Essentials of Health Justice

Law, Policy, and Structural Change

SECOND EDITION

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Brief Contents

Foreword xi

Acknowledgments xiii

About the Authors xiv

Contributors xvi

Introduction xvii

PART 1 **Context and Background** 1

CHAPTER 1 **Introductory Frameworks, Definitions, and Theories for Health Justice** 3

CHAPTER 2 **Lessons from U.S. Social Movements for Health Justice** 29

PART 2 **Aspects of the Legal System that Undermine Health Justice** 49

CHAPTER 3 **The Roles of the Three Branches of Government in Health Law and Policy** 51

CHAPTER 4 **Health-Harming Legal Doctrines**.... 67

CHAPTER 5 **International Human Rights, Health, and the Failure of United States Leadership** 81

CHAPTER 6 **Discrimination, Implicit Bias, and the Limits of the Law**.... 97

PART 3 **Structural Inequity and Health Injustice** 111

CHAPTER 7 **Socioeconomic Status, Unmet Social Needs, and Health** 113

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CHAPTER 8 **Place-Based Inequities** 145

CHAPTER 9 **The Carceral State** 173

PART 4 **Historically Marginalized Populations and Health Injustice** **197**

CHAPTER 10 **Asian, Black, Indigenous, and Latinx People** 199

CHAPTER 11 **Immigrants** 227

CHAPTER 12 **Women** 247

CHAPTER 13 **LGBTQ+ People** 271

CHAPTER 14 **People with Disabilities** 297

PART 5 **Striving for Health Justice: Structural and Policy Change** **313**

CHAPTER 15 **Existing Efforts to Achieve Health Justice** . . .315

CHAPTER 16 **Law, Policy, and Structural Change: New Directions for Health Justice** 337

Conclusion **355**

Index **359**

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Contents

Foreword by Angela P. Harris and Georges C. Benjamin xi

Acknowledgments xiii

About the Authors xiv

Contributors xvi

Introduction xvii

PART 1 Context and Background 1

CHAPTER 1 Introductory Frameworks, Definitions, and Theories for Health Justice 3

Introduction 3

Medicine, Public Health, and Law: Frameworks for Health Justice 4

Medicine 4

Public Health 8

Law 10

Critical Theories: Challenging Norms and Shaping Definitions of Health Justice 13

Race and Ethnicity 13

Application of Critical Race Theory and Intersectionality to Medicine, Public Health, and Law 15

Sex and Gender 17

Application of Feminist Theory to Medicine, Public Health, and Law 19

Application of Queer Theory to Medicine, Public Health, and Law 21

Disability 22

Application of Critical Disability Theory to Medicine, Public Health, and Law . . . 24

Conclusion 25

References 25

CHAPTER 2 Lessons from U.S. Social Movements for Health Justice 29

Introduction 29

The Civil Rights Movement 30

The Poor People's Campaign 32

The Women's (Feminist) Movement . . . 33

The Gay Rights/LGBTQ+ Movement . . . 35

The HIV/AIDS Movement 37

The Disability Rights Movement 39

The Immigrants' Rights Movement . . . 40

The Environmental Justice Movement 42

The Health Care Reform Movement . . . 44

Conclusion 45

References 45

PART 2 Aspects of the Legal System that Undermine Health Justice 49

CHAPTER 3 The Roles of the Three Branches of Government in Health Law and Policy 51

Introduction 51

The Legislative Branch of Government and Health 52

Overview 52

Legislative Powers and Health Policy 52

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The Executive Branch of Government and Health . . . 58
Overview . . . 58
Executive Powers and Health Policy . . . 59
The Judicial Branch of Government and Health . . . 62
Overview . . . 62
Judicial Powers and Health Policy . . . 63
Conclusion . . . 65
References . . . 66

CHAPTER 4 Health-Harming Legal Doctrines . . . 67

Introduction . . . 67
The "No Duty to Treat" Principle . . . 68
The Exclusion of Poverty from Protection Under the Constitution . . . 70
Overview of Equal Protection Jurisprudence . . . 70
Overview of Substantive Due Process Jurisprudence . . . 71
Efforts to Apply Equal Protection and Substantive Due Process to Laws Affecting the Poor . . . 72
Future Prospects for Granting Poverty Special Status . . . 73
The "Negative Constitution" . . . 74
No Right to Counsel in Civil Legal Matters . . . 76
Criminal Legal Representation . . . 76
Civil Legal Assistance . . . 77
Conclusion . . . 78
References . . . 78

CHAPTER 5 International Human Rights, Health, and the Failure of United States Leadership . . . 81

Introduction . . . 81
The International Human Rights Regime . . . 82
Overview . . . 82
Declarations and Treaties . . . 82
Customary International Law . . . 83
Protected Rights: Civil, Political, Economic, Social, Cultural, and More . . . 83
U.N. Monitoring and Enforcement . . . 85
The Right to Health Under International Standards . . . 86
Overview . . . 86
Resource Limitations and the Principle of Progressive Realization . . . 86
The Scope of the Right to Health . . . 87
U.S. Government Attitudes Concerning International Human Rights Law . . . 88
Overview . . . 88
U.S. Government Attitudes Concerning Health as a Human Right . . . 91
Conclusion . . . 93
References . . . 93

CHAPTER 6 Discrimination, Implicit Bias, and the Limits of the Law . . . 97

Introduction . . . 97
Overview of Federal Antidiscrimination Law . . . 98
Antidiscrimination Law: Protecting Specific Classes and Promoting Equality . . . 99
The Limits of Federal Antidiscrimination Law . . . 102
The Narrowing of "Disparate Impact" Protections . . . 102
The Challenge of Remediating Implicit Bias Through Law . . . 105
Conclusion . . . 108
References . . . 108

PART 3 Structural Inequity and Health Injustice 111

CHAPTER 7 Socioeconomic Status, Unmet Social Needs, and Health . . . 113

Introduction . . . 113
SES and Health . . . 113

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Education 116
Employment 117
Income and Wealth Inequality. 118
Inequality and Poverty 119
What Does It Mean to Be Poor in America?. 120
Who Is Poor in America? 120
The Effects of Poverty on Health (and Health on Poverty) 121
Unmet Social Needs and Health. 122
The Structure of the Social Safety Net. . .123
What Is the Safety Net?. 123
Who Is Eligible for Safety Net Programs?. . 123
What Is an Entitlement? 124
Who Participates in Safety Net Programs?. .124
Do Safety Net Programs Reduce Poverty and Improve Health? 125
Income Supports 125
The Temporary Assistance for Needy Families Program 125
Unemployment Insurance 126
The Minimum Wage 127
The Earned Income Tax Credit 127
Employment Protections. 128
Workers' Compensation 128
The Family and Medical Leave Act 128
Health Care 129
Medicaid. 130
Medicare. 132
Children's Health Insurance Program . . . 132
Community Health Centers 133
Food Assistance 133
Supplemental Nutrition Assistance Program 135
The Special Supplemental Nutrition Program for Women, Infants, and Children 136
The National School Lunch and Breakfast Programs 136
The Justice Gap: Access to Legal Assistance for Low-Income People. . .137
Legal Rights, the Safety Net, and Health. . . 138
Conclusion 139
References 139

CHAPTER 8 Place-Based Inequities 145

Introduction 145
Family: Stability and Safety 146
Adverse Childhood Experiences and Toxic Stress 146
Family Violence 148
Home: Housing Affordability and Conditions 151
Housing Affordability and Health 151
Heat or Eat: Making Untenable Choices Between Housing and Other Necessities 154
Conditions: Health-Harming Housing Hazards 155
Community: Racial Segregation and Neighborhood Exposures 158
Racial Segregation and Concentrated Poverty 158
Neighborhood Exposures and Health . . . 159
Area and Region: Rural Health 161
Environment: Toxic Injustice and Climate Change 162
Placement of Environmental Hazards . . . 163
Climate Change 164
Conclusion 166
References 167

CHAPTER 9 The Carceral State . . 173

Introduction 173
Law Enforcement and the Health of Low-Income Communities of Color. . . 174
Overexposure to Law Enforcement and Health 175
America's Mass Incarceration System: Consequences for Individuals, Communities, and Public Health . . 177
The Exponential Growth of Mass Incarceration in the United States 177
Reasons for the Growth in Incarceration. 179
Reentry: The Collateral Consequences of Incarceration. 182
Mass Incarceration and Health 183

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Structural Change: Reducing Incarceration and Addressing Its Health Effects . . . 188
Improving Correctional Facility and Post-Incarceration Health Care . . . 189
Medical-Legal Partnerships: Preventing Incarceration and Supporting Reentry. 189
Diversion: Problem-Solving Courts . . . 190
Policy Change: Police Reform, Reducing Collateral Consequences, and Decarceration . . . 191
Conclusion . . . 192
References . . . 192

PART 4 Historically Marginalized Populations and Health Injustice 197

CHAPTER 10 Asian, Black, Indigenous, and Latinx People . . . 199

Introduction . . . 199
Treatment of Racial and Ethnic Minority Individuals Under the Law . . 200
Time Periods of Racism . . . 200
Employment . . . 202
Housing . . . 202
Health Care . . . 202
Employment . . . 204
Housing . . . 204
Health Care and Education . . . 205
Treatment of Racial and Ethnic Minorities by the Health Care System . . . 205
Medical Research . . . 205
Clinical Care . . . 206
Access to Quality Care . . . 208
The Social and Structural Drivers of Racial and Ethnic Health Inequities . . . 209
Social and Structural Drivers of Health . . 209
Racism as a Driver of Health . . . 211
Health Inequities . . . 214
Law, Policy, and Structural Change to Achieve Health Justice . . . 215
Institute a Truth and Reconciliation Process in Health Care . . . 215
Engage and Empower Racial and Ethnic Minority Individuals to Transform Laws and Social Drivers of Health . . . 216
Policymakers Should Employ Racial Equity Tools to Guide Structural Change . . . 216
Conclusion . . . 216
References . . . 217

CHAPTER 11 Immigrants . . . 227

Introduction . . . 227
Treatment of Immigrants Under the Law . . . 228
A Brief History of U.S. Immigration Law . . . 230
Laws Governing Immigrants' Access to Health Care and Other Government Supports . . . 231
Treatment of Immigrants by the Health Care System . . . 235
Medical Examination of Immigrants Entering the United States . . . 235
Access to Quality Health Care . . . 236
Social and Structural Drivers of Immigrant Health Inequities . . . 239
Social and Structural Drivers of Health . . . 239
Health Inequities . . . 240
Law, Policy, and Structural Change to Achieve Health Justice . . . 242
Create a Path to Legal Status for Undocumented Immigrants . . . 242
Provide Access to Health Care to People Living within U.S. borders, Regardless of Status . . . 242
Address the Social and Structural Drivers That Harm Immigrants' Health . . . 243
Conclusion . . . 243
References . . . 244

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CHAPTER 12 Women. 247

Introduction 247
Treatment of Women Under the Law . 248
Antidiscrimination Laws 248
Reproductive Rights 250
Treatment of Women by the Health Care System 254
Medical Research 254
Clinical Care 255
Access to Quality Health Care 256
Social and Structural Drivers of Women's Health Inequities 257
Social and Structural Drivers of Health . . 257
Health Inequities 263
Law, Policy, and Structural Change to Achieve Health Justice 264
Protect and Promote Reproductive Rights and Justice 264
Invest in and Prioritize Women's Health . . 264
Implement Policies That Support Women's Economic Security 265
Reframe Women's Rights as Human Rights . . 265
Conclusion 266
References 266

CHAPTER 13 LGBTQ+ People. . . 271

Introduction 271
The Importance of Language and Self-Identification 272
Treatment of LGBTQ+ People under the Law 274
Progress Toward Equal Treatment under the U.S. Constitution 274
The Rise of Religious Rights and Its Effect on LGBTQ+ Equality 275
Protection Under Civil Rights Laws 276
Legal Issues of Importance to Transgender Communities 280
Treatment of LGBTQ+ People by the Health Care System 281
Access to Quality Health Care 282
Social and Structural Drivers of LGBTQ+ Health Inequities 284
Social and Structural Drivers of Health . . 284
Health Inequities 285
Law, Policy, and Structural Change to Achieve Health Justice 289
Civil Rights 289
Culturally Appropriate Health Care 290
Data Collection 290
Conclusion 291
References 291

CHAPTER 14 People with Disabilities 297

Introduction 297
Overview of Disability in the United States . 298
Treatment of People with Disabilities under the Law 299
Antidiscrimination Laws 300
Health Care Laws 301
Treatment of People with Disabilities by the Health Care System 302
Health Care Services 302
Health-Related Services and Programs . . 303
Assumptions, Biases, and Lack of Knowledge 304
Social and Structural Drivers of Disability Health Inequities 305
Social and Structural Drivers of Health . . 305
Health and Health Care Inequities 306
Law, Policy, and Structural Change to Achieve Health Justice 307
Strengthen and Enforce Existing Laws . . 307
Educational Initiatives 308
Data to Support Research and Policy 308
Conclusion 308
References 309

PART 5 Striving for Health Justice: Structural and Policy Change 313

CHAPTER 15 Existing Efforts to Achieve Health Justice 315

Introduction 315
Health Care System Reform 316

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A New Focus on Population Health Management . . . 316
Payment Reform: Opportunities to Address Health Inequities . . . 317
Value-Based Payment . . . 317
Data-Driven Strategies to Address Social Drivers of Health . . . 319
Hotspotting . . . 319
Geomarkers . . . 320
Community Health Needs Assessments . . . 320
Medical and Social Care Integration . . . 321
Screening for Social Risks . . . 322
Interprofessional Health Care Teams . . . 324
Partnerships Between Health Care and Community-Based Organizations . . . 325
Moving Further Upstream: Equity-Focused Public Health Interventions and Policy . . . 327
Public Health Agencies: Federal and State Focus on Equity . . . 327
Health Impact Assessments . . . 328
Health in All Policies . . . 329
Community-Driven Efforts . . . 329
Linking Health, Law, and Justice . . . 330
Medical–Legal Partnerships . . . 331
Conclusion . . . 333
References . . . 334

CHAPTER 16 Law, Policy, and Structural Change: New Directions for Health Justice . . 337

Introduction . . . 337
Health Justice Starts with Confronting America's Past . . . 338
Health Justice, Self-Determination, and Democratic Engagement . . . 339
Investments That Target the Root Causes of Health Injustice . . . 341
Addressing the Black–White Wealth Gap . . . 341
Reversing Economic Inequality . . . 342
Access to Health Care . . . 344
Accountability for Health Injustice . . . 345
Data and Evidence-Based Policy . . . 345
Equal Access to the Legal System . . . 346
Health Justice as Human Rights . . . 347
A Multisector Movement for Health Justice: What You Can Do . . . 347
Goals and Strategies of Health Justice Advocacy . . . 348
Conclusion . . . 351
References . . . 352

Conclusion . . . 355

Index . . . 359

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Foreword

by Angela P. Harris and Georges C. Benjamin

In this foreword, we (Harris, a legal scholar, and Benjamin, a public health scholar) offer some reflections on the "health justice" framework. The World Health Organization describes health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity."[1] This definition of health is a holistic one, reminding us that 80% of what makes people healthy occurs outside the doctor's office and that social drivers may either hinder the quest for health or help improve it. Health is a fundamental human right under the United Nations' Universal Declaration of Human Rights, but not under U.S. law. Nevertheless, in order for the people of this nation to benefit at the highest level from the human right to health, we must have just and equitable social systems and a framework of accountability through law, policy, and social norms.

In the past few decades, the United States has seen an explosion of organizing and policy frameworks that incorporate the word *justice*: environmental justice, reproductive justice, water justice, land justice, food justice, data justice, and more. These "[x] justice" frameworks share at least three central commitments.[2] First, they analyze social inequalities as the outcome of structural oppression. For example, as the authors of this book explain in the Introduction, "laws, policies, and deeply rooted norms and practices have far more to say about the health and well-being of individuals and the communities they form than do human biology, individual behavioral choices, and access to medical care services." Without conscious and persistent policy intervention across institutions, structural inequalities reproduce themselves across space and time. Moreover, structural inequalities appear in the lives of individuals, families, and groups along preexisting power differentials that interlock and overlap in complex ways, a phenomenon that legal scholar Kimberlé Crenshaw calls "intersectionality."[3]

Second, the health justice framework, like other [x] justice frameworks, adopts a social change perspective in recognition of how structural inequalities affect existing institutions and professional discourses. For instance, as this book explains, as a result of historical racism and sexism, discourses of law and public health tend to emphasize universalist and individualist policy interventions, even though such interventions fail to address the structural root causes of unjust disparities.[4] Social movements are essential to structural change. They can shift the policy landscape quickly, moving the needle of public opinion. They can also effectively challenge oppressive norms and analytical blind spots within elite discourses. Indeed, several justice frameworks, including those used in environmental justice and reproductive justice, emerged in reaction to blind spots in established legal, scientific, and policy frameworks.[5] Health justice, like these other frameworks, seeks to remedy historic oppression and work toward a future in which, as the authors of this book put it, "all people have the opportunity to reach their full health potential."

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Third, the health justice framework, like other [x] justice frameworks, provides a holistic language for addressing human flourishing. As this book emphasizes, the drivers of health and disease exist at multiple scales, from the planetary (as we have witnessed during the COVID-19 pandemic) to the individual. Linked to the global concept of "health," the aspirational language of "justice" calls our attention to these multiple scales and challenges us to imagine what it might look like to put human health at the center of each one. For example, "health law" conventionally focuses on the laws and regulations that shape individual access to health care services, such as the law relating to insurance reimbursement for clinical care.[6] "Health justice" asks us to imagine—as this book does—how purportedly non-health-related legal arenas, such as the carceral system, affect human health. What might it mean to orient all political, economic, and social institutions around the promotion of human flourishing?

Imagine a future where society focuses its efforts on achieving equitable access to health care and public health services, equity in the quality of care received within the health care setting, and the absence of discrimination based on race, ethnicity, sexual orientation, age, or disability across all human interactions and where the non-health societal factors that influence health are viewed through the lens of promoting human flourishing. This text tries to create a better understanding of how such a vision might be achieved through the use of law, policy, and structural change. We hope its readers adopt this vision in their daily work to achieve health justice for all.

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Professor Tobin-Tyler has served on numerous advisory boards and committees related to health justice, including the State of Rhode Island Pregnancy and Postpartum Death Review Committee, the Advisory Board for the Center for Prisoner Health and Human Rights, and the Advisory Council for the Child and Family Policy Center's Learning Collaborative on Health Equity and Young Children. She is also the recipient of several awards including the pro bono service award from the Legal Services Corporation, the Distinguished Advocate award from the National Center for Medical-Legal Partnership, and, for multiple years, the Dean's Excellence in Teaching award at the Alpert Medical School. She has also been selected for several fellowships, including as a Postgraduate Fellow in Public Policy by the A. Alfred Taubman Center at Brown, as a Bray Visiting Scholar at the Cogut Center for Humanities at Brown, and as a Public Health Law Education Faculty Fellow by the Robert Wood Johnson Foundation. In 2018–2019, she served a visiting fellow at the Law, Health, Justice Centre at the University of Technology in Sydney, Australia.

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Introduction

The photograph on the front cover of this textbook is of San Francisco's first "safe sleeping village," located in the shadow of City Hall and opened during the early months of the COVID-19 pandemic. The city had long resisted authorizing homeless-tent encampments, but the pandemic ultimately forced San Francisco—along with several other cities in the United States—to embrace the idea, at least temporarily, in the name of safeguarding unhoused people against the pandemic.

Putting aside the fact that no reasonable person should be euphemistically referring to that encampment as a "village" and despite the fact that its occupants have access to food, water, toilets, showers, and health care, readers of this textbook should, in our view, be clear-eyed about what the photo represents: structural inequity, systemic disadvantage, concentrated deprivation, flawed social safety nets, and major wealth inequities. Put differently, the photo represents the opposite of *health justice*, which we define to mean that all people have the opportunity to reach their full health potential through the recognition of two things: (1) that individual and population health and well-being are primarily driven by upstream structural factors (laws, policies, practices, and systems) rather than by genetics and individual behaviors or choices and (2) that health justice is impossible unless the human rights, civil rights, value, and dignity of all people are acknowledged and actively fostered. The meaning of health justice is discussed more fully in Chapter 1.

This textbook aims to acknowledge, describe, analyze, and spur change to the root causes of the many types of health injustices exemplified by the image on the front cover, which in turn translate into the nation's relatively poor health and well-being. These root causes—oftentimes referred to as "structural drivers" for reasons explained later—include laws, policies, systems of governance, and societal norms and practices that are, in many cases, deeply grounded in history. Just a few of the questions explored in this book include: Are current laws designed to ensure that people can optimize their health over their life span? What can we observe about how laws actually operate as opposed to how they were intended to operate? By what methods should stakeholders evaluate the effects of laws and policies? In an intensely polarized environment, when cultural factors seemingly play an outsized role in political participation and social solidarity, how can policymakers be convinced to act in ways that benefit all people rather than narrow constituencies? These are not mere theoretical questions; as you will discover, laws, policies, and deeply rooted norms and practices have far more to say about the health and well-being of individuals and the communities they form than do human biology, individual behavioral choices, and access to medical care services. This is a key assertion of this textbook, and it bears restating in various ways:

- Structural drivers—laws, policies, systems, practices—are leveraged by those in power to determine whether resources, opportunities, and ultimately well-being are equally distributed or unjustly distributed based on characteristics such as race, ethnicity, gender, social class, and so on.

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- Health inequities (defined in Chapter 1)—whether based on race, ethnicity, socioeconomic status, age, geography, language, gender, disability status, citizenship status, sexual identity and/or sexual orientation, or other categories—stem primarily from structural drivers, not from biological differences or solely from individual decisions around health behaviors such as tobacco/alcohol/drug use, sexual practices, diet, or exercise.
- Of the various factors that drive health injustice, most operate on a level outside the control of individuals and communities, and most exact a toll on individuals and populations long before people actually become unwell. This effectively means that at the individual and community level, there may be no amount of knowledge, health-promoting behavior, or political engagement that will actually make people physically, mentally, or emotionally healthy or even healthier.
- Of the various factors that drive health injustice, most are mutable. Existing laws and policies that have created inequitable systems and enabled unfair practices need not be permanent; they can be changed. These laws and policies represent choices we make as a society.
- If structural drivers are utilized by those in power to shape society and distribute resources, opportunities, and wellness, then the conditions and material circumstances that result from the design and operation of those structures can be thought of as social drivers (or "social determinants") of health (more fully defined later and in Chapter 1). Studies have shown that over the course of one's life span, social drivers—education, housing, access to health insurance, environmental factors, access to healthy foods, and the like—may account for fully 80% to 90% of the modifiable contributors to healthy outcomes.[1]

One crucial and undeniable aspect of structural drivers of health is that some of the nation's laws, policies, norms, and practices date back to the founding of the country—which is to say, they are rooted in a time marked by overt, legally sanctioned racism and discrimination. Indeed, America's earliest social mores, economic systems, and laws were conceived during an era of genocide, enslavement, and legalized racial oppression, as North America colonizers tortured Native Americans and Black Americans alike. As barbaric as this treatment was, its long-term consequences have been equally damaging: centuries of race-based prejudice, discrimination, and injustice that flow from laws, policies, and societal practices that perpetuate the myth that People of Color are inferior to White people. This is called *systemic racism* (which, as you will read about in Chapter 1, includes *discrimination*), and it remains a devastating driver of health even today, as the legacy of racialized laws, policies, and practices are carried through generations, generally relegating People of Color—Black and Indigenous people, in particular—to a lower social, financial, educational, and health status relative to White people. Systemic racism refers, quite literally, to discrimination that is woven into the fabric of society, and it has left an indelible mark on the health of People of Color (and, it should be noted, frequently on impoverished people of all races and ethnicities), who have been systematically excluded from the health-promoting resources and opportunities necessary for maximal health outcomes.[2] The U.S. Centers for Disease Control and Prevention, the American Medical Association, and the American Public Health Association all agree, as each one has declared systemic racism to be a public health crisis.

One of the many ways that systemic racism affects health is through the fostering of racial wealth gaps. As you will read below and in others parts of this textbook, wealth and health are closely correlated: The wealthier are

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generally healthier, and the better one's health, the easier it is to amass wealth. Alongside that axiom sit more than 400 years of federal and state housing and education law and policy that have largely benefited White households and in some cases completely excluded Black, Latinx, and Asian people. For example, today, the typical White household holds 10 times more wealth than the typical Black household.

The health effects of systemic racism are also evident in the COVID-19 pandemic, which set in motion the worst economic, social, and health crisis since World War II. The loss of lives, homes, jobs, opportunities, and connections has been felt across the globe and the country. But the pandemic's burden has fallen disproportionately on historically marginalized populations, including Communities of Color and women, LGBTQ+ individuals, and people with disabilities of all races and ethnicities. For example, across every facet of the pandemic—susceptibility, exposure, infection/hospitalization/death rates, job loss, ability to pay rent/mortgage, and more—Communities of Color have been far more ravaged than those of White people. Data released during the writing of this book indicate that between 2018 and 2020, White Americans lost 1.36 years of life expectancy, while Black Americans and Hispanic Americans lost 3.25 years and 3.88 years, respectively.[3]

Similarly, women have disproportionately experienced economic harm and stress from the pandemic due to their traditional caretaking roles; they were more likely than men to become unemployed during the pandemic. Women in low-wage jobs—particularly Black and Latina women—are also more likely to be deemed "essential workers" (e.g., those who work in health care, the service industry, and agriculture), which both amplified their job loss (in industries that shut down) and heightened their exposure to COVID-19 when they could not work from home. Furthermore, LGBTQ+ people, who have long endured stigma and social alienation, experienced higher rates of mental health and substance use problems during the pandemic; systemic barriers to health care and reinforced social stigma likely played a part. People with disabilities also experienced greater isolation during government shutdowns than nondisabled individuals. In a nutshell, the pandemic illuminated in stark terms the long-standing linkages between one's social status and the opportunity to maintain health. Indeed, while COVID-19 may be the technical "cause" of much of the national destruction that began in early 2020, that's only true to a point; for People of Color and other historically marginalized populations, the real cause is properly located in centuries of systemic racism that permitted COVID-19 a foothold that simply was not available to it in other communities. This point will be elucidated at various places throughout this text.

Before giving way to a description of the specific topics covered in the textbook, 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. Wealth equals health—and the United States currently faces historically high levels of economic inequality.
2. Social factors play a critical role in individual and population health.
3. U.S. society is too willing to medicalize social needs and criminalize social deficiencies.
4. There is no across-the-board right to health, health care services, or health insurance in the United States.

Wealth Equals Health

The United States is, unfortunately, a prolific purveyor of both wealth and health inequities. As to the former, it is widely understood that income inequality in the United States is greater than in any other high-income nation,

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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. As to the latter, while health inequities are a global concern, it is well known that they are more acute in the United States than in all other wealthy nations. These two facts are linked: In the United States, a person's or community's wealth effectively determines that person's or community's overall level of health; in turn, one's level of health affects one's ability to improve upon his/her/their economic status, since it is exceedingly difficult to overcome the forces associated with low economic status without good health. Consider the following:

- 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.[4]
- Almost every chronic condition, including stroke, heart disease, and arthritis, follows a predictable pattern: Prevalence increases as income decreases.[5]
- People living in poverty are disproportionately burdened by higher crime rates (which can lead to injury and poor mental/emotional health), decreased residential home values (which further contributes to the wealth–health cycle), and higher health care costs.[6]
- Poor and middle-class individuals pay a larger share of their incomes for health care than do the affluent, thereby deepening inequities in disposable income.[7]
- 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."[8] This wealth–health connection ties in with the other overarching topics you will next read about: 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 driver that would require purposeful correction if health justice is to be achieved.

The Role of Social Drivers in Individual and Population Health

According to the U.S. Department of Health and Human Services, social drivers 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."[9] 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 status, 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 and health care inequalities (defined in Chapter 1). Sadly, the overall level of these inequalities has been on the rise in the United States over the past several decades and is now among the highest in high-income countries as measured by differences, for example, in life expectancy, the number of people who are uninsured, and the amount of money that individuals spend on health care needs relative to their overall income.

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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 irrespective of whether a person ever sees the inside of a physician's office. To better understand this, consider for a moment differences in life expectancy, one of the metrics frequently used to comparatively measure health inequality. At time of birth, life expectancy in the United States can vary by 20 years or more, depending on the location in which a person is born. For example, the next baby born in Summit County, Colorado—which is nearly 95% White—has a life expectancy of approximately 87 years. The next baby born in Ogala Lakota County, South Dakota—which is nearly 95% Native American—has a life expectancy of approximately 66 years. One can drive from one county to the other in about 7 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 1 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 more significant drivers of health than either genes or access to health care services: No number 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.[10] If the nation did more correcting of this type, it could reduce the differential burdens of key drivers of health, in turn reducing health inequalities and moving closer to achieving health justice.

Society Medicalizes Social Needs and Criminalizes Social Deficiencies

Next, we contextualize the concept of health justice by focusing briefly 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**.

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 high-income nations. But the real story resides in how the country spends that money: Unlike every other nation represented, the United States 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. Given these spending patterns, readers might think that while the United States spends less than perhaps it should on social care, its runaway spending on health care services would nonetheless keep the population relatively healthy. Unfortunately, this is far from the case. Compared to most other high-income countries, the United States actually has similar or worse outcomes on several key measures of health, including maternal health, infant mortality, and chronic disease prevention. What may be 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[11] and

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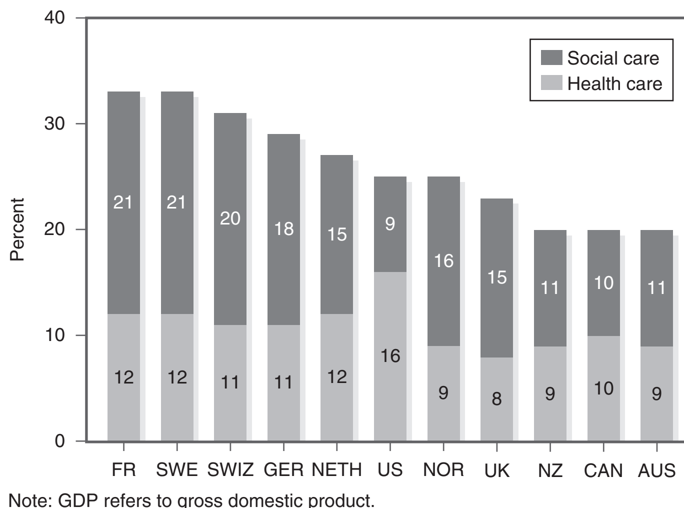

Figure 1 Health and social care spending as a percentage of gross domestic product (GDP)

Reproduced from The Commonwealth Fund. Health and Social Care Spending as a Percentage of GDP (Exhibit 8). Retrieved from: https://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-global-perspective.

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 United States "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. No state in the United States has an adequate supply of rental housing affordable and available for low-income households, and the same can be said for every major metropolitan area.[12] 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, as illuminated by the picture on the front cover. Being unhoused often prompts responses from law enforcement, 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. Interactions with police, in turn, can have terrible consequences for people already struggling to survive, as some people without adequate shelter 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 unhoused persons who come into contact with the police are temporarily incarcerated, which in itself can be devastating: Research indicates that being incarcerated for even just a few days can adversely impact

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future chances of employment and the well-being of dependent children. (It is worth noting that incarcerating unhoused persons costs two to three-times as much as providing long-term supportive housing.[13])

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 to every other nation in the world, the United States has the highest incarceration rate: Approximately 640 people for every 100,000 residents are in U.S. jails and prisons, while only two other countries (El Salvador and Rwanda) top 500 people per 100,000 residents, and virtually all other nations are below 350 people per 100,000 residents.[14] 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 United States has only 5% of the world's population, it has nearly 25% of its prisoners—which equates to approximately 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.[15] While Blacks make up approximately 13% of the nation's population, they account for 28% of all arrests, 40% of the incarcerated population, and 48% of people serving life, life without parole, or "virtual life" sentences.[16] And Native Americans are incarcerated at more than twice the rate of Whites, while Latinxs are held under state jurisdiction at 1.7 times the rate for Whites.[17] Emerging research indicates that this level of mass incarceration may be harming entire communities and contributing to health inequities in the United States.[18]

A few of the factors driving the U.S. incarceration rate have more to do with criminal justice policy than 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. A majority of jail and prison inmates report mental health concerns, and studies have shown that some two-thirds of jail inmates meet standards for a diagnosable substance abuse disorder.[19] Overall, most of prisoners suffer from either drug addiction or mental illness, and many suffer from both.[20] Indeed, the number of individuals with serious mental illness in prisons and jails now exceeds by 10 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.[21] 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 behavior that often results from illness. (The U.S. carceral state and its effect on health and well-being are discussed in detail in Chapter 9.)

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

The final topic worth touching on at this early stage is that there is no universal right to health, to health care services, or even to insurance coverage of health care expenses in

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the United States. This sets the country apart from every other high-income nation and from some middle- and low-income countries as well. The key distinction is that the United States generally treats access to health services like it treats access to food, shelter, and vacuum cleaners—which is to say, one is welcome to them if one can afford them—while other high-income countries generally accept 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 them—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."[22] 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."[23]

The topics previously summarized have common threads: They are "structural" in nature, they deeply affect health and well-being, and they are changeable. Economic inequality, affordable housing shortages, and a commodified health care system are societal policy choices, not laws of nature. They are, without debate, hugely significant drivers of health that fall outside the control of individuals and have nothing to do with how individuals choose to live their lives. And they all could be modified and improved, and rather quite easily, provided that population-wide welfare—the chief object of social justice—was the goal. In the end, this becomes the primary aim of those committed to health justice: To understand that health *in*justice results from a range of unmet human needs that are not experienced evenly across populations; to accept that the United States has the means to both ameliorate and prevent this type of disuniform deprivation; and to strive for a framework of laws, policies, systems, and practices that effectively rewrite the nation's existing social contract in favor of one that actually secures the opportunity for optimal health and wellness for everyone.[24]

Rationale for and Structure of *Essentials of Health Justice*

This textbook was originally conceived as a primer that would serve as a companion to another textbook in a course on law, medicine, public health, nursing, or health care administration in which health justice was just one of many covered topics. That was in the spring of 2017, and while stand-alone courses on health justice existed, they were not widespread and rarely more than one credit in scope. The social, political, and health events of the intervening years have reshaped what it means to study, teach, and work in the health justice space. Criminal justice reform is now regularly

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viewed—at least among most academicians and some policymakers—as a health justice concern. So, too, are voting rights and rights to a quality education. Efforts to promote opportunity and prosperity for all while reducing persistent wealth inequities now comfortably fall under the health justice umbrella, as do many other topics not historically linked to the study of "health justice." As a result, professors and students across a range of disciplines are seeking textbooks that holistically analyze entrenched health injustice in the United States and that can serve as the primary text for an extensive variety of courses that fall along a health and social justice spectrum.

This edition of *Essentials of Health Justice* reflects the events of the past 5 years. It has a new subordinate title—the "Primer" designation has been replaced with "Law, Policy, and Structural Change"—is double the length of its predecessor, and covers a far wider range of topics than did the previous book. *Essentials of Health Justice: Law, Policy, and Structural Change* is divided into five parts. Part I provides context and background. Chapter 1 covers definitions, theories, and frameworks that influence conceptions of health justice, while Chapter 2 describes lessons learned from a diverse range of past social justice movements. In Part II, the legal underpinnings of health injustice are discussed from four different vantage points. First, Chapter 3 considers how each of the three branches of government operates in ways that can hamper widespread health justice. Chapter 4 then covers an array of health-harming legal doctrines, including the no duty to treat principle and the "negative Constitution." Chapter 5 describes health justice through the lens of human rights, a perspective that is too often missing in U.S. policy making and jurisprudence. Chapter 6 completes Part II by focusing on legal theories related to proving discrimination.

Across three chapters, Part III describes the role of structural inequity in health injustice. Chapter 7 covers socioeconomic inequality, Chapter 8 gives attention to place-based health inequities, and Chapter 9 details the role of the American carceral state in shaping population health and wellness. Part IV tackles health justice for historically excluded populations, including Asian, Black, Indigenous, Latinx, and other People of Color (Chapter 10); immigrants (Chapter 11); women (Chapter 12), LGBTQ+ people (Chapter 13), and people with disabilities (Chapter 14). Finally, Part V lays out a more vibrant health justice agenda. Chapter 15 summarizes existing efforts to achieve health justice, including medical care system innovations and public health initiatives that target structural change. Lastly, Chapter 16 offers new directions for addressing the root causes of health injustice through community empowerment, policy change, multisector policy advocacy, and a reframing of health justice that leverages human rights perspectives. 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.

It is our hope that this textbook provides a useful frame for instructing students from different disciplines about the structural role of law in health and well-being, illuminates for students the particular pathways between social policies and the injustices they can create, and offers students concrete ideas about how to practice health justice advocacy skills. By delving into the historical, structural, and legal underpinnings of racial, ethnic, gender-based, and ableist inequities in health, readers will explore (1) how health and justice intersect; (2) how law and policy structure medical, public health, and other social service systems in the United States; (3) how extant social structures lead to inequities that disproportionately harm particular populations; and (4) how health and other social systems could be reshaped to be more responsive to health injustice.

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