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HEALTH LAW AS SOCIAL JUSTICE

*Lindsay F. Wiley**

Health law is in the midst of a dramatic transformation. From a relatively narrow discipline focused on regulating relationships among individual patients, health care providers, and third-party payers, it is expanding into a far broader field with a burgeoning commitment to access to health care and assurance of healthy living conditions as matters of social justice. Through a series of incremental reform efforts stretching back decades before the Affordable Care Act and encompassing public health law as well as the law of health care financing and delivery, reducing health disparities has become a central focus of American health law and policy. This Article labels, describes, and furthers a nascent "health justice" movement by examining what it means to view health law as an instrument of social justice. Drawing on the experiences of the reproductive justice, environmental justice, and food justice movements, and on the writings of political philosophers and ethicists on health justice, I propose that health justice offers an alternative to the market competition and patient rights paradigms that currently dominate health law scholarship, advocacy, and reform. I then examine the role of law in reducing health disparities through the health justice lens. I argue that the nascent health justice framework suggests three commitments for the use of law to reduce health disparities. First, to a broader inquiry that views access to health care as one among many social determinants of health deserving of public attention and resources. Second, to probing inquiry into the effects of class, racial, and other forms of social and cultural bias on the design and implementation of measures to reduce health disparities. And third, to collective action grounded in community engagement and participatory parity. In exploring these commitments, I highlight tensions within the social justice framework and between the social justice framework and the nascent health justice movement. These tensions illustrate, rather than undermine, the power of viewing health law as social justice. They raise important questions that should prompt more fruitful and rigorous thinking within health law

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activism and scholarship and with regard to the relationships between law and social justice more broadly.

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INTRODUCTION

> "[The dream] that preventable death and disability ought to be minimized is a dream of social justice."
>
> —Dan Beauchamp, *Public Health as Social Justice*[1]

African-Americans are eight times more likely to be diagnosed with HIV, twice as likely to die within the first year of life, and 50% more likely to die prematurely of heart disease or stroke than their non-Hispanic white peers.[2] Non-Hispanic black children are about 1.6 times as likely to be diagnosed with asthma than are their Hispanic or non-Hispanic white peers, and they are six to seven times as likely to die of

[1] Dan E. Beauchamp, *Public Health as Social Justice*, 13 INQUIRY 6 (1976), *reprinted in* NEW ETHICS FOR THE PUBLIC'S HEALTH 101, 105 (Dan E. Beauchamp & Bonnie Steinbock eds., 1999).

[2] Ctrs. for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, MORBIDITY & MORTALITY WEEKLY REPORT Nov. 22, 2013, at 1, 113.

Electronic copy available at: http://ssrn.com/abstract=2551052

asthma.[3] Hispanic women are 1.6 times as likely as non-Hispanic white women, and people living in poverty are about twice as likely as those with higher incomes, to be diagnosed with diabetes.[4] Over the last few decades, life expectancy has increased dramatically among people in the top half of the income distribution, while remaining nearly flat among those in the bottom half,[5] and even declining among women in many parts of the country.[6] Average life expectancy can vary by as much as twenty-five years between neighborhoods just a few miles apart.[7]

Reducing social disparities in health[8] has become a central—and deeply controversial—theme of the American health reform agenda.[9]

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3 Lara J. Akinbami et al., *Status of Childhood Asthma in the United States, 1980-2007*, 123 PEDIATRICS S131 (2009). Notably, Puerto Rican children have the highest rates of asthma—they are about 1.5 times as likely as non-Hispanic black children, 2.5 times as likely as non-Hispanic white children and about three times as likely as Mexican-American children to be diagnosed. *Id.*

4 Ctrs. for Disease Control and Prevention, *supra* note 2, at 101.

5 Peter G. Peterson Foundation, *Increases in Longevity Have Gone Largely to High Earners*, PETER G. PETERSON FOUND. (July 1, 2011), http://pgpf.org/Chart-Archive/0015_life-expectancy (discussing data from a 2007 Social Security Administration Report).

6 *See, e.g.*, David A. Kindig & Erika R. Cheng, *Even as Mortality Fell in Most U.S. Counties, Female Mortality Nonetheless Rose in 42.8% of Counties From 1992 to 2006*, 32 HEALTH AFFAIRS 451, 453 (2013); Haidong Wang et al., *Left Behind, Widening Disparities for Males and Females in US County Life Expectancy*, POPULATION HEALTH NMETRICS, no. 8, July 10, 2013, at 3, http://www.pophealthmetrics.com/content/11/1/8.

7 Comm'n to Build a Healthier Am., Robert Wood Johnson Found., *New Orleans: Short Distances to Large Disparities in Health*, ROBERT WOOD JOHNSON FOUND., http://www.rwjf.org/content/dam/images/Sandbox/2013%20Commission/Charts/fig5_Health_NOLA.pdf (last visited Aug. 31, 2014).

8 I use the term "social disparities" to refer to disparities among racial and ethnic groups, as well as disparities along economic, gender conformity, functional ability, and geographic lines. *See* MICHAEL MARMOT & RICHARD G. WILKINSON, SOCIAL DETERMINANTS OF HEALTH 2 (2d ed. 2006) (describing the "social gradient in health," by which social position determines health status, as demonstrating "how sensitive health is to social and economic factors, . . . enabl[ing] us to identify the determinants of health among the population as a whole."). A few racial disparities are biologically or genetically determined and therefore not amenable to intervention, but scientists are largely in agreement that the majority of racial disparities with regard to health outcomes are determined by social factors, as one would expect given the evidence that race and ethnicity are primarily social and political categories without a strong genetic or biological basis. *See* DOROTHY ROBERTS, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY (2011).

9 FAMILIES USA MINORITY HEALTH INITIATIVE, ISSUE BRIEF: MOVING TOWARD HEALTH EQUITY: HEALTH REFORM CREATES A FOUNDATION FOR ELIMINATING DISPARITIES (May 2010), *available at* http://www.sph.umich.edu/sep/downloads/IssueBriefMay10.pdf (noting that the Affordable Care Act "provides a critical foundation for addressing racial and ethnic health disparities through a number of key provisions—both those that will affect everyone but have a disproportionate impact on communities of color, as well as those that are designed specifically to eliminate health disparities"); KAISER FAMILY FOUND., HEALTH REFORM AND COMMUNITIES OF COLOR: IMPLICATIONS FOR RACIAL AND ETHNIC HEALTH DISPARITIES (Sept. 2010), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8016-02.pdf (discussing "key provisions of the [Patient Protection and Affordable Care Act] that will expand health coverage and are likely to improve access to care for people of color, as

From a relatively narrow discipline focused on highly individualistic interactions among patients, health care providers, and third-party payers,[10] health law is expanding into a far broader field committed to assuring healthy living conditions and access to health care. Legal scholars examining these developments have begun to draw parallels between health law and other socially conscious fields like civil rights law,[11] disability law,[12] and human rights law,[13] while largely maintaining an emphasis on individual rights of access to affordable, high-quality health care. Indeed, the competing health law paradigms of "patient rights" and "market competition" are united in their near-exclusive focus on health care access and rationing of health care resources.[14] At the same time, politi-

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well as some of the other provisions that will likely have either a direct or indirect impact on health disparities"). A documentary series, Unnatural Causes, which aired on PBS in the spring of 2008 and again in October 2009 while health reform was being actively debated in Congress, raised public awareness of health disparities and the social determinants of health. Excerpts from the series were shown as part of health reform town hall and community forum events across the country. *See* Press Release, Unnatural Causes, Award-Winning Documentary Series Changing the Way Americans Think About Health to Be Rebroadcast by PBS, *available at* http://www.unnaturalcauses.org/assets/uploads/file/Press_Rebroadcast.pdf (last visited Sept. 7, 2014).

10 *See* Mark A. Hall & Carl E. Schneider, *Where Is the "There" in Health Law: Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 103–04 (2004) (proposing "an analytical framework that views health care law as a law of relational webs [among patients, their family and friends, physicians, medical institutions, health insurers, and employers] rather than a law of transactions."); Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 369–70 (2006) (describing health law as "address[ing] a unique set of relations among persons involved in the treatment of health problems" including patients, doctors, hospitals, employers and the government "that affect our health care"); William M. Sage, *Relational Duties, Regulatory Duties, and the Widening Gap Between Individual Health Law and Collective Health Policy*, 96 GEO. L.J. 497, 501 (2008) ("A relational perspective, particularly where the delivery of medical services is concerned, is a defining characteristic of American health law.").

11 *See* Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855 (2012) [hereinafter Watson, *Section 1557*]; Sidney D. Watson, *Health Care in the Inner City, Asking the Right Question*, 71 N.C. L. REV. 1697 (1993); Sidney D. Watson, *Reinvigorating Title VI Defending Health Care Discrimination—It Shouldn't Be So Easy*, 58 FORDHAM L. REV. 939 (1990); Sidney D. Watson, *Race, Ethnicity and Quality of Care, Inequalities and Incentives*, 27 AM J.L. & MED. 203 (2001).

12 *See* Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 MINN. L. REV. 1963, 1964 (2013) ("[T]he ACA constitutes one of the most significant civil rights victories for the disability community in recent history.").

13 *See* Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities*, 55 HOW. L.J. 887 (2012).

14 *See* Hall & Schneider, *supra* note 10, at 102 (describing the "patient's rights" approach, which "at heart hopes that medicine can be regulated by endowing patients with rights of autonomy to which medical professionals and institutions must defer" and the "law and economics approach," which "at heart hopes that medicine can be regulated in the market, by consumers making purchasing decisions that discipline medical institutions," as the two "competing paradigms" of health law); Rand E. Rosenblatt, *The Four Ages of Health Law*, 14 HEALTH MATRIX 155, 155 (2004) (describing the rise of the "modestly egalitarian social contract" paradigm in which the role of law is "to achieve a fair resolution of conflicting interests, especially in the light of highly unequal information and power between patients and [physi-

cal philosophers and ethicists have begun a productive discussion of the multi-faceted relationship between health and social justice, which ranges far beyond individual health-care rights to focus on collective needs and problem solving with regard to the social determinants of health, broadly defined.[15]

This Article explores what it means to view health law as social justice. I propose "health justice" as a distinct alternative to the "patient rights" and "market competition" paradigms that currently dominate health law scholarship, advocacy, and reform.[16] I define health law broadly to encompass the law of health care financing and delivery as well as public health law, which concerns the state's authority and obli-

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cians and other stakeholders with interests in the health care system]," with "fairness . . . typically . . . articulated as access to care largely on the basis of medical need, high quality of care, and respect for patient autonomy and dignity" and the rise of "market competition" (as an alternative to the modestly egalitarian social contract paradigm), in which the role of law "is to ensure that choices about health insurance and health services are made by individuals based on their own financial resources (assuming them to be above some specified minimum), and . . . to eliminate as much as possible hidden 'cross-subsidies.' "); *cf.* Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449 (1994) (describing four competing health law paradigms, all of which focus on access to health care and rationing of health care resources).

15 *See* SRIDHAR VENKATAPURAM, HEALTH JUSTICE (2011); SHLOMI SEGALL, HEALTH, LUCK, AND JUSTICE (2010); JENNIFER PRAH RUGER, HEALTH AND SOCIAL JUSTICE (2009); NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY (2008); MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY (2006).

> Social determinants of health are 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. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." In addition to the more material attributes of "place," the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources 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.

Social Determinants of Health, HEALTHYPEOPLE.GOV, *available at* http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39#five (last visited Sept. 18, 2014) (describing the Social Determinants of Health as a new topic for the Healthy People 2020 initiative whereby the U.S. Department of Health and Human Services identifies ten-year goals and objectives for health promotion and disease prevention); *see also* World Conference on Social Determinants of Health, *Rio Political Declaration on Social Determinants of Health*, WORLD HEALTH ORG. (October 2011), http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=1 ("Health inequities arise from the societal conditions in which people are born, grow, live, work and age, referred to as social determinants of health. These include early years' experiences, education, economic status, employment and decent work, housing and environment, and effective systems of preventing and treating ill health.")

16 *See* note 14, *supra*.

gation to assure healthy living conditions.[17] I describe social justice as a communitarian approach (in its emphasis on collective problems and collective problem-solving) to ensuring the essential conditions for human well-being, including redistribution of social and economic goods and recognition of all people as equal participants in social and political life. Rather than merely adopting social justice as the "core value" of *public health* as Beauchamp and others have done,[18] I argue that social justice is emerging as a core value of health law and policy *writ large*.

I suggest that the convergence of three distinct social movements (environmental justice, reproductive justice, and food justice) on health disparities as a central focus; the growing prominence of health disparities as a focus of health reform efforts; the recent boom in "health and social justice" monographs by political philosophers and ethicists; and the growing emphasis on social consciousness (as opposed to distinctly individualistic values like patient autonomy) in health law scholarship might together indicate the beginnings of a loosely defined "health justice" movement. Bearing in mind that this movement—if it can even be described as such—is in its infancy, I sketch out the basic contours of its potential influence on health law scholarship, advocacy, and reform by examining the use of law as a tool for reducing health disparities through the health justice lens.

This Article proceeds in Part I with an exploration of the social justice framework and its manifestation in three ongoing movements that focus on health disparities—environmental justice, reproductive justice, and food justice. Part II describes the health law toolkit for reducing health disparities by ensuring access to affordable, high-quality health care, encouraging healthier behaviors, and creating healthier living conditions. Part III draws on the social justice framework described in Part

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17 Public health law is commonly treated as a distinct sub-field within health law. It is defined as the study of the legal powers and duties of the state to assure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the common good.

LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (3d ed. forthcoming 2015) (manuscript on file with author). Public health law is distinguished by its population orientation and prevention focus, with an emphasis on "upstream" interventions to prevent disease by encouraging healthier behaviors and creating healthier communities rather than "downstream" health care interventions.

18 Lawrence O. Gostin & Madison Powers, *What Does Social Justice Require for the Public's Health: Public Health Ethics and Policy Imperatives*, 25 HEALTH AFF. 1053, 1053 (2006) ("Justice is viewed as so central to the mission of public health that it has been described as the field's core value."); *cf.* Sage, *supra* note 10, at 519 ("[P]ublic health law represents the paradigm case for a regulatory, collective approach to health policy, but has been marginalized both legally and financially compared with the diagnosis and treatment of individual patients.").

I, as well as the recent writings of ethicists and political philosophers on health and social justice, to assess the health disparities interventions described in Part II. I argue that the nascent health justice framework suggests three commitments for the use of law as a tool for reducing health disparities: First, to a broad scope of inquiry and action that puts access to health care in its place as one among many social determinants of health. Second, to collective responsibility for creating healthier communities and probing inquiry into the effects of social and cultural bias on the design and implementation of measures to reduce health disparities. And third, to collective action grounded in community engagement and participatory parity.

I do not claim that the social justice framework offers definitive answers to the fraught questions permeating current health law debates. I highlight tensions within the social justice framework, and between the social justice framework and the nascent health justice movement. These tensions illustrate, rather than undermine, the power of viewing health law as social justice. In sketching out the potential influence of health justice as a framework for legal scholarship, advocacy, and reform, I seek to raise important questions that are ripe for future inquiry within and beyond the field of health law.

I. THE SOCIAL JUSTICE FRAMEWORK

Three recent social movements—environmental justice, reproductive justice, and food justice—have adopted health disparities as a central focus and offer valuable lessons for health law scholarship, advocacy, and reform. Each has emerged as a critique from within a progressive project that preceded it. The environmental justice movement originated as a civil-rights based attack on the process and outcomes of environmental protection. The reproductive justice movement began as a critique by women of color working from within the pro-choice movement. And the food justice movement emerged in response to concerns about elitism in the alternative (fresh/unprocessed/healthy/local/etc.) food movement. In each case, the response has involved particular attention to the wide-ranging impacts of income inequality and white privilege, with eventual expansion to address other issues of bias and structural advantage such as ableism,[19] privileged gender expression,[20] hetero-

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[19] *See, e.g.*, Valerie Ann Johnson, *Bringing Together Feminist Disability Studies and Environmental Justice*, CTR. FOR WOMEN POLICY STUDIES (Feb. 2011), http://www.centerwomenpolicy.org/programs/waxmanfiduccia/BFWFP_BringingTogetherFeministDisabilityStudiesandEnvironmentalJustice_ValerieAnnJohnso.pdf; Mia Mingus, Georgians for Choice, *Disabled Women and Reproductive Justice*, THE PRO-CHOICE PUB. EDUC. PROJECT, http://protectchoice.org/article.php?id=140 (last visited Aug. 31 2014).

[20] *See, e.g.*, NEW PERSPECTIVES ON ENVIRONMENTAL JUSTICE: GENDER, SEXUALITY, AND ACTIVISM (Rachel Stein ed., 2004); Laura Nixon, *The Right to (Trans) Parent: A Reproductive*

normativity,[21] and nativism.[22] Before turning to an examination of what it means to add "justice" to the projects of environmental protection, reproductive health, or food system sustainability, I will take a moment to consider what it means to add "social" to justice.

A. What is Social Justice?

A 2006 United Nations report refers to social justice as "a recent and politically charged concept."[23] The choice of the term "social justice" reflects "the idea that all developments relating to justice occur in society" and "the related desire to restore the comprehensive, overarching concept of the term 'social,' which in recent times has been relegated to the status of an appendix of the economic sphere."[24] It is inherently communitarian in its

> attention to what is often ignored in contemporary policy debates: the social side of human nature; the responsibilities that must be borne by citizens, individually and col-

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Justice Approach to Reproductive Rights, Fertility, and Family-Building Issues Facing Transgender People, 20 WM. & MARY J. WOMEN & L. 73 (2013).

[21] *See, e.g.*, Alisa Wellek & Miriam Yeung, The Lesbian, Gay, Bisexual & Transgender Cmty. Ctr., *Reproductive Justice and Lesbian, Gay, Bisexual & Transgender Liberation*, THE PRO-CHOICE PUB. EDUC. PROJECT, http://protectchoice.org/article.php?id=135 (last visited Aug. 31, 2014); Pro-Choice Pub. Educ. Project & Lesbian, Gay, Bisexual & Transgender Cmty. Ctr., *Silenced Bodies: Conversations with Gay Men, Bisexual & Transgender Persons, and Queer Women of Color on Sexual & Reproductive Health, Rights & Justice*, THE CENTER 6, http://www.gaycenter.org/files/imce/docs/causesSilencedbodies.pdf.

[22] *See, e.g.*, *Immigrant Power for Environmental Health and Justice*, CHINESE PROGRESSIVE ASS'N, http://www.cpasf.org/node/12 (last visited Aug. 31, 2014); Jessica Gonzales-Rojas & Aishia Glasford, Nat'l Latina Inst. for Reprod. Health, *Immigrant Rights and Reproductive Justice*, THE PRO-CHOICE PUB. EDUC. PROJECT, http://protectchoice.org/article.php?id=136 (last visited Aug. 31, 2014).

[23] International Forum for Social Development, Nov. 2001–Nov. 2004, , *Social Justice in an Open World: The Role of the United Nations* 11, U.N. Doc. ST/ESA/305 (2006), *available at* http://www.un.org/esa/socdev/documents/ifsd/SocialJustice.pdf. "Recent" is relative of course:

> [T]he notion of social justice is relatively new. None of history's great philosophers—not Plato or Aristotle, or Confucius or Averroes, or even Rousseau or Kant—saw the need to consider justice or the redress of injustices from a social perspective. The concept first surfaced in Western thought and political language in the wake of the industrial revolution . . . as an expression of protest against what was perceived as the capitalist exploitation of labour and as a focal point for the development of measures to improve the human condition . . . . Following the revolutions that shook Europe in the mid-1800s, social justice became a rallying cry for progressive thinkers and political activists . . . . By the mid-twentieth century, the concept of social justice had become central to the ideologies and programmes of virtually all the leftist and centrist political parties around the world . . . . Social justice became more clearly defined when a distinction was drawn between the social sphere and the economic sphere.

Id. at 11–12.

[24] *Id.* at 3.

> lectively, in a regime of rights; the fragile ecology of families and their supporting communities; the ripple effects and long-term consequences of present decisions.[25]

Social justice is perhaps most easily understood as an alternative to "market justice."[26] A rejection of "the prevailing political consensus, whether explicitly or implicitly endorsed, . . . that it is not the responsibility of the state to tinker with the outcomes of a market system in which everyone is freely allowed the opportunity to buy and sell."[27] In our current political climate, this contrast between market justice and social justice risks conflation of market justice with something like "whatever political conservatives or libertarians identify as their goals" and social justice with something like "whatever political liberals or progressives identify as their goals."[28] It elides important distinctions between social justice, which emphasizes *collective* responsibility and action, and progressivism, which maintains a central focus on *individual* rights. The key tenets of progressivism—that "everyone gets a fair shot, everyone does his or her fair share, and everyone plays by the same rules"[29]—might be understood as setting a high bar for "free and equal opportunity," rather than offering a true alternative to market justice.

"These models of justice furnish a symbolic framework or blueprint with which to think about and react to the problems of the public, providing the basic rules to classify and categorize problems of society as to whether they necessitate public and collective protection, or whether individual responsibility should prevail."[30] They "mak[e] visible some conditions in society as public issues or concerns, [while] hiding, obscuring or concealing other conditions that might otherwise emerge as public

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[25] *The Responsive Communitarian Platform*, THE COMMUNITARIAN NETWORK, http://communitariannetwork.org/platform (last visited Aug. 31, 2014). The platform was formulated by a group of "academicians and social commentators" helmed by sociologist Amitai Etzioni in 1990. *Who We Are*, THE COMMUNITARIAN NETWORK, http://communitariannetwork.org/who-we-are (last visited Aug. 31, 2014).

[26] Beauchamp, *supra* note 1, at 102–08 (contrasting social justice and market justice).

[27] Andrew Bradstock, *Recovering the Common Good: The Key to a Truly Prosperous Society?*, 44 VICTORIA U. WELLINGTON L. REV. 319, 329 (2013).

[28] *See* Anna E. Carpenter, *The Project Model of Clinical Education: Eight Principles to Maximize Student Learning and Social Justice Impact*, 20 CLINICAL L. REV. 39, 55–56 (2013).

> Throughout legal scholarship . . . "social justice" is a term that is commonly employed but not often clearly defined [but is] typically associated with a "progressive" political and law reform agenda . . . seek[ing] to promote substantive equality and equality of opportunity, and to overcome the fact of legal, social, and political oppression, as well as the impact of oppression.

Id. at 55.

[29] AL YATES & ANNE BARTLEY, PROGRESSIVE THINKING: A SYNTHESIS OF AMERICAN PROGRESSIVE VALUES, BELIEFS AND POSITIONS (2012), *available at* http://www.scribd.com/doc/131793272/Progressive-Thinking.

[30] Beauchamp, *supra* note 1, at 102.

issues or problems were a different map or model of justice in hand."[31] For my purposes, the implications of each model of justice for redistributive policies and spending programs are particularly important. According to the market justice model:

> If some people in a society find themselves without what might be considered the essentials of life, then that is simply a consequence of the various transactions that take place within the market: provided none of these transactions is coerced . . . . We may say that those at the bottom of the heap have suffered bad luck or misfortune, but not injustice, and therefore the appropriate response is individual charity, not state redistribution.[32]

Libertarian adherents to the market justice framework have a very *narrow* understanding of coercion and thus *rarely* support redistribution. Progressive adherents have a very *broad* understanding of coercion and *often* support redistribution, but they share a primary emphasis on "a fair distribution of opportunity."[33] In contrast, the social justice model views assurance of the essential conditions for human well-being as the legitimating purpose of government.

In addition to redistribution, social justice is also concerned with recognition of all people as "full partners in social interaction."[34] While *redistribution* attacks economic inequality, *recognition* attacks cultural subordination. The dual goals of redistribution (which emphasizes material outcomes) and recognition (which emphasizes process, participation, respect, and identity) threaten to pull social movements in opposing directions. But they can and should function as complementary strains of social justice argument, allowing for advocacy strategies that combine a "cultural politics of identity" with a "social politics of equality," promoting just distribution of economic and social goods rooted in participatory parity.[35]

The social justice framework has found expression in three recent social movements that speak to the practice and scholarship of law as a tool for addressing disparities generally and health disparities in particular. Although the three movements described here are diverse in their origins and concerns, each began as a critique from within a progressive

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31 *Id.*

32 Bradstock, *supra* note 27, at 329.

33 YATES & BARTLEY, *supra* note 29, at 26.

34 Nancy Fraser, *Rethinking Recognition*, 3 NEW LEFT REV. 107, 113 (2000).

35 Nancy Fraser, *From Redistribution to Recognition?: Dilemmas of Justice in a "Post-socialist" Age*, 212 NEW LEFT REV. 68, 69 (1995); *see also* Nancy Fraser, *Social Justice in the Age of Identity Politics: Redistribution, Recognition, and Participation*, *in* NANCY FRASER & AXEL HONNETH, REDISTRIBUTION OR RECOGNITION? A POLITICAL-PHILOSOPHICAL EXCHANGE 7 (2003).

reform project that preceded it. Three common themes emerge that are particularly relevant to the project of this Article[36]: First, each movement has rejected siloed, narrowly defined priorities in favor of a broad understanding of the social determinants of inequality. Second, each movement has offered an internal critique of the influence of social and cultural biases on the aims and strategies of the progressive reform project that preceded it. Third, each movement has struggled to balance the role of experts in prioritizing and achieving substantive reforms with a commitment to community engagement and participatory parity. In addition to detailing these common themes, I will highlight the relationship of each movement to health disparities.

B. Environmental Justice

Galvanized by controversy over the location of waste and industrial sites in predominantly black communities, the environmental justice movement emerged in the 1980s as a response to "environmental racism."[37] Its focus is more expansive than that of the environmental protection movement that preceded it. Posing crucial questions about "how individual events reflect broader historical and societal inequities,"[38] the movement emphasizes just distribution of environmental risks and benefits and recognition of socially marginalized groups in related decision-making processes.[39] Together, the sustainability and environmental jus-

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36 My analysis of the first and second themes I identify here is heavily influenced by Dean Spade. *See* Keynote Address at the Columbia Journal of Gender and Law Symposium*:* Law Reform and Cooptation (April 2009), *in* 19 COLUM. J. GENDER & L. 1086, 1096 (2010) (discussing the environmental justice, reproductive justice, and food justice movements as part of an exploration of the relationship between "resistance to coercive gender norms" and "narratives of citizenship and belonging that undergird colonialism and white supremacy" while noting that "[i]n each of these instances, the addition of 'justice' indicates a critique of narrower framings [in terms of individual rights to be left alone or treated equally by the state] and an analysis of the issues in question that centers racial and economic justice.").

37 *See* Gerald Torres, *Environmental Justice: The Legal Meaning of a Social Movement*, 15 J.L. & COM. 597, 598–607 (1996) (describing the origins of the environmental justice movement as a response to "environmental racism" while also critiquing the framing in terms of "racism" as opposed to "white supremacy" or "white advantage"); Alice Kaswan, *Environmental Justice and Environmental Law*, 24 FORDHAM ENVTL. L. REV. 149, 150–51 (2013) (noting that a siting dispute over a Polychlorinated Biphenyl (PCB) disposal facility in a predominantly African-American community in North Carolina in the 1980s "was a nationally galvanizing event, sparking widespread attention to distributional, participatory, and social environmental justice.").

38 *See* Kaswan, *supra* note 37, at 151.

39 *See* GORDON WALKER, ENVIRONMENTAL JUSTICE: CONCEPTS, EVIDENCE AND POLITICS 1 (2012) (defining environmental justice very broadly to encompass "the intertwining of environment and social difference—how for some people and some social groups the environment is an intrinsic part of living a 'good life' of prosperity, health and well-being, while for others the environment is a source of threat and risk, and access to resources such as energy, water, and greenspace is limited or curtailed . . . [;] how some of us consume key environmental resources at the expense of others, often in distant places, and about how the power to effect

tice movements "guard against the risk of 'tunnel vision': one-dimensional environmental policymaking that fixates on a single goal . . . without considering or addressing broader implications."[40]

The relationship between environmentalism and environmental justice is not entirely harmonious. "Since at least the early 1990s, activists from the environmental justice movement consistently have criticized what they consider the 'mainstream' environmental movement's racism, classism, and limited activist agenda . . . ."[41] In their efforts to probe the influence of elitism on mainstream environmentalism, environmental justice advocates also grapple with difficult questions about the appropriate role for lawyers and other experts in defining the movement's priorities and strategies.[42] They have also sought to balance the distributive and participatory commitments of social justice.[43] Especially in cases where Native American tribal governments have opted to allow environmentally hazardous operations within their jurisdictions, legal scholars have struggled to conceptualize and operationalize the environmental justice movement's commitment to procedural justice and self-determination for socially disadvantaged communities.[44]

The environmental justice framework enjoys significant influence at the federal level. A 1994 Executive Order directed all federal agencies, not merely the EPA, to incorporate the achievement of environmental justice into their missions by "identifying and addressing . . . disproportionately high and adverse human health or environmental effects of [their] programs, policies, and activities on minority populations and low-income populations."[45] But commentators argue that the environ-

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change and influence environmental decision-making is unequally distributed . . . [; and] the way that people should be treated, the way the world should be.").

[40] *Id.* at 171.

[41] Phaedra C. Pezzullo & Ronald Sandler, *Introduction* to ENVIRONMENTAL JUSTICE AND ENVIRONMENTALISM: THE SOCIAL JUSTICE CHALLENGE TO THE ENVIRONMENTAL MOVEMENT 2 (Phaedra C. Pezzullo & Ronald Sandler eds., 2007).

[42] *See, e.g.*, Luke W. Cole, *Empowerment as the Key to Environmental Protection: The Need for Environmental Poverty Law*, 19 ECOLOGY L.Q. 619 (1992) ("solutions to poor peoples' environmental problems should be found by the victims of those problems, not by environmental lawyers"); Eleanor N. Metzger, *Driving the Environmental Justice Movement Forward: The Need for a Paternalistic Approach*, 45 CASE W. RES. L. REV. 379 (1994).

[43] *See* Kevin Gover & Jana L. Walker, *Escaping Environmental Paternalism: One Tribe's Approach to Developing a Commercial Waste Disposal Project in Indian Country*, 63 U. COLO. L. REV. 933, 942 (1992); Giancarlo Panagia, *Tota Capita Tot Sententiae: An Extension or Misapplication of Rawlsian Justice*, 110 PENN ST. L. REV. 283, 305 (2005); POVERTY ALLEVIATION AND ENVIRONMENTAL LAW (Yves Le Bouthillier et al. eds., 2012) (exploring apparent tensions between the goals of poverty alleviation and environmental protection).

[44] *See, e.g.*, Ezra Rosser, *Ahistorical Indians and Reservation Resources*, 40 ENVTL. L. 437, 472–74 (2010) (arguing that these scenarios necessitate a reconceptualization of environmental justice).

[45] Exec. Order No. 12,898, 59 Fed. Reg. 7629 (Feb. 16, 1994).

mental justice framework has been watered down as it has been integrated within the mainstream environmental protection project.[46]

Notably for my purposes, the articulation of environmental justice in terms of disproportionate "human health *or* environmental effects" would arguably encompass all health disparities within existing environmental justice efforts.[47] Indeed, the Interagency Working Group created by Clinton's Executive Order and reconvened by the Obama Administration in 2010[48] has, at times, interpreted the "environmental" part of "environmental justice" quite broadly. For example, in a description of environmental justice community outreach meetings held by the Interagency Working Group in 2011, Department of Health and Human Services (DHHS) officials noted that "[e]verywhere we have gone, we have heard repeated calls for attention to environmental justice, with people asking for greater access to health care, clean air and water, healthy and affordable food, community capacity building through grants and technical assistance, and training to educate the health workforce about environmentally associated health conditions."[49]

DHHS strategies developed pursuant to E.O. 12898 frequently reference the agency's broader efforts to increase access to health care, healthy food, and healthy living conditions, but with an emphasis on how those efforts are particularly relevant to the narrower environmental justice project of "reducing the health disparities that may result from disproportionate exposures to environmental hazards in minority and low-income populations and Indian Tribes."[50] For example, DHHS officials emphasize national objectives in traditional environmental protection areas like "outdoor air quality, surface and ground water quality, [and] toxic substances and hazardous wastes."[51] EPA officials, in turn,

> recognize that addressing environmental health disparities through the lens of EPA is touching the tip of the iceberg in communities that experience environmental justice issues. Although EPA's actions focus on racial/ethnic and income differences in environmental health outcomes, they directly relate and contribute to the

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46 *See, e.g.*, Mike Ewall, *Legal Tools for Environmental Equity vs. Environmental Justice*, 13 SUSTAINABLE DEV. L. & POL'Y 4, 4–5(2012–2013) (criticizing EPA's watering down of the environmental justice framework).

47 Exec. Order 12,898, 59 Fed. Reg. at 7629 (emphasis added).

48 *See* Kaswan, *supra* note 37, at 153–55.

49 J. Nadine Gracia & Howard K. Koh, *Promoting Environmental Justice*, 101 AM. J. PUB. HEALTH S14, S15 (2011) (emphasis added).

50 *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, 2012 ENVIRONMENTAL JUSTICE STRATEGY AND IMPLEMENTATION PLAN 6 (2012), *available at* http://www.hhs.gov/environmentaljustice/strategy.pdf.

51 Gracia & Koh, *supra* note 49, at S15.

> broader conversation within the health sector to eliminate health disparities . . . . [P]opulations that experience health disparities related to other social determinants of health, such as access to health care and access to healthy foods, tend to be the same populations that live in communities overburdened with environmental pollution.[52]

The fact that federal agencies have explicitly adopted a broad-based and cross-cutting commitment to environmental justice is fortuitous for my purpose here. On the other hand, given that environmental justice began as a critique of mainstream environmental protection law, EPA responsibility for ensuring environmental justice arguably amounts to "[a]sking the fox to guard the henhouse."[53] A 1998 administrative decision regarding a Title VI complaint filed with the agency's Office of Civil Rights illustrates the pitfalls of asking an agency—whose mandate adopts a market-justice oriented conception of government's cabined role in ensuring environmental protection—to add a thin veneer of social justice to its activities. Ruling on a complaint filed against Michigan's environmental agency for permitting a steel company to build a new mill in the predominantly African-American neighborhood of Flint, Michigan, the EPA "assumed that the proposed steel mill would be in compliance with environmental laws, and held that complying with environmental laws means that there would be no 'adverse effect' on the community" and therefore no discriminatory effect.[54] This decision and others indicate that, notwithstanding E.O. 12898, the breadth of the environmental justice mission is still very much in dispute within the EPA.

C. Reproductive Justice

The SisterSong Women of Color Reproductive Justice Collaborative (a network of eighty grassroots organizations) defines reproductive justice in terms of "the right to have children, not have children, and to parent the children we have in safe and healthy environments."[55] It has

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52 Onyemaechi C. Nweke & Charles Lee, *Achievement of Environmental Justice: Perspectives on the Path Forward Through Collective Action to End Health Disparities*, 101 AM. J. PUB. HEALTH S6, S6 (2011).

53 *See* Ewall, *supra* note 46, at 9; *see also* Kaswan, *supra* note 37 (discussing the tension between environmental justice and dominant environmental law paradigms as one explanation for the limited impact of federal administrative environmental justice initiatives, but ultimately lauding EPA efforts under the Clinton and Obama administrations to "provide mechanisms for citizen and grassroots input").

54 Ewall, *supra* note 46, at 10.

55 *Why is Reproductive Justice Important for Women of Color?*, SISTER SONG, http://www.sistersong.net/index.php?option=com_content&view=article&id=141&Itemid=81 (last visited Aug. 31, 2014).

been described as a transformation of the pro-choice movement for abortion rights.[56] "[H]ighlighting the lived experience of reproductive oppression in communities of color," the reproductive justice movement "represents a shift for women advocating for control of their bodies from a narrower focus on legal access and individual choice (the focus of mainstream organizations) to a broader analysis of racial, economic, cultural, and structural constraints on our power."[57]

From its inception, the reproductive justice movement has been globally conscious and explicitly tied to the environmental justice movement. Although the term "reproductive justice" and the emphasis on the experiences of women of color were developed as a critique from within the U.S. pro-choice community, Loretta Ross, a key figure in the reproductive justice movement, traces the movement's roots to the 1994 International Conference on Population and Development in Cairo.[58] "The 1994 Conference was explicitly given a broader mandate on development issues than previous population conferences, reflecting the growing awareness that population, poverty, patterns of production and consumption and the environment are so closely interconnected that none of them can be considered in isolation."[59] The Programme of Action that arose out of the Cairo meeting recognized reproductive health as a human right and recognized gender equality, empowerment of women, and equal access to education for girls as sustainable development priorities.[60] Scholars and grassroots advocates continue to identify and strengthen linkages between the reproductive justice movement and the environmental justice movement that preceded it.[61]

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56 Loretta Ross, *Understanding Reproductive Justice: Transforming the Pro-Choice Movement*, OFF OUR BACKS 14, no. 4, 2006, at 14.

57 SISTERSONG, *supra* note 55.

58 *Id. See also* Joan C. Chrisler, *Introduction: A Global Approach to Reproductive Justice—Psychosocial, and Legal Aspects and Implications*, 20 WM. & MARY J. WOMEN & L. 1 (2013).

59 International Conference on Population and Development, Cairo, Egypt, Sept. 5-13, 1994, *Report of the International Conference on Population and Development*, U.N. Doc. A/CONF.171/13/Rev.1 (1995), *available at* http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf.

60 *See id.* ¶ 1.1–1.15.

61 *See* Kristen Zimmerman & Vera Miao, *Fertile Ground: Women Organizing at the Intersection of Environmental Justice and Reproductive Justice,* MOVEMENT STRATEGY CTR. 6 (2009), *available at* http:// fundcrservices.rnovementstrategy.org/a/wp-content/uploads/FcrtileGround.pdf; Chinue Turner Richardson, *Environmental Justice Campaigns Provide Fertile Ground for Joint Efforts with Reproductive Rights Advocates*, GUTTMACHER POL. REV., Winter 2006, at 14, 17, *available at* http://www.guttmacher.org/pubs/gpr/09/1/gpr090114.pdf ; MOVEMENT STRATEGY CTR., EXECUTIVE SUMMARY: GENDER, ORGANIZING, AND MOVEMENT BUILDING AT THE INTERSECTION OF ENVIRONMENTAL JUSTICE AND REPRODUCTIVE JUSTICE 4 (2000), *available at* http://movementbuilding.movementstrategy.org/media/docs/9946_FertileGround_ExecSum.pdf; Angie McCarthy, *On Fertile Ground: The Environmental and Reproductive Justice Movements as a Unified Force for Reforming Toxic Chemical Regulation*,

Legal scholar Robin West's urging of "a broader political argument for reproductive justice in women's lives that embraces, but does not center upon, rights-based claims" explores many of the insights of the reproductive justice movement.[62] Her critique of *Roe v. Wade* and "the various 'choice-based' arguments put forward by the pro-choice advocacy community" suggests that although they have "secured for individuals a fairly robust constitutional right to legal abortion," they have simultaneously "ill served not only progressive politics broadly conceived, but also have ill served women, both narrowly in terms of our reproductive lives and needs, and more generally."[63] Progressive politics and women themselves would be better served, West argues, by "putting legal abortion in its place" in the context of a reproductive justice agenda that "seek[s] greater justice for pregnant women who choose to carry their pregnancies to term, working families, and struggling mothers."[64]

Like the environmental justice movement, the reproductive justice movement has struggled over the role of lawyers and other formally educated experts in defining and achieving social justice goals.[65] Legal scholar Sarah London's analysis of this issue points to the ways in which lawyers are implicated in the elitism challenged by each of the three movements discussed in this Article.[66] She suggests that the reproductive justice movement's historical development as a critique from within the reproductive rights movement shapes its response to lawyers' involvement. The women of color who organize the reproductive justice movement reject the lawyer-driven focus of the pro-choice movement on a narrow legal right to abortion framed in terms of privacy.[67] While "[l]awyers have played a significant role in shaping the [reproductive rights] movement's agenda, in developing its strategy and in constricting its rhetoric," their role in the reproductive justice movement is necessarily more marginal in light of the "disempowering effects" of lawyer-centeredness and the government-centered strategies that lawyers tend to favor.[68]

SUSTAINABLE DEV. L. & POL'Y, no. 1, 2012–2013, at 20; Sarah London, *Reproductive Justice: Developing a Lawyering Model*, 13 BERKELEY J. AFR.-AM. L. & POL'Y 71 (2011).

62 Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1396–97 (2009).

63 *Id.* at 1396.

64 *Id.* at 1427. Rachel Rebouché has articulated a similar critique in her exploration of the "gap between law and practice," of the legal right to abortion in the South African context, which "highlight[s] some of the limitations of decriminalization and liberalization agendas for those advocating on behalf of reproductive rights." Rachel Rebouché, *The Limits of Reproductive Rights in Improving Women's Health*, 63 ALA. L. REV. 1, 3 (2011).

65 *See* London, *supra* note 61.

66 *Id.*

67 *Id.* at 85–88.

68 *Id.* at 83.

Although reproductive justice advocates do not often rely explicitly on health disparities data, access to health care and healthy living conditions feature prominently among their priorities. Access to health care—not merely as a matter of the "right to choose" contraception or abortion, but as a matter of the general affordability, availability, and cultural appropriateness of a wide range of health services for women and families—is a priority issue for the movement. Additionally, advocates' emphasis on "safe and healthy environments" for raising children encompasses access to clean air, water, and safe and healthy food as well as health care, housing, education, employment, and other social determinants of health.

D. Food Justice

Like the reproductive justice movement, the food justice movement's origins are linked to the seminal framework of the environmental justice movement. Robert Gottlieb and Anupama Joshi, authors of a recent book on food justice, point to a key moment when food policy scholars began to draw parallels between "environmental justice advocacy and the approach of some emerging community food groups."[69] There is tension within the food justice movement, however, over the centrality of economic and racial justice. "The shift toward a new language has not always been smooth" as groups seeking to reform industrial food production have adopted the food justice framework.[70] The muddiness here may be attributable to the food justice movement's occasional conflation with the alternative food movement, which journalist Michael Pollan has described as being "unified as yet by little more than the recognition that industrial food production is in need of reform because its social/environmental/public health/animal welfare/gastronomic costs are too high."[71] Legal scholar Rebecca Goldberg suggests that the food justice movement might be understood as arising out of concerns that the alternative food movement is elitist.[72] "[W]ith its focus on farmers' markets and a do-it-yourself avoidance of processed food," she writes, "many of the food movement's goals do seem aimed at those with disposable income and disposable time."[73] In contrast, the food justice

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69 ROBERT GOTTLIEB & ANUPAMA JOSHI, FOOD JUSTICE 4 (2010) (citing Robert Gottlieb & Andy Fisher, *Community Food Security and Environmental Justice: Converging Paths Towards Social Justice and Sustainable Communities*, RACE, POVERTY & ENV'T, no. 2, 2000, at 18).

70 *Id.* at 7.

71 Michael Pollan, *The Food Movement, Rising*, N.Y. REV. BOOKS, June 10, 2010, *available at* http://www.nybooks.com/articles/archives/2010/jun/10/food-movement-rising/.

72 Rebecca L. Goldberg, *No Such Thing as a Free Lunch: Paternalism, Poverty, and Food Justice*, 24 STAN. L. & POL'Y REV. 35, 48–49 (2013).

73 *Id.* at 49.

movement "focuses on the barriers that low-income or otherwise marginalized groups face in realizing the goals of the broader food movement, such as access to fresh, unprocessed food."[74]

Christopher J. Curran and Marc-Tizoc González have gone considerably further in centering their discussion of food justice on race.[75] They suggest "that food justice be understood and practiced as interracial justice,"[76] pointing to urban farming as "the latest evolution in the long struggle for interracial justice," at least in one community.[77] The story they tell about urban farmers, community organizations, and the role of government in the city of Oakland, California puts health disparities front and center: "This broad movement for food justice has arisen due to a deepening community health crisis; communities of color have long faced disproportionate rates of cancer, diabetes, and illnesses associated with lack of access to nutritious food and other forms of environmental racism."[78] As legal scholars, Curran and González advocate for the use of laws and policies (primarily at the local and state level) to support the food justice movement's response to this crisis.[79] But they are careful to note that some activists within the movement explicitly reject government intervention in favor of community activism.[80]

Many definitions of food justice put health in the foreground. For example, Just Food (a nonprofit organization devoted to "[b]uilding a just and sustainable food system" for New York City)[81] proclaims that "[f]ood justice is communities exercising their right to grow, sell, and eat healthy food."[82] The group goes on to define "healthy" food in a way that extends beyond a narrow conception of physical human health: "Healthy food is fresh, nutritious, affordable, culturally-appropriate, and grown locally with care for the well-being of the land, workers, and ani-

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74 *Id.*

75 Christopher J. Curran & Marc-Tizoc González, *Food Justice as Interracial Justice: Urban Farmers, Community Organizations and the Role of Government in Oakland, California*, 43 U. MIAMI INTER-AM L. REV. 207, 210 (2011) (noting that "without an express commitment to anti-racism, and a multidimensional conceptualization of interracial justice that is grounded in Oakland's concrete locality and history, we fear and predict that food justice efforts will likely exacerbate existing racial conflicts, as have so many prior laws and policies that are bound by colorblindness or the nascent post-racial ideology.").

76 *Id.* at 209.

77 *Id.* at 207.

78 *Id.* Others have similarly pointed to the ways in which "food oppression" is a form of structural racism. *See, e.g.*, Andrea Freeman, *Fast Food: Oppression Through Poor Nutrition*, 95 CAL. L. REV. 2221 (2007); Kate Meals, *Nurturing the Seeds of Food Justice: Unearthing the Impact of Institutionalized Racism on Access to Healthy Food in Urban African-American Communities*, 15 SCHOLAR 97 (2012).

79 *See* Curran & González, *supra* note 75, at 229–31.

80 *Id.* at 230–31.

81 *About Us*, JUST FOOD, http://justfood.org/about-us (last visited Aug. 31, 2014).

82 *Food Justice*, JUST FOOD, http://justfood.org/food-justice (last visited Aug. 31, 2014).

mals."[83] The group also emphasizes the benefits of "[p]eople practicing food justice" in terms of "a strong local food system, self-reliant communities, and a healthy environment."[84] In other definitions, health recedes into the background as one of many concerns implicated by food systems. Tim Lang and Michael Heasman have pointed to a wide range of injustices in the food system, including "the maldistribution of food, poor access to a good diet, inequities in the labour process and unfair returns for key suppliers along the food chain."[85] Gottlieb and Joshi hold that food justice seeks to "ensur[e] that the benefits and risks of where, what, and how food is grown and produced, transported and distributed, and accessed and eaten are shared fairly."[86] They describe the movement as having "the potential to link different kinds of advocates, including those concerned with health, the environment, food quality, globalization, workers' rights and working conditions, access to fresh and affordable food, and more sustainable land use."[87] Goldberg has taken a different approach altogether, describing the food justice movement as offering a "narrative . . . regarding food in low-income communities" that she contrasts with the anti-hunger narrative on the one hand and the public health anti-obesity narrative on the other.[88]

Goldberg points to the fact that scholars and lawyers are merely catching up to grass roots activists.[89] "For the food justice movement, this grassroots activism generally takes the form of not-for-profit organizations that work to give low-income neighborhoods access to the types of food that are prized by the broader food movement—fresh, whole food that is as divorced as possible from industrial production."[90] She points out that "[s]uch groups . . . almost never speak in terms of obesity, though some commentators see that as one underlying motivator. They speak instead about rights, equality, community empowerment, cultural appropriateness, and, of course, justice."[91]

II. LAW AS A TOOL FOR REDUCING HEALTH DISPARITIES

The interrelated social justice movements described in Part I have all focused to some extent on reducing health disparities. While few dis-

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83 *Id.*

84 *Id.*

85 TIM LANG & MICHAEL HEASMAN, FOOD WARS: THE GLOBAL BATTLE FOR MOUTHS, MINDS AND MARKETS 8 (2004).

86 GOTTLIEB & JOSHI, *supra* note 69, at 6.

87 *Id.* at 5.

88 Goldberg, *supra* note 72, at 40–55.

89 Goldberg, *supra* note 72, at 50 (quoting Gerald Torres, *Environmental Justice: The Legal Meaning of a Social Movement*, 15 J.L. & COM. 597, 601 (1996)).

90 *Id.* at 50.

91 *Id.* at 50–51.

pute this basic goal, lawmakers, scholars, and the general public are deeply divided over the most appropriate means for achieving it. Sharp disagreement over our increasingly collective approach to financing health care is spilling over into a national conversation about individual versus collective responsibility for health in which social and cultural biases are undeniably in evidence.[92] While conservatives lambast the Obama administration for expanding Medicaid eligibility beyond the "deserving" poor, progressives argue that the administration is undermining its own health reform goals by gutting legal protections for individual Medicaid recipients and providers.[93] Anti-hunger groups are clashing with public health advocates over proposals to restrict the use of nutrition assistance benefits to purchase unhealthy food and beverage products.[94] Nutrition and public health advocates have suggested that the opposition of some civil rights groups to anti-obesity regulations can be explained away by their financial ties to the soda industry.[95]

Before sketching out how the tension between individual and collective responsibility for health can be productively and rigorously examined through a social justice lens in Part III, I will provide an overview of the legal toolkit for reducing health disparities. Policymakers at every level of government are developing and implementing a diverse array of law and policy interventions for improving health generally and reducing health disparities in particular. Ensuring more equitable access to health care has been the primary focus of these efforts at the federal level. Recognizing that access to medical care is far from a complete response to health disparities, state and local governments have pioneered innovative approaches for encouraging healthier behaviors and creating healthier communities. Some of these efforts explicitly target low-income or minority communities. Most are universally applicable, but have a disparate impact on the poor or other socially disadvantaged groups (whether by design or incidentally). My aim in this Part is to make the case for health law's increasing emphasis on access to health care and healthy living conditions, while also highlighting the many tensions generated by this new focus.

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92 *See* Janet L. Dolgin & Katherine R. Dieterich, *Weighing Status: Obesity, Class, and Health Reform*, 89 OR. L. REV. 1113 (2011); Dayna Bowen Matthew, *The Social Psychology of Limiting Healthcare Benefits for Undocumented Immigrants—Moving Beyond Race, Class, and Nativism*, 10 HOUS. J. HEALTH L. & POL'Y 201 (2010); Lindsay F. Wiley, *Access to Health Care as an Incentive for Healthy Behavior? Assessing the Affordable Care Act's Personal Responsibility for Wellness Reforms*, 11 IND. HEALTH L. REV. 641 (2014).

93 *See* Brietta R. Clark, *Medicaid Access, Rate Setting, and Payment Suits: How the Obama Administration is Undermining Its Own Health Reform Goals*, 55 HOW. L.J. 771 (2012).

94 *See infra* Part II.B.

95 *See infra* Part II.C.

A. Ensuring Access to Affordable, High-Quality Health Care

Universal access to health care has been the subject of intense political debate in the United States for more than a hundred years. While many other industrialized countries adopted compulsory private insurance systems or universal public insurance, U.S. progressives struggled to eke out even the most modest reforms.[96] High-profile federal proposals were defeated during the Progressive Era at the turn of the twentieth century and again during the New Deal of the 1930s.[97] Eventually, Medicare (for the elderly and disabled) and Medicaid (for carefully delineated categories of the "deserving" poor) were created as part of the War on Poverty of the 1960s.[98] Since the initiation of these programs, there have been many (mostly unsuccessful) efforts to expand eligibility, including proposals to adopt "Medicare for all" as a form of single-payer health care. But, as legal scholars Janet Dolgin and Katherine Dieterich note,

> [in our] competitive and uncertain socioeconomic setting, large groups of Americans—especially those struggling to sustain middle-class status—have long feared that expanding health care coverage and extending it to larger groups of people will blur the boundaries between those at the lower reaches of the middle class and those even less well-off. The fear has not generally been directly or expressly acknowledged.[99]

In addition to bringing about a major expansion of health care coverage for groups who were not well served by the private employer-based system, the establishment of publically financed health care programs (particularly Medicare) gave the federal government powerful influence over the organization of the health care delivery system.[100] The Johnson administration took advantage of the infusion of federal money into the health care system, coupled with Title VI's prohibition on discrimination by recipients of federal funding, to desegregate American hospitals as a condition of participation in Medicare.[101] But this impres-

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96 *See* Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75 (2003).

97 *See id.* at 76.

98 *See id.* at 77.

99 Dolgin & Dieterich, *supra* note 92, at 1116; *see also* Ed Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1 (1981) (describing Medicaid and other progressive reform efforts as pitting the working class against the very poor and calling for legal services advocates to use health law as a means to unite the poor and working poor under a shared social cause).

100 *See* ROBERT I. FIELD, MOTHER OF INVENTION: HOW THE GOVERNMENT CREATED "FREE MARKET" HEALTHCARE (2013).

101 Watson, *Section 1557*, *supra* note 11, at 865.

sive effort left behind considerable racial segregation in nursing homes and physician practices that persists to this day.[102] Explicit, implicit, and structural biases continue to shape the health care experiences of racial and ethnic minorities and other socially and economically disadvantaged people. People of color, people with disabilities, and people with limited means are less likely to have health insurance coverage and less likely to receive needed medical care even if they do have coverage.[103] The quality of care that they receive tends to be lower, they are subject to higher rates of medical error, and their health outcomes suffer as a result.[104]

The misfit between the civil rights paradigm of assigning blame to individual perpetrators of discrimination and the structural nature of health care disparities has hampered the effectiveness of civil rights laws in this context. "[D]isparity issues are complex and may be deeply embedded in providers' actions and patients' decisions, as well as in institutional policies and practices. Given this genesis, many disparities are unlikely to be suitable to the approach required by civil rights laws."[105] Health law regulations aimed at improving access and quality for all without explicitly targeting historically disadvantaged groups gradually came to be seen as a more promising avenue for reducing disparities.[106]

In the 1980s and 1990s, health care providers and private health plans were subjected to considerable regulation aimed at curtailing widely reviled practices like patient dumping and exclusion of coverage for pre-existing conditions. The Emergency Medical Treatment and Labor Act of 1986[107] (EMTALA) required that hospitals operating emergency departments and accepting federal Medicare reimbursement to provide screening and stabilizing treatment for emergency medical conditions to all patients who come to the emergency room, regardless of ability to pay.[108] EMTALA created a safety net of last resort,[109] obligat-

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102 *Id.*

103 *See* Ctrs. for Disease Control and Prevention, supra note 2, at 3.

104 *Id.*

105 SIDNEY WATSON, THE COMMONWEALTH FUND, EQUITY MEASURES AND SYSTEMS REFORM AS TOOLS FOR REDUCING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 3 (2005).

106 *Id.* ("The adoption of systems reform, which moves disparity-reduction efforts from the civil rights arena into the world of health care quality regulation, may ease this limitation.").

107 42 U.S.C. § 1395dd (2013).

108 *See* W. David Koeninger, *The Statute Whose Name We Dare Not Speak: EMTALA and the Affordable Care Act*, 16 J. RACE, GENDER & JUST. 139 (2013); *see also* Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21 (1989).

109 The Affordable Care Act is expected to achieve major gains in health care coverage, but there will still be around 30 million uninsured after full implementation. *See* Rachel Nardin et al., *The Uninsured After Implementation of the Affordable Care Act: A Demographic and Geographic Analysis*, HEALTH AFFAIRS BLOG (June 6, 2013), http://healthaffairs.org/blog/2013/06/06/the-uninsured-after-implementation-of-the-affordable-care-act-a-demographic-

ing health care providers to provide treatment in cases where they determine that a patient's symptoms are acute and severe enough "that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual . . . in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."[110]

In addition to the emergency care provided pursuant to EMTALA, more routine charity care for those who lack sufficient health insurance coverage is sometimes provided by nonprofit hospitals free of charge or at a reduced price. Charity care requirements were attached to federal funding under the 1946 Hill Burton Act,[111] and have been incorporated into some community benefit requirements attached to the tax-exempt status of nonprofit hospitals. Community benefit requirements at the state and federal level have been made somewhat more stringent in recent years,[112] but the care provided pursuant to these requirements is negligible compared to community needs—to the extent that they might fairly be characterized as largely symbolic.

The Health Insurance Portability and Affordability Act of 1996[113] (HIPAA) prohibited private employer-based health plans from denying coverage or imposing differential terms on individuals based on health-related factors. It also sharply limited the exclusion of coverage for pre-existing conditions. Combined with COBRA's provision for temporary extensions of coverage, HIPAA's portability regulations provided considerable protection for individuals and families who rely on employer-based coverage. Many states also adopted regulations curtailing private health plan managed care practices like utilization review, limited provider networks, and provider payment arrangements that create incentives for reducing care.[114]

HIPAA and COBRA helped those who receive health insurance as a benefit of employment, state laws provided some additional protections to those with private health insurance, and EMTALA provided for limited emergency care regardless of insurance status, but millions of Amer-

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and-geographic-analysis/. As a result, the last-resort safety net of mandated emergency care continues to be quite relevant to health care access.

110 42 U.S.C. § 1395dd(e)(1)(A) (2013).

111 The Hospital Survey and Construction Act of 1946, P.L. 79-725, (commonly known as the Hill-Burton Act) was enacted to provide federal financial assistance for the planning, construction, and improvement of health care facilities through grants and guaranteed loans.

112 *See* MARTHA H. SOMERVILLE ET AL., HOSPITAL COMMUNITY BENEFITS AFTER THE ACA (2013), *available at* http://community-wealth.org/sites/clone.community-wealth.org/files/downloads/paper-somerville-et-al-Hilltop.pdf.

113 29 U.S.C. §§ 1181–1191c (1996).

114 *See* Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Managed Care Regulation*, 65 L. & CONTEMP. PROBS. 169 (2002). With respect to self-insured health plans, these state regulations are preempted by ERISA's deemer clause.

icans still struggled to obtain affordable, high-quality health insurance and those left without it had a very difficult time accessing needed care. In 2010, the Affordable Care Act deployed a combination of ambitious private health insurance market reforms, subsidies for the purchase of private insurance, and expanded Medicaid eligibility[115] to move the country closer to universal coverage.[116]

The ACA also included significant provisions to improve the quality of health care for all Americans, with a special emphasis on reducing disparities. Although a great deal of health care quality improvement regulation takes place at the state level, federal conditions on Medicare participation also play a hugely important role and the Centers for Medicare and Medicaid Services uses a wide range of tools to promote higher quality care, particularly in hospitals. The Affordable Care Act revitalized these efforts and focused them more explicitly on addressing disparities.[117]

ACA reforms are supplemented by the Obama Administration's efforts to make reduction of health disparities a priority for federal agencies.[118] These efforts—which include development of the National Partnership for Action to End Health Disparities,[119] its National Stakeholder Strategy for Achieving Health Equity,[120] and the DHHS Action

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115 The ACA, as drafted, would have required all states accepting Medicaid funds (which is to say, all states) to expand Medicaid eligibility to millions of uninsured Americans who were previously ineligible under federal law. The provision is particularly important for non-disabled, non-elderly adults who do not have dependent children (because they were not previously eligible at any income level), as well as for many non-disabled parents and older children (who were previously covered only at extremely low income levels). In *NFIB v. Sebelius*, however, the Supreme Court held that the ACA's penalty for states unwilling to expand Medicaid was unconstitutionally coercive. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012). The result is that the expansion is entirely optional for states. The expansion remains a very attractive financial proposition for states, with the federal government picking up 100% of the tab initially, phasing down to 90% over the course of a few years. In our divisive political climate, however, many Republican legislatures and governors declined the expansion as a way of staking out their opposition to the President and the ACA. The result is that eligibility now varies even more dramatically from state to state than in the past, and many poor, uninsured adults will be left without coverage.

116 Carter C. Price & Christine Eibner, *For States that Opt Out of Medicaid Expansion: 3.6 Million Fewer Insured and $8.4 Billion Less in Federal Payments*, 32 HEALTH AFF. 1030 (2012).

117 Majette, *supra* note 13, at 915.

118 *See id.* at 926–27.

119 National Partnership for Action to End Health Disparities, *Learn About the NPA*, U.S. DEP'T. OF HEALTH AND HUMAN SERVICES (Apr. 4, 2011, 8:44 A.M.), http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=11.

120 National Partnership for Action to End Health Disparities, *National Stakeholder Strategy for Achieving Health Equity*, U.S. DEP'T. OF HEALTH AND HUMAN SERVICES (Sept. 19, 2011, 10:35 A.M.), http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286.

Plan to Reduce Racial and Ethnic Health Disparities[121]—parallel the administration's adoption of the environmental justice framework in many ways.[122]

As the bedrock of health law efforts to ensure financial access to health care for the poor, the Medicaid program warrants more detailed discussion here. The coverage provided by traditional Medicaid was designed specifically to meet the needs of low-income families, offering benefits like long-term care and dental care not typically covered by private health plans. Even as eligibility is expanding under the ACA, however, many advocates are expressing concern that the quality of coverage is suffering from increased flexibility in federal requirements and state budget cuts.[123] At the same time, the rights of Medicaid beneficiaries are being sharply curtailed by the courts.[124]

About one quarter of the U.S. population is covered by Medicaid or the Children's Health Insurance Program (CHIP), a federally block-granted adjunct to Medicaid.[125] Unlike Medicare, which is entirely federally run, Medicaid and CHIP are funded and administered jointly by

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121 DEP'T OF HEALTH AND HUMAN SERVICES, ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES: A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE (2011), *available at* http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

122 DEP'T OF HEALTH AND HUMAN SERVICES, REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES AS REQUIRED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148), at ii, *available at* http://minorityhealth.hhs.gov/Assets/pdf/Checked/FINAL_Report_to_Congress_on_Minority_Health_Activities_Nov_2013.pdf (noting that "[t]he HHS Disparities Action Plan . . . leverages other national initiatives [including] the HHS Environmental Justice Strategy."). The Obama administration has linked Affordable Care Act implementation (like environmental protection) to civil rights. *See, e.g.*, Louise Radnofsky, *Obama Asks African-American Churches for Help with Health Law*, WALL ST. J., Aug. 26, 2013, http://blogs.wsj.com/washwire/2013/08/26/obama-asks-african-american-churches-for-help-with-health-law/?KEYWORDS=health+law; Sam Baker, *Sebelius Ties Healthcare Law to Civil Rights Anniversary*, THE HILL (Aug. 26, 2013), http://thehill.com/blogs/healthwatch/health-reform-implementation/318861-sebelius-ties-healthcare-law-to-civil-rights-anniversary; David Morgan, *Sebelius Seeks Civil Rights Support for U.S. Healthcare Law*, REUTERS (Apr. 12, 2012), http://www.reuters.com/article/2012/04/12/us-usa-healthcare-rights-idUSBRE83B1O820120412.

123 Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431 (2011); Sara Rosenbaum, *Medicaid at Forty: Revisiting Structure and Meaning in a Post-Deficit Reduction Act Era*, 9 J. HEALTH CARE L. & POL'Y 5 (2006); Dayna Bowen Matthew, *The "New Federalism" Approach to Medicaid, Empirical Evidence that Ceding Inherently Federal Authority to the States Harms Public Health*, 90 KY. L.J. 973 (2001–2002).

124 *See* Brietta R. Clark, *Medicaid Access, Rate Setting, and Payment Suits: How the Obama Administration Is Undermining Its Own Health Reform Goals*, 55 HOW. L.J. 771 (2012).

125 *Medicaid Enrollment as a Percent of Total Population, FY2010*, HENRY J. KAISER FAMILY FOUNDATION (2010), http://kff.org/medicaid/state-indicator/medicaid-enrollment-as-a-of-pop/ (indicating Medicaid enrollment as of 2010 as 21% of the total U.S. population); DIANE ROWLAND ET AL., MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, REPORT TO THE CONGRESS ON MEDICAID AND CHIP, (June 2013), *available at* https://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NWE3MTM2NWU4NjhhND

the federal government and the states. As such, they are governed by relatively broad federal guidelines that give states considerable leeway to determine the exact contours of eligibility and benefits.[126] Through a series of legislative reforms and readily granted administrative waivers,[127] that flexibility has increased to the point where many states are now shifting a large proportion of Medicaid beneficiaries into privatized plans, complete with cost-sharing requirements and benefits that fall below traditional Medicaid's generous coverage. Supporters argue that privatization and flexibility will protect the economic viability of the Medicaid program and may encourage more health care providers to accept Medicaid patients.

Opportunities for reform, experimentation, and advocacy on behalf of Medicaid beneficiaries are uniquely shaped by the program's joint federal-state administrative structure. Federal guidelines may constrain state and local authorities interested in pioneering reforms. In recent years, however, DHHS has granted waiver requests quite liberally to allow states to experiment with incentives to reward patient compliance and other healthy behaviors. Citing health disparities, West Virginia, Florida, and Idaho created incentive-based "wellness programs" in the mid-2000s.[128] A recent evaluation of these programs found that they had little to no impact on improving health behaviors or outcomes for Medicaid beneficiaries. Nonetheless, in late 2013, DHHS granted approval for Iowa to implement a similar program.

Some progressive advocates have taken issue with incentive-based programs, arguing that they inappropriately shift costs onto low-income patients and put the onus on individuals and families to change their health behaviors without necessarily making it easier for them to do so. Particularly in the context of political controversy over the Medicaid eligibility expansion, the rhetoric surrounding incentive-based reforms has taken on a punitive tone. For example, the governor of Idaho has indicated that he would only consider expanding Medicaid eligibility if there were some provision for "requir[ing] more personal responsibility and better health outcomes."[129] The Governor's statements indicate that he is clearly contemplating a punitive approach:

VmYQ (providing enrollment numbers for 2013 that equate to 23% of the total U.S. population).

126 *See* Huberfeld, *supra* note 123, at 447–48.

127 Section 1115 of the Social Security Act gives the DHHS Secretary authority to waive regulations with respect to approved experimental, pilot, or demonstration projects. With a § 1115 waiver, a state may develop and implement new approaches to coverage that would otherwise by prohibited under federal law. *Id.*

128 *See* Wiley, *supra* note 92.

129 Audrey Dutton, *Idaho Gov. Otter Wants More Personal Accountability in Medicaid*, IDAHO STATESMAN, May 30, 2013, http://www.idahostatesman.com/2013/05/30/2595854/carrots-and-sticks-for-medicaid.html.

> If you're smoking, you gotta quit smoking. . . and if you don't quit smoking, some part of the benefit, or all of it, goes away.
>
> If you've got a history of diabetes in your family, and you're told to change a certain lifestyle, and you don't do it, then you don't get [benefits] . . . anymore.[130]

Enforcement of federal spending program regulations can be quite weak and the interests of beneficiaries are sometimes treated as collateral to the power plays between the federal government and the states. The courts have approached these programs like quasi-contractual agreements between the federal government as funder and the states as administrators. The penalty for noncompliance with federal conditions on acceptance and use of the funds is typically revocation of the funds. In the case of Medicaid, the only enforcement tool available to the federal agency is total revocation—a blunt instrument that has occasionally been threatened, but never deployed.

Historically, private advocates have played an important role in enforcing federal guidelines.[131] But Medicaid beneficiaries seeking to litigate against states to ensure compliance with federal law are facing ever-mounting legal obstacles. For example, federal Medicaid law mandates that states must establish reimbursement rates for doctors and other health care providers that are adequate to ensure that Medicaid recipients' access to care is comparable to that of the general population.[132] This purported comparability of access is, in reality, a farce. But when patients and health care providers have sought to enforce this and other federal rules against states, they have encountered significant legal obstacles.[133] Initially, advocates found that § 1983 provided an avenue for

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130 *Id.*

131 Federal litigation is a particularly important tool for Medicaid recipients because "state administrative remedies are suited more for resolving individual Medicaid eligibility or service issues than for challenging systemic agency policy or practices." Ann B. Lever & Herbert A. Eastman, *"Shake It Up in a Bag": Strategies for Representing Beneficiaries in Medicaid Litigation*, 35 ST. LOUIS U. L.J. 863, 864 (1991). For example, private parties sued the Missouri program pursuant to § 1983 and the Supremacy Clause to get azidothymidine (AZT) added to the Medicaid drug formulary for AIDS patients. Gene P. Schultz & Charles A. Parmenter, *Medical Necessity, AIDS, and the Law*, 9 ST. LOUIS U. PUB. L. REV. 379 (1990).

132 Additionally, the ACA provided a temporary fee-for-service reimbursement rate increase for physician-provided primary care services applicable in 2013 and 2014 in an effort to encourage doctors to accept Medicaid enrollees as the expansion rolls out. KAISER COMM'N ON MEDICAID AND THE UNINSURED, INCREASING MEDICAID PRIMARY CARE FEES FOR CERTAIN PHYSICIANS IN 2013 AND 2014: A PRIMER ON THE HEALTH REFORM PROVISION AND FINAL RULE (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8397.pdf.

133 *See* Ruqaiijah Yearby, *Litigation, Integration & Transformation, Using Medicaid to Address Racial Inequalities in Health Care*, 13 J. HEALTH CARE L. & POL'Y 325 (2010).

litigation with compensatory damages available. Over time, however, the Supreme Court has tightened the standards for when a § 1983 claim may be brought to enforce Spending Clause legislation.[134] Advocates also turned to the Supremacy Clause (which allows for injunctive relief, but not compensatory damages) as a basis for litigation, but that avenue may also be narrowing.[135]

B. Encouraging Healthier Behavior Choices

Along with increasingly collective responsibility for ensuring access to health care comes renewed interest in collective responsibility for "upstream" prevention of disease and injury as a strategy for reducing health care costs, improving the public's health and wellbeing, and reducing health disparities. Over the last couple of decades, public health law has evolved from a narrow field focused primarily on "communicable disease law"[136] to the "study of the legal powers and duties of the state to assure the conditions for people to be healthy."[137] "New public health"[138] differs from "old public health"[139] in its expanded focus on non-communicable diseases (NCDs) such as heart disease, stroke, and diabetes and injuries, such as those caused by motor vehicle crashes, drug overdoses, and firearms. It also represents a major push beyond education and communication campaigns urging people to make healthier choices.[140] Experts and community groups have developed a host of strategies for using law and policy tools to improve health behaviors across the board, but particularly for socially and economically disadvantaged groups.

The use of law as a tool for changing health-related behaviors encompasses long-standing measures like vaccination mandates as well as

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134 *Id.*

135 *See* Steven Clark, *At Risk Patients and Doctors: Why Increased Agency Enforcement and Private Causes of Action Under the Supremacy Clause are Needed to Protect Medicaid Providers and Beneficiaries*, 101 KY. L.J. 183 (2012); Douglas v. Indep. Living Ctr., 132 S. Ct. 1204 (2012) (declining to decide whether Medicaid beneficiaries and providers can challenge a state law in federal court on the basis that it violates the federal Medicaid Act and therefore is "preempted" by the Supremacy Clause of the U.S. Constitution, on the grounds that the issue should be reheard by the Ninth Circuit in light of DHHS approval of the challenged state law).

136 Lawrence O. Gostin, Scott Burris & Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 62 (1999).

137 GOSTIN & WILEY, *supra* note 17.

138 *See* Wiley, *supra* note 92.

139 *See* Richard A. Epstein, *Let the Shoemaker Stick to His Last: In Defense of the "Old" Public Health*, 46 PERSPS. BIOLOGY & MED. S128 (2003).

140 *See* Wiley, *supra* note 92, at 219–25 (comparing the communication- and education-focused "behavioral model" that dominated public health in the second half of the twentieth century with the "ecological model"—emphasizing the social, environmental, and cultural factors that influence health behaviors—that is the focus of new public health).

more recent applications like seat-belt laws, smoking bans, and excise taxes. These measures tend to be universally applicable, but they often have a disproportionate impact on socially disadvantaged groups.

Whether that disparate impact is a good thing or a bad thing can be difficult to tease out. For example, acceptance of childhood vaccinations is actually higher among low-income families than among the well-to-do.[141] The protection afforded by immunization is certainly a good thing, but to the extent that wealthy parents who perceive vaccinations as risky and have the wherewithal to opt out of mandates are free-riding on herd immunity supported by the actions of lower-income parents, there may be a significant fairness problem. In another example, studies evaluating the impact of making failure to wear a seat belt a primary offense (meaning that seat-belt use alone is a legitimate basis for a traffic stop) have found that primary enforcement is associated with a disproportionate increase in seat-belt use among African-Americans.[142] The researchers lauded this as a positive strategy for reducing long-standing disparities in seat-belt use (and fatality rates for motor vehicle crashes) among African-Americans. But that framing elides the deeply concerning reasons that primary enforcement has a particularly strong influence on black drivers and passengers.[143] Indeed, civil liberties and anti-discrimination groups have opposed primary enforcement reforms, based on concerns about racial bias in traffic stops.[144] Tobacco control laws have successfully "denormalized" smoking as a socially acceptable behavior, turning the tide against one of the leading risk factors for premature death and illness. But some advocates question whether stigmatization continues to be an appropriate strategy in light of widening social disparities between people with higher incomes and more formal education (among whom smoking rates have declined most rapidly) and those with lower incomes and less formal education (who make up an increasingly disproportionate share of the 18% of Americans who are current smok-

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141 Total lack of vaccination is more common among children who are non-Hispanic white, whose mothers are older and have received more formal education, and who come from households earning more than $75,000. Undervaccination—receipt of some, but not all recommended vaccinations—remains a persistent problem among low-income families. P.J. Smith et al., *Children Who Have Received No Vaccines: Who Are They and Where Do They Live?*, 114 PEDIATRICS 187, 189 (2004).

142 Nathaniel C. Briggs et al., *Seat Belt Law Enforcement and Racial Disparities in Seat Belt Use*, 31 AM J. PREVENTATIVE MED. 135 (2006).

143 *Id*. at 139 (noting that researchers in two studies finding that primary enforcement has a disparate impact on seat belt use among African Americans "attributed findings to a perception among blacks of an increased likelihood of being ticketed for seat belt law violations in primary-law states because of the potential for differential enforcement").

144 *See* NAT'L HIGHWAY TRANSP. SAFETY ADMIN., U.S. DEP'T OF TRANSP., DOCUMENTING HOW STATES RECENTLY UPGRADED TO PRIMARY SEAT BELT LAWS (2011).

ers).[145] These and many other examples illustrate the "[g]enuine ambivalence about obliterating disparities in health and socioeconomic status [that] underlies 'prevention' efforts."[146]

Because NCDs associated with unhealthy eating habits are a primary driver of death, disability, and health disparities, law and policy interventions for promoting healthy eating merit special attention here. Justice Scalia famously warned that if the government can force people to buy health insurance, there is nothing to stop it from forcing them to buy broccoli as well.[147] So far, no one has seriously proposed an "eat your vegetables" mandate, but state and local governments are pursuing a wide range of strategies to make healthy choices easier and unhealthy choices harder, including subsidization of fresh produce and taxation of harmful products.[148] The ACA itself includes a calorie-labeling mandate for restaurant menu items, which was first pioneered by local and state governments.[149]

Like tobacco taxes, "soda taxes," whereby state and local governments either impose a special tax on sugar sweetened beverages or simply revoke the regular sales tax exemption that applies to other food and beverage sales, have been adopted by several state and city governments.[150] But the tide appears to be turning against these measures, driven by "controversy over their effectiveness, their impact on the poor,

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145 *See* Kirsten Bell et al., *Smoking, Stigma and Tobacco 'Denormalization': Further Reflections on the Use of Stigma as a Public Health Tool. A Commentary on Social Science & Medicine's Stigma, Prejudice, Discrimination and Health Special Issue*, 70 SOC. SCI. & MED. 795, 795 (2010) (suggesting that "stigmatizing smoking will not ultimately help to reduce smoking prevalence amongst disadvantaged smokers — who now represent the majority of tobacco users. Rather, it is likely to exacerbate health-related inequalities by limiting smokers' access to healthcare and inhibiting smoking cessation efforts in primary care settings"). It may also be the case that social disparities are what make the use of shame-based interventions politically feasible in the first place. *See* Ronald Bayer & Jennifer Stuber, *Tobacco Control, Stigma, and Public Health: Rethinking the Relations*, 26 AM. J. PUB. HEALTH 47, 49 (2006) (noting that states with aggressive antismoking campaigns began to "embrace a strategy of denormalization" only after "the social class composition of smokers underwent a dramatic shift downward").

146 Dolgin & Dieterich, *supra* note 92, at 1139.

147 James B. Stewart, *How Broccoli Landed on Supreme Court Menu*, N.Y. TIMES, June 13, 2012, at A1, *available at* http://www.nytimes.com/2012/06/14/business/how-broccoli-became-a-symbol-in-the-health-care-debate.html?_r=0.

148 *See* Lindsay F. Wiley, Manel Kappagoda & Anne Pearson, *Public Health Law: Healthy and Unhealthy Behaviors*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW (Glenn Gohen, Allison Hoffman & William Sage eds., forthcoming 2014) (describing the public health law toolkit for influencing health behaviors through environmental changes).

149 Patient Protection and Affordable Care Act, Pub. L. No. 111-1448, § 4205, 124 Stat. 119, 573–576 (2010) (requiring restaurants to disclose calorie counts on menus).

150 Lawrence O. Gostin et al., *Assessing Laws and Legal Authorities for Obesity Prevention and Control*, 37 J.L. MED. & ETHICS 28, 31 (Supp. 1 2009).

general aversion to increased taxes,"[151] as well as a well-financed lobbying campaign by the beverage industry.[152] The regressive nature of excise taxes has been noted ruefully by public health advocates,[153] but they argue that the disproportionate financial burden of these taxes on the poor is outweighed by their disproportionate *benefit* in addressing high consumption of tobacco, sugary drinks, and the like (and associated disparities in health problems like lung cancer and diabetes) among low-income and nonwhite communities.

Several state and local policymakers have expressed interest in a more targeted approach: restricting the use of Supplemental Nutrition Assistance Program (SNAP, but better known as "food stamps") benefits

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151 Judith A. Monroe et al., *Legal Preparedness for Obesity Prevention and Control: A Framework for Action*, 37 J.L. MED. & ETHICS 15, 18 (Supp. 1 2009).

152 New soda tax proposals since 2010 have overwhelmingly met with political defeat, and some states have even repealed previously adopted taxes. Joey Peters, *Soda Taxes Fizzle in Wake of Industry Lobbying*, WASH. POST, Jul. 13, 2010, http://www.washingtonpost.com/wp-dyn/content/article/2010/07/13/AR2010071303494.html; Duff Wilson & Janet Roberts, *Special Report: How Washington Went Soft on Childhood Obesity*, REUTERS (Apr. 27, 2012), http://www.reuters.com/article/2012/04/27/us-usa-foodlobby-idUSBRE83Q0ED20120427 (reporting that during the past two years, each of the twenty-four states and five cities that considered "soda taxes" to discourage consumption of sugary drinks has seen the efforts dropped or defeated); *but see* Caroline Scott-Thomas, *D.C. Council Approves Soda Tax*, FOOD NAVIGATOR USA (May 28, 2010), http://www.foodnavigator-usa.com/Regulation/D.C.-Council-approves-soda-tax (noting that the Washington, D.C. Council approved a measure including sweetened soft drinks in its six percent sales tax bracket in May of 2010). A new federal tax on sugar-sweetened beverages was proposed as part of health reform efforts in 2009, but the proposal was dropped after lobbying from the beverage industry. Tom Hamburger & Kim Geiger, *Beverage Industry Douses Tax on Soft Drinks*, L.A. TIMES, Feb. 7, 2010, http://articles.latimes.com/2010/feb/07/nation/la-na-soda-tax7-2010feb07.

153 Critics of so-called "sin taxes" point out that the taxes are regressive in that they are assessed at a fixed rate, without regard to ability to pay, and that fixed rate makes up a much larger share of income for the poor than for the wealthy. *See* Matthew C. Farrelly et al., *The Consequences of High Cigarette Excise Taxes for Low-Income Smokers*, PLOSONE (Sept. 12, 2012), http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0043838; Jendi B. Reiter, *Citizens or Sinners? The Economic and Political Inequity of "Sin Taxes" on Tobacco and Alcohol Products*, 29 COLUM. J.L. & SOC. PROBS. 443 (1996). Sales taxes in general are quite regressive—the poor spend an average rate of 7% of their income on sales taxes, while those with middle incomes pay a 4.6% rate and the wealthiest taxpayers pay less than 1%. For excise taxes in particular, the rates are even more regressive, with low-income households paying a share of their income that is sixteen times greater than that paid by the wealthiest. INSTITUTE ON TAXATION AND ECON. POL'Y, WHO PAYS? A DISTRIBUTIONAL ANALYSIS OF THE TAX SYSTEMS IN ALL 50 STATES 2 (2013). Popular support for taxes on sugary beverages declined sharply from 2010 to 2012, largely in response to heavy campaigns by industry groups that emphasized their impact on low- and middle-income communities and minorities. *See 63% Oppose "Sin Taxes" on Junk Food and Soda*, RASMUSSEN REPORTS (May 6, 2012), http://www.rasmussenreports.com/public_content/lifestyle/general_lifestyle/may_2012/63_oppose_sin_taxes_on_junk_food_and_soda; Daniel Zingale, *Gulp! The High Cost of Big Soda's Victory*, L.A. TIMES, Dec. 9, 2012, http://articles.latimes.com/2012/dec/09/opinion/la-oe-zingale-soda-tax-campaign-funding-20121209.

as an anti-obesity intervention.[154] Some proposals would prohibit the use of SNAP benefits for particular items, such as sugary drinks or candy.[155] Others would go farther, limiting SNAP recipients to a specified list of healthy products that excludes many staples of the American diet, including meat, white potatoes, white rice, pasta, and flour tortillas.[156]

These proposals have prompted a significant rift between public health and nutrition advocates, who largely favor restrictions,[157] and anti-hunger and poverty groups, who vehemently oppose them. Pro-restriction nutrition and public health advocates point to financial ties between anti-hunger groups like FRAC and the food and beverage industry, sug-

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154 In June of 2013, as major cuts to SNAP were being debated in Congress, New York City Mayor Michael Bloomberg and seventeen other mayors of large cities sent a letter to House leaders urging them to allow local governments to "test and evaluate approaches limiting SNAP's subsidization of products, such as sugar-sweetened beverages, that are contributing to obesity." Ralph Becker et al., *SNAP Letter to House*, SCRIBD (June 18, 2013), http://www.scribd.com/doc/148590000/SNAP-Letter-to-House-6-18-13.

155 In 2004, for example, USDA denied a request from the state of Minnesota to waive federal regulations and allow the state to prohibit the purchase of candy and soda with food stamp benefits. Letter from Ollice C. Holden, Regional Administrator, Food Stamp Program, Food and Nutrition Serv., U.S. Dep't of Agric., to Maria Gomez, Assistant Comm'r, Econ. and Cmty. Support Strategies, Minn. Dep't of Human Services. (May 4, 2004), *available at* http://heartland.org/sites/all/modules/custom/heartland_migration/files/pdfs/15364.pdf. In 2010, New York City requested a waiver to ban the use of SNAP benefits for the purchase of high-sugar, low-nutrient beverages, which USDA also denied. Memorandum from Food and Nutrition Serv., U.S. Dep't of Agriculture, to Elizabeth Berlin, Exec. Deputy Comm'r, N.Y. State Office of Temporary and Disability Assistance (Aug. 19, 2011), *available at* http://www.food-politics.com/wp-content/uploads/SNAP-Waiver-Request-Decision.pdf.

156 In 2013, policymakers in South Carolina and Wisconsin announced plans to restrict SNAP recipients to the approved foods list used for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Dylan Scott, *Wisconsin, South Carolina Hope to Make Food-Stamp Purchases Healthier*, GOVERNING (May 7, 2013), http://www.governing.com/blogs/view/gov-should-states-limit-what-foods-are-purchased-with-food-stamps.html. The current WIC food packages restrict eligible purchases to: breakfast cereal; milk, cheese, tofu, and soy-based beverages; fruits, vegetables, and legumes; peanut butter; canned fish; whole wheat breads and other whole grains; juice; eggs; baby formula; and baby food. Eligible foods within each of these categories are subject to more specific federal guidelines. For example, eligible breakfast cereals must contain minimum amounts of iron and whole grains and may not exceed maximum amounts of sugar and fat. The only eligible beverages are milk, soy milk (containing required amounts of calcium and protein and meeting specific fortification guidelines), and 100% juice (unsweetened and containing specified amounts of vitamin C). Lindsay F. Wiley, *The U.S. Department of Agriculture as a Public Health Agency?: A "Health in All Policies" Case Study*, 9 J. FOOD L. & POL'Y 61 (2013).

157 *See* AM. MED. ASS'N, MEMORIAL RESOLUTIONS 14 (June 2013), http://www.ama-assn.org/assets/meeting/2013a/a13-resolutions.pdf (resolution to "support modifying federal guidelines for the Supplemental Nutrition Assistance Program (SNAP) to eliminate sugar-sweetened beverages and consumption of high-density caloric foods"); Michael Pollan, *Farmer In Chief*, N.Y. TIMES MAG., Oct. 12, 2008, at MM62, *available at* http://www.nytimes.com/2008/10/12/magazine/12policy-t.html?pagewanted=all&_r=0 ("It makes no sense for government food-assistance dollars, intended to improve the nutritional health of at-risk Americans, to support the consumption of products we know to be unhealthful.").

gesting that their opposition to restrictions is insincere and should not be taken seriously.[158] Anti-restriction groups point out that the food purchases of SNAP beneficiaries are, if anything, slightly healthier than those of non-participants, in spite of the difficulties that many low-income people have in accessing fresh and appealing produce.[159] They argue that pro-restriction policymakers are simply "attacking poor people,"[160] Indeed, the rhetoric of some pro-restriction lawmakers echoes Regan-era complaints about "welfare queens" driving Cadillacs and "strapping young bucks" using food stamps to buy T-bone steaks.[161] In some cases SNAP restriction proposals have been made as part of broader efforts to cut down on consumption of sugary drinks and unhealthy foods for all consumers. But in many jurisdictions, policymakers who sharply oppose universally applicable food and beverage regulations have simultaneously supported special restrictions that target the poor.[162]

C. Creating Healthier Communities

The "social-ecological" model of public health points to various strategies for facilitating healthier living through changes to our neigh-

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158 MICHELE SIMON, EAT, DRINK, POLITICS, FOOD STAMPS: FOLLOW THE MONEY 12 (2012), *available at* http://www.eatdrinkpolitics.com/wp-content/uploads/FoodStampsFollowtheMoneySimon.pdf.

159 *Id.*

160 Mark Bittman, *Regulating Our Sugar Habit*, N.Y. TIMES, Feb. 26, 2012, http://opinionator.blogs.nytimes.com/2012/02/26/regulating-our-sugar-habit/.

161 *See, e.g.*, Paul Krugman, *Republicans and Race*, N.Y. TIMES, Nov. 19, 2007, http://www.nytimes.com/2007/11/19/opinion/19krugman.html (describing Reagan campaign speeches in southern states referencing the legendary Cadillac-driving "welfare queen" and the Food Stamp-using "strapping young buck" buying "T-bone steaks"); Katie Sanders, *Ronda Storms' Food Stamp Law Affects Cash Assistance Too*, POLITIFACT FLORIDA (Feb. 10, 2012), http://www.politifact.com/florida/article/2012/feb/10/ronda-storms-food-stamp-law/ (detailing statements by the sponsor of a Florida bill to restrict the use of SNAP benefits for sugary and salty snacks and to prohibit withdrawals from cash assistance programs at strip clubs, casinos, and bars); Editorial, *Food Stamp Food Police?*, L.A. TIMES, Jan. 31, 2012,http://articles.latimes.com/2012/jan/31/opinion/la-ed-foodstamps-20120131 (comparing the same Florida legislator to Marie Antoinette).

162 As a legal matter, of course, this inconsistency is explained by government's special authority to determine how public funds are used. *See, e.g.*,Scott, *supra* 156 (quoting Wisconsin State Rep. Dean Kaufert as saying that "These food stamps are supposed to go toward making sure there's nutritious food in the cupboards for families that are struggling. That was the original intent . . . I don't want to be big government, big nanny state, but the difference is that these are tax dollars."). The rhetoric used illustrates how the "logic [of the private/public distinction] has obscured how law structures dependency and the distribution of life chances such that certain populations, such as welfare recipients, women, and people with disabilities are constructed as forgoing their right to privacy because they cannot meet arbitrary norms of independence that hide the forces that subsidize and support the lives of white men, high wage earners and the wealthy, and people constructed as able-bodied." Spade, *supra* note 36, at 1088.

borhoods, schools, workplaces, and marketplaces.[163] Like behavior-focused interventions, the growing popularity of community-focused interventions reveals "the public's interest in the question of whether and how government might influence the diets [and other health-determinants] of low-income communities."[164] This particular attention to the needs of the poor has potential to bring about meaningful improvements to their living conditions, but it also generates tension over concerns about fairness and cultural bias.

Federal efforts in this regard have been directed at increasing the health focus of existing federal programs. For example, the Healthy, Hunger-Free Kids Act of 2010[165] introduced sweeping changes to the school food environment, not only for the millions of kids receiving free or reduced meals at breakfast and lunch, but for all students who purchase food, whether in à la carte lines in the food service area, at a school store, or in vending machines. In a few fairly limited instances, however, federal legislation has reached beyond existing areas of federal involvement to nationalize approaches pioneered by state and local governments. For example, the ACA adopted a calorie-labeling mandate for restaurant menu items,[166] which had been pioneered by the City of New York and several other state and local governments. The ACA also included regulations to facilitate breastfeeding in workplaces,[167] and grants to fund other community-level prevention strategies.[168]

The community strategy has been most successful at the state and local level. Some cities have specifically targeted particular neighborhoods for these efforts. In 2008, for example, the Los Angeles City Council approved a moratorium on permits for any new fast food restaurants in a thirty-two-square-mile area of the city.[169] The ordinance was

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163 *See, e.g.*, KAREN GLANZ ET. AL., HEALTH BEHAVIOR AND HEALTH EDUCATION: THEORY, RESEARCH, AND PRACTICE 470 (2008) ("Ecological models specify that factors at multiple levels, often including intrapersonal, interpersonal, organizational, community, and public policy, can influence health behaviors. Concepts that cut across these levels include sociocultural factors and physical environments, which may apply to more than one level."); NANCY ADLER ET AL., Inst. of Med., Building the Science for a Population Health Movement (2013) (experts "view health as the product of multiple determinants at the biologic, genetic, behavioral, social, and environmental levels and their interactions among individuals, communities, time, and place").

164 Goldberg, *supra* note 72, at 59.

165 Healthy, Hunger-Free Kids Act of 2010, Pub. L. No. 111-296, 124 Stat. 3183 (codified in scattered sections of 7 U.S.C., 20 U.S.C, and 42 U.S.C.).

166 Patient Protection and Affordable Care Act, Pub. L. No. 111-1448, § 4205, 124 Stat. 119, 573–576 (2010) (requiring restaurants to disclose calorie counts on menus).

167 *Id.* at § 4207 (requiring employers to provide adequate break time and facilities for nursing mothers).

168 *Id.* at § 4201 (establishing community transformation grants).

169 The moratorium, adopted via an Interim Control Ordinance, applies to the South Los Angeles, Southeast Los Angeles, West Adams, Baldwin Hills, and Leimert Park community planning areas. The ordinance defines a fast food restaurant as "[a]ny establishment which

expressly intended to "address the over-concentration of [land] uses which are detrimental to the health and welfare of the people of the community."[170] The designated area was purportedly selected based on data regarding its especially high concentration of fast food restaurants. But commentators have been quick to note that it also encompasses predominantly low-income, minority communities with a higher incidence of obesity than the city as a whole.[171] The ordinance has generated tension over the propriety of singling out socially disadvantaged groups for paternalistic intervention.[172] A few jurisdictions have explored similar zoning strategies,[173] while others have implemented subsidies to promote the availability of healthier food marketplaces in particular neighborhoods.[174]

Most strategies for creating healthier communities have been broadly applicable, but with a potentially disproportionate impact on socially disadvantaged groups. For example, product safety and nutrition-focused regulations run the risk of disproportionately harming the poor by pricing them out of certain markets. On the other hand, there is a concern that some public health interventions—such as calorie labeling on restaurant menus or nutrition labeling on packaged foods—are problematic precisely because they are less likely to be effective for consumers who lack formal education or the financial resources to make purchasing decisions based on factors other than price.

New York City's proposed prohibition on the sale of sugar sweetened beverages at food service establishments in containers larger than

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dispenses food for consumption on or off the premises, and which has the following characteristics: a limited menu, items prepared in advance or prepared or heated quickly, no table orders, and food served in disposable wrapping or containers." L.A., Cal., Ordinance 180103 (July 29, 2008).

170 *Id.*

171 *See* Goldberg, *supra* note 72, at 55–56.

172 *Id.* at 57 ("Writing in 2008, William Saletan accused the Los Angeles City Council of 'depicting poor people, like children, as less capable of free choice,' and called the original moratorium 'a disturbingly paternalistic way of solving the problem' of unequal food options between low-income neighborhoods and wealthier neighborhoods.").

173 Lisa M. Feldstein, *Zoning and Land Use Controls: Beyond Agriculture*, 65 ME. L. REV. 467 (2013) ("Framed variously as an environmental justice, civil rights, and health equity issue, utilizing zoning to promote more equitabl[y] built environments in low-and higher-income neighborhoods has found broad support amongst advocates as well as public health and planning professionals."). Many local governments have imposed zoning restrictions on fast-food establishments that are justified in terms of aesthetic values. Other have adopted restrictions that target schoolchildren. Phoenix has banned mobile street vendors within 600 feet of schools during school hours. Detroit similarly banned the opening of new fast food restaurants within 500 feet of schools. *See* Paul Diller & Samantha Graff, *Regulating Food Retail for Obesity Prevention: How Far Can Cities Go?*, 39 J.L. MED. & ETHICS 89, 91 (2011).

174 *Id.* at 91.

sixteen ounces[175] generated enormous public controversy and was recently invalidated by the New York Court of Appeals on the grounds that enacting such a rule was the province of the City Council, not the Board of Health.[176] Autonomy concerns about the portion rule dominated the public discourse,[177] but equity concerns about its disproportionate impact on low-income people and people of color also played an important role.

Among the named plaintiffs challenging the portion rule were two associations of minority-run businesses.[178] The New York State Conference of the National Association for the Advancement of Colored People (NAACP) and the Hispanic Federation[179] filed an amicus brief arguing that the portion rule "arbitrarily discriminates against citizens and small business owners in African-American and Hispanic communities."[180] Noting that "[s]oft drinks are bought by one-third of the poorest 2 million New Yorkers, but only one-sixth of the richest 1 million,"[181] the NAACP and the Federation argued that the portion rule "disproportionately affects freedom of choice in low-income communities,"[182] and pointed to the "threatened disparate impact on minority-owned businesses."[183] Both groups have spoken strongly in favor of education-only solutions to

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175 While some might classify the portion rule as a behavioral intervention, I believe it is more properly understood as a social-ecological intervention aimed at making restaurants more conducive to healthy consumption habits.

176 N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health & Mental Hygiene, No. 134, 2014 WL 2883881 (N.Y. Ct. App. June 26, 2014).

177 To be clear, the anti-paternalism argument against the portion rule is not a *legal* argument. Lindsay F. Wiley, *Sugary Drinks, Happy Meals, Social Norms, and the Law: The Normative Impact of Product Configuration Bans*, 47 CONN. L. REV. __ (forthcoming 2014) *draft available through* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2460866 ("In cases where a fundamental right or suspect classification is implicated, a purely paternalistic government interest may not be sufficiently compelling to justify infringement pursuant to strict scrutiny. But there is no fundamental right to sell or purchase particular products or services in particular configurations." (citations omitted)).

178 Named plaintiffs included a statewide coalition of Hispanic Chambers of Commerce and an association of Korean-American grocers.

179 The Hispanic Federation is "a network of nearly 100 Latino-serving organizations throughout the northeast United States. The organization's mission is to empower and advance the Hispanic community." Brief for the New York State Conference of the NAACP & the Hispanic Federation as Amici Curiae Supporting Petitioners at 4, *In re* N.Y. Statewide Coal. of Hispanic Chambers of Commerce v. N.Y.C. Dep't of Health and Mental Hygiene, 110 A.D.3d 1 (2013) (No. 653584/2012) [hereinafter NAACP Amici Brief].

180 *Id.* at 8.

181 *Id.* at 3 (quoting Brian Wansink, *How Bloomberg's Soft Drink Ban Will Backfire on NYC Public Health*, THE ATLANTIC (June 14, 2012), http://www.theatlantic.com/health/archive/2012/06/how-bloombergs-soft-drink-ban-will-backfire-on-nyc-public-health/258501/).

182 *Id.* at 2.

183 *Id.* at 3; *see also* Hazel N. Dukes, *Sugar-Sweetened Beverages Ban: Short-Sighted and Misdirected*, HUFFINGTON POST (Aug. 27, 2012), http://www.huffingtonpost.com/hazel-n-dukes/ny-sodaban_b_1834816.html.

the obesity crisis.[184] The education-only approach has been deemed utterly inadequate by public health experts, but it is frequently touted by the food and beverage industries (like the tobacco, automobile, and other industries before them) seeking to shift the blame away from unhealthy products toward "personal responsibility."[185] Indeed, public health and nutrition advocates have suggested that the involvement of civil rights groups in anti-obesity policy debates has been tainted by a financial ties between civil rights groups and the food and beverage industry.[186]

There is widespread agreement that health disparities are troubling. But, as illustrated by the examples described here, interventions to reduce disparities can generate considerable tensions between the goals of health promotion and social justice and between the notions of personal and collective responsibility. As our increasingly collective approach to health care financing prompts greater public interest in upstream prevention, these tensions are likely to grow. They warrant rigorous examination from a variety of perspectives.

III. HEALTH JUSTICE AS A FRAMEWORK FOR REDUCING HEALTH DISPARITIES

Do the developments described in Part II suggest a "health justice" movement similar to the environmental, reproductive, and food justice movements described in Part I? Although the label "health justice" has not yet gained much traction,[187] simultaneous social, lawyering, and

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184 *See* NAACP Amici Brief, *supra* note 179, at 4 (pointing to the NAACP's development of a program called "Project HELP (Healthy Eating, Lifestyles, and Physical Activity)," which "is designed to improve the overall quality of life for African-Americans through health education, focusing on educating participants on the risk factors that lead to chronic diseases, including obesity, diabetes, hypertension, stroke, and cardiovascular disease."). *See also* Jose Calderon, *Obesity Demands Our Attention*, FOX NEWS LATINO (July 3, 2012), http://latino.foxnews.com/latino/health/2012/07/03/jose-calderon-education-to-preventobesity/.

185 *See* Lindsay F. Wiley et al., *Who's Your Nanny? Choice, Paternalism and Public Health in the Age of Personal Responsibility*, 41 J.L. MED. & ETHICS 88, 89 (2013).

186 *See, e.g.*, Michael Grynbaum, *In NAACP, Industry Gets Ally Against Soda Ban*, N.Y. TIMES, Jan. 23, 2013, http://www.nytimes.com/2013/01/24/nyregion/fight-over-bloombergs-soda-ban-reaches-courtroom.html (reporting on NAACP's close ties to big soda companies, pointing out that the amicus brief was submitted by King & Spaulding, Coca-Cola's "longtime Atlanta law firm." Moreover, when asked about the NAACP's position on this issue, the state conference referred those questions to the American Beverage Association, which in turn referred questions to Coca-Cola.); Nancy Huehnergarth, *How Big Soda Co-Opted the NAACP and Hispanic Federation*, HUFFINGTON POST (Jan. 25, 2013), http://www.huffingtonpost.com/nancy-huehnergarth/minorities-soda-lobby_b_2541121.html (citing donations amounting to more than $2 million to the NAACP and various state conferences over the past twenty-five years).

187 The label has been used only occasionally, most notably by a handful of advocacy groups, a law school clinic at Loyola Chicago based on the medical-legal partnership model, and Sridhar Venkatapuram, one of several political philosophers exploring the relationship between health and social justice. *See* VENKATAPURAM, *supra* note 15; *The Praxis Project*, HEALTHJUSTICE, http://www.healthjustice.us/ (last visited Apr. 3, 2014) (offering "resources to

scholarly movements focusing on health disparities, the social determinants of health, and the relationships between health and social justice are certainly underway.

In spite of the growing influence of these movements (those that are specific to health as well as those in related areas), the social justice framework is sometimes assumed, but rarely discussed in health law scholarship. Many attempts to conceptualize health law's burgeoning commitment to reducing health disparities are unified by a dominant emphasis on expanding access to health care through the recognition of individual patient rights—an approach that may actually be counter to lessons drawn from the environmental, reproductive, and food justice movements and from the work of political philosophers and ethicists interested in health justice. In this Part, I sketch out the contours of the health justice lens, presenting it as a distinct alternative to the libertarian market justice of the "market competition" paradigm, but also to the progressive market justice of the "patient-rights" paradigm.[188]

A. What Is Health Justice?

The Praxis Project, which describes itself as a nonprofit intermediary providing support for organizing and change work at local, regional, and national levels, has organized its work on environmental justice, food justice, and health care access, under the label of "health justice." Praxis defines health justice broadly, with an emphasis on the social determinants of health, fighting cultural bias, and promoting health at the community level:

> A community's health is as much the result of institutional policies and practice as it is personal choice.

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support organizing and policy advocacy to advance health justice in your community"); *Mission*, ACCESS WOMEN'S HEALTH JUSTICE, http://accesswhj.org/mission (last visited Apr. 3, 2014) (describing the work of a reproductive justice organization that has adopted "health justice" as part of its identity); Beazley School of Law Institute for Health Law and Policy, *Health Justice Project*, LOYOLA UNIVERSITY CHICAGO, http://www.luc.edu/law/centers/healthlaw/hjp/index.html (last visited Apr. 3, 2014) ("The Health Justice Project was founded by Professor Emily Benfer in the summer of 2010 and is a medical-legal partnership clinic between Loyola University Chicago School of Law and Erie Family Health Center, a Federally Qualified Health Center that serves over 40,000 low-income patients annually. Students of law, social work, public health and medicine enrolled in the clinic engage in interprofessional collaboration to identify and address social and legal issues that negatively affect the health of low-income individuals."). The medical-legal partnership model is part of a broader movement to incorporate a wide range of social services and assistance into health-care clinical settings, exemplified by the work of nonprofit organizations like Health Leads. *See Our Vision,* HEALTH LEADS, https://healthleadsusa.org/what-we-do/our-vision/ (last visited June 23, 2014).

188 *See supra* note 14 and accompanying text (discussing patient rights and market competition as the currently dominant health law paradigms); *supra* notes 26–36 and accompanying text (contrasting libertarian market justice with progressive market justice).

> Which communities have fresh, nutritious food? Where do governments allow dumping? Who is more often targeted by advertisers with unhealthy products? Which communities have state-of-the-art medical facilities? Which ones don't?
>
> All of these factors (or social determinants) are symptoms of the bias and privilege that shape virtually every aspect of our lives. It is no secret that across nearly every indicator of health status, poor people and people of color are more likely to be sick, injured, or die prematurely . . . . It will take organizing from the ground up; social change that transforms the current systems of neglect, bias, and privilege into systems—policies, practices, institutions—that truly support health[y] communities for all. That's health justice.[189]

In addition to growing interest in health justice among community groups, the last several years have seen an upsurge in scholarly interest among political philosophers and ethicists in "the bearing of justice on health, and the practical normative implications of the relationships between health and society."[190] Sridhar Venkatapuram, Dan Beauchamp, Norman Daniels, Bruce Jennings, Madison Powers and Ruth Faden, Jennifer Prah Ruger, Shlomi Segall, and Kristin Voigt have explored these implications by drawing on Rawls' theory of justice,[191] the capabilities

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189 *The Praxis Project*, *supra* note 187.

190 JOHN COGGON, WHAT MAKES HEALTH PUBLIC? A CRITICAL EVALUATION OF MORAL, LEGAL, AND POLITICAL CLAIMS IN PUBLIC HEALTH 170 (2012).

191 *See* JOHN RAWLS, A THEORY OF JUSTICE (rev. 2d ed. 1999); JOHN RAWLS, JUSTICE AS FAIRNESS: A RESTATEMENT (2001); JOHN RAWLS, THE LAW OF PEOPLES (2001); DANIELS, *supra* note 15 (adopting a framework heavily influenced by Rawls). References to health in Rawls' own work would seem to undercut the usefulness of his theory to an examination of the mutually reinforcing relationship between poverty and ill health. Rawls has been criticized for intentionally restricting his discussion of justice to "normal" "healthy" workers and for relegating "surfers" (those who are able, but unwilling to work) and "hard cases" (those whose disability or ill health prevents them from working) to voluntary charity care, echoing the market justice model. In his earlier work, Rawls classified health, along with vigor, intelligence, and imagination, as "natural primary goods" based on his understanding that society had little influence over them. Eventually, he dropped the "natural" designation in response to criticism pointing out the many ways in which health and intelligence are heavily influenced by social forces. Rawls noted in passing that we have a "duty" to help people with health issues, but it cannot be covered under his conception of social justice. Mahasweta M. Banerjee, *Social Work Scholars' Representation of Rawls: A Critique*, 47 J. SOC. WORK ED. 189, 199–200 (2011) (documenting key changes between the 1971 and 1999 editions of Rawls' *Theory of Justice* and clarifications in Rawls' 2001 works *Justice as Fairness: A Restatement* and *The Law of Peoples* as part of a critique of social justice-oriented social work scholars' reliance on and misrepresentation of Rawls). Daniels "departs from Rawls by allowing and demanding that the contractors [(rational, disinterested figures whom Rawls imagines to be deciding on the principles of justice behind a veil of ignorance)] consider questions of disease and disabil-

approach of Amartya Sen and Martha Nussbaum,[192] the luck egalitarianism approach developed by Ronald Dworkin, G.A. Cohen, and Richard Arneson,[193] and a strongly communitarian approach to justice that might be understood as having roots in feminist and relational political philosophies.[194] A discussion of the unique contributions of each of these scholars is beyond the scope of this Article (thankfully, given that it would also be beyond my expertise).[195] But the three common themes identified in the social movements discussed in Part I, above, are also evident in the work of political philosophers and ethicists on health and social justice. Their writings provide useful reference points as I translate the common commitments of environmental, reproductive, and food justice to the health justice context.

As a lens for examining the role of law in reducing health disparities, social justice does not provide clear answers to all questions. Rather, it reveals certain questions as particularly crucial and prompts more rigorous discussion of them. With these caveats in mind, I argue that three interrelated commitments should shape the health justice ap-

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ity to feature in deliberations (an intended omission on Rawls' part)." COGGON, *supra* note 190, at 180.

192 *See* AMARTYA SEN, DEVELOPMENT AS FREEDOM (1999); POWERS & FADEN, *supra* note 15 (developing a pragmatic framework that is closely related to the capabilities approach); RUGER, *supra* note 15 (developing a health capabilities approach); VENKATAPURAM, *supra* note 15 (applying Sen and Nussbaum's capabilities approach to health). Sen himself has also written on the application of the capabilities approach to health issues. *See, e.g.*, Amartya Sen, *Why Health Equity?*, *in* PUBLIC HEALTH, ETHICS, AND EQUITY 21 (Sudhir Anand, Fabienne Peter & Amartya Sen eds., 2004).

193 *See, e.g.*, RONALD DWORKIN, SOVEREIGN VIRTUE (2000); G.A. Cohen, *On the Currency of Egalitarian Justice*, 99 ETHICS 906 (1989); Richard Arneson, *Equality and Equal Opportunity for Welfare*, 56 PHIL. STUDIES 77 (1989); Richard Arneson, *Against Rawlsian Equality of Opportunity*, 93 PHIL. STUDIES 7 (1999); SEGALL, *supra* note 15 (applying the luck egalitarianism conception of distributive justice to issues of health care and the social determinants of health).

194 *See, e.g.*, DAN BEAUCHAMP, HEALTH CARE REFORM AND THE BATTLE FOR THE BODY POLITIC (1996); Dan Beauchamp, *Community: The Neglected Tradition of Public Health*, *in* NEW ETHICS FOR THE PUBLIC'S HEALTH, *supra* note 1, at 57; BRUCE JENNINGS, CIVIC HEALTH: A POLITICAL THEORY OF PUBLIC HEALTH AND HEALTH POLICY (forthcoming 2014) (described by Jennings as a book on the relationship between public health and political theory and the role of grassroots participation in health policy); WILLARD GAYLIN & BRUCE JENNINGS, THE PERVERSION OF AUTONOMY: COERCION AND CONSTRAINTS IN A LIBERAL SOCIETY (2d ed. 2003); Bruce Jennings, *From the Urban to the Civic: The Moral Possibilities of the City*, 78 J. URBAN HEALTH 88 (2001). *See* COGGON, *supra* note 190, at 187 (linking Jennings' communitarian approach to political theory within the feminist literature). Kristin Voigt is currently developing an approach that reconciles distributive and relational justice. *See Social Justice: Reconciling Distributive and Relational Perspectives*, MONTREAL HEALTH EQUITY RESEARCH CONSORTIUM, http://mherc.net/projects/social-justice-reconciling-distributive-and-relational-perspectives/ (last visited Aug. 31, 2014); Kristin Voigt, *Appeals to Individual Responsibility for Health: Reconsidering the Luck Egalitarianism Perspective*, 22 CAMBRIDGE Q. HEALTHCARE ETHICS 146 (2013).

195 See COGGON, *supra* note 190, at 164–93, for an extremely helpful review, upon which I have relied heavily in drafting this paragraph.

proach to using law to reduce health disparities: First, the health justice framework lends itself to a broad conceptualization of health law as concerned with all of the social determinants of health rather than remaining narrowly focused on the law of health care delivery and financing. Second, the health justice framework demands that we probe the influence of social bias and structural advantage on interventions aimed at reducing health disparities, particularly those interventions that adopt an individualistic, personal responsibility approach. Third, interventions to reduce health disparities should be designed and implemented in a way that maximizes community engagement, but this should not be confused with an approach that makes individualistic self-determination paramount. I will sketch out each of these proposed commitments by reference to the health justice work of ethicists and political philosophers, the social justice movements described in Part I, and the health law reforms and controversies described in Part II. Each of these issues is ripe for further exploration in future publications.

B. Broadening the Scope of Inquiry and Action: Putting Access to Health Care in Its Place

Focusing on the experiences of low-income communities, communities of color, and other socially and culturally marginalized groups has led the environmental, reproductive, and food justice movements to broaden the scope of the progressive projects that preceded them: From protecting the natural environment to fighting the overlapping forms of oppression that result in an unjust distribution of environmental hazards. From a privacy-based right to choose abortion to redistribution of resources to protect meaningful self-determination with regard to reproduction and family life. From rejection of some forms of industrial food production to an insistence that food policy can play a role in fighting class and racial oppression.

In the same way, the health justice framework might function as a critique from within the progressive patient-rights focused project of ensuring access to health care. Health justice naturally expands the focus beyond access to health care to address the community conditions that play such an important role in determining health disparities. Powers and Faden "contend that it is impossible to make progress in our understanding of the demands of justice *within* medical care without looking *outside* of medical care to public health and to the other determinants of inequalities in health."[196] Beauchamp is a bit more pointed about decentering health care. He argues that "over-investment and over-confidence in curative medical services" are attributable to the market justice

196 POWERS & FADEN, *supra* note 15, at x.

perspective and stand as "fundamental obstacles to collective action to prevent death and injury."[197]

In his seminal work on health justice, Venkatapuram argues that "health is not determined just by or even largely by healthcare. It is vitally important, just as food is to someone starving, but health justice . . . involves many more dimensions than the availability and distribution of healthcare."[198] Social epidemiologists study the causal pathways by which socio-economic status, race and ethnicity, disability, gender expression, geographic location, and other factors influence health outcomes.[199] Differential access to health care services (in terms of financial access but also language access,[200] geographic access,[201] etc.) and differential quality of health care (in terms of discriminatory treatment decisions by individual clinicians, differential access to highly skilled health care providers, disregard for the needs of particular subpopulations in medical research,[202] etc.) are certainly among those pathways, but other pathways are equally, if not more, important. Application of this view to health policy suggests that health care is a component of the broader public health system—rather than the other way around, as many health law scholars assume.

Putting access to health care in its place as one among many social determinants of health runs counter to decades of health law reform, activism, and scholarship. As Venkatapuram explains, "[F]or most of the twentieth century, policies to protect and promote health focused on clinical medical care and on personal behaviour, . . . divorcing it from its social bases."[203] Daniels links this bias to the bioethics tradition, which, since its inception "has focused heavily on . . . the dyadic relationship between doctors and patients or research subjects, or on the potential benefits and risks for those individuals that can arise from new [medical]

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197 BEAUCHAMP, *supra* note 1, at 104.

198 VENKATAPURAM, *supra* note 15, at 16.

199 *See, e.g.*, MARMOT & WILKINSON, *supra* note 8; SOCIAL EPIDEMIOLOGY (Lisa F. Berkman & Ichiro Kawachi eds., 2000); Michael G. Marmot, *Understanding Social Inequalities in Health*, 46 PERSP. BIOLOGY & MED. S160 (2003); JULIE G. CWIKEL, SOCIAL EPIDEMIOLOGY: STRATEGIES FOR PUBLIC HEALTH ACTIVISM (2006).

200 *See, e.g.*, Joel Teitelbaum, Lara Cartwright-Smith & Sara Rosenbaum, *Translating Rights into Access: Language Access and the Affordable Care Act*, 38 AM. J.L. & MED. 348 (2012).

201 *See, e.g.*, Michele Goodwin, *Race & Urban Health: Confronting a New Frontier*, 5 DEPAUL J. HEALTH CARE L. 181 (2002); Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023 (2005).

202 *See, e.g.*, Lisa C. Ikemoto, *Bioprivilege*, 42 WASH. U. J.L. & POL'Y 61 (2013); Vernellia R. Randall, *Inequality in Health Care Is Killing African-Americans*, 36 HUMAN RIGHTS 20 (2009); Vernellia R. Randall, *Eliminating Racial Discrimination in Health Care: A Call for State Health Care Anti-Discrimination Law*, 10 DEPAUL J. HEALTH CARE L. 1 (2006).

203 VENKATAPURAM, *supra* note 15, at 11.

technologies."[204] Health law scholar Bill Sage adds the traditional view of government regulation as a complement to private legal claims; political preferences for policies that save identifiable rather than statistical lives; and the rise of health consumerism as a frame for health reform as sources of health law's relational bias.[205]

Health law has struggled to define itself as a field,[206] and many scholars essentially conflate it with the law of health care delivery and financing.[207] The law of public health—"what we, as a society, do collectively to assure the conditions for people to be healthy"[208]—has generally been relegated to a sub-topic of health law, when it is given any consideration at all.[209] The environmental justice movement's emphasis on social determinants of environmental health disparities; the reproductive justice movement's emphasis on social determinants of maternal, child, and family health; and the food justice movement's emphasis on access to healthy food as a social determinant of health are already

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[204] DANIELS, *supra* note 15, at 2. Daniels began by writing extensively on "the social function of health care, broadly construed to include traditional public health and medicine." *See* NORMAN DANIELS, JUST HEALTH CARE (1985). *Just Health*, which he represents as a sequel to *Just Health Care*, is his effort to "seek answers to a broader set of questions, rectifying what he describes as his previous "failure to understand the full dimensions of a population view." *Id.* Other influential political philosophers writing about health and social justice have maintained a dominant focus on access to affordable, high-quality health care. *See, e.g.*, RUGER, *supra* note 15; SEGALL, *supra* note 15.

[205] Sage, *supra* note 10, at 501–10.

[206] *See* Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347 (2006); Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365 (2006); Henry T. Greely, *Some Thoughts on Academic Health Law*, 41 WAKE FOREST L. REV. 391 (2006); Theodore W. Ruger, *Health Law's Coherence Anxiety*, 96 GEO. L.J. 625 (2008).

[207] *See, e.g.*, Elhauge, *supra* note 206, at 370 (treating "health" as synonymous with "health care"); Greely's initial definition of health law is more expansive:

> I believe health law should be defined very loosely, as encompassing all legal and public policy issues involving the provision of health care (medical or otherwise) or health status. Importantly, this includes policy questions about what the laws or, more broadly, the non-legal rules or standards as they affect health care should be and not just what they are. Its center, to me, includes issues of access to health care, assurance of health care quality, and the relationships between patients and health care providers. But it also extends to issues of drug and medical device regulation, bioethics, biomedical research, mental health, and (I would argue) disability discrimination. I would also extend it to public health issues, from infectious disease to addiction to obesity, although even I get nervous about extending the definition to include some issues I think are legitimate public health issues, such as automobile accidents or crime.

Greely, *supra* note 206, at 392. After this initial breadth, however, Greely's discussion largely conflates health with health care or medicine. *Id.*

[208] COMM'N FOR THE STUDY OF THE FUTURE OF PUB. HEALTH, INST. OF MED., THE FUTURE OF PUBLIC Health 19 (1988).

[209] *See* Greely, *supra* note 206, at 392; Sage, *supra* note 10, at 519 ("[P]ublic health law . . . has been marginalized both legally and financially compared with the diagnosis and treatment of individual patients.").

broadening the focus of some advocacy groups that target health disparities. But most health law scholars and many advocacy groups continue to focus almost exclusively on health care access. It is not surprising, then, that discussions of health disparities in the health law literature have largely shared this focus.

Three recent articles by progressive health law scholars who discuss health law as a tool for reducing disparities by drawing parallels between health law and other socially conscious fields of law, are illustrative. Sidney Watson's work on the relationship between health law and civil rights law argues that "provisions expanding access to affordable health insurance offer a critical tool to improve minority access to health insurance and reduce inequities both in the health care system and among communities."[210] Jessica Roberts frames her work on health law as disability rights law as addressing health disparities, but her focus is similarly dominated by access to high-quality health care responsive to the needs of people with disabilities.[211] In assessing the ACA in light of global health and human rights norms, Gwendolyn Majette does discuss the social determinants of health beyond health care access[212] and acknowledges that elimination of health care disparities is a "complex problem demanding a multifaceted solution." However, she considers public

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210 Watson, *Section 1557*, *supra* note 12, at 855.

211 Roberts, *supra* note 12. Roberts purports to address public health issues in two brief sections but her discussion barely scratches the surface. She rightly points out that federal public health surveillance and research activities have historically excluded health disparities among people with disabilities as a category of interest—a bias that the ACA attempts to correct. *See* Roberts, supra note 12, at 1997–99, 2026–28. But her interest in this issue is largely limited to the "lack of good, reliable data on disability and health-care access" that has resulted from past omission, and the ACA's recognition of "people with disabilities as a population with its own specific health-care needs." *Id.* at 1999, 2027.

212 *See* Majette, *supra* note 13, at 935. Majette references social determinants as an important focus of global health norms and the National Prevention, Health Promotion and Public Health Council (now known simply as the "National Prevention Council") "to facilitate a health-in-all-policies approach to eliminate health disparities and improve the daily conditions in which people live, work, and play." Other than her mention of the National Prevention Council, however, Majette's discussion of the ACA's attention to the social determinants of health focuses on information gathering with respect to disparities in health care access and quality. *See id.* at 922–23. Majette has endorsed a broader view of law as a tool for reducing health disparities in her other work, however. *See* Gwendolyn Roberts Majette, *Global Health Law Norms: A Coherent Framework to Understand PPACA's Approach to Eliminate Health Disparities and Address Implementation Challenges*, *in* LAW AND GLOBAL HEALTH – CURRENT LEGAL ISSUES 419, 428–29 (Michael Freeman et al. eds., vol. 16, 2014); Gwendolyn Roberts Majette, *PPACA and Public Health: Creating a Framework to Focus on Prevention and Wellness and Improve the Public's Health,* 39 J.L. MED. & ETHICS 366 (2011). Majette joins the call for a shift from a biomedical model to an ecologic, population-based approach as a way to significantly improve the health of the U.S. population. *Id.* at 367, 376 n.17. The ACA prevention provisions her article describes, however, include many that are dominated by provisions of preventive health care, as well as wellness incentive programs that adopt a personal responsibility approach, which is problematic from a social justice perspective. *See infra* Part III.C.

health, prevention, and wellness as one part of the "health care system,"[213] and her recommendations for future efforts to reduce health disparities for people of color focus almost exclusively on eliminating disparities in health care access and quality.[214] Each of these articles makes very important contributions,[215] and their relatively narrow focus is completely understandable given that the statute they are analyzing is similarly focused predominantly on ensuring access to health care.[216]

Is it advisable, or even feasible to reframe health care access as one among many social determinants of health, rather than considering public health law and social determinants as a sub-field of health care law, as scholars typically do? To the extent that scholars have grappled with the expansion of health law and policy to address the social determinants of health at all, they have highlighted two distinct concerns. First, a concern that expansion of health law to address the social determinants of health poses a threat to individual liberty by categorizing personal problems (such as unhealthy eating and physical inactivity) as public concerns in an effort to legitimize improper government overreach.[217]

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213 Majette, *supra* note 13, at 926.

214 *Id.* at 926–35.

215 Eliminating racial, ethnic, and other social disparities in health care is an extremely important issue. INSTITUTE OF MEDICINE, UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2003). My point is simply that elimination of health disparities requires much more than elimination of health care disparities. *See id.* at 35 ("the reasons for . . . health status disparities are complex . . . . Racial and ethnic disparities in health status largely reflect differences in social, socioeconomic, and behavioral risk factors and environmental living conditions . . . . Healthcare is therefore necessary but insufficient in and of itself to redress racial and ethnic disparities in health status.").

216 The Affordable Care Act does include significant provisions aimed at ensuring healthy living conditions and influencing health behaviors. Perhaps the most important provisions in this regard are those that provide for funding for community-level action on the social determinants of health, reflecting the importance of state and local—as opposed to federal—intervention in these areas.

217 Richard A. Epstein, *In Defense of the "Old" Public Health*, 69 BROOK. L. REV. 1421, 1424 (2004) (arguing that labeling health behaviors like diet, exercise, smoking, and tanning as "public health" problems triggers legal doctrines that privilege heavy handed state intervention over protection of individual rights: "[T]he case for government intervention . . . gets that extra boost of legitimacy" when framed as a public health issue"); Richard A. Epstein, *Let the Shoemaker Stick to His Last: A Defense of the "Old" Public Health*, 46 PERSP. IN BIOLOGY & MED. S138 (2003) (critiquing "new public health"); Richard A. Epstein, *What (Not) to Do About Obesity: A Moderate Aristotelian Answer*, 93 GEO. L.J. 1361 (2005); Mark A. Rothstein, *Rethinking the Meaning of Public Health*, J.L. MED. & ETHICS 144, 148–49 (2002) [hereinafter Rothstein, *Rethinking*] ("The broad power of government to protect public health includes the authority to supersede individual liberty and property interests in the name of preserving the greater public good. It is an awesome responsibility, and therefore it cannot and must not be used indiscriminately."); Mark A. Rothstein, *The Limits of Public Health: A Response*, 2 PUB. HEALTH ETHICS 84, 85 (2009) [hereinafter Rothstein, *Limits*] ("One of the main reasons that I support a narrow definition of public health is that public health laws give public health officials a range of coercive powers to protect the population. Unless the scope of permissible governmental action is carefully circumscribed, there is a threat to civil liberties by governmental confiscation of property, restraint on the movement of individuals, mandating of

And second, a concern that while elimination of poverty, racism, and other injustices might be laudable and appropriate governmental concerns, cooptation of these efforts under the banner of health is inappropriate and possibly counterproductive.[218]

The first concern, which I will call the libertarian objection, is often cast by public health advocates as motivated largely by a desire to protect powerful industries from regulation and liability. Particularly "[w]hen public health advocates seek to address the root causes of non-communicable diseases and injuries, they put themselves on a collision course with powerful, wealthy interests that are contributing to those public health problems."[219] I have argued elsewhere, however, that legal scholars should engage more productively with the libertarian objection in an effort to more fully develop the basis for treating non-communicable disease threats like heart disease and diabetes as public problems demanding collective action.[220]

The second concern, which I will call the progressive objection, is more rarely addressed by health law scholars and perhaps less easily dismissed. Most of this Article is devoted to exploring the value of examining health disparities through the lens of social justice. But what value is added when activists or scholars situated within the field of health law and policy discuss social injustice in terms of health disparities? Why not simply focus on the narrower areas of our expertise—health care financing and delivery or the authority of public health agencies—and leave discussion of economic and racial injustice to others? In her work on health policy and social justice, Jennifer Prah Ruger argues that it is

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medical examinations and similar measures."); Mark A. Hall, *The Scope and Limits of Public Health Law*, 46 PERSP. IN BIOLOGY & MED. S199, S199 (2003); Roger Magnusson, *Mapping the Scope and Opportunities for Public Health Law in Liberal Democracies*, 35 J.L. MED. & ETHICS 571, 573 (2007) ("Debate about [the] goals and definitions [of public health law] reflects competing claims about the boundaries for the legitimate exercise of political and administrative power.").

218 *See* Hall, *supra* note 217, at S208 ("Beyond the public health arena, there are other good reasons for the government to pursue the more general aims of education, taxation, regulation, and redistribution, but these are broader social and economic policies or they belong to legal realms other than health. Public health advocates can be commended for calling our attention to the health implications of social disparities, but health promotion should not be the primary objective of corrective measures."); Rothstein, *Rethinking*, *supra* note 217, at 144 ("[J]ust because war, crime, hunger, poverty, illiteracy, homelessness, and human rights abuses interfere with the health of individuals and populations does not mean that eliminating these conditions is part of the mission of public health."); Rothstein *Limits*, *supra* note 217, at 86 ("[C]oncerns about social justice should play a part in priority setting for public health. My point is simply that resolution of underlying socioeconomic and political problems is beyond the domain of public health.").

219 Wiley et al., *supra* note 185, at 89–90.

220 *See* Lindsay F. Wiley, *Rethinking the New Public Health*, 69 WASH. & LEE L. REV. 207 (2012).

"unwise to attempt to improve health with broad non-health policies."[221] She suggests that the broad-based approaches to eliminating health disparities advocated by Daniels and others "cloud rather than clarify the means and ends of health policy, and diminish our ability to evaluate public policy's impact on health."[222]

The incorporation of the environmental justice movement into mainstream environmental law might serve as something of a cautionary tale with regard to the progressive objection. Initially, environmental justice lawyering and legal scholarship were largely channeled toward the use of Title VI to challenge the disparate impact of governmental decisions about environmental protection on minority groups.[223] When those efforts were foreclosed by the federal executive's unwillingness to adopt a Title VI strategy and the Supreme Court's imposition of insurmountable hurdles for private advocates interested in doing so, many scholars and environmental lawyers interested in environmental justice redirected their attention to strengthening environmental protection laws for everyone with the hope that this strategy would have disparate benefits for the socially disadvantaged.[224] Arguably, the effect has been to

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221 RUGER, *supra* note 15, at 100. Notably, Ruger and some scholars adopt a broad scope of inquiry when addressing global health disparities, while tending to narrow their focus on health care when addressing disparities in the U.S. context. *See, e.g.*, Jennifer Prah Ruger, *Normative Foundations of Global Health Law*, 96 GEO. L.J. 423 (2008) ("extending [Ruger's theory of health and social justice] in evaluating the role of international law in health" and adopting a broad focus on public health issues ranging from infectious disease control to occupational hazards, tobacco control, and transboundary environmental pollution). The fact that international health law instruments, unlike domestic health law statutes, focus predominantly on public health concerns rather than medical care may help explain this focus, but global health law extends beyond international instruments to encompass domestic policies in the global context. In her monograph, Ruger explicitly notes that "the relationship between health policy and other public policies affecting health" is "particularly relevant to *developing* countries, where many determinants of health lie outside the health care system." RUGER, *supra* note 15, at 99 (emphasis added). Venkatapuram takes the opposite position, arguing that "ensuring health and longevity capabilities will require the functioning and fixing of many basic social institutions, processes and values, as well as . . . perpetual monitoring and management of relative social inequalities . . . , especially in *wealthy* countries." VENKATAPURAM, *supra* note 15, at 152 (emphasis added). This interesting dichotomy warrants further examination.

222 RUGER, *supra* note 15, at 100. Ruger suggests that evaluation of policies in "non-health" domains like employment, housing, or education might be supplemented with "indicators that take their effects on health into account," but that is not her primary concern. *Id.* at 100–01.

223 *See* Luke W. Cole, *Civil Rights, Environmental Justice and the EPA: The Brief History of Administrative Complaints Under Title VI of the Civil Rights Act of 1964*, 9 J. ENVTL. L. & LITIG. 309 (1994).

224 *See* Mike Ewall, *Legal Tools for Environmental Equity vs. Environmental Justice*, 13 SUSTAINABLE DEV. L. & POL'Y 4 (2012–2013) (describing the blow to the environmental justice movement's litigation strategy inflicted by *Alexander v. Sandoval*, 532 U.S. 275 (2001), and Gonzaga Univ. v. Doe, 536 U.S. 273 (2002), that effectively foreclosed private suits alleging disparate impact discrimination under Title VI and the resulting shift toward generally applicable environmental protection policies as a tool for addressing environmental injustice).

neutralize environmental justice as a distinct lens, reducing it to a superficial reframing of the same old environmental protection goals in a way that builds broader appeal beyond the traditionally white, economically privileged groups that have prioritized them.

Watson's, Roberts', and Majette's contributions might be viewed as moving toward a similar approach. Each of them shepherds evidence regarding health disparities in support of traditionally progressive health law goals. Watson highlights the ACA's anti-discrimination provision as a potential avenue for continuing the desegregation of health care begun under Title VI. Roberts sets up health law provisions aimed at ensuring access and quality for all as having a disparate benefit for people with disabilities. Majette explicitly positions herself as championing the ACA's access and quality reforms as an important step toward American realization of individual rights and norms recognized in international law. Each author's call for attention to the positive impacts of ACA reforms on health disparities adds value to the broader conversation among health law academics and advocates about health reform, but ultimately frames health disparities as a reason to support the general health law reforms championed by progressives. These are certainly crucial goals, but their narrow focus on health care access is regrettable.

Environmental justice scholarship has been at its most productive when it pushes for a broader inquiry into the root causes of racial and economic disparities in the distribution of environmental risks and benefits that moves past citing those disparities as yet another reason for supporting general environmental protection. I believe health justice scholarship should similarly push for expansive and rigorous examination of the causal pathways by which social disadvantage translates into poor health, and of the role of law and policy (and not merely *health* law and policy) in reinforcing or disrupting those pathways.

Elsewhere, I have defended the broad scope of health law[225] and the centering of social justice in the study of public health law as a distinct field.[226] Here, my aim is different and perhaps more radical. Here, I am

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225 *See* Wiley, *supra* note 220.

226 *See* GOSTIN & WILEY, *supra* note 17. Controversy over the implications of social epidemiology for legal advocacy and scholarship also permeate recent discussions over how public health law should be defined as a field distinct from the law of health care financing and delivery. Some legal scholars who identify themselves as working within a social determinants of health framework, including myself, have placed social justice at the center of their inquiries about the role of law in protecting the public's health in general and reducing health disparities in particular. In 2000, the first edition of Lawrence Gostin's seminal text on modern public health law asserted that "[t]he prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice." LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 4 (1st ed. 2000); *see also* GOSTIN & WILEY, *supra* note 17. Other scholars, however, have questioned the propriety of defining the field in terms of its commitment to social justice.

suggesting that rather than viewing public health law as a distinct subfield within health law, scholars interested in the use of law as a tool for reducing health disparities would do well to view access to health care as a distinct (and very important) issue within a broader social determinants framework. Rather than defending social justice as the "core value" of public health law, I am arguing—particularly in light of the ACA's transformation of the Medicaid program, the private health insurance market, and the government's role in ensuring the quality of health care and containing its costs as matters of public concern—that social justice is emerging as a core value of health law writ large. I am not suggesting that social justice provides an organizing principle for health law field-building efforts. Social justice cannot, by itself, define the contours of health law as a coherent field of academic inquiry. But I do believe that more rigorous development of social justice as an *approach* to practicing, studying, teaching, and writing about health law—and as an alternative to the libertarian market competition paradigm and the progressive patient rights paradigm—is likely to further the development of health law as a field.[227]

C. *Collective Responsibility: Probing the Influence of Bias on Health Disparity Interventions*

In addition to intentionally broadening the scope of inquiry beyond narrow, siloed concerns, the environmental, reproductive, and food justice movements have adopted a skeptical stance toward elitism within the progressive projects that preceded them. Each movement has probed the influence of class and racial bias on the goals and processes adopted by progressive reformers. In doing so, the three movements have particularly highlighted the importance of collective responsibility for assuring healthy living conditions, rather than reinforcing individualistic assumptions about personal responsibility for health.

In the same way, health justice as a framework for reducing health disparities might dictate a preference for interventions that reflect collective responsibility for health rather than individualistic interventions aimed at urging people to change their behaviors without necessarily

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Micah Berman has suggested that health law's lack of a "readily apparent normative value—like environmentalism—[to use] as an organizing principle" impedes its coherence as a field. Micah L. Berman, *Defining the Field of Public Health Law*, 15 DEPAUL J. HEALTH CARE L. 45, 58 (2013). Berman argues that as potential organizing principles, law and economics and social justice "reflect the ideological and methodological approach of the scholar, but fail to illuminate anything unique about the study of health law." *Id.*

227 In this, it would seem that Berman and I are in agreement. *See* Berman, note 226, at 58 n.60 ("Many foundational fields, including Contracts, Torts, and Property, are regularly taught from either a law and economics or a social justice perspective. These perspectives bring valuable insights to the fields, but do not define them.").

making it easier for them to do so. Beauchamp describes "explanations for death and disability that 'blame the victim'" as "yet another way in which the market ethic obstructs the possibilities for minimizing death and disability, and alibis the need for structural change."[228] In Beauchamp's view,

> Victim-blaming misdefines structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioral failures or deficiencies of the victims. These behavioral explanations for public problems tend to protect the larger society and powerful interests from the burdens of collective action, and instead encourage attempts to change the 'faulty' behavior of victims.[229]

In the same vein, Voigt has suggested that personal responsibility interventions to discourage unhealthy behaviors through individually targeted incentives and penalties are counter to the communitarian commitment of social justice.[230]

Our increasingly collective approach to ensuring health care access is undeniably generating increased public interest in the root causes of poor health. There is deep disagreement, however, over whether those root causes are a matter of collective responsibility or personal responsibility. On the one hand, social epidemiology suggests that social, economic, and environmental factors are the true "causes of the causes" of death, disease, and disability, demanding collective responsibility for regulation of commercial activities that are harmful to the public's health and assurance of social support for basic human needs. On the other hand, measures that put the onus on individuals to change their behaviors (without necessarily making it more feasible for them to do so) are far more politically palatable. Many of the most important drivers of death, illness, and injury in the United States—cancer, heart disease, diabetes, and stroke attributable to alcohol and tobacco use, unhealthy eating, and physical inactivity—are constructed as matters of individual choice and personal responsibility. These behaviors are "divorced" from their social bases in the popular imagination and in much of health law and policy scholarship.[231]

In emphasizing the social determinants of health, the environmental, reproductive, and food justice movements adopt the "ecological" model of health that has come to dominate public health science and practice,

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228 Beauchamp, *supra* note 1, at 104

229 *Id.* at 104; *see also* VENKATAPURAM, *supra* note 15, at 77 (arguing that outdated models of disease "misclassif[y] causes as beyond social action").

230 Voigt, *supra* note 194.

231 VENKATAPURAM, *supra* note 15, at 11.

but that ecological model has not yet fully permeated into the public consciousness, particularly with respect to NCDs. Early efforts to prevent so-called "lifestyle diseases" were heavily influenced by the behavioral model of public health, which emphasized the importance of individual behavior choices (about diet, exercise, smoking, drug and alcohol use, etc.)[232] Strategies developed in the 1980s and 1990s relied almost exclusively on public education campaigns and doctor-patient counseling.[233]

Among scientists and environmental, reproductive, and food justice advocacy groups the individualistic behavioral model has been eclipsed by the ecological model, which places supposedly private, individual choices and risks into their social context and emphasizes structural explanations for health behaviors and outcomes. In this view, using tobacco, abusing alcohol, or eating a diet high in calories and fat and low in nutrients are not merely a matter of personal choice. These behaviors are heavily influenced by environmental factors: an information environment that is loaded with commercial marketing by the manufacturers and sellers of harmful products[234] and marketplaces that are saturated with unhealthy options that are cheaper and more readily accessible than healthy choices.[235] Not getting enough exercise is not simply a personal failure, it is a behavior influenced by a built environment that discourages walking for transportation and provides few opportunities for active entertainment.[236] In turn, the environments that one lives and works in are dependent upon underlying social and economic factors. Poor neighborhoods have more fast food establishments, liquor stores, and corner stores, and fewer full-service grocery stores than middle-income neighborhoods.[237] Children from low-income families are more likely to live in communities where public parks and playgrounds are in disrepair and

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232 *See* Wiley, *supra* note 220, at 219–21 (describing the rise of the behavioral model of health).

233 *Id.*

234 *See, e.g.*, ELIZABETH S. MOORE, IT'S CHILD'S PLAY: ADVERGAMING AND THE ONLINE MARKETING OF FOOD TO CHILDREN – REPORT (2006), *available at* http://www.kff.org/entmedia/upload/7536.pdf; CTR. FOR SCI. IN THE PUB. INTEREST, PESTERING PARENTS: HOW FOOD COMPANIES MARKET OBESITY TO CHILDREN (2003), *available at* http://www.cspinet.org/new/pdf/pages_from_pestering_parents_final_pt_1.pdf; David Ashton, *Food Advertising and Childhood Obesity*, 97 J. Royal Soc'y Med. 51 (2004).

235 *See, e.g.*, Diller & Graff, *supra* note 173; Adam Drewnowski, *Obesity and the Food Environment: Dietary Energy Density and Diet Costs*, 27 Am. J. Prev. Med. 154 (2004).

236 *See, e.g.*, Wendy C. Perdue, *Obesity, Poverty, and the Built Environment: Challenges and Opportunity*, 15 GEO. J. ON POVERTY L. & POL'Y 821 (2008); Montrece McNeil Ransom et al., *Pursuing Health Equity: Zoning Codes and Public Health*, 39 J.L. MED. & ETHICS 94 (2011)

237 *See, e.g.*, Neissa Smith, *Eatin' Good? Not in This Neighborhood: A Legal Analysis of Disparities in Food Availability and Quality at Chain Supermarkets in Poverty-Stricken Areas*, 14 MICH. J. RACE & L. 197, 217 (2009).

where the threat of violence keeps people indoors.[238] Predominantly African-American or Latino communities are more likely to be affected by communicable disease, substance abuse, mental health problems, and other risks that are exacerbated by disproportionate incarceration rates.[239]

But this ecological approach runs up against long-standing bias toward individualistic explanations of disease. Attribution of chronic disease, substance abuse, and other health problems to personal failures "[s]erves a symbolic, or value expressive function . . . reinforcing a world view consistent with a belief in a just world, self determination, the Protestant work ethic, self-contained individualism, and the notion that people get what they deserve."[240] Rhetoric that frames health disparities in terms of personal responsibility for unhealthy behavior choices also implicates class, racial, and other forms of bias and structural disadvantage. Efforts to reveal the importance of economic and social factors that influence individual health behaviors run the risk of overstating the associations between poverty or race and unhealthy behavior. Measures that target the individual behaviors of low-income or nonwhite people as "unhealthy"—such SNAP restrictions or Medicaid wellness reforms—are inherently suspect from a social justice standpoint and should be carefully assessed.

Libertarian objections to public health paternalism have garnered a great deal of attention in recent years,[241] while social justice objections have been underappreciated. The rich discussion over the role of paternalism in ensuring environmental justice provide useful lessons that might be fruitfully applied to similar conundrums in public health law and policy. Indian law and poverty law scholar Ezra Rosser has described the challenge presented by an informed decision by a Native American tribal government to approve or conduct environmentally harmful waste disposal or natural resource removal activities on tribal land.[242]

> Separating good from bad and right from wrong is easy when tribes are suffering from the policies or practices

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238 *See, e.g.*, Gary Bennet et al., *Safe to Walk?: Neighborhood Safety and Physical Activity Among Public Housing Residents*, 4 PLoS MED. 1599, 1603 (2007); Dustin Duncan et al., *Association Between Neighborhood Safety and Overweight Status Among Urban Adolescents*, BMC PUBLIC HEALTH (Aug. 11, 2009) http://www.biomedcentral.com/1471-2458/9/289.

239 Michael Massoglia, *Incarceration, Health, and Racial Disparities in Health*, 42 L. & SOC'Y REV. 275, 280–81 (2008); James C. Thomas & Elizabeth Torrone, *Incarceration as Forced Migration: Effects on Selected Community Health Outcomes*, 98 AM. J. PUB. HEALTH S181, S182–83 (2008).

240 Christian S. Crandall & Rebecca Martinez, *Culture, Ideology, and Antifat Attitudes*, 22 PERSONALITY & SOC. PSYCHOL. BULL. 1165, 1166 (1996).

241 *See* Wiley et al., *supra* note 185.

242 Ezra Rosser, *supra* note 44, at 469; *see also* JAMES M. GRIJALVA, CLOSING THE CIRCLE: ENVIRONMENTAL JUSTICE IN INDIAN COUNTRY (2008).

> of non-Indians, without tribal involvement, that reflect environmental racism or environmental injustice. It is much harder to know if environmental racism or injustice is involved when a tribe itself makes "an affirmative and informed decision to undertake an environmentally controversial project."[243]

As Rosser points out, the environmental justice movement has, from its inception, tackled the potential tensions between environmental protection and economic growth:

> In 1991, at the First National People of Color Environmental Leadership Summit, a broad concept of social justice that recognized "both public health and economic opportunity as indispensible aspects of the quality of life" emerged. Those at the summit concluded that "people should not be faced with choosing between an unsafe livelihood and unemployment."[244]

On the one hand, the fact that tribal governments generally opt to permit environmentally harmful activities because those governments' limited economic opportunities may justify the objection of environmental groups—and even environmental justice groups. On the other hand, denying tribes the right to participate in environmental degradation in the same way that other self-governing groups do negates their sovereignty. Reproductive justice scholars have also deeply probed the race and class biases evident in abortion—on both sides of the issue.[245] And recent food justice scholarship evinces a similar critical self-examination with regard to issues of race and class.[246] The health justice movement is not alone in struggling to reconcile recognition and redistribution as distinct, and potentially compatible, goals.

Health advocates argue that low-income or nonwhite consumers disproportionately "choose" unhealthy food and beverage products because they are cheaper and more heavily marketed. Laws and polices discouraging, or even restricting, those choices serve as a needed counter-weight to industry influence. At the same time, singling out poor or nonwhite consumers for paternalistic restrictions that could not feasibly be imposed on all consumers (as the targeted permitting restriction in L.A. County did or SNAP restrictions would) raises legitimate concerns. USDA's 2007 report opposing proposed SNAP restrictions concludes,

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243 Rosser, *supra* note 44, at 469 (quoting A. Cassidy Sehgal, Note, *Indian Tribal Sovereignty and Waste Disposal Regulation*, 5 FORDHAM ENVTL. L.J. 431, 454 (1994)).

244 *Id*. at 470.

245 *See* Mary Ziegler, *Roe's Race: The Supreme Court, Population Control, and Reproductive Justice*, 25 YALE J.L. & FEMINISM 1 (2013).

246 *See* Goldberg, *supra* note 72.

"the problems of poor food choices, unhealthy diets, and excessive weight characterize all segments of American society; the basis for singling out low-income food stamp recipients and imposing unique restrictions on their food choices is not clear."[247] As FRAC has put it, "those suggesting strategies aimed uniquely at keeping poor people from the normal streams of decision-making and commerce bear a burden of justifying that targeting."[248]

The reproductive justice movement's insistence that women have the right to determine whether and how they mother regardless of their dependence upon social assistance might also suggest new ways of thinking about the social justice implications of proposals to restrict access to and use of public benefits in the name of reducing health disparities. Joan Chrisler, for example, notes that "[u]nlike reproductive rights, which can be seen as based on the principle of negative rights (i.e., the right to resist being told by authorities what one can and cannot do with one's own body), reproductive justice is based on the principle of positive rights," which she roots in a communitarian commitment to "support [for] pursuit of a good quality of life" as the legitimating purpose of government authority.[249]

The social justice framework demands more rigorous attention to these issues. Scholars and lawyers have an obligation to probe proposed interventions—ostensibly aimed at reducing health disparities—more deeply for evidence of social, cultural, and structural bias. It might be tempting to point to proposals to restrict SNAP benefits or Medicaid wellness reforms as positive indications that policymakers have made reducing health disparities a bipartisan public priority. But, as I have argued elsewhere, the heavy emphasis on personal responsibility that permeates these proposals threatens to do more harm than good to the cause of progressive reformers interested in changing our social and physical environments to facilitate healthier lifestyles.[250] It might be tempting to dismiss the opposition of civil rights, anti-poverty, or anti-hunger groups as evidence of industry influence, but to do so would be to pass up an important opportunity to more fully explore and articulate the relationships between health and social justice.

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247 U.S. DEP'T OF AGRIC., IMPLICATIONS OF RESTRICTING THE USE OF FOOD STAMP BENEFITS – SUMMARY (2007), http://www.fns.usda.gov/ora/menu/Published/snap/FILES/ProgramOperations/FSPFoodRestrictions.pdf.

248 FOOD RESEARCH AND ACTION CTR. A REVIEW OF STRATEGIES TO BOLSTER SNAP'S ROLE IN IMPROVING NUTRITION AS WELL AS FOOD SECURITY 13 (2013), *available at* http://frac.org/wp-content/uploads/2011/06/SNAPstrategies.pdf.

249 Chrisler, *supra* note 58, at 4.

250 *See* Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 U.C. Davis L. Rev. 121 (2013).

D. Collective Action: Moving Beyond Expert-Driven Agendas to Community Engagement

In addition to broadening the agendas of the progressive projects that preceded them and probing the substantive goals of those projects for the influence of elitism and bias, the environmental, reproductive, and food justice movements have also emphasized the importance of recognition, participatory engagement, and voice for historically underrepresented groups. The insistence on participatory engagement has, in some cases, contributed to a sense of unease regarding the role of lawyers and other formally educated experts. It has also prompted fruitful examination of the tension between pursuing particular legal reforms that experts believe would best serve the interests of the poor and socially disenfranchised and the autonomy of those groups to choose other approaches that might be disfavored by experts. Scholars of "new social justice lawyering" as a practice untethered to any particular issue-based movement, have particularly emphasized the ways in which poverty acts as "a barrier to accessing the legal system and to exercising political power."[251] Some, like Ascanio Piomelli, have gone so far as to suggest a shift in "what we mean by and count as social justice and social change"—a shift away from substantive law reform to better serve the interests of low-income and otherwise marginalized communities and toward a process-based conception of social justice lawyering as a democratic, participatory, collaborative project to ensure recognition of and self-determination for marginalized individuals.[252]

Although the environmental justice, reproductive justice, and food justice movements have continued to champion *substantive* law reforms aimed at ensuring a fair distribution of risks and benefits, commitment to participatory engagement by the poor and socially marginalized in decision-making *processes* that concern their interests is clearly a hallmark of each movement. In the same way, the health justice framework might root ongoing efforts to ensure access to health care and healthy living conditions more firmly in community engagement and participatory parity. Jennifer Prah Ruger describes her capabilities approach to health and social justice as emphasizing both opportunity and process elements of freedom. "The process aspect makes public participation and deliberation in political decisions and social choice a constitutive part of public policy." Quoting Amartya Sen, she notes that "[t]hese processes are cru-

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251 Artika R. Tyner, *Planting People, Growing Justice: The Three Pillars of New Social Justice Lawyering*, 10 HASTINGS RACE & POVERTY L.J. 219, 219–20 (2013).

252 Ascanio Piomelli, *Sensibilities for Social Justice Lawyers*, 10 HASTINGS RACE & POVERTY L.J. 177, 177, 182–83 (2013).

cial to the formation of values and priorities . . . and we cannot . . . take preferences as given independently of public discussion."[253]

The Obama administration's efforts to engage a wide range of stakeholders and community voices on the issues of health disparities and environmental justice are laudable. But the most impactful public health measures are being pioneered at the local level. And although local government is typically associated with greater democratic engagement, in the case of many recent healthy eating and tobacco control measures, there has been a deliberate attempt to eschew political accountability in favor of insulated experts.

Mayor Bloomberg's administration explicitly framed its pioneering public health law interventions as efforts to reduce health disparities. These measures threaten the interests of politically powerful industries, and for that reason it is perhaps entirely understandable that Bloomberg pursued them through his Board of Health, which is far more insulated from political accountability than the directly elected City Council. On the other hand, public health, local government, and administrative law scholars have been critical of the anti-democratic nature of Bloomberg's strategy.[254] For example, public health law scholar Wendy Parmet has recently suggested that popular backlash against Bloomberg-style interventions might be better understood as anti-expertise and pro-democratic process, rather than anti-paternalistic. Parmet's argument makes sense to me, and I have similarly written about the importance of framing public health intervention in terms of democratic engagement—communities coming together to protect their health collectively in ways that they cannot accomplish individually.[255] By pursuing the substantive reforms believed to be in the interests of the poor without recognizing affected community members as full participants in a collaborative problem-solving process, the Bloomberg strategy epitomizes a remedy for maldistribution that exacerbates misrecognition.[256] Bloomberg's public health legacy raises important and difficult questions about how best to reconcile the substantive and procedural aims of social justice.

It is difficult to argue against procedural fairness, but the highly individualistic notion of participatory engagement that permeates the

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253 RUGER, *supra* note 15, at 55.

254 *See, e.g.*, Rick Hills, *The Soda Portion Cap, Redux: Why Are New York City's Agencies More Constrained than Federal Agencies*, PRAWFSBLAWG (July 30, 2013), http://prawfsblawg.blogs.com/prawfsblawg/2013/07/the-soda-portion-cap-redux-why-are-new-york-citys-agencies-more-constrained-than-federal-agencies.html; *but see* Paul Diller, *Local Health Agencies, The Bloomberg Soda Rule, and the Ghost of Woodrow Wilson*, 41 FORDHAM URBAN L.J. 1859 (2013) (arguing that Bloomberg's Board of Health could have better insulated the portion cap rule from a separation of powers challenge by relying more explicitly on its health sciences expertise).

255 *See* Wiley et al, *supra* note 185.

256 FRASER & HONNETH, *supra* note 35, at 86–87.

new social justice lawyering movement is inconsistent with the communitarian emphasis of the emerging health justice movement. The reality is that individual rights to self-determination can, in some instances, undermine community goals. Recent decisions by the Canadian, Israeli, and Brazilian courts to strike down provisions that strengthen publically financed health care systems by abrogating individual rights to circumvent the public system are instructive here.[257] Canadian health law scholar Colleen Flood, Israeli health law scholar Ayeal Gross, and others argue persuasively that rights-based arguments for access to health care grounded in individual rights to self-determination are undermining collective interests in cases across the globe.[258] It is perhaps a stretch to suggest that the private cause of action to enforce federal Medicaid law could be similarly dangerous, but the Obama administration's position on this issue—that private litigation threatens to undermine delicate negotiations between the federal government and the states over the sustainability of the Medicaid program as a whole—does strike a similar note.[259]

Again, environmental justice scholarship offers a wealth of rigorous thinking about similar issues regarding the decisions of socially disadvantaged communities to take on environmental risks in exchange for (real or perceived) economic benefits. Notably, this environmental justice scholarship has implicitly adopted an orientation toward *collective* engagement, rather than reifying the individual as the central focus of discussions about justice and fairness. In this regard, it provides a helpful model for bridging the gap between the highly individualistic orientation of the new social justice lawyering movement—which prioritizes the self-determination of individual clients over the lawyer's conception of a good outcome—and the strongly communitarian orientation of the health justice movement.

For health justice, the key may be to optimize participatory engagement as a matter of the collectively-held right of communities to protect themselves from hazards and to act together to ensure that essential needs are met. Arguments against state and federal preemption of local

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257 *See* Ayeal Gross, *Is There a Human Right to Health Care?*, 41 J.L. MED. & ETHICS 138 (2013) (describing the use of rights-based arguments to reinforce privatization of health care and describing the Chaoulli (Canada) and Kiryati (Israel) cases); Octavio Luiz Motta Ferraz, *The Right to Health in the Courts of Brazil: Worsening Health Inequities?* 11 HEALTH & HUM. RTS. 33 (2009).

258 *See generally* THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY (Colleen M. Flood & Aeyal Gross eds., 2014).

259 Brief for the United States as Amicus Curaie Supporting Petitioner, Douglas v. Indep. Living Ctr., 132 S. Ct. 1204 (2012) (Nos. 09-958, 09-1158 and 10-283), *available at* http://www.justice.gov/osg/briefs/2010/3mer/1ami/2009-0958.mer.ami.pdf.

government public health authority are on point here.[260] Examples of community engagement as a strategy for ensuring that measures to reduce health disparities are consistent with broader social justice goals have begun to garner some scholarly attention. For example, the Los Angeles anti-fast-food permitting ordinance, which raises a red flag by targeting low-income and nonwhite neighborhoods, can perhaps be redeemed by its democratic origins.[261] The ordinance was developed through collaborative engagement between formally-trained experts and community groups and enjoys broad public support.[262] Compromises hammered out in state legislatures between public health advocates and civil rights advocates over the move to primary enforcement seat belt laws offer a similarly hopeful counter-example to the anti-democratic narrative about the Bloomberg legacy.[263] When interventions to address racial profiling in traffic stops were incorporated into primary enforcement seatbelt bills, the result was a win for public health and for broader social justice goals.

CONCLUSION

In spite of growing agreement that health law can and should be used as a tool for reducing health disparities, there has been little exploration of what social justice offers in the way of a conceptual framework for health law scholarship, activism, and reform distinct from the currently dominant paradigms of market competition and patient rights. We may or may not be seeing the beginnings of a "health justice" movement. But either way, I believe that health law advocates and scholars have much to gain from more rigorous engagement with the fruitful ideas being generated in legal scholarship influenced by the environmental, reproductive, and food justice movements and by political philosophers and ethicists writings on the multifaceted relationship between social justice and health. In this Article, I have proposed three interrelated "health justice" commitments for the use of law as a tool for reducing health disparities. Others adopting a health justice framework may add to this list or may disagree with me altogether, but my purpose is to start a conversation, not to end one.

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260 *See* Mark Pertschuk et al., *Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers*, 19 J. PUB. HEALTH MGMT. & PRAC. 213 (2013) (discussing the negative impact of preemption on grassroots movement building).

261 *See* LaVonna Blair Lewis et al., *Transforming the Urban Food Desert from the Grassroots Up: A Model for Community Change*, 34 FAMILY & COMMUNITY HEALTH S92 (2011) (describing the coalition of community groups, informed by research, that led to the adoption of the Interim Control Ordinance in South Los Angeles).

262 *Id.*

263 *See* U.S. DEP'T OF TRANSP., *supra* note 144 (noting compromise measures reached in several state legislatures that incorporated interventions to address racial profiling into bills adopting primary enforcement for seat belt mandates).

In the absence of more rigorous engagement with the social justice framework, there is a risk that "each reform effort [will be] perceived as an isolated exception to the norm of market-justice [while] the norm itself still stands."[264] Many (though not all) of the interventions being proposed and deployed in the name of reducing health disparities are encouraging from a social justice standpoint. "But as long as these actions are seen as merely minor exceptions to the rule of individual responsibility, the goals of public health will remain beyond our reach. What is required is for the public to see that protecting the public's health takes us beyond the norms of market-justice categorically, and necessitates a completely new health ethic."[265] The health justice framework offers a powerful critique of the ways in which market justice—even in its progressive form with an emphasis on patient rights and equal opportunity—shores up a narrow vision of health that is dominated by the health care industry, an impoverished vision of community as the mere aggregation of quasi-contractual relationships between autonomous and atomized individuals and their exogenous social environment, and a lopsided vision of reform as driven by privileged experts who fail to engage meaningfully with the communities they seek to serve.

264 Beauchamp, *supra* note 1, at 105.
265 *Id.*