



Law in a Social Determinants Strategy

A Public Health Law Research Perspective

Scott Burris



Robert Wood Johnson Foundation

The Gradient Cuts Across the Range of Wicked Problems

More problems

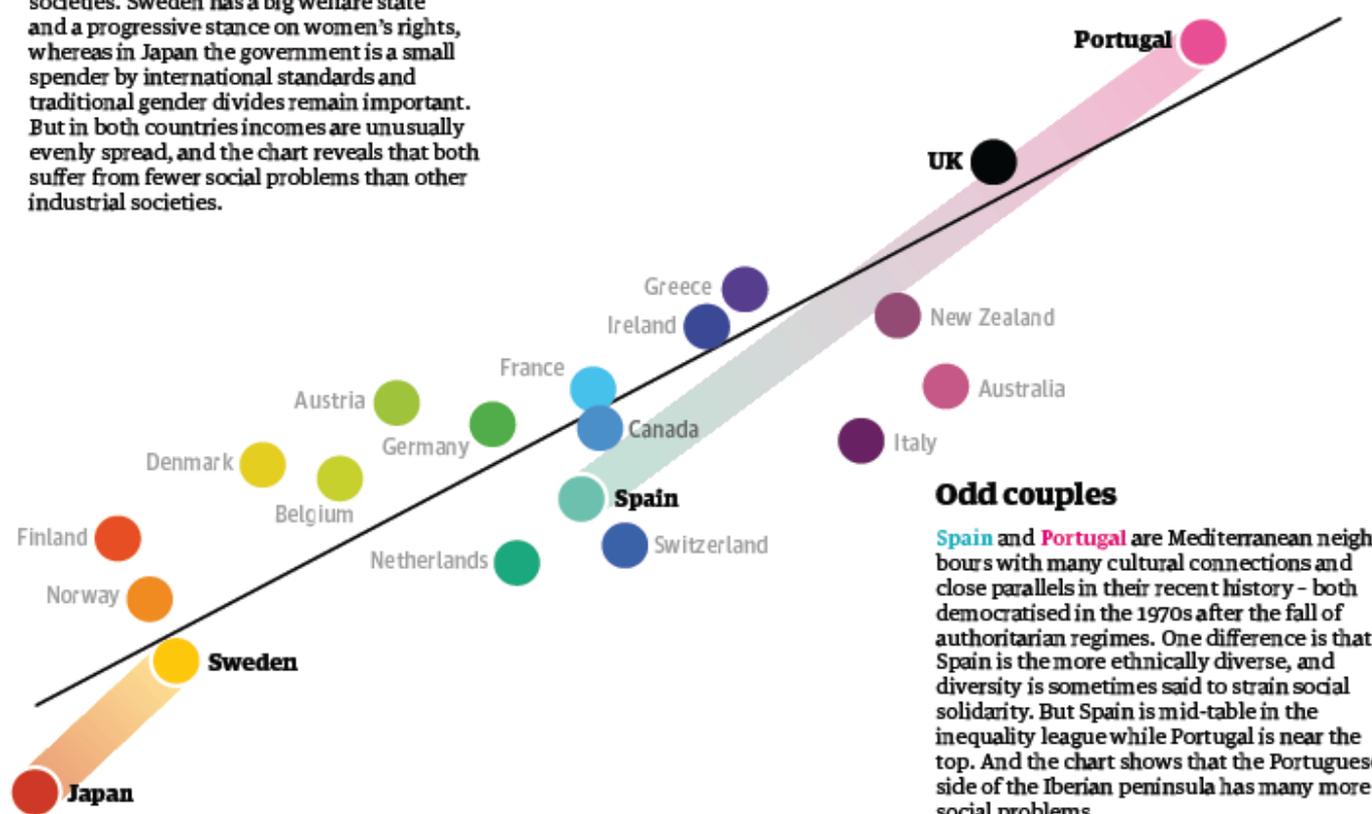
Combined social problem score

US

Odd couples

Japan and Sweden are challenging societies. Sweden has a big welfare state and a progressive stance on women's rights, whereas in Japan the government is a small spender by international standards and traditional gender divides remain important. But in both countries incomes are unusually evenly spread, and the chart reveals that both suffer from fewer social problems than other industrial societies.

The Guardian | Friday 13 March 2009



Odd couples

Spain and Portugal are Mediterranean neighbours with many cultural connections and close parallels in their recent history - both democratised in the 1970s after the fall of authoritarian regimes. One difference is that Spain is the more ethnically diverse, and diversity is sometimes said to strain social solidarity. But Spain is mid-table in the inequality league while Portugal is near the top. And the chart shows that the Portuguese side of the Iberian peninsula has many more social problems.



The Spirit Level

Why Equality is Better for Everyone

Richard Wilkinson and Kate Pickett

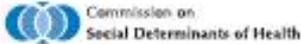
'A big idea, big enough to change political thinking' Sunday Times

'A sweeping theory of everything' Guardian

Fewer problems

More equal

More unequal



Closing the gap in a generation

Health equity through action on
the social determinants of health



Public Health Law Research:
Making the Case for Laws that Improve Health

http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

NCHHSTP will reduce health disparities in HIV/AIDS, viral hepatitis, STDs, and TB by promoting health equity

A Rose by Any Other Name...

Before the gradient, there were the twin curves...

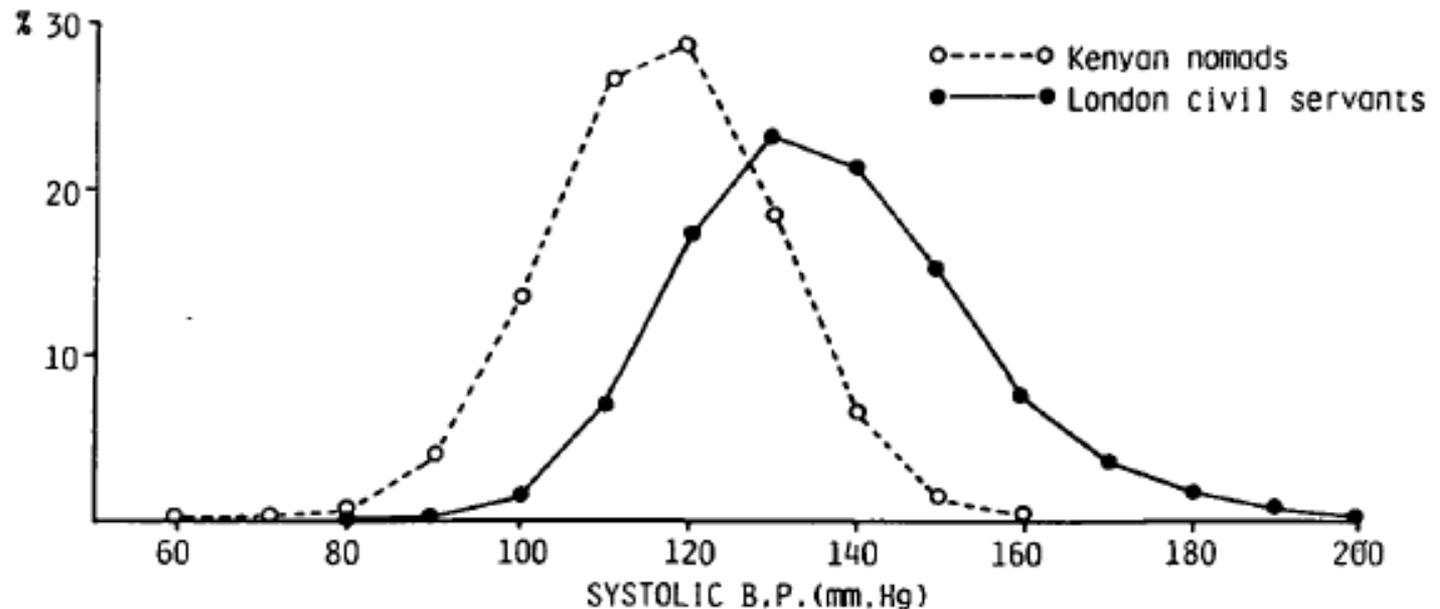


FIGURE 2 *Distributions of systolic blood pressure in middle-aged men in two populations.*^{2,3}

A Rose by Any Other Name...

Sick Individuals and Sick Populations

GEOFFREY ROSE

Rose G (Department of Epidemiology, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK). Sick individuals and sick populations. *International Journal of Epidemiology* 1985, 14, 32-38. Aetiology confronts two distinct issues: the determinants of individual cases, and the determinants of incidence rates. If exposure to a necessary agent is homogeneous within a population, then case-control and cohort methods will fail to detect it: they will only identify markers of susceptibility. The corresponding strategies in control are the 'high-risk' approach, which seeks to protect susceptible individuals, and the population approach, which seeks to control the causes of incidence. The two approaches are not usually in competition, but the prior concern should always be to discover and control the causes of incidence.

THE DETERMINANTS OF INDIVIDUAL CASES

In teaching epidemiology to medical students, I have often encouraged them to consider a question which I first heard enunciated by Roy Adenon: 'Why did this patient get this disease at this time?'. It is an excellent starting-point, because students and doctors feel a natural concern for the problems of the individual. Indeed, the central ethos of medicine is seen as an acceptance of responsibility for sick individuals.

It is an integral part of good doctoring to ask not only, 'What is the diagnosis, and what is the treatment?' but also, 'Why did this happen, and could it have been prevented?'. Such thinking shapes the approach to nearly all clinical and laboratory research into the causes and mechanisms of illness. Hypertension research, for example, is almost wholly preoccupied with the characteristics which distinguish individuals at the hypertensive and normotensive ends of the blood pressure distribution. Research into diabetes looks for genetic, nutritional and metabolic reasons to explain why some people get diabetes and others do not. The constant aim in such work is to answer Adenon's question, 'Why did this patient get this disease at this time?'.
The same concern has continued to shape the thinking of all of us who came to epidemiology from a background in clinical practice. The whole basis of the case-control method is to discover how sick and healthy individuals differ. Equally the basis of many cohort studies is the search for 'risk factors', which identify

certain individuals as being more susceptible to disease; and from this we proceed to test whether these risk factors are also causes, capable of explaining why some individuals get sick while others remain healthy, and applicable as a guide to prevention.

To confine attention in this way to within-population comparisons has caused much confusion (particularly in the clinical world) in the definition of normality. Laboratory 'ranges of normal' are based on what is common within the local population. Individuals with 'normal blood pressure' are those who do not stand out from their local contemporaries; and so on. What is common is all right, we presume.

Applied to aetiology, the individual-centred approach leads to the use of relative risk as the basic representation of aetiological force: that is, 'the risk in exposed individuals relative to risk in non-exposed individuals'. Indeed, the concept of relative risk has almost excluded any other approach to quantifying causal importance. It may generally be the best measure of aetiological force, but it is no measure at all of aetiological outcome or of public health importance.

Unfortunately this approach to the search for causes, and the measuring of their potency, has to assume a heterogeneity of exposure within the study population. If everyone smoked 20 cigarettes a day, then clinical, case-control and cohort studies alike would lead us to conclude that lung cancer was a genetic disease, and in one sense that would be true, since if everyone is exposed to the necessary agent, then the distribution of cases is wholly determined by individual susceptibility.

Within Scotland and other mountainous parts of Britain (Figure 1, left section) there is no discernible relation between local cardiovascular death rates and the softness of the public water supply. The reason is apparent if one extends the enquiry to the whole of the

Department of Epidemiology, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK.
Based on a lecture to the Xth Scientific Meeting of the International Epidemiological Association, 27 August 1984, Vancouver.

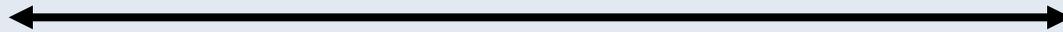
The
Causes of
Incidence



The Causes of
Cases

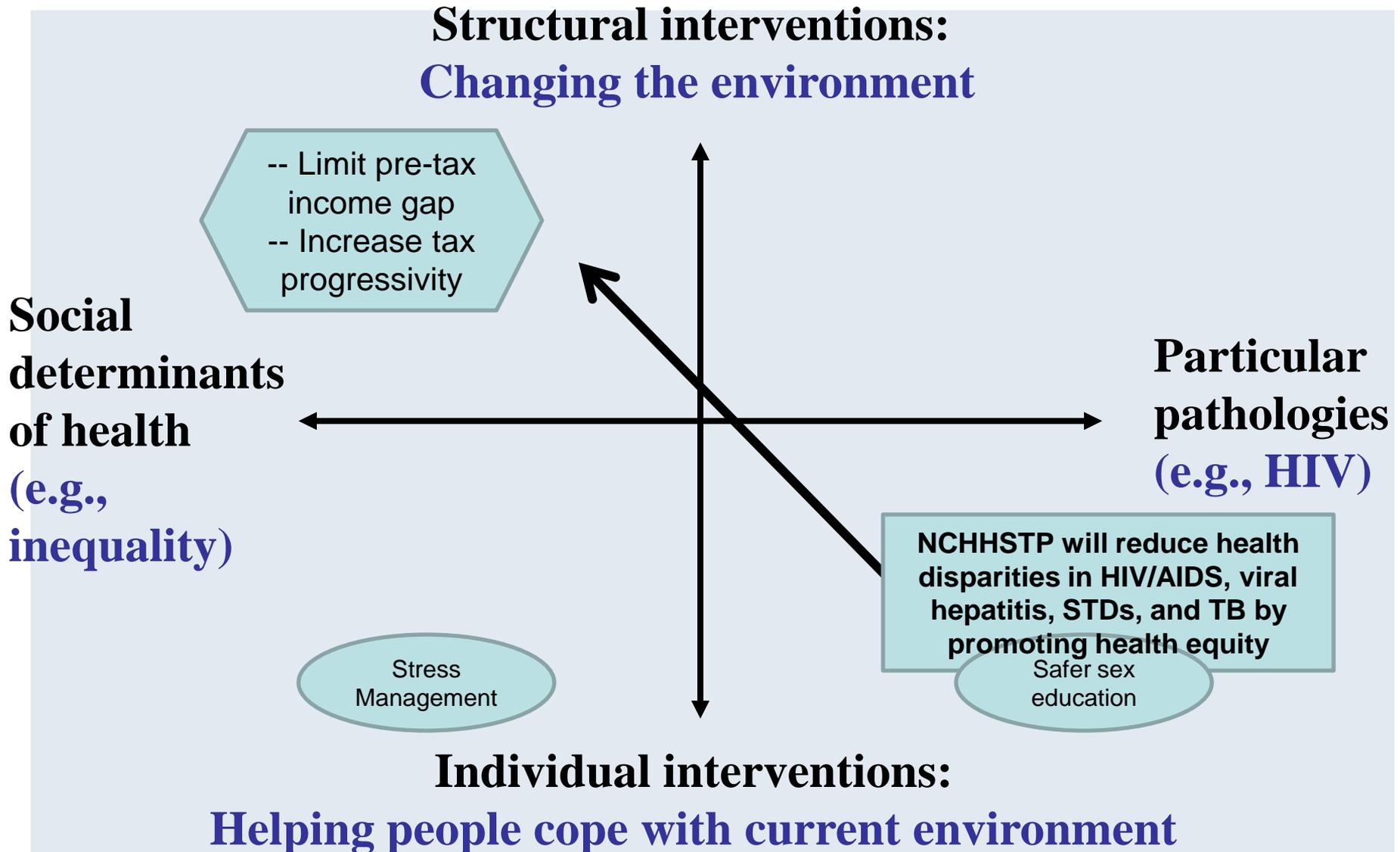
A Rose by Any Other Name...

**Social
determinants
of health**
(e.g.,
inequality)



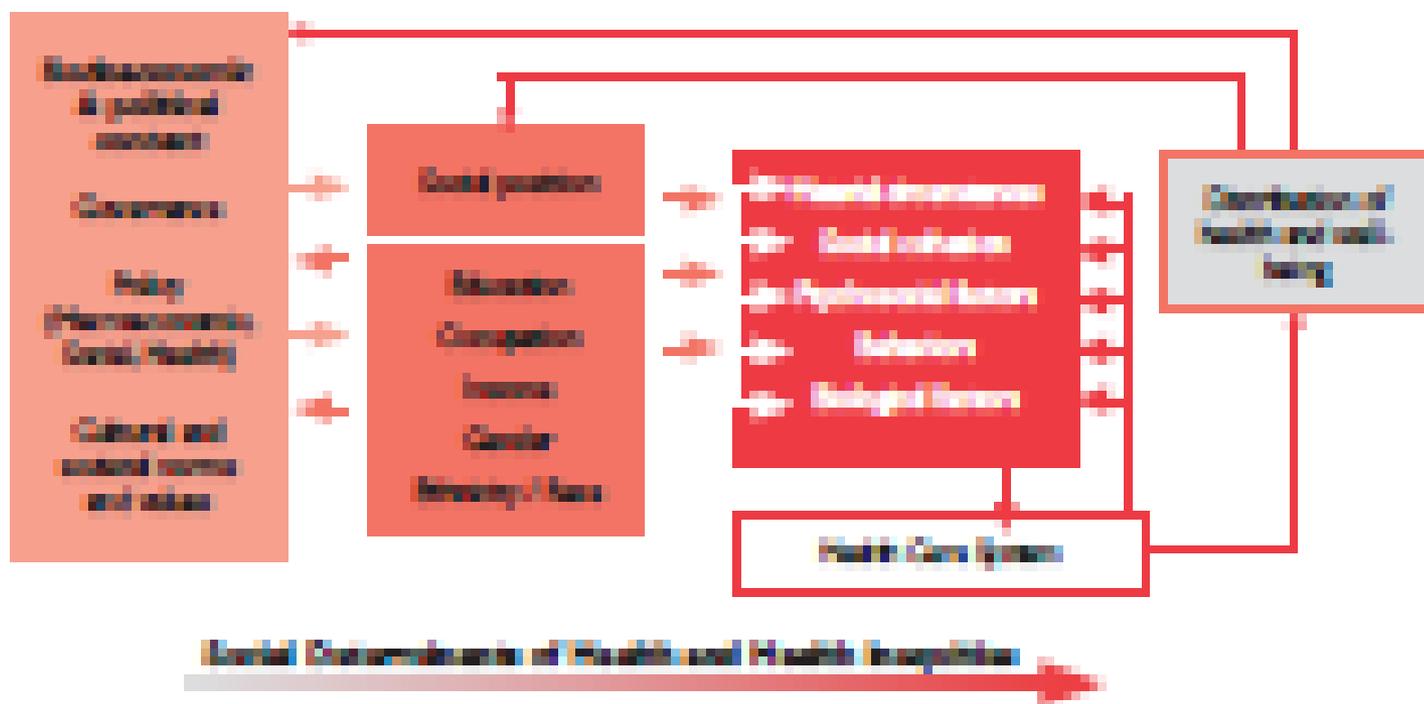
**Particular
pathologies**
(e.g., HIV)

A Rose by Any Other Name?



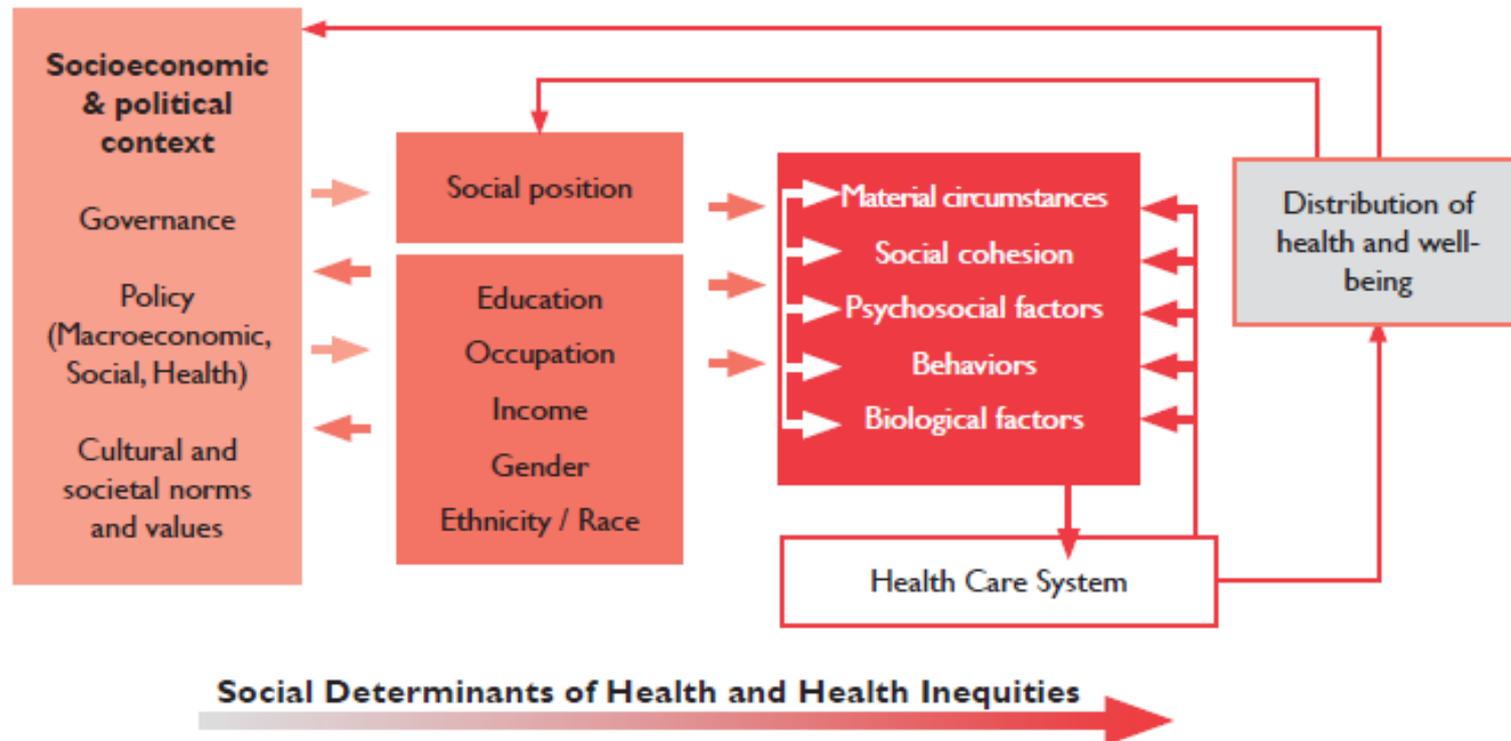
Law is There, But It's Fuzzy

Figure 1.1 **Contribution to Social Determinants of Health Conceptual Framework**



In Fact, “The Law Is All Over”

Figure 4.1 Commission on Social Determinants of Health Conceptual Framework



Integrating Law and Social Epidemiology

Scott Burris, Ichiro Kawachi, and Austin Sarat

Social epidemiology has made a powerful case that health is determined not just by individual-level factors such as our genetic make-up, access to medical services, or lifestyle choices, but also by social conditions, including the economy, law, and culture. Indeed, at the level of populations, evidence suggests that these "structural" factors are the predominant influences on health. Legal scholars in public health, including those in the health and human rights movement, have contended that human rights, laws, and legal practices are powerfully linked to health. Social epidemiology and health-oriented legal scholarship are complementary in their focus and their research needs. Legal scholarship has identified plausible ways in which legal and human rights factors could be influencing health, but empirical evidence has been limited. Epidemiology has marshaled considerable evidence that social structures are broadly related to the level and distribution of health in a society, but bolstering claims of causation and intervening both require the elucidation of the mechanisms through which social structures actually influence health. As Marmor has argued, finding these mechanisms requires the integration of all the sciences that can offer explanations of the phenomena at issue, from the physiology of stress to the sociology of social status.¹ Law, we suggest here, is an important mechanism to pursue.

In this article, we present a heuristic framework for including law as a social factor in epidemiological research, and conversely for understanding how law can have health consequences worthy of consideration by lawyers. The framework posits law operating simultaneously in two broadly defined roles: Laws and legal practices contribute to the development, and influence the stability, of social conditions that have been associated with population health outcomes

Journal of Law, Medicine & Ethics, 30 (2002): 510-521.
© 2002 by the American Society of Law, Medicine & Ethics.

(i.e., law contributes to the creation and perpetuation of fundamental social determinants of health); and law operates as a pathway along which broader social determinants of health have an effect (i.e., law is one of the social systems through which more fundamental social characteristics work to create health effects). Consideration of existing data in epidemiology and the social science of law supports the plausibility and usefulness of this framework.

THE FRAMEWORK

Social epidemiology

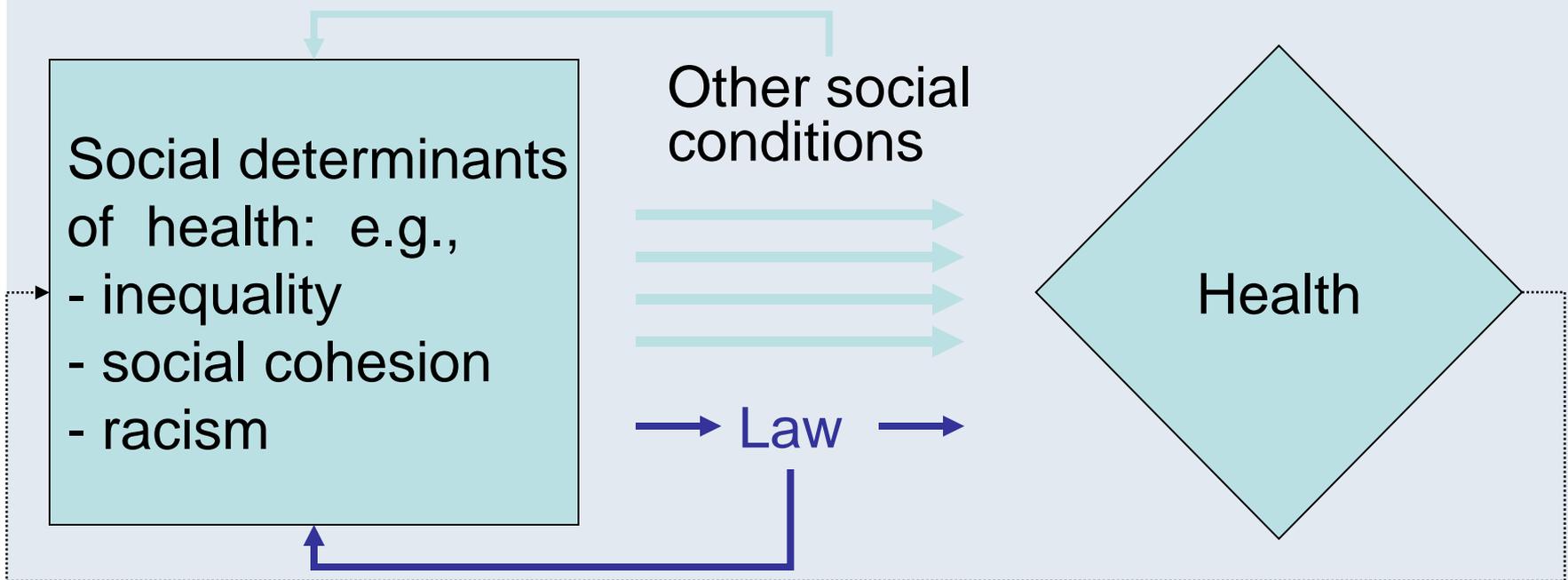
Social epidemiology seeks to uncover the social determinants of health. The distinction between social epidemiologists and other epidemiologists can be succinctly summarized by the question that each poses. Whereas traditional epidemiologists are trained to ask the question, "Why are some individuals healthy and others not?" the social epidemiologist is concerned with the question, "Why are some societies healthy, while others are not?"² This distinction is more than a semantic difference because the causes of individual variations in health and illness are conceptually different from the causes of population well-being. Populations with the same genetic make-up, lifestyle habits, and access to medical care can nonetheless exhibit dramatic variations in health achievement. Japanese immigrants in the Niihonsan Study, for example, came to resemble, in their health, the people of their adopted U.S. homes rather than the Japanese they left behind.³ Obviously, genes had little to do with this, but neither could lifestyle factors, such as diet, account for much of the differences. One is forced to look toward societal factors to explain why Japanese have better health than Americans, despite smoking more and spending roughly half of what the United States does on medical care.

Journal of Law, Medicine and
Ethics, Vol. 30, p. 510, 2002.
Available at SSRN:
<http://ssrn.com/abstract=1004746>

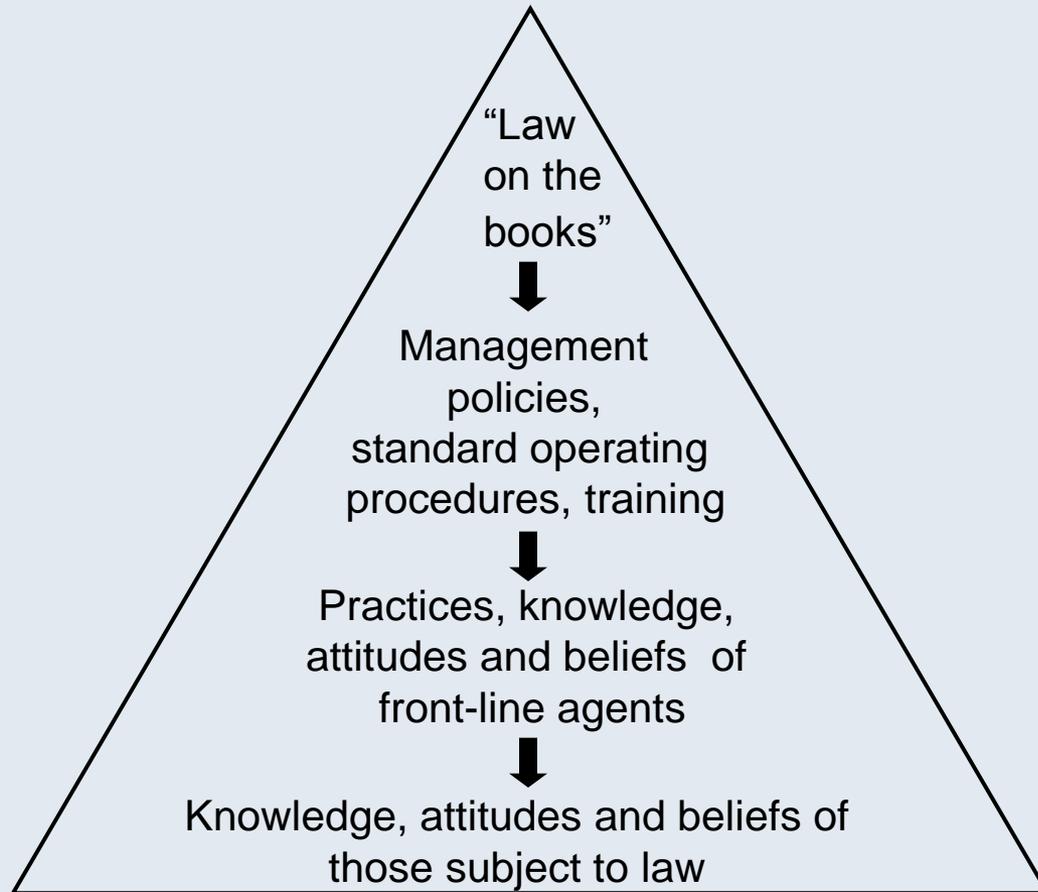
Two Relationships Between Law and Health

1: Law operates as a pathway along which fundamental social causes of disease have their effect.

2: Law contributes to the development and maintenance of unhealthy social conditions.



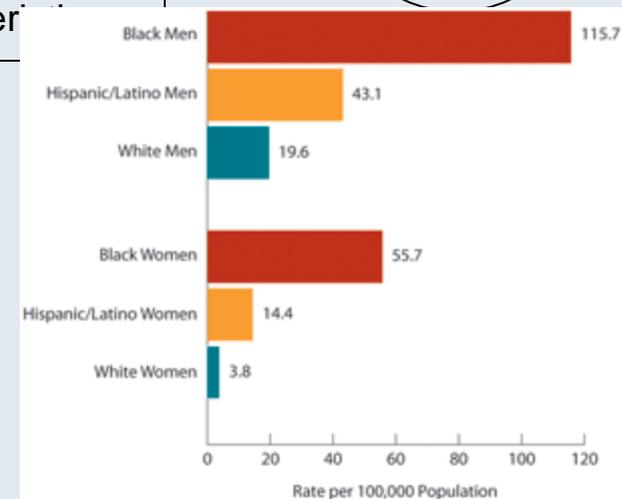
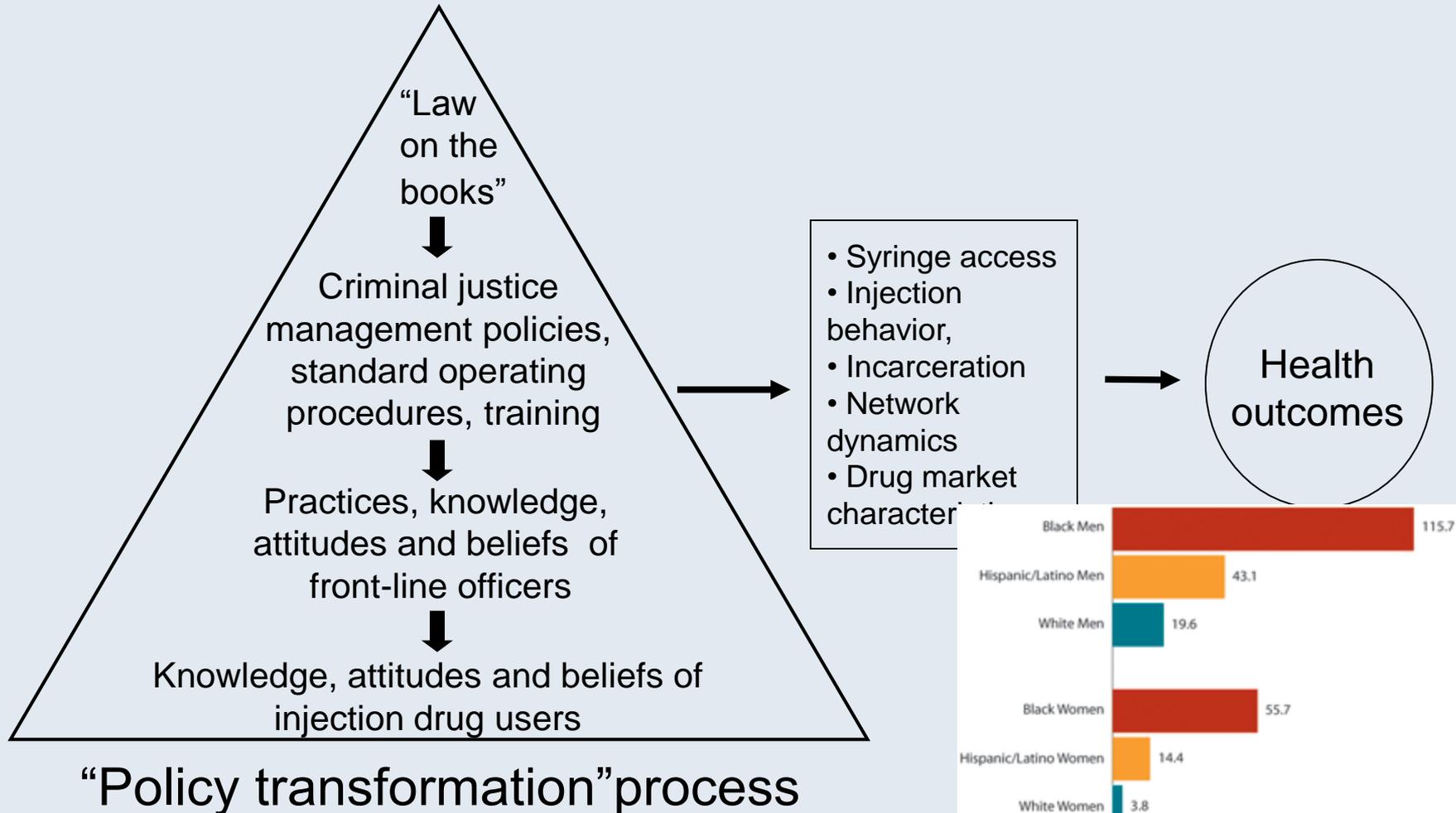
What do we mean by “law”?



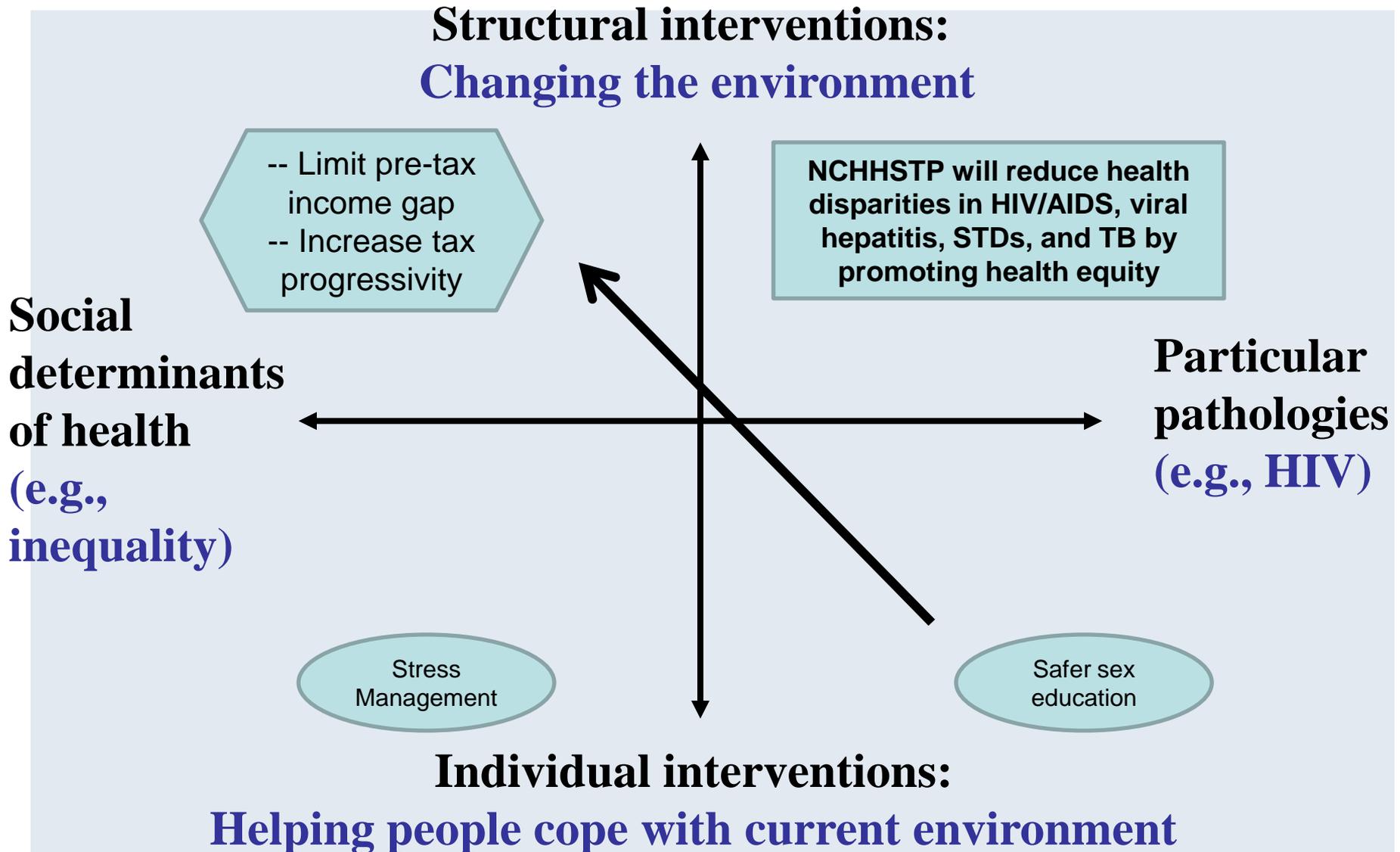
Law

“Policy-
transformation”
process

From Drug Policies to Health Outcomes of Injection Drug Users



A Rose by Any Other Name?



A Framework Convention on Global Health: Social Justice Lite, or a Light on Social Justice?

Scott Burris and
Evan D. Anderson

*We are the folksong army
Every one of us cares
We all hate poverty, war and injustice
Unlike the rest of you squares*

*We are the folksong army
Guitars are the weapons we bring
To the fight against poverty, war and injustice
Ready. Aim. Sing.*

— Tom Lehrer, “The Folksong Army”

I. Introduction

A decade ago, Jonathan Mann made a powerful case that human rights could provide a vocabulary and mode of analysis for understanding and advancing health.¹ He made the case well, and put the idea into inspired practice, but the idea was neither new nor his alone. The idea that social justice — and henceforth in this article we will use that term loosely (and with obvious imprecision) to embrace goods like human rights, social equality, and distributive justice — was intrinsically important to health resonated with the social epidemiology already gathering force (not to mention an enduring theme running through the history of public health work). That social structure and relations of power explain a great deal about the level and distribution of population health was implicit in the work of pioneers like Geoffrey Rose,² evident in Marmot’s seminal Whitehall studies,³ explicit in the writings of Mervyn Susser,⁴ and the main thrust of scholars like Nancy Krieger⁵ and Meredith Turshen.⁶ Although researchers tend to avoid using a term with such normative weight, it is safe to say that Mann — and Susser, and Marmot and Krieger among others — were right: social justice is central to the proper understanding of health.⁷

But Mann did not just argue that social justice was useful to people trying to understand health; he also argued that a social justice standpoint could help us act more effectively to advance health. This same premise animates the report of the Commission on Social Determinants of Health (CSDH),⁸ Lawrence Gostin’s campaign for a framework convention on global health,⁹ and academic writing about global health governance.¹⁰ If we can show that health is inequitably distributed in populations and through-

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<http://ssrn.com/abstract=1685858>

The Next Step: PHLR

“The scientific study of the relation of law and legal practices to population health.”

THE
MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Making the Case for Laws That Improve
Health: A Framework for Public Health Law
Research

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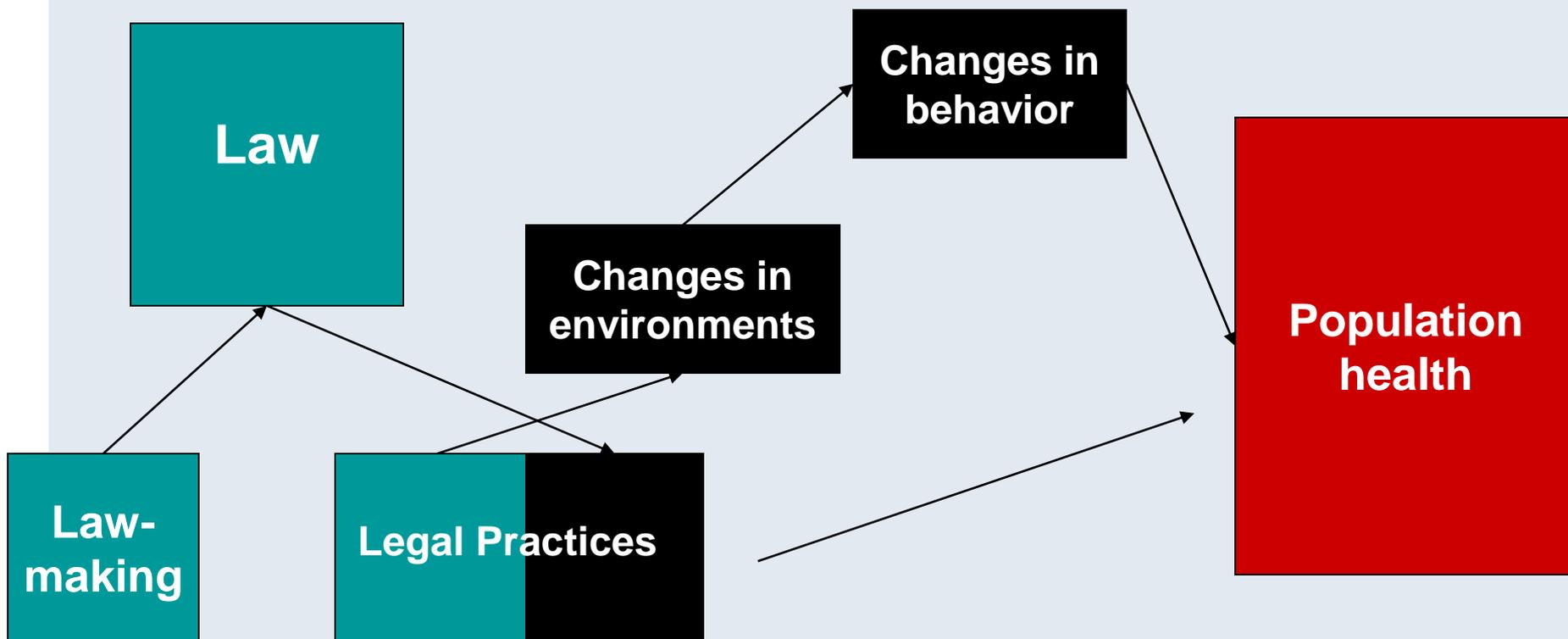
<http://www.milbank.org/quarterly/8802featBurriss.pdf>

Logic model of PHLR

Inputs

Mediators

Outcomes



Measuring Law for Evaluation Research

Evaluation Review

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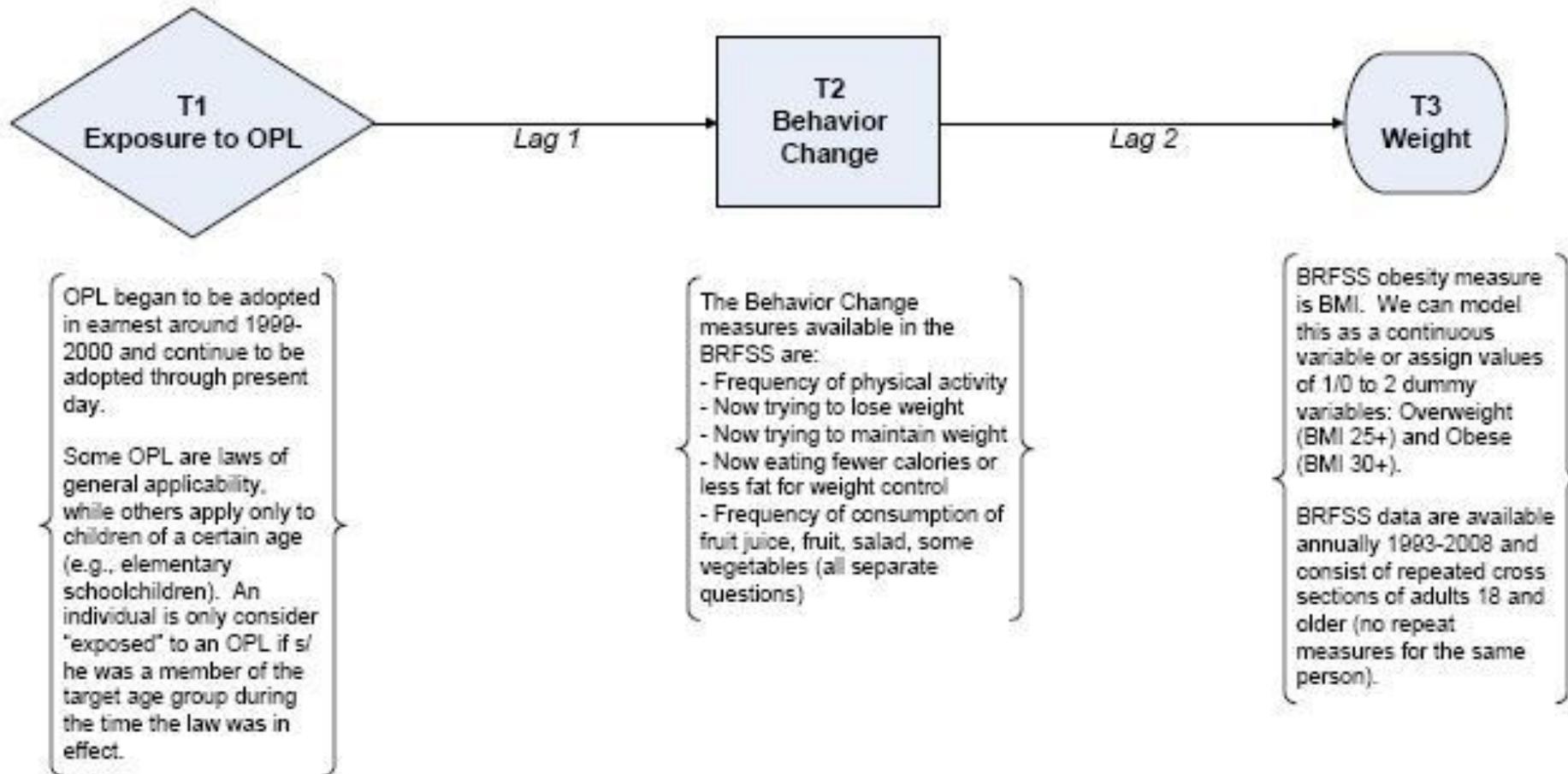


**Charles Tremper¹, Sue Thomas², and
Alexander C. Wagenaar³**

<http://www.publichealthlawresearch.org/node/178>

Effects of Obesity Prevention Laws (M. Mello)

The model relates a young person's exposure to OPL at T1 to their weight at T3. This effect is mediated by behavioral changes, including physical activity, eating, and weight monitoring. The length of time needed to produce these effects is uncertain.



PUBLIC HEALTH LAW RESEARCH

Public health law research is the scientific study of the relation of law and legal practices to population health.

Public Health Law Research (PHLR) is a five-year, \$17.3-million national program of the Robert Wood Johnson Foundation, administered by Temple University's Beasley School of Law.

The goal of this program is to build the evidence for and increase the use of effective regulatory, legal and policy solutions – whether statutes, regulations, case law or other policies – to protect and improve population health and the public health system.

The program focuses on three primary activities:

- Fund research and evaluation of public health laws and their impact

- Improve the quality of public health law research
- Support outreach to researchers, policy makers, advocates and the media

PublicHealthLawResearch.org

IMPROVING PUBLIC HEALTH THROUGH LAW

From air bag requirements for cars to smoke-free regulations in restaurants, laws can make communities healthier and safer.

Public Health Law Research and Public Health Law Network are two important initiatives that focus on the effective use of laws to improve public health.



From research to application, these initiatives can:

Build evidence to inform and guide laws that promote public health
Public Health Law Research

Develop, implement and enforce laws to solve public health challenges
Public Health Law Network



PUBLIC HEALTH LAW NETWORK

The Public Health Law Network is an initiative to help individuals and organizations apply the law to solve public health challenges. The Network includes legal experts, public health practitioners and officials, lawyers, policy-makers and advocates.

The Network provides:

- **Legal technical assistance** to help you develop, implement and enforce public health laws. The Network has access to legal experts on a wide range of topics, from health reform and emergency response to environmental public health and more.
- **Training and educational resources** about how to effectively apply the law to improve, promote and protect the public's health.

Join the Network to share your knowledge and experiences, to connect with experts and users of public health law and to create healthier, safer communities.

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