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INTRODUCTION

The history of health law in the United States has resulted in extreme inequality and undeniable disparities in low-income Americans' health access and outcomes. As the health justice framework moves more into the mainstream political discourse, this momentum must be used to address the justice gap and legal determinants of health. Experts in the field of equity in public health report that the best methods to combat these disparities are interdisciplinary collaboration and legal review. The Medical-Legal Partnership ("MLP") model embodies these recommendations and is a critical strategy to create a more equitable next era of health law.

PART 1: A BRIEF HISTORY OF HEALTH LAW

Health law in the United States has developed and changed through the years and will continue to evolve.[1] It has the potential to be a great source of harm, or a check on the power of institutions and a corrector for grave injustices.[2] So far, there have been four distinct eras in the development of health law in this country, each with its own lens through which health care is viewed and administered.[3]

The first era occurred in the late 19th and early 20th centuries.[4] This period was marked by an ideology of professional autonomy, exemplified by courts and legislatures acting with a hands-off approach that showed great deference to doctors.[5] Thus, the medical profession was guided by self-governance, with doctors in charge of enforcement of licensing, determining which patients to accept for care, and creating hospital policies.[6] The law allowed

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1 Erin Brown, et al., *The History of Health Law in the United States*, 387 NEW. ENG. J. MED. 289 (2022).

2 Yael Cannon, *Closing the Health Justice Gap: Access to Justice in Furtherance of Health Equity*, 53 Colum. Hum. Rts. L. Rev. 517 (2022).

3 Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 Health Matrix: J. LEGAL MED. 155 (2004).

4 Rosenblatt, *supra* note 3, at 162.

5 *Id.*

6 Brown, et al., *supra* note 1, at 290.

doctors to suppress salaried arrangements and instead insist on being paid for each treatment, which maximized physician profit.[7]

The second era, in the mid-20th century, was defined by a significant shift from physician paternalism toward an emphasis on patient rights.[8] The doctrine of informed consent, which requires physicians to obtain patients written informed consent for medical decisions and treatment plans, became an established part of the common law.[9] Courts began to recognize that consent to procedures was meaningless if patients were not fully informed about what they were consenting to, including the risks and benefits of different treatment options.[10] Professional autonomy gave way to ideas of health as a civil and human right.[11] Programs such as Medicaid and Medicare were developed, and Title VI of the Civil Rights Act was passed, which prohibited discrimination by hospitals and other recipients of federal funds.[12] Nevertheless, with this shift towards recognition of the need for greater access, came a greater emphasis on the funding of the hospital industry––enter the era of economic-centered health law.[13]

This period, starting in the early 1980s and continuing to the present, frames health care as a market and patients as consumers.[14] Proponents of the law and economics theory of health care believed that regulating the healthcare market would lead to greater competition and result in better and more efficient care.[15] Additionally, insurance costs were controlled by actuarial fairness.[16] In the insurance industry, actuarial fairness is the practice of charging those at greater risk higher premiums to compensate for the insurance companies' higher expected expenditures.[17] The Affordable Care Act ("ACA"), enacted in 2010, is an example of this shift towards a market-centered approach by creating a "marketplace" from which to purchase insurance from various private providers.[18] The ACA also established some regulation of insurance

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7 *Id.*
8 *Id.*
9 *Id.*
10 *Id.*
11 *Id.*
12 *Id.* at 291.
13 *Id.*
14 *Id.*
15 *Id.*
16 Rosenblatt, *supra* note 3, at 181.
17 Antonio J. Heras, *What was fair in actuarial fairness?*,33 HIST. OF HUM. SCI. 91, 91 (2019).
18 Brown, et al., *supra* note 1, at 291.

companies, such as prohibiting the exclusion of patients with preexisting conditions.[19]

The first three eras of health care law neglected the most vulnerable in our population.[20] Until the expansion of Medicaid in 2010, access to medical care was almost entirely based on the ability to pay.[21] Instead of focusing on populations' access to equitable and affordable care, the focus has been on individual patients.[22] Rising health care costs in the United States have led to a significant increase of inequitable access to care.[23]

Starting in 2010, with the implementation of the ACA expanding Medicaid to include non-elderly, low-income patients, an additional new era has entered the present realm of health law; health justice.[24] Advocates of this new era encourage a focus on equity in health law and policy and a deemphasis on actuarial fairness.[25] This movement has championed the idea of universal health care for all, regardless of health status or ability to pay.[26] This framework has significantly shifted social and political attitudes toward health care.[27] Medicare for all moved from the confines of the far left to a central platform of many democratic presidential candidates in 2020, signifying how the tenets of health justice have entered the mainstream.[28]

Additionally, the COVID-19 pandemic has brought to light even more significant disparities in health care and access.[29] Minorities and low-income peoples were quickly identified as some of the most vulnerable to the virus.[30] The pandemic has forced us to acknowledge these disparities and identify root causes.[31] The answer is most often found in political and social inequities.[32]

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19 *Id.*

20 *Id.*

21 Rachel Garfield et al, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid*, Kaiser Family Foundation (Jan 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.

22 Brown, et al., *supra* note 1, at 291.

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 Robert Draper, *How 'Medicare for All' Went Mainstream*, NYT, August 27th, 2019, https://www.nytimes.com/2019/08/27/magazine/medicare-for-all-democrats.html.

28 *Id.*

29 Diana-Lyn Baptiste, et al., *COVID-19: Shedding Light on Racial and Health Inequalities in the USA*, J. Clinical Nursing 2734 (2020).

30 *Id.*

31 *Id.*

32 *Id.*

These groups are vulnerable to poor health and premature death, not for biological reasons but for political and social ones.[33]

PART 2: THE JUSTICE GAP AND LEGAL DETERMINANTS OF HEALTH

In this country, there exists a significant "justice gap."[34] A "justice gap" refers to the disparity between the legal needs of low-income Americans and the legal resources available to fill those needs.[35] Those who do not have their legal information and representation needs met pay high costs as a result.[36] Low-income Americans pay these costs, the majority of whom are people of color, and these costs can include their homes, jobs, food security, and children.[37] In 1974, Congress established the Legal Services Corporation ("LSC") to promote equal access to justice.[38] LSC is currently the country's largest funder of civil legal aid for low-income populations, and each year they publish a report on the present justice gap in the United States.[39] In 2015, LSC reported that low-income Americans received little or no legal support with 92 percent of their substantial civil legal problems.[40] 74 percent of low-income Americans have faced at least one civil legal issue in the past year; two in five (39 percent) have experienced five or more issues; and one in five (20 percent) have experienced ten or more issues.[41] Most legal issues have involved health care, housing, or income insecurity.[42] Over half report that the problems have substantially impacted their lives, including finances, mental and physical health, safety, and relationships.[43]

Additionally, the report shows that low-income individuals rarely seek legal help.[44] Of those who did, they reported seeking it for only 25 percent of

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33 Yael Cannon, *Closing the Health Justice Gap: Access to Justice in Furtherance of Health Equity*, 53 COLUM. HUM. RTS. L. REV. 517, 545 (2022).

34 *Id.* at 528.

35 *Id.*

36 *Id.* at 517.

37 Legal Services Corporation, *The Justice Gap: The Unmet Civil Legal Needs of Low-income Americans*, Justice Gap Full Report (2022).

38 *Id.*

39 *Id.*

40 *Id.*

41 *Id.*

42 *Id.*

43 *Id.*

44 *Id.*

the legal issues they encountered.[45] There are many reasons for this—lack of access and resources available, mistrust in the legal system, and a lack of knowledge about the assistance lawyers can provide.[46] Limited awareness of lawyers' ability to help resolve everyday legal problems and knowledge to identify them when they occur create a barrier to access right from the start for many Americans.[47] Most respondents only sought assistance with problems readily identifiable as legal, such as family, safety, and wills and estates.[48] These unmet legal needs existing within the justice gap are not simply injustices; they are drivers of poor health.[49]

Health justice generally refers to the blending of social determinants of health with access to legal services.[50] It focuses on leveraging law and policy to address the root causes of poor health, not just the treatment of the symptoms.[51] The framework of health justice centers on populations rather than individuals.[52] Many legal problems impact health, such as public benefits, employment, education, domestic violence, and housing.[53] Low-income people, especially those of color, often face discrimination when trying to find housing or find themselves in housing that is not up to code and unsafe.[54] Attorneys can use laws such as the Fair Housing Act to advocate for these clients and find them healthy living conditions. A health justice approach acknowledges the direct connection between these legal problems and the health of vulnerable populations and works to end the positive feedback loop.[55]

PART 3: ADDRESSING LEGAL DETERMINANTS OF HEALTH THROUGH COLLABORATION AND INVESTIGATION

Dr. Erva Jean Stevens is a United Nations strategic adviser on inequality in health outcomes for the UN's response to the HIV-AIDS crisis.[56] The goal of

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45 *Id.*

46 *Id.*

47 *Id.*

48 *Id.*

49 *Id.*

50 Cannon, *supra* note 33, at 547.

51 *Id.* at 549.

52 *Id.* at 547.

53 *Id.* at 537.

54 *Id.*

55 *Id.* at 517.

56 Virtual Interview with Erva Jean Stevens, Health Inequalities Advisor, United Nations (October 20, 2022).

her department is to eradicate AIDS completely by 2030.[57] Each year, her teams' targets are continually missed and Stevens reports that this is due to inequitable access and outcomes within the most vulnerable groups.[58] She believes in order to improve public health and equity on a global and national scale, the most significant reforms that need to be made are the development of a multi-secular approach to health care and a complete legal reviews of all laws and policies from the perspective of health justice.[59]

Stevens explains that a multi-secular view that brings together experts from many disciplines is needed to share ideas and advise governments.[60] She uses the example of the COVID-19 pandemic to illustrate this.[61] COVID-19 highlighted the inequity that exists in health care.[62] As a result of the crisis, governments started to panic and politicians became the ones making the decisions regarding responses, often with little deference to health and human rights experts.[63] Stevens recalls a UN-sponsored conference she attended in 2021; the strategic planning was done by politicians sitting alone in a room without the input of the community, medical professionals, or human rights lawyers.[64] Stevens' department speaks to governments and reminds them that if they have a committee on health, it needs to be multi-secular to improve the functioning of health systems and achieve better health outcomes for all.[65]

While Stevens focuses on a global level with emphasis on those countries hit hardest with AIDS, she notes that the U.S.'s low health outcomes are shocking when considering it has the highest amount of GDP going towards health care.[66] While spending more on health care than any other industrialized country, the U.S. ranks 42nd in life expectancy.[67] This disparity emphasizes high inequity in access in the U.S. system.[68] Stevens explains that "just because services are available does not mean people have access to them."[69]

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57 *Id.*
58 *Id.*
59 *Id.*
60 *Id.*
61 *Id.*
62 *Id.*
63 *Id.*
64 *Id.*
65 *Id.*
66 *Id.*
67 Elizabeth H. Bradley, et al., *The American Health Care Paradox: Why Spending More is Getting Us Less*, (Public Affairs, 2013).
68 Stevens, *supra* note 56.
69 *Id.*

The poor health outcomes in the U.S. are not the result of a lack of funds available; they are a result of the funds being misspent.[70] Stevens argues that the current approach to health care and health policy is too medicalized––defining and treating human conditions as purely medical conditions––and it is not working.[71] Stevens emphasizes that social services need to be a part of the solution to address access to health, housing, education, and income.[72] Some first-world nations that spend as little as $2 on social services for every dollar they spend on medical healthcare costs have far better national health outcomes than the U.S.[73]

Stevens' second recommendation regards the need for a complete legal review of the laws and policies of a country, including laws that are directly medical and those seemingly non-medical.[74] Countries need to examine how their legislation has impeded access to health care legally.[75] For example, not legalizing same-sex marriage and criminalizing prostitution significantly limits access to health care for two large populations of a country.[76] Another example she gives is the *Dobbs* decision, which allowed states to restrict access to reproductive care.[77] *Dobbs* goes beyond the political and moral and is a retrograde step in patients' reproductive health and equity.[78]

PART 4: THE MEDICAL-LEGAL PARTNERSHIP MODEL

Since the ACA has made health care more accessible to more individuals through the expansion of Medicaid, it is an opportune time to address the legal determinants of health care through medical-legal partnership ("MLP"). Medical-legal partnerships combine health care with legal aid to help address social determinants of health.[79] The model is an interdisciplinary approach to health care which embeds lawyers into the care team of a patient.[80] When a physician

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70 National Center for Medical-Legal Partnership, *The Need*, The National Center for Medical Legal Partnership (2022), https://medical-legalpartnership.org/need/.

71 Stevens, *supra* note 56.

72 *Id.*

73 Bradley, *supra* note 67.

74 Stevens, *supra* note 56.

75 *Id.*

76 *Id.*

77 *Id.*

78 *Id.*

79 National Center for Medical-Legal Partnership, *The State of the Medical-Legal Partnership Field: Findings from the 2016 Surveys*, National Center for Medical-Legal Partnership 1, 4 (2017).

80 *Id.*

recognizes that a patient has a legal problem, such as a looming eviction or lack of income due to disability, the MLP enables them to be referred directly from the doctor's office to legal services.[81] Many health-harming social problems and inequities are entrenched in federal, state, and local laws, and they therefore require a knowledge of poverty and administrative law to combat.[82] The MLP model enables people to get help in these areas that doctors and clinics cannot address through medical treatment alone.[83]

MLPs can go further and advocate for policy change in these areas.[84] MLPs detect patterns in patients' needs that reveal opportunities for policy change and other solutions to help whole groups of vulnerable people.[85] MLPs have used this knowledge and expertise about their patients and their needs to advance local and state policy in ways that lead to safer and healthier environments for those most at risk.[86] Thus, the attorneys at MLPs are uniquely positioned to help disrupt the system that brings patients to the hospital again and again.[87]

In 2014, the U.S. Department of Human Resources and Services changed its rules to allow federal funding for on-site civil aid clinics at hospitals and medical clinics.[88] This change means that 23 million people who utilize medical centers with MLP affiliations have access to legal aid services to help improve their health.[89] Additionally, in 2016, the Department of Health and Human Services gave funds to six medical centers to develop MLPs.[90]

As of 2016, MLPs operated in over 300 healthcare organizations, helping more than 75,000 patients resolve civil legal issues relating to their health.[91] 11,446 healthcare workers have been trained through these partnerships to screen and recognize social and legal needs causing health issues.[92] The response from the doctors and other clinicians at these sites has been overwhelm-

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81 Cannon, *supra* note 33, at 530.

82 *Id.*

83 Emily A. Benfer, *Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education*, 35 J. LEGAL MED. 113, 117 (2014).

84 *Id.*

85 *Id.*

86 *Id.*

87 Shannon Mace, et al., *Connecting Community Health Center & Courts to Improve Behavioral Health of People & Communities*, 2 Medical- L Partnership Pop. Series 4, 12 (2022).

88 *Id.* at 10.

89 *Id.*

90 *Id.*

91 National Center for Medical-Legal Partnership, *The State of the Medical-Legal Partnership Field: Findings from the 2016 Surveys*, Nation Center for Medical-Legal Partnership, 1, 4 (2017).

92 *NCMLP*, supra note 79, at 25.

ingly positive.[93] In 2016, the NCMLP national survey reported that medical clinicians reported improved health outcomes for patients at 86 percent, improved patient compliance with recommendations and treatment at 64 percent, and a greater ability to perform "at the top of their license" at 38 percent, resulting from the implementation of an MLP at their facility.[94]

Moving forward, more research needs to be done and more data must be collected on medical-legal partnerships to show how the model has significantly improved access and equality. The data available and cited in this paper is from a 2016 National Survey and report and since then, there has been no readily available data on the outcomes and impacts of MLPs.

CONCLUSION

Medical-legal partnerships could be the next era of health law in this country. MLPs offer a unique opportunity to lessen health and legal services disparities simultaneously. The model is built on interdisciplinary collaboration and investigation of law and policy, both methods recommended by experts in the area of health equity. The model has the potential to change health outcomes in the United States on a micro and macro level.

93 *Id.*
94 *Id.*