalized populations into the health care system, researchers find greater connectedness, collaboration, and feelings of a shared fate."[7]

The Role of Social Determinants in Individual and Population Health

According to the U.S. Department of Health and Human Services, social determinants of health are those "[c]onditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[8] There are many examples of these types of social factors—neighborhood conditions (including the amount of crime and violence), housing quality, early childhood education and development, economic stability, access to transportation, employment, access to sufficient amounts of healthy food, access to health care services, a community's level of social cohesion—and they are key drivers of health inequalities, health disparities, and health care disparities. Sadly, the overall level of health inequality has been on the rise in the U.S.

over the past several decades and is now among the highest in developed countries as measured by differences in life expectancy, the number of people who are uninsured, the amount of money that individuals spend on health care needs relative to their overall income, and the level of racial and ethnic health disparities.

One immediate takeaway for readers is that the conditions in which people live, work, and play have an enormous impact on individual (and thus community) health totally irrespective of whether a person ever sees the inside of a doctor's office. To better understand this, let's zero in on differences in life expectancy, one of the metrics noted above that is used to comparatively measure health inequality. At time of birth, life expectancy in the U.S. can vary by as many as 25 years depending on the location in which a person is born. For example, the next baby to be born in Eagle County, Colorado (one of the counties with the highest life expectancy in the U.S.) has an average life expectancy that is more than two decades longer than the next baby to be born in Ogala Lakota County, South Dakota (a county near the bottom in terms of life expectancy). You can drive from one county to the other in about 8 hours. Even starker, perhaps, is an example from Philadelphia, Pennsylvania. A child born today in the area covered by the 19106 zip code—near the Delaware River and the famed Liberty Bell—has a life expectancy of 88 years. Less than four miles away in the area covered by the 19132 zip code, a child's life expectancy at birth is just 68 years. That 20-year difference represents approximately one year for each minute it takes to drive between the two locations. In these examples you get a sense of why social and environmental factors are bigger drivers of health than either genes or access to health care services: no amount of good genes or doctor visits could ever correct these differences in life expectancy, but realigning social factors that influence health could dramatically level the playing field. In fact, the concept of "luck egalitarianism"—the idea that justice requires correcting disadvantages resulting from brute luck—has gained ground in recent years, including in the context of health and health care.[9] If society did more correcting of this type, we would reduce differences in the key determinants of health, in turn reducing health inequalities and disparities, and thus move closer to achieving health justice.

Wealth Equals Health

Closely related to the discussion about social determinants of health is the fact that generally speaking, a person or community's wealth effectively determines that person or community's overall level of health; in turn, one's level of health affects one's ability to improve upon his or her economic status, since it is exceedingly difficult to overcome the forces associated with low economic status without good health. Consider the following:

- Over the last 30 years, life expectancy has increased dramatically among people in the top half of the income distribution, while remaining close to flat among those in the bottom half.[10]
- The risk of dying before the age of 65 is more than three times greater for those with low socioeconomic status (SES) than for those with high SES.[11]
- Almost every chronic condition, including stroke, heart disease, and arthritis, follows a predictable pattern: prevalence increases as income decreases.[12]
- People living in poverty are disproportionately burdened by the communal consequences of poor health: higher crime rates, decreased residential home values, and higher health care costs.[13]

- Poor and middle-class individuals pay a larger share of their incomes for health care than do the affluent, thereby deepening inequalities in disposable income.[14]
- Because health care indebtedness is the single largest cause of personal bankruptcy, many low-income individuals forego needed health care rather than risk indebtedness.

Taken together, the literature on the connection between wealth and health provides "overwhelming evidence that economically disadvantaged groups have poorer survival chances and a higher mortality rate, die at a younger age, experience a blighted quality of life, and have overall diminished health and well-being when compared to other members of society."[15] This wealth-health connection links back to the previous two overarching topics: the nation's treatment of health care as a commodity makes it more difficult for people stuck on the lower rungs of the SES ladder to achieve good health, and economic deprivation is a type of social determinant that would require purposeful correction if health justice is to be achieved. Indeed, it is widely known and accepted that income inequality in the U.S. is greater than in any other developed nation, has been growing for decades, and currently rests at historically high levels, with the top 1% of earners taking home nearly a quarter of the nation's income.

Society Medicalizes Social Needs and Criminalizes Social Deficiencies

The final topic we introduce here to contextualize the concept of health justice focuses on the ways in which the nation underappreciates and misconstrues the role played by social supports in the overall health of the population. To begin, review **FIGURE 1**.

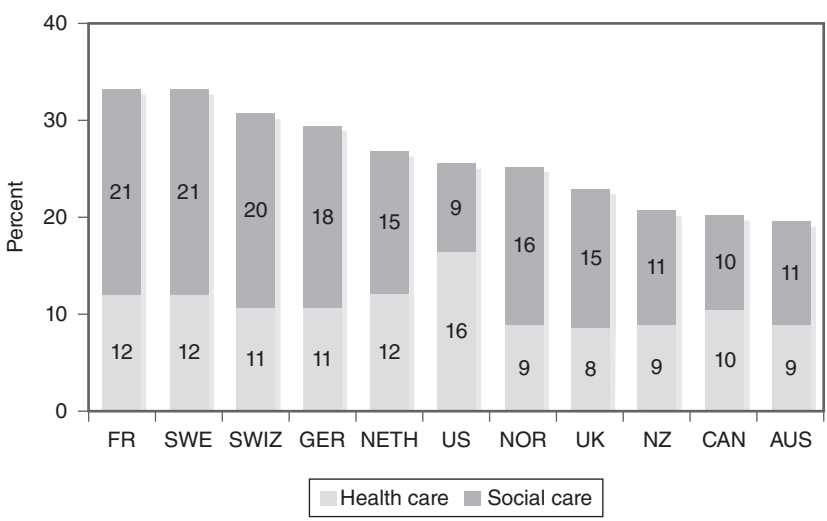

FIGURE 1 Health and social care spending as a percentage of gross domestic product (GDP).

Reproduced from The Brookings Institute. Health and Social Care Spending as a Percentage of GDP. Retireved from: https://www.brookings.edu/blog/up-front/2017/02/15/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing.

Note how, as a percentage of gross domestic product (GDP), combined U.S. spending on health and social care sits right in the middle of the pack when compared to some other developed nations. But the real story resides in how the country spends that money: unlike every other nation represented, the U.S. spends more money on health care than on social care (services targeting education, housing, nutrition, poverty, and the like), and it spends less money on social care (as a percentage of GDP) than every other nation.[16] Given these spending patterns, you might think that while we spend less than perhaps we should on social care, our runaway spending on health care would keep us fairly healthy as a nation. Unfortunately, this is far from the case. Compared to most other developed countries, the U.S. actually has similar or worse outcomes on several key measures of health, including maternal health, infant mortality, and chronic disease prevention. What is likely occurring is that instead of spending money on supports and programs that could keep people healthy (or healthier) in the first instance, the nation is overspending on relatively expensive medical treatments and procedures once individuals become ill,[17] then sending people back into communities that lack sufficient social supports, thus starting the cycle over again. This is what we mean when we say that the U.S. "medicalizes" social needs: essentially, health care services are compensating for a lack of social services spending.

In addition to medicalizing social needs, our society too often criminalizes social deficiencies. Let's use the lack of affordable housing as the first example of a social deficiency. The demand for affordable housing is immense, as very low-income earners represent 24% of all renter households and 9% of all U.S. households. Yet according to multiple reports, there is not a single county in the U.S. that can fill 100% of its low-income population's need for safe, affordable housing[18] and, on average, there are only 35 adequate and affordable housing options for every 100 very low-income households nationally. Making matters worse: the poorer the household, the worse the situation, as families with incomes in the bottom 15% of all earners face the prospect of just 17 affordable units available per 100 households. Two root causes of these deficiencies include a lack of investment in affordable housing development and generally relentless rent inflation, which usually hits the lowest-income earners the hardest.

The lack of affordable housing—coupled with the lack of available shelter space, which represents another social deficiency—subjugates hundreds of thousands of people to a life on the streets. Being homeless, in turn, often prompts responses from police, particularly as states and localities pass laws and ordinances making it a crime to perform life-sustaining activities (e.g., eating, sleeping, begging, etc.) in public spaces. These interactions can have terrible consequences for people already struggling to survive, as some homeless people have their personal property destroyed, some are pushed out of the urban centers that tend to have more reliable social supports, some accumulate fines they can't afford to pay, and many develop criminal records, which makes it more difficult to secure employment or housing. Additionally, many homeless persons who come into contact with police are temporarily incarcerated, which standing alone can be devastating: research indicates that being incarcerated for even just a few days can adversely impact future chances of employment and the well-being of dependent children. It is worth noting that incarcerating homeless persons costs two to three times as much as providing long-term supportive housing.[19]

A second example—this one related to the nation's mental health and substance use crises—drives home the point about how society too easily criminalizes social deficiencies. To start, it is important to understand that compared against every other nation in the world, the U.S. has the highest incarceration rate: approximately 700 people for every 100,000 residents are in jails or prisons.[20] No other country has a rate that tops 600 people per 100,000 residents, and save for a handful of nations, all countries are below 400 people per 100,000 residents.[21] The median rate is approximately 150 prisoners per 100,000 residents. Another way to understand the nation's incarceration rate is to grasp that while the U.S. has only 5% of the world's population, it has nearly 25% of its prisoners—which equates to 2.2 million people on any given day. (It must also be noted that U.S. prisons and jails are disproportionately populated with members of racial and ethnic minority groups. For example, while people of color make up just over 30% of the general population, they comprise more than half of the jail/prison population.[22] While blacks make up approximately 13% of the nation's population, they account for 28% of all arrests, 40% of the incarcerated population, and 42% of the population on death row.[23] And Native Americans are incarcerated at more than twice the rate of whites, while Latinos are held under state jurisdiction at 1.7 times the rate for whites.[24]) Emerging research indicates that this level of mass incarceration may be harming entire communities and contributing to health disparities in the U.S.[25]

A few of the things that drive the U.S. incarceration rate do, in fact, have more to do with criminal justice policy and less about social care deficiencies. For example, the move to mandatory minimum sentences and the implementation of tough-on-crime policies—including "three-strikes" laws and requirements that prisoners serve at least 85% of their sentences—help keep prisons well stocked. But another significant driver of the incarceration rate is society's unwillingness to grapple with its mental health and substance use crises. Some 64% of jail inmates, 54% of state prisoners, and 45% of federal prisoners report mental health concerns, and studies have shown that 65% of jail inmates meet standards for a diagnosable substance abuse disorder.[26] Overall, approximately 79% of prisoners suffer from either drug addiction or mental illness, and 40% suffer from both.[27] Indeed, the number of individuals with serious mental illness in prisons and jails now exceeds by ten times the number in state psychiatric hospitals, and there are more people behind bars for a drug offense than the number of people who were in prison or jail for *any* crime in 1980.[28] Essentially, prisons and jails have become a stand-in for treatment clinics and rehabilitation facilities. Rather than provide prevention, treatment, and other supports in the first instance to individuals who suffer from treatable mental health and substance use disorders, society defaults to the more dangerous, less-effective, and more expensive option—criminalizing the behavior that often results from illness.

Rationale for and Structure of *Essentials of Health Justice: A Primer*

In recent years, greater attention on the part of policymakers, health professionals, and educators to health disparities and to the social determinants of health has led to more inclusion of these topics in public health, medicine, nursing, health care administration, social work, and law curricula. Indeed, either as a standalone

elective course or as a component of a required course, health equity is now a fairly common topic in public health and other health professions education, and beginning in December 2018, the topics of law, policy, and health equity/social justice will together make up 30% of the content used to certify public health professionals in the examination given by the National Board of Public Health Examiners.

Essentials of Health Justice: A Primer was designed with this evolution in mind, and can be used as a standalone text or as a supplement to a wide range of public health, health administration, medicine, nursing, health policy, and health law textbooks. Created as an interdisciplinary teaching tool, it explores how health and justice intersect, how law and policy shape the health care and public health systems and the social structures affecting health outcomes, how disparate impacts of these structures affect particular populations, how social and medical systems may be reshaped to be more responsive to health inequity, and how individuals can advocate for systems change and health justice. Furthermore, this text aims to connect population health and well-being with general education and the Association of American Colleges and Universities' focus on social justice (www.aacu.org/making-excellence-inclusive).

Essentials of Health Justice: A Primer is divided into three parts. Part I is titled "Context and Background: Health-Harming Legal Doctrines, Historical Discrimination, and Implicit Bias" and includes chapters on health-harming legal doctrines (Chapter 1) and the health effects of explicit discrimination and implicit bias (Chapter 2). Part II, titled "Health Disparities and Their Structural Underpinnings" more fully describes the myriad health disparities that affect various populations (Chapter 3) and delineates the pathological social structures and systems that lead to and perpetuate health inequity (Chapter 4). Part III turns its attention to "Striving for Health Justice" by describing existing safety net programs and some health-related legal protections in the U.S. (Chapter 5), the types of coordinated systems that are needed to care for socially complex patients and populations (Chapter 6), and the ways in which readers of this text can advocate for health justice (Chapter 7). The text concludes with a call to action to recognize and affirm that the lives of medically and socially vulnerable populations can be immeasurably improved by respecting those populations' right to health justice.

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