Introduction: Entrenchment and Health Equity

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This special issue focuses on ways that law and politics can "entrench" power, with significant consequences for health equity and other social outcomes. Most of the time, actors who participate in the policymaking process take existing rules, institutions, and norms as given. They pursue incremental goals, knowing that victories and defeats are usually temporary and that the battle will have to be joined again tomorrow. At other times, however, actors seek to alter basic features of the political and social world itself. As Paul Starr (2019, 1-2) explains s in his important book *Entrenchment: Wealth, Power, and the Constitution of Democratic Societies,* "Entrenchment, like the closely related terms "lock-in' and 'consolidation' can refer to any process whereby an institution, a technology, a group, or a cultural form—any kind of social formation—becomes resistant to pressures for change."

Starr observes (2019, 5) that entrenchment can be either intended or "unplanned and emergent." Entrenchment is distinct from institutionalization; entrenched power is not always directly institutionalized, and institutions cannot always withstand the force of external attacks. Entrenchment is not *per se* desirable or undesirable. Some aspects of law and society must be fixed if people are to organize their lives and make plans for the future. Moreover, strategic politicians can purposefully design entrenchment mechanisms to endow their policies with durability, as Franklin Roosevelt demonstrated when he crafted Social Security as an "earned" entitlement, funded by earmarked taxes (Derthick 1979). Yet precisely because embedded institutions, interests, and beliefs constrain later choices and narrow democratic flexibility, the stakes in entrenchment politics are extremely high (Starr 2019, xi.)

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Though entrenchment is found in many policy domains, it is particularly pervasive in the field of health. As is well known, the United States spends dramatically more on health care as a share of the economy than other wealthy nations yet it produces worse outcomes than many of its international peers. The inefficiencies and inequities in American health persist not because most policymakers believe the current system is ideal but rather because there are high barriers to change. Venturing further afield, entrenchment can affect upstream determinants of health like housing and education. Redlining in the postwar years, for example, made it difficult or impossible for Black families to purchase homes in many affluent areas, constraining their ability to accumulate wealth and fencing them out of high-quality public schools systems. Once the doors of opportunity begin to close on marginalized populations, it becomes harder and harder to open them. Even major investments in the downstream determinants of health—such as the Affordable Care Act's investment in insurance coverage—may be insufficient to make up for entrenched patterns of health inequities.

The articles in this special issue examine laws, policies, and norms that are entrenched (or may become entrenched), with an eye to the implications for health equity. In our first article, Paul Starr explores four general strategies for overcoming pathological forms of policy entrenchment: Schumpeterian innovation, globally oriented innovation, institutional conversion, and social creativity. In the second article, Jamila Michener examines how state preemption of local housing policy can erode grassroots democracy Next, Jessica Trounstine and Sidra Goldman-Meller explore the association between residential segregation and infection and death from COVID-19. In the fourth article, Amy Kapczynski investigates how the pharmaceutical industry has entrenched its economic, political, and ideational power. In the fifth article, Jing Liu and David A. Hyman analyze whether occupational licensing requirements for dental hygienists

and other allied-health professions have a disparate impact on historically marginalized groups. Finally, Carolyn Tuohy turns to the role of narratives in entrenching the missions, values, and identities of key institutions in American and British health care. In my concluding essay, I draw out the broader lessons of the articles for scholars, advocates, and policymakers.

Taken together, our hope is that the articles will allow policymakers, researchers, and advocates to better understand how to protect existing legal precedents, institutions, and practices that afford opportunities to historically marginalized groups. We hope too that it will yield insight into how to design effective governmental and civil society responses to entrenched institutions and policies that impose disproportionate burdens on vulnerable constituencies.

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