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Health Disparities and the Law: Wrongs in Search of a Right

Mary Anne Bobinski[†]

Healthy People 2010 provides our Nation with the wide range of public health opportunities that exist in the first decade of the 21st century. With 467 objectives in 28 focus areas, Healthy People 2010 will be a tremendously valuable asset Healthy People 2010 reflects the very best in public health planning—it is comprehensive, it was created by a broad coalition of experts from many sectors, it has been designed to measure progress over time, and, most important, it clearly lays out a series of objectives to bring better health to all people in this country.¹

The current responses to the traditional health perils . . . have been weakened. At the same time, it seems to this outsider as though the entire public health establishment is united around the proposition that massive public action should be taken to deal with the new “epidemics,” such as obesity and diabetes But the use of the term “epidemic” is just the *wrong* way to think about this issue. There are no noncommunicable epidemics Yet the designation [of] obesity as a public health epidemic is designed to signal that state coercion is appropriate²

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¹ Donna E. Shalala, *Message from the Secretary* in 1 U.S. DEP’T OF HEALTH & HUMAN SERV. (HHS), HEALTHY PEOPLE 2010 (2000) [hereinafter HEALTHY PEOPLE 2010], available at <http://www.health.gov/healthypeople>. For clarity, this Article will cite to “Healthy People 2010,” the volume number and, where necessary, the focus area number and page number (e.g., 1 Healthy People 2010, 9-8 to 9-12).

² RICHARD A. EPSTEIN, IN DEFENSE OF THE “OLD” PUBLIC HEALTH: THE LEGAL FRAMEWORK FOR THE REGULATION OF PUBLIC HEALTH *35-36 (John M. Olin Program in Law & Econ., Univ. of Chi. Law Sch., Working Paper No. 170, 2d Series, 2002), available at <http://www.law.uchicago.edu/Lawecon/index.html>.

I. INTRODUCTION

Are there disparities in health? The answer seems obvious on a personal scale—we each know people who are healthier and sicker than we are. Yet these differences in health status are not distributed entirely randomly throughout society. A number of categorical factors—gender, class, age, ethnicity/race, to name a few—are associated with differences in health status.³ The federal government and the Institute of Medicine (IOM) are among the prestigious groups to agree that disparities in health status are real and that at least some types of health disparities require action by various groups in society.⁴

What is the proper role of law in addressing health disparities? To the optimistic drafters of the federal government's massive Healthy People 2010 project, law is one of a range of "interventions" that might be used to "increase the quality and years of health life" and to "eliminate health disparities."⁵ To the skeptics, health disparities are the product of many social and economic forces, only some of which can and should be the focus of direct legal intervention.⁶ Further expansion of the domain of public health might undermine and weaken governmental focus on core public health functions.⁷

This Article will explore the promise and limits of law in addressing disparities in health. Part II explores the research detailing disparities in treatment, outcomes and health status associated with gender, ethnicity/race and socioeconomic status. Part II also explores the determinants of health: which factors actually influence health status? Part II concludes that socioeconomic and behavioral factors appear to have a large impact on health status.

In Part III, this Article evaluates the proper scope of public health interventions to reduce disparities in health status. The approach taken in the federal government's Healthy People 2010 document will serve as a guide to reviewing the utility and appropriateness of legal interventions to reduce disparities in health. Most health law scholars have focused on the problem of access to healthcare. Yet, access to care accounts for a relatively small percentage of a person's health status. Health law scholars have given less attention to whether law can and should be used to address some of the socioeconomic and behavioral determinants of health status. Part III considers the utility of law in addressing determinants of health status in two general areas derived from the Healthy People 2010 framework: "behavioral" health risks and socioeconomic status. The use of the legal system to affect behavioral

³ See *infra* Part II.A. Tracking disparities in health associated with race and ethnicity can be problematic. Some fear that these differences will be ascribed to genetics rather than other factors, despite substantial evidence that concepts like "race" and "ethnicity" are socially constructed rather than genetically-based. See, e.g., Sandra Soo-Jin Lee et al., *The Meanings of "Race" in the New Genomics: Implications for Health Disparities Research*, 1 YALE J. HEALTH POL'Y L. & ETHICS 33 (2001); Lundy Braun, *Race, Ethnicity, and Health: Can Genetics Explain Disparities?*, 45 PERSPECTIVES BIOLOGY & MED. 159 (2002) (expressing concern about misperceptions about biological basis of race); Richard S. Cooper et al., *Race and Genomics*, 348 NEW ENGLAND J. MED. 1166 (2003) (questioning whether race is a useful category in medical research or practice).

⁴ See, e.g., INST. OF MED. (IOM), UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 1-27 (Brian D. Smedley et al. eds., 2002) [*hereinafter* UNEQUAL TREATMENT]; 1 HEALTHY PEOPLE 2010, *supra* note 1, at 11 (the second major goal of the project is to "eliminate health disparities among segments of the population").

⁵ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 4, 8, 11, 8-9.

⁶ See, e.g., EPSTEIN, *supra* note 2; Mark A. Rothstein, *Rethinking the Meaning of Public Health*, 30 J.L. MED. & ETHICS 144 (2002).

⁷ See generally Rothstein, *supra* note 6.

health risks such as those involving tobacco, HIV and obesity can be controversial. Part III ends with consideration of the risks and benefits of what would be the most radical use of law to affect one of the major determinants of health status: socioeconomics.

Part IV concludes that there are great risks to retaining a narrow definition of public health and public health interventions. Among other things, a narrow conception of public health will make it more difficult for society to address serious problems that have a major impact on health status. Part IV concludes that there is little public or governmental support for a more expansive conception of public health. Interventions into behavioral risk factors for poor health status often are stymied by the competing paradigm of personal responsibility. Socioeconomic factors are even less likely to be considered the proper domain of regulation. Health status disparities thus are likely to remain a wrong in search of a right.

II. DISPARITIES IN HEALTH STATUS

A. HEALTH DISPARITIES

Researchers have explored three major types of related disparities in health. The first type of disparity involves differences in the type and intensity of treatments offered to patients. Socioeconomic factors clearly can have an impact on access to care as an initial matter, as well as on the treatment ultimately offered and accepted by a patient.⁸ Yet, disparities in treatment go beyond socioeconomics.⁹ Many studies find race-based differences in medical treatment. African-Americans in particular are less likely to receive medically appropriate care than whites, even

⁸ For a detailed effort to parse apart socioeconomic factors from other factors which might explain disparate treatment, see Marian E. Gornick et al., *Understanding Disparities in the Use of Medicare Services*, 1 YALE J. HEALTH POL'Y L. & ETHICS 133 (2001) (analyzing data to demonstrate that regardless of socioeconomic status or race, individuals who used one preventive service were more likely to choose another preventive service and that individuals who quit smoking are more likely to use preventive services); see also Keven Fiscella et al., *Disparities in Health Care by Race, Ethnicity, and Language Among the Insured: Findings from a National Sample*, 40 MED. CARE 52 (2002) (finding association between lack of English fluency of Hispanic enrollees and lower levels of healthcare).

⁹ In some circumstances it may be difficult to separate socioeconomics from other factors such as racism or patient choice. See, e.g., Daniel L. Howard et al., *Distribution of African-Americans in Residential Care/Assisted Living and Nursing Homes; More Evidence of Racial Disparity?*, 92 AM. J. PUB. HEALTH 1272 (2002) (finding a high degree of racial segregation in long term care and noting the difficulty of determining cause). Researchers agree that more data is needed to better understand the complex relationships at work. See, e.g., UNEQUAL TREATMENT, *supra* note 4, at 215-244 (discussing collection of additional, standardized data and need for additional research); Arlene S. Bierman et al., *Addressing Racial and Ethnic Barriers to Effective Care: The Need for Better Data*, 21 HEALTH AFFAIRS 91 (2002).

when controlling for socioeconomic status and access to care.¹⁰ Some studies also appear to demonstrate gender-related disparities in treatment.¹¹

The second set of research studies focuses on differences in health outcomes for particular conditions.¹² Studies which include both outcome and treatment are important because they can be used to demonstrate that differential treatment produces poorer health outcomes in some groups.¹³ In one study of cardiac care and five-year mortality rates, for example, African-Americans were less likely to receive appropriate treatment and were eighteen percent more likely to die than whites.¹⁴ Other studies demonstrate that African-American women are less likely to receive appropriate treatment for breast cancer and are more likely to die from the disease.¹⁵ Children who are black or poor are more likely to experience morbidity associated with asthma.¹⁶ Not all disparities in outcome are evidence of wrongdoing, some reflect other factors, such as biology.¹⁷

The third set of research projects focuses on disparities in health status, such as differences in life expectancy and rates of particular diseases. Health status is

¹⁰ For a summary of the studies on racial and ethnic disparities, see UNEQUAL TREATMENT, *supra* note 4, at 29-30, 38-79, 285-383 (analyzing and summarizing over 100 studies). The Institute of Medicine study found particularly "convincing evidence" of disparate treatment in cardiovascular care. *Id.* at 5; see also Eric C. Schneider et al., *Racial Disparities in the Quality of Care for Enrollees in Medicare Managed Care*, 287 JAMA 1288 (2002) (noting that when blacks and whites are enrolled in same type of healthcare plan, blacks are less likely than whites to receive various forms of screening and care).

¹¹ Studies on gender-based health disparities are analyzed in Mary Anne Bobinski & Phyllis Griffin Epps, *Women, Poverty, Access to Care, and the Perils of Symbolic Reform*, 5 J. GENDER, RACE & JUSTICE 233 (2002).

¹² See, e.g., Isaac J. Powell et al., *Disease-Free Survival Difference Between African-Americans and Whites After Radical Prostatectomy for Local Prostate Cancer: A Multivariable Analysis*, 59 UROLOGY 907 (2002) (noting that death rate for African-American men with prostate cancer is twice the rate for white men; racial disparity in progression-free is survival not explained by a number of non-racial factors); Vickie L. Shavers & Martin L. Brown, *Racial and Ethnic Disparities in the Receipt of Cancer Treatment*, 94 J. NAT'L CANCER INST. 334 (2002) (summarizing data on differential cancer treatment and outcomes for racial/ethnic minorities).

¹³ Although the point may seem obvious, this research is important because many medical conditions can be treated using a range of options. Suppose that a research study demonstrates that members of an ethnic or racial group are likely to receive less aggressive treatment than members of another group. It may be difficult to conclude that the group treated less aggressively has been injured—aggressive medical care may be more risky without providing any offsetting benefits. Combination studies therefore add important evidence about the impact of differential treatment on outcomes.

¹⁴ UNEQUAL TREATMENT, *supra* note 4, at 316-319 (summarizing study); see also Eric D. Peterson et al., *Racial Variation in the Use of Coronary-Revascularization Procedures: Are the Differences Real? Do They Matter?*, 336 NEW ENG. J. MED. 480 (1997).

¹⁵ See, e.g., Sue A. Joselyn, *Racial Differences in Treatment and Survival from Early-Stage Breast Carcinoma*, 95 CANCER 1759 (2002). Note that some racial disparities in survival rates persist even when African-American women are given appropriate treatment. *Id.*

¹⁶ Lara J. Akinbami et al., *Racial and Income Disparities in Childhood Asthma in the United States*, 2 AMBUL. PEDIATRICS 382 (2002) (noting that there were no differences in the prevalence of asthma between these groups).

¹⁷ Women fare worse after experiencing a heart attack than men, but the result seems likely to be the product of biology rather than bias. See Nicholas H. Fieback et al., *Differences Between Women and Men in Survival After Myocardial Infarction*, 263 JAMA 1092 (1990) (attributing higher death rates for women to non-gender, biological factors); D.A. Alter et al., *Biology or Bias: Practice Patterns and Long-Term Outcomes for Men and Women with Acute Myocardial Infarction*, 39 J. AM. COLL. CARDIOLOGY 1909 (2002) (finding older women received less intensive cardiac care than similarly-aged men, but that women's differential survival rate from cardiac events actually improved in older age groups).

strongly related to gender: “men have a life expectancy that is 6 years less than that of women and have higher death rates for each of the 10 leading causes of death.”¹⁸ There are also very strong racial and ethnic disparities in health status which are not explained by genetic or biological variation.¹⁹ These racial and ethnic disparities are reflected in the life expectancy data. A black child born in 2000 has a life expectancy of 71.7 years compared to a life expectancy of 77.4 for a white child.²⁰ The disparities become even greater when disaggregated by gender: black male babies have a life expectancy of 68.2, compared to a life expectancy of 74.8 for white boys, 74.9 for black girls and 80.0 for white girls.²¹

As one might expect, given these significant disparities in life expectancy, there are also important disparities in the prevalence of particular diseases and in the rate of death from different conditions. The reduced life expectancy for African-Americans compared to whites is the result of the greater prevalence of some “early taker” diseases,²² as well as higher rates of mortality for shared conditions.²³ Indeed, death rates for various conditions are significantly higher for African-Americans,²⁴ Hispanics²⁵ and American Indian/Alaska Natives.²⁶ While Asian-Americans typically have lower death rates than whites, there are pockets of greater risk.²⁷ Hispanics are more likely to suffer from high blood pressure, obesity and diabetes than non-Hispanic whites.²⁸ Another example of a dramatic disparity involves kidney disease: “African, Hispanic, and Native Americans have the highest risks of end-stage renal disease,” and African-Americans have the worst outcomes.²⁹

¹⁸ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 11. Gender-based disparities will not be the focus of this Article. For more information on gender disparities in healthcare and the utility of legal interventions, see generally Bobinski & Epps, *supra* note 11.

¹⁹ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 12 (“These disparities are believed to be the result of the complex interactions among genetic variations, environmental factors, and specific health behaviors.”); *see also supra* note 10.

²⁰ NAT’L CTR. FOR HEALTH STATS., HEALTH, UNITED STATES, 2002, CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS Table 28, *available at* <http://www.cdc.gov/nchs/products/pubs/pubd/hus/02tables.htm> (last visited Mar. 11, 2003).

²¹ *Id.*

²² *See, e.g., id.* at Tables 20-25 (neonatal mortality rates analyzed by race and ethnicity of the child and mother) and Table 43 (death rates for HIV/AIDS).

²³ *Id.* at Table 30 (comparing death rates for various conditions based on gender and race). The leading causes of death vary by race and gender as well. *Id.* at Table 32.

²⁴ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 12 (compared to whites, African-Americans have a forty percent higher rate of death from heart disease, thirty percent higher death rate from all cancers, 200 percent higher death rate from prostate cancer, 700 percent higher death rate from HIV/AIDS, and 600 percent higher rate of death by homicide). Infant mortality rates are twice as high for African-American babies than for white babies. V. Haynatzka et al., *Racial and Ethnic Disparities in Infant Mortality Rates—60 Largest U.S. Cities, 1995-1998*, 51 MORBIDITY & MORTALITY WEEKLY REP. 329, 331 (2002); NAT’L CTR. FOR HEALTH STATS., *supra* note 20, at Table 30 (death rates for various conditions disaggregated by gender and race/ethnicity), Table 39 (cancer death rates), Table 41 (breast cancer death rates), Table 46 (homicide death rates) and Table 38 (death rates for cerebrovascular disease showing higher death rates for African-Americans of both genders).

²⁵ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 12. The diabetes-related death rate is twice as high for Hispanics than for non-Hispanic whites. *Id.*

²⁶ *Id.* The infant death rate for American Indians and Alaska Natives is almost twice that of whites. *Id.*

²⁷ *Id.* (noting higher rates of cervical cancer for Vietnamese women).

²⁸ *Id.* In comparison to non-Hispanic whites, Hispanics are more likely to suffer from tuberculosis, high blood pressure and obesity. *Id.*

²⁹ Chike M. Nzerue et al., *Race and Kidney Disease: Role of Social and Environmental Factors*, 94 J. NAT’L MED. ASSOC. 28S (Supp. 2002).

The data detailing disparities in health status are stark and very troubling. This would be the case even if they did not run the fault lines of what we already know to be persistent patterns of discrimination and disadvantage in society. That disparities in health status mirror patterns of historical discrimination in society is at least cause for alarm, and perhaps for action as well. But first, policy-makers must understand the causes of healthiness or unhealthiness in society.

B. DETERMINANTS OF HEALTH

What causes one population to be healthier than another? Public health officials and medical researchers have generated a considerable body of literature on the “determinants of health.”³⁰ The reflexive answer is that health is determined by access to healthcare—populations which have access to healthcare should therefore be healthier than those without. This answer turns out to be only partially true because health status depends only in part on access to healthcare.³¹ One estimate is that access to care accounts only for about ten percent of the health status of populations.³²

Other factors have a much greater impact on health status. According to the U.S. Department of Health and Human Services (HHS), “individual behaviors and environmental factors are responsible for about 70 percent of all premature deaths in the United States.”³³ Another related estimate is that health behaviors may account for fifty percent of health status, with environment accounting for twenty percent, and genetics another twenty percent.³⁴ The importance of these and other factors is underscored in the Department’s pictorial representation of the determinants of health, found at Figure 1 *infra*. Race and ethnicity are not specific independent variables; rather, Figure 1 suggests that disparities in health status may be created by a confluence of factors which themselves are correlated with membership in racial or ethnic groups. “Policies and Interventions,” to use the terminology of Figure 1, can have an impact on factors such as the physical environment, the social environment, behavior and access to care, and may in turn improve the health status of individuals and groups within a society.

³⁰ See, e.g., IOM, *IMPROVING HEALTH IN THE COMMUNITY: A ROLE FOR PERFORMANCE MONITORING* 40-58 (Jane S. Burch et al. eds., 1997) (summarizing research) [hereinafter *IMPROVING HEALTH IN THE COMMUNITY*]. Researchers tend to look beyond biomedical determinants of health and to include a wide range of environmental and social factors. See, e.g., *SOCIAL DETERMINANTS OF HEALTH* (M.G. Marmot & Richard G. Wilkinson eds., 1999) (focusing on social and economic determinants of health); *SOCIAL EPIDEMIOLOGY* (Lisa F. Berkman & Ichiro Kawachi eds., 2000) (summarizing field); *WHY ARE SOME PEOPLE HEALTHY AND OTHERS NOT?: THE DETERMINANTS OF HEALTH OF POPULATIONS* (Robert G. Evans et al. eds., 1994); *HANDBOOK OF MEDICAL SOCIOLOGY* (Chloe Bird et al. eds., 2000).

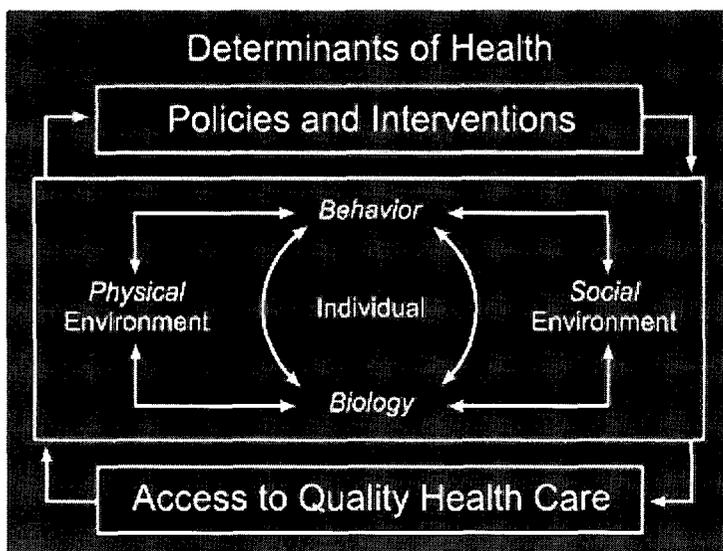
³¹ “Of the 30-year increase in life expectancy achieved . . . [in the 1900s], only 5 years can be attributed to health care services.” *IMPROVING HEALTH IN THE COMMUNITY*, *supra* note 30, at 43; see also M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 *YALE J. HEALTH POL’Y L. & ETHICS* 95, 97 (2001). *But see* Gornick et al., *supra* note 8, at 154:

The findings from this study raise questions about the views held by some that health care plays only a minor role in explaining disparities in health outcomes. The Medicare experience indicates an association between measures of mortality, morbidity, and disability, and patterns of the use of preventive and health promotion services.

³² *INST. FOR THE FUTURE, HEALTH AND HEALTH CARE 2010: THE FORECAST, THE CHALLENGE* 23 (2000).

³³ 1 *HEALTHY PEOPLE 2010*, *supra* note 1, at 18.

³⁴ *INST. FOR THE FUTURE*, *supra* note 32, at 23 (Figure 2-9). The last ten percent is affected by access to care. See *id.*

FIGURE 1: DETERMINANTS OF HEALTH.³⁵

The federal Healthy People 2010 project's goals, focus areas and objectives were established within the framework of this understanding of the determinants of health. Although it was not the first effort to centralize planning to improve the health of Americans,³⁶ the Healthy People 2010 project raised the stakes by seeking the elimination of healthcare disparities and by expanding the number of focus areas or priorities to be monitored at the federal level.³⁷ The two key objectives of

³⁵ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 18 fig. 7. For other models of the determinants of health, see IMPROVING HEALTH IN THE COMMUNITY, *supra* note 30, at 47-53; Margaret Whitehead et al., *Developing the Policy Response to Inequities in Health: A Global Perspective*, in CHALLENGING INEQUITIES IN HEALTH: FROM ETHICS TO ACTION 314 (Figure 1) (Timothy Evans et al. eds., 2001).

³⁶ The effort began in 1979 with the publication of a report by the Surgeon General. See OFFICE OF THE SURGEON GENERAL, HEALTHY PEOPLE: THE SURGEON GENERAL'S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION (1979), accessible at <http://sgreports.nlm.nih.gov/NN/ListByDate.html>. The next round of planning culminated in the 1990 publication of HEALTHY PEOPLE 2000. For reviews of the progress (or lack of progress) toward the Healthy People 2000 objectives, see CTRS. FOR DISEASE CONTROL & PREVENTION (CDC), at <http://www.cdc.gov>. According to the CDC:

At the end of the decade, the most recent data indicate that 68 objectives (21 percent) met the year 2000 targets and an additional 129 (41 percent) showed movement toward the targets. Data for 35 objectives (11 percent) showed mixed results and 7 (2 percent) showed no change from the baseline. Only 47 objectives (15 percent) showed movement away from the targets. The status of 32 objectives (10 percent) could not be assessed.

CDC, HIGHLIGHTS OF THE HEALTHY PEOPLE 2000 FINAL REVIEW (2001) [hereinafter HIGHLIGHTS], available at <http://www.cdc.gov/nchs/data/hp2000/hp2k01.pdf>.

³⁷ HEALTHY PEOPLE 2010 reduced the number of national goals from three to two (by trimming the goal of "achieving access to preventive services for all Americans") and moved from the goal of "reducing" healthcare disparities (in the 2000 goals) to "eliminating" disparities (in the 2010 version). See generally HIGHLIGHTS, *supra* note 36. The number of focus areas increased from twenty-two to twenty-eight. Some focus areas were dropped (e.g., clinical preventive services), others were separated out from previous objectives (e.g., chronic kidney disease is now its own focus area), others were merged (e.g., injury and violence prevention) and some were added (e.g., access to quality

Healthy People 2010—lengthening quality life years and eliminating disparities—are to be achieved by monitoring 467 objectives in twenty-eight focus areas.³⁸ Leaving aside whether this level of detail is an admirable effort to harness an unbelievably complex system, or a quixotic effort to achieve the unachievable,³⁹ the document reinforces the conclusion that access to healthcare is only one of a large number of important areas of concern.⁴⁰ A significant number of the focus areas are related to environmental or behavioral determinants of health.⁴¹ A majority of the “leading health indicators,” used to measure progress toward the project’s objectives, relate to environmental, behavioral and socioeconomic determinants of health.⁴² The indicators are: physical activity; overweight and obesity; tobacco use; substance abuse; responsible sexual behavior; mental health; injury and violence; environmental quality; immunization; and access to healthcare.⁴³

III. THE ROLE OF LAW IN REDUCING HEALTH STATUS DISPARITIES

What should the role of law be in reducing health disparities? Healthy People 2010 makes only occasional reference to the role of law in its discussion of goals, focus areas, leading indicators and objectives.⁴⁴ Laws and regulations lurk in the background of discussions on topics such as access to care,⁴⁵ environmental health,⁴⁶ educational and community-based programs,⁴⁷ and tobacco control.⁴⁸ The document nonetheless recognizes that achieving gains in the length and quality of life will require participation by many groups:

Healthy People 2010 seeks to increase life expectancy and quality of life over the next ten years by helping individuals gain the knowledge, motivation, and opportunities that they need to make informed decisions about their health. At the same time, Healthy People 2010 encourages local and state leaders to develop communitywide and statewide efforts that promote healthy behaviors, create healthy

health services). *Id.* The end result is that the federal government has pledged to focus attention on a wider range of even more complex health issues.

³⁸ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 8, 11, 17. The project seeks to eliminate disparities resulting from a broad range of factors. *See id.* at 11 (stating that “[t]he second goal of Healthy People 2010 is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation”).

³⁹ The document notes “[a] major challenge throughout the history of Healthy People has been to balance a comprehensive set of health objectives with a smaller set of health priorities.” *Id.* at 25.

⁴⁰ Access to healthcare is the first focus area listed out of a total of twenty-eight areas. *Id.* at 17.

⁴¹ Many of the focus areas relate to more than one determinant of health. *See id.* at 17-18. Determinants of health include biology, behaviors, social and physical environment, and policies and interventions. *Id.* at 17.

⁴² *Id.* at 24. The report notes: “[t]he Leading Health Indicators illuminate individual behaviors, physical and social environmental factors, and important health system issues that greatly affect the health of individuals and communities. Underlying each of these indicators is the significant influence of income and education.” *Id.*

⁴³ *Id.* at 24. For a detailed discussion of the leading health indicators, see *id.* at 24-45.

⁴⁴ A rough word search of the first section of Healthy People 2010 yielded only eight examples of objectives suggesting a specific role for law or regulation. *See id.*

⁴⁵ *See, e.g., id.* at 1-4, 1-5, 1-15.

⁴⁶ *See, e.g., id.* at 8-9.

⁴⁷ *See, e.g., id.* at 7-4.

⁴⁸ *See, e.g., id.* at 27-28.

environments and increase access to high-quality health care. Because individual and community health are virtually inseparable, both the individual and the community need to do their parts⁴⁹

The document also calls on a range of actors to assist in the goal of eliminating health disparities:

Healthy People 2010 recognizes that communities, States, and national organizations will need to take a multidisciplinary approach to achieving health equity—an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment, as well as data collection itself.⁵⁰

State and community leader might enact either budgetary or regulatory legislation to achieve these goals. What is—and what should be—the role of law in extending life or in eliminating health disparities?

A. THE ACCESS DILEMMA

It is fair to say that most health law scholars have sought to affect health by improving access to care, either through budgetary initiatives or regulatory adjustments.⁵¹ Despite the difficulties of applying “rights” based discourse to the problems posed by healthcare disparities,⁵² a number of creative scholars have sought to bend traditional law doctrines to the service of the elimination of healthcare disparities. Professor Gregg Bloche argues that racial disparities in the delivery of healthcare are particularly hard to address because in most situations physicians exercise clinical discretion.⁵³ Bloche explores the relatively weak legal constraints imposed under tort, Medicaid, the Emergency Medical Treatment and Active Labor Act (EMTALA) and Title VI of the Civil Rights Act of 1964.⁵⁴ Professor Bloche offers several recommendations for change, but these by and large focus on changes in medical practice rather than law. In addition, Bloche proposes tying government financial support of healthcare to adherence to standards of

⁴⁹ *Id.* at 10.

⁵⁰ *Id.* at 16. “[T]he greatest opportunities for reducing health disparities are in empowering individuals” *Id.*; see also David Satcher, *Our Commitment to Eliminate Racial and Ethnic Health Disparities*, 1 YALE J. HEALTH POL’Y L. & ETHICS 1, 2 (2001) (Dr. Satcher, a former Surgeon General of the United States, was a key figure in the HEALTH PEOPLE 2010 Initiative’s emphasis on eliminating health disparities).

⁵¹ Although the point probably is too obvious to require a supporting footnote, a quick LexisNexis search of the “lawrev/allrev” database for access to healthcare articles published after 2000 yielded 22 titles (using search date (aft 2000) and title (access and health and care)). During the same time period, there were four articles published with titles focusing on health disparities (using search date (aft 2000) and title (health and dispar!)). The Lexis/Nexis search was conducted on Jan. 20, 2003.

⁵² See, e.g., Dean M. Hashimoto, *The Proposed Patients’ Bill of Rights: The Case of the Missing Equal Protection Clause*, 1 YALE J. HEALTH POL’Y L. & ETHICS 77, 88 (2001).

⁵³ Bloche, *supra* note 31, at 99-106.

⁵⁴ Bloche, *supra* note 31, at 108-12. Professor Bloche argues that tort law fails to protect patients from racially disparate treatment decisions because there often is more than one accepted standard of care and because it is difficult for plaintiffs to prove that alterations in care caused harm in individual cases. *Id.* at 108-112. Medicaid reimburses providers at such low rates that “it would be surprising if practice within Medicaid-oriented systems were not less technologically-intensive than mainstream care.” *Id.* at 110. EMTALA guarantees only the level of screening ordinarily available in an emergency room, not the level of care that might be medically appropriate. *Id.* at 110-11. Finally, HHS enforces civil rights claims against institutional providers accepting Medicare—but not individual physicians—and has not been vigorous. *Id.* at 111-12.

practice which protect patients' access to care, strengthen the physician-patient relationship and reduce the segregation of the poor into under-funded public plans.⁵⁵

Professor Barbara Noah explores potential legal remedies for disparate care under Title VI, Equal Protection and other statutory claims.⁵⁶ She suggests that there are substantial barriers to the use of traditional legal theories.⁵⁷ Noah then articulates a number of extra-legal, prospective approaches to limiting disparities in healthcare, such as improvements in medical education.⁵⁸ Similarly, Professor Dean Hashimoto argues that the emphasis on the possible passage of a federal "Patients Bill of Rights" will do little to assist the poor, who primarily are covered by public insurance plans.⁵⁹ Hashimoto argues that the concept of "equal protection" should be used to extend similar protections to the poor.⁶⁰

Politicians of every persuasion also tend to focus on access to care issues, either favoring or opposing plans to expand Medicaid or CHIP, or to add prescription drug coverage to Medicare.⁶¹ Improving access to healthcare is undeniably important in its own right and may even help to reduce some healthcare disparities.⁶² But, if access to healthcare accounts for only ten percent of the health status of populations,⁶³ then focusing the law on access cannot address the major determinants of health status. Can law have an even more powerful role in affecting the determinants of health?

B. ECONOMIC AND BEHAVIORAL DETERMINANTS OF HEALTH

Two major determinants of health involve behavior and socioeconomics. Fifty percent of health status is related to behavior, making this factor the most powerful single determinant of health status.⁶⁴ The impact of behavior can be seen in the life expectancy and mortality data reviewed in Part II of this Article. Tobacco use alone is responsible for "more than 430,000 deaths per year among adults in the United States, representing more than 5 million years of potential life lost."⁶⁵ Other health-related behaviors include alcohol/substance abuse, improper nutrition and risky sexual behavior.⁶⁶

⁵⁵ *Id.* at 117-20. Bloche argues, for example, that cost containment policies should be explicit and public to ensure that they are subject to scrutiny and are not applied selectively. *Id.* at 117-18. He suggests changes in physician financial incentives (to the extent permitted under the federal ERISA statute). *Id.* at 118.

⁵⁶ Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998); see also Rene Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79 (2001) (analyzing and suggesting informational requirements to bolster Title VI analysis).

⁵⁷ Noah, *supra* note 56, at 156-58.

⁵⁸ *Id.* at 170-77.

⁵⁹ Hashimoto, *supra* note 52, at 89.

⁶⁰ *Id.* at 88-90.

⁶¹ See, e.g., President's Health Care Agenda, available at <http://www.whitehouse.gov/infocus/healthcare> (last visited Mar. 10, 2003).

⁶² See, e.g., Lisa A. Cooper et al., *Designing and Evaluating Interventions to Eliminate Racial and Ethnic Disparities in Health Care*, 17 J. GEN. INTERNAL MED. 477 (2002) (noting and modifying the IOM's "access" approach to reducing healthcare disparities).

⁶³ See INST. FOR THE FUTURE, *supra* note 32.

⁶⁴ See *supra* text accompanying note 34.

⁶⁵ 2 HEALTHY PEOPLE 2010, *supra* note 1, at 27-3.

⁶⁶ See *infra* Part III.C.

The perhaps unexpected influence of socioeconomic factors can be seen when comparing the data on life expectancy in the United States with that found in other countries. It is well established, for example, that the United States lags behind other countries in the length and quality of life. The life expectancy for women in the United States is lower than it is in eighteen other countries; in life expectancy for men, the United States ranks twenty-fifth.⁶⁷

The explanation, according to HHS, is that “[i]nequalities in income and education underlie many health disparities.”⁶⁸ Socioeconomic status, as measured either by income or level of education, is strongly correlated with health status. As noted in *Healthy People 2010*:

[i]n general, population groups that suffer the worst health status also are those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.⁶⁹

As if socioeconomic disparities in health were not serious enough on their own, they are also closely associated with racial and ethnic disparities in health. A greater proportion of non-whites⁷⁰ than whites are likely to live below the poverty level. Less than ten percent of whites live below the poverty level, a little more than ten percent of Asian/Pacific Islanders live below this level and nearly thirty percent of African-Americans and Hispanics are impoverished.⁷¹ African-Americans and Hispanics are less likely than whites to have completed more than twelve years of education.⁷² Health disparities associated with socioeconomic factors thus have a disproportionate impact on the health of African-Americans and Hispanics.

Finally, a number of researchers contend that societies with greater inequalities in wealth are less healthy than societies with greater income equality.⁷³ A new movement has adopted the view that this correlation implies causation—that there is something about social income disparities that affects the health of a population.⁷⁴ Harvard School of Public Health Professors Ichiro Kawachi and Bruce P. Kennedy argue in a recent book that unbridled capitalism in the United States has led to

⁶⁷ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 9 (considering only countries with more than one million in population). Men in Cuba and Costa Rica have a greater life expectancy than men in the United States. *Id.*

⁶⁸ *Id.* at 12.

⁶⁹ *Id.*; see also Amy J. Schulz et al., *Racial and Spatial Relations as Fundamental Determinants of Health in Detroit*, 80 MILBANK Q. 677 (2002).

⁷⁰ Defined in HEALTHY PEOPLE 2010 as Asian or Pacific Islanders, African-Americans and Hispanics. 1 HEALTHY PEOPLE 2010, *supra* note 1, at 14, fig. 5.

⁷¹ *Id.*

⁷² *Id.* at 15, fig. 6. A greater percentage of Asian or Pacific Islanders than whites have completed more than twelve years of education. *Id.*

⁷³ See, e.g., THE SOCIETY AND POPULATION HEALTH READER: INCOME INEQUALITY AND HEALTH (Ichiro Kawachi et al. eds., 1999). Countries with more equal distribution of income (such as Japan and Iceland) appear to enjoy better health status as measured by life expectancy. *Id.* at 28-35.

⁷⁴ See, e.g., *id.*; see also Laura D. Kubzansky et al., *United States: Social Inequality and the Burden of Poor Health*, in CHALLENGING INEQUITIES IN HEALTH: FROM ETHICS TO ACTION 105, 118-19 (Timothy Evans et al. eds., 2001) (discussing the difficulty of identifying a pathway and noting competing hypotheses).

income disparities which negatively affect the health of our society.⁷⁵ This argument has drawn a vigorous critique,⁷⁶ but it appears to have influenced the Healthy People 2010's analysis of the determinants of health.⁷⁷ It remains to be seen whether law in general and public health law in particular can be an effective tool in addressing behavioral and socioeconomic determinants of health.

C. BEHAVIORAL DETERMINANTS OF HEALTH, SOCIAL DUTIES AND PERSONAL RESPONSIBILITIES

1. General Principles

First, it is clear that public health officials are thinking about and implementing laws and regulations designed to change behavior. Professor Larry Gostin, the leading scholar of public health law in the United States, offers this definition of the responsibilities of public health entities:

The mission of public health is broad, encompassing systematic efforts to promote physical and mental health and to prevent disease, injury, and disability. The core functions of public health agencies are to prevent epidemics, protect against environmental hazards, *promote healthy behaviors*, respond to disaster and assist communities in recovery, and assure the quality and accessibility of health services.⁷⁸

Interventions designed to affect health-related behaviors are sprinkled throughout Healthy People 2010.⁷⁹ Yet, as some public health officials have noted there is the "thorn[y] question" of "whether chronic disease prevention is a legitimate role of government. Is preventing unhealthy behavior an appropriate subject for public policy and government action? Almost all public health officers would argue that it is, but doubts remain among many members of the public and many legislators."⁸⁰

⁷⁵ ICHIRO KAWACHI & BRUCE P. KENNEDY, *THE HEALTH OF NATIONS: WHY INEQUALITY IS HARMFUL TO YOUR HEALTH* (2002); *see also* Norman Daniels et al., *Justice is Good for Our Health, in IS INEQUALITY BAD FOR OUR HEALTH?* 3 (2000).

⁷⁶ *See, e.g.*, Hugh Gravelle et al., *Income Inequality and Health: What Can We Learn from Aggregate Data?*, 54 *SOC. SCI. MED.* 577 (2002) (authors use "new data set to replicate and extend the methodology in a frequently cited paper"; they find no significant statistical relationship between income inequality and health); Jennifer M. Mellor & Jeffrey Milyo, *Reexamining Evidence of an Ecological Association Between Income Inequality and Health*, 26 *J. HEALTH POL. POL'Y & L.* 487 (2002) (contradicting many claims from previous studies regarding the association between income disparities and health); Hugh Gravelle, *How Much of the Relation Between Population Mortality and Unequal Distribution of Income Is a Statistical Artifact?*, 316 *BRITISH MEDICAL J.* 382 (1998); Carlos Muntaner & J. Lynch, *Income Inequality, Social Cohesion, and Class Relations: A Critique of Wilkinson's Neo-Durkeimian Research Program*, 29 *INT'L J. HEALTH SERV.* 59 (1999) (a critique from another direction, arguing that Wilkinson ignores the importance of social class).

⁷⁷ 1 *HEALTHY PEOPLE 2010*, *supra* note 1, at 13 (noting the growth of income inequality in the United States).

⁷⁸ *PUBLIC HEALTH LAW AND ETHICS: A READER* 16 (Lawrence O. Gostin ed., 2000) (emphasis added); *see also* Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 *COLUM. L. REV.* 59 (1999) (describing various models of public health, including the behavioral model, and exploring ramifications in public health practice and law).

⁷⁹ *See supra* text accompanying note 42.

⁸⁰ Jonathan E. Fielding et al., *How Do We Translate Science into Public Health Policy and Law?*, 30 *J.L. MED. & ETHICS* 22, 25 (Supp. 2002).

There are at least three important justifications for intervention. First, of course, is the possibility that intervention will reduce human morbidity and mortality rates. Second, government intervention may reduce disparities in health to the extent that behavior is found disproportionately within certain ethnic or racial groups. Third, government intervention may reduce current levels of government expenditures on health conditions related to human behavior.⁸¹ There are countervailing considerations.

First, as Professor Epstein notes, governmental interventions designed to affect human behavior may, depending on their form, limit free choice and impair liberty.⁸² Government prohibitions most clearly negatively impact individual liberty, but lesser forms of regulation can impair choice as well.⁸³ A related concern is the problem of line drawing: which risky behaviors are sufficiently harmful to society to warrant regulation?⁸⁴ Should the government prohibit the conduct, make the conduct less appealing through taxes or regulatory restrictions, or should the government facilitate safer versions of the risky behavior?⁸⁵ Regulation might also give rise to claims of discrimination.⁸⁶ Finally, governmental intervention may conflict with norms of personal responsibility and morality.⁸⁷ The following sections will explore the tensions between these conflicting principles in three areas where individual behavior affects health status: tobacco use, intravenous drug use by persons infected with HIV and failure to maintain proper weight.

2. Regulation of Tobacco

As noted above,⁸⁸ smoking imposes a significant cost on individuals and society. Smoking is also a significant factor in creating mortality disparities for persons of lower socioeconomic classes.⁸⁹ Public health authorities advocate for laws—particularly state laws—which would directly and indirectly regulate smoking behavior. The Healthy People 2010 initiative includes twenty-one objectives related to the reduction of tobacco use, several of which involve creating stronger anti-smoking laws.⁹⁰ In an unusual foray into state-level policy, HHS committed itself to

⁸¹ Advocates note that the government spends nearly \$1 trillion annually on healthcare related to chronic health conditions. *Id.*

⁸² See *supra* text accompanying note 2.

⁸³ A criminal ban on cigarette smoking might decrease the smoking rate, but at the cost of both the freedom of those imprisoned and the freedom of choice of those who refrain from smoking under the threat of criminal sanctions. A ban on smoking in public would allow people to continue to choose to engage in the unhealthy behavior, subject to time, place and manner restrictions.

⁸⁴ Should smoking be banned or regulated? What about the use of alcohol? What about other drugs? Should “super-sized” food portions be banned or otherwise regulated?

⁸⁵ For a specific example of this debate, see *infra* Part II.C.3.

⁸⁶ Regulations might give rise to discrimination claims where, for example, one racial or ethnic group disproportionately enjoys the proscribed conduct. One example of this dispute is the regulation and closure of bathhouses during the early years of the HIV/AIDS epidemic. See generally RANDY SHILTS, *AND THE BAND PLAYED ON* (2000).

⁸⁷ For an extended discussion of some of these points, see Gostin et al., *supra* note 78, at 71-74.

⁸⁸ See *supra* text accompanying note 67.

⁸⁹ Mitchell D. Wong et al., *Contribution of Major Diseases to Disparities in Mortality*, 347 *NEW ENG. J. MED.* 1585 (2002) (assessing socioeconomic class by years of education rather than income).

⁹⁰ 2 *HEALTHY PEOPLE 2010*, *supra* note 1, at 27-10 to 27-34; see also Rosemarie Henson et al., *Clear Indoor Air: Where, Why, and How*, 30 *J.L. MED. & ETHICS* 75, 76 (Supp. 2002).

the objective of eliminating statewide anti-smoking laws that included provisions preempting more stringent local ordinances.⁹¹

The Healthy People 2010 tobacco objectives are consistent with the promulgations of other public health groups. The Task Force on Community Preventive Services is a non-federal group appointed by the director of the Centers for Disease Control and Prevention (CDC) which evaluates the effectiveness and efficiency of various public health interventions.⁹² The Task Force reviewed and recommended the enactment of a number of different policies designed to decrease smoking behavior, including smoking bans and increases in the unit price of cigarettes.⁹³

A great deal of research data supports the efficacy of these two different types of initiatives. Bans on public smoking reduce the health impact of second hand smoke, make smoking more difficult (which encourages smokers to quit) and limit opportunities for minors to perceive and model smoking behavior. Increasing the cost of smoking stimulates smokers to quit. A ten percent price increase, for instance, can stimulate about a four percent decrease in the adult smoking rate.⁹⁴

The overwhelming weight of evidence supports the dangerousness of tobacco use, the disparate impact of use on minority communities and the costs of use for governmental payors. There is also strong evidence supporting the policy interventions promoted by public health authorities. Surprisingly, however, policy-makers have offered a mixed response to the requests of public health authorities.⁹⁵ State bans on public smoking are actually more likely to preempt stricter local laws than before the Healthy People 2010 initiative.⁹⁶ Increases in tobacco taxes appear more likely to occur only because most states face significant budgetary shortfalls.⁹⁷

3. Intravenous Drug Use and HIV

Between 800,000 to 900,000 people in the United States are infected with HIV. An increasing percentage of those individuals are African-American.⁹⁸ There is a well known connection between intravenous drug use and HIV infection that is recognized in Healthy People 2010.⁹⁹ Needle exchange programs are one method of reducing the risk of HIV transmission through the use of shared needles, but Healthy People 2010 does not explicitly endorse the adoption of needle exchange policies.¹⁰⁰

⁹¹ 2 HEALTHY PEOPLE 2010, *supra* note 1, at 27-34; *see also* Henson et al., *supra* note 90, at 76.

⁹² *See generally* TASK FORCE ON CMTY. PREVENTATIVE SERVS., CDC (containing information about the Task Force, its mission, membership, and recommendations), at <http://www.thecommunityguide.org> (last modified Feb. 26, 2003).

⁹³ *See* TASK FORCE ON CMTY. PREVENTATIVE SERVS., CDC, TOBACCO, *available at* <http://www.thecommunityguide.org/tobacco> (last updated Mar. 3, 2003).

⁹⁴ 2 HEALTHY PEOPLE 2010, *supra* note 1, at 27-34; *see also* Michelle Leverett et al., *Tobacco Use: The Impact of Prices*, 30 J.L. MED. & ETHICS 88, 89 (Supp. 2002).

⁹⁵ *See, e.g.*, 2 HEALTHY PEOPLE 2010, *supra* note 1, at 27-8 (noting that legislatures have made, at best, mixed progress in meeting the objectives for 2000).

⁹⁶ Henson et al., *supra* note 90, at 76; *see also* 2 HEALTHY PEOPLE 2010, *supra* note 1, at 27-28.

⁹⁷ *See, e.g.*, HHS, REDUCING TOBACCO USE: A REPORT OF THE SURGEON GENERAL 338 (2000).

⁹⁸ 1 HEALTHY PEOPLE 2010, *supra* note 1, at 13-3, 13-6, 13-8 to 13-10.

⁹⁹ *Id.* at 13-3 to 13-4.

¹⁰⁰ *Id.* at 13-5, 13-14 to 13-15 (noting, but failing to explicitly recommend, needle exchange programs).

Other policies, such as the deregulation of needle sales, can also improve access to clean and safe needles.¹⁰¹

What explains the Healthy People 2010 document's relative silence about needle exchange and needle sale policies? In this case, good public health policy (improving access to clean needles to prevent the transmission of HIV) also conflicts with widespread beliefs about the best method of combating drug addiction (making it as difficult as possible to use drugs). Many legislators are hostile to the idea of easing needle distribution policies because they believe that the policies implicitly condone drug use.¹⁰² The personal responsibility and moralistic paradigms for behavior control have dominated over the more utilitarian public health approach.¹⁰³

4. Obesity

The Healthy People 2010 project devotes a substantial section of analysis to the problems of "nutrition and overweight."¹⁰⁴ Separate, but related, focus areas address diabetes, physical activity and fitness.¹⁰⁵ The report cites "an alarming increase in the number of overweight and obese persons."¹⁰⁶ People who are overweight or obese are alleged to be at heightened risk for a variety of serious and life-threatening illnesses.¹⁰⁷ The problem may "cost society over \$200 billion each year in medical expenses and lost productivity."¹⁰⁸ There are also racial and ethnic disparities in the prevalence of overweight and obesity.¹⁰⁹ Finally, the growing prevalence of obesity in children and adolescents raises additional concerns.¹¹⁰

The Healthy People 2010 report's obesity objectives seem most consistent with a personal responsibility paradigm for obesity.¹¹¹ The report notes the importance of

¹⁰¹ See, e.g., Scott Burris & Mitzi Ng, *Deregulation of Hypodermic Needles and Syringes as a Public Health Measure: A Report on Emerging Policy and Law in the United States*, 12 GEO. MASON U. CIV. RTS. L.J. 69 (2001).

¹⁰² See, e.g., Daniel Geysler, *Needle Exchange Program Funding*, 37 HARVARD J. ON LEG. 265 (2000) (describing the history of federal efforts to ban the use of federal funds for needle exchange).

¹⁰³ See Lawrence O. Gostin & Zita Lazzarini, *Prevention of HIV/AIDS Among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention*, 46 EMORY L.J. 587 (1997); Lawrence O. Gostin, *The Epidemics of Injecting Drug Use and Blood-Borne Disease: A Public Health Perspective*, 31 VAL. U. L. REV. 669 (1997).

¹⁰⁴ 2 HEALTHY PEOPLE 2010, *supra* note 1, at 19-1 to 19-54.

¹⁰⁵ See 1 *id.* at 5-1 to 5-40 (discussing diabetes); 2 *id.* at 22-1 to 22-39 (discussing physical activity and fitness).

¹⁰⁶ 2 *id.* at 19-4. For data on rates of health weight, overweight and obesity among adults and children, see NAT'L CTR. FOR HEALTH STATS., *supra* note 20, at Tables 70 (adults) and 71 (children and adolescents).

¹⁰⁷ The illnesses include "high blood pressure, type 2 diabetes, coronary heart disease, [and] stroke . . ." 2 HEALTHY PEOPLE 2010, *supra* note 1, at 19-5 (noting additional diseases); see also Ali H. Mokdad et al., *Prevalence of Obesity, Diabetes, and Obesity-Related Health Risk Factors, 2001*, 289 JAMA 76 (2003) (obesity and diabetes are increasing across the U.S. population; obesity and overweight associated with greater risk of other medical conditions); Kevin R. Fontaine et al., *Years of Life Lost Due to Obesity*, 289 JAMA 187 (2003) (obesity lessens life expectancy). *But see* Paul Campos, *The Weighting Game*, NEW REPUBLIC, January 13, 2003, available at www.tnr.com (prominent law professor-critic of obesity research contends that the methodology is flawed and that health status is more strongly associated with activity level than with BMI (body mass index)).

¹⁰⁸ 2 HEALTHY PEOPLE 2010, *supra* note 1, at 19-3.

¹⁰⁹ "[O]besity is particularly common among Hispanic, African-American, Native American, and Pacific Islander women." *Id.* at 19-5.

¹¹⁰ *Id.* at 19-13.

¹¹¹ See, e.g., Matt Crenson, *Less, Please; An Anti-Obesity Crusader Appeals for Restraint in the Land of Plenty*, CHICAGO TRIBUNE, Dec. 4, 2002, at 3A (noting that a "2001 poll by Princeton

“[e]stablishing healthful dietary and physical activity behaviors . . . in childhood” and the importance of nutritional education for children and adults.¹¹² Restaurants and other food suppliers “also can help consumers . . . by providing nutritional information,” which implies that informed consumers are willing and able to make wise choices.¹¹³

Compared to the tobacco objectives, the Healthy People 2010 obesity objectives focus on results rather than publicly-directed strategies for obtaining those results.¹¹⁴ There are no calls for state legislation, for example. While the report recognizes the growing importance of childhood obesity, governmental entities or private parties are not given any special responsibility to protect children from risky foods.¹¹⁵ Despite the concerns of Professor Epstein, the public health authorities are not yet poised to use “state coercion” to protect people from themselves or to promote better practices in the food industry.¹¹⁶ At most, public health authorities who developed Healthy People 2010 seem interested in increasing mandatory physical education programs in schools.¹¹⁷ For the moment at least, advocates for the use of law to fight obesity are largely found outside the public health community.¹¹⁸

University researchers found that most people consider obesity a problem of individual willpower, not a product of the increased availability of unhealthful food”). Yet, as other public health officials and legislators have noted, “[e]ffective prevention and treatment [of childhood obesity] will require both individual and community-wide efforts.” William H. Dietz et al., *Policy Tools for the Childhood Obesity Epidemic*, 30 J.L. MED. & ETHICS 83, 85 (Supp. 2002).

¹¹² 2 HEALTHY PEOPLE 2010, *supra* note 1, at 19-5 to 19-6.

¹¹³ *Id.* at 19-7.

¹¹⁴ One explanation for the differential treatment of tobacco and unhealthy or excessive food is that tobacco is physically addictive. However, Healthy People 2010 notes that patterns of obesity formed in childhood can have serious consequences into adulthood. 2 HEALTHY PEOPLE 2010, *supra* note 1, at 19-3, 19-16.

¹¹⁵ Healthy People 2010 does not address the legal aspects of parental responsibility, either for tobacco use or obesity. *See id.* at 19-1 to 19-54; *cf.* Shireen Arani, Comment, *State Intervention in Cases of Obesity-Related Medical Neglect*, 82 B.U. L. REV. 875 (2002). Nor does the report address the potential liability of purveyors of fast food and super-sized meals. *See* 2 HEALTHY PEOPLE 2010, *supra* note 1, at 19-1 to 19-54; *cf.* Franklin E. Crawford, Note, *Fit for Its Ordinary Purpose? Tobacco, Fast Food, and the Implied Warranty of Merchantability*, 63 OHIO ST. L.J. 1165 (2002).

¹¹⁶ *See supra* text accompanying note 2.

¹¹⁷ The Healthy People 2010’s objectives with respect to physical fitness include “increas[ing] the proportion of the Nation’s public and private schools that require daily physical education for all students.” 2 HEALTHY PEOPLE 2010, *supra* note 1, at 22-19. The Task Force on Community Preventive Services issued a report on increasing physical activity in the Fall of 2001; the report also recommends expanding physical education programs in schools. TASK FORCE ON CMTY. PREVENTIVE SERVS., CDC, INCREASING PHYSICAL ACTIVITY: A REPORT ON THE RECOMMENDATIONS OF THE TASK FORCE ON COMMUNITY PREVENTION STRATEGIES, 50 MORBIDITY & MORTALITY WEEKLY REP. 1, 9 (2001) (RR-18).

¹¹⁸ Advocates hoping to use the legal system to address the causes of obesity appear to be most interested in the use of tort law. *See, e.g.*, Nat Ives, *Food Companies Are Urged to Act to Deflect Blame for the Nation’s Increase in Obesity*, N.Y. TIMES, Dec. 4, 2002, at C4 (discussing potential parallels between tobacco and fast food in future regulation and litigation). For pro-food industry rejoinders to these points, see CTR. FOR CONSUMER FREEDOM.COM, at <http://www.consumerfreedom.com> (last visited Mar. 3, 2003).

Government intervention through more aggressive spending programs or more restrictive regulation seems far away. *But see* Crenson, *supra* note 111 (noting op-ed column which appeared in New York Times in 1994 suggesting a “junk-food tax”); Rogan Kersh & James Marone, *The Politics of Obesity: Seven Steps to Government Action*, 21 HEALTH AFFAIRS 142 (2002); Note, *The Elephant in the Room: Evolution, Behavioralism, and Counteradvertising in the Coming War Against Obesity*, 116 HARV. L. REV. 1161 (2003). Kersh and Marone sketch the possible future course of federal regulation:

D. SOCIOECONOMIC INEQUALITY

Socioeconomic disparities undoubtedly have a huge impact on disparities in health status.¹¹⁹ As noted above, mortality and morbidity vary with household income and education.¹²⁰ Those with lower incomes or less education are less healthy and live shorter lives.¹²¹ Those with lower socioeconomic status are less likely to have access to healthcare. They are more likely to engage in behaviors, such as smoking, which increase morbidity and mortality.¹²² They are more likely to be members of minority groups who suffer from disparate treatment in healthcare.¹²³ Finally, some research suggests that lower socioeconomic status is itself an independent variable associated with poorer health status.¹²⁴

Healthy People 2010 notes the importance of socioeconomic factors in establishing life expectancy and mortality rates from various diseases.¹²⁵ The report suggests that socioeconomic factors account for a significant percentage of the perceived disparities in care which the project hopes to eliminate by 2010.¹²⁶ Yet Healthy People 2010 does not devote significant attention to socioeconomic factors in its focus areas and objectives. Public health authorities may believe that socioeconomic factors are linked to disparities in health, but they appear unable or unwilling to confront the consequences.

At least some members of the social determinants of health movement believe that the data on socioeconomic impact is sufficiently clear to require action.¹²⁷ They concede that action “involves ethical and political choices” and will require the development of “shared values.”¹²⁸ Interventions must span every level of society.

Yet, after reviewing both the success and failures of legal approaches to behavioral health issues, one is left doubtful about the use of legal doctrines to

If the federal government were to mobilize against obesity, what might it do? Governmental policies toward alcohol, tobacco, and drugs include at least four regulatory strategies: controlling the conditions of sale through direct restrictions or limits (especially aimed at youth); raising prices through “sin taxes”; government litigation against producers of unhealthy substances with damage awards earmarked for health care or healthy alternatives; and regulating marketing and advertising. As we noted above, federal officials already promote alternatives to unhealthy eating, via education programs warning consumers about health risks; stronger education measures might include government-funded cessation programs addressing compulsive behavior, or direct subsidies for healthy alternatives. A combination of these policies—now in place at state and federal levels for tobacco, alcohol, and drugs—could be applied to unhealthy, low-nutrition foods.

Kersh & Marone, *supra* note 118, at 151.

¹¹⁹ See *supra* Part II.B; see also David R. Williams, *Racial/Ethnic Variations in Women's Health: The Social Imbeddedness of Health*, 92 AM. J. PUB. HEALTH 588 (identifying socioeconomic status as a central determinant of racial/ethnic disparities).

¹²⁰ See *supra* text accompanying note 71.

¹²¹ See *id.*

¹²² See *supra* Part II.C.2.

¹²³ See *supra* Part II.B.

¹²⁴ Researchers have not, however, identified the biological pathway through which an individual's social status affects his or her health.

¹²⁵ See *supra* text accompanying notes 36-43.

¹²⁶ See *id.*

¹²⁷ See *supra* note 8.

¹²⁸ See, e.g., Margaret Whitehead et al., *Developing the Policy Response to Inequities in Health: A Global Perspective*, in CHALLENGING INEQUITIES IN HEALTH: FROM ETHICS TO ACTION 309-10 (Timothy Evans et al. eds., 2001). Shared values can in turn lead to the development of “targets,” such as “income disparities should not increase beyond the present level . . .” *Id.* at 311.

address socioeconomic disparities. As Professor Bloche has noted, our society may abhor disparities in health related to race, but it tolerates disparities in health status caused by socioeconomic factors:

Notably missing from the national political agenda, though well documented in the research literature, are the larger problems of population-wide racial gaps in health status and access to medical care. . . . Universal health insurance coverage would greatly reduce racial differences in health care access that result from disparities in ability to afford coverage, yet universal coverage has been off the American political agenda since the collapse of the Clinton administration's reform plan in 1994 Why has racial bias in the clinical judgments physicians make on behalf of equivalently insured and socio-economically situated Americans generated a greater political response than has the racially unequal impact of allowing more than forty million Americans to go without medical coverage? And, why have racial disparities in health status . . . received less attention? The answers to both questions, I suspect, implicate our national tolerance for socio-economic inequality as a factor in disparities we deem unacceptable when they result purely and simply from racial bias.¹²⁹

A nation that cannot muster the wisdom and political will to find health coverage for our forty million uninsured is unlikely to take more aggressive action to reduce broader socioeconomic disparities in health.

V. CONCLUSION

Health law scholars and policy-makers are concerned about research revealing disparities in the delivery of healthcare based on race and ethnicity. This Article suggests, however, that many (but not all) of these disparities are likely to be related to socioeconomic and behavioral determinants of health. Narrow construction of "rights" based claims are not likely to address the "wrong" of shortened life spans. The Article analyzes examples of several public health responses to health risks created by behavior and socioeconomics. Public health policies have begun to address behavior determinants of health but have not yet confronted socioeconomic factors. Policy-makers do not yet seem comfortable regulating behaviors that present risks to health, in part because of norms of personal responsibility and autonomy. It therefore is unlikely that policy-makers will use law to address the socioeconomic determinants of health.

¹²⁹ Bloche, *supra* note 31, at 97-98 (2001).