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The role of law and legal services in mitigating health inequalities

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I want to welcome and thank this distinguished audience for participating in this event, many of whom have travelled long distances to be here today. We have a wide range of international participants from Australia, the USA, and all parts of the United Kingdom. Our participants from the fields of law and health are working in policy, practice, academia, not for profit organisations, and research funding organisations. We are looking forward to a stimulating and enjoyable day.

We are here because we share a common interest in health policy and health inequalities, and because we are keen to better understand the role and power of law - at **all of the levels** it operates in society - to help our joint mission to improve the health and wellbeing of our fellow citizens.

We want to flourish as a society, we want the next generation to achieve its potential and - in the common argot - we want to stop people being left behind. In terms of health and wellbeing, there is a pressing need to **level up.**

Although everyone in this room shares an interest the topic of 'Health Justice' or 'Justice and Health', many people here today have commented to me that they are not used to being in a room together. This is itself an important issue and one of the paradoxes in what I am calling the evolving 'Health Justice field' – and of the need to better define and develop the field.

In many respects, I am speaking to this audience as an outsider to health policy.
I am an 'access to justice' legal academic interested in law as a 'health intervention'. I believe that law and legal services, operating at a range of levels, are capable of improving the health and wellbeing of disadvantaged and vulnerable groups and reducing some of the strain on health services. I have much experience of researching legal problems that harm health, and of health needs that create their own legal problems. I do not pretend to be an expert in health inequalities or social determinants of health, but in recent years I have been reading widely in those fields and in public health law.

It was as an outsider that I was keen to organise this workshop and on my understanding of work in the health inequalities field that I wanted to highlight law and legal services as **the often forgotten, necessary discipline** in health policy and practice.

It isn't that health policy and health professionals aren't aware of the overlaps and links between law and health – they are. But while health and law are often reported together in the news – we are usually presented with only a fragment of the wide and deep interactions between law and health.

I will just provide two immediate and strikingly different examples of topical issues where the law and health are inextricably intertwined, and where law has both intended and unintended consequences on health:

First Coronavirus – Why is the CMO not here in his spot in this session? Because he is taking part in a cross-Ministerial discussion - almost certainly involving legal measures for quarantine and other procedures - that will require the power of the law to deal with the epidemic/pandemic as it evolves. In China, they have used the power of the law to enforce quarantine. They have imposed tough emergency measures which they have vigorously enforced, and this has undoubtedly had beneficial effects in containing spread. But in the initial stages of the development of the virus in Wuhan, local authorities appear to have used oppressive legal measures to conceal the threat and penalise the whistleblowing doctor, who died of the virus. This is an example of both the beneficial and repressive power of legal frameworks enacted by the State.

Second: A completely different topical example. – On 7 February 2020 (last week) the Audit Commission published a report giving their findings on enquiries with the Department of Work & Pensions about benefit claimants ending their lives by suicide because of being refused benefits or having their benefits stopped. The DWP has not had a system for investigating or collecting data or learning lessons. We have a legal framework that ostensibly provides for everyone to have income security to eat and live. But how are those legal frameworks implemented? How are decisions taken? How is law enforced at individual level among those most in need and how does this directly impact health?

I could cite numerous examples of how non-health laws passed by government and enforced at institutional and local level have direct positive and negative consequences on the health of the public, and disproportionately on the health and wellbeing of low income, vulnerable individuals and families. The benefits system, the housing system, environmental laws, employment laws, immigration law, education law, community care law, laws to protect children, domestic and elder abuse, incarceration, criminalisation of debt. The whole of our legal framework and justice systems in crime, civil and family impact the health of the public.

These are just a few immediate examples of the **direct** connections between law and health and illustrate the **three different levels** at which we will be considering the intersection of law and health today, reflected in the structure of this afternoon's panels. I will return to this shortly but thought first I might explain why I was keen to organise today's workshop and my personal interest in our discussions.

Why did I think this workshop was important?
My own access to justice research over the past 20 years has shown how legal problems affect health, and how ill-health itself creates problems for which the law provides solutions. Very often the place where these are first discussed is in

doctors' surgeries, A&E and specialist mental health and health units. Benefits, housing, homelessness, education needs, community care, immigration, family, domestic violence. A patient might come to the GP because they have asthma caused or exacerbated by living in appalling conditions; patient is suicidal because they fear imminent eviction; a patient is anxious and sleepless because they are being bullied at work. These health problems are presented to GPs, but the underlying causes will not be solved by medication. They require social welfare legal advice and possibly legal action.

In 2016 to address these issues I set up a Health Justice Partnership with a GP practice in east London providing free social welfare legal assistance to patients in the practice and began to research what difference this might make to dealing with legal problems, health and well-being, and to our ability to reach people we might otherwise not reach. This was an example of taking a free social welfare legal service to the place people go discuss their problems, rather than expecting them to identify their problem, define it as 'legal' and access dwindling free legal services. During this process I worked closely with the health system, its practitioners, its researchers, its funding and ethics mechanisms.

These are some of my outsider observations that have provided some of the stimulus for today's workshop.

I have already said that in the world of health inequalities discourse, debate, and research, the place of law and legal services is largely absent – not entirely absent – but largely absent. There is surprisingly limited consideration of law in the public health literature – limited to legislation such as sugar tax, alcohol pricing, and tobacco legislation

On health inequalities – law is almost invisible except at population level. I have become frustrated and exhausted reading ever more granular ways of describing and measuring health inequalities, while searching for focus on interventions or evaluation of interventions.

I have also learned that lawyers have been just as limited in the range of issues they have been exploring. Their preoccupations have been with medical ethics (end of life decisions, abortion, assisted dying) consent and medical negligence.

There seems to be little interest or appreciation of law and legal services as a health intervention. There is little common understanding of the different levels and ways in which the law and legal services could work better with other disciplines and policy areas to improve the lives and health of the underserved, or the research questions that we should be prioritising if we are serious about health improvement and the socio-legal causes of health problems.

And what else have I learned?

People think that the legal system is complicated. Well it's a piece of cake compared with health. Health dwarfs the justice system in terms of expenditure, resources and complexity. Its system of decision-making seems to me to be extraordinarily diffuse, and to be in a relentless state of flux and re-organisation. The capacity and appetite for responding to research evidence is also highly variable.

But there are also important similarities in policy development. While there is a need for a national framework and strategic direction, local conditions are hugely variable and to have real impact there is a requirement to respond to specific needs of groups with complex and intersecting health and legal problems.

It strikes me also that the worlds of health and law lack a common understanding and vocabulary. There are unhelpful historic suspicions between lawyers and health professionals, and little appreciation that social welfare legal services and health inequalities policy and practice **share a focus on overlapping** – if not identical - parts of our society who are underserved, disadvantaged and often excluded. This is at least part of the reason why I was keen to run this workshop today.

So, what are the objectives for today?
The programme has been designed to address our overarching question - **how can law and legal interventions mitigate health inequalities** – or **level up** those most disadvantaged by health inequalities? We will be looking at how the law in all its various guises works to both improve and, unwittingly, exacerbate health issues.

We are going to think about the connections at **three levels** within wickedly complex systems and, hopefully, **move discussion away from describing the problem of health inequalities and focus on developing transdisciplinary thinking**, exploring interventions, thinking about how to build research capacity, and the necessary evidence base that may take us some way toward achieving some solutions. Law is not the answer to all health inequalities questions, but it is an **essential** part of the picture, and not just in terms of formal legal frameworks, but in understanding how legal frameworks are **implemented** and **enforced in practice** at national, local and individual levels.

We hope that today's discussion will open dialogue and raise some difficult issues. We want to think broadly about the connections between law and health and its role **through legal frameworks, institutional implementation and individual/group enforcement** in mitigating health inequalities – **levelling up the health of those whose healthy life expectancy is woefully behind.** We hope that in the course of discussion we might challenge some existing positions and beliefs and change thinking.

Our three panels deal with law at its three levels.
Starting at the top:

Panel 1 deals with legislation at the macro population level. We will discuss legal frameworks that inevitably reflect political will but incorporate laws that have both negative as well as positive consequences for health and well-being and health inequalities. We will be asking how do we/should we take a broader 'systems approach' to developing and understanding legal frameworks and legal reform? When we change the law to achieve one objective, how much do we know about the likely broader societal impact and how much thought do we give to the downsides for health? We will be considering these questions from the perspectives of criminal justice, equality law, justice reform and legal epidemiology.

Panel 2 deals with institutional level implementation of legal frameworks where decisions are based on resources and prioritisation. If you can't do everything, what do you focus on and why? Who makes those decisions and how should those decisions be made? What evidence do we use and how do we assess and modify priorities? Do we use our resources to deal with crises by having plenty of ambulances waiting at the bottom of cliffs to scrape people up once they have fallen, or do we invest in building fences at the tops of the cliffs?

Panel 3 deals with individual level enforcement and access to legal rights and critical services – ensuring that legal protections reach those most in need and that those least able to help themselves access the critical services and material benefits to which they are entitled under the law. There will be descriptions of social prescribing and partnering health and voluntary sector community services – but these developments raise important questions about the capacity and sustainability of our community assets to deliver the presumed benefits of integrated service delivery.

In my view, some of the most important objectives of today are to bring together people from different sectors with common ambitions, interests, missions and target groups; to help us to talk together and develop a more common **recognition** of our overlapping interests; to work toward a shared understanding and vocabulary (health justice/health harming legal needs/unmet legal needs/social welfare legal problems), and to build an understanding of the potential and power of law and legal services to make a contribution and difference to mitigating health inequalities, improving the lives of some of our most disadvantaged and vulnerable groups.

Addressing health inequalities is a national and international health priority. It provides a useful framework for considering how cross-disciplinary and cross-departmental thinking, how system change and educational change - including law among a range of other disciplines - can make a difference to the conditions that harm health and the systems serving those in greatest need.

Finally, I think this in an important moment to be having this workshop. Rather than remaining in siloed policy-thinking, attitudes are changing and the appetite for cross-disciplinary policy working is increasing. I think we are seeing a different approach. The NHS is looking closely at integrated care. At improving systems to address upstream causes of poor health and provide citizens with the range of services that might better meet the full range of their needs. The Ministry of Justice is working with NHS England to think about co-location of social welfare legal assistance with health and other services. We are starting to look more systematically at the complexity of the systems that result in growing health inequalities, and to think about how we understand and address those challenges in terms of transdisciplinary solutions that may be effective and at how research investment can stimulate capacity and work in this field.

Hopefully, our discussions today will be a step toward those goals.