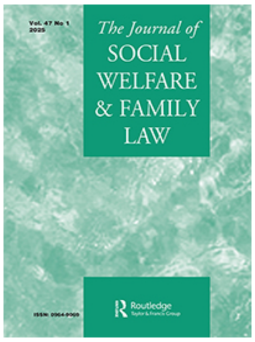

Routledge
Taylor & Francis Group

Journal of Social Welfare and Family Law

ISSN: 0964-9069 (Print) 1469-9621 (Online) Journal homepage: www.tandfonline.com/journals/rjsf20

Health justice interventions in England and Australia: an intersectional approach to legal capability and health literacy

Jess Mant, Naomi Creutzfeldt & Sonila M. Tomini

To cite this article: Jess Mant, Naomi Creutzfeldt & Sonila M. Tomini (18 Jul 2025): Health justice interventions in England and Australia: an intersectional approach to legal capability and health literacy, Journal of Social Welfare and Family Law, DOI: 10.1080/09649069.2025.2530885

To link to this article: https://doi.org/10.1080/09649069.2025.2530885

JOURNAL OF SOCIAL WELFARE AND FAMILY LAW
https://doi.org/10.1080/09649069.2025.2530885

Routledge
Taylor & Francis Group

Health justice interventions in England and Australia: an intersectional approach to legal capability and health literacy

Jess Mant[a], Naomi Creutzfeldt[b] and Sonila M. Tomini[c]

[a]Monash Law School, Melbourne, UK; [b]University of Kent Law School, Canterbury, UK; [c]University College London, Global Business School for Health, London, UK

ABSTRACT
Scholarship to date has evidenced a clear relationship between poor health and unmet legal need, particularly among disadvantaged and marginalised social groups. In this article, we draw upon comparative insights from England and Australia to argue that, despite the success of such initiatives in England to date, there remain a range of overlooked early intervention opportunities for addressing the cumulative and compounding ways that legal and health problems intersect at the individual level. We map the current landscape of scholarly evidence regarding the relationship between health and justice and introduce a conceptual framework of intersectionality as reinforced by vulnerability theory as a fresh lens through which to explore the diverse ways that individualised experiences of health and legal problems intersect with wider marginalisation. We argue that health justice interventions must be better matched to the individualised needs of service users, and that with stronger understanding of how individuals experience and respond to health and/or legal problems, it will be possible to diversify interventions to a broader range of settings. To aid this understanding, we propose that future development and evaluation of such initiatives must be clearly focused on ensuring that services are three things: responsive, holistic, and community-embedded.

KEYWORDS
Health justice interventions; intersectionality; access to justice; vulnerability

Introduction

Scholarship to date has evidenced a clear relationship between poor health and unmet legal need. Decades worth of legal need surveys and empirical studies consistently show that those who have unresolved legal problems are disproportionately more likely to face health issues, and vice versa (Sandefur 2015, Parkinson and Buttrick 2015, Balmer *et al.* 2023). This is particularly prevalent in social welfare law, given that issues like housing and social security tend to dictate: the quality and security of people's living conditions; stress levels; affordability of food and medications; and exposure to physical health risks. At the same time, poor health affects a person's capacity to undertake paid employment and the likelihood that they will need to rely on state subsidies. As this literature

CONTACT Naomi Creutzfeldt N.Creutzfeldt@kent.ac.uk

demonstrates, legal problems and health problems are not only likely to be experienced simultaneously, but the experience of one problem type increases the chance that an individual will be faced with the other. To this, we add that there is also an intersecting category of context-specific problems which straddle both health and justice, such as a dispute concerning Personal Independence Payments (or 'Disability Support Pensions' in Australia) (Machin 2017).

To date, the evidenced bi-directionality of the relationship between health and justice has inspired several new models of service delivery around the world. Sometimes referred to as 'health justice partnerships' (HJPs) or 'medico-legal partnerships', these initiatives seek to target legal and health interventions at marginalised groups in a concerted way, either via co-located services or strong referral networks between distinct services. While Australia now enjoys an extensive network of services through the national Health Justice Australia (HJA) network, the health justice movement in England is still emerging, and to date has been largely limited to primary care settings (Genn 2019). Primary care services are the main way in which people access the health system through a range of public or private providers. In England and Australia these services are made up of GPs, dental practices, optometrists and community pharmacies. This includes nursing, midwifery, aboriginal health services, and allied health care services in Australia (Australian Institute for Health and Welfare 2024).

In this article, we draw upon comparative insights from both of these jurisdictions to argue that, despite the success of developing initiatives in England to date, there remain a range of underexplored early intervention opportunities for reaching people who are contending with legal and health problems. Specifically, we argue that at present, there is limited understanding of how individuals may differently experience and respond to health problems, legal problems, as well as those problems that have both health and law dimensions, is essential for informing the design of health justice interventions. In this article, we demonstrate that by tracing the individualised journeys of citizens facing with these problems, there is scope to gain fresh insight into the diverse needs, responses and challenges associated not only with simultaneous legal and health problems, but also intersecting health-justice problems.

In order to unravel the nuance of these experiences, we use a lens of intersectionality reinforced by Martha Fineman's vulnerability theory (2008, 2010, 2013) to explore the complicated convergence of health and justice within everyday experiences of disadvantage and marginalisation. Through this lens, it is possible to look beyond traditional indicators of marginalisation and appreciate the broad and complex range of factors that can affect a citizen's capability to seek assistance in relation to their health, legal, or multidimensional health-legal problems. It also reveals the unique ways in which capability, confidence and resources may fluctuate for each individual, depending on their circumstances. Vulnerability theory is particularly useful for reinforcing intersectionality because it provides a flexible, all-encompassing conceptual device through which to understand marginalisation and inequality, beyond the intersections of specific categories such as gender, race and class which are conventionally understood as metaphors for disadvantage. Many socio-legal scholars have already used vulnerability theory in this way to garner better understandings of disadvantage and marginalisation within society and relate this to issues of legal need (Curran and

Noone 2007), access to justice (Cannon 2021, Mant 2022), and legal inequalities (Harding 2020, Newman *et al.* 2021, Gordon-Bouvier 2021). For the purposes of this article, we use vulnerability theory to evaluate the various resources required for a citizen to take action in response to either legal or health problems and view these problems within the broader context of barriers and inequalities that frame individual experiences of society. In particular, we assert that those who are marginalised from public services may only emerge when they are forced to engage with hospitals due to health emergencies, and others may not engage with any traditional healthcare or legal settings at all; instead seeking help from a variety of generalised community services such as libraries, council offices, food banks, or local support groups. To this end, we propose that any services seeking to target legal and/or health interventions must be three things: responsive, holistic, and community-embedded.

In doing so, we expose the limitations of siloed working when it comes to devising health and justice interventions and propose a fresh perspective on how to understand (and approach) the intersection between legal need and health inequalities in England (Thomson 2023). Drawing on examples from each jurisdiction, we assert that the populations who experience simultaneous and intersecting legal and health problems are far from homogenous and are likely to emerge at a variety of different settings, and with different severities of legal and/or health problems. As such, services must be designed in such a way as to capture legal need in a range of different contexts beyond those where patients actively self-present for medical advice (e.g. in GP surgeries). These insights come at an important time for both access to justice scholarship and legal service providers working in health settings, given the increasing post-pandemic appetite for innovative, cross-sector solutions to the linked issues of rising legal need and growing health inequalities.

The article begins by mapping the current landscape of scholarly evidence regarding the relationship between health and justice, which has paved the way for a range of health justice initiatives across England and Australia. Then, a conceptual framework of intersectionality as reinforced by vulnerability theory is articulated. This framework provides a means of exploring the diverse ways that health and legal problems intersect with individual trajectories of marginalisation within society. Employing this lens, we then draw out key insights from the development of interventions across these two countries, reflecting on the extent to which services are embedded within local communities and are equipped to respond holistically to various experiences of legal need. Building on these insights, we consider future directions for interventions targeted at addressing health and/or legal problems, emphasising the importance of operationalising existing measurement tools such as the social determinants of health and legal needs surveys to inform service design. Finally, we conclude by arguing, first, that England has much to learn from the ‘bottom up’ approach to service design in Australia, and second, that future development and evaluation of health and justice interventions must be clearly focused on ensuring that services are responsive, holistic, and community-embedded.

The relationship between health and justice

The compounding relationship between health inequalities and legal problems is already well-evidenced across the disciplines of law and health (Bateman 2008, Beardon and Genn 2018). In law, the rise in legal needs surveys over the past two decades have brought a wealth of statistical data regarding the prevalence, severity, nature, and extent of legal problems that citizens experience as part of their daily lives. This evidence base has substantiated a clear link between the experience of legal problems and the experience of both physical and mental health implications, both as a precursor to and a consequence of the impact of legal problems (Pleasence *et al.* 2008; Marshall and Barclay 2003). In Australia, the *Public Understanding of Law Survey*, conducted by the Victoria Law Foundation, reveals that 20% of people who experienced legal and health problems directly attributed their health problem to their legal problem, and over 70% of people who experience legal problems report experiencing varying degrees of stress, which may or may not require medical support (Balmer *et al.* 2023). In particular, legal needs surveys have shown that this intersection between legal and health problems is especially prevalent when it comes to social welfare law issues. Despite the variation in legal and social context of each jurisdiction, the top recorded social welfare needs are consistently identified as: housing, employment, public benefits, immigration, family, education and healthcare (Newman *et al.* 2021). The specific links between social welfare law problems and health problems are particularly compounding; as one problem escalates, there is an increased risk of experiencing further health and legal issues that require more urgent intervention. Moreover, poor physical and mental health can exacerbate legal problems and make them more difficult to resolve, for instance by affecting work capability and the need for welfare support (Genn 2019).

The same story of simultaneous and compounding problems can be told from a health perspective, where ‘social determinants of health’ have achieved international prominence as a vital area of multi-disciplinary practice and research (Beardon and Genn 2018). The determinants have been developed as a mechanism of identifying the non-medical factors that can account for up to 55% of negative health outcomes (World Health Organisation WHO 2023). The determinants are attributes, characteristics or exposures that increase or decrease the likelihood that a person will develop a disease or health disorder. They include the extent to which citizens have access to: education, housing and basic amenities, affordable health services, income and social protection, employment security, food security, social inclusion and healthy working life conditions. Many risk factors can be changed or controlled to improve health outcomes or reduce the chance of ill health. In turn, a person’s health status influences social and socioeconomic factors; for example, their ability to work, earn an income or participate in their community (Marmot 2005). As such, these determinants map onto the findings of legal needs surveys almost exactly in terms of identifying social welfare related factors that are proven to either facilitate or exacerbate health problems. In other words, although these evidence bases have been developed from separate disciplinary perspectives, they both indicate that the interaction between health issues and social welfare law problems frequently manifest in self-perpetuating marginalisation and disadvantage.

There is also a consensus across these separate literatures that individuals are not always able to take proactive steps in response to their problems. As literature on legal capability demonstrates, many citizens find it challenging to identify how and where to seek legal assistance and may lack access to a network through which they can be signposted to such support. This can be attributed to the (actual or perceived) expense of legal services and courts (Balmer and Pleasence 2019). However, there are also several barriers that relate to public consciousness of law and confidence asserting legal rights and entitlements. For example, legal need surveys undertaken in both Australia and England demonstrate that a core component of legal capability is the ability to recognise problems as 'justiciable' - that is, problems for which there are potential legal solutions or remedies available (Genn and Beinart 1999). For the many citizens who characterise their problems simply as 'bad luck' or even as personal failings, legal capability is distinctly challenging and bound up with wider experiences of marginalisation in society (Balmer and Pleasence 2019; Pleasence *et al.* 2004). As a consequence, only a small proportion of those who experience legal need tend to be those who actively seek legal advice at an early stage of their problems, and these individuals tend to carry greater privilege in terms of both understanding where to seek support as well as confidence in their entitlements to just resolutions. In contrast, the majority of citizens tend to present at legal advice clinics or law centres only when legal problems reach a particular 'trigger' point which necessitates action, such as an eviction notice. For this reason, members of the general public typically have low levels of legal capability, and do not often seek specialist legal advice at an early stage of their legal problem.

Similarly, health equity research indicates that many population groups face barriers to accessing and using health services, including the availability and quality of health services, particularly in regional or rural locations, as well as the cost of accessing services where free-to-access clinics are not available. In England and Wales, the NHS has been subjected to decades of underfunding and is overwhelmed, causing limited availability of appointments and long waiting times for specialist services. This creates barriers to the availability of healthcare and in many cases exasperates the problems. There is a costly private healthcare option available, with shorter waiting times and specialist services. In Australia, the high concentration of health services in the major cities poses a significant challenge for ensuring availability of appropriate healthcare in regional areas. There are also unique cost-related barriers; the national 'Medicare' scheme provides the facility for GPs and other frontline healthcare settings to 'bulk bill', which means to directly claim eligible costs of provided services from the government rather than requiring a patient to pay upfront and then submit an individual claim for the proportion of cost that is covered by Medicare. Bulk billing ensures that services are either free or subsidised at the point of access, and the Australian government has introduced a range of financial incentives in recent years to encourage bulk billing for patients who are elderly, under the age of 16, on low incomes, or are living in regional areas. Although these incentives are supporting the expansion of bulk billed services across regional areas, research indicates that there are still only a minority of healthcare settings offering bulk billed services in Australian cities (Zhang 2024).

However, it is also important to recognise that health inequalities cannot be attributed solely to a lack of availability of free-to-access health services. Rather, the ability to access and use healthcare services also hinges significantly on an individual's 'health literacy'. Health literacy can be understood as a parallel concept to legal capability, in that it comprises a range of similar capabilities, including the ability to find, understand and make sense of information and to know where and how to seek treatment. Health literacy is also shaped by individual behaviours and social determinants of health and wellbeing, such as, housing, income, level of education, and employment (The Health Foundation 2022). The ability to seek out health services, therefore, may also be extremely challenging for marginalised groups who may not have the time and resources to visit GP surgeries at an early stage of their health problem, and may delay seeking help in the hope that their health problem will resolve itself over time. In Australia, data indicates that only 41% of adults have a level of health literacy that allows them to meet complex demands of everyday life (Australian Institute for Health and Welfare 2018). In England, the picture is similar, where only 39% of the English working age population are able to routinely understand information about health and wellbeing (Public Health England 2015). For those who are not able to access early health interventions, the first engagement with a healthcare context may be more likely to occur in a hospital, through a health-related 'trigger' event such as an urgent health crisis or a diagnosis of a severe or life-threatening condition.

By drawing these two disciplinary narratives together, we emphasise the importance of understanding the diverse ways in which individuals may perceive and respond to problems that affect their legal entitlements and/or their health and wellbeing, particularly in light of the different contextual factors that can affect availability and accessibility of support services in different locations. The importance of tracing individual journeys in this way is particularly pertient when it comes to considering the sub-category of context-specific problems that have both health and legal dimensions, such as disputes regarding Personal Independence Payments. For these multidimensional problems, there is likely to be an even broader range of possible responses and strategies to problem-solving that may be taken.

At present, the premise of health and justice interventions is that there is a distinction between how people respond to each of these problem types, and an assumption that concerted service provision is an effective way of capturing health or legal problems that are simultaneously experienced. This has prompted governments to invest in a range of initiatives geared towards identifying legal problems within health contexts, such as legal clinics within hospitals or 'social prescribing' where GPs are able to refer patients for legal advice or support. While the integration of legal support into health services is undoubtedly an innovative and dynamic solution to the problem of limited legal capability, we assert that this overlooks the issue of health literacy. Far from being distinct capabilities, we argue that there are many transferable capabilities that underpin both concepts, such as: the financial and social resources necessary to seek out support; awareness of available services and the support they provide; an individual's ability to interpret technical and specialist information and apply it to their own circumstances; and the confidence to voice their concerns and advocate for their own interests or entitlements. As such, there are likely to be a proportion of individuals who face a range of barriers to seeking support from either legal or health contexts.

Understanding the broader context that frames the ways that citizens recognise and respond to these problems has never been more important due to the pandemic-related impact on the ways that people access and use public services within society (Young and Bates 2022). COVID-19 prompted a rapid shift to remote advice provision, amplified risks to public health, and consequential impacts of lockdown measures on individuals' financial and employment circumstances. This has intensified a prevailing trend of intersecting legal issues and entrenched health inequalities driven by broader economic circumstances and austerity policies (Genn 2019, OECD 2020, Newman *et al.* 2021, Denvir *et al.* 2023). Moreover, these problems are becoming an increasingly urgent need as we face a global cost of living crisis, in which the need for legal advice and health inequalities have been exacerbated by rising interest rates, costs and levels of debt, as well as employment precarity, reduced funding for legal advice, and unprecedented burden on justice systems as they contend with unmet legal need (OECD 2019, Comelli 2021).

As such, despite the clear positive impacts of existing efforts to combine interventions for health and legal problems, this has in practice led to an extrapolation of these problems from the wider context of inequality and marginalisation in which they occur. To address these gaps, a fresh conceptualisation of the relationship between health and justice is needed, which focuses on individual experiences and responses to health and legal problems. To this end, we now articulate the utility of an intersectionality approach reinforced by vulnerability theory as a more nuanced lens through which to understand the health-justice relationship that accounts for both legal capability and health literacy, and the consequential implications for service design and delivery.

Understanding health-justice problems: intersectionality and vulnerability

As explored so far, there are a range of factors and circumstances that can affect an individual's ability to seek assistance in relation to either legal or health problems. Many of these can be traced to structural disadvantage, such as gender or race based oppression and marginalisation, the unequal distribution of resources in society, as well as ableist or Anglocentric barriers that characterise public institutions. Naturally, these structures do not exist in isolation: citizens often experience multiple, overlapping forms of disadvantage, which gives rise to unique, amplified experiences of marginalisation that in turn affect capability to take action in relation to legal and health problems. The notion of intersectionality has emerged from the foundational work of Kimberlé Crenshaw (1989, 1991), which articulates an analytical framework to understand the experiences of disadvantage that exist at these 'intersections' of marginalisation.

The intersectionality approach has since been taken forth by other socio-legal scholars in relation to a broad range of issues that require attentiveness to the different structures of inequality that frame experiences of society (see eg: Ashiagbor 2013, Grabham 2006, Conaghan *et al.* 2009, Grabham *et al.* 2009). The idea that multiple forms of oppression or marginalisation can intersect and produce specific experiences of disadvantage has provided an important resource for scholars seeking to expose and explore the implications of multiple different and overlapping structures of inequality, such as gender, race, and class, which all work together to frame the conditions in which people experience society.

An intersectional approach therefore seeks to expose the *complexity* of experiences that are omitted from law and legal practice, by telling stories that account for diverse experiences and resisting the temptation to explore just the aspects of people's lives that the law determines to be relevant or important (Conaghan 2013, pp. 12–14). Bringing the intricacies of everyday life to the fore in this manner usefully challenges the legitimacy that law derives from its supposed objectivity, and further complicates our understanding of the lives of those who are the intended targets of legal services (Conaghan *et al.* 2009).

However, the expansion of intersectionality has gone 'hand in hand with intersectional insights moving from the margins of feminist scholarship to their centre' (Kerner 2016). While a welcome reinforcement to feminist scholarship, this has also led to concerns about how this shift has depoliticised the concept of intersectionality, by firmly constraining its conceptual power inside the parameters of the very structures that it seeks to critique (Kerner 2016). In other words, while the concept of intersectionality has been useful for advocating for better recognition of amplified or multiplied disadvantage within the legal system, this advocacy cannot go as far as to critique the ways that that law itself is implicated in propping up these marginalising structures within society (Conaghan *et al.* 2009). The constraints that have been placed around intersectionality therefore limit its capacity to challenge these power structures from below and to locate law (and the design of legal services) within its historical, social, and ideological context. To this end, we argue that intersectionality needs to be reinforced with other conceptual tools that can permit a more detailed interrogation of how legal discourse may operate to exclude the perspectives of people who are differently affected by other inequalities, which may intersect in ways that cannot be disentangled (Conaghan *et al.* 2009, p. 74). Therefore, we now introduce Martha Fineman's (2013) vulnerability thesis as a means of reinforcing intersectionality. Together, these approaches provide a flexible conceptual framework that is useful for understanding the relationship between health and justice in a way that accounts for both specific and nuanced structural factors of inequality and disadvantage.

Fineman describes vulnerability not as a state of weakness or frailty that affects only certain population groups, but as something that should be recognised as a 'universal and constant' feature of the human condition' Fineman (2008): 1. To this end, she has developed the concept of the 'vulnerable legal subject'; a metaphor through which scholars can reimagine the relationship between individuals and the state. Specifically, it reframes the concept of vulnerability as an inherent prerequisite of the human condition. This debunks the dominant liberal idea that citizens are by default autonomous and self-sufficient individuals whose needs for support can be met informally or through traditionally 'private' structures like the family. Rather, it recognises that every citizen, to varying extents, experiences need for support at various points during their life, but their ability to ameliorate this depends on their position within the political and economic structures of society. By reconceptualising legal subjects as inherently vulnerable, inequality within society can be better understood as stemming from the levels and kinds of resources that each person is able to access and use to mitigate their specific experiences of vulnerability. Through this lens, it is possible to appreciate that health and justice needs are inevitable – at some stage during the life course, all citizens will need to seek legal and/or medical advice. However, some citizens will need to do this more often or more urgently than others, and will be able to obtain services of better or lesser quality than others. As Fineman (2013, p. 21) explains, vulnerability 'must be simultaneously understood as particular, varied, and unique on the individual level'. Physical health problems, disability, chronic health conditions, and mental ill-health are just some of the factors that can require repeated engagement with support services.

Importantly, from this perspective, it is possible to purposefully step back from the idea that legal capability and health literacy are distinct concepts, and embrace a broader understanding of how inequality and marginalisation frame experiences of legal and health problems. For example, it is clear that intersecting health and justice problems not only occur as cumulative clusters among low-income groups and those vulnerable to social exclusion, including people with chronic illnesses, disabilities, and mental health difficulties (Balmer 2013, Franklyn *et al.* 2017), but that these population groups are also least likely to possess the necessary financial, practical, and cultural resources to be able to act in response to those problems. By reconceptualising citizens as 'vulnerable subjects', we therefore understand that legal problems and health problems are unavoidable experiences of vulnerability that affect people to varying degrees.

Combined with the foundational concept of intersectionality, this conceptual framework reveals the importance of designing services in ways that account for both individual trajectories of inequality as well as the generalised risk of legal and health needs that exist among the wider population. Given that a proportion of legal problems may never be identified within health contexts that rely on patients self-presenting for medical advice, this indicates a need for further investigation to understand the range of possibilities regarding *when* and *where* citizens may emerge with these intersecting problems, to inform a more flexible and proactive service design. In practice, there are a variety of community-based services which may function as the first point of contact for legal and/or health problems. Crucially, there are likely to also be some situations, particularly for those contending with amplified experiences of marginalisation, where citizens do not make any contact with services at all, until problems escalate to the point where urgent care is required at a hospital.

We will now explore insights from a range of services from across England and Australia. In doing so, we will reflect on the advantages and disadvantages of current strategies for responding to the interrelated vulnerabilities experienced by those facing legal and health problems.

Insights from England and Australia

Australia

In Australia, there is a clearly established network of HJPs, which comprehensively imported the USA's medical-legal partnership model (Lawton *et al.* 2011) to Australia in 2012 (Advocacy Health Alliance 2013). In 2014, Health Justice Australia was founded; a national organisation that supports the integration of legal and health services. Through this network, HJPs have rapidly expanded across the States and Territories, attracting attention from policy, healthcare and legal professionals as a means to address underlying social determinants of health and to improve health outcomes, especially for disadvantaged groups. Since 2014, the number of HJPs has rapidly increased, and are now well-established and centred around the traditional healthcare system in both metropolitan and regional areas (Health Justice Australia HJA 2022). Australian HJPs are supported by a variety of formats and funding models but share a strong focus on embedding legal help into healthcare services and teams, often specifically targeted at population groups who are vulnerable to intersecting legal and health problems, but who are unlikely to turn to legal services for solutions (Health Justice Australia HJA 2022).

As explored earlier, intersecting health and justice problems must be understood holistically, as they occur within a broader context of disadvantage, for all citizens but particularly and repeatedly for certain populations. Across Australia, there is evidenced commitment to holistic, cross-sector collaboration in responding to intersecting health and legal problems. HJPs have been described as an example of a 'socio-legal model of health in action' (Schram *et al.* 2021, p. 905), because they demonstrate how the law can be used as a tool to ameliorate or mitigate wider social and health inequalities. The authors go on to state that:

> Health justice partnerships provide a road map for implementing a sociolegal model of health to reduce health inequities by strengthening legal capacities for health among the health workforce and patients. This in turn will enable them to resolve health issues with legal solutions, to dismantle service silos, and to drive systemic policy and law reform.

The collaborative approach to embedding health and legal services in Australia is therefore clearly underpinned by a drive to target legal support at groups experiencing a range of health problems. There is an integrated and embedded approach to early intervention wherever possible, as well as a fundamental recognition that early intervention may not be possible for all citizens. To this end, there are a range of HJPs in Australia which are organised around major hospitals in capital cities, in order to capture support needs that have not emerged in primary healthcare settings.

A further strength of the Australian approach is the way that Health Justice Australia seeks to respond to changing landscapes. An example of this responsiveness can be seen in the Australian experience of the COVID-19 pandemic. In Australia, 2020 was characterised not only by one global health crisis, but also unprecedented bushfires bringing displacement and disadvantage across regional areas of the country. In response, Health Justice Australia committed to consolidating the lessons learned about how cross-sector collaboration can ameliorate the impact of such events on service providers and their ability to reach those experiencing health and legal problems (Health Justice Australia HJA 2021). This demonstrates a clear recognition of the need to ensure services are adaptable during times of unforeseen crisis.

What is perhaps most distinctive about the Australian approach to designing interventions through HJPs is its capacity to incorporate learnings from research to improve and extend services systematically. This is imperative; as explored earlier in relation to vulnerability theory, the repeated and cyclical impact of disadvantage and inequality within society reveals the importance of not only addressing the specific health and legal problems faced by citizens, but also the broader facilitating factors of inequality. To this end, evaluations and impact assessments have brought different partnership models into the Australian system, which allows a diversity of models and approaches to match the target audiences and different communities (Victoria Law Foundation 2022). Now, Health Justice Australia supports a range of partnerships that integrate health and legal support with other overlapping systems, such as the child protection system (Health Justice Australia HJA 2022). Similarly, there are several HJPs in Australia that have invested efforts into identifying new opportunities for preventative actions that contribute to ameliorating the structural factors that create cycles of health and legal problems.

For example, public legal education is being undertaken by some Australian HJPs, and in-house evaluations of these measures have indicated that these community-based efforts have the ability to combat public mistrust of legal professionals. In turn, these HJPs are capable of achieving more proactive (rather than reactive) methods of service delivery, and enabling a more comprehensive understanding of the constellation of issues facing disadvantaged communities (Justice Connect 2018).

England

While they are far less systematic, combined health and legal services that integrate welfare rights advice into patient care also exist across England (Beardon and Genn 2018, Beardon *et al.* 2022). These arrangements are premised upon indicative evidence of two key benefits for the English context. The first is premised upon concerns about limited legal capability in England and Wales; delivering legal services in healthcare settings enables partnerships to reach people who are likely to have legal needs but may not have the knowledge, means, or confidence to access advice, especially in light of diminishing availability of free legal advice services across England and Wales (The Low Commission 2014, Woodhead *et al.* 2017, Beardon *et al.* 2022). The second is focused on concerns about limited health literacy; these partnerships aim to both improve health and reduce health inequalities by addressing issues such as safe housing, education and neighbourhoods that affect disadvantaged groups in society (Allmark *et al.* 2013; Alegría *et al.* 2018, Genn 2019). Based on these benefits, there is growing interest in place-based partnerships and collaborative arrangements formed by the organisations responsible for arranging and delivering healthcare services in a locality or community. Further, place-based partnerships are starting to emerge, for example, in Croydon (NHS Providers 2024) offering community solutions to fight health inequalities and deprivation. However, these interventions are largely confined to sporadic initiatives, rather than fully integrated and endorsed as they are in Australia.

Nevertheless, England's commitment to cross-sector collaboration is emerging. Embedded services have become an important policy focus in both the health and legal fields in recent years, laying the foundations for growth in collaborations between the sectors. Following a succession of health policy proposals aimed at improving collaboration and cross-sector working, the Health and Care Act 2022 has now formally established Integrated Care Systems (ICS) across the country. ICSs bring together health services, local authorities, and voluntary and community sector organisations to plan and deliver care for their local populations (NHS 2022). The commitment to moving away from siloed working can also be seen in a recent Ministry of Justice (MoJ) proposal to introduce legal support hubs into health settings to deliver services in a more effective and accessible way (Ministry of Justice 2023).

While this demonstrates a clear appetite for cross-sector collaboration, the responsiveness of England's approach is less clear. Through the lens of vulnerability theory, it is possible to appreciate that legal problems and health problems are unavoidable experiences of vulnerability that affect people to varying degrees, at different stages in their lives. Therefore, in order to maximise the benefits of holistic service provision, services must be capable of adapting to unforeseen events and responding to increased or varied needs as they emerge. During the COVID-19 pandemic, where services had no choice but to adapt to a rapidly changing and unpredictable landscape, there were indeed some unprecedented examples of joined-up approaches emerging between councils, NHS, the voluntary sector and local communities including mutual aid agreements, data sharing, and commitments to collaboration in the interest of patients and communities and decision-making (NHS 2021). However, responsive service delivery is not limited to global events or national crises. Rather, England appears to have limited capacity to respond to the many citizens who are unable to self-present to primary care services. As explored earlier, many citizens may not engage with a health setting until their medical issue is urgent or life-threatening. Yet, in England, the integration of legal interventions into healthcare settings has been largely focused on primary care health settings, such as GP surgeries, where legal welfare advisors either come to visit or have some form of regular placement. These arrangements vary in size and type of interaction between health and justice advice. Despite the growing appetite for cross-sector collaboration, the health justice movement in England appears to be limited to collaborations between primary healthcare settings and advice centres (Beardon *et al.* 2021; Parkinson and Buttrick 2015), which risks missing some of the most marginalised populations who do not seek early support for health-related problems. This marks a clear gap in comparison to Australia, where HJPs are located in a range of services from community hubs to hospitals; recognising that emergency and specialist care are likely to be important locations for responding to some of the most complex and urgent legal needs experienced by citizens who face significant marginalisation within society.

The final observed difference between the two countries is the underpinning pressure of government funding. In 2018, Beardon and Genn (2018) conducted a mapping study to explore the health justice landscape in England and Wales. Their report found over 380 services in the UK that worked with healthcare providers, and revealed that these services comprise a combination of national and local charities, local authorities, healthcare services, independent organisations and partnerships of providers. This suggests that the range of combined interventions in England are provided by a constellation of organisations that, to varying extents, are reliant on government funding or charitable grants. This funding landscape is subject to rapid change, due to shifting government commitments to social welfare provision. As a result, UK health justice research is often focused on possibilities for maximising available funding models and methods of measuring the impact of these partnerships to keep them afloat (Beardon *et al.* 2022, Tobin-Tyler *et al.* 2023, Beardon 2023). This, in turn, limits the capacity in England to undertake evaluative research that seeks to improve and extend the reach of health justice initiatives in the same way as Australia.

Lessons to be learned

On the basis of these comparative insights, we propose three principles to inform a more expansive approach to thinking about the relationship between health and justice, and by extension, the ways that health and legal interventions can be most effectively designed to meet these various and intersecting needs.

The first is that support must be provided *holistically* through methods and formats appropriate to individual trajectories of vulnerability. In other words, by recognising that all citizens are likely to face legal and health problems at some point during their lives, and that some population groups are more at risk of urgent and severe problems than others, services should account for the fact that users will require different levels and types of support at particular moments, including wraparound support.

The second is that public services must be *responsive* to the lived realities of citizens who experience legal and health problems. Rather than assuming that health literacy can serve as a substitute for legal capability, services must be attuned to the reality that many citizens will not actively self-present to health contexts at all, and as such will not emerge until a much later stage. Emergency and specialist care are likely to be important locations for responding to some of the most complex and urgent legal needs experienced by citizens who face significant marginalisation within society. However, to date, hospitals have been largely overlooked as a key site for legal interventions in England. In 2021, the Administrative Justice Council (2021) undertook a study which revealed several potential benefits of incorporating social welfare advice into specialist and secondary healthcare settings, such as cost-saving for the National Health Service and strengthened, holistic responses to ongoing patient welfare beyond discharge from hospital settings. While hospitals have been acknowledged in UK health-justice mapping studies (Beardon and Genn 2018), the Administrative Justice Council (AJC) study emphasised the 'lacuna' that exists in terms of evidence and initiatives that seek to operationalise the hospital setting as an intervention point for legal need (Administrative Justice Council 2021, p. 4). This is a marked gap compared to Australia, where 47 of the 105 HJPs recorded in 2022 had physical presence in hospitals (Health Justice Australia HJA 2022).

The third is that support services must recognise the potential role of *community embedded* organisations and initiatives for providing a conduit to formal legal and health interventions. To this end, planned interventions must look beyond traditional legal and healthcare environments to identify new opportunities for capturing problems at an early stage, as well as to integrate research-led innovations, lived experiences, and evidence-based change in order to continually improve and extend the reach of health justice initiatives.

Next steps

Access to legal advice can support people with health issues in many different ways. In this article, we have explored and compared developments and examples from England and Australia. In doing so, we have revealed that combining interventions geared towards addressing legal and health problems offers significant benefits in terms of their ability to support marginalised populations who access services at different points, particularly in Australia, where there is a strongly integrated network of services with clear capacity to respond effectively to changing demands and needs. In England, however, health justice interventions are still in their infancy. To date, English health justice interventions are located mainly in GP surgeries and other primary care settings, which risks omitting a significant population of those who do not actively seek support at an early stage.

On the basis of these insights, we argue that there are several gaps in the development and reach of health justice interventions in England. In particular, there are overlooked pockets of marginalisation within hospitals. Acute or traumatic illness, mental health and the diagnosis of serious conditions can all trigger legal needs for both patients and their families. Moreover, when in hospital, a person's entitlement to benefits can stop, potentially leading to a requirement for their eligibility to be reassessed. As demonstrated by the Australian experience, an integrated support service in a hospital setting could provide timely intervention, comprehensive care and reduce health inequalities. Here, the Australian approach provides a core example of how services can be designed in a way that is person centric; meeting the patients where they are, rather than replicating the status quo of service provision (Muñoz 2007, Wiig and O'Hara 2021). In addition, we would add that the ability for patients to access an on-site service at a hospital can also go some way towards ameliorating broader facilitators of disadvantage. By supporting patients for what awaits them on discharge, such a service would go some way to preventing the enduring cycle of legal and health problems that exists for those facing intersecting inequalities within society. This is therefore an important point for early intervention that is presently overlooked in the English context (Creutzfeldt *et al.* 2020).

We have also argued that it is not simply a case of expanding the existing models of health justice interventions into other health settings. Rather, it is also essential for such interventions to be community-led, and to have the capacity to conduct evaluations, incorporate lived experiences of users, and produce robust evidence that can be used to improve and extend the reach of services. As the Australian experience demonstrates, these services also have the potential to contribute to future problem prevention through community empowerment, public legal education and community-led health and justice initiatives (Jean *et al.* 2017, 2019). Looking to the future, further research is required that draws together the existing (and complimentary) evidence from global legal needs surveys with the medical literature on the social determinants of health, to ensure that legal capability and health literacy are viewed together. It is also necessary to draw upon appropriate wider social science literature and refine programme theories to elucidate what benefits accrue, how (e.g. linking to psychosocial, material and behavioural frameworks), to whom and under what circumstances. This would increase understanding of the benefits for various stakeholders and inform effective service delivery approaches.

On the basis of the insights presented here, we propose that England is in a particularly strong position to learn from the Australian experience and demonstrate the economic and social value of holistic, responsive, and community-embedded health justice solutions. In this regard, the hospital setting in particular is a clearly identified setting in which empirical research is desperately needed. For governments around the world, it is a crucial point to be able to harness the potential of these partnerships to improve health outcomes and address unmet legal need.

Conclusion and research agenda

In this article, we have discussed the importance of acknowledging the interconnection between health and legal problems. Through a lens of intersectionality and vulnerability theory, we have explored the complex interaction between health and justice that occurs for citizens as they traverse different structures of marginalisation and inequality within society. We have argued for the importance of designing solutions to intersecting health and legal problems which are *responsive, holistic*, and *community-embedded*. In Australia, the political appetite and long-term investment has assisted to create a range of health justice partnerships that demonstrate the benefits of each of these design principles. We have argued that England is in a crucial position to learn from the Australian experience; not simply by increasing the number of interventions geared towards addressing health and legal problems but to commit to deepening and extending the reach of such initiatives. This can be done by ensuring that they are embedded within local areas, designed to accommodate the ways in which people experience legal need, and integrate evaluative mechanisms to ensure adaptability and holistic service provision in the longer-term, particularly in order to ensure they can withstand and respond to major crises such as the COVID-19 pandemic.

In England the political appetite is now gaining momentum, and more attention is being paid to create spaces in which people with health issues can also be supported in their legal needs. These emerging arrangements, however, are – at present – mainly limited to a focus on GP surgeries and other primary care settings. They lack funding, visibility, consistency in their implementation and reach, and placement in areas that will reach those who are most disadvantaged and in need of both medical and legal support. We propose that hospitals are an overlooked site of significant importance for health justice interventions in England. Going forward, we argue that there is an urgent need for research that seeks to better understand how we can create and sustain constructive partnerships between legal welfare advisers and hospital settings. As the space where intersecting justice and health needs are most prevalent, this is a key first step towards integrating lessons from Australia and enhancing the health and justice outcomes of the English population.

More broadly, we also invite scholars working in the fields of health and law to consider the concepts of legal capability and health literacy as two useful, fundamentally linked ways of appreciating how individuals perceive, understand, and respond to health problems, legal problems, as well as problems that have both legal and health dimensions. As we have demonstrated in this article, bringing these two concepts into conversation with one another is vitally important for understanding how individuals experience unique trajectories of marginalisation that may include intersecting legal and health problems, and the reality of how many citizens may be effectively excluded from the benefits of early interventions if they are unable to engage with either health or legal services. Rather, these individuals may only be effectively reached if interventions are integrated into a broader range of community-based services. This would allow services to offer flexible and responsive interventions at the diverse range of locations where individuals actually present, rather than relying on assumptions about citizens' capabilities when they are contending with potentially life-threatening or life-changing problems.

Disclosure statement

No potential conflict of interest was reported by the author(s).

ORCID

Jess Mant http://orcid.org/0000-0002-1070-9326
Naomi Creutzfeldt http://orcid.org/0000-0001-7254-3475
Sonila M. Tomini http://orcid.org/0000-0002-4241-2121

References

Administrative Justice Council, 2021. Access to social welfare advice in a hospital setting: integration of services. Available from: https://ajc-justice.co.uk/wp-content/uploads/2021/06/AJC-Health-Justice-Report-Final.pdf.

Advocacy Health Alliance, 2013. Symposium report. Available from: https://arcjustice.org.au/wpcontent/uploads/2020/08/Advocacy-Health-Alliances-Symposium-report-Mar-2013-1.pdf.

Alegría, M., *et al.*, 2018. Social determinants of mental health: where we are and where we need to go. *Current Psychiatry Reports*, 20 (11), 95.

Allmark, P., *et al.*, 2013. Assessing the health benefits of advice services: using research evidence and logic model methods to explore complex pathways. *Health & Social Care in the Community*, 21 (1), 59–68.

Ashiagbor, D., 2013. The intersection between gender and 'race'in the labour market: lessons for anti-discrimination law. *In*: A. Morris and T. O'Donnell, eds. Feminist perspectives on employment law. Cavendish: Routledge, 165–186.

Australian Institute for Health and Welfare, 2018. Australia's health. Available from: https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus221.pdf.

Australian Institute for Health and Welfare, 2024. General practice, allied health and other primary care services. Available from: https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care.

Balmer, N., 2013. English and Welsh civil and social justice panel Survey: wave 2'. Legal services commission. Available from: http://doc.ukdataservice.ac.uk/doc/7643/mrdoc/pdf/7643_csjps_wave_two_summary_findings.pdf.

Balmer, N., *et al.* 2023. Everyday problems and legal need. Victoria Law Foundation. Available from: https://puls.victorialawfoundation.org.au/publications/everyday-problems-and-legal-need.

Balmer, N. and Pleasence, P., 2019. Law … what is it good for? How people see law, lawyers and the courts in Australia. Victoria Law Foundation. Available from: https://discovery.ucl.ac.uk/id/eprint/10084550/1/Law-What-is-it-Good-For-Report.pdf .

Bateman, N., 2008. *Just what the Doctor ordered: welfare benefits advice and healthcare*. London: Age Concern England.

Beardon, S., *et al.* 2022. *Research briefing – health-justice partnerships in England: and implementation study*. London: NIHR School for Public Health Research.

Beardon, S., 2023. The case for embedding welfare rights advisers throughout the NHS. *Health service journal*. Available from: https://www.hsj.co.uk/health-inequalities/the-case-for-embedding-welfare-rights-advisers-throughout-the-nhs/7035022.article .

Beardon, S., *et al.*, 2021. International evidence on the impact of health-justice partnerships: a systematic scoping review. *Public Health Reviews*, 42, 1603976.

Beardon, S. and Genn, H., 2018. The health justice landscape in England and Wales: social welfare legal services in health settings. UCL centre for access to justice. Available from: https://www.ucl.ac.uk/access-to-justice/sites/access-to-justice/files/lef030_mapping_report_web.pdf- .

Cannon, Y., 2021. Closing the health justice gap: access to justice in furtherance of health equity. *Columbia Human Rights Law Review*, 53, 517–581. doi:10.2139/ssrn.3886893.

Comelli, M., 2021. The impact of welfare on household debt. *Sociological Spectrum*, 41 (2), 154–176. doi:10.1080/02732173.2021.1875088.

Conaghan, J., 2009. Intersectionality and the feminist project. *In*: E. Grabham, *et al.* In: eds. *Intersectionality and beyond: Law, power and the politics of location*. Cavendish, London: Routledge.

Conaghan, J., 2013. *Law and gender*. Oxford: OUP.

Crenshaw, K., 1989. Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1, 139.

Crenshaw, K., 1991. Mapping the margins: Intersectionality, identity politics and violence against women of color. *Stanford Law Review*, 43 (6), 1241. doi:10.2307/1229039.

Creutzfeldt, N., *et al.* 2020. The Social and Local Dimensions of Governance of Energy Poverty: Adaptive Responses to State Remoteness. *Journal of Consumer Policy*, 43 (3), 635–658. doi:10.1007/s10603-019-09442-z.

Curran, L. and Noone, M.A., 2007. The challenge of defining unmet legal need. Journal of Law & Social Policy, 21 (1), 63–89. doi:10.60082/0829-3929.1014.

Denvir, C., *et al.* 2023. *Access to Justice and the Future of Legal Aid*. Oxford: Hart Publishing.

Fineman, M.A., 2008. The Vulnerable Subject: Anchoring Equality in the Human Condition. *Yale Journal of Law & Feminism*, 20 (1), 1–23.

Fineman, M.A., 2010. The Vulnerable Subject and the Responsive State. *Emory Law Journal*, 60, 1–41.

Fineman, M.A., 2013. Equality, Autonomy, and the Vulnerable Subject in Law and Politics. *In*: M. A. Fineman and A. Grear, eds. *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics*. Abingdon: Routledge, 1–15. https://www.taylorfrancis.com/chapters/edit/10.4324/9781315547862-2/equality-autonomy-vulnerable-subject-law-politics-martha-albertson-fineman?context=ubx&refId=82283842-4ae4-4be4-99a6-30f040d680b5.

Franklyn, R., *et al.* 2017. Findings from the Legal Problem and Resolution Survey 2014-15. Ministry of Justice Analytical Series. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/596490/legal-problem-resolution-survey-2014-to-2015-findings.pdf.

Genn, H., 2019. When law is good for your health: mitigating the social determinants of health through access to justice. *Current Legal Problems*, 72 (1), 159–202. doi:10.1093/clp/cuz003.

Genn, H. and Beinart, S., 1999. *Paths to justice: what people do and think about going to law*. Oxford: Hart Publishing.

Gordon-Bouvier, E., 2021. *Relational Vulnerability: Theory, Law and the Private Family*. London: Palgrave Macmillan.

Grabham, E., 2006. Taxonomies of equality: Lawyers, maps and the challenge of hybridity. *Social and Legal Studies*, 15 (1), 5. doi:10.1177/0964663906060971.

Grabham, E., *et al.* 2009. *Intersectionality and beyond: Law, power and the politics of location*. Milton: Routledge.

Harding, R., 2020. Reflections on Ageing and the Binaries of Vulnerability. *In*: D. Bedford and J. Herring, eds. *Embracing Vulnerability: Challenges and Implications for Law*. London: Routledge, 79–87.

The Health Foundation, 2022. Available from: https://health.org.uk/.

Health Justice Australia (HJA), 2021. Collaboration through the COVID-19 crisis. Health Justice Australia. Available from: https://healthjustice.org.au/resource/report/collaboration-through-the-covid19-crisis/.

Health Justice Australia (HJA), 2022. Health Justice Landscape Report: 2022. Health Justice Australia. Available from: https://healthjustice.org.au/app/uploads/downloads/November-2022-Health-justice-landscape-report-4.pdf .

Jean, B.S., *et al.* 2019. The central roles of information in health justice, part 2: Consumer health information justice and the connections between health, ability, and literacy. The International Journal of Information, Diversity, & Inclusion, *3* (4), 1–5. doi:10.33137/ijidi.v3i4.33057.

Jean, B.S., Jindal, G., and Liao, Y., 2017. Is ignorance really bliss?: Exploring the interrelationships among information avoidance, health literacy and health justice. *Proceedings of the Association for Information Science and Technology*, *54* (1), 394–404. doi:10.1002/pra2.2017.14505401043.

Justice Connect, 2018. Starting Health Justice Partnership – a toolkit. Available from: https://justiceconnect.org.au/wpcontent/uploads/2018/11/HJPs_Toolkit_final_new_brand_20181023.pdf.

Kerner, I., 2016. Relations of Difference: Power and Inequality in Intersectional and Postcolonial Feminist Theories. *Current Sociology*, 65 (6), 846–866. doi:10.1177/0011392116665152.

Lawton, E., *et al.* 2011. Medical-Legal Partnership: A New Standard of Care for Vulnerable Populations. *In*: E.T. Tyler, et al. ed. *Poverty, Health and Law: Readings and cases for medical legal partnership*. USA: Carolina Academic Press.

The Low Commission, 2014. Tackling the Advice *Deficit: A strategy for access to advice and legal support on social welfare law in England and Wales*. London: Legal Action Group.

Machin, R., 2017. Made to measure? An analysis of the transition from Disability Living Allowance to Personal Independence Payment. *Journal of Social Welfare and Family Law*, *39* (4), 435–453. doi:10.1080/09649069.2017.1390291.

Mant, J., 2022. *Litigants in Person and the Family Justice System*. Oxford: Hart Publishing.

Marmot, M., 2005. Social determinants of health inequalities. *Lancet*, 365 (9464), 1099–1104. doi:10.1016/S0140-6736(05)71146-6.

Marshall, A.M. and Barclay, S., 2003. In their own words: How ordinary people construct the legal world. Law Social Inquiry, *28* (3), 617–628. doi:10.1111/j.1747-4469.2003.tb00209.x.

Ministry of Justice, 2023. Evaluation of Integrated Advice Hubs in Primary Healthcare Settings: Feasibility Study. Available from: https://www.gov.uk/government/publications/evaluation-of-integrated-advice-hubs-in-primary-healthcare-settings.

Muñoz, J.P., 2007. Culturally responsive caring in occupational therapy. *Occupational Therapy International*, 14 (4), 256–280. doi:10.1002/oti.238.

Newman, D., Mant, J., and Gordon, F., 2021. Vulnerability, legal need and technology in England and Wales. *International Journal of Discrimination and the Law*, 21 (3), 230–253. doi:10.1177/13582291211031375.

NHS, 2022. Integrated care systems. https://www.england.nhs.uk/integratedcare/what-is-integrated-care/.

NHS England, 2021. Thriving places. Available from: https://www.england.nhs.uk/wpcontent/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf .

NHS Providers, 2024. Providers in place-based partnerships: Croydon. Available from: https://nhsproviders.org/case-studies-of-local-collaboration/croydon.

OECD, 2019. Legal Needs Survey and Access to Justice. Available from: https://www.oecdilibrary.org/governance/legal-needs-surveys-and-access-to-justice_g2g9a36cen;jsessionid=ULxzZDpf0sYr2lTdLB8ySQJ5EzV33Hv3N9_Nxcsz.ip-10-240-5-102.

OECD, 2020. *How's Life? 2020: Measuring Well-being*. Paris: OECD Publishing.

Parkinson, A. and Buttrick, J., 2015. The Role of Advice Services in Health Outcomes: Evidence Review and Mapping Study. Available from: https://www.thelegaleducationfoundation.org/wp-content/uploads/2015/06/Role-of-Advice-Services-in-Health-Outcomes.pdf.

Pleasence, P., *et al.* 2004. Multiple justiciable problems: common clusters and their social and demographic indicators. *Journal of Empirical Legal Studies*, 1 (2), 301–329. doi:10.1111/j.1740-1461.2004.00009.x.

Pleasence, P., Balmer, N.J., and Buck, A., 2008. The health cost of civil-law problems: Further evidence of links between civil-law problems and morbidity, and the consequential use of health services. *Journal of Empirical Legal Studies*, 5 (2), 351. doi:10.1111/j.1740-1461.2008.00127.x.

Public Health England, 2015. Improving health literacy to reduce health inequalities. Available from: https://www.gov.uk/government/publications/local-action-on-health-inequalities-improving-health-literacy.

Sandefur, R.L., 2015. What we know and need to know about the legal needs of the public. *South Carolina Law Review*, *67*, 443–459.

Schram, A., *et al.* 2021. Advancing Action on Health Equity Through a Sociolegal Model of Health. *The Milbank Quarterly*, 99 (4), 904–927. doi:10.1111/1468-0009.12539.

Thomson, M., 2023. Health Inequalities: Law & the Pain of Others. *Social & Legal Studies*, 32 (4), 586–605. doi:10.1177/09646639221123028.

Tobin-Tyler, E., *et al.* 2023. Health Justice Partnerships: An international comparison of approaches to employing law to promote prevention and health equity. *Journal of Law, Medicine & Ethics*, 51 (2), 332–343. doi:10.1017/jme.2023.84.

Victoria Law Foundation, 2022. Health justice partnerships: Understanding their design, implementation and value. Available from: https://www.victorialawfoundation.org.au/news/health-justice-partnerships-understanding-their-design-implementation-and-value.

Wiig, S. and O’Hara, J.K., 2021. Resilient and responsive healthcare services and systems: challenges and opportunities in a changing world. *BMC Health Services Research*, 21 (1), 1037–1041. doi:10.1186/s12913-021-07087-8.

Woodhead, C., *et al*. 2017. Impact of co-located welfare advice in healthcare settings: prospective quasi-experimental controlled study. *The British Journal of Psychiatry*, 211 (6), 388–395. doi:10.1192/bjp.bp.117.202713.

World Health Organisation (WHO), 2023. Social determinants of health. Available from: https://www.who.int/health-topics/social-determinants-of-healthtab=tab1.

Young, D. and Bates, G., 2022. Maximising the health impacts of free advice services in the UK: A mixed methods systematic review. *Health & Social Care in the Community*, 30 (5), 1713–1725. doi:10.1111/hsc.13777.

Zhang, Y., 2024. How Can the Australian Government Make Primary Care and Private Health Insurance More Affordable? *Australian Economic Review*, 57 (2), 174–178. doi:10.1111/1467-8462.12553.