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Healthy Reform, Healthy Cities: Using Law and Policy to Reduce Obesity Rates in Underserved Communities

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HEALTHY REFORM, HEALTHY CITIES: USING LAW AND POLICY TO REDUCE OBESITY RATES IN UNDERSERVED COMMUNITIES

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INTRODUCTION

South Los Angeles is a low-income African-American and Latino neighborhood with disproportionately high obesity rates—35% of the adult population is obese, compared to 22% in Los Angeles County as a whole.[1] South Los Angeles was once a thriving middle class African-American neighborhood, but it became impoverished when, as in many cities, jobs and higher-income residents left the urban core.[2] Fast food restaurants were abundant, yet residents had no

1. NICKY BASSFORD ET AL., CMTY. HEALTH COUNCILS, INC., FOOD RES. DEV. WORKGROUP, FOOD DESERT TO FOOD OASIS: PROMOTING GROCERY STORE DEVELOPMENT IN SOUTH CENTRAL LOS ANGELES 4 (2010), *available at* http://www.chc-inc.org/downloads/Food%20Desert%20to%20Food%20Oasis%20July%202010.pdf.

2. Scott Gold, *Central Avenue Is Dreaming Again*, L.A. TIMES, Sept. 25, 2009, http://articles.latimes.com/2009/sep/25/local/me-southla-centralave25.

access to a grocery store.[3] In 2008, residents decided to change that by pushing the Los Angeles city council to place a moratorium on new fast food restaurants in the neighborhood, while also offering a package of incentives to attract a new grocery store.[4] The incentive package successfully attracted at least four grocery store developments to the neighborhood.[5] The targeted strategy was considered controversial by some because it focused on an African American and Latino neighborhood and was perceived by outsiders as paternalistic.[6] But what many didn't realize is that neighborhood groups supported the fast food restrictions.[7]

The South Los Angeles example illustrates the challenges urban communities across the United States face. Obesity is one of many chronic conditions that people of color experience disproportionately, putting them at greater risk for many serious preventable diseases such as diabetes, heart disease and cancer.[8] In this Article, we focus on the national obesity epidemic and discuss ways to use policy interventions, such as those that improved access to healthy food in South Los Angeles, to reduce disparities experienced by underserved communities and specific racial and ethnic groups.

We start with an overview of the obesity epidemic and its underlying causes—the social determinants of health. Next, we review the role of government in ending the obesity epidemic, including a discussion of Affordable Care Act (ACA) provisions that support population-level interventions to address the epidemic. Enterprising local and state governments have been leading the way on obesity prevention for a decade. A number of provisions within

3. NICKY BASSFORD ET AL., CMTY. HEALTH COUNCILS, INC., FAST FOOD RESTAURANT REPORT: PROMOTING HEALTHY DINING IN SOUTH LOS ANGELES 7–9 (2011) [hereinafter BASSFORD ET AL., FAST FOOD REPORT], *available at* http://www.chc-inc.org/downloads/PB%20Fast%20Food%20Report.pdf; BASSFORD ET AL., *supra* note 1, at 7–9.

4. L.A., CAL., ORDINANCE 180103 (2008), http://clkrep.lacity.org/onlinedocs/2007/07-1658_ord_180103.pdf; *see also* CMTY. REDEVELOPMENT AGENCY, CITY OF L.A., MARKET OPPORTUNITIES: INCENTIVES FOR FOOD RETAILERS 1 (2008), *available at* http://www.crala.org/internet-site/Development/upload/Market_Opportunities_08.pdf.

5. BASSFORD ET AL., FAST FOOD REPORT, *supra* note 3, at 4.

6. *See* Kim Severson, *Los Angeles Stages a Fast Food Intervention*, N.Y. TIMES, Aug. 12, 2008, at F1.

7. BASSFORD ET AL., FAST FOOD REPORT, *supra* note 3, at 5.

8. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, CDC HEALTH DISPARITIES AND INEQUALITIES REPORT—UNITED STATES, 2011, at 62–65, 73–76, 84–86, 90–93 (Jan. 14, 2011), *available at* http://www.cdc.gov/mmwr/pdf/other/su6001.pdf.

the ACA, however, provide an unprecedented opportunity to "scale up" obesity prevention activities. The ACA specifically calls on policymakers in states and localities to identify strategies to reduce obesity rates among populations bearing the brunt of the epidemic, namely people of color and low-income people. Finally, we propose a framework for developing disparities-focused obesity prevention policies. Policymakers at all levels of government can use this tool to help them decide how to allocate their limited resources to policies that directly address disparities in obesity rates. This framework is intended to support communities and states that will be heeding the federal government's call to action on obesity and health disparities.

I. THE OBESITY EPIDEMIC AND SOCIAL DETERMINANTS OF HEALTH

Social and environmental factors, such as the proliferation of fast food restaurants or lack of safe sidewalks for walking, are different in different communities; these disparate conditions lead to worse health outcomes for people of color and people with low incomes.[9] In this section, we provide an overview of the obesity epidemic in the United States and how social and environmental factors increase the risk for obesity and related chronic diseases.

A. Rising Obesity Rates

Since the late 1970s, adult obesity rates[10] have more than doubled,[11] while the rates for children and adolescents have tripled in the same

9. *See generally* Youfa Wang & May A. Beydoun, *The Obesity Epidemic in the United States—Gender, Age, Socioeconomic, Racial/Ethnic, and Geographic Characteristics: A Systematic Review and Meta-Regression Analysis*, 29 EPIDEMIOLOGIC REV. 6 (2007), *available at* http://epirev.oxfordjournals.org/content/29/1/6.full.pdf+html.

10. For simplicity of reporting data, we will focus on obesity rates. Being overweight, but not obese, also increases a person's risk of chronic disease. Obesity and overweight are determined using a person's body mass index. The body mass index is calculated by dividing a person's weight in kilograms by their height in meters squared. BMI has been shown to be correlated with body fat. "Overweight" for adults is defined as having a BMI between 25 and 30, and "obese" for adults is defined as having a BMI above 30. For children and teens, "obesity" and "overweight" are defined using BMI-for-age growth charts. Children are overweight when their BMI falls between the 85th and 95th percentiles. Obesity in children is defined as having a BMI equal to or above the 95th percentile. *See About BMI for Children and Teens*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/healthyweight/assessing/bmi/childrens_BMI/about_childrens_BMI.html (last visited May 14, 2013); *About BMI for Adults*, CTRS. FOR DISEASE

time period.[12] Currently, 17% of children and adolescents in the nation are obese, a proportion that has risen significantly since the 1980s.[13] Approximately 36% of adult men and women in the U.S. are obese, representing a significant increase in a twelve-year period for men, but not women.[14] Although adult obesity rates are still rising, the rate of increase is not as rapid as in previous decades.[15]

Obesity is a national concern because it is a risk factor for cancer, diabetes, and a host of other debilitating and potentially deadly diseases.[16] Obese children are more likely to have asthma, diabetes, joint problems, and even early signs of heart disease.[17] They are also more likely to be obese adults.[18] Obesity puts adults at greater risk for an even longer list of diseases and conditions, including cancer, liver disease, and stroke.[19] Obese children are teased and bullied and, as a result, experience anxiety, depression, and many other mental

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CONTROL & PREVENTION, http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html (last visited May 14, 2013).

11. *Cf.* Katherine M. Flegal et al., *Prevalence and Trends in Obesity Among US Adults, 1999–2008*, 303 J. AM. MED. ASS'N 235, 235 (2010), *available at* http://jama.jamanetwork.com/article.aspx?articleid=185235#ref-joc90148-3.

12. CYNTHIA OGDEN & MARGARET CARROLL, NCHS HEALTH E-STAT, PREVALENCE OF OBESITY AMONG CHILDREN AND ADOLESCENTS: UNITED STATES, TRENDS 1963–1965 THROUGH 2007–2008, at 5 (2010), *available at* http://www.cdc.gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.html; Cynthia L. Ogden et al., *Prevalence and Trends in Overweight Among US Children and Adolescents, 1999–2000*, 288 J. AM. MED. ASS'N 1728, 1731 (2002), *available at* http://jama.jamanetwork.com/article.aspx?articleid=195387.

13. Cynthia L. Ogden et al., *Prevalence of Obesity and Trends in Body Mass Index Among US Children and Adolescents, 1999–2010*, 307 J. AM. MED. ASS'N 483, 485–87 (2012), *available at* http://jama.jamanetwork.com/article.aspx?articleid=1104932.

14. Katherine M. Flegal et al., *Prevalence of Obesity and Trends in the Distribution of Body Mass Index Among US Adults, 1999–2010*, 307 J. AM. MED. ASS'N 491, 493–95 (2012), *available at* http://jama.jamanetwork.com/article.aspx?articleid=1104933.

15. *Id.* at 496.

16. Ivana Vucenik & Joseph P. Stains, *Obesity and Cancer Risk: Evidence, Mechanisms, and Recommendations*, 1271 ANN. N.Y. ACAD. SCI. 37, 38 (2012), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3476838/pdf/nyas1271-0037.pdf; *Overweight and Obesity: Causes and Consequences*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 27, 2012), http://www.cdc.gov/obesity/adult/causes/index.html; *Basics About Childhood Obesity*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 27, 2012), http://www.cdc.gov/obesity/childhood/basics.html.

17. *Basics About Childhood Obesity*, supra note 16.

18. *Id.*

19. *Overweight and Obesity: Causes and Consequences*, *supra* note 16.

health problems.[20] Obese adults are less likely to be hired and promoted and make less money than their healthy weight peers.[21] Treatment of obesity and related diseases costs the United States healthcare system an estimated $147 billion annually, which translates to approximately $1,400 in additional spending per obese person compared to people with healthy weights.[22] Obesity costs employers over $30 billion annually in lost productivity.[23]

Some groups bear a greater burden of obesity than others. The most striking obesity disparities are those between whites, African Americans, and Latinos. Twenty-one percent of Latino children and adolescents and 24% of African-American children and adolescents are obese, while only 14% of white children are obese.[24] Disparities also exist for adults, with 50% of African Americans and 38% of Latinos being obese, compared to 35% of whites.[25] Variation in obesity rates across incomes is more complex.[26] With some exceptions, obesity rates generally decline as income increases for both adults and children.[27] Some studies, however, have found that obesity rates rise with income for African American and Latino men,

20. *See* Shelly Russell-Mayhew et al., *Mental Health, Wellness, and Childhood Overweight/Obesity*, J. OBESITY 3–4 (June 24, 2012), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3388583/pdf/JOBES2012-281801.pdf.

21. In many cases, these outcomes are the result of weight bias, a term used for discrimination against children and adults who are overweight or obese. *See* Reginald L. Washington, *Childhood Obesity: Issues of Weight Bias*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y, Sept. 2011, at A94, *available at* http://www.cdc.gov/pcd/issues/2011/sep/pdf/10_0281.pdf. Efforts to decrease obesity must take care to avoid stigmatizing individuals for obesity and should fight against such discrimination. *See* ROBERTA R. FRIEDMAN & REBECCA M. PUHL, YALE RUDD CTR. FOR FOOD POL'Y & OBESITY, WEIGHT BIAS: A SOCIAL JUSTICE ISSUE—A POLICY BRIEF 7, 9 (2012), *available at* http://www.yaleruddcenter.org/resources/upload/docs/what/reports/Rudd_Policy_Brief_Weight_Bias.pdf.

22. Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer- and Service-Specific Estimates*, 28 HEALTH AFF. w822, w828 (2009), *available at* http://content.healthaffairs.org/content/28/5/w822.full.pdf.

23. Eric A. Finkelstein et al., *The Costs of Obesity in the Workplace*, 52 J. OCCUPATIONAL & ENVTL. MED. 971, 975 (2010).

24. Ogden, *supra* note 13, at 485–86.

25. *See* Flegal et al., *supra* note 14, at 493.

26. *See, e.g.*, Gopal K. Singh et al., *Dramatic Increases in Obesity and Overweight Prevalence and Body Mass Index Among Ethnic-Immigrant and Social Class Groups in the United States, 1976–2008*, 36 J. CMTY. HEALTH 94 (2010), *available at* http://link.springer.com/article/10.1007%2Fs10900-010-9287-9?LI=true#page-1.

27. Paula A. Braveman et al., *Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us*, 100 AM. J. PUB. HEALTH S186, S191 (2010), *available at* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2009.166082; *see also* Wang & Beydoun, *supra* note 9, at 9-11.

which may reflect different body size norms for men or a greater likelihood that lower-income men have physically-demanding jobs.[28]

B. How the Social Determinants of Health Drive Obesity Disparities

Why have obesity rates increased so dramatically in the past several decades, and why do they vary among different racial and economic groups? Social and environmental conditions, ranging from income to race to air quality and more, are considered to be the main factors determining health outcomes.[29] These factors are known as the social determinants of health.[30] This concept has existed in global health circles for decades,[31] but has only recently been applied systematically in the United States.[32]

The emphasis on social determinants of health in obesity prevention stems from a growing body of research linking socioeconomic status, race, and ethnicity to obesity. The differences in health outcomes according to these factors are known as health

28. Virginia W. Chang & Diane S. Lauderdale, *Income Disparities in Body Mass Index and Obesity in the United States, 1971-2002*, 165 J. AM. MED. ASS'N 2122, 2127 (2005), *available at* http://archinte.jamanetwork.com/article.aspx?articleid=486733; *see also* Wang & Beydoun, *supra* note 9, at 9–12.

29. Steven A. Schroeder, *We Can Do Better—Improving the Health of the American People*, 357 NEW ENG. J. MED. 1221, 1225–26 (2007), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMsa073350; *see also* J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 J. AM. MED. ASS'N 2207, 2210 (1993), *available at* http://jama.jamanetwork.com/article.aspx?articleid=409171.

30. *See, e.g.*, Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099 (2005), *available at* http://www.who.int/social_determinants/strategy/en/Marmot-Social%20determinants%20of%20health%20inqualities.pdf.

31. COMM'N ON SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 33–34 (2008), *available at* http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.

32. Howard K. Koh, *A 2020 Vision for Healthy People*, 362 NEW ENG. J. MED. 1652, 1656 (2011), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1001601. An analysis of social determinants of health and public policy in the United States contends that the U.S. focuses primarily on racial and ethnic health disparities, to the exclusion of social class and income disparities. Furthermore, the United States emphasizes the role of access to healthcare more so than other social and environmental factors that drive health outcomes. *See* Dennis Raphael, *Shaping Public Policy and Population Health in the United States: Why Is the Public Health Community Missing in Action?*, 38 INT'L J. HEALTH SERVS. 63, 80–84 (2008), *available at* http://www.mlhc.org/wp-content/uploads/2010/01/Shaping-public-policy.pdf.

disparities.[33] By most measures, health improves consistently as socioeconomic status (i.e., income and education) rises, for nearly all racial and ethnic groups.[34] For example, infant mortality rates decline as maternal education levels increase for African American and white babies.[35] Life expectancy, diabetes rates, and heart disease rates all improve as incomes rise for African Americans, Latinos, and whites.[36]

Some health disparities experienced by people of color can be explained by differences in socioeconomic status.[37] But others cannot. Despite the positive health effects of education and income for all races and ethnicities, African Americans and Latinos at the highest education and income levels still have worse health than whites at the same, and even lower, education and income levels.[38] For example, infants born to African American mothers with at least a college degree have lower birth weights than infants born to white mothers without a high school degree.[39] Latinos born in the United States and African Americans have worse health than whites, even when researchers control for socioeconomic status.[40] Long-term disadvantage and discrimination likely explain these health disparities, although researchers are still exploring exactly how these experiences lead to poor health.[41]

33. Paula Braveman & Sofia Gruskin, *Defining Equity In Health*, 57 J. EPIDEMIOLOGY & CMTY. HEALTH 254, 254 (2003), *available at* http://jech.bmj.com/content/57/4/254.full.pdf+html ("[E]quity in health can be defined as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy . . . .").

34. *See, e.g.*, Braveman et al., *supra* note 27, at S191.

35. *Id.* at S190, S192.

36. *Id.* at S191, S193.

37. Steven H. Woolf & Paula Braveman, *Where Health Disparities Begin: The Role of Social and Economic Determinants—And Why Current Policies May Make Matters Worse*, 30 HEALTH AFF. 1852, 1853–54 (2011).

38. Braveman et al., *supra* note 27, at S191, S193.

39. NAT'L CTR. FOR HEALTH STAT., CTRS. FOR DISEASE CONTROL & PREVENTION, HEALTH, UNITED STATES, 2011: WITH SPECIAL FEATURE ON SOCIOECONOMIC STATUS AND HEALTH 86 (2012), *available at* http://www.cdc.gov/nchs/data/hus/hus11.pdf.

40. Eileen M. Crimmins et al., *Hispanic Paradox in Biological Risk Profiles*, 97 AM. J. PUB. HEALTH 1305, 1307–08 (2007), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1913070. Interestingly, health disparities between foreign-born Latinos and whites go away when researchers control for socioeconomic status. *See id.*

41. *See, e.g.*, David R. Williams & Selina A. Mohammed, *Discrimination and Racial Disparities in Health: Evidence and Needed Research*, 32 J. BEHAV. MED. 20

Neighborhood quality is another social determinant of health that is intertwined with socioeconomic status, race, and ethnicity.[42] African Americans often live in highly segregated neighborhoods that have high levels of poverty and few amenities that promote health. Even higher-income African Americans are more likely than lower-income whites to live in neighborhoods with low-quality housing and limited services.[43] Residents of segregated areas often do not have access to recreational facilities or safe streets where they can be physically active.[44] Communities of color also have fewer supermarkets and more fast food restaurants.[45] Parks and grocery stores are health-promoting infrastructure and are associated with lower rates of obesity, diabetes, and other chronic conditions and diseases, but are not available in every neighborhood.[46] In the next sections, we consider how policy interventions can address the social determinants of health and reduce health disparities in the obesity epidemic.

(2009), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821669; *see also* Braveman et al., *supra* note 27, at S192.

42. *See, e.g.*, David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404 (2001), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497358/pdf/12042604.pdf.

Communities of color and low-income neighborhoods are also more likely to have sewage treatment plants and other polluting facilities. Rachel Morello-Frosch et al., *Understanding the Cumulative Impacts of Inequalities in Environmental Health: Implications For Policy*, 30 HEALTH AFF. 879, 881 (2011). Low-income African American and Latino households tend to live in older homes that have not been renovated, exposing them to higher levels of indoor pollutants, like lead paint, than other households. *Id.* Exposure to all of these pollutants is linked to a plethora of health risks, including respiratory diseases, stress, and mental health problems. *Id.*

43. Williams & Collins, *supra* note 42, at 410.

44. *Id.*

45. Kimberly Morland et al., *Neighborhood Characteristics Associated with the Location of Food Stores and Food Service Places*, 22 AM. J. PREV. MED. 23, 27–28 (2002); Williams & Collins, *supra* note 42, at 410.

46. *See, e.g.,* James F. Sallis & Karen Glanz, *Physical Activity and Food Environments: Solutions to the Obesity Epidemic*, 87 MILBANK Q. 123 (2009), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2879180/ (reviewing how the built environment affects obesity); *see also* John E. Stewart et al., *Diabetes and the Socioeconomic and Built Environment: Geovisualization of Disease Prevalence and Potential Contextual Associations Using Ring Maps*, 10 INT'L J. HEALTH GEOGRAPHICS 18 (2011), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3066107/.

II. USING LAW AND POLICY TO END THE OBESITY EPIDEMIC

The obesity prevention movement[47] has focused on changing environments that promote over-consumption of junk food and physical inactivity, with the goals of changing social norms[48] about personal nutrition and physical activity and, ultimately, reducing obesity rates.[49] These strategies—which are based on lessons learned from the earlier tobacco control movement[50]—use policy to change the context of people's lives, to "make healthy options the default choice, regardless of education, income, . . . or other societal factors."[51] As the Centers for Disease Control and Prevention (CDC) director Thomas Frieden notes, "the defining characteristic of [these strategies] is that individuals would have to expend significant effort not to benefit from them."[52]

Traditionally, public health practitioners used education campaigns to inform the public about health threats and how to avoid them, with the goal of stopping risky behaviors, like unprotected sex and smoking.[53] For example, during the early years of the tobacco control

47. By "obesity prevention movement," we mean government officials, policymakers, advocates, and other experts working to reduce obesity rates and improve health.

48. Social norms are "social attitudes of approval and disapproval, specifying what ought to be done and what ought not to be done." Cass R. Sunstein, *Social Norms and Social Roles*, 96 COLUM. L. REV. 903, 914 (1996). In other words, social norms show us how to behave in the world. They are shaped by the people and environment around us. *See id.* at 914–16.

49. *See* Rebecca Bunnell et al., *Fifty Communities Putting Prevention to Work: Accelerating Chronic Disease Prevention Through Policy, Systems and Environmental Change*, 37 J. CMTY. HEALTH 1081, 1082 (2012); Laura Kettel Khan et al., *Recommended Community Strategies and Measurements to Prevent Obesity in the United States*, 58 MORBIDITY & MORTALITY WEEKLY REP. 1–2 (2009), *available at* http://www.cdc.gov/mmwr/pdf/rr/rr5807.pdf; Sallis & Glanz, *supra* note 46, at 124–27.

50. *See, e.g.*, Samantha Graff & Jacob Ackerman, *A Special Role for Lawyers in a Social Norm Change Movement: From Tobacco Control to Childhood Obesity Prevention*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y, July 2009, at A95, *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2722393/pdf/PCD63A95.pdf.

51. Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. PUB. HEALTH 590, 591 (2010), *available at* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2009.185652.

52. *Id.*

53. For example, anti-smoking education campaigns often associate smoking with death, disfigurement, and other bad outcomes as a way to stigmatize smoking. *See, e.g.*, *Graphic Anti-Smoking Ads*, DAILY NEWS, Oct. 1, 2008, http://www.nydailynews.com/life-style/health/graphic-anti-smoking-ads-gallery-1.26510?pmSlide=0; *Tips from Former Smokers*, CTRS. FOR DISEASE CONTROL &

movement, public health advocates learned that aggressive media campaigns showing the harms of smoking were more effective when combined with policy strategies that changed the environment by making it more difficult to smoke in public.[54] Namely, tobacco taxes and clean indoor air laws both have been shown to decrease smoking rates by ten percent or more by themselves, whereas media campaigns are most effective when combined with tobacco control policies.[55] There is growing evidence that this approach—known as social norm change[56]—is a more successful, and cost-effective, approach to reducing premature death and chronic disease rates.[57] In the obesity prevention context, local laws that prevent fast-food restaurants from being sited near schools,[58] limit portion sizes of sugary drinks,[59] and facilitate the development of grocery stores[60] serve to nudge people into thinking differently about the unhealthy social norms related to food that we have adopted as a society.

Before the passage of the ACA, a number of related but distinct obesity prevention efforts incorporated this social norm change approach. In 2010, for example, the CDC provided significant funding and technical assistance to communities developing obesity

PREVENTION (Jan. 3, 2013), http://www.cdc.gov/tobacco/campaign/tips/resources/videos/#anthem.

54. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, BEST PRACTICES FOR COMPREHENSIVE TOBACCO CONTROL PROGRAMS—2007 (2007), *available at* http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf.

55. David T. Levy et al., *The Effects of Tobacco Control Policies on Smoking Rates: A Tobacco Control Scorecard*, 10 J. PUB. HEALTH MGMT. PRAC. 338, 343, 346 (2004).

56. Marice Ashe et al., *Local Venues for Change: Legal Strategies for Healthy Environments*, 35 J. LAW, MED. & ETHICS 138, 138 (2007); *see also* Hao Tang et al., *Changes of Attitudes and Patronage Behaviors in Response to a Smoke-Free Bar Law*, 93 AM. J. PUB. HEALTH 611, 616 (2003), *available at* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.93.4.611; Sunstein, *supra* note 48, at 914–16.

57. Bobby Milstein et al., *Why Behavioral and Environmental Interventions Are Needed to Improve Health at Lower Cost*, 30 HEALTH AFF. 823, 829 (2011). It should be noted that combining environmental change with increased access to health insurance and better primary care was more cost effective than any of those three interventions alone.

58. DETRIOT, MICH., ZONING ORDINANCE §§ 61-12-91, 61-12-228 (2012), *available at* http://www.detroitmi.gov/portals/0/docs/legislative/cpc/pdf/Ch%2061%20Nov%2021,%202012.pdf.

59. N.Y.C. HEALTH CODE § 81.53 (2013), *available at* http://www.nyc.gov/html/doh/downloads/pdf/about/healthcode/health-code-article81.pdf.

60. L.A., CAL., ORDINANCE No. 180103 (2008), *available at* http://clkrep.lacity.org/onlinedocs/2007/07-1658_ord_180103.pdf.

prevention initiatives through its Communities Putting Prevention to Work (CPPW) initiative,[61] which was funded by the American Recovery and Reinvestment Act of 2009 (commonly referred to as ARRA or the Stimulus Act).[62] ARRA set aside $650 million to be administered by the CDC for the purpose of carrying out "evidence-based clinical and community-based prevention and wellness strategies . . . that deliver specific, measurable health outcomes that address chronic disease rates."[63] Through the CPPW initiative, the CDC funded fifty local communities across the country to implement prevention strategies to reduce obesity and tobacco use.[64] In total, the funded communities had more than 55 million residents, expanding the reach of prevention policy to a substantial proportion of the U.S. population.[65] At the same time, First Lady Michelle Obama's Let's Move campaign raised the profile of childhood obesity exponentially.[66]

Philanthropic initiatives targeting obesity predated the CPPW program. In particular, the Robert Wood Johnson Foundation (RWJF) identified childhood obesity prevention as one of its major program areas in the early 2000s and has since committed significant resources to reversing the alarming trends in obesity rates.[67] Recognizing the toll the epidemic takes on communities of color, RWJF has invested heavily in supporting public health research that focuses on these communities.[68] Thus, communities moved to action by the funding and vision articulated in the ACA have a firm foundation to build upon.

61. Bunnell et al., *supra* note 49, at 1082.

62. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115, 180–81 ("Prevention and Wellness Fund").

63. *Id.*

64. Bunnell et al., *supra* note 49, at 1081. The CPPW initiative had several goals for improved health in the funded communities: increasing levels of physical activity; improving nutrition; reducing obesity rates; and reducing smoking prevalence, teen smoking initiation, and exposure to second-hand smoke. *Id.*

65. *Id.*

66. *See* LET'S MOVE, http://www.letsmove.gov/ (last visited May 14, 2013).

67. *See Program Areas: Childhood Obesity*, ROBERT WOOD JOHNSON FOUND., http://www.rwjf.org/en/about-rwjf/program-areas/childhood-obesity.html (last visited May 14, 2013). The authors of this Article work for the National Policy & Legal Analysis Network to Prevent Childhood Obesity (NPLAN), one of the childhood obesity prevention programs funded by RWJF.

68. *See, e.g.*, AFRICAN AM. COLLABORATIVE OBESITY RES. NETWORK, http://www.aacorn.org/ (last visited May 14, 2013); SALUD AMERICA! THE RWJF RES. NETWORK TO PREVENT OBESITY AMONG LATINO CHILDREN, http://www.salud-america.org/ (last updated July 29, 2010).

The obesity prevention movement's work, whether privately or publicly funded, centers around five broad goals, as described in a 2012 report by the Institute of Medicine (IOM), a prestigious national nonprofit that provides independent, evidence-based advice to governmental bodies[69]:

- Increasing physical activity levels;
- Increasing access to healthy foods and beverages and limiting access to unhealthy foods and beverages;
- Changing messages about nutrition and physical activity, including limiting junk food marketing to children;
- Working with healthcare providers, insurers, and employers; and
- Improving nutrition and physical activity in schools.

As the IOM notes, this multi-faceted approach is necessary when addressing an epidemic like obesity, which is caused by many different external factors.[70] The laws and policies used to implement these goals address the role of environments (e.g., schools, neighborhoods, media) in the obesity epidemic.[71] For example, we know that people are more physically active when they have sidewalks.[72] Local policymakers can establish street design standards to ensure that safe sidewalks are available throughout the community to encourage residents to walk in their neighborhoods, increasing physical activity levels.[73]

In the next section, we provide a brief overview of the legal framework that regulates public health in the United States. This discussion is not meant to be a comprehensive discussion of the laws that govern public health in the United States. Rather, it serves to ground the later discussion of the ACA and the relationship between this landmark federal law and local obesity prevention policies.

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69. DAN GLICKMAN ET AL., INST. OF MED., ACCELERATING PROGRESS IN OBESITY PREVENTION: SOLVING THE WEIGHT OF THE NATION 10–16 (2012), *available at* http://www.iom.edu/Reports/2012/Accelerating-Progress-in-Obesity-Prevention.aspx.

70. *Id.* at 21–26.

71. *See, e.g.*, Kettel Khan, *supra* note 49.

72. Ross C. Brownson et al., *Environmental and Policy Determinants of Physical Activity in the United States*, 91 AM. J. PUB. HEALTH 1995, 1999–2000 (2001), *available at* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.91.12.1995; *see also* Gina S. Lovasi et al., *Built Environments and Obesity in Disadvantaged Populations*, 31 EPIDEMIOLOGIC REV. 7, 13 (2009), *available at* http://epirev.oxfordjournals.org/content/31/1/7.full.pdf+html.

73. Kettel Khan, *supra* note 49, at 17–18; Sallis & Glanz, *supra* note 46, at 127–28.

A. The Power to Regulate Public Health

Most policy interventions designed to help people live, work, and play in healthier environments flow from the police power, which is the inherent authority of the state to protect and promote the health, safety, morals, and general welfare of the people.[74] Specifically, under the Tenth Amendment of the Constitution, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the [s]tates, are reserved to the [s]tates respectively, or to the people."[75] As there is no federal police power enumerated in the U.S. Constitution, the police power resides with states.[76]

All states, to varying degrees, delegate their police power to local governments.[77] The ability to protect public health is a traditional function of the police power.[78] Thus states and many localities have the presumptive authority to pass public health laws. The laws typically address zoning, licensing, retail operations, and so on, and are generally subject to "rational basis review"—a legal standard that is very deferential to government actions.[79] The regulations need only bear a rational relationship to a legitimate government purpose.[80]

As states and localities explore how best to address their residents' needs related to their health and welfare under the police power, some of the most interesting policy innovations occur. Consequently, the initial impetus for action on a public health issue frequently comes from localities and states that want to be responsive to the needs of their communities. Massachusetts provides a relevant example of state-level policy innovation that led to federal action. In 2006, the state passed a law that transformed its healthcare system by expanding health insurance coverage to the state's uninsured

74. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 92 (2d ed. 2008); *see also* Seth E. Mermin & Samantha K. Graff, *A Legal Primer for the Obesity Prevention Movement*, 99 AM. J. PUB. HEALTH 1799 (2009), *available at* http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2008.151183 (providing an excellent summary of the legal issues most relevant to obesity prevention advocates).

75. U.S. CONST. amend. X.

76. U.S. CONST. art. 1, § 8.

77. GOSTIN, *supra* note 74, at 92.

78. *Id.*

79. Samantha K. Graff et al., *Policies for Healthier Communities: Historical, Legal, and Practical Elements of the Obesity Prevention Movement*, 33 ANN. REV. PUB. HEALTH 307, 312 (2012), *available at* http://www.annualreviews.org/doi/pdf/10.1146/annurev-publhealth-031811-124608.

80. Consol. Rock Prods. Co. v. City of Los Angeles, 370 P.2d 342, 346–47 (Cal. 1962).

population.[81] This law is widely regarded as the model for the ACA, although the federal law is much broader and includes a range of national initiatives that could not be contemplated under a single state's law.[82]

Although the federal government has no general police power, the enumerated powers that Congress and the president may exercise—such as Congress's ability to regulate interstate and international commerce—have been interpreted very broadly;[83] thus, there is often concurrent national and state regulation of public health.[84] Furthermore, the federal government uses its power to tax and spend to allocate resources to states and localities for public health activities.[85]

Health and Human Services (HHS) is the agency that oversees most of the programs that fund public health activities. HHS houses eighteen operating divisions, which include the CDC and the National Institutes of Health.[86] These national agencies have access to research and data that enable them to identify trends, share best practices, and coordinate efforts among states.[87] When confronting a national health threat like obesity, the federal government can use its resources to guide a national response by developing response plans, providing data to inform the response, and directing funding for state and local responses.[88] Armed with this funding and data, states and localities can implement plans and create policies that respond to the unique needs of their communities. As we explore later, the federal government established a national obesity prevention strategy through the ACA, recommending specific interventions based on the

81. An Act Providing Access to Affordable, Quality, Accountable Healthcare, 2006 Mass. Acts ch. 58, *available at* http://www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58.

82. Kavita Patel & John McDonough, *From Massachusetts to 1600 Pennsylvania Avenue: Aboard the Health Reform Express*, 29 HEALTH AFF. 1106, 1106 (2010).

83. *See, e.g.*, Gonzales v. Raich, 545 U.S. 1, 2–3 (2005).

84. GOSTIN, *supra* note 74, at 80.

85. *See, e.g.*, South Dakota v. Dole, 483 U.S. 203, 206–07 (1987); GOSTIN, *supra* note 74, at 99–104.

86. *About HHS*, U.S. DEP'T OF HEALTH & HUM. SERVS., http://www.hhs.gov/about/index.html (last visited May 14, 2013).

87. *See, e.g.*, *CDC Surveillance Resource Center*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/surveillancepractice/ (last updated Feb. 6, 2013).

88. In the obesity context, the CDC does this primarily through the Division of Nutrition, Physical Activity, and Obesity (DNPAO). For more information about DNPAO's activities, see generally *About Us*, *Division of Nutrition, Physical Activity, and Obesity*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nccdphp/DNPAO/aboutus/index.html (last updated Dec. 20, 2012).

best available data and providing funding to states and communities to implement community-based interventions. This delegation of responsibilities reflects the importance of state and local control through the police power in public health policy development.

The ACA established a national framework that incorporates the obesity prevention goals identified above and supports the use of policy and law to change social norms and reverse the obesity epidemic.[89] It provides crucial national coordination of and funding for state and local responses.[90] Most importantly, it elevates health disparities as a problem of national concern that all states and localities should be addressing as part of public health practice.[91] In the next section, we delve into the specific ways that the ACA moves obesity prevention forward.

B. How the Affordable Care Act Supports Community-Based Obesity Prevention Strategies

The ACA, signed into law in 2010, represents the most significant regulatory overhaul of the United States healthcare system since the passage of Medicare and Medicaid in 1965.[92] Broadly speaking, it represents a sea change for the role of prevention in our healthcare system. Through the National Prevention Strategy and the Prevention and Public Health Fund, the federal government has now created and funded a national plan for prevention. The Strategy and the Fund identify obesity as a key national health threat.

89. Patient Protection and Affordable Care Act, Pub. L. 111-148, tit. IV, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

90. *Id.* §§ 4001–4004, 4201, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.).

91. *See, e.g.*, *id.* §§ 4004, 4201, 4302, 124 Stat. 119 (codified as amended in scattered sections of 42 U.S.C.); NAT'L PREVENTION COUNCIL, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL PREVENTION STRATEGY 25–27 (2012), *available at* http://www.surgeongeneral.gov/initiatives/prevention/strategy/report.pdf.

92. Candace Natoli et al., *Who Will Enroll in Medicaid in 2014? Lessons From Section 1115 Medicaid Waivers*, MAX CENTERS FOR MEDICARE & MEDICAID SERVICES 1 (May 2011), http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/downloads/MAX_IB_1_080111.pdf; *see also*, *The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures: Hearing Before the H. Comm. on the Budget*, 112th Cong. (2011) (statement of Richard S. Foster, Chief Actuary, Ctrs. for Medicare & Medicaid Servs.), *available at* http://budget.house.gov/uploadedfiles/fostertestimony1262011.pdf (providing a detailed overview of the changes to Medicaid and Medicare under the ACA).

As noted above, the federal government's power to protect public health comes primarily from the Commerce Clause of the U.S. Constitution, which states that Congress shall have the power "[t]o regulate Commerce with foreign Nations, and among the several States."[93] This power is reflected in the ACA provisions that increase access to health insurance;[94] it is also exercised in the law's groundbreaking provisions that provide robust funding for public health prevention.[95] In particular, for our purposes here, the ACA provides financial support to state and local governments that want to address the obesity epidemic,[96] as well as evidence-based interventions to improve nutrition and physical activity rates in communities.[97]

The ACA provisions that increase funding for population-based prevention efforts and articulate a vision of prevention as a national health priority hold the most promise for addressing disparities in obesity rates because of the broad impact these provisions can have. Thus, the discussion below focuses on three elements of the ACA that we believe are most relevant to addressing obesity rates in low-income communities of color.

93. U.S. CONST., art. 1, § 8, cl. 2.

94. *See, e.g.*, Genevieve M. Kenney et al., *A Decade of Health Care Access Declines for Adults Holds Implications for Changes in the Affordable Care Act*, 31 HEALTH AFF. 5899 (2012); Benjamin D. Sommers et al., *The Affordable Care Act Has Led to Significant Gains in Health Insurance and Access to Care for Young Adults*, 32 HEALTH AFF. 1165 (2013); *see also* Georges C. Benjamin, *Transforming the Public Health System: What Are We Learning?*, INST. MED. NAT'L ACADS. (Nov. 30, 2012), http://iom.edu/~/media/Files/Perspectives-Files/2012/Commentaries/VSRT%20-%20Transforming%20the%20Public%20Health%20System.pdf.

95. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 4002, 124 Stat. 119, 541 (2010) (codified at 42 U.S.C. § 300u-11 (2012)); *see also* VANESSA FORSBERG & CAROLINE FICHTENBERG, AM. PUB. HEALTH ASS'N, THE PREVENTION AND PUBLIC HEALTH FUND: A CRITICAL INVESTMENT IN OUR NATION'S PHYSICAL AND FISCAL HEALTH (2012), *available at* http://www.apha.org/NR/rdonlyres/D1708E46-07E9-43E7-AB99-94A29437E4AF/0/PrevPubHealth2012_web.pdf; Jeffrey Levi, *Prevention for a Healthier America*, HEALTH AFF. BLOG (Mar. 1, 2012, 3:59 PM), http://healthaffairs.org/blog/2012/03/01/prevention-for-a-healthier-america/.

96. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 4002, 124 Stat. 119, 541 (2010) (codified at 42 U.S.C. 300u-11 (2012)).

97. *See e.g.*, NAT'L PREVENTION COUNCIL, *supra* note 91, at 34–40 ("Healthy Eating" and "Active Living" chapters).

1. The Affordable Care Act Establishes a National Prevention Strategy

The ACA establishes the National Prevention, Health Promotion, and Public Health Council (the "Council"), whose mandate is to provide federal coordination and leadership in prevention, wellness, and health promotion.[98] The Council is composed of the heads of seventeen federal agencies, including the Departments of Agriculture, Defense, and Education, and chaired by the Surgeon General.[99] The diversity of the agencies represented reflects the wide range of expertise needed to address the root causes of poor health at the population level.

In 2011, the Council developed a National Prevention and Health Promotion Strategy (the "Strategy").[100] The Strategy lays out national priorities for wellness and prevention.[101] Although the concepts within the NPS are not particularly groundbreaking—most of the ideas have been implemented in one form or another by enterprising cities or states—the existence of the Strategy elevates the importance of prevention nationally and validates and coordinates these efforts. As Dr. Regina Benjamin, the United States Surgeon General, noted in her introduction:

> The National Prevention Strategy will move us from a system of sick care to one based on wellness and prevention. It builds upon the state-of-the-art clinical services we have in this country and the remarkable progress that has been made toward understanding how

98. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 4001, 124 Stat. 119, 538–41 (2010) (codified at 42 U.S.C. 300u-10 (2012)).

99. *Id.* (listing the Departments of Agriculture, Defense, Education, Health and Human Services, Homeland Security, Housing and Urban Development, Justice, Labor, Veterans Affairs, and Transportation; Bureau of Indian Affairs; Federal Trade Commission; Environmental Protection Agency; Office of National Drug Control Policy; Domestic Policy Council; Corporation for National and Community Service; and Office of Management and Budget); *see also* 75 C.F.R. § 33983 (2010) (Executive Order 1354475 of June 10, 2010, Establishing the National Prevention, Health Promotion, and Public Health Council).

100. NAT'L PREVENTION COUNCIL, *supra* note 91.

101. NAT'L PREVENTION COUNCIL, *supra* note 91, at 10–12. The Department of Health and Human Services also released an action plan in 2011 focused entirely on health disparities. This plan is closely aligned to the National Prevention Strategy, but its primary goal is to transform the healthcare system. This focus is reflected in research priorities and access to clinical care. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., HHS 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/templates/content.aspx?lvl=1&lvlid=33&ID=285.

> to improve the health of individuals, families, and communities through prevention.[102]

The ACA requires that every year from 2010 to 2015, the Council must release an annual report to the President and Congress about the progress made in reaching the goals within the Strategy.[103]

The overarching goal of the Strategy is to increase the number of Americans who are healthy at every stage of life. It has four strategic directions: healthy and safe community environments; clinical and preventive services; empowered people; and the elimination of health disparities.[104] The strategic directions serve as guiding principles for priority areas, which include the promotion of healthy eating and active living, core obesity prevention approaches.

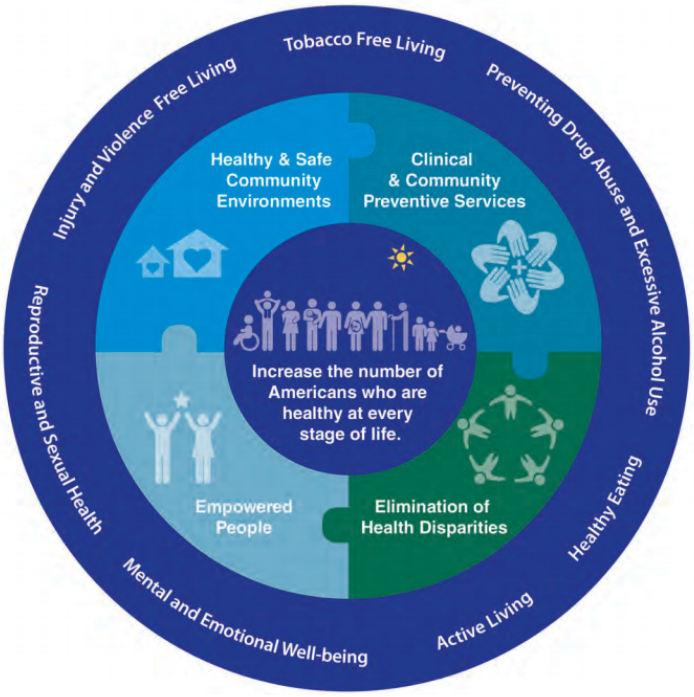

Figure 1.[105]

102. NAT'L PREVENTION COUNCIL, *supra* note 91, at 3.

103. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 4001(h), 124 Stat. 119, 540–41 (2010) (codified at 42 U.S.C. §§ 300u-10 (2012)).

104. NAT'L PREVENTION COUNCIL, *supra* note 91, at 7.

105. NAT'L PREVENTION COUNCIL, *supra* note 91, at 1.

The Strategy makes a number of recommendations to promote healthy eating, including increasing access to healthy and affordable foods in communities.[106] Typically, the communities experiencing the highest obesity rates are those with high rates of poverty, limited healthy food outlets, and many fast-food restaurants. These neighborhoods are known as "food deserts", healthy food is readily available.[107] The Strategy highlights the Healthy Food Financing Initiative as an effective federal response to food deserts.[108] This initiative is a coordinated effort by the Departments of Treasury, Agriculture, and Health and Human Services to facilitate the construction of healthy food retail outlets and other projects that make healthy food available in high-poverty communities.[109] Different grant and loan programs within the three agencies provide financing and technical assistance to support the development of grocery stores and other outlets in underserved communities.[110] Additionally, the Strategy encourages state, tribal, local, and territorial governments to use their police power to help communities create healthy food environments by establishing zoning regulations that enable full-service supermarkets and farmers markets to locate in underserved neighborhoods, and by using zoning codes to discourage the disproportionately high availability of unhealthy foods in some communities.[111]

Land use policy, established by local governments under their police powers, also plays a critical role in the Strategy's active living recommendations. For example, the Strategy highlights the fact that "[p]hysical activity levels are lower in low-income communities and among children of color, due in part to people feeling unsafe in their communities.[112] One of its recommendations is that federal, state, and local community design guidelines should include features that

106. *Id.* at 34.

107. *Id.* at 34.

108. *Id.* at 36.

109. *Healthy Food Financing Initiative*, OFFICE OF CMTY. SERV., ADMIN. FOR CHILDREN & FAMILIES, U.S. DEP'T OF HEALTH & HUMAN SERV. (Jan. 18, 2011), http://www.acf.hhs.gov/programs/ocs/resource/healthy-food-financing-initiative-0.

110. *Id.*

111. NAT'L PREVENTION COUNCIL, *supra* note 91, at 36.

112. *Id.* at 38 (citing James F. Sallis et al., *A Review of Correlates of Physical Activity of Children and Adolescents*, 32 MED. & SCI. SPORTS & EXERCISE 963 (2000)).

encourage neighborhood safety, thereby increasing residents' willingness to be physically active outdoors.[113]

2. The Affordable Care Act Creates a Prevention and Public Health Fund

The ACA includes the first dedicated federal funding source for prevention and public health programs. The Prevention and Public Health Fund ("Fund") is designed to expand and sustain the necessary capacity to prevent disease, detect it early, manage conditions before they become severe, and provide states and communities the resources they need to promote healthy living.[114] Before now, there has never been dedicated funding of this magnitude for prevention activities.[115] This significant investment, which begins at $500 million per year and increases to $2 billion per year by 2022, will drastically improve and expand the capacity of public health efforts, saving thousands of lives and improving the health of many millions of Americans.[116] Although the Fund supports prevention initiatives at the federal and state level, the largest percentage of funding in 2011 and 2012—forty percent—went to local prevention activities.[117] This focus is in keeping with the strong emphasis on local control in public health prevention activities.

The Community Transformation Grant program (CTG), within the Fund, provides grants to state and local governments, community-based organizations, and tribes to implement and evaluate evidence-based community preventive activities aimed at reducing rates of chronic disease, addressing health disparities, and developing an evidence base for future prevention programming.[118] The CTG priorities overlap with the National Prevention Strategy, but the National Prevention Strategy is broader in scope. The CTG program

113. *Id.*

114. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 4002, 124 Stat. 119, 541 (2010) (codified at 42 U.S.C. § 300u-11 (2012)).

115. FORSBERG & FICHTENBERG, *supra* note 95, at 4.

116. *Id.* at 12. Since the passage of the ACA in 2010, opponents of the legislation have attempted to cut the Fund. In February 2012, the enactment of the Middle Class Tax Relief and Job Creation Act led to $6.25 billion in cuts from the Fund over nine years. *Id.* at 12; *see also* Pub. L. 112-96, 126 Stat. 156 (2012).

117. *Id.* at 14.

118. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 4201, 124 Stat. 119, 564–66 (2010) (codified at 42 U.S.C. § 300u-13 (2012)).

prioritizes four areas: tobacco-free living; active living; healthy eating; and evidence-based quality clinical preventive services.[119]

3. The Affordable Care Act Strengthens the Community Benefit Requirements for Nonprofit Hospitals

The Affordable Care Act places new requirements on nonprofit hospitals. These requirements may lead nonprofit hospitals to focus more on community prevention efforts, rather than just providing healthcare.

Nonprofit hospitals account for more than half of all hospitals in the United States; therefore, they are important stakeholders in any attempt to improve health.[120] The new requirements under the ACA may provide an additional mechanism for funding community-based obesity prevention strategies. The Internal Revenue Service (IRS) requires that non-profit hospitals provide community benefits in order to maintain their favorable tax status.[121] The federal tax exemption is estimated to be as high as $21 billion annually.[122] Over the past decade, Congress has questioned whether nonprofit hospitals are providing adequate community benefit in exchange for the valuable tax exemption, both in terms of the quantity and type of community benefit provided.[123]

In response to these concerns, the ACA mandates a number of changes related to community benefits reporting that may provide opportunities to partner with hospitals to develop obesity prevention policy strategies. First, the ACA requires that every nonprofit hospital shall conduct a community health needs assessment (CHNA)

119. *Community Transformation Grant (CTG) Program Fact Sheet*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/communitytransformation/funds/index.htm (last visited June 27, 2013).

120. TRUST FOR AM.'S HEALTH, A HEALTHIER AMERICA 2013: STRATEGIES TO MOVE FROM SICK CARE TO HEALTH CARE IN THE NEXT FOUR YEARS 36–37 (2013), *available at* http://healthyamericans.org/assets/files/TFAH2013HealthierAmerica07.pdf.

121. *See* 26 U.S.C. § 501(c)(3) (2012); Revenue Ruling 69-545, 1969-2 C.B. 117 (I.R.S. 1969), *available at* http://www.irs.gov/pub/irs-tege/rr69-545.pdf.

122. Martha H. Somerville, *Community Benefit in Context: Origins and Evolution—ACA § 9007*, HILLTOP INST. 1 (June 2012), http://www.hilltopinstitute.org/publications/CommunityBenefitInContextOriginsAndEvolution-ACA9007-June2012.pdf.

123. *Non-Profit, For-Profit, and Government Hospitals: Uncompensated Care and Other Community Benefits: Hearing Before the H. Comm. On Ways & Means*, 109th Cong. 19 (2005) (Statement of David M. Walker, Comptroller Gen. of the U.S., Gov't Accountability Office), *available at* http://www.gao.gov/new.items/d05743t.pdf.

at least once every three years in order to maintain their tax-exempt status.[124] Even before the passage of the ACA, many hospitals prepared CHNAs and developed community-based interventions; however, the ACA provisions ensure that this practice will become standard. A CHNA lays out the major health concerns of the community in which a hospital is located and typically provides information about how a hospital will address these concerns. Given the high rates of obesity in communities across the country, it is likely that many of these assessments will identify obesity or related conditions such as diabetes, heart disease, and strokes as priority areas for intervention. For example, the 2010 CHNAs of two large nonprofit hospitals in the two largest cities in the country[125]—New York Presbyterian Hospital in New York City and Cedars Sinai Hospital in Los Angeles—both identify obesity and related conditions in the top five health concerns in their respective communities.[126]

The ACA also requires that each nonprofit hospital create an implementation strategy for how it intends to meet the needs identified by its CHNA.[127] If a hospital does not adopt the implementation strategy and report to the IRS on how it is meeting the identified needs in a given year, it may face a $50,000 excise tax that year and every subsequent year of non-compliance.[128]

Changes by the IRS may support this new community prevention focus by nonprofit hospitals. In 2011, the IRS updated the instructions for nonprofit hospital reporting to state that "some community building activities may also meet the definition of community benefit."[129] The IRS stated that community-building

124. 26 U.S.C. 501(r)(3)(A) (2012); I.R.S. Notice 2011-52, I.R.B. 2011-30 (July 25, 2010), *available at* http://www.irs.gov/pub/irs-irbs/irb11-30.pdf.

125. Largest cities based on population defined by the Census Bureau. *See Top 20 Cities: Highest Ranking Cities, 1790-2010*, U.S. CENSUS BUREAU (July 19, 2012), http://www.census.gov/dataviz/visualizations/007/508.php.

126. CEDARS-SINAI MED. CTR., CEDARS-SINAI MEDICAL CENTER COMMUNITY DEVELOPMENT PLAN: 2010 UPDATE 8 (2010), *available at* http://cedars-sinai.edu/Community-Benefit/Documents/Community-Benefit-Report-10.pdf; N.Y.-PRESBYTERIAN HOSP., U. HOSP. OF COLUMBIA & CORNELL, NEW YORK-PRESBYTERIAN HOSPITAL 2010 COMMUNITY SERVICE PLAN: COMPREHENSIVE REPORT YEAR 2 UPDATE, 10 (2011), *available at* http://nyp.org/pdf/communityserviceplan2010.pdf.

127. 26 U.S.C. § 6033(b)(15)(A) (2012).

128. 26 U.S.C. § 4959 (2012).

129. I.R.S., TREASURY DEP'T, INSTRUCTIONS FOR SCHEDULE H (FORM 990), at 4 (2012) [hereinafter INSTRUCTIONS FOR SCHEDULE H], *available at* http://www.irs.gov/pub/irs-pdf/i990sh.pdf.

activities include, but are "not limited to, efforts to support policies and programs to safeguard or improve public health, access to health care services, housing, the environment, and transportation."[130] Although the change to the IRS reporting form seems to suggest that nonprofit hospitals will be able to meet their community benefit obligations through community-based public health initiatives, it needs to clarify the meaning of "community-building activities."[131] Prominent public health experts have called on the IRS to clarify that it will give community benefit credit for evidence-based activities that fall within the four strategic directions of the National Prevention Strategy.[132] Given the importance of nonprofit hospitals in the healthcare sector and the billions of dollars that they must provide in community benefits, they could be an important leader in obesity prevention policy.

A number of the strategies highlighted in the recent CHNAs prepared by Cedar-Sinai and New York Presbyterian to address obesity rates are closely connected to policy interventions and provide examples to build upon. For instance, Cedar Sinai has put resources into health education programs in preschools and schools to address active living and healthy eating habits.[133] A hospital system like Cedar Sinai could further the impact of its interventions by partnering with local school districts to inform the development of school district wellness policies so that school district policy related to students' healthy habits reinforces the investments that Cedar Sinai is making through its health education programs.

130. *Id.* at 5.

131. Although the IRS has provided definitions of community benefits, *see* Revenue Ruling 69-545, 1969-2 C.B. 117 (I.R.S. 1969); INSTRUCTIONS FOR SCHEDULE H, *supra* note 129, the language used about community building activities is not clear. "Some community building activities may also meet the definition of community benefit . . . ." INSTRUCTIONS FOR SCHEDULE H, *supra* note 129, at 5. The use of the word "may" has led hospitals to infer that community building costs do not count as community benefits. *See* Kevin Barnett & Martha H. Somerville, *Hospital Community Benefits After the ACA: Schedule H and Hospital Community Benefit—Opportunities and Challenges for the States*, HILLTOP INST. (Oct. 2012), http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-ScheduleHIssueBrief4-October2012.pdf (providing a detailed examination of this issue).

132. *See* TRUST FOR AM.'S HEALTH, PARTNER WITH NONPROFIT HOSPITALS TO MAXIMIZE COMMUNITY BENEFIT PROGRAMS' IMPACT ON PREVENTION 2 (2013), *available at* http://healthyamericans.org/assets/files/Partner%20With%20Nonprofit%20Hospitals04.pdf.

133. CEDARS-SINAI MED. CTR., supra note 126, at 13.

New York Presbyterian has provided funding through its community benefit program for initiatives that focus on children's health and creating healthy school environments.[134] Funded coalitions working on issues related to student health have engaged, from time to time, in public policy activities. For example, staff testified at listening sessions hosted by the New York Council on Food Policy calling for policy changes that promote healthy foods in underserved neighborhoods;[135] staff also pushed for the passage of state legislation that addressed air quality near schools.[136] If all nonprofit hospitals incorporated public policy components into their community benefits' programs that address chronic diseases, the collective impact would be substantial.

In this section, we highlighted three key ACA provisions that provide unprecedented financial and strategic support for obesity prevention and health disparities interventions. Much of the policy development needed to support these interventions occurs at state and local levels.[137] These policies are the focus of the next sections of this Article.

C. State and Local Policy to Address Obesity

For over a decade, public health advocates have recognized the importance of state and local-level interventions to address the obesity epidemic.[138] State and local governments are implementing a variety of legal, policy, and voluntary strategies to change social norms and achieve obesity prevention goals.[139] These strategies define how public resources (time and money) are allocated, influence private decisions by individuals or businesses, or do both. Public resource policies determine, for example, where new parks are

134. *See* N.Y.-PRESBYTERIAN HOSP., *supra* note 126, at 16, 20, 24–26, 27; *see also* HEALTHY SCHS. HEALTHY FAMS. NEWSL., Fall 2009, at 4, *available at* http://nyp.org/pdf/HSHFNewsletter_OLD_1-25-10.pdf.

135. Written Comments to the Food Policy Council, Melissa Pflugh, Program Manager, Healthy Schools, Healthy Families, Apr. 3, 2008, at 19, *available at* http://www.nyscfp.org/docs/NYC%20Comments%20to%20CFP2_5.03.08.pdf.

136. *Healthy Schools Healthy Families Newsletter*, *supra* note 134, at 5.

137. *See also* JOHN E. MCDONOUGH ET AL., THE COMMONWEALTH FUND, A STATE POLICY AGENDA TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES vii (2004), *available at* http://www.commonwealthfund.org/programs/minority/mcdonough_statepolicyagenda_746.pdf ("Policy advances in states frequently lead to policy innovation at the federal level as well.").

138. Graff et al., *supra* note 79, at 308–09.

139. *See, e.g.*, Bunnell et al., *supra* note 49.

built, how streets are maintained, and what foods are in school vending machines. Obesity prevention policies that influence private decisions include sugar-sweetened beverage taxes, as well as zoning policies that allow farmers markets in residential neighborhoods or require developers to provide bicycle parking.[140]

As discussed earlier, these strategies can be organized into five broad goals of the obesity prevention movement. Below are examples of strategies being pursued at the state and local levels:

140. GLICKMAN ET AL., *supra* note 69, at 22–27 (discussing the need for engagement on obesity prevention solutions at all levels of society—public and private, individuals and institutions.)

Goal	Community/State example
Increasing physical activity levels	The North Carolina Department of Transportation is developing a Statewide Bicycle and Pedestrian Plan to identify ways the department can support bicycle and pedestrian infrastructure and to prioritize bicycle and pedestrian infrastructure projects.[141]
Increasing access to healthy foods and beverages	Minneapolis, Minnesota adopted an ordinance that requires licensed grocery stores to stock specific categories of staple foods that match the product mix stores are required to stock in order to accept federal Supplemental Nutritional Assistance Program benefits.[142]
Changing messages about nutrition and physical activity	Several school districts in suburban Denver adopted school wellness policies that established standards for foods that could be advertised in the schools.[143]
Working with healthcare providers, insurers, and employers	The state of Nebraska worked with its health insurance provider to reduce premiums for employees and their families who enroll in a wellness program and complete annual health screenings. The wellness program provides healthy lifestyle support, such as health coaching, to employees.[144]
Improving nutrition and physical activity in schools	The Pueblo of Jemez school district in New Mexico implemented a policy requiring after-school programs to provide 45 minutes of physical activity and a healthy snack each day.[145]

141. TRUST FOR AM.'S HEALTH, IMPLEMENT THE NATIONAL PREVENTION STRATEGY 2 (2013), *available at* http://healthyamericans.org/assets/files/Implement%20National%20Prevention%20Strategy04.pdf.

142. MINNEAPOLIS, MINN., CODE OF ORDINANCES §§ 203.10–203.30 (2013).

143. *CPPW Success Stories by State*, TRUST FOR AM.'S HEALTH 12 (2011), http://healthyamericans.org/health-issues/wp-content/uploads/2011/08/CPPW-Success-Stories-8-8.pdf.

144. TRUST FOR AM.'S HEALTH, PROVIDE WORKPLACE WELLNESS PROGRAMS TO ALL AMERICAN WORKERS 3 (2013), *available at* http://healthyamericans.org/assets/files/Provide%20Workplace%20Wellness%20Programs03.pdf.

145. *CPPW Success Stories*, *supra* note 143, at 33.

The exact mix of strategies necessary to decisively reduce obesity rates is still uncertain,[146] which means that policymakers must try new ideas and evaluate what works. Much of the innovation in public health policy occurs at the local level.[147] The Institute of Medicine has repeatedly recognized the leadership of local governments in the obesity prevention movement.[148] As the organization noted in a 2009 report,

> Local governments are in a unique position to improve the health of their communities by advancing local policies that have an impact on the availability of healthy foods and places for physical activity and that also limit less healthy options. Local governments have jurisdiction over land use, food marketing, community planning, and transportation.[149]

Obesity prevention innovation at the local level requires local governments to have the authority to enact public health laws. Preemption has long been used to quash innovation at the local level.[150] Recently, the Mississippi legislature enacted a law intended to prevent local governments from passing laws that limit portion sizes of sugar-sweetened beverages.[151] This law was a direct response to New York City's groundbreaking portion size policy.[152] Preemptive laws, like the one in Mississippi, raise concern because

146. Jennifer Leeman et al., *An Evaluation Framework for Obesity Prevention Policy Interventions*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y (2012), http://www.cdc.gov/pcd/issues/2012/pdf/11_0322.pdf.

147. Mark Pertschuk et al., *Assessing the Impact of Federal and State Preemption in Public Health: A Framework for Decision Makers*, J. PUB. HEALTH MGMT. PRAC., June 15, 2012, at 0, *available at* http://www.yaleruddcenter.org/resources/upload/docs/what/law/PreemptionFramework_JPHMP_6.12.pdf.

148. *See, e.g.*, INST. OF MED., LOCAL GOVERNMENT ACTIONS TO PREVENT CHILDHOOD OBESITY (Lynn Parker et al. eds., 2009) [hereinafter INST. OF MED., LOCAL GOVERNMENT ACTIONS], *available at* http://books.nap.edu/openbook.php?record_id=12674&page=R1 (highlighting the role of local government in childhood obesity prevention efforts); INST. OF MED., PREVENTING CHILDHOOD OBESITY: HEALTH IN THE BALANCE 6, 10–12, 131–34, 193–221 (Jeffrey P. Koplan et al. eds., 2005), *available at* http://www.nap.edu/openbook.php?record_id=11015&page=R1.

149. INST. OF MED., LOCAL GOVERNMENT ACTIONS, *supra* note 148, at 27.

150. Graff et al., *supra* note 79, at 313.

151. S.B. 2687, 2013 Reg. Sess. (Miss. 2013), *available at* http://billstatus.ls.state.ms.us/documents/2013/html/SB/2600-2699/SB2687IN.htm.

152. *See* Kim Severson, *'Anti-Bloomberg Bill' in Mississippi Bars Local Restrictions on Food and Drink*, N.Y. TIMES (Mar. 13, 2013), http://www.nytimes.com/2013/03/14/us/anti-bloomberg-bill-in-mississippi-bars-local-restrictions-on-food-and-drink.html.

the obesity prevention field is still evolving and thus requires evaluation of many different strategies.[153]

1. Addressing Disparities Through Obesity Prevention Policy

As noted above, obesity policies generally act by prioritizing public resources, influencing private decisions, or both. Obesity policy influences disparities through these same mechanisms. For example, local governments can reverse health disparities by prioritizing public resources to support healthy behavior on the part of those experiencing the negative effects of the disparity. An example appears in the context of crossing guards. Research shows that children who walk or bike to school experience lower rates of obesity than those who do not.[154] Crossing guards can make the experience of walking or biking to school safer[155] and can increase parents' willingness to allow children to walk or bicycle to school.[156] In Florida, crossing guards at intersections near schools are currently paid for by a state fund.[157] But in larger jurisdictions, like Miami-Dade County, the fund cannot cover the entire cost of a crossing guard and schools must close the funding gap or have fewer crossing guards than they need. Lower income schools in the City of Miami have particular difficulty closing this funding gap.[158] A change in state law would authorize the city to levy a surcharge on fines for school

153. NAT'L POL'Y & LEGAL ANALYSIS NETWORK TO PREVENT CHILDHOOD OBESITY, THE CONSEQUENCES OF PREEMPTION FOR PUBLIC HEALTH ADVOCACY 2–3 (2010), *available at* http://changelabsolutions.org/sites/default/files/documents/Preemption_PublicHlthAdvcy_FINAL_20100330.pdf.

154. Jason A Mendoza et al., *Active Commuting to School and Association with Physical Activity and Adiposity Among US Youth*, 8 J. PHYSICAL ACTIVITY & HEALTH 488, 488 (2011), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115568/pdf/nihms300755.pdf.

155. N.J. SAFE ROUTES, MORE THAN CROSSING STREETS: TRAINING, POLICIES AND PROCEDURES FOR SCHOOL CROSSING GUARDS IN NEW JERSEY 5–6 (2012), *available at* http://www.saferoutesnj.org/wp-content/uploads/2011/12/More-Than-Crossing-Streets.pdf (discussing the insufficiency of studies on crossing guard effectiveness but noting materials supporting this proposition).

156. Claudia Chaufan et al., *The Safe Routes to School Program in California: An Update*, 102 AM. J. PUB. HEALTH e8, e8 (2012) (studying eighty-one California towns and finding that of the substantial number of parents indicating concern about inadequate numbers of crossing guards, half would allow their children to walk or bicycle to school if this concern were addressed).

157. FLA. STAT. § 318.21(3), (11) (2012).

158. Telephone Interview with Derek Slagle, Project Coordinator, WalkSafe, Univ. of Miami Miller Sch. of Med. Kidz NeuroScience, Florida Atlantic Univ. School of Pub. Admin. (June 22, 2012).

zone traffic offenses, enabling the jurisdiction to supply additional crossing guards to low-income neighborhoods and improve safety for children walking or biking to school.[159] This change in state law would give local jurisdictions a new potential source of revenue to support safer walks to school in low-income neighborhoods.

Policies that influence private decisions can also affect disparities. Such policies generally create incentives for health-promoting activities or deterrents for disease-promoting activities. These incentives or deterrents can be for businesses or individuals. New York City offers tax and zoning incentives to grocery store owners who open or expand locations in food deserts,[160] addressing inequitable access to fresh fruits and vegetables.[161] Incentives such as these are intended to make neighborhoods with limited food access more attractive to business owners by decreasing the cost of development.[162] Other policies, like labeling menus with calorie counts and nutrition information, are intended to influence the behavior of individuals.[163]

Policy change can also be a hybrid of these two categories, affecting both public and private actions. Taxing sugar-sweetened beverages to reduce their sale and consumption is an important obesity prevention strategy that affects both public and private actions.[164] Such taxes generally affect private behavior by increasing

159. *See, e.g.*, Memorandum from ChangeLab Solutions, A New Surcharge to Fund Crossing Guards: The Solution to Keeping Children Physically Active and Safe (Oct. 25, 2011) (on file with author).

160. *Food Retail Expansion to Support Health*, N.Y.C. ECON. DEV. COUNCIL, http://www.nyc.gov/html/misc/html/2009/fresh.shtml (last visited May 14, 2013).

161. NAT'L PREVENTION COUNCIL, *supra* note 91, at 34, 36.

162. GLICKMAN ET AL., *supra* note 69, at 157.

163. *Id.* at 259.

164. A growing body of research indicates that consumption of sugar-sweetened beverages increases a person's risk of obesity and chronic diseases. *See, e.g.*, Lawrence de Koning et al., *Sweetened Beverage Consumption, Incident Coronary Heart Disease and Biomarkers of Risk in Men*, 125 CIRCULATION 1735 (2012), *available at* http://circ.ahajournals.org/content/125/14/1735.full.pdf+html; Kiyah J. Duffey et al., *Drinking Caloric Beverages Increases the Risk of Adverse Cardiometabolic Outcomes in the Coronary Artery Risk Development in Young Adults (CARDIA) Study*, 92 AM. J. CLINICAL NUTRITION 954, 954 (2010), *available at* http://ajcn.nutrition.org/content/92/4/954.full.pdf+html; Y. Claire Wang et al., *Increasing Caloric Contribution from Sugar-Sweetened Beverages and 100% Fruit Juices Among US Children and Adolescents, 1988–2004*, 121 PEDIATRICS e1604 (2008), *available at* http://pediatrics.aappublications.org/content/121/6/e1604.full.pdf+html.

prices, thereby reducing consumption.[165] Sugar-sweetened beverage (SSB) taxes also affect public resources by generating revenue for the government.[166] A proposal in Vermont, for example, would have allocated one-third of the tax revenue raised to obesity prevention initiatives for low-income residents, including subsidies for fruit and vegetable purchases.[167]

These tax proposals typically generate a strong reaction. Opponents of SSB taxes criticize them for being regressive, disproportionately hurting low-income people and people of color who can least afford it.[168] A regressive tax is one for which low-income people pay a higher percentage of their income than high-income people.[169] For instance, lower-income people spend a larger share of their income on food and beverages and consume more SSBs than their higher-income counterparts.[170] African Americans are more likely to be regular SSB drinkers.[171] Thus, opponents argue that a SSB tax would affect low-income people and people of color more than people who are wealthier and white. A similar argument was raised concerning tobacco taxes, but was successfully challenged by proponents, who pointed out that low-income people have a higher prevalence of smoking-related illnesses.[172] Likewise, SSB tax proponents argue that underserved communities and communities of

165. ROBERTA R. FRIEDMAN & KELLY D. BROWNELL, YALE RUDD CTR. FOR FOOD POLICY & OBESITY, SUGAR-SWEETENED BEVERAGE TAXES: AN UPDATED POLICY BRIEF 6 (2012), *available at* http://www.yaleruddcenter.org/resources/upload/docs/what/reports/Rudd_Policy_Brief_Sugar_Sweetened_Beverage_Taxes.pdf.

166. *Id.* at 2.

167. H.B. 151, 2011-2012 Leg. Reg. Sess. (Vt. 2011).

168. FRIEDMAN & BROWNELL, *supra* note 165, at 6.

169. *See* Dahlia K. Remler, *Poor Smokers, Poor Quitters, and Cigarette Tax Regressivity*, 94 AM. J. PUB. HEALTH 225, 225 (2004), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448232/pdf/0940225.pdf (providing a basic definition of regressive tax); Y. CLAIRE WANG, THE POTENTIAL IMPACT OF SUGAR-SWEETENED BEVERAGE TAXES IN NEW YORK STATE: A REPORT TO THE NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE 15–16 (2010), *available at* http://www.columbia.edu/~ycw2102/SSB%20tax%20brief%20Wang%202010%2006%2021%20_Final_.pdf (discussing whether SSB taxes are regressive).

170. FRIEDMAN & BROWNELL, *supra* note 165, at 3.

171. AFRICAN AMERICAN COLLABORATIVE OBESITY RESEARCH NETWORK, IMPACT OF SUGAR-SWEETENED BEVERAGE CONSUMPTION ON BLACK AMERICANS' HEALTH 3 (2011), *available at* http://aacorn.org/uploads/files/AACORNSSBBrief2011.pdf.

172. Kelly D. Brownell et al., *The Public Health and Economic Benefits of Taxing Sugar-Sweetened Beverages*, 361 NEW ENG. J. MED. 1599, 1603 (2009), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMhpr0905723.

color disproportionately bear the health burdens of SSB consumption.[173]

Although there are signs of progress in reversing the epidemic, little progress has been made to eliminate, or even narrow, the health disparities experienced by low-income people and communities of color.[174] Disparities endure despite an overall flattening obesity rate trend.[175] For example, New York City recently saw a 6% drop in obesity rates for children in kindergarten through eighth grades.[176] Looking at the data more closely, however, the results are not as encouraging. Obesity rates for Latino and African-American students declined by 3% and 2%, respectively, while rates declined by 8% and 13% for Asian and white students, respectively.[177] Existing policy efforts do not appear to be sufficient to eliminate obesity disparities. In the next Part, we present a framework for identifying disparities-focused policies to improve nutrition, increase physical activity, and reduce obesity rates.

III. A POLICY FRAMEWORK FOR ADDRESSING DISPARITIES IN OBESITY RATES

As discussed above, policy change strategies are crucial for reducing obesity rates and eliminating disparities. Enterprising states and communities have tried a variety of approaches to addressing obesity disparities, with limited success. Federal policy now explicitly promotes and provides funding for public health interventions intended to reverse disparities,[178] which means that more and more jurisdictions around the country will be looking for ways to improve health equity among their residents.

173. AFRICAN AMERICAN COLLABORATIVE OBESITY RESEARCH NETWORK , *supra* note 171, at 3.

174. Robert Wood Johnson Found., *Declining Childhood Obesity Rates—Where Are We Seeing the Most Progress?*, HEALTHY POL'Y SNAPSHOT 2 (Sept. 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401163.

175. *See, e.g.*, Lauren M. Rossen & Kenneth C. Schoendorf, *Measuring Health Disparities: Trends in Racial-Ethnic and Socioeconomic Disparities in Obesity Among 2- to 18-Year Old Youth in the United States, 2001–2010*, 22 ANNALS OF EPIDEMIOLOGY 698 (2012); GLICKMAN ET AL., *supra* note 69, at 66.

176. Magdalena Berger et al., *Obesity in K–8 Students—New York City, 2006-07 to 2010-11 School Years*, 60 MORBIDITY & MORTALITY WEEKLY REP. 1673 (2011), *available at* http://www.cdc.gov/mmwr/pdf/wk/mm6049.pdf.

177. *Id.*

178. Patient Protection and Affordable Care Act, Pub. L. 111-148, §§ 4001–4004, 124 Stat. 119, 538–546 (2010) (codified in scattered sections of 42 U.S.C.); NAT'L PREVENTION COUNCIL, *supra* note 91, at 7.

But the path to health equity via policy change is not clear.[179] Although health policy experts have explored health equity policy for decades,[180] their research generally has not focused on detailed implementation recommendations. In consequence, few resources exist to guide policymakers in drafting disparities-focused obesity prevention policies.[181] Policymakers and the public health community need information about how to craft obesity prevention policy to decrease disparities.[182]

The task of identifying such tactics is not simple. There has been limited evaluation of obesity prevention policies themselves, and practitioners are still learning about how to effectively address obesity, much less how to use policy to address disparities.[183] Individual communities may report successful reduction of disparities,[184] but success may follow implementation of multiple

179. *See, e.g.*, Piroska Ostlin et al., *Priorities for Research to Take Forward the Health Equity Policy Agenda*, 83 BULL. WORLD HEALTH ORG. 948, 951 (2005), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2626494/pdf/16462988.pdf (describing challenges and noting that "[u]ntil recently, research on health equity has described inequalities more than it has explained or proposed interventions to address them").

180. *See, e.g.*, GÖRAN DAHLGREN & MARGARET WHITEHEAD, WORLD HEALTH ORG. REG'L OFFICE FOR EUROPE, POLICIES AND STRATEGIES TO PROMOTE EQUITY IN HEALTH (1992), *available at* http://whqlibdoc.who.int/euro/-1993/EUR_ICP_RPD414%282%29.pdf (describing four levels of disparities-focused policy intervention: structural change; living and working conditions; social support; and individual lifestyles); *see also* Braveman & Gruskin, *supra* note 33.

181. *See, e.g.*, MCDONOUGH ET AL., *supra* note 137, at xii–xiii ("Our inability to find best practices prompts our recommendation that researchers and public officials work together to evaluate the effectiveness of disparities interventions and to document and publicize those programs and policies that yield positive results. Equally important is the need to identify interventions that do *not* work so that resources can be channeled productively.").

182. *See, e.g.*, ALA. DEP'T OF PUB. HEALTH, A PRELIMINARY STATE PLAN OF ACTION TO REDUCE AND ELIMINATE HEALTH DISPARITIES IN ALABAMA 62 (2008), *available at* http://www.adph.org/minorityhealth/assets/DraftStatePlanEliminate Disparities.pdf (discussing need for a "focus on policy discussions to gain insight on effective and ineffective actions toward health disparities elimination").

183. MCDONOUGH ET AL., *supra* note 137, at ix. Such problems are not unique to obesity policy, but extend to other health disparities as well. *See, e.g.*, Matthew D. Adler, *Risk Equity: A New Proposal*, 32 HARV. ENVTL. L. REV. 1, 3 (2008) (noting need for "tools to measure the degree of inequality between members of advantaged and disadvantaged groups with respect to the effects of health and safety hazards, and for measuring the equity impact of policies that mitigate these hazards").

184. *See, e.g.*, Jessica M. Robbins et al., *Prevalence, Disparities, and Trends in Obesity and Severe Obesity Among Students in the Philadelphia, Pennsylvania, School District, 2006–2010*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y (2012), http://www.cdc.gov/pcd/issues/2012/pdf/12_0118.pdf.

obesity prevention strategies, making it difficult to pinpoint the most effective strategy or combination of strategies. Without rigorous evaluation, it is impossible to identify those factors leading to improvements.

As a starting place, we note that most obesity prevention policies are not passed with the primary goal of reducing disparities among different groups. Even when disparities are not part of the public discourse, these policies nonetheless have an influence on health equity—increasing disparities, decreasing them, or maintaining the status quo.[185] Our proposed framework lays out a process by which policymakers can analyze how different policies might affect disparities, with the goal of prioritizing the policies that are most likely to decrease disparities. State and local obesity policy efforts over the last decade, even if most have not focused on disparities, provide lessons to inform this proposed framework. As policymakers and researchers learn from future policies, this framework will be refined and restructured, incorporating new assessments of which strategies work effectively under different conditions and against different problems.

A. Evidence for Policymaking

The types of policies identified in this framework have not been evaluated sufficiently to establish them as effective at reversing obesity trends and disparities. Few obesity prevention policies have a

185. David Mechanic, *Disadvantage, Inequality, and Social Policy*, 21 HEALTH AFF. 48, 50 (2002), *available at* http://content.healthaffairs.org/content/21/2/48.full.pdf+html (noting that "overall major initiatives intended to improve population health also may increase disparities" and "[e]nhancing overall population health and reducing disparities are different objectives and are sometimes in conflict"). David Mechanic points out that some "interventions that offer some of the largest possible gains for the disadvantaged may also increase disparities." *Id.* at 48. He gives the example of improvements in infant mortality for African American and white babies in the period between 1950 and 2000; although the disparity between infant mortality for the two groups increased significantly during this time period, the decrease in mortality rates and absolute improvement was greater for African-American infants than white infants. *Id.* at 50. As Mechanic points out, avoiding this type of intervention would not be beneficial for African Americans. *Id.* This truth does not undercut the fact that policy changes that eliminated this disparity while retaining the large absolute gains would be even more desirable, but it does illustrate the complexity of real life policy alternatives. Standard obesity policies can be placed into four categories within this framework: (1) policies that are not successful in the goal of reducing obesity; (2) policies that reduce overall obesity rates, but increase disparities; (3) policies that reduce obesity and do not affect disparities; and (4) finally, policies that reduce obesity and reduce disparities.

strong evidence base,[186] which makes it difficult for policymakers to know where to focus their attention. The Institute of Medicine recently examined the problem of limited evidence in the obesity prevention movement and concluded that the movement must not wait for randomized-control trials, considered the gold standard of evidence in research generally, to validate obesity prevention strategies.[187] Rather, the field must generate "practice-based evidence" by evaluating actual policies and programs being implemented across the United States.[188]

This framework is a decision-making tool, not a guide to evidence-based policy. Ideally, it will be used to develop disparities-focused policies, which can then be evaluated and contribute to the evidence base on obesity prevention strategies. Obesity prevention policies and programs should always have a built-in evaluation component so that policymakers can learn whether their ideas are effective and make corrections to improve effectiveness.

Policymakers should also use epidemiological data during the policymaking process. The policymaking approach described above requires that policymakers have access to local data on obesity rates and delve into such data in sufficient detail that a nuanced picture of the various factors affecting obesity rates in different demographic groups emerges.[189] Without this level of understanding, advocates may embrace policy options that are unsuccessful in decreasing disparities.[190]

According to the IOM, these data characterize the problem and help justify solutions, even if the solutions themselves lack supportive

186. INST. OF MED., BRIDGING THE EVIDENCE GAP IN OBESITY PREVENTION: A FRAMEWORK TO INFORM DECISION MAKING 19 (Shiriki K. Kumanyika et al. eds., 2010), *available at* http://www.nap.edu/openbook.php?record_id=12847&page=R1.

187. *Id.* at 169.

188. *Id.*

189. The choice of measure of inequality is important as well, and contains pitfalls for the unwary. *See* Niko Speybroeck et al., *Inequalities of Health Indicators for Policy Makers: Six Hints*, 57 INT'L J. PUB. HEALTH 855 (2012) (erratum in 57 INT'L J. PUB. HEALTH 859 (2012)).

190. Barbara Starfield, *State of the Art in Research on Equity in Health*, 31 J. HEALTH POL. POL'Y & L. 11, 15 (2006) (describing research showing that "for more preventable causes of death (i.e., those about which more is known regarding prevention and treatment), socioeconomic status (SES) is more strongly associated with mortality than for less preventable causes, because what is known about cause can more easily be manipulated by the more socially advantaged by virtue of their greater exposure to resources").

evidence.[191] Fortunately, many components of needed data are available from local and state health departments.

B. The Framework

The framework covers five broad approaches to crafting policies that reduce obesity and related health disparities: (1) general policies; (2) policies focusing on the demographic group experiencing poor health, including policies based on race or ethnicity and policies based on income; (3) policies based on the health problem in question, both policies that focus on health indicators and policies that focus on unhealthy practices and products; (4) policies based on location; and (5) policies that address residential segregation.

In developing this framework, we have taken equity as the guiding principle to whether a particular approach is justified or not. By understanding the range of options and approaches available, policymakers can reverse inequities in our communities, guaranteeing that all neighborhoods have access to health-promoting features and no neighborhood bears an unfair burden of disease-promoting features.

1. General or Universal Policies

Sometimes general policies can be effective in decreasing health disparities.[192] When a general policy has the effect of eliminating a negative condition for a particular group, it may well function to decrease disparities.[193] General policies are likely to be successful in addressing disparities when they operate to provide a given resource to everyone.

Universal national policies may function in this manner. Policies intended to improve health across the board, such as universal vaccination, may have a positive effect on disadvantaged

191. *Id.* at 92.

192. WORLD HEALTH ORG. REG'L OFFICE FOR EUROPE, HOW CAN THE HEALTH EQUITY IMPACT OF UNIVERSAL POLICIES BE EVALUATED? 1 (Beth Milton et al. eds., 2010), *available at* http://www.euro.who.int/__data/assets/pdf_file/0019/155062/E95912.pdf.

193. *See, e.g.*, *Promoting Health Equity, Education Programs and Policies: Full-Day Kindergarten—Task Force Finding & Rationale Statement*, GUIDE TO COMMUNITY PREVENTIVE SERVICES, http://www.thecommunityguide.org/healthequity/RRfulldaykindergarten.html (last updated Apr. 25, 2013) (reviewing research and finding substantial evidence that full-day kindergarten programs improve the health prospects of low-income children and children of color).

populations.[194] General policies at the local level may have a similar effect. In 2009, for example, the City Council of Austin, Texas adopted a resolution providing that all residences in the urban core should have a family-friendly park or recreation area within a quarter mile.[195] Such a policy does not differentiate between lower-income and higher-income residents of a city, and may increase physical activity and reduce obesity for both groups. Implementing this policy, however, is likely to have greater effects on physical activity for low-income groups[196]: there are generally fewer parks in low-income areas of town;[197] low-income residents may have less access to alternative physical activity venues, such as private gyms; and lower income residents may experience transportation barriers in accessing more distant parks.[198] Thus, the policy likely will address the unique needs of a subpopulation while providing a commitment that applies generally.

General policies may also address disparities in communities in which a large proportion of the population experiences negative health disparities. When passing law at the local level in these communities, any successful obesity prevention policy will likely affect the target population. The population of Hialeah, Florida, is

194. Mechanic, *supra* note 185, at 50.

195. City Council of the City of Austin Resolution No. 20091119-68 (Nov. 19, 2009); *see also* CITY OF AUSTIN URBAN PARKS WORKGROUP, REPORT RECOMMENDATIONS 7 (2011), *available at* https://www.austintexas.gov/sites/default/files/files/Capital_Planning/Bond_Development/Parks_Open_Space_Committee/urban-parks-workgroup-final-report.pdf (this report contains the City Council Resolution in Appendix H).

196. CITY OF AUSTIN URBAN PARKS WORKGROUP, *supra* note 195, at 19.

197. *See, e.g.*, Lisa M. Powell et al., *The Relationship Between Community Physical Activity Settings and Race, Ethnicity and Socioeconomic Status*, 1 EVIDENCE-BASED PREVENTIVE MED. 135, 140–43 (2004) (finding "that higher levels of poverty significantly reduce the likelihood of having parks and green space and bike paths/lanes in the community"); Penny Gordon-Larsen et al., *Inequality in the Built Environment Underlies Key Health Disparities in Physical Activity and Obesity*, 117 PEDIATRICS 417, 421 (2006) (finding in nationally representative study that "all major categories of [physical activity]-related resources are distributed inequitably, with high-minority, low-educated neighborhoods at a strong disadvantage [and] . . . this inequitable distribution is significantly associated with subsequent disparities in health-related behaviors and obesity measured at the individual level").

198. TODD LITMAN, VICTORIA TRANSP. POLICY INST., EVALUATING TRANSPORTATION EQUITY GUIDANCE FOR INCORPORATING DISTRIBUTIONAL IMPACTS IN TRANSPORTATION PLANNING 7 (2013), *available at* http://www.vtpi.org/equity.pdf.

ninety-five percent Latino[199] and is tied for first nationally among cities with the highest proportion of residents speaking Spanish at home.[200] As a result, policies under consideration to address the city's childhood obesity problem do not need to specifically target the city's Latino population in order to address disparities experienced by this group. The strategies being employed reflect the cultural preferences of Hialeah's residents, including partnering with *vianderos* (street vendors) to provide access to healthy food, and providing public transportation to the flea market, which includes a daily produce market featuring fruits and vegetables common in Caribbean and Latin American cuisine.[201] To the extent that these policies are successful, they will be addressing health disparities.

Under other conditions, general policies may not be successful in ameliorating health disparities.[202] For example, if all population groups receive the same benefit from a new policy, but one group starts out at a disadvantage, the disparity will be maintained. As discussed above, a community may desire to increase physical activity opportunities by addressing its parks. The policy approach noted above required that all homes be within a quarter mile of a park. But the community might instead take another approach, passing a law requiring an upgrade of all playgrounds to install new equipment encouraging physical activity.[203] As noted above, lower-income

199. *State & County QuickFacts: Hialeah (City), Florida*, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/12/1230000.html (last updated June 6, 2013).

200. *Cities with the Highest Percentage of Spanish Speaking People*, STATJUMP, http://www.statjump.com/lists/language-spoken-dp2c129tc.html (last visited May 15, 2013) (source data from the 2000 U.S. Census).

201. HIALEAH HEALTHY FAMILIES (¡FAMILIAS SALUDABLES!), CALL TO ACTION: A COMMUNITY'S PLAN TO COMBAT CHILDHOOD OBESITY 24 (2011), *available at* http://testweb.hialeahfl.gov/Announcements_files/CallToAction.pdf.

202. *See, e.g.*, Starfield, *supra* note 190, at 16–17.

> Moreover, the salience of particular interactions among types of influences in pathways differs from one population to another. For example, neighborhood poverty rates and housing inadequacy increase the rates of very preterm births for African Americans, whereas the fraction of female-headed households is influential for Hispanics, and the low fraction of people employed in professional occupations is influential in white subpopulations. Thus, in analyses directed at influencing policy, it is important to stratify populations into relevant subgroups as well as to consider the particular health outcomes that are the target for change.

Id.

203. Research shows that active playground design can increase children's physical activity. *See, e.g.*, ACTIVE LIVING RESEARCH, THE POTENTIAL OF SAFE, SECURE AND ACCESSIBLE PLAYGROUNDS TO INCREASE CHILDREN'S PHYSICAL ACTIVITY 4 (2011),

neighborhoods often begin with fewer playgrounds. If such is the case, then this law will provide larger benefits to more affluent neighborhoods. Such a law is unlikely to reduce disparities, and indeed may have the effect of exacerbating them.[204] As we will discuss, there are ways to tailor community-wide policies to reduce inequities in resources, such as by prioritizing underserved areas for new or renovated infrastructure.[205]

2. Policies Based on Demographic Groups

Disparities in obesity rates occur across a variety of demographic indicators: race, income, age, sex, disability, and so on. One strategy to address these disparities is to draft policy that directly targets those who disproportionately experience negative health outcomes by focusing on the demographic group in question. But the legal and political feasibility of these approaches may depend on whether the demographic group is defined by race or ethnicity, or instead by some other characteristic, such as income.

a. Policymaking Based on Race or Ethnicity

Sometimes policymakers or advocates propose a disparities-focused policy that explicitly singles out a specific racial or ethnic group at high risk for disease. For example, the Missouri Office of Minority Health analyzed state data and found numerous health

available at http://www.activelivingresearch.org/files/ALR_Brief_SafePlaygrounds_0.pdf. Research is also underway on integrating technology into playgrounds to increase active play. *See e.g.*, *User Modeling in Playware Physical Interactive Playground*, CTR. FOR COMPUTER GAMES RES., http://game.itu.dk/index.php/User_Modeling_in_Playware_Physical_Interactive_Playground (last updated Feb. 24, 2011). Architects and builders are starting to use "Active Design" for homes and workplaces as well as playgrounds, to promote greener, healthier communities. *See e.g.*, Paula Melton, *Architects Fight Obesity Epidemic Through Active Design*, ENVTL. BUILDING NEWS (Feb. 1, 2012), http://www.buildinggreen.com/auth/article.cfm/2012/2/2/Architects-Fight-Obesity-Epidemic-Through-Active-Design/.

204. WENDELL TAYLOR & DEBBIE LOU, ACTIVE LIVING RESEARCH, DO ALL CHILDREN HAVE PLACES TO BE ACTIVE? DISPARITIES IN ACCESS TO PHYSICAL ACTIVITY ENVIRONMENTS IN RACIAL AND ETHNIC MINORITY AND LOWER-INCOME COMMUNITIES 8–9, 11–12 (2011), *available at* http://www.activelivingresearch.org/files/Synthesis_Taylor-Lou_Disparities_Nov2011.pdf.

205. David R. Williams et al., *Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Health and Reduce Disparities*, 14 J. PUB. HEALTH MGMT. PRAC. (SUPP.) s8, s10 (2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3431152/pdf/nihms392772.pdf.

disparities affecting people of color in Missouri.[206] When the office held focus groups to explore the issue, among the solutions proposed by participants were programs to target health-promoting resources to identified communities based on race.[207]

Although it *may* be possible to direct resources to communities by race, it is significantly harder from a legal standpoint to direct resources through race, ethnicity, or national origin than it is to use most other ways of categorizing people.[208] As a result, if a policy is likely to be equally effective in addressing health disparities without requiring an explicit focus on race, it will be safer from a legal perspective to take this approach.[209] If, however, using race is crucial in order for the policy to be effective, such an approach may be possible.

The complexity of enacting policies based on race or ethnicity derives from the jurisprudence surrounding the United States Constitution's Equal Protection Clause.[210] In addition, many states have laws that prohibit state action based on race or gender.[211] The Equal Protection Clause of the Fourteenth Amendment prohibits state and federal governments from denying equal protection of the law to anyone.[212] Although it originally passed to prevent states from discriminating against African Americans in the wake of slavery, in

206. MO. DEP'T OF HEALTH & SENIOR SERV., MO. OFFICE OF MINORITY HEALTH, STATE OF MISSOURI HEALTH DISPARITIES REPORT: PROMOTING HEALTH EQUITY & REDUCING HEALTH DISPARITIES IN MISSOURI 6–8 (2008), *available at* http://health.mo.gov/living/families/minorityhealth/pdf/DisparityReport.pdf.

207. *Id.* at 39.

208. City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 440 (1985) (setting out the Equal Protection standard, whereby strict scrutiny is applied to classifications based on race, alienage, or national origin).

209. Note that if another approach is deemed equally effective as a matter of law, strict scrutiny prohibits the use of race. *See* Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701 (2007).

210. U.S. CONST. amend. XIV. Other state and federal laws can also apply depending on the circumstances.

211. *See, e.g.*, CAL. CONST. art. 1, § 31(a); H.B. 623, 2011 Session (N.H. 2011). *See generally* ARTHUR L. COLEMAN ET AL., AM. ASS'N FOR THE ADVANCEMENT OF SCI. DIVERSITY & LAW PROJECT, BEYOND FEDERAL LAW: TRENDS AND PRINCIPLES ASSOCIATED WITH STATE LAWS BANNING THE CONSIDERATION OF RACE, ETHNICITY, AND SEX AMONG PUBLIC EDUCATION INSTITUTIONS (2012), *available at* http://php.aaas.org/programs/centers/capacity/documents/BeyondFedLaw.pdf.

212. Adarand Constructors, Inc. v. Pena, 515 U.S. 200, 217 (1995) ("This Court's approach to Fifth Amendment equal protection claims has always been precisely the same as to equal protection claims under the Fourteenth Amendment." (quoting *Weinberger v. Wiesenfeld*, 420 U.S. 636, 638 n.2 (1975)) (alteration and internal quotation marks omitted)).

recent decades courts have interpreted the Equal Protection Clause to not only restrict laws that create burdens for individuals of color, but also to restrict laws providing benefits for individuals of color.[213] A complex body of law has developed around questions such as when the government can provide affirmative action for prospective students, subcontractors, or job applicants,[214] when government can consider race in prison or school assignments,[215] and so on.

Supreme Court precedent holds, pursuant to the Equal Protection Clause, that when a law classifies people by race, national origin, or ethnicity, it is reviewed skeptically by courts under the rigorous legal standard of strict scrutiny.[216] For a law to survive strict scrutiny, it must be shown that the governmental goal or interest in passing the law was compelling, and that the law was narrowly tailored to accomplish that goal.[217] To demonstrate that the law is narrowly tailored, it is generally necessary to show that race neutral alternatives were considered but were insufficient to accomplish the goal.[218] When laws classify people in most other ways—such as income, neighborhood location, incidence of chronic disease, and so on—the more lenient legal standard of rational basis review is applied.[219] Rational basis review simply considers whether the

213. Jen-L A. Wong, Adarand Constructors Inc. v. Pena*: A Colorblind Remedy Eliminating Racial Preferences*, 18 U. HAW. L. REV. 939, 943 (1996)("What is missing from recent constitutional review of race conscious affirmative action measures is any reference to the original intent of the framers of the Fourteenth Amendment."); John C. Duncan, Jr., *The American "Legal' Dilemma: Colorblind I/Colorblind II—The Rules Have Changed Again: A Semantic Apothegmatic Permutation*, 7 VA. J. SOC. POL'Y & L. 315, 392 (2000)("The history of the Reconstruction following the Civil War reveals that the Fourteenth Amendment was enacted to combat the notorious 'Black Codes' of the South following the Civil War.").

214. *See, e.g.*, Fisher v. Univ. of Tex. at Austin, No. 11-345, 2013 WL 3155220 (U.S. June 24, 2013)(rejecting presumption that university's good faith sufficed to uphold consideration of race in admissions; remanding for application of strict scrutiny); Gratz v. Bollinger, 539 U.S. 244, 270 (2003) (deeming the policy of granting automatic points to students of color in undergraduate admissions process not to be narrowly tailored to the compelling interest in diverse student body); *Adarand Constructors*, 515 U.S. at 238–39 (remanding for application of strict scrutiny to federal incentives for subcontracts to small disadvantaged business operators).

215. Johnson v. California, 543 U.S. 499, 505–06 (2005); Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701 (2007) (addressing voluntary race-based school integration programs).

216. Grutter v. Bollinger, 539 U.S. 306, 326 (2003).

217. *Johnson,* 543 U.S. at 505–06.

218. Danile Kiel, *Accepting Justice Kennedy's Dare: The Future of Integration in A Post*-PICS *World*, 78 FORDHAM L. REV. 2873, 2888 (2010).

219. Courts have also recognized an intermediate level of scrutiny, which is applied, for example, to gender classifications. Even if the Equal Protection Clause

government action is rationally related to a legitimate government interest;[220] the government's interest does not need to be compelling, but can merely be a legitimate potential reason, and the fit between the act and the interest can be much less exact than under strict scrutiny. This does not mean that a law burdening a non-protected group will never be struck down under rational basis review; indeed, such a law might well be found to be motivated by hostility to the group in question, which is not a legitimate government interest, and struck down.[221] When rational basis review is required, however, government action is given considerable deference and is much more likely to be upheld.

When a law uses a racially based classification, it is more likely to face a tougher constitutional challenge.[222] In some contexts, there may be no substitute for consideration of race or ethnicity. For example, in the context of housing or education, if a law is seeking to address evidence that social factors or unconscious bias are leading to racial segregation, there may be no way to address this problem without an explicit focus on race.[223] Programs such as Missouri's Minority Infant Mortality Prevention Initiative[224] are likely based on a conclusion that a racially directed program is necessary to successfully reduce the huge disparity in mortality rates for African American infants and other infants of color.

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does not provide strong protection against other types of discrimination, however, discrimination based on age, disability, and other classifications may receive protection under specific federal or state statutes.

220. Romer v. Evans, 517 U.S. 620, 631 (1996).

221. *See, e.g.*, City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432, 440, 446–48 (1985) (striking down zoning ordinance requirement that group home for developmentally disabled individuals obtain special use permit because it did not pass the rational basis test).

222. Adarand Constructors, Inc. v. Pena, 515 U.S. 200, 237 (1995) ("[W]e wish to dispel the notion that strict scrutiny is 'strict in theory, but fatal in fact.' . . . When race-based action is necessary to further a compelling interest, such action is within constitutional constraints if it satisfies the narrow tailoring test this Court has set out in previous cases." (citation omitted)).

223. Kiel, *supra* note 218, at 2885 ("While districts should—indeed, must—first consider such race-neutral alternatives, the experiences of several districts that have attempted to implement such plans demonstrate that these policies often fail to achieve or maintain racial diversity.").

224. *Minority Health*, MISS. DEP'T HEALTH & SENIOR SERVICES, http://health.mo.gov/living/families/minorityhealth/ (last visited May 16, 2013).
See also H.B. 1269, 2007 Leg., Reg. Sess. (Fla. 2007) (creating an African American Infant Health Practice initiative).

In contrast to laws focused on bias, in the context of many health disparities, the primary goal of legislation is to improve poor health in the most affected individuals. As a result, it may be legally (and politically) less controversial to pass a law targeting resources to neighborhoods or communities with poor health indicators. Presumably, if there are disparities, such a targeting process will provide the desired resources to the group of concern, and to the extent that it ends up also incidentally encompassing other neighborhoods or groups, the benefits of addressing these health problems may not detract from the reduction in health disparities.

As the Supreme Court's approach in this area continues to evolve, there are suggestions that governmental action that does not allocate benefits or burdens to *individuals* based upon racial classifications, but instead engages in a more "general recognition of the demographics of neighborhoods," may be subject to a lesser standard of review than strict scrutiny.[225] Nonetheless, there is little basis for confidence that this approach will be widely applied to policies aimed at disparities outside the context of education. Thus, if other approaches are likely to be equally effective to the race-based approach, but have less legal risk, it will certainly be wiser to try these approaches.

b. Policymaking Based on Income

In contrast to racial or ethnic disparities, if the health disparity in question involves income or another unprotected classification, there will be little legal risk under the Equal Protection Clause in explicitly singling out this target group in legislation addressing the problem. In fact, targeting people based on income is a common approach to providing government services and support. The Supplemental Nutrition Assistance Program (SNAP) and the National School Lunch Program are two well-known programs that use income to identify eligible participants. The use of income as a determinant factor is a common one for individual service provision, while broader policies that influence the food or physical activity environment more often use the characteristics of an entire neighborhood as a proxy for income.

225. Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701, 789 (2007) (Kennedy, J., concurring); *see also* Doe *ex rel.* Doe v. Lower Merion Sch. Dist., 665 F.3d 524, 545 (3d Cir. 2011) (holding that strict scrutiny was not triggered when plan was facially neutral, despite discussions of race during adoption); Lewis v. Ascension Parish School Board, 662 F.3d 343, 355 (5th Cir. 2011).

Focusing on recipients of means-tested benefits programs like SNAP allows policymakers to tailor interventions to focus on the most vulnerable members of our society. This approach, however, may sometimes venture into territory that some consider paternalistic. A recent example illustrates the challenges of trying to implement policies that target low-income individuals. As discussed earlier, public health experts are increasingly coming to a consensus that consumption of sugar-sweetened beverages is a major contributor to a range of serious health conditions.[226] In response, in 2010, the City and State of New York requested a waiver from the U.S. Department of Agriculture granting permission for a two-year experiment to prohibit the use of SNAP benefits for sugar-sweetened beverages.[227] The experiment would have added sugar-sweetened beverages to a list of other products that cannot be purchased with SNAP benefits, such as alcohol and tobacco.[228] New York argued that this policy change would protect the health of SNAP recipients, given that the strong evidence showing that sugar-sweetened beverages are a major driver of obesity rates.[229] The USDA denied this request, however, citing concerns about stigmatizing SNAP participants, among other reasons.[230]

The beverage industry alleged that New York's waiver request was an example of government overreach.[231] They were joined by advocates for low-income people, such as the Food Research and Action Center, who felt that the approach stigmatized SNAP recipients.[232] Nutrition expert Marion Nestle initially agreed, stating that this approach promoted the idea that low-income individuals

226. *See supra* note 164 and accompanying text.

227. Anemona Hartocollis, *New York Asks to Bar Use of Food Stamps to Buy Sodas*, N.Y. TIMES, Oct. 7, 2010, http://www.nytimes.com/2010/10/07/nyregion/07stamps.html.

228. Kelly D. Brownell & David S. Ludwig, *The Supplemental Nutrition Assistance Program, Soda, and USDA Policy: Who Benefits?*, 306 J. AM. MED. ASS'N 1370, 1371 (2011), *available at* http://www.yaleruddcenter.org/resources/upload/docs/what/policy/SNAPSodaNYCUSDA_JAMA_9.28.11.pdf.

229. *Id.* at 1370.

230. *Id.*; Letter from Jessica Shahin, Assoc. Adm'r, Supplemental Nutrition Assistance Program, U.S. Dep't of Agric., to Elizabeth R. Berlin, Exec. Deputy Comm'r, N.Y. State Office of Temp. & Disability Assistance (Aug. 19, 2011), *available at* http://www.foodpolitics.com/wp-content/uploads/SNAP-Waiver-Request-Decision.pdf.

231. Brownell & Ludwig, *supra* note 228, at 1370.

232. *Id.* (citing John Dimsdale, *Will a Soda Ban Benefit Food Stamp Users and State?*, MARKETPLACE ECON. (Oct. 7, 2010), http://www.marketplace.org/topics/economy/will-soda-ban-benefit-food-stamp-users-and-state).

make worse food choices than everyone else,[233] but she subsequently came to support the ban in light of emerging evidence about the unique negative effects of liquid sugar, the high levels of obesity, and type 2 diabetes among low-income New Yorkers.[234]

From another perspective, the proposed policy's most significant effect would have been to limit governmental support for the unhealthy food industry. Researchers at the Rudd Center for Food Policy and Obesity at the Yale School of Public Health estimated that nationwide, SNAP benefits pay at least $1.7 to $2.1 billion annually for sugar-sweetened beverages purchased in grocery stores.[235] This price tag raises the question of whether it makes sense for the government to subsidize the purchase of a class of products known to contribute significantly to a range of chronic diseases, particularly when the effect of these diseases is to increase costs to government.

Other policies and programs focusing on SNAP recipients are not controversial. Programs to support the fresh fruit and vegetable purchasing power of low-income consumers are increasingly common. In a number of additional states and communities, farmers markets have provided double value for consumers using SNAP benefits to purchase fresh, local fruits and vegetables.[236] Such programs direct resources to consumers based on income eligibility, encouraging use of SNAP benefits to obtain more food with the highest nutritional benefits, while incentivizing the exploration of farmers markets by new customers.[237]

3. Policies Based on Health Indicators or Unhealthy Products and

233. Marion Nestle, *New York City Says No to Using Food Stamps for Sodas*, FOOD POL. (Oct. 7, 2010), http://www.foodpolitics.com/tag/taxes/page/3/.

234. Marion Nestle, *Food Stamps Should Not Be Valid for Soda Purchases*, S.F. CHRON. (Apr. 29, 2011), http://www.sfgate.com/food/article/Food-stamps-should-not-be-valid-for-soda-purchases-2373259.php.

235. Tatiana Andreyeva et al., *Grocery Store Beverage Choices by Participants in Federal Food Assistance and Nutrition Programs*, 43 AM. J. PREVENTIVE MED. 411, 415 (2012), *available at* http://www.yaleruddcenter.org/resources/upload/docs/what/economics/SNAP_SSB_Purchases_AJPM_10.12.pdf.

236. *See, e.g.*, Tess Maune, *SNAP Cards Earn Double Savings at Tulsa Farmers Market*, OKLA.'S OWN NEWS ON 6 (July 1, 2012), http://www.newson6.com/story/18927103/snab-customers-get; *About Us*, DOUBLE UP FOOD BUCKS, http://www.doubleupfoodbucks.org/about (last visited May 16, 2013).

237. Press Release, W.K. Kellogg Found., W.K. Kellogg Foundation Provides $1.2 Million for Healthy Food by Doubling Food Stamp Benefits at Michigan Farmers' Markets: "Double Up Food Bucks" Scales up Foundation's Initial Investment in Pioneering Idea (Feb. 9, 2011), http://www.wkkf.org/news/articles/2011/02/double-up-food-bucks.aspx.

Practices

Policies can also reduce disparities by focusing directly on the issues of concern: high prevalence of negative health conditions, such as obesity or diabetes, and the factors and products that led to them. Each of these areas is discussed separately.

a. Policies Based on Health Indicators

Health indicators are another potential basis for policymaking. By focusing on specific health risk factors or conditions experienced primarily or disproportionately by a specific demographic group, policies will reduce health disparities.[238] Such policies can have a neighborhood focus or can target the health problem at hand more generally.

Thus, if a community is concerned about limited access to healthy food by certain demographic groups, rather than wade into the perilous waters of targeting resources based on demographic category, a policy could instead directly address the individuals or neighborhoods of concern by targeting the health problem itself. For example, in 2008, the New York City Health Department introduced its Green Carts program to contend with limited access to fruits and vegetables in low-income neighborhoods.[239] The program created 1,000 new street vending permits for vendors who would locate in identified food deserts and sell only fruits and vegetables.[240] The health department selected the eligible neighborhoods based on population data showing low levels of fruit and vegetable consumption.[241] The program not only benefited people of color as customers, but also created entrepreneurship opportunities for new

238. Christine Bahls, *Achieving Equity in Health*, HEALTH POL'Y BRIEF 5 (Oct. 6, 2011), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_53.pdf (noting that the "Million Hearts" campaign launched by the Department of Health and Human Services in 2011, which aims to prevent 1 million heart attacks and strokes over the next five years, will particularly benefit the health of African Americans, because rates of hypertension are vastly higher among African Americans than whites); *see also* Mechanic, *supra* note 185, at 51–52 ("Interventions may improve population health without increasing disparities if directed at problems that are much more prevalent among disadvantaged groups and that offer a relatively simply executed and efficacious remedy.").

239. *Green Cart Implementation: Year One,* CITIZENS' COMM. FOR CHILDREN OF N.Y., INC. 6–7 (2010), http://www.cccnewyork.org/wp-content/publications/CCCReport.GreenCarts.Sept2010.pdf.

240. *Id.* at 6.

241. *Id.*

immigrants from Asia and Latin America, where street vending is common.[242]

When considering this approach, policymakers should be sensitive to two issues. First, for policies based on individuals' (rather than populations') obesity measurements, they should be careful not to stigmatize overweight people.[243] Second, it may be difficult to obtain specific types of health data at the neighborhood or even community level, making it difficult to craft policy contingent on health indicators. Obesity and other health indicator data are most commonly available at the county level, although many large city-level health departments collect their own data with more discrete neighborhood-level breakdowns.

b. Policies Targeted at Practices and Products that Cause Negative Health Conditions

A less direct way to improve health outcomes for people of a specific race, ethnicity, or income is to target specific problems that affect those experiencing health disparities. For example, Latinos are more likely to report consuming energy drinks and sports drinks than people of other races or ethnicities.[244] The soft drink industry currently targets marketing of both of these beverage lines to Latinos and intends to target more marketing towards Latinos in the future.[245] Policies that decrease access to these beverages, while applying throughout a community, could have greater success in reducing obesity in Latinos, since they are disproportionately likely to consume these beverages. For example, vending restrictions in public parks and recreation centers could prohibit these high-calorie beverages from vending machines and concessions.[246]

242. Glenn Collins, *Customers Prove There's a Market for Fresh Produce*, N.Y. TIMES, Jun. 11, 2009, http://www.nytimes.com/2009/06/11/nyregion/11carts.html.

243. *See* GLICKMAN ET AL., *supra* note 69, at 103–05. "Policies and practices to address obesity must take this potential for harm [from stigma] into account and incorporate appropriate safeguards, including the institution of measures to track such outcomes. The case for addressing the obesity epidemic cannot be made at the expense of obese people." *Id.* at 103.

244. CHANGELAB SOLUTIONS, BREAKING DOWN THE CHAIN: A GUIDE TO THE SOFT DRINK INDUSTRY 40 (2012), *available at* http://changelabsolutions.org/publications/breaking-down-chain.

245. *Id.* at 26, 35–38, 41.

246. Although it may be tempting to pursue restrictions on junk food advertising in Latino communities as a solution to targeted marketing, the First Amendment is a significant hurdle to this approach. *See* Jennifer L. Harris & Samantha K. Graff, *Protecting Children from Harmful Food Marketing: Options for Local Government*

Policies that target specific products, however, can spark intense political debate. In September 2012, the New York City Board of Health enacted a rule prohibiting New York City's food service establishments, including restaurants, bodegas, street carts, delis, fast-food franchises, and movie theaters, from selling sugar-sweetened beverages in any cup or container capable of holding more than sixteen ounces.[247] The National Association for the Advancement of Colored People (NAACP) and Hispanic Federation filed an amicus brief in support of a lawsuit by the American Beverage Association (and other trade groups) challenging the Board of Health's authority to unilaterally ratify the soda rule. In the brief, the NAACP and Hispanic Federation assert that the soda rule "arbitrarily discriminates against citizens and small business owners in African-American and Hispanic communities" who have to compete with 7-Eleven and other convenience stores, which are excluded due to a loophole in the law.[248] Also, these groups argue that the ban is "a superficial and ineffective attempt" to address a complex health problem that disproportionately affects African Americans and Latinos.[249] Although the prohibition of sugar-sweetened beverages over sixteen ounces was ultimately struck down in 2013,[250] this example illustrates how health advocates have found themselves at odds with their longtime political allies on the issue of obesity prevention, an uncomfortable position for many in the public health community.

to Make a Difference, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y, Sept. 2011, at A92, *available at* http://www.cdc.gov/pcd/issues/2011/sep/pdf/10_0272.pdf.

247. N.Y.C. HEALTH CODE, § 81.53 (2013), *available at* http://www.nyc.gov/html/doh/downloads/pdf/about/healthcode/health-code-article81.pdf.

248. Brief for Nat'l Ass'n for the Advancement of Colored People and the Hispanic Fed'n as Amici Curiae Supporting Petitioner at 8, Am. Beverage Ass'n v. N.Y.C. Bd. of Health, No. 65384 (N.Y. Sup. Ct. 2012).

249. *Id.*

250. Michael M. Grynbaum, *Judge Blocks New York City's Limits on Big Sugary Drinks,* N.Y. TIMES, Mar. 11, 2013, http://www.nytimes.com/2013/03/12/nyregion/judge-invalidates-bloombergs-soda-ban.html. New York City appealed the ruling in June 2013. Michael M. Grynbaum, *City Argues to Overturn Ruling That Prevented Limits on Sugary Drinks*, N.Y. TIMES, June 11, 2013, http://www.nytimes.com/2013/06/12/nyregion/bloomberg-presses-for-reversal-of-court-ban-on-sugary-drink-limits.html.

4. Policymaking Based on Neighborhood

Neighborhood-based policies are a common approach to improving specific environmental drivers of disparities. For example, as discussed previously, the Los Angeles City Council passed a moratorium on new fast food restaurants in South Los Angeles in 2008.[251] This moratorium was limited in geographic scope to South Los Angeles, rather than encompassing the whole city.[252] Many on the outside perceived this controversial measure as a paternalistic over-reach by the city council,[253] but the measure actually originated with the predominantly low-income African American residents of that part of Los Angeles.[254] The policy was paired with economic development incentives to attract a grocery store to the neighborhood.[255] By focusing on the needs of the neighborhoods in question, the measure was tailored to decrease health disparities in Los Angeles.

Neighborhood-based policymaking often focuses on limited infrastructure. The general plan for the city of Santa Rosa, California, includes a requirement to prioritize park renovation in underserved neighborhoods.[256] New York City offers tax incentives to new or renovated grocery stores in neighborhoods that lack healthy food retailers.[257]

A novel policy approach with a neighborhood-based focus is the notion of a general policy that requires improved environmental conditions (through either public resource allocation or influencing private decisions) for people affected by disparities before the rest of the population can experience its benefits. For example, low-income

251. L.A., CAL., ORDINANCE NO. 180103 (2008), *available at* http://clkrep.lacity.org/onlinedocs/2007/07-1658_ord_180103.pdf; Severson, *supra* note 6.

252. L.A., CAL., ORDINANCE NO. 180103.

253. Others critiqued the assumptions underlying the ban. *See, e.g.*, Roland Sturm & Deborah A. Cohen, *Zoning for Health? The Year-Old Ban on New Fast-Food Restaurants in South LA*, 28 HEALTH AFF. w1088 (2009), *available at* http://content.healthaffairs.org/content/28/6/w1088.full.pdf+html.

254. Patricia Nazario, *Activists Push for Permanent Fast-Food Restaurant Ban in South LA*, KPCC S. CAL. PUB. RADIO (Sept. 7, 2010), http://www.scpr.org/news/2010/09/07/19023/fast-food-ban./

255. *See* Severson, *supra* note 6.

256. CITY OF SANTA ROSA, SANTA ROSA GENERAL PLAN 2035, at 6-15 to 6-16 (2009), *available at* http://ci.santa-rosa.ca.us/doclib/Documents/2035_General_Plan.pdf.

257. *Food Retail Expansion to Support Health*, N.Y.C. ECON. DEV. COUNCIL, http://www.nyc.gov/html/misc/html/2009/fresh.shtml (last visited May 16, 2013).

neighborhoods may find themselves unable to convince farmers markets to locate in what may be seen as a less profitable part of town. In response, the community might pass a policy that initially only allows new farmers markets to be established in specific areas that need access to healthy food. Once the underserved neighborhoods have farmers markets, then new markets can come into other neighborhoods. This approach is a way to prioritize the needs of people or neighborhoods experiencing disparities. It allows for new amenities to be established anywhere, but ensures that the neighborhoods that need them most get those amenities first. It might encourage people in areas not experiencing disparities to help bring new amenities to underserved areas.

a. Policies that Encourage Integration

As we contemplate neighborhood-based policy solutions, we return to the problem of residential segregation in the United States. The approaches that we have described above focus on how to ensure that underserved and low-income communities have good access to healthy community features and less exposure to unhealthy features. These approaches provide specific ways to address the imbalance in resources and amenities among different neighborhoods and communities.[258]

But a more overarching problem is responsible for fewer resources in low-income communities and communities of color: the problem of housing segregation by race and class itself. Housing segregation creates barriers for individuals from underserved communities who want to access the benefits available in other wealthier places.[259] As crucial as it is to improve conditions in low-income communities, high-quality schools and many other key resources are, for the foreseeable future, likely to be far more widely available in middle and upper income communities. Promoting residential integration is

258. *See, e.g.*, Rachel Tolbert Kimbro et al., *Young Children in Urban Areas: Links Among Neighborhood Characteristics, Weight Status, Outdoor Play, and Television Watching*, 72 SOC. SCI. & MED. 668 (2011), *available at* http://europepmc.org/articles/PMC3058513.

259. *See* Mindy Fullilove, *Unsorting Our Cities: To Improve the Health of Residents of Disadvantaged Neighborhoods, We Have to Address Inequality, Not Medical Care*, SHELTERFORCE, Spring 2012, *available at* http://www.shelterforce.org/article/2770/unsorting_our_cities/.

a key goal for healthy communities and the long-term elimination of health disparities.[260]

Policies that communities can adopt to make it easier for low-income individuals to live in middle-income neighborhoods include the creation of permanently affordable housing through trusts and tax protections.[261] Rent control, development of diverse housing stock, and inclusionary zoning practices can also assist both in avoiding displacement in neighborhoods that are developing and in creating new opportunities for diversity in middle-income neighborhoods. Public health professionals must embrace housing integration policy as a public health measure crucial to generating long-term community health improvements and ending health disparities.

C. Unintended Consequences

In considering the framework for disparities policy as well as policies more generally, it is crucial that policymakers remain vigilant for unintended negative effects on low-income communities and communities of color.[262] Some unintended consequences may follow relatively directly. For example, some school districts have banned chocolate milk in school lunches, reasoning that the added sugar in chocolate milk contributes to obesity and chronic disease.[263] But African American, Latino, and Asian communities have low calcium and dairy food consumption,[264] with average intakes near the threshold below which bone loss and hypertension can occur.[265] If the

260. *See, e.g.*, Jens Ludwig et al., *Neighborhoods, Obesity, and Diabetes—A Randomized Social Experiment*, 365 NEW ENG. J. MED. 1509 (2011), *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMsa1103216; s*ee also* LYNETTE RAWLINGS ET AL., RACE AND RESIDENCE: PROSPECTS FOR STABLE NEIGHBORHOOD INTEGRATION (2004), *available at* http://www.urban.org/publications/310985.html.

261. *See, e.g.*, MARCIA ROSEN & WENDY SULLIVAN, POVERTY & RACE RESEARCH ACTION COUNCIL, NAT'L HOUSING LAW PROJECT, FROM URBAN RENEWAL AND DISPLACEMENT TO ECONOMIC INCLUSION: SAN FRANCISCO AFFORDABLE HOUSING POLICY 1978–2012 (2012), *available at* http://nhlp.org/files/SanFranAffHsing-1.pdf.

262. GLICKMAN ET AL., *supra* note 69, at 7.

263. Kim Severson, *A School Fight Over Chocolate Milk*, N.Y. TIMES, Aug. 24, 2010, http://www.nytimes.com/2010/08/25/dining/25Milk.html.

264. May A Beydoun et al., *Ethnic Differences in Dairy and Related Nutrient Consumption Among US Adults and Their Association with Obesity, Central Obesity, and the Metabolic Syndrome*, 87 AM. J. CLINICAL NUTRITION 1914, 1916–18 (2008), *available at* http://ajcn.nutrition.org/content/87/6/1914.full.pdf+html.

265. Judith K. Jarvis & Gregory D. Miller, *Overcoming the Barrier of Lactose Intolerance to Reduce Health Disparities*, 94 J. NAT'L MED. ASS'N 55, 56–57 (2002), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594135/pdf/jnma00319-0034.pdf.

removal of chocolate milk decreases calcium and protein consumption by schoolchildren, then this policy has the potential to have negative overall health effects for children of color.[266] Districts can proactively evaluate the actual extent to which removing chocolate milk decreases calcium intake and explore options such as taking steps that increase the attractiveness of plain milk and other calcium-containing foods.[267]

Other effects may be deeply complex. For example, some policies promote schools that are located close enough to students' homes that students can get physical activity on the way to and from school. These policies are a reaction to school siting decisions that have moved new schools farther away from where students live: in the late 1960s, almost half of elementary school students lived one mile or less from school, but by 2001, this was true for less than one-quarter of elementary school students.[268] As a result, only thirteen percent of today's students get to school by walking or bicycling.[269] One proposed solution is to adopt policies that encourage small schools located in residential neighborhoods that nearby children can attend. But a problem emerges when advocates step back from the health-related goals of school siting work and consider the social context of neighborhoods. Neighborhoods in the United States tend to be highly segregated by race and income, and as a result, neighborhood

266. A further complication is the issue of lactose intolerance, which is more prevalent among non-white Americans than among white Americans. *See id.* at 61 ("In the United States, some degree of primary lactose maldigestion occurs in an estimated 15% (6% to 19%) of whites, 53% of Mexican Americans, 62% to 100% of Native Americans, 80% of African Americans, and 90% of Asian Americans."). Lactose intolerance is uncommon in young children, and develops with age. NAT'L INSTS. OF HEALTH, LACTOSE INTOLERANCE AND HEALTH 7 (2010), *available at* http://consensus.nih.gov/2010/docs/LI_CDC_2010_Final%20Statement.pdf. Flavored milks may be more easily digested by lactose intolerant individuals. Jarvis & Miller, *supra* note 265, at 61.

267. Severson, *supra* note 263 (describing how the director of Boulder, Colo.'s school food program Ann Cooper installed a chilled milk dispenser to keep milk consumption up after removing chocolate milk).

268. *KidsWalk-to-School: Then and Now—Barriers and Solutions*, CENTERS FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/nccdphp/dnpa/kidswalk/then_and_now.htm (last updated Feb. 25, 2008).

269. Noreen C. McDonald, Austin L. Brown, Lauren M. Marchetti & Margo S. Pedroso, *U.S. School Travel 2009: An Assessment of Trends*, 41 AM. J. PREVENTIVE MED. 146, 148 (2011), http://planning.unc.edu/people/faculty/noreenmcdonald/McDonald_etal_SchoolTravel2009NHTS_AJPM2011.pdf.

schools tend to promote increased school segregation, even while offering specific health benefits to students of all races and incomes.[270]

The challenge of seeking to alter school siting and assignment policies is illustrated by an ongoing controversy in North Carolina. In 2010 the Wake County Public School System eliminated its much-lauded income-based integration plan.[271] This change generated enormous discord, with some embracing the shift as supporting neighborhood schools, while many feared a return to racial and economic segregation, with negative effects on academic performance and other life indicators for low-income students and students of color.[272]

School siting policies can be crafted to support both diversity and walkability.[273] Such approaches will differ depending on local patterns of racial and economic segregation, but may include emphasizing school locations that span different neighborhoods; designating magnet schools to encourage diverse attendance; creating assignment policies that balance walkability and diversity; and an emphasis on busing for diversity rather than routine transport.[274] Without an understanding of the unintended consequence in question and appreciation of the benefits of integration, physical activity school siting advocates might have advocated for policies with negative effects on communities of color, policies that might ultimately increase disparities.

270. *See, e.g.*, GARY ORFIELD, JOHN KUCSERA & GENEVIEVE SIEGEL-HAWLEY, CIVIL RIGHTS PROJECT/PROYECTO DERECHOS CIVILES, E PLURIBUS . . . SEPARATION: DEEPENING DOUBLE SEGREGATION FOR MORE STUDENTS (2012), *available at* http://civilrightsproject.ucla.edu/research/k-12-education/integration-and-diversity/mlk-national/e-pluribus...separation-deepening-double-segregation-for-more-students.

271. Wake County, N.C. Bd. of Educ., *Resolution Establishing Board Directive for Community Based School Assignments* (Mar. 1, 2010), http://www.wcpss.net/about-us/our-leadership/board-of-education/resolutions/2010_march1_resolution.pdf.

272. Stacy Teicher Khadaroo, *Busing to End in Wake County, N.C. Goodbye, School Diversity?*, CHRISTIAN SCI. MONITOR (Mar. 24, 2010), http://www.csmonitor.com/USA/Education/2010/0324/Busing-to-end-in-Wake-County-N.C.-Goodbye-school-diversity.

273. *See, e.g.*, *Smart School Siting: How School Locations Can Make Students Healthier and Communities Stronger*, CHANGELAB SOLUTIONS, http://changelabsolutions.org/publications/smart-school-siting (last visited June 27, 2013).

274. *See id.*

Addressing unintended consequences is a recurrent challenge in policymaking.[275] Seeking background information and fully researching the context of a policy proposal are important first steps.[276] As demonstrated by the two examples discussed above, proponents must understand both the scientific and the historical context of a policy arena.

Another crucial method to ensure that such potential problems are identified and addressed is listening to key stakeholders[277] and creating meaningful community engagement.[278] Health impact assessments are a new and increasingly popular method of creating an authentic community engagement process to identify the wide range of effects that a policy may have.[279] A variant of health impact assessments known as "health disparity impact assessments" are an emerging tool designed to "inform policymakers of likely impacts of proposed policies and programs on health and healthcare disparities among racial and ethnic minorities, and to reduce disparities through improving new policies and programs."[280] Additionally, policymakers

275. Meryl Bloomrosen et al., *Anticipating and Addressing the Unintended Consequences of Health IT and Policy: A Report from the AMIA 2009 Health Policy Meeting*, 18 J. AM. MED. INFORMATICS ASS'N 82, 83 (2011), *available at* http://jamia.bmj.com/content/18/1/82.full.pdf (describing several axes of unintended consequences: desirable/undesirable; anticipated/unanticipated; direct/indirect; latent/obvious). Note that unintended consequences can also occur that do not implicate disparity issues. *See, e.g.*, Senarath Dharmasena & Oral Capps, Jr., *Intended and Unintended Consequences of a Proposed National Tax on Sugar-Sweetened Beverages to Combat the U.S. Obesity Problem*, 21 HEALTH ECON. 669 (2011) (explaining that sugar sweetened beverage taxes will reduce sugar intake, but that some models exaggerate the amount of decrease by failing to account for likely substitution of other caloric drinks for sugar sweetened beverages). Policymakers should make a practice of inquiring about unintended consequences and modifying approaches to mitigate undesired effects.

276. In considering unintended consequences, it is worth recalling the list of likely causes for such consequences: "ignorance, error, overriding of longterm interest by immediate interest, basic values that require or prohibit action, and self-defeating prophecy." Bloomrosen, *supra* note 275, at 82.

277. INST. OF MED., UNINTENDED CONSEQUENCES OF HEALTH POLICY PROGRAMS AND POLICIES: WORKSHOP SUMMARY 3 (2001), *available at* http://www.nap.edu/openbook.php?record_id=10192&page=R1.

278. GLICKMAN ET AL., *supra* note 69, at 26–27 (emphasizing importance of ensuring full participation in democratic decisionmaking institutions).

279. *Health Impact Assessment Factsheet*, HUM. IMPACT PARTNERS, http://www.humanimpact.org/component/jdownloads/finish/12/192/0 (last visited May 16, 2013) (engaging and empowering stakeholders is one of key goals of health impact assessments).

280. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 101, at 28. The Department of Health and Human Services is currently conducting pilot assessments of the use of this approach.

can learn about a community's health needs through the hospitals' community health needs assessment (CHNA) process described earlier. Frank conversations can allow members of a community to flag the negative effects that may not have occurred to a health-focused team. Furthermore, community members may be able to challenge general trends or statistics that may not hold true for their particular community. Responsive community engagement processes also ensure that the community is generally supportive of the approach selected, so that concerns about paternalism and undesired burdens are diminished and the effectiveness of the ultimate policy is increased.[281]

If an adopted policy results in unintended adverse consequences, lawmakers must be willing to amend the policy to fix the identified problems.[282] Pilot programs, annual updates, and reports to legislative bodies all provide built-in processes for addressing unintended consequences.[283] These types of evaluation procedures can be included in every policy. Policymakers must engage in research, public outreach, evaluation, and reassessment to ensure that low-income communities and communities of color actually benefit from a policy.

CONCLUSION

The federal focus on prevention through the ACA provides an opportunity for concerted local, state, and federal action to reverse and prevent health disparities. Disparities-focused policymaking is fraught with legal and political challenges, making it difficult for policymakers to proceed, even with federal funding and momentum. In this Article, we proposed a framework to guide policymakers as they contemplate obesity prevention policies that aim to reverse disparities. Although developed with local and state policymakers in mind, it can be used at all levels of government.

281. Concerns about the propriety of race-oriented policy prescriptions may emerge from different points on the political spectrum. Recognizing the history of detrimental race-based health categorizations, both deliberate and unconscious, proposed approaches should not be implemented without solid support both by data and by the community in question. *See, e.g.*, Erik Lillquist & Charles A. Sullivan, *The Law and Genetics of Racial Profiling in Medicine*, 39 HARV. C.R.-C.L. L. REV. 391 (2009).

282. INST. OF MED., *supra* note 277, at 3.

283. *Id.* at 9.

One potential use of the disparities framework is as a checklist. Once a policymaker has identified a particular obesity prevention goal as a candidate for policy—such as making it safer to walk to school by improving sidewalks—then she or he can consider the various strategies in the framework and identify the approach that is most likely to increase physical activity options for community members most affected by the obesity epidemic. This process will require data about sidewalk infrastructure, physical activity levels, and obesity rates for the community so that the improvements can be focused on the places that need it most.

To achieve health equity goals, we make the following recommendations for federal, state, and local governments:

1. Characterize and monitor health disparities by collecting data. Data should identify health disparities across the population and catalogue the resources (or lack thereof) needed to reverse those disparities. Release regular public reports about health disparities and trends.
2. Build the capacity of public health department staff to interpret health disparities data, communicate about those disparities with the public, elected officials, and community partners, and translate disparities data into concrete strategies.
3. Address health disparities through not only public health policy per se, but also other areas of policy that affect the social determinants of health. Poverty, education, and housing segregation all drive health outcomes, yet these are policy areas that rarely see engagement from the public health community.

To improve the impact of the ACA on obesity disparities, we recommend the following implementation-related actions:

4. Build a broad-based coalition to advocate for the Public Health Prevention Fund. The public health community must reach out to partners from a diverse range of sectors, including civil rights, consumer protection, transportation, and labor, to explain how the Public Health Prevention Fund, and better population health in general, can further their goals.
5. Hold the National Prevention Council accountable for its stated goals and the implementation of the National Prevention Strategy, particularly the goals related to obesity and related health disparities. This can be done by reviewing the council's annual status reports, responding to requests for comments, and cultivating relationships with individual members.
6. Ensure that a proportion of hospital community benefits go toward reversing health disparities by addressing the social

> determinants of health at the community level, not just by providing on-going care and treatment for existing health problems.

The ACA has renewed an important national conversation about the obesity epidemic and health disparities affecting urban and rural areas across the country. This conversation creates a window for transforming both the health care and public health systems to focus on prevention and health disparities. Stakeholders in both systems must work across sectors to seize this opportunity to improve health equity in the communities they serve.