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Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities

GWENDOLYN ROBERTS MAJETTE*

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*“Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health. Health equity is central to this premise”*¹

INTRODUCTION

The existence of health disparities for racial and ethnic minorities is a longstanding problem in the United States. According to the Institute of Medicine (IOM), a health disparity is the “difference in health or clinical outcomes that is not attributable to clinical appropriateness or patient preferences.”² Health disparities have multiple causes³ including barriers to access to care. Some of the barriers encountered by people of color include: financing health care and the lack of health insurance, a shortage of institutional and individual providers, difficulties in communications because of cultural insensitivity and language differences, stereotyping, and discrimination.⁴

The consequence of encountering numerous barriers to health care means that racial and ethnic minorities have a disproportionately worse health status. People of color have “higher infant mortality, premature death rates and disease burden, and lower quality of health care when compared with the national average.”⁵ The magnitude of

1. COMM’N ON SOC. DETERMINANTS OF HEALTH, INTERIM STATEMENT (2007) (Commission’s Vision and Mission Statement), available at http://www.who.int/social_determinants/resources/csdh_media/csdh_interim_statement_07.pdf.

2. INST. OF MED., FUTURE DIRECTIONS FOR THE NATIONAL HEALTHCARE QUALITY AND DISPARITIES REPORT 44 (Cheryl Ulmer et al. eds., 2010) [hereinafter IOM FUTURE DIRECTIONS OF NHQR & NHDR]. The focus of the Institute of Medicine (IOM) analysis is two-fold: “(1) the operation of healthcare systems and the legal and regulatory climate” governing the systems; and (2) “discrimination at the individual, patient-provider level.” INST. OF MED., UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 4 (Brian D. Smedley et al. eds., 2003) [hereinafter IOM, UNEQUAL TREATMENT].

3. Other causes include determinants of health like the social and physical environment, biology and genetics, and human behavior. David Satcher & Eve J. Higginbotham, *The Public Health Approach to Eliminating Disparities in Health*, 98 AM. J. PUB. HEALTH 400, 400 (2008).

4. Gwendolyn Roberts Majette, *Access to Health Care: What a Difference Shades of Color Make*, 12 ANNALS HEALTH L. 121, 123-39 (2003) [hereinafter Majette, *Access to Health Care*] (discussing the common barriers to care for people of color and proposing an interdisciplinary approach to eliminate those barriers that relies on the work of lawyers, physicians, business leaders, and health economists); see IOM, UNEQUAL TREATMENT, *supra* note 2, at 1. The IOM’s non-legal definition of discrimination is “the differential and negative treatment of individuals on the basis of their race, ethnicity, gender, or other group membership.” *Id.* at 95. A cause of discrimination is bias or prejudice. *Id.* at 127.

5. Satcher & Higginbotham, *supra* note 3, at 400.

the problem is reflected in a startling statistic which estimated that 886, 202 deaths could have been avoided if mortality rates between white and black individuals were equal in the United States.⁶

The Department of Health and Human Services first recognized that there were significant health and health care disparities for people of color in 1985 when it released the Report of the Secretary's Task Force on Black and Minority Health (Heckler Report).⁷ Thereafter, in 1998, President Clinton announced the Presidential Initiative to Eliminate Racial and Ethnic Disparities in Health.⁸ This national initiative sought for the first time to eliminate, not simply reduce, disparities in health in six areas: (1) cancer screening and management, (2) cardiovascular disease, (3) diabetes, (4) HIV/AIDS, (5) immunization rates, and (6) infant mortality.⁹ In 2000, elimination of health care disparities became a goal of Healthy People 2010, the nation's health-promotion and disease-prevention agenda.¹⁰

Despite these and other initiatives, in 2010, former Surgeon General David Satcher wrote, "not much progress has been made, to date, in moving toward the reduction and ultimate elimination of disparities in health."¹¹ Additionally, current Assistant Secretary for Health, Howard K. Koh concluded that "the goal of eliminating disparities remains unmet."¹² A major cause of the failure to eliminate health care disparities for racial and ethnic minorities is the lack of commitment of resources.¹³

6. This estimate is based on a nine-year period from 1991–2000. Michael G. Marmot & Ruth Bell, *Action on Health Disparities in the United States: Commission on Social Determinants of Health*, 301 J. AM. MED. ASS'N 1169, 1170 (2009).

7. Howard K. Koh et al., *Reducing Racial and Ethnic Disparities: The Action Plan from the Department of Health and Human Services*, 30 HEALTH AFF. 1822, 1822 (2011).

8. *President Clinton Announces New Racial and Ethnic Health Disparities Initiative*, U.S. DEP'T HEALTH & HUM. SERVICES (Feb. 21, 1998), <http://archive.hhs.gov/news/press/1998pres/980221.html>.

9. David Satcher & Eve J. Higginbotham, *supra* note 3, at 400; David Satcher, *Our Commitment to Eliminate Racial and Ethnic Health Disparities*, 1 YALE J. HEALTH POL'Y L. & ETHICS 1, 2 (2001); David Satcher, *The History of the Public Health Service and the Surgeon General's Priorities*, 54 FOOD & DRUG L.J. 13, 19 (1999).

10. Howard K. Koh, *A 2020 Vision for Healthy People*, 362 NEW ENG. J. MED. 1653, 1653 (2010).

11. Edward J. Sondik et al., *Progress Toward the Healthy People 2010 Goals and Objectives*, 31 ANN. REV. PUB. HEALTH 271, 280 (2010).

12. Koh, *supra* note 10, at 1653, 1656.

13. Sondik et al., *supra* note 11, at 271. At least one scholar, Professor Ruqaiijah Yearby, argues that a major cause of the persistence of health disparities for people of color is "the failure to meaningfully acknowledge and address the root cause of racial disparities: racial discrimination." Ruqaiijah Yearby, *Does Twenty-Five Years Make a Difference in "Unequal Treatment"? The Persistence of Racial Disparities in Health Care Then and Now*, 19 ANNALS HEALTH L. 57, 58 (2010).

In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which President Obama signed into law on March 23, 2010.¹⁴ Passage of this piece of legislation provides the United States with a significant opportunity to eliminate health care disparities. Elimination of health disparities for people of color is not simply a national concern; it is also of international concern. Health and human rights norms impose obligations on countries to address discrimination and inequality.¹⁵ Both the World Health Organization and the United Nations Special Rapporteur for Health recognize the inequitable treatment of disadvantaged groups across the world as an issue of international concern.¹⁶ Additionally, Professor Vernellia Randall argues that, “persistent discrimination in U.S. health care contributes to continuing health disparities . . . [in] violation of the U.S. obligations under [the International Convention for the Elimination of Racial Discrimination].”¹⁷

This Article analyzes how PPACA constitutes framework legislation that complies with global health law norms protecting a right to health in its approach to the reduction of health care disparities for racial and ethnic minorities in the United States. Part I identifies the

14. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

15. Paul Hunt, Missed Opportunities: Human Rights and the Commission on Social Determinants of Health, Address at the Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health Conference (Nov. 6-7, 2008), in GLOBAL HEALTH PROMOTION, Apr. 8, 2009, at 36, 37, available at http://ped.sagepub.com/content/16/1_suppl/36.full.pdf+html [hereinafter Hunt, *Missed Opportunities*].

16. In a report of the Special Rapporteur for Health, Paul Hunt notes that health care systems must be accessible to “all disadvantaged individuals and communities.” Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Economic, Social and Cultural Rights*, ¶ 6, at 5, Comm’n on Human Rights, Econ and Soc. Council, U.N. Doc. E/CN.4/2006/48 (Mar. 3, 2006) (by Paul Hunt) [hereinafter ECOSOC Special Rapporteur Report]; see also WHO, *Engaging for Health: Eleventh General Programme of Work, 2006–2015; A Global Health Agenda*, at 15 (May 2006), available at http://whqlibdoc.who.int/publications/2006/GPW_eng.pdf. Additionally, the U.N. Charter requires countries to pledge the “promotion of universal respect for and observance of human rights and fundamental freedoms” for all without distinction as to race, sex, language, or religion. Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III), at pmbl., art. 2 (Dec. 10, 1948) [hereinafter UDHR].

17. Vernellia R. Randall, *Racial Discrimination in Health Care in the United States as a Violation of the International Convention on the Elimination of All Forms of Racial Discrimination*, 14 U. FLA. J.L. & PUB. POL’Y 45, 50 (2002). Professor Randall analyzes the existence of persistent racial discrimination in the United States health care system up to the new millennium; she argues that institutional racism contributes to health disparities and violates ICERD articles 2(1)(a), 2(1)(c), 2(1)(d), and 5(ε)(iv). *Id.* at 68; see also Ruqaiyah Yearby, *Is It Too Late for Title VI Enforcement?—Seeking Redemption of the Unequal United States’ Long Term Care System Through International Means*, 9 DEPAUL J. HEALTH CARE L. 971, 978 (2005) (examining the United States’ disregard for elderly African Americans’ right to equality).

global health laws that impose a duty on the United States to eliminate health disparities for people of color. Part II analyzes the legislative framework that PPACA creates to protect the right to health and eliminate health care disparities. Finally, Part III concludes with my recommendations on future efforts to reduce and eliminate health care disparities for people of color in the United States.

I. GLOBAL HEALTH LAWS THAT IMPOSE A DUTY ON THE UNITED STATES TO REDUCE OR ELIMINATE HEALTH DISPARITIES

Global health law is a field that encompasses the legal norms, processes, and institutions needed to create the conditions for people throughout the world to attain the highest possible level of physical and mental health. The field seeks to facilitate health-promoting behaviour among the key actors that significantly influence the public's health, including international organizations, governments, businesses, foundations, the media, and civil society.¹⁸

There are several global health laws that impose a duty on the United States to reduce or eliminate health disparities for people of color including global health governance documents by the World Health Organization (WHO); the International Convention on the Elimination of Racial Discrimination (ICERD); and non-binding, aspirational laws and documents such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), and reports by the United Nations Special Rapporteur for Health.

The United States is a member of the World Health Organization whose constitution includes a provision to protect the right to health.¹⁹ Health is defined as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."²⁰ The WHO Constitution provides that health is a fundamental right. It states that, "[t]he enjoyment of the highest attainable standard of

18. Lawrence O. Gostin & Allyn L. Taylor, *Global Health Law: A Definition and Grand Challenges*, 1 *PUB. HEALTH ETHICS* 53, 55 (2008) ("The mechanisms of global health law should [(1)] stimulate investment in research and development, [(2)] mobilize resources, [(3)] set priorities, [(4)] coordinate activities, [(5)] monitor progress, [(6)] create incentives, and [(7)] enforce standards."). The guiding principle of global health law is social justice. *See id.*

19. *See* World Health Organization [WHO], *Constitution of the World Health Organization*, pmbl., at 1 (July 22, 1946), available at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

20. *Id.*

health is one of the fundamental rights of every human being without distinction of race, . . . economic or social condition.”²¹

A. The Right to Health Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), General Comment 14, and Reports of the Special Rapporteur for Health

While Presidents Carter and Clinton have recommended ratification of the International Covenant on Economic, Social and Cultural Rights, the United States Senate has not ratified this treaty.²² ICESCR contains the most comprehensive article on the right to health in human rights law. Like the WHO Constitution, this covenant recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”²³ A country like the United States fully realizes that right when it addresses the “reduction of the stillbirth-rate and of infant mortality” and promotes the healthy development of the child; prevents, treats and controls “epidemic, endemic, occupational and other diseases;” and creates conditions to “assure to all medical service and medical attention in the event of sickness.”²⁴ In the context of a health care system, the right to health is the “right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.”²⁵ If the health care system in the United States was accessible to all,²⁶ this would help reduce health disparities for people of color.

21. *Id.*

22. Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 *RUTGERS L. REV.* 335, 347-48 (2008) [hereinafter Kinney, *Recognition of RTH in the U.S.*].

23. United Nations, Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No. 14, ¶ 2, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment 14] (internal quotation marks omitted).

24. International Covenant on Economic, Social, and Cultural Rights, art. 12(2)(a), (c), (d), Dec. 16, 1966, 1966 U.S.T. 521, 993 U.N.T.S. 3 [hereinafter ICESCR]. Article 12(2)(b) requires governments to improve “all aspects of environmental and industrial hygiene.” *Id.*

25. ECOSOC Special Rapporteur Report, *supra* note 16, ¶ 4; *see also* General Comment 14, *supra* note 23, ¶ 4 (explaining that the right to health includes a number of socioeconomic factors).

26. A health care system is accessible to all when health care and its underlying determinants are geographically, economically, and informationally accessible on a non-discriminatory basis. *See* General Comment 14, *supra* note 23, ¶ 12(b). As discussed in the introduction, people of color disproportionately encounter significant barriers to care and adverse social and economic determinants of health. *See* discussion *supra* Introduction. In 2010, people of color represented a disproportionate percentage of the uninsured in the United States: Hispanics

B. The International Convention on the Elimination of Racial Discrimination

In contrast to ICESCR, the United States has ratified the International Convention on the Elimination of Racial Discrimination (ICERD).²⁷ This treaty explicitly addresses the rights of people of color. ICERD not only condemns racial discrimination and segregation, but it encourages countries to promote understanding among all races.²⁸

1. Treaty Requirements and Prohibitions

ICERD prohibits countries from engaging in racial discrimination; requires countries to take “effective measures” to review, amend, rescind, and nullify policies and laws that have the “effect of creating or perpetuating racial discrimination;” and requires countries to prohibit and end “racial discrimination by any persons, group, or organization.”²⁹ It further requires that countries take “special and concrete measures to ensure the adequate development and protection of certain racial groups . . . for the purpose of guaranteeing them the full and equal enjoyment of human rights and fundamental freedoms.”³⁰ Moreover, countries must “guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law . . . [in e]conomic, social and cultural rights, . . . [like t]he right to public health, [and] medical care.”³¹

(32%), American Indians (30%), African Americans (22%), and Asians (19%). See KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER* 7 fig.5 (2011), available at <http://www.kff.org/uninsured/upload/7451-07.pdf>. In contrast, whites were only 14% of the uninsured population. *Id.*

27. The United States ratified the treaty with three reservations, one understanding, and one declaration. For an in-depth analysis of the history of the United States adoption of ICERD, the effect of its reservations, and the expected impact of adoption, see Gay J. McDougall, *Toward a Meaningful International Regime: The Domestic Relevance of International Efforts to Eliminate All Forms of Racial Discrimination*, 40 *How. L.J.* 571 (1997).

28. International Convention on the Elimination of All Forms of Racial Discrimination, art. 2(1), (3), Dec. 21, 1965, S. EXEC. DOC. C, 95-2 (1978), 660 U.N.T.S. 195 [hereinafter ICERD].

29. *Id.* art. 2(1)(a), (c), (d).

30. *Id.* art. 2(2). Special measures must be of a limited duration and must end when the objectives for which they were adopted have been achieved. *Id.*

31. *Id.* art. 5(e)(iv).

2. United States' Report and Recommendations to the United States from the Committee on the Elimination of Racial Discrimination

To monitor compliance with ICERD, countries are required to file reports every two years and whenever the Committee on the Elimination of Racial Discrimination (CERD Committee) requests.³² These reports should identify the “legislative, judicial, administrative or other measures” adopted to give effect to the treaty.³³ In both the United States' initial and subsequent reports to the CERD Committee, it acknowledged the existence of significant disparities in health status and access to care for racial and ethnic minorities.³⁴ Based on the last report filed by the United States in 2007,³⁵ the CERD Committee identified some positive aspects of governmental efforts to address the health care needs of racial and ethnic minorities. The CERD Committee commended the United States Department of Health and Human Services for creation of the “National Partnership for Action to End Health Disparities for Ethnic and Racial Minority Populations” (NPA) in 2007, “as well as the various programmes adopted . . . to address the persistent health disparities affecting low-

32. *Id.* art. 9(1)(b).

33. *Id.* art. 9(1).

34. PERIODIC REPORT OF THE UNITED STATES OF AMERICA TO THE U.N. COMMITTEE ON THE ELIMINATION OF RACIAL DISCRIMINATION CONCERNING THE INTERNATIONAL CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION 86, ¶ 258 (Apr. 2007) [hereinafter U.S. PERIODIC REPORT TO CERD (2007)], available at <http://www.state.gov/documents/organization/83517.pdf>.

35. The United States has only filed two reports with the Committee on the Elimination of All Forms of Racial Discrimination (CERD Committee). The initial report which constituted the first, second, and third report was filed on September 21, 2000. Comm. on the Elimination of Racial Discrimination, Reports Submitted by States Parties Under Article 9 of the Convention 1, 1, U.N. Doc. CERD/C/351/Add.1 (Oct. 10, 2000). The reports were due on November 20, 1995, November 20, 1997, and November 20, 1999. *Id.* The second report contained the fourth, fifth, and sixth periodic reports and was filed as a single document on April 24, 2007. U.S. PERIODIC REPORT TO CERD (2007), *supra* note 34, at 1. This report covered the years from September 2000 to April 2007. *See id.* In response to questions from the CERD Committee, the United States filed a supplemental report to its second report in March 2008. *See generally* QUESTIONS PUT BY THE RAPPORTEUR IN CONNECTION WITH THE CONSIDERATION OF THE COMBINED FOURTH, FIFTH AND SIXTH PERIODIC REPORTS OF THE UNITED STATES OF AMERICA, CERD/C/USA/6 (2008) [hereinafter U.S. RESPONSE TO CERD QUESTIONS], available at <http://www.state.gov/documents/organization/107109.pdf> (providing the United States' answers to the CERD Committee's questions). The CERD Committee has requested that the United States file its next report as single document on November 20, 2011. U.N. Comm. on the Elimination of Racial Discrimination, 72d Sess., *Consideration of Reports Submitted by States Parties Under Article 9 of the Convention: Concluding Observations of the Committee on the Elimination of Racial Discrimination, United States of America*, 13, ¶ 46, U.N. Doc. CERD/C/USA/CO/6 (Feb. 2008) [hereinafter CERD, *Concluding Observations on U.S. Reports*]. The third report, which has not been filed yet, will constitute the seventh, eighth, and ninth report.

income persons belonging to racial, ethnic and national minorities.”³⁶ When the 2007 report was filed, the NPA was a new initiative of the Office of Minority Health.³⁷ It was based on three core principles: “(1) national leadership and community solutions; (2) effective communications; and (3) broad-based partnerships.”³⁸

The CERD Committee also identified several areas of concern. In light of ICERD article 3, which prohibits racial segregation, the Committee was “deeply concerned” about the disproportionate concentration of racial and ethnic minorities, especially Latino and African American persons, in poor residential neighborhoods with numerous problems including “inadequate access to health care facilities.”³⁹ The CERD Committee was concerned about the large number of racial and ethnic minorities that lacked health insurance and encountered “numerous obstacles to access . . . health care.”⁴⁰ These concerns were based on ICERD article 5(e)(iv), which prohibits racial discrimination and guarantees everyone, “without distinction as to race, colour, or national or ethnic origin, . . . equality before the law . . . [in t]he right to public health, [and] medical care.”⁴¹ Additionally, the Committee was troubled about the poor sexual and reproductive health status of racial and ethnic women. Some areas of concern include infant and maternal mortality and the significant disparities in HIV infection.⁴²

The Committee generally recommended that the United States address “persistent health disparities” among racial and ethnic minorities by continuing efforts to reduce barriers to care by increasing access to health insurance; correcting unequal distribution of health care resources; and improving the poor quality of care provided in public health care services.⁴³ It further requested that the United States

36. CERD, *Concluding Observation on U.S. Reports*, *supra* note 35, at 2, ¶ 8.

37. *Id.*

38. U.S. PERIODIC REPORT TO CERD (2007), *supra* note 34, at 88; *see also* U.S. RESPONSE TO CERD QUESTIONS, *supra* note 35, at 85 (discussing how some of the partnerships would include the faith community and private businesses). *See infra* Part II.B.3 for a discussion of the current status of NPA.

39. CERD, *Concluding Observation on U.S. Reports*, *supra* note 35, at 4, ¶ 16.

40. *Id.* at 10-11, ¶ 32.

41. *Id.*; ICERD, *supra* note 28, art. 5(e)(iv).

42. *See* CERD, *Concluding Observation on U.S. Reports*, *supra* note 35, at 11, ¶ 33.

43. *Id.* at 10-11, ¶ 32. In its 2001 Concluding Observations and Recommendations to the United States, the CERD Committee also identified the existence of persistent disparities in public and private health care as an area of concern. U.N. Gen. Assembly, Comm. on the Elimination of Racial Discrimination, Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America, ¶ 19, U.N. Doc. CERD/C/59/Misc.17/Rev.3 (2001). While acknowledging generically the “numerous laws, institutions, and measures de-

“collect statistical data on health disparities affecting persons belonging to racial, ethnic and national minorities [that is] disaggregated by age, gender, race, ethnic or national origin, and to include [that information] in its next periodic report.”⁴⁴

C. Report of the United Nations Special Rapporteur for Health on Factors to Strengthen a Health System to Protect the Right to Health

In 2008, the United Nations Special Rapporteur for Health submitted a report to the Human Rights Council that identified seventeen features of a health care system that protects the right to health (RTH-Strengthening Health Systems report).⁴⁵ This report was designed as a resource for countries to use to develop or strengthen their health care systems.⁴⁶ The features were derived from features that existed in health systems, features recognized in international health instruments, or features advocated for in the medical and public

signed to eradicate racial discrimination,” the CERD Committee recommended that the United States “take all appropriate measures, including special measures [pursuant] to article 2, paragraph 2 . . . to ensure the right of everyone without discrimination as to race, colour, or national or ethnic origin to the enjoyment of the rights contained [within] article 5.” *Id.*

44. CERD, *Concluding Observation on U.S. Reports*, *supra* note 35, at 10-11, ¶ 32. The importance of data collection to enforcement of non-discrimination laws and the lack of availability of this information in the United States has been previously recognized by the United States Commission on Civil Rights, civil rights advocacy groups, and legal scholars like Professor Vernellia Randall. See U.S. COMM’N ON CIVIL RIGHTS, *THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY*, VOLUME 1, *THE ROLE OF GOVERNMENTAL AND PRIVATE HEALTH CARE PROGRAMS AND INITIATIVES* 50-52 (1999); Randall, *supra* note 17, at 63. See generally *Madison-Hughes v. Shalala*, 80 F.3d 1121 (6th Cir. 1996) (concerning a civil rights advocacy group’s demands for the government to collect more data pertaining to health care and minority groups).

45. Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, *Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights*, ¶¶ 36-66, U.N. Gen. Assembly, Human Rights Council, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008) (by Paul Hunt) [hereinafter *RTH-Strengthening Health Systems Report*]. The seventeen features include: (1) a people-centered approach; (2) a focus on process and outcome; (3) transparency; (4) participation; (5) equity, equality, and non-discrimination; (6) respect for cultural difference; (7) the provision of medical care coupled with attention to the underlying determinants of health; (8) progressive development of a health care system that protects the right to health in light of resource availability; (9) adherence to the immediate core obligations; (10) an emphasis on the provision of quality care; (11) the provision of primary and secondary care coupled with effective referrals to specialists; (12) the development of a comprehensive integrated system instead of a disease/condition focused approach; (13) coordination of activities between the public and private actors at the national and international level; (14) an emphasis on health as a global public good; (15) making tough policy choices in light of a limited budget through a fair, transparent, and participatory process; (16) monitoring and accountability of conduct, performance, and outcomes of a health system; and (17) an approach to the right to health as a legally binding obligation. See *id.* ¶¶ 37-66.

46. See *id.* at 2.

health literature.⁴⁷ The Special Rapporteur for Health also consulted with a wide range of stakeholders in eight countries.⁴⁸

This important report does not rely heavily on legal authority. In fact, it rarely cites legal authorities.⁴⁹ Instead, it is a forward-looking report targeted to health policy development that incorporates a right to health approach.⁵⁰ There are three features from the RTH-Strengthening Health Systems report that are particularly important to helping the United States reduce health care disparities for racial and ethnic minorities. They are factor 5–Equity, Equality, and Non-Discrimination; factor 7–Medical Care and the Underlying Determinants of Health; and factor 10–Quality.

1. Factor 5–Equity, Equality, and Non-Discrimination

Equity, equality, and non-discrimination are related concepts that emphasize social justice.⁵¹ Equity is a health concept that has an ethical focus.⁵² Equity requires the provision of “health care to all individuals in a manner that does not vary in quality because of personal characteristics such as gender, *ethnicity*, geographic location, and *socioeconomic* status.”⁵³ According to the Institute of Medicine (IOM), equity is a core aspect of quality and should be included in the United States’ “nation[al] quality improvement agenda.”⁵⁴ In the global health context, the WHO has a longstanding policy to achieve health equity through its Health for All policy, which sets a goal “for all citizens of the world” to attain a level of health that “lead[s to] socially

47. *Id.* at 6, ¶ 18.

48. *Id.* at 6 n.5. The eight countries included: the United Kingdom of Great Britain and Northern Ireland, the United States of America, New Zealand, Australia, Switzerland, Italy, and Zimbabwe. *Id.*

49. The report cites the Alma Ata Declaration (most cited); the International Covenant on the Rights of the Child; General Comment 14 (referring to the meaning of progressive realization and immediate core obligations); and makes a brief reference to the U.N. Charter and UDHR in the context of international assistance and cooperation. *Id.* at 12 n.22, ¶ 47, ¶ 51 n.26, ¶ 60, ¶ 90 n.39.

50. See Paul Hunt & Sheldon Leader, *Developing and Applying the Right to the Highest Attainable Standard of Health: The Role of the U.N. Special Rapporteur (2002-2008)*, in *GLOBAL HEALTH AND HUMAN RIGHTS: LEGAL AND PHILOSOPHICAL PERSPECTIVES* 28, 28 (John Harrington & Maria Stuttaford eds., 2010).

51. See *id.* at 47; see also RTH-Strengthening Health Systems Report, *supra* note 45, at 12.

52. See Hunt & Leader, *supra* note 50, at 46; Audrey R. Chapman, *The Social Determinants of Health, Health Equity, and Human Rights*, *HEALTH & HUM. RTS.*, 2010, at 17, 21-22.

53. IOM FUTURE DIRECTIONS OF NHQR & NHDR, *supra* note 2, at 44 (emphasis added) (internal quotation marks omitted).

54. *Id.*

and economically productive li[ves].”⁵⁵ For the WHO, health equity is a tool to “eliminat[e] disparities in health and in health’s major determinants that are systematically associated with underlying social disadvantage within a society.”⁵⁶ Therefore, a health care system that protects the right to health distributes health care by ensuring “equal access to health care according to need.”⁵⁷

Equality is a global health law concept. The concept of equality is reflected in two human rights instruments. Article 7 of the Universal Declaration of Human Rights and article 26 of the International Covenant for Civil and Political Rights both provide that “all are equal before the law and are entitled without any discrimination to equal protection of the law.”⁵⁸ The meaning of equality is often not defined, but merely viewed as the positive equivalent to non-discrimination, a negative concept.⁵⁹ Scholars like Gillian MacNaughton distinguish equality from discrimination.⁶⁰ More specifically, positive equality re-

55. GIAN LUCA BURCI & CLAUDE-HENRI VIGNES, WORLD HEALTH ORGANIZATION 162 (2004) (internal quotation marks omitted). The “Health for All” agenda began in 1977 through passage of a world health resolution. *See id.*

56. WHO, *25 Questions & Answers on Health and Human Rights*, HEALTH & HUM. RTS. PUBL’N SERIES, 2002, at 24, available at http://www.who.int/hhr/activities/en/25_questions_hhr.pdf. “[E]quity in health can be defined as the absence of systematic disparities in health . . . between social groups who have different levels of underlying social advantage/disadvantage.” P. Braveman & S. Ruskin, *Defining Equity in Health*, 57 J. EPIDEMIOLOGY & COMMUNITY HEALTH 254 (2003). Health equity can be assessed at the local, national, and global level.

57. RTH-*Strengthening Health Systems Report*, *supra* note 45, ¶ 43 (internal quotation marks omitted).

58. UDHR, *supra* note 16; International Covenant on Civil and Political Rights, art. 26, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR]. The preamble to ICERD incorporates the language from the UDHR that all are equal before the law. ICERD, *supra* note 28, pmbl.

59. Gillian MacNaughton, *Untangling Equality and Non-Discrimination to Promote the Right to Health Care for All*, 11 HEALTH & HUM. RTS. 47, 47–48 (2009). Non-discrimination is viewed as the negative form of equality because it prohibits different treatment based on expressly stated grounds. *Id.* For example, both the UDHR and ICCPR have separate non-discrimination provisions that identify prohibited distinctions that impair the exercise of covenant rights. *Id.* at 49–50. Article 2 of the UDHR and article 2 of ICCPR both guarantee to individuals the rights under the declaration or covenant “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.” UDHR, *supra* note 16, art. 2; ICCPR, *supra* note 58, art. 2.

60. While the exact meaning of non-discrimination, equality before the law, and equal protection of the law is not clear under UDHR and ICCPR, it is clear that the drafters of UDHR and ICCPR viewed them as distinct concepts. MacNaughton, *supra* note 59, at 47-48, 50. See also General Comment 18 of the ICCPR, which recognizes three protections by stating, “[a]rticle 26 not only entitles all persons to equality before the law as well as equal protection of the law but also prohibits any discrimination under the law” U.N. High Comm’r for Human Rights, General Comment No. 18: Non-Discrimination, U.N. Doc. HRI/GEN/1/Rev.6 (Nov. 10, 1989) [hereinafter General Comment 18]. General Comment No. 18 further clarifies the distinction between the concepts of equality and non-discrimination by noting that “article 26 [equality] does not merely duplicate the guarantee already provided for in article 2 [discrimination] but provides in itself an autonomous right.” General Comment 18, ¶ 12; MacNaughton, *supra* note 59, at 51.

quires “that everyone be treated in the same manner unless some alternative justification is provided.”⁶¹ For health systems, the U.N. Special Rapporteur for Health interprets this to mean that the health system offers the same health facilities, goods, and services to all.⁶²

Non-discrimination is also a global health law concept. Several treaties prohibit discrimination.⁶³ ICERD prohibits racial discrimination.⁶⁴ Racial discrimination is any distinction, exclusion, restriction, or preference based on prohibited grounds (race, color, descent, and national or ethnic origin) with the intent or effect of impairing the enjoyment of a covenant right.⁶⁵ This means that countries like the United States, which provide public health and medical care services, must do so in a non-discriminatory manner. Moreover, ICESCR—which protects the right to health in article 12—also provides that such treaty rights will be provided “without discrimination of any kind as to race, colour, . . . language, . . . or other status.”⁶⁶ Thus, “health facilities, goods, and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination”⁶⁷ based on prohibited grounds. Ensuring access to the most vulnerable or marginalized sections of the population, such as ethnic minorities and indigenous people, includes “outreach and other programmes to ensure that disadvantaged indi-

61. MacNaughton, *supra* note 59, at 47.

62. RTH-*Strengthening Health Systems Report*, *supra* note 45, at 11.

63. Only four human rights treaties explicitly define discrimination: ICERD, CEDAW, ILO Convention Concerning Discrimination in Respect of Employment and Occupation, and UNESCO Convention Against Discrimination in Education (1960). Anne F. Bayefsky, *The Principle of Equality or Non-Discrimination in International Law*, 11 HUM. RTS. J. 1, 8 (1990).

64. ICERD, *supra* note 28, art. 1.

65. *Id.*

66. ICESCR, *supra* note 24, art. 2. The text of ICESCR does not define non-discrimination. However, the Committee on Economic Social and Cultural Rights adopted the non-discrimination language from ICERD in General Comment 20. U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights), ¶ 7, U.N. Doc. E/C.12/GC/20 (July 2, 2009) [hereinafter General Comment 20].

67. General Comment 14, *supra* note 23, ¶ 12(b). General Comment 14 addresses non-discrimination in several other provisions. Paragraph 43 provides that countries have a core obligation to ensure that access to health facilities, goods, and services are provided in a non-discriminatory way. *Id.* ¶ 43(a). This means that countries must immediately implement this protection instead of progressively incorporating the right over time. Additionally, in a section entitled, “Non-discrimination and equal treatment,” countries are reminded that ICESCR prohibits “discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement on the grounds of race, colour, . . . language, national or social origin, . . . social or other status” *Id.* ¶ 18.

viduals and groups have the same access as those who are more advantaged.”⁶⁸

2. Factor 7—Medical Care and Underlying Determinants

The right to health is a broad concept. It includes medical care and the underlying determinants of health.⁶⁹ Public health and societal factors constitute underlying determinants of health.⁷⁰ Public health is what a society does to improve population health.⁷¹ It includes conditions that impact population health like access to nutritious food, housing, safe working conditions, and a healthy environment.⁷² Societal factors include statuses that result in exclusion such as gender, race, poverty, etc.

If a country wants to improve the health of its citizens, it must not only provide medical care, but it must address public health. In 2010, the Institute of Medicine reiterated the importance of the United States in focusing its resources and efforts on improving public health

68. RTH-*Strengthening Health Systems Report*, *supra* note 45, at 11. Taking affirmative or outreach measures to ensure that vulnerable or marginalized groups like racial and ethnic people of color have access to care is also consistent with ICERD’s provision authorizing States to take special measures to protect racial groups’ rights to public health or medical care. ICERD, *supra* note 28, art. 2(2).

69. See *supra* Part II.A; PPACA, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029; RTH-*Strengthening Health Systems Report*, *supra* note 45, ¶ 45.

70. RTH-*Strengthening Health Systems Report*, *supra* note 45, ¶ 45. More specifically, “[s]ocial determinants of health refers to the social conditions, in which people are born, grow, live, work, and age, that shape their health and disease exposures, vulnerabilities and outcomes.” WHO, PUTTING OUR OWN HOUSE IN ORDER: EXAMPLES OF HEALTH-SYSTEM ACTION ON SOCIALLY DETERMINED HEALTH INEQUALITIES, at xi (2010). The phrase underlying determinants of health, broadly interpreted, is equivalent to the phrase social determinants of health. This Article adopts that broader view, as does the RTH-*Strengthening Health Systems Report* of the Special Rapporteur for Health and General Comment 14. General Comment 14 adopts a broader view when considered in its totality by mentioning underlying determinants of health while simultaneously emphasizing the need for equal access to all and prohibiting discrimination and distinctions based on race, poverty, gender, etc. General Comment 14, *supra* note 23, ¶¶ 4, 10, 12, 18, 19. Paragraph 10 explicitly notes the broader meaning of determinants of health to include, for example, resource distribution and gender exclusion. The benefit of a broad interpretation of underlying determinants of health or social determinants of health is that it links injustice and inequalities with social structures that affect opportunities economically, culturally, and socially. Chapman, *supra* note 52, at 21. Social determinants of health is discussed more fully *infra* Part I.D.

71. Gwendolyn Roberts Majette, *PPACA and Public Health: Creating a Framework to Focus on Prevention and Wellness and Improve the Public’s Health*, 39 J.L. MED. & ETHICS 366, 366 (2011) (providing an insider’s perspective on Congress’s approach to public health during the drafting of the PPACA and analysis of how PPACA shifts the U.S. health care system to focus on prevention, wellness, and public health consistent with IOM and human rights norms) [hereinafter *PPACA and Public Health*].

72. General Comment 14, *supra* note 23, ¶ 4; RTH-*Strengthening Health Systems Report*, *supra* note 45, ¶ 45.

through increased attention on preventing disease and promoting health, and not solely focusing on improving the efficiency and effectiveness of clinical care.⁷³ Health care systems that effectively protect the right to health integrate medical care and public health and are accessible to all.⁷⁴ This integrated approach requires governments to look at the interrelationship between the right to health and other protected human rights like the rights to housing, education, human dignity, non-discrimination, and equality.⁷⁵

3. Factor 10–Quality

An essential element of the right to health is quality.⁷⁶ Health facilities, goods, and services must be scientifically and medically appropriate and of good quality,⁷⁷ which “requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs,⁷⁸ [safe and adequate] hospital equipment, safe and potable water, and adequate sanitation.”⁷⁹ Good quality care also governs how patients are treated.⁸⁰ Patients should be treated with politeness and respect, and not be subjected to the biases of health care providers.⁸¹

73. INST. OF MED., COMM. ON PUB. HEALTH STRATEGIES TO IMPROVE HEALTH, FOR THE PUBLIC’S HEALTH: THE ROLE OF MEASUREMENT IN ACTION AND ACCOUNTABILITY 2 (2011); *PPACA and Public Health*, *supra* note 71, at 367. Majette also recognizes the need for the United States to discontinue its past practice of spending a disproportionate amount of its health care spending on medical care (ninety-six percent) compared to prevention (four percent). *Id.* at 376 n.17.

74. ECOSOC Special Rapporteur Report, *supra* note 16, ¶ 4. For an analysis of how the Patient Protection and Affordable Care Act helps the United States to integrate its medical care and public health systems, see Lorian E. Hardcastle, Katherine L. Record, Peter D. Jacobson & Lawrence O. Gostin, *Improving the Population’s Health: The Affordable Care Act and the Importance of Integration*, 39 J.L. MED. & ETHICS 317, 317 (2011).

75. General Comment 14, *supra* note 23, ¶ 3 (noting the dependency of the right to health on the “realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibitions against torture, privacy, access to information, and the freedoms of association, assembly and movement.”).

76. *Id.* ¶ 12(d).

77. *Id.*

78. Health care systems should have a regulatory system that tests for “substandard, counterfeit, or contaminated drugs.” U.N. Gen. Assembly, *The Right of Everyone to Enjoy the Highest Attainable Standard of Physical and Mental Health*, 15, U.N. Doc. A/58/427 (Oct. 10, 2003).

79. General Comment 14, *supra* note 23, ¶ 12(d); see World Health Org. & the United Nations Human Rights Council, *Human Rights, Health and Poverty Reduction Strategies*, HEALTH & HUM. RTS. PUBL’N SERIES, Dec. 2008, at 23.

80. RTH-*Strengthening Health Systems Report*, *supra* note 45, ¶ 54.

81. *Id.* WHO, *WHO’s Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Health and Freedom from Discrimination*, HEALTH & HUM. RTS. PUBL’N SERIES, Aug. 2001, at 9.

Domestically, the Institute of Medicine defines quality of health-care as “the degree to which health services for individuals and populations increase the likelihood of desired healthcare outcomes and are consistent with current professional knowledge.”⁸² Quality healthcare is safe, effective, patient-centered, timely, efficient, and *accessible*.⁸³ Equity is a cross-cutting theme that applies to every aspect of quality assessment.⁸⁴ Quality health care is “doing the right thing for the right patient, at the right time, in the right way to achieve the best possible results.”⁸⁵ Moreover, quality health care “is based on scientific and medical evidence, it takes the specific details of a patient’s life into consideration, and it is aimed at improving the health and life of the patient being treated.”⁸⁶

According to the 2010 National Healthcare Quality Report and the National Healthcare Disparities Report, the quality of care and access to care is “suboptimal” in the United States, “especially for minority and low-income populations.”⁸⁷ Additionally, while “quality is improving; access and disparities are not improving.”⁸⁸

82. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM, A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 232 (2001) [hereinafter CROSSING THE QUALITY CHASM].

83. Safe health care does not harm the patient. Effective care is based on scientific knowledge. Patient-centered health care responds to patient preferences and values. Timely care is delivered in a manner to reduce wait times and delays. Efficient care avoids waste. CROSSING THE QUALITY CHASM, *supra* note 82, at 6, 232. Accessible care is “the timely use of personal health services to achieve the best possible health outcomes.” IOM FUTURE DIRECTIONS OF NHQR & NHDR, *supra* note 2, at 46.

84. Equitable care does not vary because of gender, ethnicity, geography, or socio-economic status. CROSSING THE QUALITY CHASM, *supra* note 82, at 6. In 2011, the IOM expanded the concept of equity to apply across every dimension of quality assessment. IOM FUTURE DIRECTIONS OF NHQR & NHDR, *supra* note 2, at 41-42.

85. NAT’L COMM. FOR QUALITY ASSURANCE, THE ESSENTIAL GUIDE TO HEALTH CARE QUALITY 8, available at http://www.ncqa.org/Portals/0/Publications/Resource%20Library/NCQA_Primer_web.pdf. [hereinafter ESSENTIAL GUIDE TO QUALITY].

86. *Id.*

87. U.S. DEP’T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, 2010 NATIONAL HEALTHCARE DISPARITIES REPORT 2 (2011) [hereinafter AHRQ, NHDR]. This is not the first time that the quality of care generally provided in the United States has been found deficient and barriers to access to care have been identified. The IOM published two seminal reports on quality, TO ERR IS HUMAN (2000) and CROSSING THE QUALITY CHASM (2001). INST. OF MED., COMM. ON QUALITY OF HEALTH CARE IN AM., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (2000); CROSSING THE QUALITY CHASM, *supra* note 82. It also published a seminal report on access barriers for people of color in 2003. IOM, UNEQUAL TREATMENT, *supra* note 2.

88. AHRQ, NHDR, *supra* note 87, at 2. AHRQ’s definition of disparity used in the NHDR differs from the IOM definition provided in IOM Future Directions of the National Healthcare Quality and Disparities Report. IOM, FUTURE DIRECTIONS OF NHQR & NHDR, *supra* note 2, at 44. AHRQ’s definition is a broader concept that focuses on “simple differences.” *Id.*

In the United States, at the federal level, there are five major areas of health care quality initiatives: (1) research, (2) quality measure development, (3) quality data collection and reporting, (4) patient safety improvement, and (5) implementation of health information technology.⁸⁹ The IOM recently identified eight priority areas for quality improvement in the United States.⁹⁰ One of those priorities is “ensur[ing] that care is accessible and affordable for all segments of the U.S. population.”⁹¹ For all eight priority areas, there were “disparities related to race, ethnicity, and socio-economic status.”⁹²

D. Global Health Governance—Commission on Social Determinants of Health

A global infrastructure has been created to advance social determinants of health as a basis to improve health and lower health inequity worldwide. The catalyst for the creation of this infrastructure was the Commission on Social Determinants of Health (SDH Commission).⁹³ The Commission was created in 2005 by the Director General of the WHO, Dr. J.W. Lee.⁹⁴ It was chaired by Dr. Michael Marmot, a pioneer known for his work on the impact of social inequity on health.⁹⁵ The vision of the SDH Commission was to establish a global movement to address health equity.⁹⁶ A task of the SDH Commission

89. See generally *New Frontiers in Quality Initiatives: Hearing Before the Subcomm. on Health of the H. Comm. on Ways and Means, 108th Cong. 9-19 (2004)* (statement of Carolyn M. Clancy, M.D.) (outlining some federal health care quality initiatives).

90. IOM, *FUTURE DIRECTIONS OF NHQR AND NHDR*, *supra* note 2, at 34. The priority areas are improving patient and family engagement, population health, safety, care coordination, palliative care, and access to care for all. *Id.* It also includes improving the capabilities of the infrastructure of health systems to support quality care and eliminating overuse of services. *Id.*

91. *Id.* As of 2011, two priority areas were improving (palliative care and patient and family engagement); two needed more data (health system infrastructure and care coordination); and three were lagging (access, population health, and safety). AHRQ, *NHDR*, *supra* note 87, at 2.

92. *Id.*

93. See Ruth Bell, Sebastian Taylor, & Michael Marmot, *Global Health Governance: Commission on Social Determinants of Health and the Imperative for Change*, 38 J.L. MED. & ETHICS 470, 476 (2010) [hereinafter Marmot, *GHG-Comm'n SDH*]. The term “social” as used in the commission’s name is used in its broadest sense to include environmental, economic, political, and cultural conditions. *Id.*

94. *Id.*

95. Chapman, *supra* note 52, at 18. Dr. Marmot is a Professor of Epidemiology and Public Health and the head of the Department of Epidemiology and Public Health at University College London. Marmot, *GHG-Comm'n SDH*, *supra* note 93, at 470. After serving as Chair of the Commission on Social Determinants of Health, he chaired the Review of Health Inequalities in England. *Id.*

96. Marmot, *GHG-Comm'n SDH*, *supra* note 93, at 475.

was to shift global health from a biomedical model to a social model, which includes social and political conditions.⁹⁷ This shift is important because it recognizes the social gradient in health: “the lower the position in the social hierarchy, the worse the health.”⁹⁸

While the SDH Commission was an initiative of the WHO, it was created as a separate independent organization with twenty commissioners.⁹⁹ The role of the commissioners was to serve as champions of health equity in their own countries, regionally, and globally.¹⁰⁰ The SDH Commission had a four-part structure that focused on knowledge, action, leadership, and advocacy.¹⁰¹ Its core operational elements included subject matter work groups,¹⁰² country partners,¹⁰³ civil society partners, the WHO, and the Commissioners.¹⁰⁴

1. Closing the Gap in a Generation—Recommendations from the SDH Commission’s Final Report

The SDH Commission made three specific recommendations, but could not prioritize them because of the different social, economic, and political needs of countries.¹⁰⁵ One of the recommendations requires countries to improve the daily living conditions of individuals.¹⁰⁶ For health systems, they should provide universal coverage.¹⁰⁷

97. *See id.*

98. *Id.* at 472. Income inequality can adversely affect social conditions that are important for good health. *See* Marmot & Bell, *supra* note 6, at 1170. Among Organization for Economic Co-operation and Development (OECD) countries, the United States has the third highest poverty rate and the fourth highest disposable income inequality. *Id.*

99. *See* Marmot, *GHG-Comm’n SDH*, *supra* note 93, at 476; Chapman, *supra* note 52, at 18. The commission was composed of a diverse group that included “former heads of government, former and current government ministers, national policy makers and international advisors, leaders in international organizations and civil society, and eminent academics.” Marmot, *GHG-Comm’n SDH*, *supra* note 93, at 476.

100. *Id.*

101. *Id.*

102. The formal name of this component is “knowledge networks.” Chapman, *supra* note 52, at 18 (internal quotation marks omitted). The knowledge networks addressed nine topics: “globalization, early childhood development, employment conditions, women and gender equity, social exclusion, health systems, priority public health conditions, urban settings, and measurement and evidence.” *Id.*; Marmot, *GHG-Comm’n SDH*, *supra* note 93, at 476.

103. These countries were the first to implement the ideas of and share their experience with the commission on taking action through initiatives on social determinants of health. *See* Marmot, *GHG-Comm’n SDH*, *supra* note 93, at 477. There were eight country partners: England, Sweden, Canada, Brazil, Chile, Iran, Sri Lanka, and Kenya. *Id.*

104. *Id.* at 476.

105. *See id.* at 477.

106. *See* WHO, Comm’n. on Soc. Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, at 202 (2008) [hereinafter Comm’n, *SDH Final Report*]; WHO, *Commission on Social Determinants of Health: Report by the Secretariat*, ¶ 10 (Mar. 16, 2009) [hereinafter *Comm’n SDH Secretariat Report*]. Conditions

Creation of a system with universal coverage should be a priority issue and an action item. The core values of the system should be equity, disease prevention, and health promotion.¹⁰⁸ Quality care should be provided, and equitable financing mechanisms should be employed to ensure that care is provided regardless of the ability to pay.¹⁰⁹

Second, countries must tackle inequitable distribution of power, money, and resources, which constitute the structural drivers of health.¹¹⁰ Countries should include health equity in all policies, systems, and programs.¹¹¹ This can be done by including a health equity impact assessment in all policies.¹¹² Third, countries should measure and understand the problem and assess the impact of action.¹¹³ This means countries must engage in health equity surveillance.¹¹⁴

From a governance perspective, governments must make health equity a priority at the global, national, and local levels.¹¹⁵ The health sector must include social determinants in policy matters.¹¹⁶ Health must be approached from a multi-sectoral point of view. This means that all parts of society will address health, reflecting “health-in-all” policies.¹¹⁷

2. SDH Commissioners’ Advice to the United States on How to Reduce Health Disparities

It is critical that the United States invests significantly in addressing social determinants of health to improve population health and reduce health care disparities. Four SDH commissioners have recom-

of daily living encompasses where people are born, grow, live, work and age. Thus early childhood development should be emphasized; environments should be healthy; work should be available, provide equal pay, and be safe; and social protections that support sufficient income levels should be provided. Comm’n, *SDH Final Report*, *supra*, at 202-03.

107. Comm’n, *SDH Final Report*, *supra* note 106, at 203; *Comm’n SDH Secretariat Report*, *supra* note 106, ¶¶ 10,11(f).

108. *See* Comm’n, *SDH Final Report*, *supra* note 106, at 203.

109. *Id.*

110. *See id.* at 43, 204; *Comm’n SDH Secretariat Report*, *supra* note 106, ¶¶ 10, 11(f).

111. Comm’n, *SDH Final Report*, *supra* note 106, at 204; *Comm’n SDH Secretariat Report*, *supra* note 106, ¶ 12(b).

112. *See* Marmot, *GHG-Comm’n SDH*, *supra* note 93, at 477; Comm’n, *SDH Final Report*, *supra* note 106, at 204.

113. *See* Comm’n, *SDH Final Report*, *supra* note 106, at 206; *Comm’n SDH Secretariat Report*, *supra* note 106, ¶¶ 10, 13.

114. *See* Comm’n, *SDH Final Report*, *supra* note 106, at 206; *Comm’n SDH Secretariat Report*, *supra* note 106, ¶ 13.

115. *See* Marmot, *GHG-Comm’n SDH*, *supra* note 93, at 477; *Comm’n SDH Secretariat Report*, *supra* note 106, ¶ 12(a).

116. *See* *Comm’n SDH Secretariat Report*, *supra* note 106, ¶ 12(b).

117. *Id.* ¶ 14; *see* Marmot, *GHG-Comm’n SDH*, *supra* note 93, at 477-78.

mended that the United States incorporates social determinants of health in its policy and legislation that impact health. The former Chair of the SDH Commission, Michael Marmot, and Dr. Ruth Bell, another commissioner, recommended that the United States improve population health, without spending more money on health, by focusing on social determinants of health.¹¹⁸ Throughout the world, for everyone below the top socio-economic position, health inequities exist.¹¹⁹ But these inequities can be reduced through political, social, and economic changes.¹²⁰

SDH Commissioners Marmot and Bell provided three recommendations on how the United States could improve population health in light of the work of the SDH Commission. First, health equity must be a key performance indicator for social and economic policy.¹²¹ Second, working on social and economic policy to address health inequity must be a priority at the highest level of government.¹²² Third, communities across the United States should work on health inequity.¹²³ Commissioners Marmot and Bell also made recommendations on how the United States could help reduce health inequalities worldwide. The United States should take a leadership role in ensuring that the “international community recommit[s] to a more representative multilateral system with fairer participation by all countries and the opportunity to place health equity at the heart of multilateral policy development in areas including trade, finance, responses to climate change, and international security.”¹²⁴

In 2009, two American SDH commissioners, David Satcher, a former Surgeon General, and Gail Wilensky, a former administrator of the Health Care Financing Administration, urged adoption of a health improvement agenda that included addressing social determi-

118. Marmot & Bell, *supra* note 6, at 1171.

119. *See id.* at 1170. Health inequities and disparities exist between countries and within countries. *See id.* at 1169. Life expectancy in Japan is 82.4 years compared to Zambia, which is 41.2 years. *Id.* In life expectancy from birth to age 65, the United States ranks 36th for men and 42nd for women. *Id.* The gap in life expectancy between the most advantaged and least advantaged in the United States is 20 years. Michael Marmot, *Social Determinants of Health Inequalities*, 365 LANCET 1099, 1099 (2005). The gradient for life expectancy by socioeconomic deprivation in the United States has worsened for men and women since 1980. Marmot & Bell, *supra* note 6, at 1170. When comparing illness rates and life expectancy of the United States to England, the United States has a higher rate of illness and shorter life expectancy. *Id.* at 1169.

120. *See* Marmot & Bell, *supra* note 6, at 1170.

121. *See id.* at 1171.

122. *See id.*

123. *See id.*

124. *Id.* (internal quotation marks omitted).

nants of health as part of any national health care reform legislation.¹²⁵ They also acknowledged that this approach would likely be far less costly than addressing problems with the health care system.¹²⁶ Commissioners Satcher and Wilensky highlighted the importance of addressing social determinants of health for children and the impact of determinants throughout the child's life. Attention should be paid to childhood development and education, nutrition, the provision of safe and nurturing environments, reduction of substance abuse (including smoking) by young people and pregnant women, and ensuring access to health care (i.e. enrolling in Medicaid or the Children's Health Insurance Program).¹²⁷

E. World Health Organization Initiatives and Resolution on Social Determinants of Health

In addition to helping to create the SDH Commission, WHO took important steps to continue to advance the work on social determinants of health. First, through its strategic plan for 2008-2013, WHO incorporated initiatives to work on social determinants of health.¹²⁸ Thus, its policies and programs would address social determinants of health. It would focus on health equity and approaches that were (1) pro-poor, (2) gender responsive, and (3) human rights focused.¹²⁹ Second, WHO made a commitment to support member states working on social determinants of health by monitoring and developing policies to improve health and lower health inequities.¹³⁰ It also developed partnerships with the United Nations, civil society, and the private sector to improve health and lower health inequities.¹³¹ Third, the World Health Assembly in May 2009 passed a resolution to support action on social determinants of health as a means to reduce

125. *PPACA and Public Health*, *supra* note 71, at 371-72 (describing Dr. Satcher's testimony before the United States Congress on the impact of social determinants of health on population health and the need to adopt a public health approach that includes social determinants of health as part of health care reform legislation); Gail R. Wilensky & David Satcher, *Don't Forget About the Social Determinants of Health*, 28 HEALTH AFF. 2, w194, w194-95, w198 (2009).

126. Wilensky & Satcher, *supra* note 125, at w195.

127. *See id.* at w195-97.

128. Marmot, *GHG-Comm'n SDH*, *supra* note 93, at 477.

129. *Id.*

130. *See id.*; WHO-EUROPE, *Putting Our Own House in Order: Examples of Health-System Action on Socially Determined Health Inequalities*, at 2 (2010), available at http://www.euro.who.int/_data/assets/pdf_file/0004/127318/e94476.pdf.

131. Marmot, *GHG-Comm'n SDH*, *supra* note 93, at 477. The SDH-Commission also recommended that WHO be strengthened so that it could be a leader in global health work with other multilateral agencies. *Id.* at 479.

health inequity.¹³² The resolution included a request to the Director-General to convene a global event in order to discuss future plans to address social determinants of health and report on the progress of social determinants of health at the World Health Assembly in 2012.¹³³

II. CREATING A LEGISLATIVE FRAMEWORK TO PROTECT THE RIGHT TO HEALTH AND ELIMINATE HEALTH DISPARITIES

A. General Comment 14 Urges Governments to Protect the Right to Health Through Policy and Legislative Mechanisms

Pursuant to General Comment 14, governments that have ratified ICESCR must implement a national strategy to ensure that everyone has access to health care facilities, goods, and services.¹³⁴ This strategy should be based on human rights principles and include benchmarks and indicators to monitor progress (or access).¹³⁵ It should also include identification of the available resources to execute the strategy.¹³⁶ Once the strategy is created, governments are encouraged to “adopt [] a framework law to operationalize” it.¹³⁷

In recognition that the government alone cannot protect the health of its population, the government is encouraged to make the private business sector and civil society aware of the importance of the right to health.¹³⁸ The government should also identify potential areas of collaboration with civil society, the private sector, and international organizations.¹³⁹

132. WHO, World Health Assembly, *Reducing Health Inequities Through Action on Social Determinants of Health*, Res. 62.14 62d Sess., WHA Doc. A62/VR8 (May 22, 2009) [hereinafter WHO, *SDH Resolution*]; Marmot, *GHG-Comm'n SDH*, *supra* note 93, at 481-82. The resolution provided that WHO would work with other multilateral agencies to develop measures and to promote policy coherence to reduce health inequity. *Id.* at 482. WHO would also strengthen its internal capacity to work on SDH. *See* WHO, *SDH Resolution*, *supra*, ¶ 4(2). The SDH Commission also made a recommendation that WHO “institutionalize social determinants of health as guiding principle across WHO departments and country programs.” Marmot, *GHG-Comm'n SDH*, *supra* note 93, at 480.

133. *See* WHO, *SDH Resolution*, *supra* note 132, ¶¶ 4(11), 4(13); Marmot, *GHG-Comm'n SDH*, *supra* note 93, at 482.

134. *See* General Comment 14, *supra* note 23, ¶ 53.

135. *See id.*

136. *See id.*

137. *Id.* ¶ 56. Like the national right to health strategy, the framework law should also establish a national monitoring mechanism, which contains targets, timeframes, means, and collaborative opportunities with non-governmental entities. *Id.*

138. *Id.* ¶ 55.

139. *Id.* ¶ 56.

According to Professor Eleanor Kinney, the right to health is not protected in the United States pursuant to an international obligation.¹⁴⁰ As discussed previously, the U.S. has not ratified ICESCR, the seminal treaty creating a human right to health.¹⁴¹ Instead the right to health, to the extent it exists, is protected through a legislative infrastructure created pursuant to federal and state law.¹⁴² This legislative infrastructure includes: (1) legislation that finances health care services to certain vulnerable groups through Medicare, Medicaid, and CHIP; (2) federal and state legislation that regulates private insurance to protect consumer interest (ERISA, HIPPA, state benefit mandates); (3) legislation that provides health care services to covered groups; (4) legislation that protects and promotes public health (public health reporting laws); and (5) legislation that prohibits discrimination in access to health care services (Title VI and the ADA).¹⁴³ The PPACA furthers this legislative focus.

B. Patient Protection and Affordable Care Act's Legislative Framework to Reduce Health Disparities Among People of Color

1. PPACA Makes Health and Health Inequity Priority Issues

PPACA creates a legislative framework that protects the right to health¹⁴⁴ and helps reduce health care disparities for people of color in the United States. PPACA adheres to global health law norms, specifically the SDH Commission, by making health and health inequity priority issues at the highest levels of government. Section 10334 of PPACA elevates these issues through structural changes and accountability mechanisms. First, the Office of Minority Health (OMH) is

140. Kinney, *Recognition of RTH in the U.S.*, *supra* note 22, at 348.

141. *See supra* Part I.A.

142. *See* Kinney, *Recognition of RTH in the U.S.*, *supra* note 22, 364-65.

143. Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World*, 34 *IND. L. REV.* 1457 (2001).

144. In another piece presented at the 34th Annual Health Law Professors Conference, I argue that PPACA creates a new governance architecture that protects the right to health even in the absence of an international obligation to do so. That piece uses a 2008 report of the United Nations Special Rapporteur for Health on factors countries can use to strengthen their health care systems to protect the right to health to identify the new governance architecture. Gwendolyn R. Majette, Presentation at the Loyola University Chicago School of Law 34th Annual Health Law Professors Conference: Coherency Within the Patient Protection and Affordable Care Act: A Framework to Create A Health Care System that Protects the Human Right to Health (manuscript on file with the author); *see also* Lance Gable, *The Patient Protection and Affordable Care Act, Public Health, and the Elusive Target of Human Rights*, 39 *J.L. MED & ETHICS* 340 (2011) (“[The PPACA] represents a significant turning point in the evolution of health care law and policy in the United States.”).

moved from the Office of Public Health and Science to the Office of the Secretary.¹⁴⁵ The office will be led by the Deputy Assistant Secretary for Minority Health who reports directly to the Secretary of Health and Human Services.¹⁴⁶ The office is tasked with improving minority health, improving the quality of care for minorities, and eliminating racial and ethnic health disparities.¹⁴⁷ Second, six offices of minority health are created within agencies of the Department of Health and Human Services.¹⁴⁸ Offices are created within the Center for Medicare and Medicaid Services (CMS), the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the Health Resources Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Agency for Healthcare Research and Quality (AHRQ).¹⁴⁹ The Director of each of the OMH offices reports to the head of the agency.¹⁵⁰ The final structural change is the elevation of the National Center on Minority Health and Health Disparities at the National Institutes of Health to a National Institute on Minority Health and Health Disparities.¹⁵¹ The Institute shall “plan, coordinate, review and evaluate research and other activities conducted or supported by” the National Institutes of Health on Minority Health and Health Disparities.¹⁵²

PPACA provides for an accountability mechanism by requiring the Secretary of Health and Human Services to provide reports to the United States Congress.¹⁵³ The Secretary must submit the reports on a biannual basis to the congressional committees with jurisdiction over health.¹⁵⁴ The biannual report is based on the reports that each agency head must biannually file with the Deputy Assistant Secretary for Minority Health on its “minority health activities.”¹⁵⁵

Health and health inequity are also prioritized at the highest level of government by the creation of the first department-wide strategic plan to reduce health disparities. In November 2010, the Secretary of

145. PPACA, Pub. L. No. 111-148, § 10334(a), 124 Stat. 119, 971 (2010).

146. *Id.*

147. *Id.*

148. *See id.* § 10334(b)(1)(a).

149. *Id.* § 10334(b)(1)(b).

150. *See id.* § 10334(b)(1)(a).

151. *See id.* § 10334(c)(1)(ii).

152. *Id.* § 10334(c)(2)(C).

153. *See id.* § 10334(a)(1)(A).

154. *Id.* § 10334(a)(3).

155. *See id.*

Health and Human Services charged the agency with developing a plan to reduce disparities.¹⁵⁶ The Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities was released in April 2011.¹⁵⁷ It “outlines the goals and actions [that] HHS will take to reduce health disparities among racial and ethnic minorities.”¹⁵⁸

The plan’s vision is “a nation free of disparities in health and health care.”¹⁵⁹ The plan is based upon the Secretary’s five goals for the department: “(I) Transform health care; (II) Strengthen the nation’s Health and Human Services infrastructure and workforce; (III) Advance the health, safety and well-being of the American people; (IV) Advance scientific knowledge and innovation; and (V) Increase the efficiency, transparency, and accountability of HHS programs.”¹⁶⁰

Each goal is supported by specific strategies necessary to its achievement. An important strategy to transform the U.S. health care system is the “reduct[ion] of disparities in the quality of health care.”¹⁶¹ As previously discussed in section I(C)(3), the 2010 NHDR concluded that quality of care for racial and ethnic minorities is suboptimal on core indicators for “preventive care, acute treatment, or chronic disease management.”¹⁶² The plan identifies HHS actions that will remove barriers to timely, patient-centered care and use of evidence-based clinical guidelines.¹⁶³ An important strategy designed

156. U.S. DEP’T OF HEALTH & HUMAN SERVS., HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES 11 (2011), available at http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf [hereinafter HHS ACTION PLAN TO REDUCE DISPARITIES].

157. See Press Release, U.S. Dep’t of Health & Human Servs., HHS Announces Plan to Reduce Health Disparities (Apr. 8, 2011), <http://www.minorityhealth.hhs.gov/npa/templates/content.aspx?ID=289> [hereinafter Press Release, HHS Announces Plan to Reduce Health Disparities]; Press Release, U.S. Dep’t of Health & Human Servs., The HHS Action Plan to Reduce Racial and Ethnic Health Disparities (Apr. 4, 2011), available at <http://www.hhs.gov/news/press/2011pres/04/04hdplan04082011.html> (last visited Mar. 24, 2012).

158. Press Release, HHS Announces Plan to Reduce Health Disparities, *supra* note 157.

159. See HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 11.

160. *Id.*

161. *Id.* at 17.

162. See *supra* Part I.C.1; HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 17.

163. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 17. One action item commanded by PPACA section 1311(g) is to improve the quality of care provided in the health insurance exchange through quality improvement strategies. See PPACA, Pub. L. No. 111-148, § 1311(g)(1), 124 Stat. 119, 173 (2010). These strategies can include the use of financial incentives to promote activities to reduce health disparities. *Id.* § 10104 (amending § 1311(g)). PPACA identifies use of language services, community outreach, and cultural competency trainings as mechanisms health plans may use to reduce disparities. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 17. The HHS Plan goes beyond PPACA by identifying additional mechanisms that can be used to reduce disparities in chronic conditions. CMS will be the lead agency working on quality in the exchange and may use additional activities to reduce disparities such as “health education, wellness promotion, and evidence-based approaches to

to advance the health, safety, and well-being of the American people is the “reduc[ti]on of] disparities in population health by increasing the availability and effectiveness of community-based programs and policies.”¹⁶⁴ Consistent with health and human rights norms, the HHS Action Plan to Reduce Disparities includes universal and targeted interventions designed “to close the modifiable gaps in health, longevity, and quality of life [for] racial and ethnic minorities.”¹⁶⁵

The HHS Action Plan to Reduce Disparities will be implemented to achieve the Secretary’s overarching priorities. The plan will ensure that each HHS program and policy is assessed to determine its impact on the reduction of disparities.¹⁶⁶ The availability and quality of data necessary to improve the health of minorities will be increased.¹⁶⁷ Measurements and incentives will be used to improve the quality of care provided to minority populations.¹⁶⁸ The Centers for Medicare and Medicaid Services will play a critical role in setting and reviewing quality improvement incentives and participating in “cross-departmental and inter-agency collaborations between CMS, HRSA, AHRQ, SAMHSA, and the Indian Health Service.”¹⁶⁹ HHS will be

manage chronic conditions.” *Id.* The timeline for implementation is 2011–2014. *Id.* Another important quality strategy to reduce disparities for racial and ethnic minorities is to “[d]evelop, implement, and evaluate interventions to prevent cardiovascular diseases and their risk factors.” *Id.* at 18. Cardiovascular disease is one of the leading causes of premature death for racial and ethnic minorities. *Id.* The HHS Action Plan notes this initiative is different because it will use multiple efforts to address prevention of cardiovascular disease—such as quality improvement initiatives, reimbursement incentives, and collaborations with minority and other providers serving minority populations. *See id.*

164. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 25. This goal focuses on “[c]reating environments that promote healthy behaviors to prevent and control chronic diseases and their risk factors.” *Id.* While the focus is population health, it also targets interventions to vulnerable populations, racial and ethnic minorities. *See id.* This goal also includes initiatives that address social determinants of health. *See id.* HHS will “[i]ncrease education programs, social support and home-visiting programs to improve prenatal, early childhood, and maternal health.” *Id.* at 26. The Agency for Children and Families and HRSA will lead this action beginning in 2011. *Id.*

165. *Id.* at 25.

166. *Id.* at 12.

167. *Id.*

168. *Id.* at 13.

169. *Id.* Improving the quality of care for vulnerable populations requires setting incentives and monitoring chronic disease burdens unique to racial and ethnic minorities such as heart attacks, renal failure, stroke, hypertension and diabetes. The Centers for Medicare and Medicaid Services (CMS) will also review existing measures including hospital value-based purchasing, hospital and home health compare, and Children’s Health Insurance Program Pediatric Quality Measures. *Id.* Existing health disparities projects will be expanded. *Id.* This includes the “CMS initiative to reduce avoidable hospital admissions for [individuals] dually eligible for Medicare and Medicaid, racial and ethnic analyses of CMS Survey and Claims Data, and Quality Improvement Organization Disparities Special Initiatives.” *Id.*

held accountable through monitoring and evaluative efforts of its success in implementing the plan.¹⁷⁰

2. PPACA Ensures that U.S. Health Policy Addresses Health Disparities and Social Determinants of Health

Consistent with the recommendations of the SDH Commission, PPACA also ensures that government policy regarding the U.S. health sector addresses health disparities and social determinants of health. First, PPACA makes reduction of health disparities a priority issue for the National Strategy for Quality Improvement in Health.¹⁷¹ PPACA requires the creation of a comprehensive¹⁷² national quality strategy “to improve the delivery of health care services, patient . . . outcomes, and population health.”¹⁷³ It must be updated annually.¹⁷⁴ The strategy explicitly addresses health care disparities by making the reduction of health disparities a priority focus of the strategy.¹⁷⁵ It also addresses health disparities by mandating that improvement initiatives, especially those designed to improve “health outcomes, efficiency, and patient-centeredness [focus on] all populations, including . . . vulnerable populations.”¹⁷⁶ When the actual strategy was released on March 21, 2011, it included several broad aims. The first aim establishes the overall purpose of the strategy: “To improve overall quality, by making health care more patient-centered, reliable, accessible, and safe.”¹⁷⁷ The second aim focuses on social determinants of health. The strategy seeks to “improve the health of the U.S. population by supporting . . . interventions” that improve quality of

170. *Id.* at 14.

171. PPACA, Pub. L. No. 111-148, sec. 399HH(a)(1), § 3011, 124 Stat. 119, 378 (2010).

172. PPACA also mandates that the National Quality Strategy coordinate efforts among agencies within HHS; include agency specific goals and benchmarks; include a process for agency reporting to the Secretary; align public and private payer initiatives on quality and patient safety; and address quality initiatives for health information technology. *Id.* sec. 399HH(b)(2), § 3011. The strategy should also reflect consultation with State agencies that operate Medicaid and the Children’s Health Insurance Program. *Id.* sec. 399HH(a)(2)(D), § 3011.

173. *Id.* sec. 399HH(a)(1), § 3011.

174. *Id.* sec. 399HH (a-c), § 3011.

175. *See id.* sec. 399HH (a)(2)(B)(i), § 3011.

176. *Id.* (emphasis added).

177. U.S. DEP’T OF HEALTH & HUM. SERVS., REPORT TO CONGRESS, NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE 1 (2011), available at <http://www.healthcare.gov/law/resources/reports/quality03212011a.html>. The initial National Quality Strategy did not include agency specific information, nor did it contain specific measures and short and long term goals. *Id.* All of this information will be included in the next strategy. *Id.* Additionally, all quality measures selected will be capable of electronic collection. *Id.*

care and “address behavioral, social, and environmental determinants of health.”¹⁷⁸

Second, PPACA creates the National Prevention Strategy, which, like the National Quality Strategy, also focuses on elimination of health disparities and promotes health equity. The National Prevention, Health Promotion, Public Health, and Integrative Health Care Strategy is designed to identify effective means to improve population health and lower preventable illness and disability.¹⁷⁹ According to the first annual report of the council responsible for drafting the strategy, because “vast inequities” exist in the U.S. health system, “specific action and metrics” should be used to monitor and eliminate disparities related to race, ethnicity, and socioeconomic status.¹⁸⁰ Elimination of disparities in traditionally underserved populations is a priority in the conception and final draft of the strategy.¹⁸¹ The National Prevention Strategy also seeks to ensure that the private sector works with the government in accomplishing its goals by acknowledging them as partners in the endeavor.¹⁸² Government collaboration with partners complies with health and human rights norms articulated in General Comment 14.¹⁸³

178. *Id.* (emphasis added). The final broad aim is to “reduce the cost of quality health care.” *Id.*

179. PPACA § 4001(g); *PPACA and Public Health*, *supra* note 71, at 373.

180. See NAT’L PREVENTION, HEALTH PROMOTION & PUB. HEALTH COUNCIL, DEP’T OF HEALTH & HUMAN SERVS., 2010 ANNUAL STATUS REPORT 4 (2010) [hereinafter 2010 ANNUAL STATUS REPORT OF THE PREVENTION COUNCIL], available at <http://www.hhs.gov/news/reports/nationalprevention2010report.pdf>.

181. *PPACA and Public Health*, *supra* note 71, at 373; NAT’L PREVENTION, HEALTH PROMOTION & PUB. HEALTH COUNCIL, DEP’T OF HEALTH AND HUMAN SERVS., DRAFT FRAMEWORK NATIONAL PREVENTION STRATEGY 3 (2011) [hereinafter DRAFT PREVENTION STRATEGY FRAMEWORK]; NAT’L PREVENTION COUNCIL, DEP’T OF HEALTH AND HUMAN SERVS., NATIONAL PREVENTION STRATEGY: AMERICA’S PLAN FOR BETTER HEALTH AND WELLNESS 25 (2011) [hereinafter NATIONAL PREVENTION STRATEGY], available at <http://www.healthcare.gov/prevention/nphpphc/strategy/report.pdf>. The National Prevention Strategy contains five recommendations to eliminate health disparities. First, there should be a “strategic focus on communities at greatest risk.” *Id.* at 25-26. Second, the health care system should be reformed to eliminate disparities in access to quality care. *Id.* at 26. Third, the capacity of the prevention workforce to identify and address disparities must be expanded. *Id.* Fourth, research needs to be increased to identify effective strategies to eliminate health disparities. *Id.* Fifth, data must be standardized and collected to identify and address disparities. *Id.* Two important commitments made by the federal government to advance the Prevention Strategy’s focus on eliminating health disparities include a commitment to “[s]upport and expand cross-sector activities to enhance access to high quality education, jobs, economic opportunity, and opportunities for healthy living.” *Id.* The federal government also commits to “[i]dentify and map high-need areas that experience health disparities and align existing resources to meet these needs.” *Id.*

182. See 2010 ANNUAL STATUS REPORT OF THE PREVENTION COUNCIL, *supra* note 180, at 4; NATIONAL PREVENTION STRATEGY, *supra* note 181, at 9–10.

183. See *supra* Part II.A.

Third, PPACA gives the Community Preventive Services Task Force (CP Task Force) new duties which also focus on the reduction of health disparities and inclusion of social determinants of health. PPACA makes permanent the Community Preventive Services Task Force.¹⁸⁴ The CP Task Force reviews “the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services.”¹⁸⁵ The CP Task Force shall make recommendations and interventions regarding “social, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations.”¹⁸⁶

3. PPACA Adopts a Multi-Sectoral Approach to Health

PPACA also adheres to global health law norms established by recommendations of the SDH Commission by facilitating a multi-sectoral approach to health. A seminal provision that requires non-health governmental agencies to consider the impact of their policies and regulations on health is Section 4001, which creates the National Prevention, Health Promotion and Public Health Council (National Prevention Council).¹⁸⁷ A key responsibility of the National Prevention Council is “to provide leadership on and coordinate public health activities by federal agencies.”¹⁸⁸ The National Prevention Council is composed of health-focused officials, the Surgeon General as Chair, the Secretary of Health and Human Services, and eleven other non-health executive-level leaders like the Secretaries of Agriculture, Education, Transportation, Labor, and Homeland Security.¹⁸⁹ The National Prevention Council is tasked with drafting the National

184. PPACA sec. 4003(b)(1), § 399U(a). The Community Preventive Task Force began in 1996 and operated under the general authority of the Secretary under Title III General Powers and Duties of the Public Health Service. H.R. REP. NO. 111-299, at 704 (2009).

185. PPACA sec. 4003(b)(1), §399U(a)). An example of a community prevention recommendation targeted to a subpopulation to reduce disparities would be to provide “client reminders and small media campaigns promoting breast cancer screening among African-American women” to educate this population of the importance of breast cancer screening to reduce disparities in breast cancer mortality due to late diagnosis. H.R. REP. NO. 111-299, at 705 (2009).

186. PPACA § 4003(b)(1).

187. See *PPACA and Public Health*, *supra* note 71, at 374.

188. *Id.* at 373; PPACA § 4001(g).

189. Other members include the Chairman of the Federal Trade Commission, the Administrator of the Environmental Protection Agency, the Director of the Office of National Drug Control Policy, the Director of the Domestic Policy Council, the Assistant Secretary for Indian Affairs, and the Chairman of the Corporation for National and Community Service. PPACA § 4001(c); *PPACA and Public Health*, *supra* note 71, at 373.

Prevention, Health Promotion, Public Health, and Integrative Health Care Strategy and “provid[ing] recommendations to the President and Congress concerning the most pressing health issues confronting the United States.”¹⁹⁰

Like the National Prevention Council, the Interagency Working Group on Health Care Quality (Interagency Working Group on Quality) exemplifies a multi-sectoral approach to health at the highest level of government. This working group is convened at the request of the President, chaired by the Secretary of Health, and composed of senior agency officials.¹⁹¹ The Interagency Working Group on Quality was created to ensure collaboration, cooperation, and consultation between federal agencies on quality improvement initiatives; to avoid duplication; to streamline quality reporting and compliance; and to align public and private sector quality initiatives.¹⁹² The activities of the working group must adhere to national improvement priorities such as improving the health outcomes, efficiency, and patient-centeredness for vulnerable populations and reduce health disparities across health disparity populations.¹⁹³

Another multi-sectoral approach to health issues is reflected in the Federal Interagency Health Equity Team (FIHET). The work of this existing team is enhanced by passage of the PPACA. FIHET was created by the Office of Minority Health to guide development of the National Stakeholders Strategy for Achieving Health Equity and implement the National Partnership for Action to End Health Disparities.¹⁹⁴ Its vision is “to attain the highest level of health for racial and

190. PPACA § 4001; *PPACA and Public Health*, *supra* note 71, at 373-74.

191. PPACA § 3012(c). The Working Group on Quality is composed of senior level officials from several agencies of HHS (CMS, AHRQ, NIH, CMS, HRSA, FDA, ONC, ACF) and senior-level officials from the Department of Commerce, Office of Management and Budget, the United States Coast Guard, the Federal Bureau of Prisons, the National Highway Traffic Safety Administration, the Federal Trade Commission, the Social Security Administration, the Department of Labor, the United States Office of Personnel Management, the Department of Defense, the Department of Education, the Department of Veterans Affairs, the Veterans Health Administration, and any other federal agency and department with responsibilities to improve health care quality as identified by the President. *Id.*

192. PPACA § 3012(b). The Interagency Working Group on Quality must file an annual report to Congress on its activities and progress, and make the report publically available on the internet. PPACA § 3012(d).

193. PPACA § 3012(b)(1).

194. U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF THE SEC'Y, OFFICE OF THE ASSISTANT SEC'Y FOR HEALTH, OFFICE OF MINORITY HEALTH, REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES AS REQUIRED BY THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, P.L. 111-148, at 62 (2011) [hereinafter REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES], available at <http://www.healthcare.gov/law/resources/reports/minorities03252011a.pdf>. NPA is a public-private partnership that has a three-part structure composed of the (1) NPA

ethnic minorities and underserved populations.”¹⁹⁵ This vision explicitly incorporates a global health law norm previously discussed—part of WHO’s definition of health.¹⁹⁶ FIHET is composed of representatives from federal agencies whose missions affect the determinants of health.¹⁹⁷ The federal agencies include the Departments of Health and Human Services, Agriculture, Commerce, Defense, Education, Housing and Urban Development, Homeland Security, Justice, Labor, Transportation, Veterans Affairs, and the Environmental Protection Agency.¹⁹⁸ FIHET not only facilitates communication and implementation of NPA activities within federal agencies, but it also seeks to improve the efficiency and effectiveness of the policies and programs designed to end health disparities sponsored by their respective agencies.¹⁹⁹

One year after the passage of the PPACA, the first National Stakeholder’s Strategy for Achieving Health Equity was announced. It was released simultaneously with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities in April 2011.²⁰⁰ This strategy adheres to global health law norms by including strategies that focus on social determinants of health, recognizing the importance of the work of the SDH Commission, and explicitly referencing the commission’s recommendations in its final report, “Closing the Gap in a Gen-

partners, (2) FIHET, and (3) Regional Equity Councils. See U.S. Dep’t of Health & Human Servs., Nat’l P’ship for Action to End Health Disparities, *Frequently Asked Questions*, MINORITYHEALTH.HHS.GOV, available at <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=5#7>. The NPA partners are public, private, and non-profit organizations that work on prevention or social determinants of health to reduce health disparities. *Id.* These organizations agree to undertake one significant project per year. *Id.* The Regional Councils are responsible for developing recommendations for state and local governments based on the NSS. *Id.* There are ten regional councils composed of leaders and change agents working on disparities reduction. See U.S. Dep’t of Health & Human Servs., Nat’l P’ship for Action to End Health Disparities, *Establishment of Regional Health Equity Councils*, MINORITYHEALTH.HHS.GOV, available at <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=42>. While the ten regions correspond to the ten HHS regions, the Regional Equity Councils are not advisors to OMH, HHS, the federal government, or the NPA partners. *Id.*

195. See U.S. Dep’t of Health & Human Servs., Nat’l P’ship for Action to End Health Disparities, Fed. Interagency Health Equity Team, MINORITYHEALTH.HHS.GOV, available at <http://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=36> (last visited Apr. 12, 2012) [hereinafter NPA Federal Interagency Health Equity Team].

196. See *supra* Part I (“[WHO defines health as] a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”).

197. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 9.

198. REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES, *supra* note 194, at 62.

199. NPA Federal Interagency Health Equity Team, *supra* note 195; See REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES, *supra* note 194, at 62.

200. Press Release, HHS Announces Plan to Reduce Health Disparities, *supra* note 157.

eration: Health Equity Through Action on Social Determinants of Health.”²⁰¹

The National Stakeholder Strategy is a “comprehensive, community-driven approach to reduce health disparities.”²⁰² Its vision is to “promote systematic and systemic change to improve the health of the nation and its most vulnerable populations.”²⁰³ The strategy has five goals which target twenty strategic areas. The goals are: (1) increasing awareness about disparities; (2) developing leadership to work on eliminating health disparities; (3) improving the health system and individual’s life experiences “to improve the health and health care outcomes for racial, ethnic, and underserved populations”; (4) diversifying the health care work force and “improv[ing] cultural and linguistic competency”; and (5) “improv[ing] data availability and the coordination, use[], and diffusion of research.”²⁰⁴ A few of the strategic areas under the goal to improve health systems and life experiences focus on quality and social determinants of health.²⁰⁵ In looking at access to care, the National Stakeholders Strategy reiterates the need to “incentivize health service providers to adhere to quality improvement standards.”²⁰⁶

The final example of a multi-sectoral approach to health is reflected in the HHS Action Plan to Reduce Disparities in which HHS announced that beginning in 2012, it will work on disparities by “engaging other key federal departments, the private sector, and community-based organizations to adopt a ‘health in all policies’ approach, including a health impact assessment for key policy and program decisions.”²⁰⁷ Health in all policies requires all sectors of the government to focus on health and well-being.²⁰⁸ HHS will also test and evaluate

201. U.S. DEP’T OF HEALTH AND HUMAN SERVS., NAT’L P’SHIP FOR ACTION TO END HEALTH DISPARITIES, NATIONAL STAKEHOLDER STRATEGY FOR ACHIEVING HEALTH EQUITY 8, available at <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286> [hereinafter NATIONAL STAKEHOLDER STRATEGY].

202. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 1.

203. NATIONAL STAKEHOLDER STRATEGY, *supra* note 201, at 2.

204. *Id.*

205. Examples of targeted social determinants of health include meeting the social and physical environmental needs of at-risk children, improving the high school graduation rates by working at every level to tie educational attainment to life-time health benefits, and implementing policies that create “social, environmental, and economic conditions required to realize healthy outcomes.” *Id.* at 6.

206. *Id.* at 121.

207. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 28.

208. See DEP’T OF HEALTH, GOV’T OF S. AUSTRALIA, IMPLEMENTING HEALTH IN ALL POLICIES: ADELAIDE 2010, at 14 (2010), available at <http://www.who.int/sdhconference/resources/implementinghiapadel-sahealth-100622.pdf>. The concept of health-in-all policies has evolved over

health disparity impact assessments for selected national programs.²⁰⁹ The health disparity impact assessment will assess the “likely impacts of proposed policies and programs on health and healthcare disparities among racial and ethnic minorities.”²¹⁰ These initiatives will be led by the Office of Minority Health and all agencies will participate.²¹¹ HHS will also collaborate in a pilot program with national foundations to evaluate health disparity impact assessments.²¹²

4. PPACA Makes Universal Coverage, a Key Aspect of Universal Health Care, a Priority Issue

PPACA complies with the global health law norm of providing universal coverage as recommended by the SDH Commission and the CERD Committee. As previously discussed, in 2008, the CERD Committee recommended that the United States comply with ICERD article 5(e)(iv) and address the large number of uninsured racial and ethnic minorities.²¹³ PPACA expands access to care by increasing access to insurance through creation of insurance exchanges,²¹⁴ the provision of federal subsidies to individuals whose incomes are at or below 400% of the federal poverty line,²¹⁵ and expanding Medicaid coverage to non-elderly, non-pregnant individuals below 133% of the federal poverty line.²¹⁶ PPACA also expands access to preventive care by eliminating copayments for preventive services approved by the United States Preventive Services Task Force.²¹⁷ Eliminating eco-

a thirty-year period. *Id.* at 4. The Alma Ata Declaration of 1978 was a seminal effort that reflects the beginning of an inter-sectoral approach to health. *Id.* The second major evolution of the concept is reflected in the Ottawa Charter of 1986, introducing the healthy public policy concept. *Id.* at 16. It focuses on health, equity, and accountability for determinants of health. *Id.*

209. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 28.

210. *Id.*

211. *See id.*

212. *Id.*

213. *See supra* Part I.B.2.

214. Section 1311 of the PPACA authorizes the creation of either the American Health Benefit Exchange and/or the Small Business Health Options Exchange for businesses. *See* PPACA, Pub. L. No. 111-148, § 1311 (a)-(b), 124 Stat. 119 (2010). These exchanges will facilitate the purchase of insurance by individuals and small businesses. *See id.* The exchanges will be created by the state or the federal government if the state fails to establish it. *Id.* The exchanges must be operational by January 1, 2014. *Id.* sec. 10104, §1311 (modified by 10104).

215. Premium credits and cost-sharing subsidies are provided in the exchange to make insurance more affordable to individuals at or below 400% of the poverty line. *See id.* sec. 10105, §1401.

216. *Id.* sec. 10201, 1004, 1201, § 2001. This new category does not include individuals otherwise eligible for Medicaid. *Id.*

217. Private health insurance plans must include services with a grade of A or B by the United States Preventive Services Task Force, immunizations as recommended by the CDC Ad-

conomic barriers to preventive care was viewed by some congressional staffers as a mechanism to reduce disparities in mortality rates for racial and ethnic minorities by facilitating early diagnosis and treatment of diseases.²¹⁸

5. PPACA Requires the U.S. Government to Monitor Social Determinants of Health and Health Equity

Health and human rights norms articulated in General Comment 14 and the recommendations of the SDH Commission both encourage countries to monitor their progress in protecting human rights and in addressing determinants of health that create health inequities. Through the creation of the National Quality Strategy discussed previously, PPACA requires the Secretary of HHS to file annual reports with the health-related congressional committees regarding the short and long-term goals of the strategy and the progress made.²¹⁹ This means that the Secretary must assess the effectiveness of its quality improvement initiatives that are designed to improve the quality of care to vulnerable groups and its initiatives designed to address behavioral, social, and environmental determinants of health that adversely affect health.

Another mechanism to monitor the effectiveness of initiatives designed to reduce health disparities is through the work of the National Prevention, Health Promotion, and Public Health Council. The Council must provide a report to Congress and the President on the prevention, health promotion, and public health initiatives and the national progress on the goals advanced through the initiatives.²²⁰ Given that the National Prevention Strategy drafted by the Council targets elimination of health disparities for racial and ethnic minorities, the Council must evaluate the success of public health and prevention activities designed to reduce disparities based on race and ethnicity, socioeconomic status, or “other characteristics historically linked to discrimination or exclusion.”²²¹

visory Committee on Immunization Practices, and preventive care and screenings for women and children as recommended by the Health Resources and Services Administration. *Id.* §1001. Access to preventive services is also expanded for the Medicare and Medicaid programs. *Id.* §§ 4104-06.

218. This conclusion is based on my personal experience as a Senate Legislative Fellow.

219. PPACA sec. 3011, § 399HH(d)(2). The report must also identify any barriers HHS encounters to achieve the goals articulated in the National Quality Strategy. *Id.*

220. *Id.* § 4001(h)(1); *PPACA and Public Health*, *supra* note 71, at 373-74.

221. NATIONAL STAKEHOLDER STRATEGY, *supra* note 201, at 9. The National Prevention Strategy seeks to reduce disparities for all Americans and give everyone the opportunity to live a

PPACA also facilitates the monitoring of health disparities by requiring data collection and analysis in federally conducted or supported health related programs by race, ethnicity, sex, primary language, and disability status.²²² Data must also be collected from the Medicaid and CHIP programs.²²³ Furthermore, the HHS Secretary must submit a report with recommendations for improving health disparities data collection under Medicaid and CHIP.²²⁴ These provisions enable the United States to meet the 2008 CERD Committee recommendation to provide statistical data disaggregated by race, ethnicity, and national origin in its next periodic report.

The United States can use the National Healthcare Disparities Report (NHDR) and the HHS Health Disparities Reduction Plan, in addition to the PPACA provisions discussed above, to monitor the progress of initiatives designed to eliminate health disparities. The NHDR has been produced since 2003.²²⁵ As required by federal statute, the report addresses disparities in health care delivery that are due to racial and social economic factors.²²⁶ The report not only identifies existing disparities, but it shows how the disparities have changed over time and where is the greatest need to reduce disparities.²²⁷ Pursuant to the HHS Health Disparities Reduction Plan, HHS will monitor its effectiveness in addressing social determinants of health and reduction in health disparities.²²⁸ Each agency within HHS will develop an evaluation plan for its area of responsibility within the HHS Health Disparities Reduction Plan.²²⁹ These plans will work in conjunction with existing monitoring and evaluation systems.²³⁰

“long, healthy, independent, and productive [life], regardless of their race or ethnicity; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; . . . geographic location; or other characteristics [historically linked to discrimination or exclusion].” DRAFT PREVENTION STRATEGY FRAMEWORK, *supra* note 181, at 2; *see also* NATIONAL PREVENTION STRATEGY, *supra* note 181, at 25.

222. *See* PPACA § 4302.

223. *Id.*

224. *Id.*

225. *See* AHQR, NHDR, *supra* note 87, at 1.

226. *See* 42 U.S.C. § 299a-1(a)(6) (2006).

227. AHQR, NHDR, *supra* note 87, at 1.

228. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 34.

229. *Id.*

230. *Id.*

C. PPACA's Emphasis on Quality Provides Additional Tools to Reduce and Eliminate Health Disparities

Global health law norms articulated in General Comment 14 and reports of the Special Rapporteur for health require the provision of quality care.²³¹ Specifically, the U.S. health care system should be designed to ensure that patients receive care that is scientifically and medically appropriate given their health condition.²³² In the United States there are significant disparities in the quality of care provided to people of color.²³³ Thus, all the provisions in the PPACA that seek to improve quality should also help reduce disparities in the quality of care.

Some of the PPACA quality provisions specifically mention health disparities. For example, the National Strategy for Quality Improvement requires a focus on vulnerable populations when designing quality strategies to improve health outcomes.²³⁴ Similarly, improvement initiatives of the Interagency Working Group on Health Care Quality must consider vulnerable populations and reduction of health disparities.²³⁵ The Patient-Centered Outcomes Research Institute is tasked with "assist[ing] patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of [clinical] evidence . . . through research and evidence synthesis . . ." ²³⁶ The Institute is authorized to seek data from CMS, federal, state, and private organizations to address priority areas like disparities in health care delivery and patient outcomes.²³⁷ Another quality provision that explicitly mentions disparities facilitates the development of quality measures that evaluate equity in health services and health disparities.²³⁸ These measures will be used to assess the

231. See discussion *supra* Part I.C.3.

232. *Id.*

233. See *id.* (discussing the findings of the 2010 National Healthcare Disparities Report).

234. See discussion *supra* Part II.B.2 (discussing the National Quality Improvement Strategy).

235. See discussion *supra* Part II.B.3 (discussing the Interagency Working Group on Health Care Quality).

236. PPACA, Pub. L. No. 111-148, § 6301(a), 124 Stat. 119, 727-28 (2010). The Patient-Centered Outcomes Research Institute is a private, nonprofit, tax-exempt entity. *Id.* Its nineteen-member board includes the directors of the Agency for Health Care Research and Quality and the National Institutes of Health. *Id.*

237. *Id.*

238. See PPACA § 3013(a)(4). The quality measures are "standard[s] for measuring the performance and improvement of population health[.]" health plans, service providers, or clinicians. *Id.*

“performance and improvement of population health,” health plans, service providers, or clinicians.²³⁹

Other provisions generally focus on improving the quality of care provided in the U.S. health care system. For example, the PPACA creates the Center for Quality Improvement and Patient Safety inside of AHRQ.²⁴⁰ This center is important because it will identify best practices for quality improvement in health care delivery and identify health care providers that consistently deliver “high-quality, efficient health care . . . and [use] best practices that are adaptable . . . [for] diverse health care settings”²⁴¹ The Center will also translate the information for use in practice and create strategies for quality improvement.²⁴² Of particular relevance to reduction of health care disparities among racial and ethnic minorities is the Center’s authority to provide grants to organizations to provide technical assistance to poor performers and health care providers and suppliers “for which there are disparities in care among subgroups of patients”²⁴³

The final general quality provision that will likely positively impact the health of racial and ethnic minorities is the provision governing identification of clinical practice guidelines developed using best practices identified by the Institute of Medicine. Today, while many clinical practice guidelines exist, they are of poor quality.²⁴⁴ Section 10303(c) corrects this problem by authorizing the Secretary of Health to enter into a contract with the Institute of Medicine to identify existing and newly-created clinical practice guidelines that were developed using best practices.²⁴⁵ These guidelines can be used to establish the standard of care for various treatments. The standards can then serve as a mechanism of positive equality to ensure that racial and ethnic minorities receive the care recommended in the clinical practice guideline.²⁴⁶ This puts the burden on the health care provider

239. *Id.*

240. *Id.* §3501.

241. *Id.* The center will also identify processes or system designs that “reliably result in intended health outcomes, improve patient safety, and reduce medical errors” *Id.*

242. *See id.*

243. *Id.*

244. *See* Barry R. Furrow, *Regulating Patient Safety: The Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1727, 1736 (2011). Existing clinical practice guidelines are often not based in good science and “serve primarily as self-protective shields created by insurers and medical societies.” *Id.*

245. PPACA § 10303(c).

246. *See* M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y L. & ETHICS 95, 114 (2001) [hereinafter Bloche, *Race and Discretion*]; discussion *supra* Part I.C.1.

to justify or explain why he or she deviated from the clinical practice guideline.

III. MY RECOMMENDATIONS ON FUTURE EFFORTS TO REDUCE AND ELIMINATE HEALTH DISPARITIES FOR PEOPLE OF COLOR IN THE UNITED STATES

Elimination of health care disparities is a complex problem demanding a multifaceted solution. The nature of this issue highlights the importance of viewing health law problems through the lens of the emergent logic perspective created by Professor Gregg Bloche. This approach rejects the single big theory,²⁴⁷ or one unifying theme for health law, and the narrow case-by-case approach, which focuses on one discrete problem.²⁴⁸ Instead emergent logic considers the interrelationship between the players and the parts of the health care system.²⁴⁹ The players include the patients, providers, third-party payors, and the multitude of regulators (e.g. courts, agencies, and accreditors). The health care system has three parts: the financing of health care (coverage), the delivery system, and the public health, prevention, and wellness system. Each of these parts significantly impacts the ability of the United States' health care system to reduce health care disparities among racial and ethnic minorities.

Future efforts to reduce health care disparities should include continued advocacy, publicity, and use of a multi-pronged and integrated approach to disparities reduction. In light of the global health law norm reflected in General Comment 14, that countries create national strategies to protect the right to health, my first recommendation for future efforts to reduce health care disparities in the United States is to impose a requirement that the Department of Health and Human Services creates a national strategy to reduce health care disparities on a periodic basis. The strategy would be equivalent to the HHS Action Plan to Reduce Racial and Ethnic Health Disparities released in 2011. A mandate of this nature is not a new idea. A similar idea was proposed by Senator Edward M. Kennedy in the Minority

247. There are four primary big theory approaches to health law: market competition, patient autonomy, professional authority, and public determination. See M. Gregg Bloche, *The Emergent Logic of Health Law*, 82 S. CAL. L. REV. 389, 408 (2009).

248. *Id.*

249. See *id.* at 396. Bloche also argues that the legal governance of health care is an emergent system, which is unguided by one actor. *Id.* at 397. Instead, he finds that it is the sum total of inputs and mutual adjustments by stakeholders and decision-makers. *Id.* at 396.

Health Improvement and Health Disparity Elimination Act of 2007.²⁵⁰

There are several benefits to imposing a mandate on HHS to develop a National Health Care Disparities Strategy. First, it provides a strategic focus for HHS and the elevated Office of Minority Health. Merely having an office tasked with improving minority health, raising the quality of care, and eliminating disparities does not begin the implementation of activities designed to effectively achieve those goals.²⁵¹ Second, it is a means to integrate and coordinate the multitude of existing and new public health and health care activities of HHS, which are designed to reduce health disparities and address social determinants of health. Given the infrastructure created by PPACA, which includes reduction of health disparities and attention to social determinants of health through a multitude of unconnected provisions, there must be a mechanism to ensure that all of the governmental policies, programs, and regulations are coherent, effective, and adhere to similar priorities. Third, the National Health Care Disparities Strategy can serve as a framework for cooperative work between federal and state governments as well as with private non-governmental organizations. Fourth, requiring production of the strategy on a periodic basis helps ensure that HHS continues its public health responsibilities to protect the health of people of color when administrations change or new threats or risks arise that are adverse to the health of people of color.

My second recommendation would focus on strengthening the regulatory structure designed to improve the quality of care provided in the health care delivery system at the individual physician level. PPACA includes several system-wide initiatives to improve quality,

250. Minority Health Improvement and Health Disparity Elimination Act, S. 1576, 110th Cong. § 501 (2007). Senator Edward M. Kennedy introduced the legislation and it had six original co-sponsors: Senators Thad Cochran (MI), Barack Obama (IL), Jeff Bingaman (NM), Hillary Clinton (NY), Sherrod Brown (OH) and Richard Durbin (OH). *Id.* Section 501 required the secretary to “develop and implement a comprehensive Department-wide plan to improve minority health and eliminate health disparities in the United States” *Id.*

251. I recognize that the creation of a strategy does not necessarily ensure that implementation steps will occur. This is especially so if HHS becomes more consumed with creating the strategy than implementing it or never implements it. However, requiring the creation of a strategy on the front end provides an accountability mechanism for interested stakeholders. Congress, people of color, and the public can use the strategy as a standard to evaluate the effectiveness of the department’s implementation of PPACA and other regulatory requirements designed to improve the health of people of color. As the former Special Rapporteur for Health Paul Hunt admonishes, ensuring the availability of effective accountability measures is necessary to protect the right to health. Hunt, *Missed Opportunities*, *supra* note 15, at 39.

such as the creation of the national quality strategy discussed previously and the requirement that insurance companies report on activities designed to improve care²⁵² as part of the medical loss ratio disclosures. PPACA also includes general provisions targeted to improve the quality of care provided by physicians. Each of these general provisions should be revised to include improving the quality of care provided to racial and ethnic minorities. This is consistent with global health law norms of health equity, equality, and non-discrimination articulated in the SDH Commission's recommendations, reports of the Special Rapporteur for Health, ICERD, and ICESCR.

In PPACA section 3007, the Medicare reimbursement policy will be changed in 2015 to include "a value-based payment modifier" focusing on quality and costs.²⁵³ This shifts the Medicare reimbursement structure from a fee-for-service payment methodology—rewarding mere provision of service—to a pay-for-performance model—valuing quality.²⁵⁴ Through rulemaking, CMS could include measures that consider quality initiatives designed to reduce health care disparities. This would be consistent with the priorities established in the national quality strategy that address health care disparities,²⁵⁵ as well as the IOM's recommendation that any national quality

252. PPACA, Pub. L. No. 111-148, § 10101(f), 124 Stat. 119, 883-86 (2010).

253. *Id.* § 3007. In December 2011, CMS announced that it will use data from the Physician Quality Reporting System (PQRS) to create the quality component of this new payment methodology. Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012, 76 Fed. Reg. 73,026, 73,427 (Nov. 28, 2011). For more information on PQRS, see discussion *infra* Part III. Because CMS recognizes the limits of some of its data and the complexity of designing a new payment methodology, it will proceed cautiously. *Id.* at 73,427.

254. Both the Institute of Medicine and the Medicare Payment Advisory Committee (MedPac) have recommended that physician payment methodology be changed to incentivize the provision of quality care. INST. OF MED., REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE 1 (2006); MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO CONGRESS: MEDICARE PAYMENT POLICY 196-203 (2005); CROSSING THE QUALITY CHASM, *supra* note 82, at 17-19. Health law scholars have also called for a change in the physician reimbursement methodology under the Medicare program or private managed care plans to improve quality of care. See, e.g., David Hyman, *Health Care Fragmentation We Get What We Pay For*, in THE FRAGMENTATION OF U.S. HEALTH CARE 31 (Einer Elhauge ed., 2010); Timothy Stoltzfus Jost & Lawrence P. Casalino, *Value-based Purchasing Opportunities in Traditional Medicare: A Proposal and Legal Evaluation*, in THE FRAGMENTATION OF U.S. HEALTH CARE 204 (Einer Elhauge ed., 2010); Bloche, *Race and Discretion*, *supra* note 246, at 114-15; Gwendolyn Roberts Majette, *From Concierge Medicine to Patient-Centered Medical Homes: International Lessons and the Search for a Better Way to Deliver Primary Health Care in the U.S.*, 35 AM. J.L. & MED. 585, 617 (2009) [hereinafter Majette, *Concierge Medicine*]; William M. Sage, *Pay for Performance: Will it Work in Theory?* 3 IND. HEALTH. L. REV. 303, 308 (2006); Gwendolyn Roberts Majette, *Changing Payment Policy to Improve Quality & Reduce Fragmentation: The Medical Home Concept*, CONCURRING OPINIONS BLOG (Oct. 12, 2010, 9:56 AM), <http://www.concurringopinions.com/?s=fragmentation>.

255. See discussion *supra* Part II.B.2.

improvement initiative includes a focus on the equitable provision of care.²⁵⁶ Care that is equitably provided does not vary because of a patient's personal characteristics like race or ethnicity.

Another incentive mechanism that can be further designed to address health care disparities is PPACA § 3002, which extends the Physician Quality Reporting System (PQRS) under the Medicare program until 2014.²⁵⁷ PQRS began in 2007 and is the largest physician-focused pay-for-performance program in the United States.²⁵⁸ This program provides a small incentive payment to physicians for reporting on designated quality measures.²⁵⁹ PPACA further provides that beginning in 2015, physicians will be penalized 1.5% (increasing to 2% in 2016) of their total Medicare reimbursement for failing to report.²⁶⁰

PQRS has the ability theoretically to improve quality and reduce disparities. However, the full potential of the program has not been realized.²⁶¹ With respect to disparities in particular, PQRS, like many

256. See discussion *supra* Part I.C.1. Professors Gregory Bloche, Timothy Jost, and Sidney Watson have advocated for focusing on quality regulations as a means to reduce racial disparities for racial and ethnic minorities in the United States. See SIDNEY D. WATSON, EQUITY MEASURES AND SYSTEMS REFORM AS TOOLS FOR REDUCING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 7 (2005) (urging incorporation of racial and ethnic performance measures into the quality assessment and performance improvement initiatives that apply to Medicaid and Medicare Advantage managed care plans and hospitals that accept Medicare and Medicaid); Bloche, *Race and Discretion*, *supra* note 246, at 114-15 (urging private managed care plans to use more nuanced physician withholding incentives that emphasize “health promotion and disease screening practice, patient satisfaction, measurable treatment success, [and] frugality” to achieve the provision of colorblind care); Timothy Stoltzfus Jost, *Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services Can, and Should Do*, 9 DEPAUL J. HEALTH CARE L. 667, 704-705 (2005) (urging changes in the accreditation and certification requirements under the Medicare program to expand the quality assessment and performance improvement initiatives (QAPI) to all providers and to modify the QAPI to address access barriers and equity concerns).

257. PPACA § 3002(a).

258. See generally Alex D. Federman & Salomeh Keyhani, *Physicians' Participation in the Physicians' Quality Reporting Initiative and Their Perceptions of Its Impact on Quality of Care*, 102 HEALTH POL'Y 229 (2011).

259. *Id.* The incentive was 1% for 2011 and will be .5 % for 2012–2014. PPACA § 3002(a).

260. PPACA § 3002(b).

261. Physician perceptions on the impact of PQRS to improve quality are mixed, ranging from no impact to little impact. Federman & Keyhani, *supra* note 258. There are three significant factors that likely influenced physicians' perceptions that PQRS does not improve quality. First, the program to date does not provide payment or feedback based on the provision of quality care, but instead only provides for the correct reporting of the quality data. See Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2012, 76 Fed. Reg. 73,425-26 (Nov. 28, 2011). However, CMS promulgated recent regulations which provide through a separate program, the Medicare Feedback program, for a limited group of physicians to receive limited feedback on the quality of care provided to Medicare beneficiaries beginning in 2012 based on PQRS. *Id.* at 73,436. PPACA Section 3003 extended the scope of the Feedback program to include feedback on quality in addition to resource use. PPACA § 3003. Second,

other pay-for-performance programs, was not originally designed to impact the reduction of health care disparities.²⁶² After three years of operation, however, CMS began to address disparities.²⁶³ Those initial steps continue as reflected in, the most recent regulations describing PQRS. The 2012 PQRS Program will include measures “that are high impact and support CMS and HHS priorities for improved quality of care to Medicare beneficiaries.”²⁶⁴ One of the priority topics is the elimination of health disparities.²⁶⁵

some of the quality measures are narrowly defined, limited to a few conditions, or are inappropriate. Federman & Keyhani, *supra* note 258, at 231; Chris Silva, *Medicare Pay-for-Reporting Still Gets Bad Grades from Physicians*, AMEDNEWS.COM (Mar. 1, 2010), <http://www.ama-assn.org/amednews/2010/03/01/gvsc0301.htm>. Third, before 2011, there was no published empirical report regarding whether the program actually improved quality. See Letter from Michael D. Maves, MD, Exec. Vice President, CEO Am. Med. Ass’n, to Donald Berwick, MD, Adm’r Ctrs. for Medicare and Medicaid Servs., DHHS (Aug. 24, 2010), available at <http://www.ama-assn.org/resources/doc/washington/2011-physician-fee-schedule-comment-letter.pdf>. CMS reported in the 2009 Reporting Experience Including Trends (2007-2010), that despite the data limitations, it has noticed some improvements in quality since inception of the program. CMS, 2009 REPORTING EXPERIENCE INCLUDING TRENDS (2007-2010), PHYSICIAN QUALITY REPORTING SYSTEM AND ELECTRONIC PRESCRIBING (eRx) INCENTIVE PROGRAM xiii-xiv, 25-31 (2011) [hereinafter CMS, 2009 PQRS REPORTING EXPERIENCES & TRENDS], available at <http://www.cms.gov/pqrs/2009/itemdetail.asp?itemid=CMS1246584>.

262. Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), 73 Fed. Reg. 69,726, 69,831 (Nov. 19, 2008) (acknowledging receipt of industry comments addressing “gaps in the PQRI measure set . . . on equity/disparities.”); Alyna T. Chien & Marshall H. Chin, *Incorporating Disparity Reduction into Pay-for-Performance*, 24 J. GEN. INTERNAL MED. 135, 135 (2008); Alyna T. Chien et al., *Pay for Performance, Public Reporting, and Racial Disparities in Health Care: How are Programs Being Designed?*, 64 MED. CARE RES. & REV. 283S, tbl.1 (2007).

263. Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010, 74 Fed. Reg. 61,738, 61,814 (Nov. 25, 2009) (CMS lists without further detail the “elimination of health disparities” as a consideration that was applied in selecting the “2010 PQRI quality measures”). This change was not mandated by PPACA. In fact, PPACA did not address disparities in PQRS Section 3002. PPACA § 3002.

264. Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition and Other Revisions to Part B for CY 2012, 76 Fed. Reg. 73,026, 73,340 (Nov. 28, 2011) (to be codified at 42 C.F.R. pts. 410, 414, 415, 495).

265. *Id.* To date PQRS addresses disparities by including measures relevant for diseases where the literature shows disparities exist based on race and ethnicity. For example, measures exist for preventive care items such as the provision of immunizations or screening items like colonoscopy for colon cancer, mammograms for breast cancer, and body mass index to detect obesity. See generally IOM FUTURE DIRECTIONS OF NHQR & NHDR, *supra* note 2. These measures were included to make the areas measured a priority for physicians, which in turn will hopefully lead to better care and a reduction in health disparities. This approach is consistent with best practices on the development of a pay-for-performance program that addresses disparities reduction. Chien et al., *supra* note 262, at 135 (does not discuss PQRS). It is unclear what impact PQRS has had on the actual reduction of health care disparities. The 2009 Reporting Experience, which includes trends from 2007 – 2010 does not address this topic. See generally CMS, 2009 PQRS REPORTING EXPERIENCE & TRENDS. As PQRS continues to evolve, CMS hopes that it will shed light on how doctors address health disparities.

PQRS can be further designed to address the elimination of racial and ethnic disparities by incorporating specific measures that evaluate equity in health services and health disparities that will be developed pursuant to PPACA incentives.²⁶⁶ Furthermore, PQRS can be designed to capture information that evaluates the existence of racial and ethnic disparities within an individual physician's patient population.²⁶⁷ This type of information will enable CMS or newly created PPACA entities²⁶⁸ to provide assistance to those providers to eliminate those disparities.

Not only can physicians be incentivized through reimbursement policy to address health care disparities, they can also be incentivized through public reporting that can affect their professional reputations. PPACA requires the Secretary to develop a "Physician Compare" website for physicians participating in the Medicare program.²⁶⁹ The information for this website will come from the Physician Quality Reporting System.²⁷⁰ The website should ultimately allow patients to compare physicians based on quality and personal experience measures that are scientifically sound.²⁷¹ In keeping with my overall recommendations on physician quality initiatives, the quality and personal experience measures should be designed to capture information that can be used to monitor and reduce racial and ethnic disparities. Personal experience data can help ensure that patients are not subject to the racial bias of an individual physician in keeping with the global health law norms articulated by the Special Rapporteur for

266. See *supra* Part II.C.

267. The program does not currently collect this type of data, and CMS acknowledged that my recommendation would be a good idea. Implementation of this recommendation is even more likely because of the PPACA requirement that federal health related programs collect data on race, ethnicity, and primary language. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4302, 124 Stat. 119, 578-582 (2010); see *supra* Part II.C.

268. See *supra* Part II.C (discussing the Center for Quality Improvement and Patient Safety within AHQR).

269. PPACA § 10331. To encourage beneficiaries to use the Physician Compare website, PPACA allows incentives to be offered beginning in 2019. This is equivalent to what other countries have done. For example, Belgium encouraged patients to use their designated primary care provider who maintained their global health record by providing a 30% reduction in their out-of-pocket cost. See Majette, *Concierge Medicine*, *supra* note 254, at 605.

270. PPACA § 10331(a)(2). The text of PPACA also mentions other criteria such as an "assessment of patient health outcomes and the functional status of patients; . . . continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use; . . . efficiency, . . . patient experience and . . . family engagement; . . . safety, effectiveness, and timeliness . . . ; and other information as determined appropriate by the Secretary." *Id.*

271. PPACA § 10331(b)(2)-(3). There are many protections provided to a physician to ensure that the information presents a "robust and accurate portrayal of [the] physician's performance." *Id.* The physician also has an opportunity to review the information before it is made public. *Id.*

health.²⁷² To the extent the Physician Quality Reporting System includes data or measures that are relevant to efforts to eliminate health disparities, this information should also be reflected in the Physician Compare website.²⁷³

My final recommendation is that the Office of Civil Rights within HHS (OCR) should be viewed as an integral partner in the overall HHS health disparities reduction strategy and be encouraged to actively enforce Title VI of the Civil Rights Act of 1964.²⁷⁴ This recommendation helps eliminate health disparities among racial and ethnic minorities that are caused by discrimination in violation of global health law norms articulated in ICERD and ICESCR.

The HHS Office of Civil Rights has repeatedly been criticized for its lack of robust enforcement of Title VI.²⁷⁵ Title VI prohibits discrimination on the basis of race, color, and national origin in programs and activities that receive federal financial assistance.²⁷⁶ Today, intentional discrimination is less common than more subtle forms of discrimination. Because the Office of Civil Rights is the only entity

272. See *supra* Part I.C.3.

273. Use of the Physician Compare website to monitor physician efforts to eliminate health disparities is analogous to the use of report cards to monitor compliance with civil rights laws proposed by Professor David Barton Smith in 1998. See David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. HEALTH POL. POL'Y & L. 75, 100 (1998). Creation of the Physician Compare website is also consistent with the Office of Minority Health Culturally and Linguistically Appropriate Services Standard No. 14. This standard is a recommendation by OMH that "health care organizations . . . regularly make available to the public . . . their progress and successful innovations in implementing the CLAS standards . . ." U.S. DEP'T OF HEALTH AND HUMAN SERVS. OFFICE OF MINORITY HEALTH, NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE: FINAL REPORT 109 (2001), available at <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>.

274. OCR's membership on FIHET and the HHS Health Disparity Council discussed *supra*, note 194, possibly suggests that it is viewed as an important contributor to efforts to reduce health disparities.

275. See, e.g., Randall, *supra* note 17, at 64 (arguing that the Office of Civil Rights has not sufficiently prepared its investigative staff to identify and confront discrimination in the context of managed care); Yearby, *supra* note 17, at 975 (arguing that, for example, the Office of Civil Rights does not collect racial data, regulate admission practices, or survey the racial makeup of nursing homes as required by Title VI, and therefore cannot prevent the institutional racism in those homes causing a disparate impact on elderly African Americans). See generally U.S. COMM'N ON CIVIL RIGHTS, THE HEALTH CARE CHALLENGE: ACKNOWLEDGING DISPARITY, CONFRONTING DISCRIMINATION, AND ENSURING EQUALITY, VOLUME II: THE ROLE OF FEDERAL CIVIL RIGHTS ENFORCEMENT (1999) (discussing the limitations of Title VI and the resulting inadequate enforcement which has led to continued discriminatory practices); Jost, *supra* note 256 (pointing out that the OCR has never been aggressive or successful in addressing racial disparities in Medicare, and recommending that it undertake enforcement actions and aggressively pursue the complaints it receives).

276. 42 U.S.C. § 2000(d) (2006).

authorized to bring Title VI disparate impact cases,²⁷⁷ its enforcement activity is critical to elimination of discrimination as a cause of health disparities among people of color. OCR enforcement of disparate impact cases is also mandated by ICERD, which requires governments to prohibit conduct that has discriminatory effects.²⁷⁸

To the extent that the HHS Office of Civil Rights has enforced Title VI, it has concentrated its efforts on language discrimination cases, “low hanging fruit,”²⁷⁹ instead of taking a more balanced approach to include traditional Title VI enforcement. In the 2007 report that the United States submitted to the ICERD Committee, all of the cases described were limited English proficiency discrimination cases.²⁸⁰ More recently, when the Chief of Section Three in the Civil Rights Division of OCR spoke at the Symposium on Health Disparities at American University, he noted that, “for the present moment, the enforcement of Title VI” has been primarily limited English proficiency cases.²⁸¹

In light of the multitude of PPACA provisions that can be used to reduce health disparities and HHS’s renewed commitment to this issue, it is curious that recent HHS reports spend insufficient time addressing Title VI. First, the March 23, 2011 Report to Congress on Minority Health Activities, mandated by PPACA, does not mention

277. In *Alexander v. Sandoval*, the United States held that the Title VI statute only prohibits intentional discrimination. *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001). While the Title VI regulations prohibit discrimination based on disparate impact, there is no private right of action to enforce these regulations. *Id.* at 288-89; Majette, *Access to Health Care*, *supra* note 4, at 128.

278. The CERD Committee has repeatedly advised the United States that ICERD prohibits both intentional discrimination and discrimination that results from disparate impact. *See, e.g.*, CERD, *Concluding Observations on U.S. Reports*, *supra* note 35, ¶ 10 (“[The United States should] review the definition of racial discrimination used in the federal and state legislation and in court practice . . . to ensure [compliance with] . . . article 1, paragraph 1, [which] prohibits racial discrimination in all its forms, including practices and legislation that may not be discriminatory in purpose, but in effect.”); U.N. Gen. Assembly, Rep. of the Comm. on the Elimination of Racial Discrimination, Jul. 30-Aug. 17, 2001, ¶¶ 280-407, U.N. Doc. A/56/18; GAOR, 59th Sess., Supp. No. 18 (2001). Article 1(1) defines racial discrimination as conduct that has the purpose or effect of impairing human rights and fundamental freedoms based on race, color, descent, national or ethnic origin. International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) art. 1, Jan 5, 1969, 660 U.N.T.S. 195.

279. In a 2005 article, Professor Jost notes that when he spoke with individuals at HHS about civil rights enforcement, they referred to limited English proficiency cases as “low-hanging fruit.” Jost, *supra* note 256, at 702.

280. U.S. RESPONSE TO CERD QUESTIONS, *supra* note 35, at 89-90.

281. It is entirely possible that the phrase “for the present moment” signals a future change in enforcement policy. *See* Spring Health Law Symposium, *Health Disparities*, HEALTH L. & POL’Y BRIEF, Fall 2010, at 16 (quoting panelist Kenneth D. Johnson, Department of Health and Human Services, Office of Civil Rights, Panel II—State and Federal Perspectives on Health Care Disparities).

racism or Title VI. It references OCR one time as a member of the HHS Health Disparities Council.²⁸² The Health Disparities Council is tasked with coordinating and making cohesive all of the HHS strategies designed to reduce health disparities, as well as implementing the HHS Health Disparities Reduction Plan.²⁸³ Similarly, the HHS Disparities Reduction Plan does not use the word racism and does not mention OCR or Title VI in the main text. The term discrimination is used rarely. In the main text it appears twice. Title VI is only mentioned in appendix A, in the context of a reference to PPACA Section 1557, which expands the applicability of non-discrimination laws like Title VI to private health insurance plans.²⁸⁴

There is one recent document that provides hope that the HHS Office of Civil Rights will begin a more robust enforcement of Title VI. The most comprehensive discussion of Title VI as a mechanism to reduce health disparities for racial and ethnic minorities is contained in the National Stakeholder Strategy. This document explicitly states that racism, as a social determinant of health, is a cause of health disparities for racial and ethnic minorities.²⁸⁵ It explains that Title VI prohibits discrimination based on race, color, or national origin, and that it applies to virtually all hospitals and most health care providers that receive federal funds.²⁸⁶ It lists and provides examples of prohibited discriminatory conduct. Prohibited discriminatory conduct includes: denying a service or other benefit, providing different services or providing services in a different manner, segregating, or separately treating individuals because of their race, color, or national origin.²⁸⁷ Moreover, the National Stakeholder Strategy encourages all participants in the health care system (quality improvement team members,

282. REPORT TO CONGRESS ON MINORITY HEALTH ACTIVITIES, *supra* note 194, at 61. The HHS Health Disparities Council is chaired by the Assistant Secretary for the Office of Minority Health, composed of the Directors of the Offices of Minority Health and a member of the Office of Civil Rights.

283. *Id.* at 62. The Health Disparities Council is also responsible for tracking progress of the HHS Disparities Reduction plan and keeping the agency heads informed of the agency's progress as well as the progress of HHS as a whole. Additionally, the Council must "assure [the] successful implementation" of activities of the National Partnership for Action to End Health Disparities that are aligned with the HHS Disparities Reduction Plan. *Id.*

284. HHS ACTION PLAN TO REDUCE DISPARITIES, *supra* note 156, at 39.

285. NATIONAL STAKEHOLDER STRATEGY, *supra* note 201, at 7. It distinguishes between institutional racism caused by "differential access to the goods, services, and opportunities of society by race" from personally mediated racism. *Id.* at 21. Personally mediated racism is "prejudice and discrimination by individuals toward others." *Id.*

286. *Id.* at 20.

287. *Id.*

clinicians, patient advocates, board members, employees, and health care professionals) to report violations.²⁸⁸

CONCLUSION

The continuing existence of significant health care disparities for people of color is a substantial problem for the United States. The United States has an obligation under its public health and global health law duties to protect population health. These duties are especially important for vulnerable or societally disadvantaged groups. While the United States' commitment to eliminate health disparities is inconsistent, passage of the PPACA helps the United States satisfy its global health law obligations to address the health concerns of racial and ethnic minorities.

The WHO, the Special Rapporteur for Health, ICERD, ICESCR, and General Comment 14 create global health law norms that prohibit discrimination, promote health equity, and require the provision of scientifically and medically appropriate care. Through a multitude of provisions, the PPACA creates a framework to eliminate health disparities for racial and ethnic minorities consistent with these global health law norms.

PPACA not only elevates the issue of disparities reduction to the highest levels of government, by moving the Office of Minority Health to the Office of the Secretary for HHS; it also creates several permanent structures to eliminate health disparities and address social determinants of health. Of particular note is the creation of a permanent inter-sectoral governmental body, the National Prevention, Health Promotion and Public Health Council, to facilitate a health-in-all policies approach to eliminate health disparities and improve the daily conditions in which people live, work, and play. It also requires creation of a national quality strategy that will target improvements in the quality of care provided to racial and ethnic minorities which, to date, is suboptimal.

The commitment of the United States to eliminate health disparities for racial and ethnic minorities is further advanced by the creation of the Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholders Strategy for Achieving Health Equity released in 2011. Both of these documents

²⁸⁸. *Id.*

provide priorities and standards for cooperative work among government entities and the private sector.

As noted above, elimination of health disparities among people of color is a complex problem that requires a multi-faceted solution. First, a legislative mandate should be imposed on HHS which requires it to create a national strategy to reduce health care disparities on a periodic basis. This facilitates efficiency and coordination. Second, general quality mechanisms targeted to physicians like value-based purchasing, PQRS, and the Physician Compare website should specifically address reduction of racial and ethnic health disparities. Finally, vigorous enforcement of Title VI by the HHS Office of Civil Rights should be a central component of the HHS plan to reduce health disparities for people of color.