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Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both

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ABSTRACT

Principles of health equity require that all people have equal opportunity to develop and maintain their health, yet in the face of widespread and presumptively inequitable health disparities, the law has done little. This paper argues that health equity demands the use of coercive legal mechanisms in certain circumstances given the existence of current disparities and the evidence of effectiveness of direct regulation as compared to its alternatives. Moreover, the paper argues that Healthy People 2020, which is the nation's "master blueprint for health" and explicitly seeks to achieve health equity, has not fully incorporated the principles of health equity in the formulation of its objectives and indicators because it fails to recognize the varying distributive effects of policies that could achieve population health targets. To truly incorporate the principles of health equity, Healthy People 2020 should advocate for those demonstrably effective coercive legal mechanisms that would both achieve its population health objectives and *reduce health disparities.*

I. INTRODUCTION

In the state of nature, indeed, all men are born equal, but they cannot continue in this equality. Society makes them lose it, and they recover it only by the protection of the laws.[1]

Although health equity was not a part of seventeenth-century political discourse, Montesquieu accurately captured the conflict that surrounds the concept today. In theory, people are born with equal potential for healthy lives, yet the minute their lives begin, a confluence of factors render some people immensely more likely than others to have the capability to lead healthy

1. CHARLES DE MONTESQUIEU, THE SPIRIT OF LAWS, bk. VIII, § 3 (1750), *available at* http://www.constitution.org/cm/sol_08.htm.

lives. These disparities in individuals' capabilities to achieve good health raise important social justice questions—What obligation does society have to take measures to reduce health disparities based on race or ethnicity, socioeconomic status (SES), gender, sexual orientation, education, disability, and other factors, particularly where behavioral risk factors are a contributing factor to disease? Stated differently, how much "choice" do individuals truly possess regarding their health, and what can and should government do to address the societal influences that negatively impact health status?

Routinely, society looks at an individual health outcome and ascribes the result to modifiable lifestyle choices, good or bad, with the implicit assumption that people who are healthy deserve praise for their responsible choices and those who are not deserve at least partial blame for failing to act in ways that would improve their health. However, this personal responsibility framework fails at a population level. It is well-documented that there is a socioeconomic gradient to health, in which individuals are likely to be healthier as their socioeconomic status increases.[2] But no serious scholar ascribes population level socioeconomic health disparities to the superior willpower of the wealthy in making healthy lifestyle choices. Similarly, there is a persistent racial and ethnic component to health that is not explained by other factors,[3] pursuant to which certain racial and ethnic groups are more likely to have worse health outcomes than others. But no one argues that African-Americans have worse health outcomes on average than whites because African-Americans are not as motivated as whites to protect their health. There is no basis for making such population-wide generalities about motivation regarding health behavior.[4] Yet in the face of these widespread and presumptively inequitable disparities, the law has done little. This paper argues that coercive legal mechanisms are an essential element of eliminating health disparities and achieving health equity. Moreover, the paper argues that Healthy People 2020 (HP 2020), which is the nation's "master

2. *See* Michael Marmot, *Achieving Health Equity: From Root Causes To Fair Outcomes*, 370 LANCET 1153 (2007).

3. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVS., ACTION PLAN TO REDUCE RACIAL AND ETHNIC DISPARITIES 1 (2011).

4. DONALD A. BARR, HEALTH DISPARITIES IN THE UNITED STATES: SOCIAL CLASS, RACE, ETHNICITY AND HEALTH 66 (JOHNS HOPKINS UNIV. PRESS 2008). Note, however, that, historically, use of racial generalities by governments and individuals was common. *Id.* at 114-15.

blueprint for health"[5] and explicitly seeks to achieve health equity, has not fully incorporated the principles of health equity in the formulation of its objectives and indicators because HP 2020 fails to recognize the varying distributive effects of policies that could achieve population health targets. To truly incorporate the principles of health equity, HP 2020 should advocate for those demonstrably effective coercive legal mechanisms that would both achieve its population health objectives *and* reduce health disparities.

The federal government has monitored health disparities in one form or another since at least 1985[6] and has advocated for the elimination of health disparities since at least 2000, with the release of the Healthy People 2010 goals.[7] However, decisive action on the reduction of disparities has been lacking, and, on average, disparities have not improved over at least the past fifteen years. Although health equity is a mainstay of health law and policy discourse, the concept has not had a significant role in mainstream political discussions. As it is commonly understood, health equity exists when "all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health."[8] There are strong philosophical and social justice reasons that support government action to reduce disparities—among them are human rights principles of equality underlying the right to health;[9] Nussbaum's theory of health as an essential human capability necessary to fully function in life;[10] Amartya Sen's theory of the capability for health as an

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5. MIRTHA R. BEADLE ET AL., WORLD CONFERENCE ON SOCIAL DETERMINANTS OF HEALTH, A NATIONAL PARTNERSHIP FOR ACTION TO END HEALTH DISPARITIES IN THE UNITED STATES 2 (2011), *available at* http://www.who.int/sdhconference/resources/draft_background_paper13_usa.pdf.

6. DEP'T OF HEALTH & HUMAN SERVS., NAT'L STAKEHOLDER STRATEGY FOR ACHIEVING HEALTH EQUITY 1 (2011), *available at* http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf.

7. DEP'T OF HEALTH & HUMAN SERVS., 1 HEALTHY PEOPLE 2010 11 (2000), *available at* http://www.healthypeople.gov/2010/Document/pdf/uih/uih.pdf. Note, however, that one of the three overarching goals of Healthy People 2000 was to *reduce* (but not eliminate) disparities. *Disparities*, HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/about/DisparitiesAbout.aspx (last visited Oct. 1, 2012) [hereinafter *Disparities*, HP 2020].

8. WHO, HEALTH PROMOTION GLOSSARY 7 (1998), *available at* http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf.

9. *See* Braveman et al., *infra* note 12.

10. Nussbaum, *infra* note 19.

instrumental human freedom;[11] and principles of equality and nondiscrimination among people based on characteristics such as SES, race or ethnicity, gender, sexual orientation, religion, disability, rural/urban geography, and other characteristics historically linked to discriminatory treatment.[12]

The question, then, is, What means are both necessary and effective for reducing health disparities and achieving health equity? It is here that distributive consequences of policies become important, leading to the conclusion that coercive legal mechanisms such as direct regulation and taxation are essential to a serious strategy to reduce disparities. While coercive legal mechanisms are not suited to solve every problem and must always be balanced against concern for personal liberties and principles of autonomy, there are many instances in which coercive legal mechanisms are demonstrably the most effective way of reducing health disparities and improving population health. Unfortunately, when discussing these mechanisms, advocates are often cowed by advocates of "personal choice" into watering down interventions to the point that the likely result is—even with an improvement in population health—no change or a worsening in health disparities. This approach is problematic from a health equity standpoint, given that health equity by its nature requires the elimination of health disparities associated with social disadvantage.[13]

The U.S. government has made the achievement of health equity and the elimination of health disparities a national priority in HP 2020, recognizing the importance of working toward the realization of health equity.[14] Every ten years since 1979, the Department of Health and Human Services (HHS) issues new "Healthy People" nationwide health goals for the forthcoming decade, the most recent of which are HP 2020. The essential aim of the Healthy People project (the Project) is to establish national health priorities by setting targets for improvement of health across a broad spectrum of topics, ranging

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11. AMARTYA SEN, DEVELOPMENT AS FREEDOM, *infra* note 21.

12. Paula A. Braveman et al., *Health Disparities and Health Equity: The Issue Is Justice*, 101 ENVTL. JUST. S149 (2011) (citing COMM. ON ECON., SOC. AND CULTURAL RIGHTS, NON-DISCRIMINATION IN ECONOMIC, SOCIAL AND CULTURAL RIGHTS (July 2, 2009), *available at* http://www2.ohchr.org/english/bodies/cescr/comments.htm).

13. *Id.* at S149-50.

14. *About Healthy People*, HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/about/default.aspx (last visited Oct. 1, 2012).

from access to health services to environmental health to more discrete diseases such as cancer and heart disease and, for the first time in HP 2020, including the social determinants of health. In some instances, HP 2020 advocates the adoption of specific coercive legal mechanisms that would both further a population health goal and reduce disparities—for example, passage of smoke-free legislation would both reduce overall population exposure to secondhand smoke *and* more strongly affect disadvantaged groups (who have higher rates of smoking and are more likely to work in places where smoking is permitted),[15] thereby resulting in a reduction in the disparity in rates of exposure to secondhand smoke. This advocacy is laudable. However, in most instances, HP 2020 chooses to set broad, population-based targets for health measures without expressing a preference between means of achieving those targets, as in the case of access to health insurance coverage, where HP 2020 sets a target of 100% coverage without acknowledging the obvious—that there is no evidence that anything other than a coercive legal mechanism is a realistic way to achieve that goal.

The determination of which coercive legal mechanisms HP 2020 supports appears to be made not on the ground of epidemiological evidence of a policy's effectiveness; rather, HP 2020 seems to be willing to advocate for direct regulation only in areas that are relatively politically uncontroversial, such as helmet laws and certain tobacco control measures. This paper argues that a true internalization of the principles of health equity requires that HP 2020 acknowledge the predictably different distributive consequences of various policy interventions and urge the adoption of those coercive legal mechanisms that are demonstrably effective in reducing health disparities. Without such a framework under which to operate, the likely result is that, even if overall population health improves, health disparities will widen between the most vulnerable population groups and the already advantaged, or remain essentially

15. *See, e.g., CDC Health Disparities and Inequalities Report – United States 2011*, 60 MORBIDITY AND MORTALITY WKLY. REP. 109, CTRS. FOR DISEASE CONTROL AND PREVENTION (Jan. 14, 2011), *available at* http://www.cdc.gov/mmwr/pdf/other/su6001.pdf (detailing higher rates of smoking among disadvantaged groups); NAT'L CANCER INST., CANCER TRENDS PROGRESS REPORT 2011/2012 UPDATE: SECONDHAND SMOKE (2012), *available at* http://progressreport.cancer.gov/doc_detail.asp?pid=1&did=2011&chid=101&coid=1012&mid=#high (discussing increased likelihood that persons with low socioeconomic status are exposed to tobacco smoke in the workplace).

stagnant, as they did under HP 2010.

More broadly, this paper argues that health equity demands the use of coercive legal mechanisms[16] in certain circumstances given the existence of current disparities and the evidence of effectiveness of direct regulation as compared to its alternatives. This is true for a number of reasons, including that purely voluntary policy initiatives often result in little impact on the most vulnerable populations (e.g., in the case of trans fat initiatives, discussed *infra* Part III.B.3), and because market-based initiatives have failed to adequately account for the health needs of certain population groups (as in the case of access to health services, discussed *infra* Part III.B.1). Only with a candid assessment and acceptance of the critical role that coercive legal mechanisms play in furthering population health can progress be made toward the achievement of the HP 2020 goals and ultimately, health equity.

Part II of this paper discusses health equity in the U.S. and how HP 2020 incorporates health equity into its goals. Part III discusses the importance of law in public health and health equity and uses specific HP 2020 goals and objectives as examples of the essential role of coercive legal mechanisms in achieving those goals while also furthering health equity. Part IV proposes certain additional legal mechanisms that could inform selection of strategies for achieving the HP 2020 goals and health equity, including the use of a "health in all policies" approach to government, the use of health impact assessments in policymaking, and the use of various indices to measure the effects of various policies and assess progress toward disparities reduction.

16. For a fuller discussion of legal tools governments may use in promoting health, see *infra* Part III.A. In this paper, "coercive legal mechanisms" is primarily intended to mean instances of regulation in which individual behavior is directly affected at the point of action by virtue of the relevant law (e.g., taxation directly increases the purchase price of a good; regulation directly changes the content or form of a product). Coercive legal mechanisms are intended to be contrasted with policy initiatives seeking to indirectly alter consumer behavior (e.g, educational campaigns urging people to eat healthier foods).

PART II

A. HEALTH EQUITY, HEALTH DISPARITIES, AND FEDERAL EFFORTS TO ELIMINATE HEALTH DISPARITIES

Much has been written about the difficulty of defining health equity and in developing a framework for determining which health disparities should be considered unjust and thus subject to redress. To establish why health should be distributed equitably necessarily implicates the human right to health, which was first iterated in the 1948 Universal Declaration of Human Rights and restated in the World Health Organization (WHO) Constitution as "[t]he enjoyment of the highest attainable standard of health . . . without distinction of race, religion, political belief, economic or social condition."[17] Although it is intuitive that health[18] is important and that rational people want a high level of

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17. WHO, CONST. pmbl., *available at* http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf; *see also* WHO AND OFFICE OF THE U.N. HIGH COMM'R FOR HUMAN RIGHTS, THE RIGHT TO HEALTH: FACT SHEET NO. 31 *available at* http://www.ohchr.org/Documents/Publications/Factsheet31.pdf. Although the right to health is not judicially recognized in U.S. law, the U.S. is a party or signatory to a number of international agreements that do recognize the right to health and is thus bound, at a minimum, not to take actions that directly contravene the object or purpose of those treaties. The U.S. has signed (but not ratified) the International Convention on Economic, Social, and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child, each of which recognizes the right to health in one form or another. Moreover, the U.S. has ratified the International Convention on the Elimination of all Forms of Racial Discrimination and has thus bound itself to guarantee equality before the law in enjoyment of the right to public health, medical care, social security, and social services. However, as Yamin observes, the U.S. "has been uniquely averse to accepting international human rights standards and conforming national laws to meet them." Alicia Ely Yamin, *The Right to Health Under International Law and its Relevance to the United States*, 95 AM. J. PUB. HEALTH 7, 1157 (2005). Nonetheless, Yamin points out that the international law language of health as a right, rather than a privilege, can serve to shape the discourse around public perception and commitments, creating at least non-binding mechanisms by which to hold the government accountable, and thus the international law approach of health as a human right serves a valuable purpose even in a discussion about domestic goals such as HP 2020. *Id.* at 1157-58. Finally, that the U.S. has not formally recognized a justiciable right to health is not determinative of the government's moral obligation to take measures to reduce or eliminate health disparities. Moreover, by expressly adopting the human rights language of health equity in Healthy People 2020, the federal government has demonstrated at least a desire to seek to uphold the right to health.

18. Although the final HP 2020 document does not contain a definition of health, see INST. OF MED., COMM. ON LEADING HEALTH INDICATORS FOR HEALTHY PEOPLE 2020, LEADING HEALTH INDICATORS FOR HEALTHY PEOPLE 2020: LETTER REPORT 25-

health, it is useful to consider various theoretical bases for the importance of health as a human right—once the critical nature of health to the human experience is established, the social justice and philosophical reasons for equitable distribution of health become clearer.

1. THE IMPORTANCE OF HEALTH EQUITY

Among all other rights, the case is often made that health is special in that it has a particular significance to individuals—without health, individuals cannot fully function as human beings. Martha Nussbaum developed the "capability to function" framework, in which just societies should aim to give their citizens certain basic functional capabilities, including "[b]eing able to live to the end of a complete human life, as far as is possible; not dying prematurely; . . . [b]eing able to have good health; to be adequately nourished; [and] to have adequate shelter."[19] Nobel Laureate economist Amartya Sen considered the capability to avoid preventable ill-health and premature mortality to be an instrumental human freedom, arguing that expansion of fundamental freedoms, including health, is both the primary end and principal means of development.[20] Without this capability for health and other fundamental freedoms, Sen argued, people are not free to do things that a person "has reason to value."[21] Incorporating Sen's theory, the WHO Commission on the Social Determinants of Health spoke of concern for people

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26 (2011) (observing that its work in selecting leading health indicators was made more complicated by the lack of a definition of health) [hereinafter INST. OF MED., LEADING HEALTH INDICATORS], the Project's subcommittee on health equity and health disparities appears to have based its recommendations on the broadly accepted international law definition of health as "[a] state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity." Minutes of the Secretary's Advisory Committee Meeting, Appendix 2 (May 1, 2008), *available at* http://www.healthypeople.gov/2010/hp2020/advisory/faca2appendix2.htm?visit=1 (stating that "[h]ealth is defined as a complete state of physical, mental, and social well-being, not merely the absence of disease"); *see also* WHO, CONST. pmbl., *available at* http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf (containing the same definition of health).

19. Martha C. Nussbaum, *Human Functioning and Social Justice: In Defense of Aristotelian Essentialism*, 20 POL. THEORY 2, 221-22 (1992).

20. Amartya Sen, Keynote Address to the Fifty-second World Health Assembly: Health in Development (May 18, 1999), *available at* http://apps.who.int/gb/archive/pdf_files/WHA52/ewd9.pdf; *see also* AMARTYA SEN, DEVELOPMENT AS FREEDOM, *infra* note 21, at 36-37.

21. AMARTYA SEN, DEVELOPMENT AS FREEDOM 36-37 (1999).

who, by virtue of ill-health, are "without the freedom to lead flourishing lives."[22] The Commission observed that, in addition to its intrinsic value, health also serves an instrumental function, allowing people to fully participate in society, with potentially positive consequences for economic development.[23] In essence, health is requisite for much of what is considered a full life—the ability for individuals to "recreate, socialize, work, and engage in family and social activities that bring meaning and happiness to their lives."[24] Moreover, in explaining why health is essential not only for individual functioning, but also for population health, Gostin observes:

> Without minimum levels of health, people cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art, and provide for the common security . . . . Population health becomes a transcendent value because a certain level of human functioning is a prerequisite for activities that are critical to the public's welfare—social, political, and economic.[25]

Thus, it is not possible to have a well-functioning society if health disparities exist such that disadvantaged population segments are unable to fully participate in the essential activities of society.

2. DEFINING "HEALTH EQUITY" AND "HEALTH DISPARITIES"

Having established the importance of health to individual and population functioning, the question arises as to what exactly is intended by the terms "health equity" and "health disparities." Why should society care about the distribution of health across populations, irrespective of averages, and what obligation should governments have to seek an "equitable" distribution of health? If it is incumbent on government to take steps to enable individuals and populations to achieve health, a degree of relative precision about that obligation is necessary to allow meaningful

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22. Marmot, *supra* note 2, at 1155.

23. *Id.*

24. Lawrence O. Gostin, *Socioeconomic Disparities in Health: A Symposium on the Relationships Between Poverty and Health*, 15 GEO. J. ON POVERTY L. & POL'Y 571, 576 (2008); *see generally* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 7-8 (2d ed. 2008) [hereinafter GOSTIN, PUBLIC HEALTH LAW].

25. GOSTIN, PUBLIC HEALTH LAW, *supra* note 24, at 8.

assessment of progress. Although public health practitioners and scholars often take as self-evident that health disparities based on social disadvantage are unjust, the concept of health equity is far from accepted in mainstream political discourse, particularly when tangible measures to reduce health disparities are concerned. Thus, it bears discussing the philosophical and social justice rationales in support of government obligation to further the achievement of health equity.

As Asada observed, the use of the term "equity" in connection with health is intended to convey a moral judgment—that greater health disparities are less desirable than smaller health disparities.[26] Stated differently, there are moral implications of the distribution of health within and among societies. Various moral justifications have been offered in support of health equity. One is based on the concept discussed above of health as a special good. If one accepts that health is essential to human flourishing, then "is it not inevitable that we pay particular attention to health equity?"[27] Others tie the concept of health equity more closely to general philosophical notions of equality and justice, particularly the notion of ensuring equitable distribution of essential capabilities.[28] However, unlike those who argue that health is a special good, this approach regards health as one of a number of goods whose distribution is morally significant, but not automatically deserving of elevation above other goods.[29] A third approach views the distribution of health among a population as an indicator of general social justice.[30] Under any of these approaches, the question arises as to what exactly constitutes an "equitable" distribution of health.

Incorporating the theories of Nussbaum, Sen, and others, members of a subcommittee of the Secretary's Advisory Committee for HP 2020 (the Subcommittee) attempted to provide a tangible basis for assessing progress by developing proposed definitions for health equity and health disparities that should be

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26. YUKIKO ASADA, HEALTH INEQUALITY: MORALITY AND MEASUREMENT 7 (2007).

27. *Id.* at 22.

28. *Id.*; *see generally* Fabienne Peter, *Health Equity and Social Justice*, 18 J. APPLIED PHIL. 159 (2001); Fabienne Peter & Timothy Evans, *Ethical Dimensions of Health Equity*, *in* CHALLENGING INEQUALITIES IN HEALTH: FROM ETHICS TO ACTION, (M. Whitehead et al. eds., 2001).

29. ASADA, *supra* note 26, at 23.

30. *Id.* at 23-24.

applied to HP 2020 and to U.S. public health policy in general.[31] HP 2020 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."[32] The Subcommittee further explained that health equity is

> the value underlying a commitment to reduce and ultimately eliminate health disparities . . . . Health equity means social justice with respect to health . . . . Health equity means striving to equalize opportunities to be healthy. In accord with the other ethical principles of beneficence (doing good) and nonmalfeasance (doing no harm), equity requires concerted effort to achieve more rapid improvements among those who were worse off to start, within an overall strategy to improve everyone's health.[33]

The Subcommittee does not view health equity from a strictly egalitarian view because it expressly rejects the possibility of closing health gaps by worsening advantaged groups' health (the so-called "leveling-down" objection).[34] This explanation is consistent with the general global health understanding of health equity, which the WHO describes as existing when "all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health."[35]

However, the Subcommittee's explanation of health equity does not specify *which* health disparities must be eliminated in order for health equity to exist. It is not possible to eliminate all health disparities because certain health factors are not amenable to government intervention, including genetic factors and some behavioral risk factors where government interference with individual decision-making would be at odds with

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31. *See* Braveman et al., *supra* note 12.

32. *Disparities*, HP 2020, *supra* note 7 (citing U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF MINORITY HEALTH, NAT'L P'SHIP FOR ACTION TO END HEALTH DISPARITIES, THE NAT'L PLAN FOR ACTION DRAFT as of Feb. 17, 2010, ch. 1).

33. Braveman et al., *supra* note 12, at S151.

34. *Id.*; *see also* ASADA, *supra* note 26, at 28-30.

35. WHO, HEALTH PROMOTION GLOSSARY (1998), *available at* http://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf.

democratic ideals. But a cogent theory for determining what constitutes unjust health disparities is necessary because, as the Subcommittee explained, "[r]eductions in health disparities (by improving the health of the socially disadvantaged) are the metric by which progress toward health equity is measured."[36]

Asada described three competing theories for determining which health disparities should be considered unjust and thus subject to government intervention. The first incorporates the historic practice of conducting empirical analysis of health equity by considering health disparities correlated with socioeconomic status. This theory, popularized by Hausman, suggests that we are concerned with health disparities based on SES because poor health tends to correlate with less success in other valued spheres of life, such as income, occupation, and education.[37] Another theory, led by Whitehead, incorporates the value of individual choice:

> Judgments on which situations are unfair will vary . . . but one widely used criterion is the degree of *choice* involved. Where people have little or no choice of living or working conditions, the resulting health differences are more likely to be considered unjust than those resulting from health risks that were chosen voluntarily.[38]

This theory attempts to balance the sometimes competing interests of health and autonomy, and the obvious difficulty is determining which factors are truly beyond or within individual control, and to what degree. For example, in assessing levels of physical activity across socioeconomic groups, the "individual choice" theory would undertake to determine the degree to which residents of certain neighborhoods (usually low income) have less access to safe recreational facilities, thereby diminishing the ability of residents to maintain sufficient levels of physical activity, before determining whether the disparity would be considered unjust.

Finally, the third theory, which is largely adopted by the Subcommittee in its definition of health disparities, concerns itself not with the precise causes of disparities or the degree of

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36. Braveman et al., *supra* note 12, at S151.

37. ASADA, *supra* note 26, at 39-40 (internal citations omitted).

38. Margaret Whitehead, *The Concepts and Principles of Equity and Health*, 22 INT'L J. HEALTH SERVS. 429, 433 (1992).

individual choice, but whether the causes are amenable to human intervention.[39] So, in the physical activity example above, the "amenable to human intervention" theory would determine that differences in physical activity levels based on neighborhood are unjust, irrespective of the recreational facilities available, because the disparity would be susceptible to human intervention in the form of programs designed to increase physical activity. Thus, the choice of theory is important because different governmental obligations are implied by each in certain circumstances. As another example, health disparities based on risky individual behavior such as riding a motorcycle without a helmet would be regarded as inequitable under a strict interpretation of the amenable to human intervention theory, but not under the SES or individual choice theories.

Varying definitions of health disparities have been adopted by governments and international organizations, reflecting incorporation of one or more of the theories described above. In its landmark report, "Closing the Gap in a Generation," the WHO Commission on the Social Determinants of Health explained "[w]here systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair."[40] Moreover, the Commission said, "[p]utting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice. Reducing health inequities is . . . an ethical imperative."[41] Writing for the Commission in a complementary article published in *The Lancet*, Sir Michael Marmot explained, "Not all health inequalities are unjust or inequitable. If good health were simply unattainable, this would be unfortunate but not unjust. Where inequalities in health are avoidable, yet are not avoided, they are inequitable."[42] Thus, the WHO Commission seems to rely primarily on the amenable to human intervention theory in determining which disparities are unjust and thus require societal action.[43]

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39. ASADA, *supra* note 26, at 42.

40. WHO, COMM'N ON SOC. DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 8 (2008), *available at* http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf [hereinafter WHO, COMM'N ON SOC. DETERMINANTS OF HEALTH].

41. *Id.*

42. Marmot, *supra* note 2, at 1154.

43. The Commission also frames its claim of the social injustice of health inequities in the human rights language of the right to health, which, as noted above,

HP 2020 defines health disparities as "particular type[s] of health difference[s] that [are] closely linked with social, economic, and/or environmental disadvantage."[44] In addition, HP 2020 explains that "[h]ealth disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[45] The Subcommittee, however, defines health disparities in a slightly different way: "Health disparities are systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups."[46] Importantly, the health differences must be both systematic—i.e., not isolated or exceptional findings—*and* they must be systematically linked with social disadvantage (but causation need not be definitively established).[47]

The Subcommittee considers that health differences associated with social disadvantage raise special social justice concerns because ill-health reinforces and/or compounds the negative effects of social disadvantage, making it more difficult to overcome.[48] The component of the definition requiring that the health differences be "plausibly avoidable" evokes the amenable to human intervention framework discussed above. The Subcommittee explained that "plausibly avoidable" intends to convey that "[i]t must be plausible, but not necessarily proven, that policies could reduce the disparities . . . [T]he criterion is whether the given condition is *theoretically avoidable*, based on current knowledge of plausible causal pathways and biological mechanisms, and assuming the existence of sufficient political will."[49] Acknowledging political reality and limited resources, the Subcommittee does not establish an obligation that all

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is not firmly entrenched in U.S. political discourse. WHO, COMM'N ON SOC. DETERMINANTS OF HEALTH, *supra* note 40, at 42.

44. *Disparities*, HP 2020, *supra* note 7 (citing DEP'T OF HEALTH AND HUMAN SERVS., SECRETARY'S ADVISORY COMMITTEE ON NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES: PHASE I REPORT, § IV, *available at* http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917).

45. *Id.*

46. Braveman et al., *supra* note 12, at S149.

47. *Id.* at S151.

48. *Id.*

49. *Id.* at S152 (emphasis added).

theoretically avoidable health differences are disparities (as the amenable to human intervention framework implies); rather the Subcommittee seems to establish a sort of sliding scale, stating that "[t]he more solid the knowledge, the more reasonable and politically viable it will be to invest resources in interventions; feasibility, costs, and potentially harmful unintended consequences must be considered."[50]

The Subcommittee's definition of health disparities raises a critical question for measurement and assessment purposes—What factors constitute "social disadvantage" such that correlated health differences should be considered (unjust) health disparities? The Subcommittee says that "social disadvantage" refers to the "unfavorable social, economic, or political conditions that some groups of people systematically experience based on their relative position in social hierarchies."[51] In addition, social disadvantage means "restricted ability to participate fully in society and enjoy the benefits of progress . . . [and] is reflected, for example, by low levels of wealth, income, education, or occupational rank, or by less representation at high levels of political office."[52] This definition is quite broad and could prove infeasible for purposes of assessing progress. Perhaps for this reason, for measurement purposes, HP 2020 takes a slightly narrower view. HP 202 0 says that, for purposes of assessing U.S. progress toward eliminating disparities over the coming decade, it will measure results across the following factors: income, race and ethnicity, gender, sexual identity and orientation, disability status or special health care needs, and geographic location (rural and urban).[53]

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50. The most problematic part of this framework for establishing which health differences constitute disparities is the requirement, however vague, that there be a degree of political will present in order to make a health difference theoretically avoidable. Although the reference appears to be intended as a straightforward acknowledgment that political will is almost always determinative of which priorities among many are made into policy, taken to its logical conclusion the premise implies that societal indifference to systematic health differences associated with disadvantage could take them outside the framework of disparities. It seems unlikely this is what the Subcommittee intended. Braveman et al., *supra* note 12, at S152.

51. Braveman et al., *supra* note 12, at S151.

52. *Id.*

53. *Disparities*, HP 2020, *supra* note 7.

3. THE FEDERAL GOVERNMENT ROLE IN HEALTH EQUITY

HP 2020 is not the first instance in which the federal government has made disparities a national health priority. Federal recognition of health disparities related to SES and race or ethnicity dates to at least 1985, with the release of the congressionally mandated "Report of the Secretary's Task Force on Black and Minority Health," which documented a significant pattern of disparities among racial and ethnic groups.[54] Shortly thereafter, the Office of Minority Health was established within HHS and today exists within six federal agencies.[55] In 1998, President Clinton announced the Initiative to Eliminate Racial and Ethnic Disparities in Healthcare, the goal of which was to eliminate racial and ethnic health disparities in six key areas of health status by 2010.[56] When the HP 2010 goals were released, one of the two overarching goals was the elimination of health disparities.[57]

The federal focus on disparities has increased in the last decade, particularly since 2002, with the release of the Institute of Medicine's (IOM) landmark report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, which documented significant disparities in health care.[58] Since then, the Agency for Healthcare Research and Quality (AHRQ) has

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54. MARGARET M. HECKLER, DEP'T OF HEALTH & HUMAN SERVS., REPORT OF THE SECRETARY'S TASK FORCE ON BLACK & MINORITY HEALTH (1985).

55. The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, 971 (2010), required the establishment of Offices of Minority Health (OMH) within six agencies of HHS: the Agency for Healthcare Research and Quality (AHRQ); the Centers for Disease Control and Prevention (CDC); the Centers for Medicare & Medicaid Services (CMS); the Food and Drug Administration (FDA); the Health Resources and Services Administration (HRSA); and the Substance Abuse and Mental Health Services Administration (SAMHSA). *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., NAT'L P'SHIP FOR ACTION TO END HEALTH DISPARITIES, OFFICES OF MINORITY HEALTH, http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=35. In addition, each of the 50 states has an office of minority health. *Id.*

56. *See* Jennifer Brooks, *Clinton Announces Racial and Ethnic Disparities Initiative*, CLOSING THE GAP, LOOKING FOR MONEY, April 1998, *available at* http://minorityhealth.hhs.gov/assets/pdf/checked/Clinton%20Announces%20Racial%20and%20Ethnic%20Health%20Disparities%20Initiative.pdf.

57. U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTHY PEOPLE 2010, GOALS, *available at* http://www.healthypeople.gov/2010/About/goals.htm.

58. INST. OF MED. OF THE NAT'L ACADS., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE (2002), *available at* http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx.

issued yearly National Health Disparities Reports, which document healthcare-related disparities among racial, ethnic, and socio-economic groups in the United States.[59] In 2011, the CDC issued its first "Health Disparities and Inequalities Report," containing a broad array of health disparities measurements, including those based on SES, race or ethnicity, geography, and others.[60] Most recently, thousands of community and government leaders collaborated on the National Partnership for Action to End Health Disparities (NPA), sponsored under the auspices of HHS.[61] The NPA was created to "mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity."[62] The result of this collaborative effort is the "National Stakeholder Strategy for Achieving Health Equity," which is described as "a roadmap for eliminating health disparities through cooperative and strategic actions."[63] In addition, the collaboration resulted in the "HHS Action Plan to Reduce Racial and Ethnic Health Disparities,"[64] which outlines specific HHS actions in regard to racial and ethnic health disparities, building on provisions of the Affordable Care Act. Unfortunately, notwithstanding the various federal initiatives to address health disparities, progress has been slow, and, since 2000, virtually nonexistent.[65] In light of the lack of

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59. *See* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, NATIONAL HEALTHCARE QUALITY REPORT 3 (2011), *available at* http://www.ahrq.gov/qual/nhqr10/nhqr10.pdf [hereinafter NHQ Report].

60. CTRS. FOR DISEASE CONTROL AND PREVENTION, MORBIDITY AND MORTALITY WKLY REP., CDC HEALTH DISPARITIES AND INEQUALITIES REPORT – UNITED STATES 2011 4 (Jan. 14, 2011), *available at* http://www.cdc.gov/mmwr/pdf/other/su6001.pdf.

61. DEP'T OF HEALTH & HUMAN SERVS., NAT'L P'SHIP FOR ACTION TO END HEALTH DISPARITIES, NATIONAL STAKEHOLDER STRATEGY FOR ACHIEVING HEALTH EQUITY (2011), *available at* http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286.

62. *Id.* at 1.

63. *Id.*

64. U.S. DEP'T OF HEALTH AND HUMAN SERVS., NAT'L P'SHIP FOR ACTION TO END HEALTH DISPARITIES, HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC DISPARITIES 11 (2011), *available at* http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=285.

65. Healthy People 2010 Final Review: Executive Summary (2010), at ES-22-32, *available at* http://www.cdc.gov/nchs/healthy_people/hp2010/hp2010_final_review.htm. *See also* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, NATIONAL HEALTHCARE QUALITY REPORT 2-8 (2011), *available at* http://www.ahrq.gov/qual/nhqr10/nhqr10.pdf. Note, however, that difficulties in the measurement of disparities have been observed. *See* R.J. Klein and L.T. Bilheimer, *Data and Measurement Issues in the Analysis of*

progress even in the face of what appears to be a significant federal effort, it is fair to ask whether federal policies have truly prioritized reduction of disparities.

In addition, when considering health equity and disparities it is helpful to place the United States in context relative to other developed countries, in regard to both statistics and the legal environment. Although precise country comparisons are difficult given the differences in the way countries monitor health and health disparities, in general, the state of health equity in the U.S. appears to be worse than in most industrialized nations.[66] For example, among lower SES groups in the U.S. and Canada (which has generally adopted more interventionist health promotion approaches than the U.S., including a national health care system), adverse personal health-related behaviors have a more significant impact on the U.S. cohort than on the comparable Canadian group.[67] Similarly, differences in health outcomes by racial and ethnic group are more pronounced in the U.S. than in Canada.[68]

Finally, from a policy perspective, it is useful to observe the close interaction between efforts to reduce disparities and efforts to address what are referred to as the "social determinants of health." HP 2020 (and other U.S. health policy initiatives) consider social determinants of health to be the "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[69] Differences in health

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Disparities, 45 HEALTH SERVICES RESEARCH 1489 (Oct. 2010) (observing that larger sample sizes are necessary for evaluation of disparities for major population subgroups and concluding that evaluation of existing methodologies for assessing health disparities should be a priority for health services researchers).

66. HILARY GRAHAM, UNEQUAL LIVES: HEALTH AND SOCIOECONOMIC INEQUALITIES (2007). *See also* Stephen Bezruchka, *Health Equity in the USA*, 29 SOC. ALTERNATIVES 50 (2010).

67. Kimberlyn M. Mcgrail et al., *Income-Related Health Inequalities in Canada and the United States: A Decomposition Analysis*, 99 AM. J. PUB. HEALTH 1856, 1856-63 (2009).

68. Arjumand Siddiqi and Quynh C. Nguyen, *A Cross-National Comparative Perspective on Racial Inequities in Health: The United States versus Canada*, 64 J. EPIDEMIOLOGY AND COMM. HEALTH 29, 29-34 (2010).

69. *Social Determinants of Health*, HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39. It is important to note that the phrase "social determinants of health" refers not just to traditional social factors such as education (both accessibility and quality) and discrimination (among others), but also physical factors such as the "built

status that are linked to these factors reflect a lack of health equity.[70] An advantage of the amenable to human intervention theory in addressing social determinants is that it avoids to some extent the implicit "blame" contained in the individual choice theory, recognizing that even health inequalities based on modifiable personal behavior are influenced by external factors. Thus, the amenable to human intervention theory implicitly views disparities in the context of the social determinants of health.[71] In this framework, strategies to achieve health equity must necessarily incorporate approaches to mitigate the effects of the social determinants of health—that is, strategies to reduce health disparities must be directed at factors beyond traditional health care services. The strong influence of the social determinants of health on ultimate health outcomes presents a particular challenge for HP 2020 in that many of the factors are outside the traditional purview of HHS—indeed, this jurisdictional issue may account for the fact that the social determinants of health are the only topic for which HHS has not yet set objectives and indicators.

B. The Healthy People 2020 Goals In Relation To Health Equity

The Healthy People Initiative describes its work as providing "science-based, 10-year national objectives for improving the health of all Americans," and, since its inception roughly thirty years ago, Healthy People has "established benchmarks and monitored progress over time in order to: encourage collaborations across sectors[,] empower individuals toward making informed health decisions, [and] [m]easure the impact of prevention activities."[72] HP 2020 is the latest in a series of Healthy People goals, which have been issued roughly every ten years since 1979, with each iteration becoming more ambitious in seeking to address the pressing health problems of the U.S. through the addition of new topic areas and objectives.[73] HP 2020

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environment" (e.g., the quality of housing, sidewalks, roads), the natural environment (e.g., pollution), and aesthetic elements.

70. *Social Determinants of Health*, HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39.

71. However, to a lesser degree, the individual choice theory also recognizes that individual choice is both circumscribed and influenced by societal factors.

72. *About Healthy People*, HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/about/default.aspx.

73. *History & Development of Healthy People*, HEALTHY PEOPLE 2020, *available*

builds on the achievements and shortcomings of prior Healthy People goals, most recently HP 2010.

Key changes from HP 2010 to HP 2020 include a movement from two overarching goals to four (though, in both the 2010 and 2020 iterations, the elimination of disparities is an overarching goal), the inclusion of social determinants of health as an explicit focus, as well as the addition of a number of new topic areas.[74] In evaluating the goals of HP 2020, it is noteworthy that the HP 2010 final review found that the areas of weakest progress were in regard to obesity and health disparities, which essentially did not improve over the decade in which HP 2010 was in effect.[75] This lack of improvement is disappointing, but it is perhaps unsurprising that overall health disparities did not improve during the term of HP 2010. Although there were many federal efforts to monitor disparities, as described above, in the context of overall population health efforts, very little was done to directly address the causes of health disparities.

While the approach of making the elimination of disparities an overarching goal that theoretically applies to all targets and objectives is effective in that the goal is implicitly incorporated in every objective, this approach also creates potential problems when looking at the specific objectives. Just as in HP 2020, HP 2010 very rarely advocated for specific legal mechanisms such as direct regulation or taxation, even where public health evidence

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at http://www.healthypeople.gov/2020/about/history.aspx.

74. For instance, adolescent health, blood disorders and blood safety, dementias, including alzheimer's disease, early and middle childhood, genomics, global health, health-related quality of life and well-being, healthcare-associated infections, lesbian, gay, bisexual and transgender health, older adults, preparedness, sleep health, and social determinants of health. *What's New for 2020,* HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/about/new2020.aspx.

75.

> While much progress has been made with regard to most of the 2010 health objectives, it is clear from the Healthy People assessment that the nation still comes up short in a number of critical areas, including efforts to reduce health disparities and the obesity rate.
>
> Over the past decade, health disparities have not changed for approximately 80 percent of the health objectives and have increased for an additional 13 percent. And, the report found that obesity rates increased across all age groups. Among children aged 6-11 years, obesity rates rose by 54.5 percent, and among adolescents aged 12-19 years, the obesity rate rose 63.6 percent. In addition, the proportion of adults who are obese rose by 48 percent.

Press Release, U.S. Dep't of Health and Human Servs., HHS Releases Assessment of Healthy People 2010 Objectives (Oct. 2011), *available at* http://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review_press_release.pdf.

supported such interventions.[76] Without direct action, it is unlikely such disparities will remedy themselves. Given that HP 2010 acknowledged that disparities were an area of particularly weak progress,[77] HP 2020 presents an opportunity for relevant governmental agencies to take a new approach in policy formulation—explicitly acknowledging the distributive impacts of policy choices and advocating for specific measures, particularly coercive legal mechanisms, to reduce disparities in addition to improving population health, rather than setting broad population health targets with no specific recommendations for their achievement.

This distributive approach is essential to an effort to achieve health equity. HP 2020 incorporates health equity as a pillar upon which the HP 2020 goals are conceived. In addition to the many specific goals discussed herein, HP 2020 has four overarching goals:

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death;
- **Achieve health equity**, eliminate disparities, and improve the health of all groups;
- Create social and physical environments that promote good health for all;
- Promote quality of life, healthy development, and healthy behaviors across all life stages.[78]

In addition, HP 2020 utilizes four foundational health measures to measure progress towards achieving these goals:

- General Health Status
- Health-Related Quality of Life and Well-Being

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76. *See* Mary Anne Bobinski, *Health Disparities and the Law: Wrongs in Search of a Right*, 29 AM. J.L. & MED. 363, 370 (2003).

77. *See id.* Note also that tobacco use was identified as an area of particular concern, as only minor strides were made in reducing smoking rates, although tobacco control was considered an area of success. *Id.*

78. HEALTHY PEOPLE 2020, FRAMEWORK, *available at* http://www.healthypeople.gov/2020/Consortium/HP2020Framework.pdf (emphasis added). Although only one of the four overarching goals explicitly addresses health equity, the other three have obvious health equity implications in that their achievement would contribute to the elimination of disparities.

- Determinants of Health
- **Disparities**[79]

As discussed above, health disparities are almost always considered to reflect a lack of health equity; thus, utilizing disparities as a foundational health measure of progress ensures that health equity will remain a key focus area as progress toward the HP 2020 goals is measured. While improvement in each of the other three foundational health measures is obviously both desirable and necessary to achieving the HP 2020 goals, improvement in those three measures alone will not inevitably signal progress toward health equity because health equity necessarily involves elimination of disparities. In Part III, this paper discusses the particular importance assessing the distributive consequences of policy interventions and why coercive legal mechanisms are essential to achieving the population health objectives of HP 2020 while also reducing disparities.

PART III

A. THE IMPORTANCE OF LAW IN PUBLIC HEALTH AND THE ACHIEVEMENT OF HEALTH EQUITY

Scholars have long debated the appropriate role of law in furthering the public's health. Broadly speaking, the overarching tension is between paternalism and autonomy—that is, between government's right or obligation to enact laws that either circumscribe individual autonomy (e.g., helmet laws) or shift the decision-making paradigm toward more desired choices (e.g., tobacco taxes) versus an individual's freedom to engage in conduct not immediately and directly harmful to others.[80] Law is an essential tool in reducing health inequity because it is axiomatic that a laissez-faire system disadvantages those individuals with less education, fewer resources, and less political power. The distributive consequences of health policy interventions become quite relevant in any consideration of

79. HEALTHY PEOPLE 2020, FRAMEWORK, *available at* http://www.healthypeople.gov/2020/Consortium/HP2020Framework.pdf (emphasis added).

80. *See, e.g.*, Lawrence O. Gostin and Kieran G. Gostin, *A Broader Liberty: JS Mill, Paternalism and the Public's Health*, 123 PUB. HEALTH 214-22 (2009); INST. OF MED., FOR THE PUBLIC'S HEALTH: REVITALIZING LAW AND POLICY TO MEET NEW CHALLENGES 88 (2011) [hereinafter INST. OF MED., FOR THE PUBLIC'S HEALTH].

health equity—where a laissez-faire system may aggravate disparities affecting the already disadvantaged, there are other options, particularly coercive legal mechanisms, that would both improve overall population health and reduce disparities. In some situations, coercive legal mechanisms are the tool by which government can and should "level the playing field," enabling all people to have an equal opportunity to achieve complete health. The more difficult question is how to do so while preserving a level of autonomy that is consistent with democratic ideals.

Although HP 2020 explicitly seeks to achieve health equity, its unwillingness to advocate for legal approaches in achieving specific objectives is problematic because many voluntary policy initiatives first—and sometimes only—impact population groups that are already at the top of the health ladder. For example, educational campaigns designed to increase desired health behaviors are necessarily less likely to positively affect individuals with limited health literacy.[81] Urging people to eat healthier foods and exercise more means little if steps are not taken to address the myriad social determinants affecting individual choices about food and exercise. The disparate impacts of purely voluntary health promotion policies further the case that coercive legal measures have a key role to play in eliminating disparities. By virtue of their broad applicability and uniform application, well-crafted coercive legal measures are better suited than purely voluntary initiatives to lead to health improvements across all population groups, and, in many instances, to a reduction in disparities.

In the U.S., even where government action on behalf of public health is desired, there is an additional tension between the role of the federal government as compared to that of states and localities. The federal government lacks the state general police power in regard to health and welfare, so federal actions affecting health must be justified under one of Congress's enumerated powers, usually the Commerce Clause.[82] Moreover,

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81. *See, e.g.*, Christian von Wagner et al., *Functional Health Literacy and Health-promoting Behaviour in a National Sample of British Adults*, 61 J. EPIDEMIOLOGY COMM. HEALTH 1086, 1086-90 (2007) (observing the link between health literacy and health promoting behaviors).

82. INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 27-28 (citing Lawrence O. Gostin, *Healthy People, Healthy Places: How to Have a Healthy Life, Community, and Country*, 11 INSIGHTS ON L. AND SOC. 12 (2010)). *See also* Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825,

even where the federal government has the power to act, there is also the question of which governmental body should act to address various public health concerns. Gostin has observed that "[t]he level of government best situated for dealing with public health threats depends on the evidence identifying the nature and origin of the specific threat, the resources available to each unit for addressing the problem, and the probability of strategic success."[83] In that vein, concerns often arise regarding federal preemption of a field of regulation, particularly "ceiling preemption," whereby states and localities are prohibited from enacting measures more stringent than those required by federal law. A recent report by the IOM on the role of law in public health (IOM LPH Report) recommends that, wherever appropriate, federal and state laws set floors rather than ceilings, thereby allowing states and localities the flexibility to enact more stringent standards to protect public health.[84] Similarly, the HHS Action Plan To Reduce Racial And Ethnic Health Disparities[85] recognizes the importance of legal approaches in combating disparities, although its analysis in that regard is primarily confined to the recently enacted Patient Protection and Affordable Care Act (Affordable Care Act or ACA).[86]

Even once the questions of the desirability of government

1862-63 (2011) (observing that a problem with Commerce Clause challenges to Congress's ability to mandate the purchase of health insurance is that, taken further, the same logic could also "preclude, for instance, federal action to mandate vaccinations or other preventive measures even in the worst conceivable public health emergency, such as an outbreak of the avian flu that realistically might threaten tens of millions of lives").

83. Lawrence O. Gostin and Madison Powers, *What Does Social Justice Require for the Public's Health? Public Health Ethics and Policy Imperatives*, 25 HEALTH AFFAIRS 1053, 1056 (2006).

84. INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 50-51. An obvious failing in this regard is in recently enacted federal menu labeling standards, which entirely preempt the field. *See* further discussion *infra* Section III.B.3, "Heart Disease and Stroke."

85. U.S. DEP'T OF HEALTH AND HUMAN SERVS., ACTION PLAN TO REDUCE RACIAL AND ETHNIC DISPARITIES 11 (2011). The Action Plan builds on the goals of HP 2020 with specific strategies for reducing or eliminating health disparities. To that end, the Action Plan incorporates four overarching priorities of the HHS Secretary: (i) assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities; (ii) increase the availability, quality, and use of data to improve the health of minority populations; (iii) measure and provide incentives for better healthcare quality for minority populations, and (iv) monitor and evaluate the department's success in implementing the HHS disparities Action Plan. *Id.* at 12-14.

86. *Id.* at 39, app. A.

intervention and the appropriate governmental level (federal, state, or local) to implement policies are settled, there is another critical question—Which legal and public policy options will best further population health *and* health equity? As the IOM LPH Report observes, when government acts to protect public health it has a broad array of legal and public policy options from which to choose, including:

- [T]axation, incentives, and spending (e.g., cigarette and other "sin" taxes, and allocation of the tax to combat the problem, may include pricing policies and financial incentives);
- [A]ltering the informational environment (e.g., food or drug labeling, and disclosure of health information);
- [A]ltering the built/physical environment (e.g., zoning, toxic waste);
- [A]ltering the natural environment (e.g., clean water, air, environmental justice);
- [D]irect regulation (e.g., seatbelts, helmets, drinking water fluoridation, folate fortification of grain-based products, iodized salt; licensure of medical care providers and facilities);
- [I]ndirect regulation (e.g., tort litigation in tobacco); and
- [D]eregulation (e.g., distribution of sterile injection equipment or criminalization of HIV risk behaviors).[87]

As the report notes, cost and cost-effectiveness are often of primary concern among government officials; thus, it is necessary for public health advocates to remind decision makers that evidence strongly supports the position that certain policy interventions offer excellent health returns for the funds invested.[88] The IOM LPH Report concludes that governments can and should utilize effective legal and policy tools to address the leading causes of injury, disease, and early death.[89] However, the IOM does not take a position as to which legal tools are most

87. INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 58.
88. *Id.* at 67.
89. *Id.* at 68.

likely to eliminate disparities, either in general or in specific instances. Among the legal tools available to governments, the most "coercive" are direct regulation and taxation, in that they directly affect consumer behavior either before or at the point of decision-making. Moreover, direct regulation and taxation in general apply to all individuals, and, therefore, in theory, where the behavior intended to be affected is more heavily concentrated among disadvantaged groups, the coercive legal mechanism will affect those groups more strongly, therefore *reducing* health disparities.[90] However, important concerns about the regressive nature of certain taxes (e.g., cigarette taxes or soda taxes) argue for careful adoption of taxation only in instances where the harm of the product outweighs the hardship imposed by the tax. In addition, taxation in the absence of complementary measures (e.g., tobacco cessation assistance) could be considered unjust in that persons most strongly affected by the tax (lower income individuals) will be the least able to offset the hardship of that tax. Notwithstanding the importance of complementary measures, when assessing policy interventions purely from a perspective of which are more likely to reduce disparities within an overall population health framework, there are many instances in which coercive legal mechanisms are not only the best, but also the *only* realistic means of doing so. HP 2020's failure to advocate for those coercive legal mechanisms thus undermines its central objective of achieving health equity.[91]

However, even well-intentioned legal mechanisms must be assessed not only for their capacity to improve overall population health, but also for their likely impact on vulnerable populations. For example, the ACA encourages employers to implement "wellness programs," allowing employers to offer significant financial incentives to employees who meet health-related goals.[92]

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90. *See* Dahlia K. Remler, *Poor Smokers, Poor Quitters, and Cigarette Tax Regressivity*, 94 AM. J. PUB. HEALTH 225 (2004).

91. Note, however, that HP 2020 does urge adoption of specific regulations in certain, largely non-controversial, policy areas, including graduated driver licensing laws, bicycle laws, mandatory ignition interlock laws, physical activity policies in schools, smoke-free indoor air laws, preemptive tobacco control laws (eliminate state laws that preempt stricter local ones), enforcement of tobacco sales to minor laws, and enforcement of existing environmental laws. *Healthy People 2020 Summary of Objectives*, HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/HP2020objectives.pdf.

92. Under the ACA, employers will be permitted to offer rewards up to 30% of the cost of insurance coverage; however, the Act also provides for the possible increase of the incentive valuation of up to 50% of the value of the plan. The Patient Protection

Without recognition of the barriers to health presented by social determinants such as income level and neighborhood, wellness programs could easily become a tool of discrimination against already disadvantaged individuals.[93] Thus, to truly further health equity, HP 2020 must go further than its current approach of setting targets without recommendations for achieving its objectives—rather, the Project must acknowledge the distributive consequences of various policy options and advocate for those coercive legal measures that are likely to reduce disparities and thereby further health equity.

B. By Failing to Advocate Adoption of Effective Coercive Legal Mechanisms, Healthy People 2020 Fails to Fully Incorporate Health Equity

Healthy People 2020 is organized into a series of thirty-nine topics, each with multiple objectives.[94] Of the thirty-nine topics in HP 2020, the majority have health equity implications.[95] It is not possible to address each in depth; therefore this paper will discuss four diverse topics with particular relevance to health equity and coercive legal mechanisms: (1) Access to Health Services, (2) Environmental Health, (3) Heart Disease and Stroke, and (4) Nutrition and Weight Status. These four topics allow an assessment of the importance of legal mechanisms across a broad spectrum. Much of the analysis is applicable to other topics; for example, the analysis with respect to heart disease has implications for other disease-specific topics such as cancer, diabetes, and HIV.

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and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 977-78 (2010).

93. Indeed, in recognition of the possibility that wellness programs could be used to discriminate based on health status, the American Heart Association opposed the expansion of wellness incentives that required attainment of certain metrics for fear that failure to meet the metrics could lead to discrimination in the workplace. *See* AM. HEART ASS'N, POSITION STATEMENT ON FINANCIAL INCENTIVES WITHIN WORKSITE WELLNESS PROGRAMS, *available at* http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_428966.pdf.

94. *Topics & Objectives Index,* HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx.

95. Additional topics with obvious health equity implications include adolescent health, blood safety, cancer, diabetes, disabilities, family planning, global health, health communication and technology, healthcare-associated infections, hearing and other sensory or communication disorders, HIV, lesbian, gay, bisexual and transgender health, maternal, infant, and child health, occupational safety and health, older adults, oral health, physical activity, respiratory diseases, sexually transmitted diseases, social determinants of health, tobacco use, and vision.

1. ACCESS TO HEALTH SERVICES

Healthy People 2020 considers that Access to Health Services (Access) involves four components: coverage, services, timeliness, and workforce.[96] Of those four, the most immediately relevant to health equity are access to coverage and services.[97] Access has widespread impact on all aspects of an individual's health,[98] making disparities in Access particularly relevant to health equity. As HP 2020 states, "Disparities in access to health services affect individuals and society. Limited access to health care impacts people's ability to reach their full potential, negatively affecting their quality of life."[99]

a. Access to Coverage

The 2011 HHS Action Plan To Reduce Racial and Ethnic Health Disparities highlights the significant racial and ethnic disparities in access to health care:

Lack of insurance, more than any other demographic or

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96. *Access to Health Services*, HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=1.

97. Certainly, however, the other aspects of Access have health equity implications as well, particularly workforce, and HP 2020 falls short by failing to establish objectives for a diverse health care workforce, particularly among physicians. In that regard, the Patient Protection and Affordable Care Act, discussed *infra* Section III.B.1.c., is superior, as it has a number of sections seeking to increase diversity among medical providers. *See, e.g.*, 42 U.S.C. §§ 293, 294, 296 (2011).

98. HP 2020 states that Access means:

> the timely use of personal health services to achieve the best health outcomes . . . [and] requires 3 distinct steps:
>
> (1) Gaining entry into the health care system.
>
> (2) Accessing a health care location where needed services are provided.
>
> (3) Finding a health care provider with whom the patient can communicate and trust.

Access to Health Services: Overview, HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=1 (internal citations omitted). Moreover, Access impacts the following components of health:

- Overall physical, social, and mental health status;
- Prevention of disease and disability;
- Detection and treatment of health conditions;
- Quality of life;
- Preventable death;
- Life expectancy.

Id.

99. *Id.*

> economic barrier, negatively affects the quality of health care received by minority populations. Racial and ethnic minorities are significantly less likely than the rest of the population to have health insurance. They constitute about one-third of the U.S. population, but make up more than half of the 50 million people who are uninsured.[100]

In the HP 2020 Access objectives, the baseline rate of insured Americans is 83.2%, and the target goal is 100%.[101] However, as would be expected, the proportion of uninsured Americans is not evenly distributed across racial and ethnic groups or socioeconomic levels.[102] In the 2008 National Health Interview Survey (NHIS) Report, which is used in formulating the HP 2020 Goals and Objectives, evidence showed that persons with income below 200% of the poverty level were significantly more likely to lack insurance (29.7%) than those with incomes above 200% of the poverty level (10.4%).[103] In addition, wide variations existed across racial and ethnic groups, ranging from a rate of 10.8% of non-Hispanic whites uninsured to 34.1% of Hispanic (any origin) uninsured. Trends have not improved in the intervening years. The most recent Census Bureau report (2010) reports that the U.S. average percentage of uninsured is 16.3%, with a range of 11.7% for non-Hispanic whites to 30.7% for Hispanic (any origin).[104] Evidence indicates that uninsured persons are more likely to have negative health outcomes.[105]

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100. U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 85, at 2-3.

101. *Access to Health Services: Objectives,* HEALTHY PEOPLE 2020, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=.

102. *See* DENAVAS-WALT ET. AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES 26, 2010 (2011), *available at* http://www.census.gov/prod/2011pubs/p60-239.pdf.

103. ROBIN A. COHEN AND DIANE M. MAKUCK, NAT'L HEALTH STATISTICS REPORTS, STATE, REGIONAL, AND NATIONAL ESTIMATES OF HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER 65 YEARS OF AGE: NATIONAL HEALTH INTERVIEW SURVEY, 2004-2006, 10 (2008), *available at* http://www.cdc.gov/nchs/data/nhsr/nhsr001.pdf.

104. DENAVAS-WALT, *supra* note 102, at 26.

105. *See, e.g.,* Robert A. Fowler et al., *An Official American Thoracic Society Systematic Review: The Association Between Health Insurance Status and Access, Care Delivery, and Outcomes for Patients Who Are Critically Ill,* 181 AM. J. RESPIRATORY CRITICAL CARE MED. 1003 (2010) (linking health insurance status with health outcomes in the critical care field); Jack Hadley, *Insurance Coverage, Medical Care Use, and Short-Term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition.* 297 J. AM. MED. ASS'N. 1073 (2007); *Insuring America's Health: Principles and Recommendations,* 11 ACAD. EMERGENCY MED. 418 (2004); Jennifer S. Haas, *The Association of Race, Socioeconomic Status, and Health*

Thus, the disparities in insurance coverage are particularly relevant to health equity.

b. Access to Services

There are three key components of access to services: access to a primary care provider (PCP), access to preventive services, and access to emergency care. Though all relate to health equity, and there are disparities across all three, this paper will primarily address access to preventive services because it is the most relevant to legal interventions.[106] Although preventive services are very often received from a primary care provider, distinctions are necessary between access to a primary care provider and access to preventive services. In HP 2020, access to primary care providers primarily focuses on ensuring that there are sufficient primary care providers available to serve the population,[107] whereas access to preventive services seeks to ensure that preventive services are affordable in addition to being readily available. As with access to coverage, there are wide disparities in access to and use of preventive services.[108] Moreover, although use of preventive services is increasing in the population as a whole, disparities among population groups in utilization are not improving.[109] This is troubling because preventive services are critical to achieving health equity—empirical evidence shows that timely and effective use of preventive services leads to better health outcomes.[110] Thus, a

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Insurance Status with the Prevalence of Overweight Among Children and Adolescents, 93 AM. J. PUB. HEALTH 2105 (2003) (discussing the fact that health insurance status is associated with the prevalence of overweight in adolescents); J. Durham et al., *Self-assessed Health Status and Selected Behavioral Risk Factors Among Persons With and Without Healthcare Coverage—United States, 1994-1995*, 47 MORBIDITY AND MORTALITY WKLY REP., no. 1, CTRS. FOR DISEASE CONTROL AND PREVENTION, Mar. 13, 1998, at 176-80.

106. Moreover, access to emergency care has been largely addressed by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006), though, of course, EMTALA does not require that emergency care be provided free of charge, which often leads to devastatingly large bills for uninsured individuals who seek emergency care.

107. However, access to primary care providers also has a health equity component in that primary care providers, who already earn less on average than other physicians, have a strong disincentive to treat Medicaid patients given the lower reimbursement rates of Medicaid as compared to Medicare and private insurance plans. *See* NHQ Report, *supra* note 59.

108. *See* NHQ Report, *supra* note 59, at 17-18.

109. *Id.*

110. *See, e.g., Recommendations for Adults*, U.S. PREVENTIVE SERVICES TASK

prerequisite for achieving health equity will be narrowing—and ultimately eliminating—disparities in access to preventive services.

c. The Patient Protection and Affordable Care Act, Access, and Health Equity

This section will first consider the health equity implications of the Affordable Care Act's dramatic expansion in health insurance coverage via the expansion of Medicaid and the creation of insurance exchanges on which individuals and small businesses may purchase coverage. Next, subsection *ii* will evaluate the *content* of the insurance benefits individuals will be obtaining, assessing whether the laws applicable to the content of the benefits further health equity.

i. Expansion in Access via Medicaid and the Individual Mandate

In its Access objectives, HP 2020 makes no recommendations for how improved access to services might be achieved, nor does it advocate for a mechanism to achieve 100% insurance coverage. This is surprising because the evidence is clear that the market-based system that has dominated U.S. health care has not, and cannot, lead to universal coverage without significant regulatory change—that is, through the use of coercive legal mechanisms. The debate preceding the passage of the Affordable Care Act demonstrated this point: the Congressional Budget Office estimated that a package of market-based initiatives proposed by Republican members of the House of Representatives as an alternative to the ACA (e.g., allowing individuals to purchase insurance across state lines and reforms on medical malpractice lawsuits), would lead to essentially no reduction in the percentage of uninsured individuals over a ten-year period.[111] Yet Healthy People takes no position as to how access to coverage can be increased, nor how disparities in access to coverage can be reduced.

FORCE, http://www.uspreventiveservicestaskforce.org/adultrec.htm (last visited Oct. 2, 2012).

111. *See* Letter from Douglas Elmendorf, Director, Congressional Budget Office, to John Boehner, Republican Leader, U.S. House of Representatives, 3 (Nov. 4, 2009), *available at* http://cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10705/hr3962amendmentboehner.pdf.

The Affordable Care Act is a prime example of the necessity of coercive legal mechanisms to disparities elimination. Specifically, the Affordable Care Act contains coercive legal mechanisms that (1) require all individuals to carry health insurance and (2) regulate the content of the insurance policies and the behavior of insurance companies in issuing them, without which there would be no feasible way of extending coverage to all individuals. The Affordable Care Act is a critical component in addressing disparities in Access in that it is projected to dramatically expand access to coverage and services—at the time the law was passed, CBO estimated that an additional 32 million individuals would gain coverage under the Act.[112] The most obvious way in which the ACA furthers Access is in the combination of provisions that will allow nearly all U.S. citizens and legal residents to access health insurance.[113] The ACA accomplishes this dramatic expansion in access, estimated at an additional 32 million individuals obtaining health insurance,[114] through a combination of provisions, including the expansion of Medicaid eligibility, the establishment of "insurance exchanges," where individuals who do not receive affordable coverage through an employer can purchase health insurance, subsidies to assist individuals in purchasing health insurance, and the requirement that health insurers accept all applicants for coverage without exclusions for preexisting conditions or discrimination based on gender.

However, the mere expansion of access does not ensure that gains will be equitably distributed. Indeed, the unexpected consequence of the Supreme Court's recent decision on the constitutionality of the Affordable Care Act may be to *widen,* not narrow, disparities in access. In the decision, the Court held that the federal government may not penalize states that decline to participate in the Medicaid expansion by revoking funding for the existing Medicaid programs in those states.[115] In the aftermath of the decision, a number of governors have indicated that their

112. Letter from Douglas Elmendorf, *infra* note 114, at 9.

113. Incarcerated individuals are not eligible to participate in the insurance exchanges, unless the incarceration is pending the disposition of charges. 42 U.S.C. § 18032 (2010).

114. Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives (Mar. 20, 2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

115. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012).

states will not participate in the Medicaid expansion, even though (1) the federal government will pay 100% of the costs from 2014-2016, scaling down to 90% in 2020,[116] and (2) estimates indicate that states will actually save money by participating in the Medicaid expansion due to lower premiums for state employees and reduced expenditures for uncompensated care for uninsured individuals.[117] In states that decline to participate in the Medicaid expansion, the result will be disastrous from a social justice perspective—the sole means by which individuals under 133% of the federal poverty level were to receive coverage under the ACA was via the Medicaid expansion. Although individuals with income from 100-400% of the poverty level ($23,050-$92,200 for a family of four in 2012) are eligible for subsidies (thus theoretically enabling those with income from 100-133% of the poverty level to purchase insurance on the exchanges), persons with income below 100% of the poverty level are ineligible for subsidies, with the certain result being that they will be unable to afford coverage via the exchanges.[118]

Moreover, even in states that do participate in the Medicaid expansion, it is quite likely that the new system will be challenging for individuals to navigate in its early stages, which places already vulnerable groups at particular risk of being left behind. In recognition that procedural barriers such as cumbersome application processes and difficult and frequent eligibility determinations both create and worsen disparities in access to coverage, the Affordable Care Act contains provisions intended to facilitate access, including proposed rules to simplify eligibility rules for Medicaid and the Children's Health Insurance Program.[119] The proposed rules would require that individuals be permitted to apply based on a simple determination of Modified Adjusted Gross Income before being required to be screened based on other eligibility categories (e.g., disability); would allow

116. 42 U.S.C. § 1396(d)(y)(1) (2010).

117. EXEC. OFFICE OF THE PRESIDENT, COUNCIL OF ECON. ADVISERS, THE IMPACT OF HEALTH INS. REFORM ON STATE AND LOCAL GOV'TS 5 (2009), *available at* http://www.whitehouse.gov/assets/documents/cea-statelocal-sept15-final.pdf.

118. The average cost for an employer-provided family insurance policy in 2012 was over $15,000, with families paying over $4000 out of pocket. KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS ANNUAL 2012 SURVEY (2012), *available at* http://ehbs.kff.org/.

119. The Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. 159, 51204 (Aug. 17, 2011) (to be codified at 45 C.F.R. pts. 155, 157).

states to rely primarily on electronic data where available and permit states flexibility in determining what sources to rely upon; and critically, would allow renewal eligibility determinations no more frequently than every twelve months unless an individual reports a change in eligibility status.[120] In addition, such renewal determinations would be based first on existing information rather than requiring a new application.[121] These provisions are a promising start to addressing inequities in access, though it remains to be seen how they will be implemented in practice.

This brief discussion of the ACA would not be complete without addressing the impact of the most controversial provision of the ACA on disparities: the coercive legal mechanism known as the "individual mandate" requiring that all individuals purchase health insurance and the corresponding financial penalty (or, as the Supreme Court recently found, "tax") for noncompliance.[122] The mandate will not directly impact the poorest individuals because virtually all people who are eligible for Medicaid will be exempt from the penalty/tax on financial hardship grounds. However, many millions of Americans will be subject to the penalty/tax for failure to purchase insurance, which is a strong reason to pay particular attention to ensure that the law does not have the effect of worsening already existing health inequities if, for example, certain population segments fail to enroll in an insurance plan due to procedural, cultural, social, education,

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120. The Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. 159, 51204, 51204-06 (Aug. 17, 2011) (to be codified at 45 C.F.R. pts. 155, 157).

121. *Id.* at 51206.

122. 26 U.S.C. § 5000A (2010). The Court's decision upholding the individual mandate pursuant to Congress's taxing power does not change the substance of the mandate—individuals must purchase insurance or be subject to a tax. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2600 (2012) ("[I]mposition of a tax nonetheless leaves an individual with a lawful choice to do or not do a certain act, so long as he is willing to pay a tax levied on that choice."). Though the ACA includes a financial hardship exemption from the penalty/tax, the exemption is narrowly written in the statute. However, in recognition of the possibility that some states may decide to opt out of the Medicaid expansion, HHS Secretary Sebelius has indicated that HHS intends to exercise its authority to ensure that all individuals at or below 100% of the federal poverty level are included in the financial hardship exemption. Letter from Kathleen Sebelius, Secretary of Health and Human Services, Department of Health and Human Services, to Governors, Discussing the Recent Supreme Court Decision Concerning the Affordable Care Act, *available at* http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf.

literacy, or other barriers.[123]

In addition to enrollment barriers, the subsidies and penalties in connection with the individual mandate merit special discussion because of their relevance to disparities. The ACA and proposed rules thereto provide for subsidies for eligible individuals and families[124] to offset the cost of purchasing insurance and are expected to apply to approximately 20 million individuals.[125] The subsidies will undoubtedly help individuals afford insurance, but the mere existence of subsidies does not, on its face, make insurance affordable. A recent Treasury Department Fact Sheet,[126] explaining how the subsidies will operate, gives the example of a family of four with a household income of $50,000. Because the subsidy amount is based on the "benchmark" plan and is not reduced if an individual chooses a less expensive plan, the obvious incentive for lower-income individuals without significant health problems is to choose the least expensive plan and thereby incur lower out-of-pocket costs if no health problems develop. In the example of the family of four with $50,000 household income, choosing the least expensive plan

123. Moreover, the ACA does nothing to address the disparities between reimbursement rates for Medicaid as compared to private insurance or Medicare—given that Medicaid reimbursement is on average considerably lower than private insurance or Medicare, health care providers have a disincentive to treat Medicaid patients. *See* MEDICAID-TO-MEDICARE FEE INDEX, 2008, THE HENRY J. KAISER FAMILY FOUNDATION (2008), *available at* http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4.

124. The subsidies are structured as a tax credit refund paid directly to health insurers on the individual's behalf. Eligibility is generally restricted to individuals and families with household income of up to 400% of the Federal Poverty Level (FPL) ($22,350-$89,400 in 2011). *See* The Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, 76 Fed. Reg. 159, 51204, 51207 (Aug. 17, 2011) (to be codified at 45 C.F.R. pts. 155, 157); 26 U.S.C. § 36(B)(c)(1)(A) (2011). In addition, participants in the exchange must not be eligible for "affordable" employer-sponsored coverage, which is defined as the self-only premium exceeding 9.5% of household income. Moreover, affordable employer-sponsored coverage must meet minimum coverage requirements, which is defined as covering 60% of total allowed costs. *See also* U.S. DEP'T OF THE TREASURY, TREASURY LAYS THE FOUNDATION TO DELIVER TAX CREDITS TO HELP MAKE HEALTH INSURANCE AFFORDABLE FOR MIDDLE-CLASS AMERICANS (2011), *available at* http://www.treasury.gov/press-center/Documents/36BFactSheet.pdf.

125. Letter from Douglas Elmendorf to Nancy Pelosi, *supra* note 114, at 9, tbl. 4 (providing a detailed breakdown). *See also* U.S. DEP'T OF THE TREASURY, *supra* note 124.

126. U.S. DEP'T OF THE TREASURY, *supra* note 124.

saves the family $1,500 for a year of coverage.[127] Of course, if a family member develops extensive health problems, this $1,500 savings could quickly be outweighed by the out-of-pocket costs the family will incur, notwithstanding the ACA-imposed limits on such costs.[128]

This example raises the inevitable tension in any health equity analysis—What is "good enough," and is it equitable that the new system will permit the wealthy to access more comprehensive coverage than lower-income individuals? And, does more comprehensive coverage equal better health? While the probable distinction in coverage levels among socioeconomic groups does have marginally negative health equity implications, there was never a politically feasible way in which to guarantee uniform coverage for persons of all socioeconomic groups—i.e., "Medicare for all."[129]

In all, the evidence thus far is that health equity will be greatly furthered by the access mechanisms in the ACA, but only in states that participate in the Medicaid expansion.[130] The CBO originally estimated that the Affordable Care Act will lead to an additional 32 million individuals obtaining health insurance, fully half of which will come via the Medicaid expansion.[131] In view of the Court's decision on the ACA, the CBO has revised its estimate to allow for the likelihood that at least some states will decline to participate in the Medicaid expansion—in the new report, the CBO estimates that 29 million (rather than 32 million) will gain coverage under the ACA.[132] Given the disparities in coverage

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127. U.S. DEP'T OF THE TREASURY, *supra* note 124.

128. The ACA also contains cost-sharing subsidies on the same sliding scale as that for premium subsidies, and the hypothetical family of four's limits on out-of-pocket costs would be roughly $6,000. *See* 42 U.S.C. § 36(B) (2011); *Focus on Health Reform: What the Actuarial Values in the Affordable Care Act Mean*, THE HENRY J. KAISER FAMILY FOUNDATION (Apr. 2011), *available at* http://www.kff.org/healthreform/upload/8177.pdf.

129. Even among Medicare beneficiaries there can be varying levels of coverage if wealthier individuals purchase supplemental coverage ("Medigap" insurance), and especially in regard to drug coverage, where lower-income individuals have been severely negatively impacted by the "donut hole" in coverage (scheduled to close by 2020 under the ACA). 42 U.S.C. § 1395w-114a; § 1395w-154 (2010).

130. *See* Letter from Douglas Elmendorf to Nancy Pelosi, *supra* note 114.

131. *Id.* at 9.

132. CONGRESSIONAL BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 3 (2012), *available at* http://cbo.gov/sites/default/files/cbofiles/attachment/43472-07-24-2012-

prior to its passage, the result would be an enormous improvement. However, the Medicaid expansion is in jeopardy in many states, and it now appears that there will almost certainly be a *worsening* in disparities in a number of states as middle-income individuals gain access to affordable insurance while the poorest are completely left out. That some state officials would not only countenance but actively seek this result (even in the face of reputable estimates that including the poor would save states money) is a strong argument in support of the necessity of the direct regulatory approach of the ACA via the mandate/tax (or a similarly coercive legal approach), in which discretion for states to create such a social justice disaster is removed.

For example, although a number of states are declining to establish exchanges, the ACA better protected middle-income individuals by including a provision for the federal government to create exchanges in states that fail to do so. Thus, for those individuals, their state government's resistance to the ACA will not materially impact their ability to access affordable insurance. In addition, the importance of the direct regulatory approach (i.e., using the mandate/tax to create a large and heterogeneous risk pool to combat adverse selection in the insurance market) to expanding access to insurance cannot be overstated, as the mandate/tax is demonstrably the *only* effective mechanism for materially increasing coverage short of a single-payer system. The status quo has failed to provide coverage for over 50 million individuals and, in many cases, has provided outrageously inadequate coverage.[133] HP 2020's lack of acknowledgment of the reality of the health care system is puzzling because even in an apolitical strategy there can be no meaning to establishing a target of 100% insurance coverage without a realistic means of achieving that goal.

ii. Access to Services: The Content of Benefits

Another point relevant to disparities reduction via the ACA is that access to coverage is only meaningful if the coverage includes necessary benefits. It would be extremely inequitable to require the purchase of insurance without assurance that the

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coverageestimates.pdf. The estimate concludes that 6 million fewer individuals will be eligible for Medicaid, but that 3 million of those will qualify for subsidies to purchase insurance via the exchanges, for a net reduction of 3 million insured.

133. Letter from Douglas Elmendorf to Nancy Pelosi, *supra* note 114, at 9 (stating that 55 million people are uninsured as of March 2010).

insurance would provide meaningful coverage. In examining the ACA's ability to ensure that the coverage is adequate, a starting point must be the essential health benefits package (EHB) mandated by the Affordable Care Act. Under the ACA, essentially all insurance plans must comply with a number of requirements, including the provision of specified preventive services with no cost-sharing and coverage (with or without cost-sharing) of certain essential benefits.[134] Coverage of preventive services without co-pays is critical to reducing access disparities because evidence has demonstrated that low-income individuals are more likely than higher income persons to forego essential preventive services when co-pays are required.[135] Importantly, ACA regulations requiring essentially all private plans already in existence to cover preventive services recommended by the U.S. Preventive Task Force have already come into effect,[136] which should be most beneficial to lower income individuals given their higher price-sensitivity in regard to health services.

The precise benefits in the EHB are subject to further clarification by regulation, but a report by the IOM conducted at the request of HHS, is revealing in its approach. The IOM explicitly seeks to balance cost and access, recommending that the EHB be adjusted so that the actuarial average for the benchmark "silver" plan in the exchanges will be equivalent to the actual premium that small employers would have paid in

134. ACA Section 1302(b) defines essential benefits as: "ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care." 42 U.S.C. § 18022 (2010) (subheadings omitted).

135. *See, e.g.*, Jonathan Gruber, *The Role of Consumer Co-Payments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond*, THE HENRY J. KAISER FAMILY FOUNDATION, 12, (Oct. 2006), http://www.kff.org/insurance/upload/7566.pdf (discussing the correlation between co-payments and decrease in health service utilization).

136. Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41276 (proposed July 19, 2010) (effective September 17, 2010). Medicare will also now cover the same preventive services without cost-sharing, along with an annual wellness visit and personalized prevention plan. 42 U.S.C. § 280 (2011). Beginning in 2013, states will receive financial incentives to offer preventive services under their Medicaid programs. 42 U.S.C. § 1396 (2011).

2014 for a typical plan.[137] While a cost-sensitive approach is both necessary and sensible, the particular IOM approach presents significant problems when viewed through a health equity lens. First, the tying of the EHB to the coverage decisions of small employers, whose incentives are markedly different from the (presumed) intentions of the government, is, arguably, illogical. As health care costs rise, as current projections indicate they will,[138] small employers (who generally lack the ability to self-insure, as most large employers choose to do)[139] will likely gravitate toward the lowest-cost plan options within the limits of the ACA. This phenomenon creates a race to the bottom in which cost is prioritized over care, with little thought or reference given to structuring EHB to maximize health outcomes. When cost is the reference point, benefits will necessarily be adjusted to meet cost concerns.

To clarify its views regarding the EHB package, HHS recently issued a bulletin describing its intended approach to the EHB, in which it largely adopted recommendations by the IOM. However, in the bulletin, HHS also announced its intention to permit states, rather than the federal government, to determine the precise composition of the EHB package within statutory guidelines, using as a reference point one of four types of plans, including "the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market."[140] While the health equity concerns in this approach are obvious (i.e., the strong possibility of varying coverage by state, thereby creating disparities in access), the statutory framework of the EHB within the ACA itself is intended to provide at least a minimum threshold for acceptable coverage. In addition, the proposal by HHS to give states greater flexibility could allow for experimentation by states in increasing access to cost-effective therapies—that is, if certain states mandate coverage of certain

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137. INST. OF MED., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COSTS (2011), *available at* http://www.iom.edu/Reporte/2011/essential-health-benefite-balancing-coverage-and-cost.aspx.

138. Letter from Douglas Elmendorf to Nancy Pelosi, *supra* note 114.

139. HILDA L. SOLIS, REPORT TO CONGRESS: ANNUAL REPORT ON SELF-INSURED GROUP HEALTH PLANS, U.S. DEP'T OF LABOR ii-iii (2011), *available at* http://www.dol.gov/ebsa/pdf/ACAReportToCongress032811.pdf.

140. CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN (2011), at 9, *available at* http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

services and can demonstrate the cost-effectiveness of doing so, there is potential for other states to follow suit. More likely, however, is that more conservative states (which tend to have higher rates of uninsured residents and worse health outcomes)[141] will require relatively fewer services to be covered within the EHB package, while more progressive states will require greater coverage, thereby worsening health disparities. Even worse, there will be a strong incentive for states to engage in a race to the bottom to lure businesses to states where there are relatively fewer regulatory requirements.

Certainly, cost containment is a critical element of any health system. Resources are finite, and it is illogical to allocate them in a way that fails to account for varying levels of effectiveness among preventive services and therapeutic treatments. However, the use of cost as the primary reference point—that is, the approach recommended by the IOM and largely adopted by HHS—is not the only viable course for balancing cost and access. For example, in Great Britain the NHS works within cost constraints by using a combined cost-effectiveness index including utilization of the "quality adjusted life years measurement" (QALY) to determine what benefits will be covered, thereby prioritizing effectiveness of treatment and maximizing health return on investment.[142] While the NHS system sparks cries of "rationing" and "death panels" in some quarters, it at least avoids the IOM recommendation for arbitrary pegging of the EHB to small employer coverage. Moreover, the British approach to essential benefits explicitly considers and promotes health equity among its entire population, considering it an obligation of the NHS to implement policies that will reduce disparities and thereby further health equity.[143]

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141. *See, e.g.*, Elizabeth Mendes, *Texas and Mass. Still at Health Coverage Extremes in the U.S.: Southern States Still See Highest Uninsured Rates in the Country*, GALLUP, Sept. 6, 2011, http://www.gallup.com/poll/149321/Texas-Mass-Health-Coverage-Extremes.aspx#2; THE COMMONWEALTH FUND, AIMING HIGHER: RESULTS FROM A STATE SCORECARD ON HEALTH SYSTEM PERFORMANCE, 2009 (2009), *available at* http://www.commonwealthfund.org/Publications/Fund-Reports/2009/Oct/2009-State-Scorecard.aspx#.

142. *See Measuring Effectiveness and Cost Effectiveness: The QALY*, NAT'L INST. FOR HEALTH AND CLINICAL EXCELLENCE, http://www.nice.org.uk/newsroom/features/measuringeffectivenessandcosteffectivenesstheqaly.jsp (last updated Apr. 20, 2010).

143. UNITED KINGDOM DEP'T OF HEALTH, EQUITY AND EXCELLENCE: LIBERATING THE NHS 3 (2010), *available at* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAn

Of course, the comparison between the U.S. and British systems is necessarily imprecise in light of certain key distinctions, including the fact that the poor in the U.S. are essentially "cordoned off" into their own plan (Medicaid), which creates different political realities in considering what the benefits package should be. Nonetheless, the British system is a strong example of a value-based system in which available benefits are distributed based on the "return on health" they deliver.

Notwithstanding its shortcomings, Does the EHB package in the ACA help or hurt health equity? As with the insurance mandate and the Medicaid expansion, it is markedly better than the status quo, and to that end, it furthers health equity. However, the monitoring components included in the ACA[144] will be critical to determining the precise impact on the reduction in disparities, particularly in regard to how coverage for certain diseases and ailments (e.g., diabetes) can disproportionately affect certain population subgroups. In that regard, the final definition of "medical necessity" within the ACA will have health equity implications. Moreover, as Gostin et al., have observed, disparities are the result of many factors unrelated to the provision of health care, and the Affordable Care Act—or any legislation based solely on expanding health insurance and traditional health services—cannot resolve them.[145] Indeed, Gostin observes that, "[a]side from increasing health care access and surveillance, [ACA] does little to fund or mandate decisive interventions to reduce health inequalities based on race, income, or other factors" and advocates further development of disparity reduction initiatives, both in the traditional health sector and in

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dGuidance/DH_11735. *See also* Patricia M. Pittman, *Beyond the Sound of One Hand Clapping: Experiences in Six Countries Using Health Equity Research in Policy*, 31 J. HEALTH POL. POL'Y & L. 33, 35 (2006) (describing British efforts to incorporate health equity in national health policy).

144. The ACA requires that population surveys collect and report data on race, ethnicity and primary language; it also mandates the collection and reporting of disparities data in Medicaid and CHIP, as well as the monitoring of health disparities trends in federally funded programs. 42 U.S.C. § 300(k)(k) (2011). *See also* Dennis P. Andrulis, *Patient Protection and Affordable Care Act of 2010: Advancing Health Equity for Racially and Ethnically Diverse Populations*, JOINT CTR. FOR POLITICAL AND ECON. STUDIES 3 (July 2010), *available at* http://www.jointcenter.org/hpi/sites/all/files/PatientProtection_PREP_0.pdf.

145. Lawrence O. Gostin, et al., *Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being*, 159 U. PA. L. REV. 1777, 1814 (2011).

addressing the broader socioeconomic and environmental determinants of health.[146]

Even with its shortcomings and the uncertainty regarding implementation following the Supreme Court's decision on its constitutionality, the passage of the ACA was a milestone in U.S. history. Moreover, in addition to furthering health equity, the ACA will likely change the discourse around the provision of health care on a permanent basis. Much as Medicare is popularly considered a right (or, an "entitlement") for U.S. seniors, so too might health insurance for all Americans now be viewed. And if that is the case, the "right to health"[147] could become significantly more relevant to U.S. domestic policy. In the area of Access, the Affordable Care Act—and in particular the coercive legal mechanisms of the individual mandate and regulation of insurance company conduct and policy content—is a critical legal component toward achieving the HP 2020 objectives, and, more broadly, toward achieving health equity.

In light of the critical importance of the ACA toward achieving the HP 2020 goal of achieving universal health insurance coverage, HP 2020's lack of endorsement for a realistic way of expanding access (namely, endorsement of the ACA) arguably represents a failure of its stated objective of incorporating health equity as an overarching goal. If the nation's "master blueprint for health" consists of nothing more than targets without acknowledgment of the distributive consequences of policy choices, it is unlikely that the policies with the strongest potential of reducing disparities within an overall population health framework will be implemented. This approach was tried in HP 2010 and no reduction in disparities was observed—the objective was to increase the proportion of persons with health insurance, but no guidance was offered on how to do so. Nothing happened. To render its recommendations meaningful for both population health improvement and disparities reduction, HP 2020 should do as it does in less politically controversial areas (tobacco reduction, for instance), and urge the adoption of specific legislation that would result in the desired increase in Access, particularly where a coercive legal

146. Gostin, *supra* note 145.

147. WHO AND OFFICE OF THE U.N. HIGH COMM'R FOR HUMAN RIGHTS, THE RIGHT TO HEALTH: FACT SHEET NO. 31, at 3, *available at* http://www.ohchr.org/Documents/Publications/Factsheet31.pdf.

approach is the only realistic means of achieving the Access targets.

2. ENVIRONMENTAL HEALTH

Environmental Health (EH) is an HP 2020 topic that has particular relevance to health equity and is well-suited to coercive legal interventions. In economic terms, environmental effects are an oft-cited example of "negative externalities"—that is, that pure free-market mechanisms do not properly allocate the costs and benefits of actions with an environmental impact. The classic example is a factory that dumps its waste into a river, shifting environmental and financial costs of its business activities onto the general population. Thus, in most instances, coercive regulatory interventions are required in order to achieve optimal environmental health outcomes, and HP 2020's failure to include such interventions within its EH objectives is a missed opportunity.

HP 2020 uses the WHO definition of environmental health: "all the physical, chemical, and biological factors external to a person, and all the related behaviors."[148] Environmental health involves "preventing or controlling disease, injury, and disability related to the interactions between people and their environment."[149] There are six key themes of the EH topic in HP 2020,[150] all of which are well-suited to coercive legal interventions. Indeed, existing legal mechanisms already address these topics to some degree,[151] which raises the issue of the adequacy of such mechanisms given that current environmental health levels are both inadequate overall and within population groups. There are significant disparities in environmental health among racial and ethnic groups, as well as among socioeconomic levels.[152] In addition, there is evidence that poor environmental

148. *Environmental Health*, HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=12 (last visited Oct. 31, 2012). *See, e.g.*, WHO, PREVENTING DISEASE THROUGH HEALTHY ENVIRONMENTS 4 (2006), *available at* http://www.who.int/quantifying_ehimpacts/publications/prevdisexecsume.pdf.

149. *Id.*

150. Outdoor air quality, surface and ground water quality, toxic substances and hazardous wastes, homes and communities, infrastructure and surveillance, and global environmental health. *Id.*

151. *See, e.g.*, Clean Air Act, 42 U.S.C. § 7401 *et seq.* (2011).

152. *See* Gilbert C. Gee and Devon C. Payne-Sturges, *Environmental Health Disparities: A Framework Integrating Psychosocial and Environmental Concepts*, 112

health is linked to poor health outcomes, particularly in children.[153] Thus, successful interventions seeking to reduce disparities in environmental health would have a strongly positive impact on health equity.

The HP 2020 outdoor air quality objective is an example that demonstrates that coercive legal mechanisms must be a key element of a successful environmental health strategy. First, in order to achieve the objective of fewer bad air quality days,[154] an obvious legal mechanism would be the imposition of more significant statutory penalties for large-scale carbon emitters. There is currently no "carbon tax" in the United States. It is here that the combination of market mechanisms and coercive regulatory authority in a "cap and trade" system might be quite useful. A proposal by the Center for American Progress[155] is illustrative: in essence, total emissions would be capped, but companies could buy and sell emissions permits (auctioned off by the government) among themselves, thereby maintaining some flexibility.

There are, however, two obvious health equity concerns in any such proposal: the risk that energy prices would increase, which would disproportionately affect lower-income individuals, and the risk that pollution would become more concentrated in relatively underprivileged regions of the country. The Center's proposal effectively addresses the first concern by advocating that nearly half of the proceeds of the permit auctions be allocated to help offset increased energy costs for low and middle income Americans, but it does not address the pollution concentration risk (perhaps on the theory that the enormous projected reduction in overall carbon emissions over the longer term would outweigh any concentration concerns).[156] A more detailed analysis of

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ENV'T HEALTH PERSP. 1645 (2004).

153. *See, e.g.*, Lawrence D. Rosen & Deirdre Imus, *Environmental Injustice: Children's Health Disparities And The Role Of The Environment*, 3 PEDIATRICS 524 (2007); Gee and Payne-Sturges, *supra* note 152.

154. *Environmental Health: Objectives*, HEALTHY PEOPLE 2020, at EH-1, http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=12 (last visited Oct. 3, 2012).

155. CAP AND TRADE 101: WHAT IS CAP AND TRADE AND HOW CAN WE IMPLEMENT IT SUCCESSFULLY?, CTR. FOR AM. PROGRESS (Jan. 16, 2008), http://www.americanprogress.org/issues/2008/01/capandtrade101.html.

156. *Id.* The Center's proposal calls for a reduction of carbon emissions to 80% below 1990 levels by the year 2050, but it does not provide details on how quickly that reduction would occur over the time frame, nor does it address whether

environmental regulations is beyond the scope of this paper; carbon emissions are an example of the way in which coercive legal mechanisms are vital to achievement of the HP 2020 environmental goals and to the furtherance of health equity, yet HP 2020 takes no position on achieving cleaner air beyond the enforcement of existing laws.

Other examples of the effectiveness of coercive legal mechanisms at achieving environmental health goals are numerous, but two deserve particular mention in light of their health equity implications. First, in regard to the EH objective of increasing the use of alternative modes of transportation for work, the experience of central London is instructive. Voluntary policies urging people to drive less and use public transportation to navigate Central London were unsuccessful. Thus, in 2003, the City of London implemented a "congestion charge" with the objective of decreasing car traffic and increasing use of public transportation.[157] The tax was successful in that the City has seen a 6% increase in bus traffic, and all funds raised (nearly $240 million) must be used to improve transport in London.[158] However, no data is available on the distribution of the increase in bus traffic across population groups, though one might reasonably infer that those individuals who are most price-sensitive (i.e., lower-income persons) would be the most likely to switch to public transportation following the imposition of the congestion charge. Thus, given that longer commute times (with negative quality of life and health effects) could result from the switch to public transportation, and given that the congestion charge would disproportionately affect lower-income individuals, the congestion charge may also be an example of an instance in which coercive legal mechanisms without adequate safeguards could worsen health equity. A better coercive legal mechanism,

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"pockets" of pollution would be prohibited. CAP AND TRADE 101: WHAT IS CAP AND TRADE AND HOW CAN WE IMPLEMENT IT SUCCESSFULLY?, CTR. FOR AM. PROGRESS (Jan. 16, 2008), http://www.americanprogress.org/issues/2008/01/capandtrade101.html.

157. TRANSPORT FOR LONDON, CENTRAL LONDON CONGESTION CHARGING: IMPACTS MONITORING, SIXTH ANNUAL REPORT 1 (July 2008), *available at* http://www.tfl.gov.uk/assets/downloads/sixth-annual-impacts-monitoring-report-2008-07.pdf. When instituted in 2003, the charge was £5 per day; however, in 2005 the charge was increased to £8 per day. *Id.*

158. *Congestion Charging: Benefits*, TRANSPORT FOR LONDON, http://www.tfl.gov.uk/roadusers/congestioncharging/6723.aspx (last visited Oct. 3, 2012).

though likely more difficult to administer, could be to have a sliding scale of charges based on income, to ensure that incentives were relatively similar across socioeconomic groups. Regardless, HP 2020's failure to recognize the varying distributive consequences of policies around alternative transportation calls into question how thoroughly the principles of health equity have permeated the formulation of its objectives.

Another example of an EH objective for which a coercive legal solution is essential to achieving health equity is EH-15, which seeks to increase the number of single family homes built with radon reducing features, particularly in high-radon-potential areas.[159] Principles of health equity require that persons with fewer resources not be subject to higher levels of environmental toxins like radon; however, free market mechanisms without a minimum level of regulation would almost certainly lead to an inequitable outcome. To advance an equitable environmental health framework, the use of the coercive legal mechanism of a building code requiring an adequate level of radon protection is required—indeed, twenty-five states already have either statewide or local building codes requiring a minimum level of radon protection.[160] HP 2020 sets a target of 100% of new single family home construction in high-radon-potential areas having radon reducing features (an increase from the current estimate of 28.6%), but the Project takes no position as to how that target could be achieved.[161] To truly advance health equity, the Project should acknowledge that the environmental health benefits of radon reducing features will only accrue to the entire population through the use of a broadly applicable coercive legal mechanism like a building code and advocate for passage of state or federal legislation reflecting that reality.

Environmental health is an HP 2020 goal whose achievement would significantly improve health equity, particularly because it is already vulnerable persons (who are disproportionately minority and/or of lower SES) who suffer most

159. *Environmental Health: Objectives,* HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=12 (last visited Oct. 3, 2012).

160. *Listing of States and Jurisdictions with RRNC Codes*, U.S. ENVTL. PROT. AGENCY, http://www.epa.gov/radon/rrnc/code_listing.html (last visited Oct. 3, 2012).

161. *Environmental Health: Objectives*, HEALTHY PEOPLE 2020, *supra* note 159.

from a lack of environmental health.[162] Moreover, evidence and analysis of voluntary or pure free market mechanisms strongly indicate that it is *only* through the use of coercive regulatory mechanisms that disparities in environmental health can realistically be improved. Thus, HP 2020 does not fully incorporate health equity in its EH objectives when it fails to acknowledge that legal mechanisms are in many instances the only realistic means of reducing disparities in environmental health.

3. HEART DISEASE AND STROKE

Heart Disease and Stroke (HDS) is only one example of the disease-specific HP 2020 goals,[163] but it is one where coercive legal mechanisms show strong promise for aiding the progress toward meeting the objectives because certain preventive aspects of HDS can be effectively addressed through regulatory measures. HDS is an enormous burden on the health of the U.S. population, and disparities are rampant. Heart disease is the leading cause of death in the U.S., and stroke is the third leading cause.[164] The estimated economic burden of HDS is $500 billion *annually*.[165] HDS is strongly associated with certain modifiable risk factors: high blood pressure, high cholesterol, cigarette smoking, diabetes, poor diet and physical inactivity, and overweight and obesity.[166] A critical point is the importance of early intervention—many of these factors build over time, doing lasting damage to a person's system that can only be partially undone by modifications later in life.[167] The necessity of early stage intervention also strengthens the case for coercive legal mechanisms because paternalism concerns are less significant in the context of protecting the interests of children, though in some instances perceived infringement on parental rights could be a

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162. *See supra* notes 152, 153; *see also* Nancy Adler & Katherine Newman, *Socioeconomic Disparities In Health: Pathways And Policies*, HEALTH AFFAIRS 60, 66 (Mar., 2002) (describing greater environmental health risks encountered by persons of lower socioeconomic status).

163. As noted above, others include Cancer, HIV, Blood Disorders, and Dementias. *See supra* note 95.

164. *Heart Disease and Stroke: Overview,* HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=21 (last visited Oct. 3, 2012).

165. *Id.*

166. *Id.*

167. *Id.*

political concern.[168]

HP 2020 observes that significant reduction in morbidity and mortality associated with heart disease could be achieved if "major improvements were made across the U.S. population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use."[169] The importance of HDS interventions is reflected in the IOM's selection of two HDS objectives (reduction of coronary heart disease deaths and reduction in the percentage of the population with hypertension) in its leading health indicators report.[170]

Disparities in HDS are significant and well-documented. The most recent CDC report on the prevalence of coronary heart disease (CHD) found that although overall prevalence of CHD declined from 6.7% in 2006 to 6.0% in 2010, significant disparities exist on the basis of race and ethnicity, gender, age, education, and state of residence.[171] For example, CHD prevalence was highest among American Indians/Alaska Natives (11.6%), followed by blacks (6.5%), Hispanics (6.1%), whites (5.8%), and Asians or Native Hawaiians/Other Pacific Islanders (3.9%).[172]

As noted above, certain modifiable risk factors are strong contributors to and predictors of HDS.[173] For that reason, HP 2020's HDS section sets objectives for improvements in many of those areas, including cholesterol. Cholesterol is an HDS objective where a coercive regulatory intervention would be especially effective. For example, artificial trans fat is a known contributor to HDS, as it both raises LDL and lowers HDL cholesterol. Trans fat (primarily contained in partially

168. *See, e.g.*, M. Gregg Bloche, *Obesity and the Struggle Within Ourselves*, 93 GEO. L.J. 1335 (2005) (arguing, *inter alia*, that the law can and should make a contribution in public health efforts to combat the obesity epidemic (obesity significantly increases the risk of heart disease and stroke), and that law's particular role should be as "an ally of our longer-term will against our immediate cravings"). *Id.* at 1338.

169. *Heart Disease and Stroke: Overview*, HEALTHY PEOPLE 2020, *supra* note 164 (internal citations omitted).

170. INST. OF MED., LEADING HEALTH INDICATORS, *supra* note 18, at 4.

171. Jing Fang et. al, *Prevalence of Coronary Heart Disease – United States 2006-2010*, 60 MORBIDITY AND MORTALITY WKLY REP. 40 (Oct. 14, 2011), *available at* http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf.

172. *Id.*

173. *Heart Disease and Stroke: Overview*, HEALTHY PEOPLE 2020, *supra* note 164 (internal citations omitted).

hydrogenated oils) is a uniquely harmful man-made substance that is used to lower costs and extend the shelf-life of processed foods.[174] A study published in the New England Journal of Medicine found that trans fat is demonstrably harmful even in amounts as small as two grams per day:

> On a per-calorie basis, trans fats appear to increase the risk of CHD more than any other macronutrient, conferring a substantially increased risk at low levels of consumption (1 to 3 percent of total energy intake). In a meta-analysis of four prospective cohort studies involving nearly 140,000 subjects, including updated analyses from the two largest studies, a 2 percent increase in energy intake from trans fatty acids was associated with a 23 percent increase in the incidence of CHD.[175]

Some progressive jurisdictions such as New York City have banned the use of artificial trans fat in restaurants and prepared foods on health grounds, and the estimated health benefits are significant, including projected elimination of 500 annual deaths in New York attributed to trans fat.[176] Thus, in light of the improvement in HDS that could result from elimination of the consumption of trans fat (by some estimates as many as 228,000 heart attacks per year are caused by trans fat),[177] an effective implementation mechanism is imperative.

Currently, the FDA requires the "Nutrition Facts" panel of packaged foods to display trans fat content, though there are no limits on the amount of trans fat that a particular food can contain.[178] The food industry has taken steps to limit the amount of trans fat in both fast food and in packaged food,[179] and the ACA

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174. *See* Mozaffarian, *infra* note 175. Although some animal products contain (small) amounts of naturally occurring trans fat, the trans fat found in processed foods such as baked goods is created through industrial manufacturing techniques applied to create "partially hydrogenated" oils, which, as Mozaffarian et al. describe, are demonstrably harmful to cardiovascular health even in small amounts. *Id.*

175. Dariush Mozaffarian et al., *Trans Fatty Acids and Cardiovascular Disease,* 354 NEW ENG. J. MED. 1601 (2006).

176. *See infra* note 182; *see also* Michael Mason, *A Dangerous Fat and Its Risky Alternatives,* N.Y. TIMES, Oct. 10, 2006, http://www.nytimes.com/2006/10/10/health/nutrition/10cons.html (quoting Harvard researcher Dr. Walter Willett for the proposition that New York City's trans fat ban would save 500 lives per year).

177. Mason, *supra* note 176.

178. Nutrition Labeling of Food, 21 C.F.R. § 101.9 (2006).

179. *See, e.g.,* CTR. FOR SCIENCE IN THE PUB. INTEREST, TRANS FAT,

will require many chain restaurants and operators of vending machines to post nutritional content,[180] but it is here that the limits of these essentially voluntary and/or informational policy measures become clear, raising health equity concerns. Although trends in removal or reduction of trans fat in packaged foods are encouraging,[181] there is simply no way to know whether restaurants not subject to menu labeling requirements are reducing or eliminating their use of trans fat unless restaurants choose to disclose that information. It is generally accepted in public health policy that wealthier and more educated consumers may demand such information and have the resources to patronize only establishments that meet their demands, whereas consumers with fewer resources may have less ability to discern whether trans fat is being used and few alternatives in the event that it is. Moreover, where voluntary initiatives were attempted they resulted in essentially no impact on the rates of trans fat consumption because restaurants made no changes to their practices in the absence of regulation.[182]

Here the particular benefits of a coercive legal mechanism, such as a trans fat ban, become apparent, especially because evidence shows that trans fat bans do not lead to increased prices for food or increased costs for restaurants.[183] A ban on the use of artificial trans fat is the only feasible mechanism to "level the playing field" between socioeconomic groups in regard to trans fat consumption. Unfortunately from a disparities perspective, a review of jurisdictions that have enacted bans on the use of trans fat reveals that it is largely left-leaning, healthier states that have done so,[184] which may lead to even greater disparities

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http://cspinet.org/transfat/index.html (discussing recent developments in trans-fat reduction efforts) (last visited Oct. 3, 2012).

180. ACA § 4205 (to be codified at 21 U.S.C. § 343(q)(5)(H)). Note that the ACA also allows restaurants and vending machine operators not explicitly subject to the new labeling requirements to "opt in" to the new menu labeling regime to the exclusion of local regulations to the extent they exist, thereby effectively eliminating the ability of states to establish more stringent labeling requirements. The new requirements also explicitly preempt state and local labeling requirements for restaurant and vending machine operators to whom they apply. *Id.*

181. Mozaffarian et al., *supra* note 175, at 2037-39 (finding, *inter alia*, in a survey of 83 reformulated restaurant and packaged foods, that the reformulated foods contained less trans fat and less saturated fat than the prior version of the food).

182. *See, e.g.*, Sonia Y. Angell et al., *Cholesterol Control Beyond the Clinic: New York City's Trans Fat Restriction*, 151 ANNALS INTERNAL MED. no. 2, 132 (2009).

183. *Id.*

184. The list of jurisdictions with trans fat bans includes, among others: New York

between those states and (generally more conservative) states with the highest prevalence of heart disease. An FDA ban on the use of trans fat would be a highly cost-effective way to improve population heart health and health equity,[185] particularly because vulnerable populations would benefit from the intervention to a greater degree than advantaged groups. Thus, HP 2020's lack of advocacy for a specific, demonstrably effective coercive legal mechanism such as a trans fat ban in order to further its cholesterol reduction target represents another missed opportunity to fully incorporate the principles of health equity.

Another example of the essential nature of coercive legal mechanisms in improving HDS while furthering health equity is in the area of tobacco control. The U.S. Surgeon General Report on the consequences of involuntary exposure to tobacco smoke[186] observes that there is no safe level of exposure to secondhand smoke and that even short exposures to secondhand smoke can increase HDS risk.[187] Thus, in light of the significant risks associated with secondhand smoke, the importance of health equity in any proposed solution is clear. Here, the coercive legal mechanism of a ban on smoking in public spaces is an example of a particularly successful intervention, for a few reasons: first, by virtue of being broadly applicable, the ban protects the entire

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City, Cambridge, MA, King County, WA, Brookline, MA, Montgomery Country, MD, Philadelphia, PA, and the State of California. *See Trans Fat*, CTR. FOR SCIENCE IN THE PUB. INTEREST, http://www.cspinet.org/transfat/index.html (last visited Oct. 31, 2012).

185. Such a ban has been advocated by public health groups, though the issue has fallen out of vogue recently in light of improvements in packaged food and the passage in a number of populous and influential jurisdictions of legislation banning the use of trans fat in restaurants. *See* CTR. FOR SCIENCE IN THE PUB. INTEREST, *supra* note 184. Indeed, that the issue is no longer politically potent itself reflects a lack of health equity: there seems to be a direct correlation between privileged populations being protected from trans fat and the decline in advocacy for the less privileged on the same point.

186. U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE HEALTH CONSEQUENCES OF INVOLUNTARY EXPOSURE TO TOBACCO SMOKE: A REPORT OF THE SURGEON GENERAL (2006).

187. *Id.* at 65; *see* U.S. DEP'T OF HEALTH AND HUMAN SERVS., SURGEON GENERAL'S REPORTS, THE HEALTH CONSEQUENCES OF INVOLUNTARY EXPOSURE TO TOBACCO SMOKE: A REPORT OF THE SURGEON GENERAL, 6 MAJOR CONCLUSIONS OF THE SURGEON GENERAL REPORT (2006), *available at* http://www.surgeongeneral.gov/library/secondhandsmoke/factsheets/factsheet6.html (observing that the smoke causes blood platelets to become stickier, damages the lining of blood vessels, decreases coronary flow velocity reserves, and reduces heart rate variability, potentially increasing the risk of a heart attack).

population, not just those with the most resources to demand smoke-free spaces; second, by applying to all work spaces, it protects many individuals (e.g., service industry workers in bars and restaurants) who would otherwise lack bargaining power to secure a smoke-free workspace; and third, in the case of New York City, which has extended its ban to outdoor public spaces such as parks and beaches, the ban guarantees smoke-free outdoor space to all socioeconomic groups, not just those who can afford private homes with yards. The positive health effects of smoking bans have been demonstrated by evidence showing a reduction in hospital admissions for chest pain and heart attacks in jurisdictions where bans have been implemented.[188]

Interestingly, perhaps because tobacco control laws are more politically palatable than some of the legal mechanisms discussed above, HP 2020 does explicitly advocate for an increase in tobacco control laws, including smoking bans in public spaces.[189] While some advocacy for effective legal mechanisms is better than none, the Project arguably does health equity a disservice by advocating only for those legal mechanisms that are either already in place (as in the case of enforcement of existing environmental laws) or are not politically divisive (as for tobacco control). True advancement of health equity requires an impartial assessment of the distributive consequences of policy options and advocacy for effective coercive legal mechanisms, even where political feasibility of immediate implementation is doubtful.

4. NUTRITION AND WEIGHT STATUS

Perhaps no issue in public health is as hotly debated as what HP 2020 terms "Nutrition and Weight Status" (NWS), which encompasses both adequate nutrition and the obesity epidemic.[190]

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188. *See, e.g.*, Patricia M. Herman & Michele E. Walsh, *Hospital Admissions for Acute Myocardial Infarction, Angina, Stroke, and Asthma After Implementation of Arizona's Comprehensive Statewide Smoking Ban*, 101 AM. J. PUB. HEALTH 491 (2011) (finding statistically significant reduction in hospitalizations due to, *inter alia*, chest pain and heart attack following implementation of statewide smoking ban); Stanton A. Glantz, *Meta-Analysis of the Effects of Smokefree Laws on Acute Myocardial Infarction: An Update*, 47 PREVENTIVE MED. 452-53 (2008) (finding mean 19% reduction in hospital admissions for heart attack associated with enactment of smoke free laws).

189. *Tobacco Use: Objectives*, HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=41 (last visited Oct. 3, 2012).

190. *Nutrition and Weight Status: Overview*, HEALTHY PEOPLE 2020,

Disparities in NWS, particularly with regard to obesity rates, are stark, both among racial and ethnic groups and among socioeconomic groups. Current data indicate dramatically different obesity prevalence across ethnic groups, ranging from 49.5% for non-Hispanic blacks, who have the highest age-adjusted rates of obesity, 39.1% for Hispanics, and 34.3% for non-Hispanic whites.[191] Regional, gender, and socioeconomic disparities exist as well.[192] As with heart disease, there are some coercive legal interventions that could positively affect both population health and health equity, but HP 2020 does not suggest them. Interestingly, HP 2020 does advocate for a very few legal mechanisms to improve NWS, but only in regard to children, and only as affects food offerings at schools.[193] While advocacy of politically realistic options is laudable, clear opportunities exist for further promotion of effective legal mechanisms.

For purposes of this paper, a threshold question is the appropriateness and effectiveness of government intervention in the food market in pursuit of dietary changes (with the ultimate goal of improving NWS), whether through regulations mandating content of food, taxation on certain disfavored foods, or outright bans on the sale of certain foods. Much has been written on the

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http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=29 (last visited Oct. 3, 2012).

191. *Overweight and Obesity: Adult Obesity Objectives*, CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/obesity/data/adult.html (last visited Oct. 3, 2012); *see also* CTRS. FOR DISEASE CONTROL AND PREVENTION, MORBIDITY AND MORTALITY WKLY REP., DIFFERENCES IN PREVALENCE OF OBESITY AMONG BLACK, WHITE, AND HISPANIC ADULTS – UNITED STATES, 2006-2008 (2009), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5827a2.htm; Cynthia L. Ogden et al., *Obesity and Socioeconomic Status in Adults: United States, 2005-2008*, NAT'L CTR. FOR DATA STATISTICS BRIEF no. 50 (Dec. 2010), *available at* http://www.cdc.gov/nchs/data/databriefs/db50.pdf (documenting existence of racial/ethnic disparities prior to the most recent data).

192. Ogden, *supra* note 191 (regional and gender); *see also* Jennifer L. Black & James Macinko, *Neighborhoods and Obesity*, 66 NUTRITION REVS. 2 (2008) (providing the correlation between obesity and neighborhood income level); Virginia W. Chang & Diane .S. Lauderdale, *Income Disparities in Body Mass Index and Obesity in the United States, 1971–2002*, 165 ARCH. INTERNAL MED. 2122 (2005) (discussing the correlation between individual income and BMI/obesity).

193. *Nutrition and Weight Status: Objectives*, HEALTHY PEOPLE 2020, at NWS-1, NWS-2, http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=29 (advocating primarily for regulations setting nutrition standards for food served at schools, including reducing the sale of calorically sweetened beverages, and for mandating fruit and vegetable offerings when other foods are offered).

tension between paternalism and public health, and on the effectiveness of government intervention in general on NWS, particularly in regard to the obesity epidemic.[194] For example, Gostin observes that law at every level of government directly and indirectly affects the risk factors for overweight and obesity, although the "concerted use of legal-based strategies as an integral component of obesity prevention and control efforts is nascent."[195] This paper does not attempt to prescribe a particular approach for improving NWS as a whole, or for combating obesity. However, evidence supports the effectiveness of certain coercive legal mechanisms in improving NWS, and HP 2020's lack of advocacy for those mechanisms to achieve a number of its NWS objectives is a missed opportunity.

Among its many NWS objectives, HP 2020 sets target reductions for intake of sodium, saturated fats, solid fats, and added sugars.[196] The importance of these indicators was affirmed by the IOM, which selected reduction of the consumption of solid fats and added sugars as a critical indicator of population health.[197] The Project supplies no suggestions for how the reductions should be achieved, but there are certain coercive regulatory mechanisms that can be utilized in achieving those goals without worsening disparities or compromising health equity (as a purely voluntary initiative might). For example, Denmark has recently implemented a tax on products containing saturated fat above a specified percentage, and other European countries have implemented or considered similar initiatives.[198] In the U.S., various proposals have been made in recent years for significant taxes on calorically sweetened beverages, though none

194. *Compare* M. Gregg Bloche, *Obesity and the Struggle Within Ourselves*, 93 GEO. L.J. 1335, 1337 (2005), *with* Richard Epstein, *What (Not) To Do About Obesity: A Moderate Aristotelian Answer*, 93 GEO. L.J. 1361, 1364 (2005) (arguing that "the strong background presumption *against* government intervention has not been overcome" with regard to obesity).

195. Lawrence O. Gostin, et al., *Assessing Laws and Legal Authorities for Obesity Prevention and Control,* 37 J.L. MED. & ETHICS 28, 29 (2009).

196. *Nutrition and Weight Status: Objectives,* HEALTHY PEOPLE 2020, *supra* note 193, at NWS-17-19.

197. INST. OF MED., LEADING HEALTH INDICATORS, *supra* note 18, at 4-5.

198. *Denmark Introduces World's First Food Fat Tax*, BBC NEWS EUROPE, Oct. 1, 2011, http://www.bbc.co.uk/news/world-europe-15137948. *See* Alberto Alemanno & Ignacio Carreno, *Fat Taxes in the European Union between Fiscal Austerity and the Fight Against Obesity,* 4 EUR. J. RISK REG. (forthcoming 2011), *available at* http://ssrn.com/abstract=1945804 (discussing "fat taxes" in the European Union).

have been enacted.[199] Although it is too soon to measure the impact of the Danish tax, evidence and economic theory both suggest that the tax will have its intended effect of reducing saturated fat consumption.[200] Indeed, WHO has recognized that taxation can be an effective mechanism to influence consumer choice on food consumption.[201] Moreover, the same factors that lead to the reduction in saturated fat consumption also contribute to the likelihood that greater reductions will be seen among lower income persons than higher income individuals—thus, by narrowing disparities in saturated fat consumption, the tax would further health equity within a framework of overall population health improvement.

While promising, taxation of unhealthy foods does have problems from a health equity standpoint because food taxes are inherently regressive. Thus, many policy analysts suggest that revenues from taxation of unhealthy foods be used to support other health-promoting measures such as fruit and vegetable subsidies and/or broader changes to agricultural policy.[202] Regardless of the possible shortcomings of taxation, principles of health equity require that any policy initiative designed to achieve NWS targets in regard to solid fats, sugars, and sodium be designed to, at minimum, not worsen disparities in consumption of harmful additives and, to the extent possible, reduce such disparities. In the absence of any evidence that

199. *See Existing Soft Drink Taxes*, CTR. FOR SCIENCE IN THE PUB. INTEREST (July 2011), http://cspinet.org/liquidcandy/existingtaxes.html.

200. *See* Guy E. Faulkner et al., *Economic Instruments for Obesity Prevention: Results of a Scoping Review and Modified Delphi Survey*, 8 INT. J. BEHAV. NUTRITION PHYSICAL ACTIVITY 109 (2011), *available at* http://www.ijbnpa.org/content/8/1/109.

201. WHO, PREVENTING CHRONIC DISEASES: A VITAL INVESTMENT (2005), *available at* http://www.who.int/chp/chronic_disease_ report/full_report.pdf. *See also* WHO, GLOBAL STRATEGY ON DIET, PHYSICAL ACTIVITY AND HEALTH (2004) *available at* http://www.who.int/dietphysicalactivity/strategy/eb11344/strategy_english_web.pdf; WHO, 2008-2013 ACTION PLAN FOR THE GLOBAL STRATEGY FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 8, 13, 41 (2008) (each discussing the importance of tax measures in incentivizing healthier consumer choices in regard to food).

202. WHO, 2008-2013 ACTION PLAN, *supra* note 201; *see also* Kelly D. Brownell and Michael. F. Jacobson, *Small Taxes on Soft Drinks and Snack Foods to Promote Health*, 90 AM. J. PUB. HEALTH 854 (2000). In addition, in any food tax discussion, self-labeled consumer freedom advocates raise concerns about government infringement on personal liberties. *See, e.g.*, AMERICANS AGAINST FOOD TAXES, http://nofoodtaxes.com/ (arguing against imposition of taxes on unhealthy foods).

voluntary mechanisms will achieve its NWS objective for solid fats, sugars, and sodium, particularly without worsening disparities, HP 2020 should take the opportunity to advocate for additional taxation of foods not meeting nutritional targets.

In addition to taxation, coercive regulatory mechanisms should be incorporated as part of a successful NWS strategy. For example, in regard to sodium reduction, the status quo is unsatisfactory—the only policies in place are early-stage voluntary initiatives. One such initiative, the National Salt Reduction Initiative (NSRI), is a coalition of local and state health authorities and health organizations collaborating with food producers and restaurants to seek a 20% reduction in U.S. salt intake over five years.[203] The coalition projects that the effort, if successful, will save "tens of thousands of lives each year and billions of dollars in health care costs."[204] However, there is no evidence that the project has had any success to date.

Moreover, and aside from the lack of evidence that voluntary initiatives such as the NSRI can be successful (at least without the threat of regulation if targets are not achieved), health equity concerns exist in the particular design of the NSRI. Among the participating restaurants and food producers, it is unclear which of their food products will be targeted. For packaged foods, the 20% reduction target is not uniform across food categories, which creates the potential for worsening disparities if foods preferred by certain population groups are targeted for reduction in greater degree than those preferred by others, or if foods that are unaffordable to lower income persons are targeted for more significant reductions than less expensive foods.[205] Again, the distinction between improving overall population health and reducing disparities becomes apparent, though it is worth noting that the current voluntary approach is not out of line with prevailing international efforts.[206] However, from a health equity

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203. *See National Salt Reduciton Initiative, Goals and Summary,* NYC.GOV, http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-salt-factsheet.pdf (last visited Oct 3, 2012).

204. *Id.*

205. *National Salt Reduction Initiative Packaged Food Categories and Targets,* NYC.GOV, http://www.nyc.gov/html/doh/downloads/pdf/cardio/cardio-salt-nsri-packaged.pdf (last visited Nov. 1, 2012). For example, canned meat and sausages are targeted for only a 15% reduction in sodium, whereas frozen or refrigerated meat substitutes (e.g., veggie burgers, tofu steaks) target nearly a 26% reduction. *Id.* at 2.

206. Initiatives in other countries, among them the United Kingdom and Finland,

standpoint, a regulatory approach shows more promise in achieving sodium reduction targets because a regulatory initiative could preserve some manufacturer flexibility while still ensuring either that all categories of food are equally targeted for sodium reduction or, at a minimum, that manufacturers do not use demographic data to target reductions primarily for foods that appeal more to already healthier populations.[207]

Comparing regulation of food content versus taxation of unhealthy foods, the regulatory approach is likely to further health equity to a higher degree. This is because the regulatory approach would, in theory, benefit all population groups to a more equal degree, and indeed, those groups that consume more packaged foods—typically groups with lower health status—would benefit to a greater degree than already healthier persons. However, either approach is probably superior to a purely voluntary approach, which, for the reasons discussed above, presents significant health equity concerns. Although the political problems with advocating a regulatory approach in this context are obvious, a meaningful discussion of the feasibility of achieving HP 2020's NWS targets must involve a discussion of the effectiveness of various legal interventions and, particularly, their impact on health equity. Indeed, it is because HP 2020 explicitly incorporates health equity as one of its four overarching goals that it is obligated to prefer those policy options that would most further health equity, and the failure to do so, both in NWS and throughout, diminishes the likelihood that HP 2020 will have a meaningful impact on disparities reduction and health equity.

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primarily rely upon voluntary efforts with agreed upon targets, though the UK initiative does contemplate mandatory standards if the voluntary standards do not meet expectations, and Finland does mandate the labeling of high-salt foods. In addition, the WHO position on sodium reduction explicitly recognizes that a voluntary approach may have advantages of flexibility and speed of implementation. WHO, REDUCING SALT INTAKE IN POPULATIONS: REPORT OF A WHO FORUM AND TECHNICAL MEETING 5-7 (2007), *available at* http://www.who.int/dietphysicalactivity/Salt_Report_VC_april07.pdf; P. Pietinen et al., *Labelling the Salt Content in Foods: A Useful Tool in Reducing Sodium Intake in Finland,* 11 PUB. HEALTH NUTRITION 335 (2007).

207. Of course, industry will often raise the concern that prices will increase if various regulations are enacted. *See, e.g.*, HEALTH CANADA, SODIUM REDUCTION STRATEGY FOR CANADA (2010), *available* at http://www.hc-sc.gc.ca/fn-an/alt_formats/pdf/nutrition/sodium/strateg/reduct-strat-eng.pdf. This itself presents health equity concerns.

PART IV

HP 2020 includes for the first time an explicit focus on the social determinants of health as one of the Project's four overarching goals and as a distinct topic with its own objectives. As the precise objectives for the social determinants of health have not yet been determined, suggestions for incorporation of specific coercive legal mechanisms in the objectives may be useful to fulfilling the broader goal of achieving health equity, given the extensive overlap between the social determinants of health and health disparities.

HP 2020's broad goal regarding the social determinants of health is to "identify ways to create social and physical environments that promote good health for all" across diverse sectors, including education, childcare, housing, business, law, media, community planning, transportation, and agriculture.[208] As many scholars have observed, no amount of health care can provide population health in the absence of measures to remedy disparities in the social determinants of health.[209] Examples of non-health specific factors that influence health include "safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins."[210]

Two interrelated approaches show particular promise in incorporating a broader focus on the social determinants of health in law and policymaking: a "health in all polices" (HiAP) paradigm and the use of health impact assessments to guide policy decisions. Under an HiAP approach, all sectors of society consider the health implications of their policy decisions, including benefits, harms, and health-related costs.[211] Kickbusch and Buckett explain HiAP as involving "public service agencies

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208. *Social Determinants of Health*, HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39 (last visited Oct. 3, 2012).

209. *See, e.g.*, Gostin, et al., *supra* note 145; Erika Blacksher, *Health Reform and Health Equity: Sharing Responsibility for Health in the United States*, 39 HOFSTRA L. REV. 41 (2011) (arguing that "[h]ealth reform that makes health equity a goal demands a bolder agenda" than merely addressing health care; the approach must also address the social determinants of health).

210. *Social Determinants of Health: Overview*, HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39 (last visited Nov. 1, 2012).

211. *See, e.g.*, INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 3-5.

working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues."[212] However, as the IOM LPH Report observes, HiAP, taken to its logical conclusion, must include stakeholders in addition to government, particularly in the private sector, whose actions have a significant effect on health and on health equity.[213] HP 2020 refers briefly to an HiAP approach as an "emerging strategy" to address the social determinants of health, but does not elaborate.[214] Encouragingly, however, the ACA created a National Prevention, Health Promotion, and Public Health Council, comprised of seventeen heads of federal executive departments, agencies, and offices and charged with developing a national prevention strategy in which all government sectors work together to improve population health.[215]

Use of HiAP as a framework for policy decisions could dramatically improve health equity by addressing the social determinants of health. For example, zoning restrictions for fast food restaurants would be considered not just in view of their environmental and commercial impact, but also in regard to health effects and how those effects are distributed across population groups. However, the relative coerciveness of an HiAP strategy could significantly impact its ultimate effect on disparities reduction. The IOM offers a view of the various ways in which an HiAP approach could operate, with one end of the spectrum being that HiAP should be seen as, at minimum, a "manifestation of the precautionary principle: first, do no harm to health through policies or laws enacted in other sectors of government."[216] However, this approach speaks to population health, not to relative effect on disparities. Nonetheless, HiAP could also be used to require maximization of positive effects of

212. ILONA KICKBUSCH AND KEVIN BUCKETT, GOV'T OF S. AUSTL., DEP'T OF HEALTH, IMPLEMENTING HEALTH IN ALL POLICIES: ADELAIDE 12 (2010), *available at* http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf.

213. INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 3-14.

214. *Social Determinants of Health: Overview*, HEALTHY PEOPLE 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39 (last visited Oct. 3, 2012).

215. NAT'L PREVENTION, HEALTH PROMOTION, AND PUB. HEALTH COUNCIL, 2011 ANNUAL STATUS REPORT 1 (June 30, 2011), *available at* http://www.healthcare.gov/prevention/nphpphc/2011-annual-status-report-nphpphc.pdf.

216. INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 86.

non-health policies, and, even more directly, to address the social determinants of health by crafting relevant non-health policy with the goal of improving population health outcomes and health equity.[217] The challenge will be in the details, particularly the degree to which various agencies and private interests are required to assess health effects of their projects, and to what extent projects will be required to be modified in view of projected health effects.

Projecting and measuring health effects, particularly those of legal interventions both before and after implementation, present difficulties. However, in that regard, "health impact assessments" (HIAs) are a promising starting point. The Health Impact Project defines an HIA as:

> [A] systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program or project on the health of a population and the distribution of those effects within the population.[218]

In addition, an HIA "provides recommendations on monitoring and managing those effects."[219] Of course, as the IOM observes, conducting an HIA would require time and resources, and not every policy or intervention will require a full-scale HIA prior to implementation.[220] Thus, to the extent HIAs are required by law, the law will have to set a minimum impact threshold of some sort in order to avoid inflicting needless administrative burdens. However, notwithstanding the procedural difficulties, HP 2020's final objectives for the social determinants of health should include a recommendation for HIAs in appropriate circumstances.

A similar but slightly different proposal for quantifying health effects of both health and non-health policies is the use of a "health disparities index" (HDI) to measure over time how various policies impact disparities. The idea is somewhat analogous to the Gini coefficient and other statistical tools

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217. INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 86.

218. *Resources for Policy Makers,* HEALTH IMPACT PROJECT, http://www.healthimpactproject.org/policy-makers (citing NAT'L RESEARCH COUNCIL, IMPROVING HEALTH IN THE UNITED STATES: THE ROLE OF HEALTH IMPACT ASSESSMENT (2011), *available at* http://www.nap.edu/catalog.php?record_id=13229)).

219. *Id.*

220. INST. OF MED., FOR THE PUBLIC'S HEALTH, *supra* note 80, at 87-90.

developed as a means of measuring the relative level of income inequality within societies.[221] The HDI authors (Webb et al.) recently conducted a quantitative analysis with three goals:

> (1) to establish an index depicting variations in U.S. racial health disparities;
>
> (2) to evaluate the association between this health disparities index (HDI) and known social determinants of health; and
>
> (3) to use statistical correlations to help guide minority health legislative interventions at the state and federal levels.[222]

The authors examined racial and ethnic disparities in each state in six priority areas: cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, immunizations, and infant mortality, and evaluated raw disparities in mortality rates across the six categories in consideration with certain known social determinants of health—income and social status, education and literacy, health services, culture, and social environments.[223] The authors then ranked the states with sufficient data (thirty-two of fifty), finding that certain states had much lower HDI values than others.[224] Moreover, and perhaps unsurprisingly given what is known about the social determinants of health, the authors found the HDI was positively correlated to racial disparities in median household income, state black population, and Medicaid eligibility scores.[225] Particularly interesting in light of current health care debates, the authors found a negative correlation between HDI scores and state health spending, demonstrating that more spending on health without

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221. *See* C. GINI, VARIABILITÀ E MUTABILITÀ (Variability and Mutability), *reprinted in* MEMORIE DI METODOLOGICA STATISTICA (E. Pizetti & T. Salvemini, eds. 1955) (1912); *see also* BARR, *supra* note 4, at 87-88 (discussing uses of Gini coefficient to demonstrate correlation between health status and income inequality, as well as discussing other SES inequality measures, including "Robin Hood index," the decile ratio, the income ratio, and the poverty income ratio).

222. Bryant Cameron Webb et al., *From Politics to Parity: Using a Health Disparities Index to Guide Legislative Efforts for Health Equity*, 101 AM. J. PUB. HEALTH 554 (2011).

223. *Id.*

224. *Id.* States with the lowest (best) HDI scores were Massachusetts (0.35), Oklahoma (0.35), Washington (0.39), Nevada (0.53), and Kentucky (0.57), and those with the highest were California (1.17), North Carolina (1.20), Michigan (1.22), Wisconsin (1.32), and Illinois (1.50). A score of 1.0 represents the national average.

225. *Id.*

strategic efforts to address disparities will not result in better health or a narrowing of disparities.[226]

The authors consider that the HDI can and should be used as a mechanism to measure state progress in reducing health disparities among racial and ethnic groups.[227] Moreover, the statistical methods employed would allow for the expansion of this methodology to consider health disparities among other classifications, including gender, income, educational status, etc., which would enable precise targeting of policies and laws toward addressing the social determinants of health.

Governments can use tools like the HDI to create legal mechanisms that will assist the effort to reduce health disparities—for example, by creating financial incentives for states and private sector entities to reduce disparities that are drivers of health inequity. In addition, more precise measurements and comparisons among the states regarding health disparities can enable governments to more directly target those variables that seem to be driving the disparities. For example, knowing that Medicaid eligibility positively correlates with racial health disparities would allow governments to make targeted changes to eligibility requirements (and barriers to enrollment) and measure the correlation between those changes and changes in the HDI. Similarly, the lack of correlation between health care spending and HDI rebuts what is already known but often not internalized—that good health is driven only in relatively small part by health care spending and, importantly, that more spending does not necessarily correlate with better health outcomes.

The use of a HiAP approach, including the use of HIAs and the HDI, would be a powerful legal mechanism for furthering the broad disparities reduction and social determinants of health goals of HP 2020. Mandatory use of these tools in certain circumstances is consistent with the principles of health equity, which demands the use of coercive legal mechanisms in instances where voluntary efforts would worsen disparities. Although HP 2020 has not yet specifically urged the adoption of requirements for use of HIAs and/or the HDI, it has the opportunity to do so as

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226. Bryant Cameron Webb et al., *From Politics to Parity: Using a Health Disparities Index to Guide Legislative Efforts for Health Equity*, 101 AM. J. PUB. HEALTH 554 (2011).

227. *Id.*

it issues its specific objectives regarding the social determinants of health. Much as HP 2020 advocates for legislation in areas of children's access to unhealthy foods at school and in tobacco control, both of which would further health equity, so too should it be advocating for coercive legal mechanisms in other areas where disparities are significant and legal mechanisms are likely to be effective.

V. CONCLUSION

Healthy People 2020 is an ambitious project with broad goals, including the elimination of health disparities and the achievement of health equity. However, HP 2020 fails to fully incorporate the principles of health equity because it generally does not acknowledge the distributive consequences of policy options on the most critical health issues facing the country today, including universal insurance coverage, taxes on unhealthy foods, or regulation of carbon emissions. In many instances, there are clear and predictable distributive effects on disparities when comparing coercive legal mechanisms such as regulation and taxation with voluntary initiatives such as educational campaigns or industry-led efforts. To better serve its self-stated, overarching goal of achieving health equity, the nation's "master blueprint for health"[228] should advocate for the mechanisms—which may often be coercive in nature—that are most likely to achieve the desired population health objective while also reducing disparities. That HP 2020 does so in the case of less controversial mechanisms such as school nutrition, helmet laws, and tobacco control demonstrates that HP 2020 is not entirely apolitical. By taking a position as to the desirability and effectiveness of certain coercive legal measures, HP 2020 (and by implication HHS) has inserted itself into the policy debate, as indeed it should—Who better than HHS to opine on the effectiveness of policy options? Having shown that it is willing to advocate for some coercive legal mechanisms, HHS and HP 2020 should more fully incorporate the principles of health equity by advocating for even those politically controversial but demonstrably effective coercive legal mechanisms that could help reduce health disparities on today's most pressing health concerns. As demonstrated herein, law is an essential tool for reduction of health disparities, and in many instances, coercive legal mechanisms are the *only* effective means of addressing

228. *See* Beadle, *supra* note 5.

disparities. HP 2020 serves an invaluable purpose in setting evidence-based objectives for improving health, but to truly advocate for health equity, HP 2020 must also acknowledge and advocate for those evidence-based coercive legal interventions that will contribute to reductions in disparities. In so doing, HP 2020 will move the U.S. further down the path toward elimination of health disparities and full realization of health equity.