Title

The Civil Rights of Health: A New Approach to Challenging Structural Inequality

Journal

UCLA LAW REVIEW, 67(4)

ISSN

0041-5650

Authors

Harris, Angela P

Pamukcu, Aysha

Publication Date

2020

Peer reviewed

The Civil Rights of Health: A New Approach to Challenging Structural Inequality

ANGELA P. HARRIS*

AYSHA PAMUKCU†

An emerging literature on "the social determinants of health" reveals that a major driver of public health disparities is subordination. This body of research makes possible a powerful new alliance between public health and civil rights advocates: an initiative to promote the "civil rights of health." Understanding health as a matter of justice and civil rights law as a health intervention has the potential to strengthen public health advocacy. At the same time, understanding social injustice as a health issue as well as a moral issue has the potential to reinvigorate civil rights advocacy. This Article argues that a "civil rights of health" initiative, built on a "health justice" framework, can help educate policymakers and the public about the health effects of subordination, create new legal tools for challenging subordination, and ultimately reduce or eliminate unjust health disparities.

TABLE OF CONTENTS

* Professor Emerita and Boochever and Bird Endowed Chair for the Study and Teaching of Freedom and Equality, University of California, Davis School of Law (King Hall).

† Health Equity Lead and Senior Attorney, ChangeLab Solutions. The authors wish to thank Katie Hannon Michel and Tucker Culbertson for invaluable research assistance. Thank you as well to reviewers at ChangeLab Solutions: Marice Ashe, Erik Calloway, Saneta deVuono-powell, Kimberly Libman, Katie Hannon Michel, Hannah Sheehy, and Ben Winig. We would also like to thank Thalia Gonzalez, Lisa Ikemoto, Amy Kapczynski, Dayna Bowen Matthew, Alice Miller, Joel Teitelbaum, and Elizabeth Tobin-Tyler for formative conversations and comments on earlier drafts of this Article. Support for this publication was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

INTRODUCTION

We live in a time of increasingly steep inequalities – not only of income and wealth, but also of access to basic "public goods" like healthy food, clean water, and adequate housing.[1] Legal advocates have long sought to address these inequalities as a matter of moral fairness and fidelity to our nation's constitutional principles. Today, however, a robust body of public health and biomedical literature shows that the inequitable distribution of basic public goods and services is not only a moral or constitutional issue, but also has serious consequences for our health.[2] Literature on the "social determinants of health" reveals that "the conditions in which people live, work, and play have an enormous impact on . . . health regardless of whether a person ever sees the inside of a doctor's office."[3] In other words, our health is not just an individual matter; it is deeply influenced by institutional and structural forces that shape who has access to the opportunities and resources needed to thrive.

Chief among the structural forces creating unjust access to health-promoting opportunities and resources is subordination based on markers of perceived difference, such as race, gender, sexuality, and class.[4] In this Article, we -- a critical race theorist and a public health lawyer and advocate – argue that understanding subordination to be at the root of the social determinants of health holds the potential

---

[1] See K. Sabeel Rahman, *Constructing Citizenship: Exclusion and Inclusion Through the Governance of Basic Necessities*, 118 COLUM. L. REV. 2447, 2448-49 (2018).

[2] For an in-depth account of the interplay between individual, institutional, and systemic factors in public health, see Martha E. Lang and Chloe E. Bird, *Understanding and Addressing the Common Roots of Racial Health Disparities: The Case of Cardiovascular Disease & HIV/AIDS in African Americans*, 25 HEALTH MATRIX 109 (2015).

[3] ELIZABETH TOBIN-TYLER AND JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER xii (2018).

[4] For purposes of this Article, we use "subordination" as synonymous with "oppression" as Robin DiAngelo defines that term: "a set of policies, practices, traditions, norms, definitions, cultural stories, and explanations that function to systematically hold down one social group to the benefit of another social group." ROBIN DIANGELO, WHAT DOES IT MEAN TO BE WHITE? DEVELOPING WHITE RACIAL LITERACY 61 (2012). We use "subordination" rather than "oppression" in recognition of the legal literature distinguishing "anti-subordination" from "anti-classification" approaches to the Equal Protection Clause. *See, e.g.*, Jack Balkin & Reva Siegel, *The American Civil Rights Tradition: Anticlassification or Antisubordination?* 58 U. MIAMI L. REV. 9 (2003). For explication of the difference between the anti-classification and antisubordination approach, see *infra* Part II, Section B.

With DiAngelo, we hold that subordination is institutional, historical, and ideological, and results in systematic dominant group privilege. *Id.* at 67-70. Moreover, the forces of subordination are always "intersectional," as Kimberle Crenshaw has defined that term: that is, race, gender, sexuality, disability, and other systems of subordination overlap and interact. *See* Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex*, U.CHI. LEGAL F. 139 (1989); Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241 (1991); *see also* Part III-A *infra*.

to transform both public health and civil rights advocacy.[5]

Despite their long-standing awareness of how social context affects health,[6] and many gains in improving population health outcomes overall,[7] public health advocates have been unable to close the gap in persistent health disparities linked to social group membership. Take, for example, disparities in tobacco use, and tobacco-related disease and death. Although the overall prevalence of cigarette smoking in the United States has declined significantly over the past fifty years, these improvements have not been evenly distributed across the general population. Substantially higher rates of tobacco use exist among population groups defined by race, ethnicity, socioeconomic status, sexual orientation, and other factors,[8] and these same population groups disproportionately bear the burden of tobacco-related harm.[9]

---

[5] For purposes of this Article, we use "subordination" as synonymous with "oppression" as Robin DiAngelo defines that term: "a set of policies, practices, traditions, norms, definitions, cultural stories, and explanations that function to systematically hold down one social group to the benefit of another social group." DIANGELO, WHAT DOES IT MEAN TO BE WHITE?, *supra* n. 4, at 61. Subordination is thus an umbrella term encompassing intentional and unintentional mechanisms of group injustice at all levels of scale. By "discrimination," we mean unfair action against a social group or one or more of its members, based on prejudice against that group. *Id.* at 52. Prejudice and discrimination may be either conscious or unconscious, although existing anti-discrimination law focuses on conscious discrimination. See *infra* Part II, Section B.

[6] For example, in 1985, the Heckler Report, issued by the federal government's Task Force on Black and Minority Health, documented the existence of health and health care disparities. DEP'T OF HEALTH, EDUC. & WELFARE, REPORT OF THE SECRETARY'S TASK FORCE ON BLACK AND MINORITY HEALTH (1985).

[7] *See, e.g.*, United Health Found., America's Health Rankings Annual Report 4 (2017) (reporting that the premature death rate declined dramatically by 20 percent from 1990 to 2015, but that it has been increasing in recent years); U.S. National Cancer Institute, A Socioecological Approach to Addressing Tobacco-Related Health Disparities 3 (2017) (reporting that the overall prevalence of cigarette smoking among U.S. adults declined significantly from 1965 to 2015); Jiemin Ma et al., *Temporal Trends in Mortality in the United States, 1969-2013*, 314 J. Am. Med. Ass'n 1731, 1737 (2015) (finding an overall decreasing trend in the age-standardized death rate between 1969 and 2013 for all causes combined, and for diabetes, heart disease, cancer, stroke, and unintentional injuries).

[8] For example, although California is home to the longest running comprehensive tobacco control program in the nation, the state has not been able to close the gap in tobacco-related disparities. Cal. Dep't of Pub. Health, Cal. Tobacco Control Program, California Tobacco Facts and Figures: A Retrospective Look at 2017, at 1, 5 (2018). A 2014–2015 California survey found that 29.5% of all Native American and Alaska Native adults reported smoking, compared with 18% of all Black and African American adults, 13.4% of Whites, 11.1% of Hispanics, and 8.9% of Asian, Native Hawaiian, or Pacific Islanders. *Id.* at 5. The disparities are even more significant when socioeconomic status is taken into account. For example, nearly half (46.5%) of low-income Native American and Alaska Native adults reported smoking, compared with 24.4% of low-income Black and 23.7% of low-income White adults. *Id.* at 6.

[9] ChangeLab Solutions, Comprehensive Tobacco Retailer Licensing Ordinance: A Model California Ordinance Regulating the Tobacco Retail Environment 4-5 (2018); *see also Story of Inequity*, Tobacco Free CA, https://tobaccofreeca.com/story-of-inequity/lgbtq/ (last updated Aug. 16, 2018); U.S. Dep't of Health & Human Servs., Tobacco Use Among U.S. Racial/Ethnic Minority Groups--African Americans,

Yet these disparities are not strictly the product of individual choices to smoke. They are the result of many factors outside of individuals' control compounding over time, such as tobacco retailers' disproportionate concentration in low-income neighborhoods, and tobacco companies' systematic targeting of people of color in marketing campaigns.[10]

As the tobacco example shows, eliminating disparities in health is a different task than improving public health overall. Eliminating disparities means eliminating discrimination against stigmatized groups, changing the distribution of healthy environments, economic resources and opportunity, and equally distributing the power to affect the conditions of one's life. Accomplishing this task requires new ways of using policy and law to address the drivers of health disparities. In our view, the public health field must directly address structural subordination as a key social determinant of health. To address the "causes of the causes" of health disparities, public health advocates should add civil rights law to their toolkit.

For their part, civil rights lawyers and scholars insistently frame social inequalities as failures of justice, and have called for sweeping remedies based on principles of equality and liberty embedded in legislative and constitutional law.[11] Today, however, they face procedural and substantive barriers to using law as a tool to address institutional and structural subordination. Indeed, over a decade ago legal scholar John Valery White asked the poignant question, "Is civil rights law dead?"[12] White identified multiple barriers to civil rights litigation, including heightened

---

American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General 6, 12 (1998) (reporting that African Americans currently bear the greatest tobacco-related health burden of the four racial/ethnic populations studied, and stating that "[d]ifferences in the magnitude of disease risk are directly related to differences in patterns of smoking").

[10] ChangeLab Solutions, Tobacco Retailer Density: Place-Based Strategies to Advance Health Equity 5 (2019) (reporting that "[t]obacco retailers cluster in neighborhoods with a high percentage of low-income residents or residents of color" and that these communities "suffer disproportionately from the health harms caused by tobacco use"); ChangeLab Solutions, Comprehensive Tobacco Retailer Licensing Ordinance: A Model California Ordinance Regulating the Tobacco Retail Environment 7 (2019) (stating that the "tobacco industry has a well-documented history of developing and marketing menthol tobacco products to . . . communities of color and youth," which likely increases the prevalence of smoking among these populations); ChangeLab Solutions, Point of Sale Playbook 6 (2016) (noting that the "tobacco industry has long used the point of sale to target consumers based on their race, ethnicity, income, mental health status, gender, and sexual orientation," and that "[p]rices of tobacco products tend to be lower in African-American neighborhoods and low-socioeconomic status neighborhoods"). *See generally* Jon D. Hanson & Douglas A. Kysar, *Taking Behavioralism Seriously: Some Evidence of Market Manipulation*, 112 Harv. L.Rev. 1420 (1999) (describing efforts of the tobacco industry to manipulate consumers' perceptions about the risks of smoking).

[11] *See, e.g.*, DERRICK BELL, AND WE ARE NOT SAVED: THE ELUSIVE QUEST FOR RACIAL JUSTICE (1989) (locating black subordination at the very heart of American society).

[12] John Valery White, *Is Civil Rights Law Dead?* 63 LA. L. REV. 609 (2003).

pleading standards; restrictions on discovery; immunities to suit for government actors; strict causation rules; and, last but not least, the widespread requirement that a plaintiff challenging subordination prove conscious, invidious intent to harm.[13]

Since White published his article, the barriers to civil rights litigation have only grown higher. Scholars bemoan new procedural barriers that judges have erected to discrimination claims in employment and housing, as well as a newly-aggressive jurisprudence of "preemption" that stifles local and state attempts to create new rights or enforce existing rights.[14] At the substantive level, some argue that existing anti-discrimination jurisprudence even makes institutional and structural discrimination invisible.[15] The result has been general gloom among civil rights scholars, and reduced ambitions among legal advocates.[16] We believe that the literature on the social determinants of health presents an opportunity to revive and expand civil rights law through litigation, legislation, and policy work.

Combining these insights, we argue in this Article for collaboration among public health and legal advocates to promote "the civil rights of health." [17] We situate this initiative within the emergent "health justice" movement, a framework that identifies subordination as the key to eliminating health disparities.[18] For the public health world, promoting the civil rights of health means understanding and addressing health disparities through an anti-subordination lens. For the legal world, the civil rights of health framework offers the opportunity to leverage new types of evidence to demonstrate civil rights harms and violations, and new means for expanding the scope of anti-discrimination law. For all of us as the inheritors of a troubled national history, pursuing the civil rights of health makes visible the physical consequences of subordination, and the necessity of law and policy change so that no one is denied the opportunity to thrive.

The health justice framework suggests many possible law and public health alliances, of which the civil rights of health is only one. Nonetheless, we believe that a civil rights focus, centered on anti-discrimination law, is distinctively important.

---

[13] White, *supra* note 16, at 630. After his survey of the obstacles, White concludes, "What looked promising, even fabulously so, now seems daunting and morose. Is this what civil rights law was supposed to be?" *Id.*

[14] *See infra* Part II, Section A.

[15] *See, e.g.*, Devon Carbado & Cheryl Harris, *The New Racial Preferences*, 96 CAL. L. REV. 1139 (2008).

[16] *See infra* Part II, Section A.

[17] Our call builds on the work of others who have already seen the possibilities of collaboration between law and public health. *See, e.g.*, ChangeLab Solutions, Tools for Change: A Resource Catalog for Community Health (2018); Bowen, *supra* note 5; Angela K. McGowan et al., *Civil Rights Laws as Tools to Advance Health in the Twenty-First Century*, 37 ANN. REV. PUB. HEALTH 185 (2016); DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY (2015); see also sources listed in n. 157 *infra.*

[18] *See infra* Part III, Section A.

The body of equality-focused legislative and judicial law known as "anti-discrimination law" was expressly designed to dismantle subordination by prohibiting discrimination by public and private actors in specified areas of concern (e.g., employment, education, housing, public accommodation, voting) and by rejecting relations of caste. Moreover, anti-discrimination law draws upon a moral tradition that runs deep in American history and continues to have public resonance. From the work of Harriet Tubman and the abolitionist movement, through the suffragette movement and the social movements of the 1960s, to current movements such as #MeToo and Black Lives Matter, the creation, recognition, enforcement, and expansion of anti-discrimination law has been vital to people seeking to alter systemic social inequality.[19] Reorienting civil rights law around the unequal chances of Americans provides a unique opportunity to change the public understanding of subordination.

The Article proceeds as follows. Part I provides a brief introduction to the public health literature on the social determinants of health and health disparities, argues for the centrality of subordination in producing health disparities, and notes the limitations of conventional public health advocacy in fully confronting subordination. Part II briefly surveys the retrenchment in civil rights law that presents a barrier to effectively challenging subordination through legal means. Part III describes the health justice framework, outlines our call for recognizing the "civil rights of health," and provides examples of what this work could look like. We conclude that a civil rights of health initiative can help educate policymakers and the public about the health effects of subordination, create new legal tools for challenging subordination, and ultimately reduce or eliminate unjust health disparities.

[19] We recognize that anti-discrimination law is not capable of dismantling all forms of subordination that create health disparities. For instance, as Margaret Moss points out, American Indians suffer from dramatic health disparities as the result of a history of subordination based on political status as well as race. *See* Margaret P. Moss, *American Indian Health Disparities: By the Sufferance of Congress?*, 32 HAMLINE J. PUB. L. & POL'Y 59, 79-80 (2010). Federal statutory and administrative law directed specifically at Indian health have an important role to play in reducing these health disparities, as do tribal law and rules of jurisdiction and procedure. *See* Starla K. Roels, *HIPAA and Patient Privacy: Tribal Policies as Added Means of Addressing Indian Health Disparities*, 31 AM. INDIAN L. REV. 1 (2006) (outlining the role of tribal policies in protecting patient privacy); Sara Deer & Mary Kathryn Nagle, *Return to* Worcester*:* Dollar General *and the Restoration of Tribal Jurisdiction to Protect Native Women and Children*, 41 HARV. J. L. & GENDER 179 (2018) (arguing that a recent Supreme Court decision acknowledging tribal jurisdiction as an inherent attribute of sovereignty will redound to the benefit of indigenous women and children at risk for sexual violence). A full account of federal Indian law and tribal law as a health justice initiative, however, is beyond the scope of this Article. Thanks to Michelle Gutierrez for this point.

I. PUBLIC HEALTH ADVOCACY AND ITS LIMITATIONS

People often think of health as the product of individual choices.[20] Indeed, as Scott Burris observes, even opinion elites tend to think of health and illness "in medical terms, as something that starts at the doctor's office, the hospital, or the pharmacy."[21] In this view, the most important variables in health are the catastrophes, genetic inheritances, and/or disease agents that cause illness or injury, and the individual patient's morally responsible or irresponsible reaction to these challenges.

Yet, while individual behaviors do play a part in determining how healthy people are, it is now well documented that health outcomes are highly dependent on an individual's social background and environmental context: whether she is rich or

[20] Indeed, since at least the late 1970s health has been not only widely considered a personal responsibility, but also a highly moralized one. "Healthism" is a widely-held public frame within which ill health is blamed on bad moral character: from a healthist perspective fat people, for instance, are widely excoriated as lazy, ignorant, and slovenly. *See* Robert Crawford, *Healthism and the Medicalization of Everyday Life*, 10 INT'L J. HEALTH SERV. 365, 368 (1980) (defining healthism as "the preoccupation with personal health as a primary – often *the* primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of life styles"); JULIE GUTHMAN, WEIGHING IN (2011) (discussing healthism as applied to obesity). As evidence of this phenomenon, researchers have documented a pervasive feeling among the public that individuals are to blame for their own health problems, often due to lack of self-control in terms of known risks like tobacco, alcohol, and unhealthy foods. For example, "[a]n international survey of more than 300 policymakers reported that more than 90% believed personal motivation was a strong or very strong influence on the rise of obesity." Anthony Rodgers et al., *Prevalence Trends Tell Us What Did Not Precipitate the U.S. Obesity Epidemic*, 3 THE LANCET 162, 162 (2018). A separate study notes that weight-based stereotypes are prevalent in North America, including a common perception that "overweight and obese individuals are lazy, weak-willed, unsuccessful, unintelligent, lack self-discipline, have poor willpower, and are noncompliant with weight-loss treatment." Rebecca M. Puhl & Chelsea A. Heuer, *Obesity Stigma: Important Considerations for Public Health*, 100 AM. J. PUB. HEALTH 1019, 1019 (2010). This is true despite a significant body of scientific evidence demonstrating that the obesity epidemic has been driven by societal and environmental conditions such as reduction of manual labor; increased accessibility of inexpensive, calorie-dense foods; and decreased opportunities for physical activity due to factors like urban design and public transportation availability. *Id.*

[21] Scott Burris, *From Health Care Law to the Social Determinants of Health: A Public Health Law Research Perspective*, 159 U. PA. L. REV. 1649, 1650 (2011).

poor,[22] black or white,[23] living in a violent neighborhood or a peaceful one,[24] surrounded by healthy food options or junk food.[25] An individual's health is also influenced by broader social trends and structures. For example, the more unequal a society is, the worse its members' health becomes overall.[26]

In the last few decades, public health advocates have defined these conditions as the "social determinants of health."[27] These are the cultural, social, economic, ecological, and physical circumstances that affect our health by shaping where and how we live, work, learn, and play. The social determinants of health influence our daily experiences, our physical and emotional well-being, how long we live, and our ability to change the quality and course of our lives.[28]

---

[22] *See e.g.*, Santiago Lago et al., *Socioeconomic Status, Health Inequalities, and Non-Communicable Diseases: A Systematic Review*, 26 J. of Pub. Health 1, 10 (2018) ("The revised literature shows that people who live in areas of high inequalities tend to have shorter life expectancy and high adult mortality and that this tendency increases over time. Among the studies that conduct their analysis on individual data, the results show a strong positive effect of income on health."); Am. Pub. Health Ass'n, Improving Health by Increasing the Minimum Wage (2016), *available at* https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2017/01/18/improving-health-by-increasing-minimum-wage; PAULA BRAVEMAN, SUSAN EGERTER, & COLLEEN BARCLAY, INCOME, WEALTH, & HEALTH 3-5 (2011).

[23] *See, e.g.*, NAT'L ACADS. OF SCIENCES, ENGINEERING, & MED., COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 58-64 (2017); JUDITH BELL & MARY M. LEE, WHY PLACE AND RACE MATTER: IMPACTING HEALTH THROUGH A FOCUS ON RACE AND PLACE 19-20 (2011).

[24] *See, e.g.*, Katherine P. Theall et al., *Association Between Neighborhood Violence and Biological Stress in Children*, 171 JAMA PEDIATR. 53 (2017); Anna W. Wright, *Systematic Review: Exposure to Community Violence and Physical Health Outcomes in Youth*, 42 J. OF PEDIATRIC PSYCHOL. 364 (2017); SUSAN EGERTER ET AL., VIOLENCE, SOCIAL DISADVANTAGE, AND HEALTH 5-9 (2011).

[25] *See, e.g.*, Tarra L. Penney et al., *Local Food Environment Interventions to Improve Healthy Food Choice in Adults: A Systematic Review and Realist Synthesis Protocol*, BRITISH MED. J. OPEN (2015), https://bmjopen.bmj.com/content/5/4/e007161; Melissa Ahern, Cheryl Brown & Stephen Dukas, *A National Study of the Association Between Food Environments and County-Level Health Outcomes*, 27 J. RURAL HEALTH 367 (2011); Renee E. Walker, Christopher R. Keane, Jessica G. Burke, *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature*, 16 HEALTH & PLACE 876 (2010).

[26] For a collection of comparative national data on inequality and a number of indices of social distress, including health, see RICHARD G. WILKINSON & KATE PICKETT, THE SPIRIT LEVEL: WHY GREATER EQUALITY MAKES SOCIETIES STRONGER (2009). *See also* Kate E. Pickett & Richard G. Wilkinson, *Income Inequality & Health: A Causal Review*, Agency for Healthcare Research and Quality (page last reviewed July 2015), https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/pickett.html.

[27] *See* WORLD HEALTH ORG., COMMISSION ON THE SOC. DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 35-38, 42 (2008).

[28] U.S. DEPT OF HEALTH AND HUMAN SERVICES, SECRETARY'S ADVISORY COMMITTEE ON NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES, 2020 TOPICS AND OBJECTIVES: SOCIAL DETERMINANTS OF HEALTH, available at https://www.healthypeople.gov/2020/topics-

Mindful of the social determinants of health, public health advocates have focused for decades on population-wide interventions to prevent disease or injury, and on encouraging individuals to make healthy choices. For example, recent public health efforts have focused on preventing obesity and heart disease by creating environments that support physical activity and provide access to healthy food, especially for children, and disseminating information to the public about healthy eating and exercise. But despite many successes, public health advocates have been dogged by the stubborn persistence of "health disparities."[29] Healthy People 2020, an initiative promulgated by the federal Department of Health and Human Services, defines a health disparity as a "difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status . . . or other characteristics historically linked to discrimination or exclusion."[30]

In our view, the stubborn persistence of myriad health disparities in the United States, despite long-standing recognition of the problem,[31] is linked to the fact that

---

objectives/topic/social-determinants-of-health; Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. PUB. HEALTH 590 (2010).

[29] The legal literature on health disparities is robust. *See, e.g.*, DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE (2015); Lang & Bird, *supra* note 2, at 110; David Barton Smith, *The "Golden Rules" for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act*, 25 HEALTH MATRIX 33, 34 (2015); Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 49 (2014); Rene Bowser, *The Affordable Care Act and Beyond: Opportunities for Advancing Health Equity and Social Justice*, 10 HASTINGS RACE & POVERTY L. J. 69, 70 (2013); Peter J. Hammer, *Health Evolution: (Quality=Learning) + (Ethics=Justice)*, 10 IND. HEALTH L. REV. 415, 419 (2013); Gwendolyn Roberts Majette, *Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities*, 55 HOW. L.J. 887, 895 (2012); Emily Whelan Parento, *Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both*, 58 LOY. L. REV. 655, 657 (2012). *See also* Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281 (2012); 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 (2010); Kevin Outterson, *Tragedy and Remedy: Reparations for Disparities in Black Health*, 9 DEPAUL J. HEALTH CARE L. 735 (2005).

[30] HealthyPeople.gov, *Disparities*, https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities#6 (last accessed Feb. 5, 2019) (citing U.S. DEP'T OF HEALTH & HUMAN SERVS., THE SECRETARY'S ADVISORY COMMITTEE ON NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES FOR 2020, PHASE I REPORT: RECOMMENDATIONS FOR THE FRAMEWORK AND FORMAT OF HEALTHY PEOPLE 2020, at 28 (2008)).

[31] Daryll Dykes observes that medical and public health professionals have recognized disparities based on race since at least 1896. Daryll C. Dykes, *Health Injustice and Justice in Health: The Role of Law and Public Policy in Generating, Perpetuating and Responding to Racial and Ethnic Health Disparities Before and After the Affordable Care Act*, 41 WM. MITCHELL L. REV. 1129, 1135 (2015). In the twentieth century, the New England Journal of Medicine published research on disparities in child mortality. Mary Crossley, *Black Health Matters: Disparities, Community Health, and Interest*

conventional public health advocacy has yet to fully confront the centrality of subordination in creating and perpetuating them. Health disparities are so closely associated with "social, economic, and/or environmental disadvantage" because they result from historic and ongoing injustices against stigmatized or vulnerable groups. By definition, then, health disparities are "avoidable, unnecessary, and unjust."[32] In this Part, we provide an overview of the research on health disparities, argue that subordination lies at their root, and note the limitations of conventional public health means of eliminating them.

A. Three Pathways of Health Disparities: Populations, Place, and Power

Understanding that health is socially determined has led some public health advocates even further "upstream," to examine political factors such as the "distribution of money, power and resources at global, national and local levels."[33] In accordance with this move, we argue that subordination on the basis of race, gender, class, citizenship, sexuality, and other differentials of power and privilege is a central driver of health disparities. We will discuss three interrelated, but analytically distinct, pathways through which subordination produces health disparities: *populations*, *places*, and access to *power*.

Convergence, 22 Mich. J. Race & L. 53, 55-56 (2016). As Crossley notes, "Five years later, [the Journal of the American Medical Association] published a report by the American Medical Association's Council on Ethical and Judicial Affairs, decrying treatment disparities as unjustifiable and calling for their elimination." *Id.* More recent government reports on health disparities include*, e.g.,* AGENCY FOR HEALTHCARE RES. & QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL HEALTHCARE DISPARITIES REPORT 2011, at 2 (2012) (finding that African Americans, American Indians and Alaska Natives, and Hispanics/Latinos receive lower quality and less accessible healthcare than Whites); CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP'T HEALTH & HUM. SERVS., HEALTH DISPARITIES AND INEQUALITIES REPORT--UNITED STATES, 2011, at 1-2 (2011) (reporting, among other findings, that racial and ethnic minorities are more likely to live near and suffer from the effects of air pollution, that infants born to African American women are several times more likely to die than infants born to women of other races and ethnicities, and that coronary heart disease accounts for the largest proportion of inequality in life expectancy between white and African American individuals).

[32] Paula Braveman, *What Are Health Disparities and Health Equity? We Need to Be Clear*, 129 PUB. HEALTH REP., SUPP. 2, at 7 (2014) (citing Margaret Whitehead et al., *How Could Differences in "Control Over Destiny" Lead to Socio-Economic Inequalities in Health? A Synthesis of Theories and Pathways in the Living Environment*, 39 Health & Place 51 (2016)).

[33] WORLD HEALTH ORGANIZATION, COMMISSION ON DETERMINANTS OF SOCIAL HEALTH – FINAL REPORT, available at http://www.who.int/social_determinants/thecommission/finalreport/en/.

1. Health Disparities Based on Populations

Public health's attention to health disparities began with the recognition that, despite overall advances in health in the last few generations, certain social groups are disproportionately burdened by disease, illness, and premature death. The burden of poor health—from preventable chronic conditions to "diseases of despair"—falls disproportionately on people of color, children, families with low income, and individuals with a low level of education. Other vulnerable groups include the elderly, sexual minorities, and people with disabilities.[34]

For example, overall death rates from cardiovascular disease, the leading cause of death in the United States since the 1920s, have been declining since the late 1960s.[35] Yet throughout this period, disparities in deaths from cardiovascular disease based on race, income, and education have persisted. In 2013, for example, black Americans were 30% more likely to die from cardiovascular disease than white Americans, and 113% more likely to die from cardiovascular disease than Asians/Pacific Islanders.[36] People with low income and education levels were 46-76% more likely to die from cardiovascular disease than those with high levels of income and education.[37]

These population-based health disparities are the result of subordination, not accident, genetics, or individual choice. In the public health literature, the social groups disproportionately burdened by health disparities are often referred to as "vulnerable populations."[38] These groups, however, are vulnerable to poor health and premature death not for biological reasons, but for political and social ones. They have been, as one article puts it, "wounded by social forces placing them at a disadvantage for their health."[39]

Consider, for example, the disparity in health outcomes and mortality rates for black mothers and babies, described recently in the *New York Times* as a "life-or-

---

[34] *See* Dykes, *Health Injustice and Justice in Health, supra* n. 31, at 1132 (reviewing some of this research).

[35] Singh et al., *Widening Socioeconomic and Racial Disparities in Cardiovascular Disease Mortality in the United States*, 3 INT'L J. OF MCH & AIDS 106, 106 (2015).

[36] *Id.*

[37] *Id.*

[38] See Tobin-Tyler and Teitelbaum, *supra* n. 3, at 34-56 (summarizing research on health disparities affecting the following "vulnerable populations": low socio-economic status individuals, racial-ethnic minorities, immigrants, women, LGBT individuals, people with disabilities (including mental health and substance use disorders), people enmeshed in the criminal justice system, and rural populations).

[39] *Id.* at 35 (quoting Kevin Grumbach et al., "Vulnerable Populations and Health Disparities: An Overview," in T.E. KING et al. (eds.), MEDICAL MANAGEMENT OF VULNERABLE AND UNDERSERVED POPULATIONS: PRINCIPLES, PRACTICE AND POPULATIONS 3 (2007)).

death crisis."[40] Morbidity and mortality rates are higher for African American mothers and infants than for white mothers and infants, even after controlling for income and education.[41] Black mothers and children as a group experience more illness and death related to childbirth neither because they are genetically vulnerable, nor because black mothers are more negligent about prenatal health care than white mothers. Rather, researchers believe that an important cause is gendered racial discrimination, including "toxic stress" on black mothers from interpersonal discrimination in daily life;[42] institutional discrimination in the provision of health

[40] Linda Villarosa, "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis," THE NEW YORK TIMES, April 11, 2018, available at https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html.

[41] *See, e.g.*, *Pregnancy Mortality Surveillance System*, Ctrs. for Disease Control & Prevention (page last rev. Aug. 7, 2018), https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm#trends (finding that black women are roughly three times as likely to die from pregnancy-related causes than white women); Richard V. Reeves & Dayna Bowen Matthew, *6 Charts Showing Race Gaps Within the American Middle Class*, Brookings (Fri., Oct. 21, 2016), https://www.brookings.edu/blog/social-mobility-memos/2016/10/21/6-charts-showing-race-gaps-within-the-american-middle-class/ (reporting that "[b]abies born to well educated, middle-class black mothers are more likely to die before their first birthday than babies born to poor white mothers with less than a high school education"); David Richard & James Collins, Jr., *Disparities in Infant Mortality: What's Genetics Got to Do With It?*, 97 AM. J. PUB. HEALTH 1191 (2007) (stating that from 1953 to 2003 the "rate of death in the first year of life for Black infants increased from 1.6 times to 2.3 times the rate of White infants" and concluding, "the epidemiological evidence suggests that public health planners look to social and environmental rather than genetic differences between Black and White women in the campaign to eliminate health disparities"); Kenneth C. Schoendorf et al., *Mortality Among Infants of Blacks as Compared With White College-Educated Parents*, 326 NEW ENG. J. MED. 1522 (1992) (finding that infants born to college-educated black parents were twice as likely to die as infants born to college-educated white parents).

[42] Martha Lang and Chloe Bird explain that the experience of societal discrimination produces chronic stress, which in turn creates systemic dysregulation:

> Societal problems such as segregation, poverty, racism, homophobia, and transphobia can cause emotional and physical stress to the body and these stressors have been demonstrated to have a direct negative impact on health. [...] Allostatic load refers to cumulative dysregulation across multiple physiologic systems including metabolic (including blood sugar), cardiovascular (including blood pressure), immune (including inflammatory response), and neuroendocrine (including cortisol). The comparatively high allostatic load found in African Americans is in part acquired through stress exposures due to racism, classism, and other stressors, which have been widely reported in the research literature and are considered to be important sources of health disparities.

Lang & Bird, *supra* n. 2, at 115. Lang and Bird observe that one study discovered that African American women had the highest allostatic load of any group examined. *Id*. at 121.

care;[43] medical research that prioritizes white, male bodies;[44] and even transgenerational biological transmission of the effects of discrimination.[45] Today's discrimination occurs, moreover, against a backdrop of recent policy decisions to shift the risk of catastrophic events onto individuals and their families,[46] and a long-standing inclination to treat social ills as the fault of individuals. Elizabeth Tobin-Tyler and Joel Teitelbaum observe, for example, that the United States "medicalize[s] social needs and criminalize[s] social deficiencies,"[47] treating substance abuse, homelessness, and mental illness as individual problems, even as crimes, rather than problems to be addressed at an institutional level.[48] Vulnerability is made, not born.

2. Health Disparities Based on Place

A popular slogan among public health practitioners is that "your zip code is more important than your genetic code."[49] This saying refers to a second major pathway of the social determinants of health: place. Where people live influences their opportunity to lead a long and healthy life. For example, in Alameda County,

---

[43] According to health law scholar Dayna Bowen Matthew, for instance, "Twenty-five years of social science research confirms that implicit, anti-minority biases are pervasive among Americans generally, and among physicians in this country specifically." Dayna Bowen Matthew, *Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care*, 25 HEALTH MATRIX 61, 66 (2015). Sexual minorities also experience discrimination in the patient-provider relationship, and in insurance coverage. See Valarie K. Blake, *Remedying Stigma-Driven Health Disparities in Sexual Minorities*, 17 HOUS. J. HEALTH L. & POL'Y 183, 210-211 (2017).

[44] See Lisa C. Ikemoto, *Bioprivilege*, 42 Wash. U. J.L. & Pol'y 61, 64 (2013); Michelle Oberman and Margie Schaps, *Women's Health and Managed Care*, 65 TENN. L. REV. 555, 557 (1998) (identifying gender bias in health care research as one of four kinds of bias in the field of women's health).

[45] Researchers now posit that the children and grandchildren of people originally exposed to environmental stresses, hardships, or toxins may bear the signs in their bodies, through a phenomenon known as "epigenetic" transmission. Epigenetic changes are "alterations in the chemical modification of DNA that do not involve modifying the actual DNA sequence," but rather affect how segments of the genetic code are "expressed." Mark A. Rothstein, Yu Cai, & Gary E. Marchant, *The Ghost in our Genes: Legal and Ethical Implications of Epigenetics*, 19 HEALTH MATRIX CLEVEL. 1 (2009). Rothstein et al. explain that "the genetic code has been compared to the hardware of a computer, whereas epigenetic information has been compared to computer software that controls the operation of the hardware." *Id.* at 1-2. Large-scale environmental health disasters thus may imprint human bodies for generations. See, e.g., Zaneta M. Thayer and Christopher W. Kuzawa, *Biological Memories of Past Environments: Epigenetic Pathways to Health Disparities*, 6 EPIGENETICS 798 (2011).

[46] See JACOB HACKER, THE GREAT RISK SHIFT (2d ed 2019).

[47] See Tobin-Tyler & Teitelbaum, *supra* n. 3, at xiii. As Tobin-Tyler and Teitelbaum point out, "the number of individuals with serious mental illness in prisons and jails now exceeds by ten times the number in state psychiatric hospitals, and there are more people behind bars for a drug offense than the number of people who were in prison or jail for any crime in 1980." *Id.* (emphasis in original).

[48] *Id.* at xv; *see also* JULIA ACKER ET AL., MASS INCARCERATION THREATENS HEALTH EQUITY IN AMERICA 2, 6 (2019) (observing that the incarceration rate in the United States is higher than any other nation in the world, including totalitarian regimes, and that "substantial evidence links incarceration with poor health outcomes").

[49] PAULA BRAVEMAN & SUSAN EGERTER, RWJF COMMISSION TO BUILD A HEALTHIER AMERICA, OVERCOMING OBSTACLES TO HEALTH IN 2013 AND BEYOND 12 (2013).

California today, "a White child born in the affluent Oakland hills will live on average 15 years longer than an African-American child born just miles away in East or West Oakland."[50] Public health researchers have mapped and compared a range of health outcomes across neighborhoods, including life expectancy, rates of chronic disease and infectious disease, and accidental and intentional injury.[51] The results show that where people live -- which often is closely related to who they are -- can produce a life expectancy differential of as much as 20 years.[52]

One factor shaping the geography of health is the physical characteristics of a neighborhood. These characteristics include neighborhood walkability; housing quality; access to healthy foods; placement of "locally unwanted land uses" such as hazardous waste dumps; and access to local "environmental privileges" such as clean air and water.[53] Some communities boast well-funded schools, parks and other green spaces, full-service grocery stores, safe and affordable housing, and well-connected transportation. Conversely, some neighborhoods feature concentrated poverty, poor-quality housing, run-down streets and "brownfields," low-performing schools, and exposure to crime and violence. These characteristics of the natural and built

---

[50] Anthony Iton & Bina Patel Shrimali, *Power, Politics, and Health: A New Public Health Practice Targeting the Root Causes of Health Equity*, 20 MATERNAL AND CHILD HEALTH J. 1753, 1753 (2016).

[51] *See Mapping Life Expectancy*, Va. Commonwealth U., Ctr. on Soc. & Health (Sept. 26, 2016), https://societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html; *What and Why We Rank*, County Health Rankings & Roadmaps, http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank (last visited Feb. 15, 2019).

[52] *Mapping Life Expectancy*, Va. Commonwealth U., Ctr. on Soc. & Health (Sept. 26, 2016), https://societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html.

[53] *See* Tobin-Tyler & Teitelbaum, *supra* n. 3, at 73-82 (discussing these and other aspects of place-related health disparities). For a case study of Aspen, Colorado as a place where wealthy communities have hoarded the benefits of a clean and healthful natural environment, *see* LISA SUN-HEE PARK & DAVID PELLOW, THE SLUMS OF ASPEN (2011).

Iton and Shrimali explain:

> [A] baby embodies not just the life of her mother, but also the history of this country, a place which shaped the baby's mother's experience. This history includes segregationist policies such as discriminatory zoning rules, redlining, and regressive taxation, are examples of policies and practices determining where the baby's parents, their parents, and previous generations lived, what opportunities they had, what they were able to save, and what they could pass on to their children. The result of these policies and practices is the current reality of poor people and people of color disproportionately living in disinvested communities where residents lack access to health-promoting resources, including good schools, healthy food, safety, and strong social networks that allow for collective efficacy and voice in political decision-making.

Iton & Shrimali, *Power, Politics, and Health*, *supra* n. 50, at 1754.

environment pave the way for predictable and persistent health disparities.[54]

A second factor shaping the geography of health is the interactions of racism, capital, and political power.[55] For example, in the 1950s and 1960s, federal government policy encouraged and subsidized the building of residential suburbs.[56] The infamous "redlining" maps adopted by the Home Owners Loan Corporation (HOLC) deliberately withheld mortgage lending from black and racially integrated communities, and instead directed investments toward all-white, class-homogenous communities. Meanwhile, the law of urban "blight" gave cities the power to demolish neighborhoods seen as physically run-down or dangerous. As Wendell Pritchett observes, "Racial motivations were often submerged under the labels of 'slum clearance' or 'neighborhood revitalization,' but a primary goal of postwar urban renewal was to channel minority settlement into certain areas and to uproot minority communities in other areas. In cities across the country, urban renewal came to be known as 'Negro removal.'"[57] Land use policy in this period both fostered and entrenched racial segregation, and systematically directed economic subsidies to homeowners in all-white communities, resulting in "white flight" from cities.

Today, in contrast, the number of upper-income, white professionals living in the formerly taboo "inner city" is rising, creating a new development boom. As Audrey McFarlane explains, "Urban places that were once racialized as Black and classified as poor, dangerous, and off-limits to anyone of affluence and with choices, have taken on new meaning today. These places are now suppliers of housing that is relatively cheap, centrally located, and often architecturally rich. They are open territories for investment speculators, redevelopment agencies, and affluent professionals."[58] Public and private economic investment in places formerly classified as low-value is known as "gentrification," and it brings complex benefits and burdens. Gentrification brings amenities associated with good public health: new parks, better supermarkets, and improvements in housing quality. As McFarlane observes, all residents appreciate these changes; yet, long-term residents may also recognize that these health-promoting improvements may result in their being "priced out."[59] Moreover,

---

[54] STEVEN H. WOOLF ET AL., HOW ARE INCOME AND WEALTH LINKED TO HEALTH AND LONGEVITY? 6 (2015).

[55] Christopher Tyson argues that "For much of the twentieth century and ever since, the social, political and spatial subordination of black people has been the dominant organizing principle for American cities and metropolitan regions." Christopher J. Tyson, *From Ferguson to Flint: In Search of an Antisubordination Principle for Local Government Law*, 34 HARV. J. RACIAL & ETHNIC JUST. 1, 2 (2018).

[56] *See generally* RICHARD ROTHSTEIN, THE COLOR OF LAW: A FORGOTTEN HISTORY OF HOW OUR GOVERNMENT SEGREGATED AMERICA (2017).

[57] Wendell E. Pritchett, *The "Public Menace" of Blight: Urban Renewal and the Private Uses of Eminent Domain*, 21 YALE L. & POL'Y REV. 1, 47 (2003).

[58] Audrey G. McFarlane, *The New Inner City: Class Transformation, Concentrated Affluence and the Obligations of the Police Power*, 8 U. PA. J. CONST. L. 1, 5 (2006).

[59] McFarlane, *The New Inner City, supra* n. 58, at 29.

gentrification often means a dramatic change in the racial and ethnic character of a neighborhood. This new form of "Negro removal" appears to be the result of market forces. Yet law-driven public policy plays a central role in shaping economic development, and cash-strapped cities are making policy choices that perpetuate racial and class segregation and the health disparities that follow.[60]

3. Health Disparities Based on Access to Power

A third pathway through which health disparities appear is the exercise of *power*. Although the word is frequently used in its coercion-related sense, here we refer to its meaning as "inherently related to asserting individual and collective will:"[61] what the political science literature calls "power-to," as opposed to "power-over," [62] and what activists refer to as "empowerment."[63] One formulation of power-to comes from the psychology literature, and refers to an individual's ability to exercise agency.[64] A second aspect of power-to has to do with collective power and control, and is reflected in civic engagement and participation in public decisionmaking. In the public health literature, power-to is taking shape as "control over one's destiny," and a growing group of scholars and practitioners see it as a fundamental social determinant of health.[65] Lack of personal and collective agency -- whether caused by trauma, toxic stress, discrimination, poverty, political marginalization, or disenfranchisement -- increases risk of mental illness and chronic physical disease. Conversely, the experience of exercising self-determination,

---

[60] As McFarlane explains, "City, state, and federal policies may not be the direct cause of gentrification, but the consistent policy of encouraging the middle and upper income populations to move into the city through tax credits and abatements for new city home buyers, as well as other tools and techniques, is an inextricable and powerful factor in the process." *Id.* at 39-40. For an example of how place-based research can illuminate "how neighborhoods shape the development of human capital and support local economic policy," *see generally* RAJ CHETTY ET AL., CENTER FOR ECONOMIC STUDIES, U.S. CENSUS BUREAU, WORKING PAPERS 18-42, THE OPPORTUNITY ATLAS: MAPPING CHILDHOOD ROOTS OF SOCIAL MOBILITY (2018).

[61] Marjory Givens et al., *Power: The Most Fundamental Cause of Health Inequity?*, Health Affairs Blog (Feb. 1, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180129.731387/full/.

[62] In the political science literature, "power-to" refers to power as the capacity to act in accordance with one's will; "power-over" is relational, and refers to the ability to get someone else to do something they would otherwise not do. See HANNA PITKIN, WITTGENSTEIN AND JUSTICE 276 (1972).

[63] *See, e.g.,* Jo Rowlands, *Empowerment Examined*, 5 DEVELOPMENT IN PRACTICE 101, 103 (1995) (adopting a definition of "empowerment" as having three dimensions, personal; in close relationships; and collective).

[64] See, e.g., James W. Moore, *What Is the Sense of Agency and Why Does It Matter?*, 7 FRONTIERS IN PSYCHOL. 1272 (2016) (a "[s]ense of agency refers to the feeling of control over actions and their consequences.").

[65] *See generally* Whitehead et al., *How Could Differences in "Control Over Destiny" Lead to Socio-Economic Inequalities in Health?, supra* n. 32.

whether at the individual or collective level, has a protective effect on health.[66]

One way that individuals experience power-to is by being able to exercise enough control over their environment to meet the basic human need for a sense of safety.[67] People who are exposed to physical violence or emotional abuse without the ability to affect or escape the situation, for example, are vulnerable to the long-lasting psychological damage called trauma.[68] Trauma is associated with mental and emotional distress, as well as vulnerability to mental and physical illness.[69]

Public health advocates have identified a specific kind of trauma, "adverse childhood experiences," or ACEs, as a powerful predictor of later health.[70] ACEs include physical and emotional abuse, neglect, exposure to intimate partner violence, and parental incarceration. The more such experiences a child encounters, the more likely the child is to suffer as an adult from conditions such as heart disease, obesity, depression, and substance abuse.[71] ACEs also appear to alter brain development in young children, leading to a host of other negative outcomes.[72]

Adults as well as children are susceptible to the negative health consequences of trauma. For example, researchers now recognize the harms of Complex Post-Traumatic Stress Disorder, a condition that can be triggered by sustained exposure to trauma such as combat, family violence, poverty, or forced migration.[73] All of these

---

[66] *See, e.g.*, Alison O'Mara Eves et al., *Community Engagement to Reduce Inequalities in Health: A Systematic Review*, *Meta-Analysis and Economic Analysis*, 1 PUB. HEALTH RES., No. 4, Nov. 2013, at xvii ("Overall, community engagement interventions are effective in improving health behaviours, health consequences, participant self-efficacy and perceived social support for disadvantaged groups."); Nina Wallerstein, *Empowerment to Reduce Health Disparities*,30 SCAND J. PUB. HEALTH 72, 74 (summarizing the research on individual and collective empowerment and finding that both are correlated with improved health outcomes).

[67] For example, within psychology, "attachment theory" and "terror management theory" posit that "much of human behavior is directed toward maintaining a sense of psychological security and minimizing conscious and unconscious apprehension and anxiety about personal vulnerability – including, ultimately, death." Joshua Hart, Phillip R. Shaver, & Jamie L. Goldenberg, *Attachment, Self-Esteem, Worldviews, and Terror Management: Evidence for a Tripartite Security System*, 88 J. PERSONALITY & SOC. PSYCHOLOGY 999, 999 (2005).

[68] See generally JOHN N. BRIERE & CATHERINE SCOTT, PRINCIPLES OF TRAUMA THERAPY: A GUIDE TO SYMPTOMS, EVALUATION, AND TREATMENT (DSM-5 UPDATE) (2014).

[69] *Id.*

[70] Vincent J. Felitti et al., *Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study*, 14 AM. J. OF PREVENTIVE MED. 245, 245 (1998).

[71] *See* Felitti et al., *supra* n. 70.

[72] See Tobin-Tyler & Teitelbaum, supra n. 3, at 84 (reviewing studies).

[73] *See, e.g.*, Sabina Palic et al., *Evidence of Complex Posttraumatic Stress Disorder Across Populations with Prolonged Trauma of Varying Interpersonal Intensity and Ages of Exposure*, PSYCHIATRY RES. (2016), https://doi.org/10.1016/j.psychres.2016.10.062 ("high probability of CPTSD was found in both the childhood prolonged trauma . . . and the adulthood prolonged trauma samples with *severe*

are experiences of extreme powerlessness and lack of physical security, and like ACEs they produce a host of vulnerabilities to poor physical and mental health.

A less well-known literature suggests that individuals lacking other important forms of power-to -- such as the ability to vote and influence the political process – are also subject to negative health outcomes.[74] Poverty is a striking example. The chronic inability of poor people to control their circumstances appears to contribute to poor physical and mental health.[75]

The link between all these experiences of disempowerment and poor health appears to be "toxic stress," a state in which the stress response system is overloaded, rendering the body vulnerable to a host of negative consequences.[76]

A second form of power-to involves collective agency and self-determination. Continuing with the example of trauma, certain traumatic events can have a harmful impact on an entire community -- something an emergent line of research refers to as "adverse community experiences." Jonathan Purtle observes, "When a group is exposed to pervasive and chronic violations of human dignity—and feelings of ignominy, disrespect, and social exclusion are prevalent—elevated rates of mortality, morbidity, and disability often follow. This situation pertains especially when the mechanisms that violate dignity are discriminatory in origin and institutionalized by

interpersonal intensity (i.e. the refugees, and the ex-POWs)"); KATHRYN COLLINS ET AL., FAMILY INFORMED TRAUMA TREATMENT CNTR., UNDERSTANDING THE IMPACT OF TRAUMA AND URBAN POVERTY ON FAMILY SYSTEMS: RISKS, RESILIENCE, AND INTERVENTIONS 15, 21, 26 (2010) (concluding that children, adolescents, and adults who experience urban poverty face increased risk for exposure to ongoing trauma resulting from exposure to crime, family violence, maltreatment, and other factors).

[74] *See, e.g.*, Jonathan Purtle, *Felon Disenfranchisement in the United States: A Health Equity Perspective*, 103 AM. J. OF PUB. HEALTH 632, 634-35 (2013).

[75] *See* Dhruv Khullar & Dave A. Chokshi, *Health, Income, and Poverty: Where We Are and What Could Help*, Health Policy Brief (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/; Clancy Blair & C. Cybele Raver, *Poverty, Stress, and Brain Development: New Directions for Prevention and Intervention*, 16 ACAD. PEDIATRIC, No. 3 Supp., Apr. 2016, at 1 ("A growing body of evidence indicates that effects of poverty on physiologic and neurobiologic development are likely central to poverty-related gaps in academic achievement and the well-documented lifelong effects of poverty on physical and mental health."); DAVID L. SHERN, ANDREA K. BLANCH, SARAH M. STEVERMAN, IMPACT OF TOXIC STRESS ON INDIVIDUALS AND COMMUNITIES: A REVIEW OF THE LITERATURE 8 (2014) (identifying poverty as one of the primary sources of toxic stress, "possibly because people living in poverty exposes people to unpredictable environments, lack of resource buffers, and social stigma").

[76] For an analysis of "the disruptive impacts of toxic stress . . . [and] causal mechanisms that link early adversity to later impairments in learning, behavior, and both physical and mental well-being, *see generally, e.g.*, Jack P. Shonkoff et al., *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*, 129 PEDIATRICS, no. 1, Jan. 2012.

law."[77]

Like ACEs, community trauma is associated with serious consequences, including damage to the social fabric of a community, erosion of positive social norms, marginalization or exclusion from collective decision-making, and physical upheaval -- all of which are associated with negative health outcomes.[78] For example, Mindy Thompson Fullilove argues that neighborhoods subjected to the coercive disruptions of urban renewal policies create what she calls "root shock" in their residents, a form of trauma that produces ill health by disrupting community bonds.[79] "Serial forced displacement[s]" -- repetitive, coercive upheaval in neighborhoods that scatter the residents -- are often forced upon communities already targeted on the basis of their status.[80]

Conversely, a growing body of literature looks to personal and collective efficacy as having a protective effect on health at the individual and community levels.[81] A pioneering study on violence prevention defines collective efficacy as "social cohesion among neighbors combined with their willingness to intervene on behalf of the common good."[82] Similar phenomena associated with collective power and control, such as "social capital," a "psychological sense of community," "informal social control," and "community empowerment," appear to have a positive influence on individual health.[83] As Michael Marmot concludes, "Autonomy – how much control you have over your life – and the opportunities you have for full social engagement

[77] Jonathan Purtle, *Felon Disenfranchisement in the United States: A Health Equity Perspective*, 103 AM. J. OF PUB. HEALTH 632, 636 (2013).

[78] HOWARD PINDERHUGHES, RACHEL A. DAVIS, & MYESHA WILLIAMS, PREVENTION INSTITUTE, ADVERSE COMMUNITY EXPERIENCES AND RESILIENCE: A FRAMEWORK FOR ADDRESSING AND PREVENTING COMMUNITY TRAUMA 7-8, 30-32 (2015).

[79] MINDY THOMPSON FULLILOVE, ROOT SHOCK: HOW TEARING UP CITY NEIGHBORHOODS HURTS AMERICA, AND WHAT WE CAN DO ABOUT IT (2004).

[80] *See* Mindy Thompson Fullilove & Rodrick Wallace, *Serial Forced Displacement in American Cities, 1916-2010*, 88 J. OF URB. HEALTH 381, 381, 383-84 (2011).

[81] *See* Margaret Whitehead et al., *How Could Differences in "Control Over Destiny" Lead to Socio-Economic Inequalities in Health? A Synthesis of Theories and Pathways in the Living Environment*, 39 Health & Place 51, 52 (2016).

[82] Robert J. Sampson et al., *Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy*, 277 SCIENCE 918, 918 (1997). *See also* John R. Hipp & James C. Wo, *Collective Efficacy and Crime*, *in* 4 INT'L ENCYCLOPEDIA OF THE SOC. & BEHAV. SCI. at 169 (2nd ed. 2015); Christopher R. Browning & Kathleen A. Cagney, *Neighborhood Structural Disadvantage, Collective Efficacy, and Self-Rated Physical Health in an Urban Setting*, 43 J. OF HEALTH & SOC. BEHAV. 383, 385-86 (2002).

[83] See, e.g., Gilbert C. Gee & Devon C. Payne-Sturges, *Environmental Health Disparities: A Framework Integrating Psychosocial and Environmental Concepts*, 112 ENVIRON. HEALTH PERSPECTIVES 1645, 1649 (2004), available at doi: 10.1289/ehp.7074.

and participation – are crucial for health, well-being and longevity."[84]

4. The Root of the Problem: Subordination

These three pathways through which the social determinants of health shape health disparities – population, place, and power – are analytically distinct, but in practice they overlap and interact. For instance, the "population" factors of poverty, homelessness, and undocumented immigrant status are critical risk factors for interpersonal violence – a "power" pathway -- because they create significant barriers to victims trying to leave an abusive relationship."[85] Similarly, racial segregation, which combines "population" and "place" pathways, is associated with worse health outcomes.[86]

More importantly, these pathways share a single origin: subordination. From the colonial period to the present, dispossession, labor exploitation, and political domination on the basis of race have affected the distribution of political power and economic resources in America. The same can be said of other forms of subordination, such as those based on gender, sexuality, disability, and class. The major pathways through which health disparities travel -- population, place, and power -- can all be traced back to historic and continuing patterns of exploiting or marginalizing some communities for the benefit of others. From this perspective, the problem of health disparities is ultimately a problem of justice.

B. Limitations of Conventional Public Health Advocacy in Addressing Persistent Health Disparities

Two key limitations of the conventional public health framework continue to hinder its ability to adequately address the role of subordination in shaping the social determinants of health. First, public health advocates have focused on universally-targeted health interventions designed to benefit as many people as possible. Under this approach, however, gaps in health outcomes may persist or even widen among populations, and the systems that constrain individuals' choices remain

[84] MICHAEL MARMOT, THE STATUS SYNDROME: HOW SOCIAL STANDING AFFECTS OUR HEALTH AND LONGEVITY 2 (2004).

[85] Tobin-Tyler & Teitelbaum, *supra* n. 3, at 83.

[86] *Id.* at 78 ("Studies show correlations between neighborhood disadvantage and cardiovascular disease, obesity, depression, cancer, and risk behaviors such as smoking, early sex, and substance abuse. . . . These health disparities are thought to be the result of greater exposure in segregated neighborhoods to poverty, violence, stress, indoor and outdoor environmental pollutants, and structural problems with the built environment."). see also Dayna Bowen Matthew, *Health and Housing: Altruistic Medicalization of America's Affordability Crisis*, 81 LAW & CONTEMP. PROBS. 161 (2018) (arguing that because of these disparities, housing affordability is a public health problem).

unchallenged. Second, public health research, like health research generally, has insufficiently addressed the influence of subordination on its own assumptions, methods, and practices. The result has been an approach to remedying health disparities that has not sufficiently come to grips with the impacts of subordination, including within the field itself.

1. Universal Solutions Focused on Behavior Change Obscure Subordination's Impact on Health

The conventional approach to improving public health has been premised on universalism: a focus on solutions that apply broadly across all social groups. Although public health advocates have increasingly recognized its limitations,[87] universalism is reflected in the most important public health policy initiatives of the last few decades, such as ensuring access to affordable, high-quality health care; encouraging healthier behavior choices; and creating healthier communities.[88] For example, the campaign to reduce obesity and related chronic disease, especially among children, combines all three universalist initiatives. However, while there have been successes in addressing overall rates of obesity, unjust disparities remain. Researchers now believe that "[c]losing gaps will actually require interventions that work better in [disadvantaged communities] than they do in white or more advantaged populations," and that continuing to deploy interventions that benefit the population at large may simply deepen the disparities.[89]

The conventional public health approach also focuses on promoting individual behavior change.[90] This focus, however, can obscure the role of structural forces in

[87] For examples of emerging public health and social justice theories that acknowledge the limitations of a universalist approach, *see, e.g.*, john a. powell, Stephen Menendian, & Jason Reece, *The Importance of Targeted Universalism*, POVERTY & RACE (March/Apr. 2009), *available at* http://ceelo.org/wp-content/uploads/2018/08/The-Importance-of-Targeted-Universalism.pdf (defining "targeted universalism" as "an approach that supports the needs of the particular while reminding us that we are all part of the same social fabric," and stating, "[t]argeted universalism rejects a blanket universal which is likely to be indifferent to the reality that different groups are situated differently relative to the institutions and resources of society"), and NAT'L COLLABORATING CTR. FOR DETERMINANTS OF HEALTH, LET'S TALK: UNIVERSAL AND TARGETED APPROACHES TO HEALTH EQUITY (2013) (promoting "proportionate universalism," an approach that has been gaining acceptance in Europe and the United Kingdom and which can be defined as recognizing that to "level up the social gradient [in health outcomes], programs and policies must include a range of responses for different levels of disadvantage experienced within the population").

[88] Lindsay F. Wiley, *Health Law as Social Justice, supra* n. 29.

[89] SHIRIKI KUMANYIKA, GETTING TO EQUITY IN OBESITY PREVENTION: A NEW FRAMEWORK 4 (2017).

[90] *See* Nicholas Freudenberg et al., *New Approaches for Moving Upstream: How State and Local Health Departments Can Transform Practice to Reduce Health Inequalities*, 42 HEALTH EDUC. & BEHAV. 46S, 46S (2015) (asserting that despite evidence on how social determinants impact health, "health educators and other public health professionals still develop interventions that focus mainly on

causing health disparities.[91] For example, Mary T. Basset and Jasmine D. Graves argue that attributing differences in health to "lifestyle choices" is a "racist idea," because it "assigns responsibility to individuals without reference to the context of their lives. . . dismissing racial patterning of power and opportunity [and ignoring] the toll of daily and lifelong experiences of discrimination."[92]

Taken together, these limitations help explain why, despite overall successes across decades of public health interventions, patterns of morbidity and mortality continue to reflect vulnerabilities along the familiar differentials of populations, places, and power.[93]

2. Subordination Influences Public Health Assumptions, Methods, and Research Priorities

A second limitation of the conventional public health framework is that it has not fully reckoned with the dynamics of subordination that have shaped medical and public health research, interventions and policy. As in other disciplines, relations of power and privilege influence the path of research: which populations' problems matter, how research should be conducted, and how priorities should be set. Medical researchers, for example, often fail to question the "bioprivilege" that structures the targets and methods of basic biomedical research, such as the use of the white male body as the standard yardstick for testing medical interventions.[94]

In terms of method, public health research tends to shy away from

---

'downstream' behavioral risks"); Fran Baum & Matthew Fisher, *Why Behavioural Health Promotion Endures Despite Its Failure to Reduce Health Inequities*, 36 SOCIOLOGY OF HEALTH & ILLNESS 213, 214 (2014)

[91] *See* Wiley, *Health Law as Social Justice, supra* n. 29, at 100; Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 U.C. DAVIS L. REV. 121 (2013).

[92] Mary T. Bassett & Jasmine D. Graves, *Uprooting Institutionalized Racism as Public Health Practice*, 108 AM. J. PUB. HEALTH 457, 457 (2018)

[93] *See* Wiley, *Health Law as Social Justice*, *supra* n. 29, at 48-49 (acknowledging lingering health disparities connected to race, ethnicity, gender, and poverty).

[94] As Lisa Ikemoto explains:

> A study of anatomy textbooks found that in the non-reproductive illustrations, the male body was represented at a substantially higher rate than the female body. More specifically, the study showed that "women constituted an average of 11.1% of nonreproductive anatomy illustrations and an average of 8.8% of nonreproductive physical diagnosis illustrations, while men were drawn in 43.1% and 23.7% of the respective illustrations." The finding suggests gender bias and indicates that medical students acquire "an incomplete knowledge of normal female anatomy."

Ikemoto, *Bioprivilege*, *supra* n. 44, at 64-65.

acknowledging subordination. For example, research into racialized health disparities often accounts for "race," but not "racism." This is not a new problem. In 1851, for instance, American physician Samuel A. Cartwright notoriously hypothesized that the reason that so many enslaved Africans fled captivity was because they were uniquely susceptible to a mental illness called "drapetomania."[95] Failing to take account of racism reinforces the notion that race is an immutable biological trait.

Such thinking, unfortunately, did not end in the nineteenth century. In the 1990s, the Federal Violence Initiative laudably took a public health approach to violence in inner cities.[96] However, the leaders of the initiative framed a key research question as, "Do male and black persons have a higher potential for violence than others and, if so, why?"[97] This research question assumed that the causes of inner-city violence were to be found in the physiology of black men, not in the interactions of interpersonal, institutional, and structural discrimination that make poor and black neighborhoods dangerous.[98]

Even contemporary health research tends to treat "race" as a biological category, rather than as a social status shaped by past and continuing subordination. For example, Chandra Ford and Collins Airhihenbuwa argue that epidemiological models of disease commonly treat race as "a population characteristic that

---

[95] Samuel A. Cartwright, *Report on the Diseases and Physical Peculiarities of the Negro Race*, 1851 THE NEW ORLEANS MEDICAL AND SURGICAL JOURNAL 691 (1851), available at https://archive.org/stream/TheNewOrleansMedicalAndSurgicalJournal/The%20New%20Orleans%20medical%20and%20surgical%20journal#mode/1up. Similarly, following the Civil War, Prudential Life Insurance statistician Frederick L. Hoffman published a report entitled "Race Traits and Tendencies of the American Negro," arguing that the poor health status of blacks was attributable to inherent racial inferiority. "It is not in the *conditions of life*, but in the *race traits and tendencies* that we find the causes of excessive mortality," Hoffman concluded. Quoted in Daryll Dykes, *Health Injustice and Justice in Health*, *supra* n. 31, at 1135.

[96] Lisa C. Ikemoto, *The Racialization of Genomic Knowledge*, 27 SETON HALL L. REV. 937, 944 (1997).

[97] Ikemoto, *The Racialization of Genomic Knowledge*, *supra* n. 96, at 944. The project was shelved, Ikemoto notes, after its head, Frederick Goodwin, "publicly compared inner-city youth to "hyperaggressive monkeys who kill each other [and] are also hypersexual." *Id.*

[98] Today, in the era of "epigenetics," some scholars warn that history is about to repeat itself. In 2016, the National Institutes of Health announced a call for studies "focused on identifying and characterizing the mechanisms by which social experiences . . . affect gene function and thereby influence health trajectories or modify disease risk in ethnic/racial minority and health disparity populations." Quoted in Katie M. Saulnier and Charles Dupras, *Race in the Postgenomic Era: Social Epigenetics Calling for Interdisciplinary Ethical Safeguards*, 17 AM. J. BIOETHICS 58, 58 (2017). Some scholars fear that as before, this new scientific endeavor could be used to reinforce subordination rather than challenging it, this time by stigmatizing minority cultures instead of minority bodies. For example, this initiative might encourage researchers to identify biological "abnormalities" and link them to "'at-risk' and thus deplorable sociocultural practices (e.g., diet, lifestyle) by minority groups (e.g., indigenous populations, immigrants)." Id. at 59. *See generally* Becky Mansfield, *Race and the New Epigenetic Biopolitics of Environmental Health*, 7 BIOSOCIETIES 352 (2012).

predisposes one towards particular behaviors."[99] A better approach, they argue, is to recognize that "race" itself is a socially constructed category whose connection to physical health is mediated through social and political systems. Race, in this conception, is "less a risk factor itself than a marker of risk for racism-related exposures."[100]

Similarly, epidemiologist Nancy Krieger argues that conventional epidemiological research conflates two very different relationships between racism and health: the "biological expressions of race relations" and "racialized expressions of biology."[101] The former draws attention to how harmful physical and psychosocial exposures due to racism adversely affect our biology, in ways that ultimately are embodied and manifested in racial-ethnic disparities in health. The latter refers to how arbitrary biological traits are (erroneously) construed as markers of innate "racial" distinctions.[102] Confusing the two means that vulnerability is more readily accepted as the end of the story, and that "downstream" solutions are more likely to be considered sufficient.

Even the comparative method -- investigating health disparities by comparing the health outcomes of minority groups to those of whites – fails to sufficiently take account of subordination.[103] As Shawn Bediako and Derek Griffith point out, although the comparative approach is useful as description, it fails "to identify specific causal factors that produce disproportionately poor health outcomes for racial and ethnic minorities." The public health research agenda, then, needs to shift from describing and measuring the problem of health disparities to crafting solutions to address it.[104]

In summary, the conventional public health approach remains hindered by a universal and individualist focus and insufficient critical self-consciousness. The

---

[99] Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH suppl. 1 S30, S33 (2010).

[100] Ford & Airhihenbuwa, *supra* n. 98, at S33.

[101] Nancy Krieger, *Does Racism Harm Health? Did Child Abuse Exist Before1962? On Explicit Questions, Critical Science, and Current Controversies: An Ecosocial Perspective*, 93 AM. J. PUB. HEALTH 194, 195.

[102] *Id.*

[103] Shawn M. Bediako & Derek M. Griffith, *Eliminating Racial/Ethnic Health Disparities: Reconsidering Comparative Approaches*, 2 J. HEALTH DISPARITIES RES. & PRACTICE 49, 53 (2007).

[104] Shobha Srinivasan and Shanita D. Williams call this "shift[ing] the research agenda from a disparity model to an equity model." Shobha Srinivasan & Shanita D. Williams, *Transitioning from Health Disparities to a Health Equity Research Agenda: The Time is Now*, 129 PUB. HEALTH REP. 71, 73 (2014). They explain, "Until recently, studies of health disparities have been largely descriptive and focused on differences in population health that are closely linked with social advantage and disadvantage. The shift to health equity involves developing and implementing interventions at the neighborhood, local, community, state, and national levels." *Id.* at 72-73.

"vulnerabilities" transmitted through populations, places, and lack of power are not natural, but created – often by law, and sometimes deliberately.[105] All this suggests that addressing the social determinants of health and persistent health disparities requires grappling directly with subordination. Public health advocates have begun to acknowledge that law offers an indispensable tool for addressing the social determinants of health.[106] In the next section, we will explore the possibilities and limitations of existing civil rights law in facilitating an anti-subordination approach.

II. CIVIL RIGHTS LAW AND ITS LIMITATIONS

Legal advocates have long recognized the role of subordination in creating and sustaining inequalities. What the health literature tends to call "vulnerability" or "health disparity," the legal literature refers to as "discrimination," recognizing its deliberate production and perpetuation. Civil rights law, as the body of law developed to remedy discrimination, should thus logically be an important component of public health advocacy. Unfortunately, anti-discrimination law is in the throes of a decades-long retrenchment. Indeed, many legal scholars argue that today's civil rights law more often accommodates than challenges subordination. This Part provides a brief overview of the procedural and substantive obstacles anti-discrimination law presents to addressing subordination and its adverse impacts on health.

Before addressing the obstacles specific to anti-discrimination law, we note two overarching challenges in using American law to challenge subordination. First, not all forms of unjust social inequality that create health disparities receive legal recognition within civil rights law. For instance, poverty is a powerful driver of poor health, discrimination against the poor is common, and economic mobility in the United States is quite limited (making poverty a "quasi-immutable trait"). Yet, the Supreme Court has not recognized poverty as a status that uniformly receives anti-discrimination protection under the U.S. Constitution.[107] Rather, the Court has recognized only a few scattered constitutional rights for poor people, such as the right

---

[105] See David Ray Papke & Mary Elise Papke, *A Foe More Than a Friend: Law and the Health of the American Urban Poor*, 44 FORDHAM URB. L.J. 1, 3 (2017) (concluding that "law creates and perpetuates the health problems of the urban poor more than it eliminates or ameliorates them.").

[106] *See generally, e.g.*, Scott Burris et al., *Better Health Faster: The 5 Essential Public Health Law Services*, 131 PUB. HEALTH REP. 747 (2016); Richard A. Goodman et al., *Law and Public Health at CDC*, 55 MORBIDITY & MORTALITY WKLY. REP. 29 (2006); *Public Health Law Academy*, ChangeLab Solutions, https://www.changelabsolutions.org/public-health-law-academy (last visited Feb. 15, 2019); *The Five Essential Public Health Law Services Framework*, The Network for Pub. Health L., https://www.networkforphl.org/about_the_network/five_essential_public_health_law_services_framework/ (last visited Feb. 15, 2019).

[107] See Tobin-Tyler & Teitelbaum, *supra* n. 3, at 6-10; see also Cary Franklin, *The New Class Blindness*, 128 YALE L.J. 2 (2018) (arguing that recent judicial decisions interpreting federal anti-discrimination law wrongly presume that equal protection law contains no protections based on poverty).

to be represented by a lawyer at no cost in a criminal trial.[108] Other targets of subordination, such as people under the LGBT umbrella, have similarly incomplete legal protections against discrimination.[109]

Second, the structure of our eighteenth-century federal Constitution embraces "negative" rights – the right to be let alone by government – but not "positive" rights – obligations of the government to provide for its citizens. Thus, many rights relevant to health that are recognized in international conventions, such as the right to life, the right to food, the right to education, and the right to a clean environment (not to mention the right to health itself), do not exist at the federal level in the United States.[110]

A. Procedural Barriers to Using Civil Rights Law to Address Health Disparities

A host of judicially-imposed procedural obstacles make it difficult for today's federal civil rights litigators to achieve traction.[111] As Pamela Karlan summarizes the trend, "[T]he Court displays increasing indifference to providing individualized remedies for persons subjected to an important range of unconstitutional conduct."[112] Some of the obstacles are long-standing. For example, Karlan argues that the Supreme Court has been unable to effectively guarantee equality in areas such as

---

[108] *See* Tobin-Tyler & Teitelbaum, *supra* n. 5, at 13.

[109] *See* Alexander M. Nourafshan, *The New Employment Discrimination: Intra-LGBT Intersectional Invisibility and the Marginalization of Minority Subclasses in Antidiscrimination Law*, 24 DUKE J. GENDER L. & POL'Y 107, 109 (2017) (noting the uneven protection for LGBT people in the workplace, especially for people who are members of more than one stigmatized group).

[110] *See* Tobin-Tyler & Teitelbaum, *supra* n. 5, at 10; Courtney Jung, Ran Hirschl, & Evan Rosevear, *Economic and Social Rights in National Constitutions*, 62 AM. J. COMP. L. 1043 (2014); Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?* 56 SYRACUSE L. REV. 1 (2005). As we will see in Part II infra, however, some state constitutions do recognize specific positive rights.

[111] *See* Pamela S. Karlan, *Shoe-Horning, Shell Games, and Enforcing Constitutional Rights in the Twenty-First Century*, 78 UMKC L. REV. 875 (2010); *see also* Andrew M. Siegel, *The Court Against the Courts: Hostility to Litigation as an Organizing Theme in the Rehnquist Court's Jurisprudence*, 84 TEX. L. REV. 1097 (2006); Scott Moss, *Fighting Discrimination While Fighting Litigation: A Tale of Two Supreme Courts*, 76 FORDHAM L. REV. 981 (2007); Elizabeth M. Schneider, *The Changing Shape of Federal Civil Pretrial Practice: The Disparate Impact on Civil Rights and Employment Discrimination Cases*, 158 U. PA. L. REV. 517 (2010); Alex Reinert, *Procedural Barriers to Civil Rights Litigation and the Illusory Promise of Equity*, 78 UMKC L. REV. 931 (2010); Catherine Y. Kim, *Changed Circumstances: The Federal Rules of Civil Procedure and the Future of Institutional Reform Litigation After* Horne v. Flores, 46 U.C. DAVIS L. REV. 1435 (2013); Michael Morley, *Enforcing Equality: Statutory Injunctions, Equitable Balancing Under* Ebay, *and the Civil Rights Act of 1964*, 2014 U. CHI. LEGAL F. 177 (2014).

[112] Karlan, *Shoe-Horning*, *supra* n. 111, at 877.

voting law because it has focused solely on harms to individuals rather than harms to democratic representation as a whole.[113]

Other obstacles are more recent. In the last decade, for example, the Court has imposed rules of standing to sue that make it more difficult to bring litigation based on structural provisions of the Constitution,[114] as well as new rules concerning "qualified immunity" that make it harder for plaintiffs challenging government violation of the Constitution to find someone to sue.[115] The procedural barriers facing litigants who seek to bring class actions have also increased.[116] Finally, new judicially-imposed pleading rules compel plaintiffs bringing anti-discrimination claims to submit detailed facts about their case at the very earliest stages of litigation, or else see their claims thrown out as implausible.[117] As critics have noted, this is troubling given the lack of diversity on the federal bench; judges with little personal experience of discrimination, for example, may well find most discrimination claims implausible.[118]

[113] *See* Karlan, *Shoehorning, supra* n. 111, at 878-79.
[114] *Id.* at 881-82.
[115] *Id.* at 886; *see also* Pamela S. Karlan, *The Irony of Immunity: The Eleventh Amendment, Irreparable Injury, and Section 1983*, 53 STAN. L. REV. 1311 (2001).
[116] *See* Robert H. Klonoff, The Decline of Class Actions, 90 Wash. U. L. Rev. 729 (2013) (identifying and criticizing new procedural barriers such as heightened requirements for class certification and the acceptance of binding arbitration clauses).
[117] *See, e.g.*, Ashcroft v. Iqbal, 556 U.S. 662, 677 (2009) ("to state a claim based on a violation of a clearly established right, respondent must plead sufficient factual matter to show that petitioners adopted and implemented the detention policies at issue not for a neutral, investigative reason but for the purpose of discriminating on account of race, religion, or national origin."); Brian S. Clarke, *Grossly Restricted Pleading: Twombly/Iqbal, Gross, and Cannibalistic Facts in Compound Employment Discrimination Claims*, 2010 UTAH L. REV. 1101 (2010) (arguing that the Court's recent pleading decisions threaten claims of discrimination on two or more grounds); Raymond H. Brescia, *The* Iqbal *Effect: The Impact of New Pleading Standards in Employment and Housing Discrimination Litigation*, 100 KY. L.J. 235, 238-39, 284-85 (2012).
[118] *See* Tristin K. Green, *Racial Emotion in the Workplace*, 86 S. CAL. L. REV. 959, 983-997 (2013) (giving examples of judges' reluctance to acknowledge the impact of racist conduct in the workplace); *see also* Wal-Mart Stores, Inc., v. Dukes, 131 S. Ct. 2541, 2554 (2011) (holding that a class action could not be certified because the plaintiffs had failed to provide convincing proof of a companywide discriminatory pay and promotion policy, and stating that "left to their own devices most managers in any corporation--and surely most managers in a corporation that forbids sex discrimination--would select sex-neutral, performance-based criteria for hiring and promotion that produce no actionable disparity at all."); Suzette M. Malveaux, *The Power and Promise of Procedure: Examining the Class Action Landscape After* Wal-Mart v. Dukes, 62 DEPAUL L. REV. 659, 661 (2013); Marcia L. McCormick, *Implausible Injuries: Wal-Mart v. Dukes and the Future of Class Actions and Employment Discrimination Cases*, 62 DEPAUL L. REV. 711, 722-23, 731 (2013).

Meanwhile, some areas of civil rights litigation have been shut down entirely by recent Supreme Court rulings.[119] In the wake of these decisions, plaintiffs must rely on government actors to enforce their rights, leaving no recourse when those actors are disinclined to enforce the law.[120] Even when government agencies do take action to enforce civil rights, the range of evidence they may introduce is limited. For example, in the apparent belief that racial discrimination is a thing of the past, the Court has recently prevented government actors, including school districts and Congress, from relying on evidence of historical discrimination in the implementation of race-conscious remedies.[121]

As will be explored in more detail in Part III, while courthouse doors have been closing at the federal level, new innovations in civil rights law have emerged at the state and local level.[122] Here, however, an old procedural barrier to civil rights enforcement has taken on unexpected new life: The federal government and state

---

[119] For example, Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq. ("Title VI"), forbids discrimination by any program or activity that receives federal financial assistance. In Alexander v. Sandoval, 532 U.S. 275 (2004), the Supreme Court held that private individuals may not bring suit based on violations of this provision. After *Sandoval*, federal agencies are the only entities that may enforce Title VI. Unfortunately, these agencies have been notoriously slow and lethargic in their response to complaints of discrimination. See Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Health Care System: Reinvigorating the Role of the Federal Government in the Aftermath of* Alexander v. Sandoval, 3 Yale J. Health Pol'y, L. & Ethics 215 (2003) (discussing the negative impact of Sandoval on access to health care); Note, Dan McCaughey, *The Death of Disparate Impact Under Title VI: Alexander v. Sandoval and Its Effect on Private Challenges to High-Stakes Testing Programs*, 84 B.U. L. REV. 247 (2004) (discussing the negative effects of Sandoval on disparate-impact anti-discrimination claims).

[120] *See* Melissa A. Hoffer, *Closing the Door on Private Enforcement of Title VI and EPA's Discriminatory Effects Regulations: Strategies for Environmental Justice Stakeholders After Sandoval and Gonzaga*, 38 NEW ENG. L. REV. 971, 1004 (2004) ("As of November, 2003, of the 114 closed complaints filed with OCR, only 30 were accepted for investigation, two of which were informally resolved. Of the remaining 28, only 15 were decided on the merits--all in favor of the funding recipients."); *see also* Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Health Care System: Reinvigorating the Role of the Federal Government in the Aftermath of* Alexander v. Sandoval, 3 YALE J. HEALTH POL'Y, L. & ETHICS 215 (2003) (discussing the negative impact of *Sandoval* on access to health care); Note, Dan McCaughey, *The Death of Disparate Impact Under Title VI: Alexander v. Sandoval and Its Effect on Private Challenges to High-Stakes Testing Programs*, 84 B.U. L. REV. 247 (2004) (discussing the negative effects of *Sandoval* on disparate-impact anti-discrimination claims).

[121] See Daniel P. Tokaji, *Desegregation, Discrimination and Democracy*: Parents Involved*'s Disregard for Process*, 69 OHIO ST. L.J. 847 (2008) (criticizing the Court's decision in Parents Involved in Community Schools v. Seattle School District, No. 1, 127 S. Ct. 2738 (2007) to overrule the judgment of a local school board that race-conscious assignments were necessary to preserve diversity); Joel Heller, Shelby County *and the End of History*, 44 U. MEM. L. REV. 357 (2013) (criticizing the Court's assertion in *Shelby County* that Congress's use of data from past decades was irrational because such data reflect only "decades-old problems" and have "no logical relation to the present day.").

[122] *See* Olatunde C.A. Johnson, *The Local Turn: Innovation and Diffusion in Civil Rights Law*, 79 LAW & CONTEMP. PROBS. 115, 115-16, 118-30 (2016).

governments can block state and local innovations through preemption.[123] Unfortunately, preemption has become the tool of choice among some state legislatures seeking to strip local governments of their power to create laws aimed at eliminating health disparities.[124]

B. Substantive Barriers to Using Civil Rights Law to Address Health Disparities

As noted earlier, some social groups that experience health disparities due to subordination do not have the full protection of anti-discrimination law, such as communities under the LGBT umbrella and people in poverty. But even racialized minorities – including African Americans, who are the quintessential protected group in the minds of many Americans – are only weakly protected by current law. Much of the recent retrenchment in substantive civil rights, like the procedural retrenchment described in the previous section, has occurred in the Supreme Court. As a result, current civil rights jurisprudence is poorly suited to address the root causes of health disparities—namely, implicit bias, a form of interpersonal discrimination, and institutional and structural discrimination. Using the law of race discrimination as an example, this section explores the substantive barriers to addressing subordination within current anti-discrimination law.

1. Racial discrimination operates at multiple levels: interpersonal, institutional, and structural

Like other forms of subordination, racial discrimination operates on multiple levels. For analytic purposes, these can be identified as interpersonal, institutional, and structural.[125]

---

[123] Paul Diller, *Intrastate Preemption*, 87 B.U. L. REV. 1113 (2007); Note, *Impeding Innovation: State Preemption of Progressive Local Regulations*, 117 COLUM. L. REV. 2225 (2017).

[124] Lori Riverstone-Newell, *The Rise of State Preemption Laws in Response to Local Policy Innovation*, 47 PUBLIUS: THE JOURNAL OF FEDERALISM 403 (2017); Richard Briffault, The Challenge of the New Preemption, Colum. Pub. Res. Paper No. 14-580 (2018), available at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3119888. For discussion of the health implications of the new preemption, *see generally* RICHARD SCHRAGGER, LEGAL EFFORT TO ADDRESS PREEMPTION (LEAP) PROJECT, STATE PREEMPTION OF LOCAL LAWS: PRELIMINARY REVIEW OF SUBSTANTIVE AREAS (2017); Jennifer L. Pomeranz and Mark Pertschuk, *State Preemption: A Significant and Quiet Threat to Public Health in the United States*, 107 AM. J. PUB. HEALTH 900 (2017).

[125] *Compare* William M. Wiecek, *Structural Racism and the Law in America Today: An Introduction*, 100 KY. L. J. 1 (2011) (using "institutional" and "structural" as synonyms, whereas we distinguish the two). Some scholars also recognize an additional level of discrimination lodged within the psyche of a member of a stigmatized group, referred to as "internalized racism." *See, e.g.*, Camara Phyllis Jones,

Some Americans consciously believe that racial differences are biologically based and determine an individual's worth. This is *explicit* bias, or prejudice. Many more, however, disavow these ideas consciously, but continue to affiliate themselves unconsciously according to race. The burgeoning field of "social neuroscience" has demonstrated the existence of *implicit* bias – a tendency to perceive and act according to cultural stereotypes about social groups, whether those stereotypes are benign or malign.[126] Both explicit and implicit bias can lead to interpersonal discrimination: acts taken (consciously or not) on the basis of bias that are detrimental to one or more people belonging to a disfavored group, or beneficial to one or more people belonging to a favored group. For example, a physician's implicit bias may affect her decision whether to prescribe pain medication for a patient asking for it.[127]

Even more insidious than interpersonal discrimination are institutional and structural discrimination. "Institutional discrimination" as we mean it here refers to norms and practices, intentionally adopted or not, that perpetuate unjust disparities within a particular organization, or throughout social institutions, such as schools, the workplace, or the courtroom.[128] For example, sociologists have documented pervasive racial discrimination throughout housing, employment, and credit markets; each of these areas could be described as a social institution.[129] Institutional discrimination cannot be necessarily reduced to discrete acts of interpersonal discrimination (the "bad apples" theory). Rather, institutional discrimination is often perpetuated through policies and practices that unwittingly reproduce dynamics of

---

Levels of Racism: A Theoretic Framework and a Gardener's Tale, 90 AM. J. PUB. HEALTH 1212, 1213 (2000); *compare* DiAngelo, WHAT DOES IT MEAN TO BE WHITE?, *supra* n. 4, at 76-77 (discussing "internalized oppression"). Because civil rights law is not an appropriate tool for addressing internalized racism, we will not discuss it further in this Article.

[126] There is an extensive literature on implicit bias. For an overview of social neuroscience, see MAHZARIN R. BANAJI & ANTHONY GREENWALD, BLINDSPOT: HIDDEN BIASES OF GOOD PEOPLE (2013). For an argument that implicit bias is widespread in American courtrooms, *see* Jerry Kang et al., *Implicit Bias in the Courtroom*, 59 UCLA L. REV. 1124 (2012). For analyses of how anti-discrimination law deals with implicit bias, *see, e.g.*, Linda Hamilton Krieger, *The Content of our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 STAN. L. REV. 1161 (1995) (arguing that employment discrimination law is inadequate to address implicit bias in the workplace); Tristin K. Green, *Racial Emotion in the Workplace,* 86 S. CAL. L. REV. 959 (2013) (extending the implicit bias concept to argue that anxiety and other negative emotions hinder interracial communication in the workplace).

[127] *See generally* Dayna Bowen Matthew, JUST MEDICINE, *supra* n. 17 (arguing that implicit bias is rife in the provision of health care); *see also* Tobin-Tyler & Teitelbaum, *supra* n. 3, at 24.

[128] *See* Ian Haney Lopez, *Institutional Racism: Judicial Conduct and a New Theory of Racial Discrimination*, 109 YALE L.J. 1717 (2000) (providing a case study of institutional racism in jury service); *see also* Robin J. Ely & David A. Thomas, *Cultural Diversity at Work: The Effects of Diversity Perspectives on Work Group Processes and Outcomes*, 46 ADMIN. SCI. Q. 229 (2001) (case study of how some organizational cultures foster respect for minority employees and others do not).

[129] *See, e.g.*, Devah Pager & Hana Shepherd, *The Sociology of Discrimination: Racial Discrimination in Employment, Housing, Credit, and Consumer Markets*, 34 ANN. REV. SOCIOLOGY 181 (2008).

inclusion and exclusion, or exploitation and privilege, within a given institution or organization.[130] Indeed, institutional discrimination can be perpetuated by nonhuman actors (presumably free of prejudice). For example, researchers examining computer algorithms designed to assist in institutional decisionmaking have found that they may perpetuate racial discrimination because of the cognitive biases and blind spots of their designers and users.[131]

Finally, "structural discrimination" refers to the interaction of discriminatory institutions, resulting in the intensification and perpetuation of subordination across many spheres of social life.[132] For example, in a powerful recent article in *The Atlantic* magazine, journalist Ta-Nehisi Coates explores the history and legacy of government and private "redlining" in Chicago.[133] Residential racial discrimination may have originated as interpersonal discrimination, as individual white homeowners refused to live next to blacks. It became institutional, however, when racial segregation became official government policy, affecting mortgage loan eligibility.[134] As a form of institutional racism, residential segregation became embedded in the logic of the housing market, and all home buyers and sellers, whether they harbored interpersonal racism or not, were affected by the lower property values in African American and racially mixed neighborhoods and the higher property values in white neighborhoods.[135] Finally, residential segregation became structural, and as such it endures today -- again, regardless of whether individuals exhibit interpersonal racism. Because public education is tied to place, families in poor neighborhoods have reduced access to good schools, which affects the employment prospects of the children, which makes it less likely that the next generation will be able to amass the wealth to buy into a more expensive neighborhood with better amenities. All-white communities continue to enjoy higher property values and more amenities, while

---

[130] *See, e.g.,* Ian Haney Lopez, *Institutional Racism, supra* n. 129 (case study of racism in jury service in one jurisdiction); see also Robin J. Ely & David A. Thomas, *Cultural Diversity at Work: The Effects of Diversity Perspectives on Work Group Processes and Outcomes*, 46 ADMIN. SCI. Q. 229 (2001) (case study of how some organizational cultures foster respect for minority employees and others do not); MEERA DEO, UNEQUAL PROFESSION: RACE AND GENDER IN LEGAL ACADEMIA (2018) (qualitative study of institutional gendered racism in law faculty hiring, promotion and tenure, and workplace life).

[131] *See generally* Anupam Chander, *The Racist Algorithm?* 115 MICH. L. REV. 1023 (2017); Margaret Hu, *Algorithmic Jim Crow*, 86 FORDHAM L. REV. 633 (2017); *see also* Elizabeth E. Joh, Feeding the Machine: Policing, Crime Data, and Algorithms, 26 WM. & MARY BILL RTS. J. 287(2017) (arguing that the accuracy and effectiveness of algorithms used in predictive policing depend on the accuracy and effectiveness of the data they process).

[132] *See generally* john a. powell, *Structural Racism: Building Upon the Insights of John Calmore*, 86 N.C. L. REV. 791 (2007); William M. Wiecek, *Structural Racism, supra* n. 125.

[133] Ta-Nehisi Coates, *The Case for Reparations*, THE ATLANTIC, June 2014, available at https://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631/ (last visited January 12, 2019).

[134] *See infra* Part I (discussing the "place" pathway of health disparities).

[135] *See* Coates, *supra* n. 133.

mixed and black neighborhoods experience lower property values and fewer amenities.[136] Because most families' greatest source of wealth is their home, for generations white families have enjoyed dramatically more wealth than black families, even after controlling for household income.[137] This racial "wealth gap" is large, and shows no sign of closing.[138]

The net result of structural racism is "differential access to the goods, services, and opportunities of society by race."[139] This form of racism is particularly insidious. As the example of residential segregation shows, the structural dimension of racial subordination is "sticky," persistent over time.[140] Moreover, structural discrimination is difficult to dislodge because is embedded in institutions and processes, like housing markets, employment decisions, and medical research and treatment, that today look "colorblind." Yet, as we have seen, the results of subordination are multifaceted and pervasive: ultimately, they are written in people's bodies.

As with the pathways of health disparities, the dimensions of racism are analytically distinct but in practice often occur together and interact. Indeed, racism itself interacts with other forms of subordination, such as gender, sexuality, and citizenship.[141] The most effective way to dismantle subordination is to attack it in all its dimensions. For that, we need a varied and sophisticated legal and policy toolkit.

2. Existing Civil Rights Law Is Inadequate to Address Subordination

Unfortunately, today's anti-discrimination law is poorly tailored to dismantling racial subordination. The most important substantive limitation on contemporary anti-discrimination law is the restrictive way that the Supreme Court has defined "discrimination" itself: as interpersonal discrimination, with an emphasis on explicit interpersonal discrimination. This restrictive understanding of

---

[136] *See generally* SHERYLL CASHIN, THE FAILURES OF INTEGRATION (2005).
[137] *See generally* MELVIN L. OLIVER & THOMAS SHAPIRO, BLACK WEALTH/WHITE WEALTH: A NEW PERSPECTIVE ON RACIAL INEQUALITY (1995).
[138] *See, e.g.,* William Darity Jr. et al., What We Get Wrong About Closing the Racial Wealth Gap 2 (April 2018), available at https://socialequity.duke.edu/sites/socialequity.duke.edu/files/site-images/FINAL%20COMPLETE%20REPORT_.pdf ("Recent data from the Survey of Income and Program Participation (2014) shows that black households hold less than seven cents on the dollar compared to white households. The white household living near the poverty line typically has about $18,000 in wealth, while black households in similar economic straits typically have a median wealth near zero. This means, in turn, that many black families have a negative net worth.").
[139] Angela K. McGowan et al., *Civil Rights Laws as Tools to Advance Health in the Twenty-First Century*, supra n.17.
[140] *See* DARIA ROITHMAYR, REPRODUCING RACISM: HOW EVERYDAY CHOICES LOCK IN WHITE ADVANTAGE (2014) (demonstrating how structural racism is perpetuated over time even in the absence of interpersonal racism).
[141] *See* Part III *infra*.

discrimination is reflected in two judicially-created features of today's civil rights law: (1) the intent requirement; and (2) the anti-classification approach.

a) The intent requirement

According to the contemporary Supreme Court, the equal protection clause of the Fourteenth Amendment of the U.S. Constitution -- a highly influential element of American anti-discrimination law -- only forbids actions that are taken by state actors with the conscious "intent" to harm another on the basis of race. [142] Few public officials today would admit that their actions were intended to harm people of a particular race; indeed, as previously discussed, implicit bias, institutional racism, and structural racism all operate through "non-intentional" mechanisms. Nevertheless, the Supreme Court has not only read the intent requirement into the Constitution, but also applied the intent requirement to an expanding range of non-constitutional anti-discrimination doctrines, including key provisions of the Civil Rights Act of 1964.[143]

For example, Title VII of the Civil Rights Act of 1964 prohibits discrimination in hiring, firing, pay, and other "terms, conditions, or privileges" of work, as well as the adoption of policies or practices that "deprive any individual of employment opportunities" "because of" a protected classification ("race, color, religion, sex, or national origin").[144] Courts interpreting Title VII have recognized two broad causes of action under this section: "disparate treatment" and "disparate impact." Under the more commonly alleged approach, disparate treatment, an employee must prove that the employer engaged in "intentional" discrimination when taking an adverse employment action against them.[145] This standard of proof makes it difficult to hold employers responsible for nonintentional, subtle forms of bias in the workplace, such

[142] See, e.g., Washington v. Davis, 426 U.S. 229 (1976); McCleskey v. Kemp, 481 U.S. 279 (1987).

[143] There is no shortage of scholarly critiques of the Court's intent requirement for its failure to reckon with all the dimensions of subordination. For a small sampling, *see, e.g.,* Charles R. Lawrence, III., *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317 (1987); Linda Hamilton Krieger, *The Content of Our Categories, supra* n.127*;* Reva B. Siegel, *Why Equal Protection No Longer Protects: The Evolving Forms of Status-Enforcing State Action*, 49 STAN. L. REV. 1111 (1997); Ian Haney Lopez, *Intentional Blindness*, 87 N.Y.U. L. REV. 1779 (2012); Jerry Kang, *Rethinking Intent and Impact: Some Behavioral Realism About Equal Protection*, 66 ALA. L. REV. 627 (2015). More recently, several scholars argue that the judicial concept of discriminatory intent is not only inadequate, but conceptually confused and in need of rethinking. *See, e.g.*, Aziz Huq, *What Is Discriminatory Intent?* 103 CORNELL L. REV. 1211 (2018) (pointing out confusion and variation in definitions of intent across constitutional jurisprudence); Noah D. Zatz, *Disparate Impact and the Unity of Equality Law*, 97 B.U. L. REV. 1357 (2017) (arguing for a unified theory of discrimination in employment law).

[144] 42 U.S.C. §§ 2000e-2(a)(1)-(2) (2012).

[145] *See* Tristin K. Green, *Discrimination in Workplace Dynamics: Toward a Structural Account of Disparate Treatment Theory*, 38 HARV. C.R.-C.L. L. REV. 91, 111 (2003).

as implicit bias.[146] As a result, employment disparities on the basis of race and sex have persisted.[147]

b) The anti-classification approach

With respect to racial discrimination, the U.S. Supreme Court has moved toward the position that the Constitution prohibits government use of racial classifications, regardless of their purpose, except under the direst of circumstances.[148] For example, in *Parents Involved in Community Schools v. Seattle School Dist. 1*,[149] the defendant school district developed a student assignment plan meant to address decades of racial segregation in housing and education. The plan attempted to balance the values of parent choice and racial diversity by incorporating a "racial tiebreaker" for the most oversubscribed schools, which took effect only if the school's minority or majority enrollment fell outside of a 30% range centered on the minority/majority population ratio within the district. There was no allegation that the school district, in formulating this plan, had done so with the intent to harm white

---

[146] *See* Green, *Discrimination in Workplace Dynamics, supra* n. 145, at 117. As Stephanie Bornstein explains:

> Subjective employment decision-making systems can be--and, on occasion, have been--challenged under the alternate approach of disparate impact, as a facially neutral policy that has a disproportionate result by protected class. But, as a matter of both practice and doctrinal clarity, plaintiffs have preferred to litigate such cases as disparate treatment, which more accurately reflects the role implicit bias plays in specific workplace actions taken toward individuals or groups. Thus, theorizing employer liability for the operation of implicit bias in a workplace requires grappling with discriminatory "intent."

Stephanie Bornstein, *Reckless Discrimination*, 105 CAL. L.REV. 1055, 1064 (2017).

[147] *See* Green, *Discrimination in Workplace Dynamics, supra* n. 145, at 121-122; Bornstein, *Reckless Discrimination, supra* n. 146, at 1061.

[148] *See, e.g.*, Parents Involved in Community Schools v. Seattle School Dist. No. 1, 551 U.S. 701,748 (2007) (plurality opinion) (Roberts, C.J.) (asserting that "[t]he way to stop discrimination on the basis of race is to stop discriminating on the basis of race"); Grutter v. Bollinger, 539 U.S. 306, 326 (2003) ("[G]overnment may treat people differently because of their race only for the most compelling reasons," quoting Adarand Constructors, Inc. v. Peña, 515 U.S. 200, 227 (1995)); Rice v. Cayetano, 528 U.S. 495, 517 (2000) ("One of the principal reasons race is treated as a forbidden classification is that it demeans the dignity and worth of a person to be judged by ancestry instead of by his or her own merit and essential qualities."); Regents of the Univ. of Cal. v. Bakke, 438 U.S. 265, 291 (1978) (plurality opinion) (Powell, J.) ("Racial and ethnic distinctions of any sort are inherently suspect and thus call for the most exacting judicial examination.") Because of the Court's complicated "levels of scrutiny" jurisprudence in the equal protection clause context, this strict standard does not apply to discrimination based on gender, or to discrimination based on the exercise of an otherwise protected constitutional right. *See generally* Marcy Strauss, *Reevaluating Suspect Classifications*, 35 SEATTLE U. L. REV. 135 (2011) (reviewing the complexity and confusion in "levels of scrutiny" and "suspect classifications" doctrine).

[149] 551 U.S. 701 (2007).

families. Moreover, the school district argued that the purpose of its use of race was to "help[] to reduce racial concentration in schools and to ensure that racially concentrated housing patterns do not prevent nonwhite students from having access to the most desirable schools."[150] Nonetheless, the Supreme Court struck down the plan because it employed racial classifications. According to Justice Roberts, author of the majority opinion, "The way to stop discrimination on the basis of race is to stop discriminating on the basis of race."[151]

Similarly, in *Ricci v. DiStefano*,[152] white and Hispanic firefighters in New Haven, Connecticut objected when city officials refused to promote them based on a civil service exam. The defendants argued that relying on the exam for promotion would result in promoting a disproportionate number of white candidates over nonwhite candidates, and that embracing the exam would thus constitute racial discrimination by imposing a "disparate impact" on firefighters of color. The city won its case in the Second Circuit, but on appeal the Supreme Court reversed. The Court held that by discarding the exams, the City of New Haven violated Title VII of the Civil Rights Act of 1964. In the majority's view, New Haven failed to prove it had a "strong basis in evidence" that failing to discard the results of the exam would have subjected it to liability, as the exams were job-related, consistent with business necessity, and there was no evidence that an equally-valid, less-discriminatory alternative was available. As one commentator argued, "In effect, the conservative Justices ruled five-to-four that considering racial impact in order to avoid potential discrimination itself constituted racial discrimination. That bears repeating, though the logic induces vertigo: to consider race, even in order to avoid discrimination, is discrimination."[153]

In adhering to these conceptions of "discrimination," the Court has rejected an approach to equal protection that would examine government use of racial categories in the context of the categories' history, function, design, and effect – the so-called "anti-subordination" approach.[154] The anti-classification approach, scholars note, upholds "formal equality" – the view that all citizens should be treated the same regardless of morally irrelevant social statuses such as race – but it also invalidates

[150] *Id*. at 725.
[151] *Id.* at 748.
[152] 129 S. Ct. 2658 (2009).
[153] Ian Haney Lopez, *Intentional Blindness*, *supra* n. 144, at 1873.
[154] See, e.g., Owen Fiss, *Groups and the Equal Protection Clause*, 5 PHIL. & PUB. AFF. 107 (1976) (articulating the difference between anti-classification and anti-subordination approaches); Jack M. Balkin & Reva B. Siegel, *The American Civil Rights Tradition*, *supra* n. 4, at 9 (noting that the anti-subordination principle is also called "the antisubjugation principle, the equal citizenship principle, or the anticaste principle.").

most attempts by government actors to ameliorate past discrimination and promote racial diversity.[155]

We have seen that both conventional public health advocacy and conventional civil rights advocacy are limited in their ability to address health disparities and their root cause -- subordination. Public health advocacy has yet to fully recognize the pervasiveness of subordination; civil rights advocacy has been hampered by retrenchment in anti-discrimination law that makes many forms of subordination, such as implicit interpersonal discrimination, institutional discrimination, and structural discrimination, hard to address. We believe that the way forward is to build on the work of justice-centered social movements (referred to here as "[x] justice movements") in ways that promise to expand both public health and legal advocacy. The next Part will outline an agenda for what we call the civil rights of health.

III. A WAY FORWARD: THE CIVIL RIGHTS OF HEALTH

As we saw in Part I, the literature of the social determinants of health makes plain the impacts of subordination on health through the pathways of population, place, and power. Following this data, public health advocates have been increasingly drawn "upstream" to see law as a key tool for promoting health and wellbeing. However, public health as a field has been reluctant to directly address subordination in all its forms as a social determinant of health. Meanwhile, legal scholars and advocates are comfortable with identifying and targeting subordination, but are hampered by the limitations of current anti-discrimination law. This speaks to the importance of connecting civil rights lawyers and public health advocates around a shared agenda in which they adopt a different paradigm for change together.

In this Part, we argue that one way forward is recognizing what we call "the civil rights of health." The civil rights of health builds on an emergent "health justice" framework that places subordination at the center of the problem of health disparities. Within the health justice framework, aligning a structural understanding of the social determinants of health with civil rights advocacy promises new ways of articulating, enforcing, and expanding civil rights protections.

---

[155] See Darren Lenard Hutchinson, *"Unexplainable on Grounds Other Than Race": The Inversion of Privilege and Subordination in Equal Protection Jurisprudence*, 2003 U. ILL. L. REV. 615, 618 ("In its equal protection decisions, the Court has effectively inverted the concepts of privilege and subordination; it treats advantaged classes as if they were vulnerable and in need of heightened judicial protection, and it views socially disadvantaged classes as privileged and unworthy of judicial solicitude.").According to one empirical study, between 1990 and 2003, 73% of all laws that invoked race were struck down when subjected to strict scrutiny in federal courts. Adam Winkler, *Fatal in Theory and Strict in Fact: An Empirical Analysis of Strict Scrutiny in the Federal Courts*, 59 VAND. L. REV. 793, 795, 839 & tbl.6 (2006). The "overwhelming" majority of these laws, according to the study, were attempts to generate opportunities for discriminated-against racialized minorities. *Id*. at 834.

Section A of this Part takes a closer look at the "health justice" frame, arguing that it provides a set of philosophical and pragmatic commitments that speak to the goals and limitations of both public health and law. Section B sketches out an advocacy agenda and issues an invitation to build out the civil rights of health, suggesting that this initiative will enable public health and civil rights advocates to work together to address health disparities as a matter of justice and well-being.

A. The Emerging Health Justice Frame

Advocates and scholars steeped in public health and law have begun to use the term *health justice* to describe advocacy that combines knowledge of the social determinants of health with a commitment to legal principles of equal justice.[156] For example, Dayna Bowen Matthew calls for an approach to health disparities that begins with the recognition of structural inequality.[157] According to Emily Benfer, "health justice requires that all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity. Health justice addresses the social determinants of health that result in poor health for individuals and consequential negative outcomes for society at large."[158] Elizabeth Tobin-Tyler and Teitelbaum explain that they adopted "health justice" for their primer rather than "health equity" because the word "justice" resonates with a

[156] *See, e.g.*, Tyler-Tobin & Teitelbaum, supra n. 3.; DAYNA BOWEN MATTHEW, JUST MEDICINE, *supra* n. 17; SRIDHAR VENKATAPURAM, HEALTH JUSTICE: AN ARGUMENT FROM THE CAPABILITIES APPROACH (2011); Lindsay F. Wiley, *From Patient Rights to Health Justice: Securing the Public's Interest in Affordable, High-Quality Health Care*, 37 CARDOZO L. REV. 833 (2016); *see also* Lindsay F. Wiley, *Health Law as Social Justice, supra* n. 29; Emily A. Benfer, *Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education*, 35 J. LEGAL MED. 113 (2014); Mary Crossley, *Black Health Matters*, *supra* n. 31; Daryll Dykes, *Health Injustice and Justice in Health*, *supra* n. 31; Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 191 (2016); Charity Scott, *Incorporating Lawyers on the Interprofessional Team to Promote Health and Health Equity*, 14 IND. HEALTH L. REV. 54 (2017). Several law school clinics utilizing partnerships between health care professionals and legal professionals have adopted the "health justice" framing to describe what they do. *See, e.g.*, Emily A. Benfer, *The Health Justice Project: A Collaborative Commitment to Solving Real-World Problems*, 9 IND. HEALTH L. REV. 521 (2012) (describing the work of the Chicago Health Justice Project); Yael Cannon, *A Mental Health Checkup for Children at the Doctor's Office: Lessons from the Medical-Legal Partnership Movement to Fulfill Medicaid's Promise*, 17 YALE J. HEALTH POL'Y, L. & ETHICS 253 (2017) (describing the work of the Georgetown University Health Justice Alliance); *see also* Part III *infra.*

[157] DAYNA BOWEN MATTHEW, JUST MEDICINE, *supra* n. 17. Indeed, Matthew has called for the abandonment of the term "health disparities" altogether, calling for a "more accurate description of the inequality and injustice that disparate health outcomes represent." Dayna Bowen Matthew, *Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care,* 25 HEALTH MATRIX 61, 83 (2015).

[158] Benfer, *Health Justice*, *supra* n. 29, at 278.

broader range of people, and immediately brings the legal system to mind.[159] In this section, we argue that the term "health justice" is also appropriate for challenging persistent health disparities because of its reference to a number of vibrant social movements that similarly take aim at subordination in all its complexity.[160]

In the last few decades, North America has seen the proliferation of social movements that incorporate the word "justice": "environmental justice," "reproductive justice," "climate justice," "energy justice," "food justice," "land justice," and "water justice," to name a few.[161] Some of these "[x] justice" movements, such as climate justice, are direct spinoffs of the environmental justice movement, one of the earliest such movements. Others, such as the reproductive justice movement, emerged independently. Regardless of their provenance and their specific focus, [x] justice movements in the United States share three basic commitments reflected in their analyses and their organizing: (1) a commitment to acknowledging the centrality of subordination; (2) an understanding of the necessity and insufficiency of legal advocacy to redress subordination; and (3) a commitment to, through social movement organizing, centering state and market governance around broadly-articulated "life rights."[162] These commitments, addressed in turn below, help to address the limitations of public health and civil rights advocacy identified in Parts I and II. They thus provide an apt grounding for a health justice framework.

1. [X] Justice Movements and the Centrality of Subordination

Central to [x] justice movements is the recognition that universalist-individualist approaches to disparities in access to resources and exposure to harm are inevitably limited and inadequate. The history of these movements themselves tells the story. As Luke Cole and Sheila Foster have recounted, for instance, "environmental justice" organizing emerged in reaction to the American environmental movement of the 1970s and 1980s.[163] This "second wave" of environmentalism appealed to all Americans to recognize pollution as a gravely

---

[159] Tyler-Tobin & Teitelbaum, *supra* n. 3, at x.

[160] We agree with Lindsay Wiley, who identifies "justice" movements as a rich resource for reframing the goals and methods of health disparities research and policy. See Wiley, *Health Law as Social Justice, supra* n. 29, at 104.

[161] The account that follows builds on Angela P. Harris, *Anti-Colonial Pedagogies: "[X] Justice" Movements in the United States*, 30 CANADIAN J. WOMEN & THE L. 567 (2018).

[162] Harris, *Anti-Colonial Pedagogies*, *supra* n. 161.

[163] *See* LUKE COLE & SHEILA R. FOSTER, FROM THE GROUND UP: ENVIRONMENTAL RACISM AND THE RISE OF THE ENVIRONMENTAL JUSTICE MOVEMENT 31 (2000) (observing that "Ironically, the [first environmental justice summit] grew out of the Environmental Justice Movement's challenge to traditional environmental groups.").

important policy issue, but in the process of seeking universal appeal, the movement tended to ignore the particular environmental burdens faced by marginalized groups. The environmental justice movement, in contrast, was built on the recognition that addressing problems of pollution, waste, and environmental health required attention to race, sex, indigeneity, poverty, and other systems of caste.[164]

The "reproductive justice" movement was similarly founded as a response to the "reproductive rights" movement in the United States, which had called for protection of all women's right to choose whether to conceive and bear a child.[165] In the view of reproductive justice advocates, however, the universalist approach, with its focus on protecting the individual option of abortion, failed to challenge racially and financially differentiated access to reproductive health. As with environmental rights, poor women and women of color lacked the same ability to enjoy reproductive rights as affluent, white women. Reproductive justice advocates thus defined their mission around the need to identify the mechanisms of coercive power that produce subordination.[166]

In addition to identifying subordination as the root of unjust disparities, [x] justice movements have embraced a coalition-based, multifaceted approach to challenging that subordination. The idea that status-based forms of subordination are overlapping and mutually interaction is known in the United States as "intersectionality," in acknowledgment of Kimberle Williams Crenshaw's pioneering theoretical interventions in legal scholarship in the late 1980s.[167] [X] justice movements have consistently placed intersectionality at the center of their analyses and their organizing.[168]

---

[164] *See, e.g*, Luke W. Cole, *Empowerment as the Key to Environmental Protection: The Need for Environmental Poverty Law*, 19 ECOLOGY L. Q. 619, 643 (1992) (arguing that the struggle for environmental justice is inherently entwined with anti-poverty advocacy); COLE & FOSTER, FROM THE GROUND UP, *supra* n. 163, at 32 (describing alliances among indigenous activists, people of color, women, and other interest groups at the founding of the movement).

[165] *See generally* LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION (2017) (tracing the mobilization of women of color in response to the narrow abortion frame of the mainstream women's rights movement); JENNIFER NELSON, WOMEN OF COLOR AND THE REPRODUCTIVE RIGHTS MOVEMENT (2003) (same); JAEL SILLIMAN ET AL., UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE (2004) (same).

[166] See, e.g., SisterSong, Reproductive Justice, available at https://www.sistersong.net/reproductive-justice (last accessed February 23, 2019) ("To achieve Reproductive Justice, we must analyze power systems. Reproductive politics in the US is based on gendered, sexualized, and racialized acts of dominance that occur on a daily basis. RJ works to understand and eradicate these nuanced dynamics.").

[167] *See generally* Crenshaw, *Demarginalizing the Intersection,* and Crenshaw, *Mapping the Margins*, *supra* n. 4.

[168] *See, e.g*., SisterSong, Reproductive Justice, *supra* n. 166 ("To achieve Reproductive Justice, we must . . . Address intersecting oppressions. Audre Lorde said, 'There is no such thing as a single-issue

Finally, [x] justice movements have been rigorous in turning a critical lens on conventional scientific research methods and assumptions, recognizing the tendency of subordination to shape both.[169] These movements encourage the use of tools such as "participatory action research" to tap into the knowledge and priorities of communities themselves, serving as a corrective to unrecognized biases in mainstream research.[170]

2. [X] Justice Movements and the Limits of Law

A second commitment of [x] justice movements – the view that legal tools are necessary but insufficient to end subordination -- addresses the limitations of current anti-discrimination law.[171] Rather than focusing on creating and enforcing legal rights alone, [x] justice movements use "empowerment" as their touchstone, prioritizing the right to participation in decisionmaking and policymaking and conceiving of legal action as an adjunct to political action.

Recognizing the limits of law includes at least two related ideas. First is the recognition that how and whether laws are enforced often have just as much impact as the laws themselves. In other words, "law on the books" does not automatically translate into "law on the street;" indeed, the institutions and mechanisms of the law can sometimes perpetuate or deepen subordination.[172] Second, despite these risks,

---

struggle because we do not live single-issue lives.' Marginalized women face multiple oppressions and we can only win freedom by addressing how they impact one another.").

[169] *See, e.g*, Lisa Ikemoto, *Bioprivilege*, *supra* n. 44 at 80 (acknowledging the importance of the women's health movement and AIDS/HIV organizing for gathering and disseminating knowledge about marginalized bodies in health and disease); JASON CORBURN, STREET SCIENCE (2005) (arguing that lay people in communities affected by environmental problems should collaborate with researchers to set priorities, collect and analyze data, and establish findings).

[170] *See* Emily M.S. Houh & Kristin Kalsem, *It's Critical: Legal Participatory Action Research*, 19 MICH. J. RACE & L. 287, 337 (2014) (noting that "[a] first principle of PAR is that research should empower its participants and stakeholders.").

[171] *See* Harris, *Anti-Colonial Pedagogies*, *supra* n. 161.

[172] *See* Benfer, *Health Justice*, *supra* n. 29, at 307 ("The legal system exacerbates, and in some cases causes, poor health in many ways, including (1) court systems that inconsistently apply legal standards and mandates or that do not evaluate individual circumstances in applying them, (2) the enactment of laws that perpetuate poor health, and (3) the haphazard enforcement of laws designed to protect or remove barriers to health."); *see also* Elizabeth L. MacDowell, *Reimagining Access to Justice in the Poor People's Courts*, 22 GEO. J. ON POVERTY L. & POL'Y 473, 477 (2015) (arguing that state civil courts where many poor people go to pursue their claims are "sites of coercive state power, where individuals already vulnerable to punitive state interventions may encounter additional, unwanted interventions into their lives and families, lose rights, and suffer less immediately tangible harm, such as to their autonomy and legal consciousness.").

the law can be a means to build power-to, as long as it is understood as supplementary to the end goal of supporting individual agency and collective efficacy – which, as we have seen, are key for health and wellbeing. From a health justice perspective, the focus on empowerment speaks to the positive health impacts of participation in and influence over decisionmaking, policymaking, and health management – whether that means community participation in visioning healthy neighborhoods in cities, lay participation in developing and directing resources for wellness, or using a lawsuit as a tool to safeguard residents' health.[173]

3. [X] Justice Movements and "Life Rights"

Finally, a third shared commitment of [x] justice movements is their interest in establishing new rights connected to the fundamentals of life: land, water, health, food, energy, reproduction.[174] In the United States, it is not easy to talk about these public goods in terms of "rights." As noted earlier, Americans have inherited an eighteenth-century constitution that, with scattered exceptions, recognizes "negative" but not "positive" rights.[175] Furthermore, the U.S. has been reluctant to sign and/or ratify human rights conventions that recognize "social" and "economic" rights such as the right to housing, the right to education, and the right to health itself.[176] [X] justice movements, however, have stepped into this vacuum, sometimes leaning on international human rights discourse.[177]

As we have seen, universalist approaches to ending disparities have been inadequate, and law has its limits. Why, then, should [x] justice movements seek new universal positive rights? Advocacy for universal, positive rights serves two purposes of anti-subordination movements. First, calling for positive rights, especially economic rights, recognizes that economic injustice, including labor exploitation, racialized wealth accumulation, and opportunity hoarding, has been one of the

---

[173] *See infra* Part III-B. Lindsay Wiley, for instance, calls attention to a recent proposal to involve community leaders and community health workers in a holistic initiative to combat obesity and its related chronic diseases, such as Type 2 diabetes. Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon, supra* n. 156, at 223.

[174] Harris, *Anti-Colonial Pedagogies*, *supra* n. 161.

[175] *See infra* Part II-A.

[176] *Id.*

[177] *See, e.g.*, SisterSong, What Is Reproductive Justice, *supra* n. 166 ("RJ is based on the United Nations' internationally-accepted Universal Declaration of Human Rights, a comprehensive body of law that details the rights of individuals and the responsibilities of government to protect those rights.").

central mechanisms of subordination in the United States.[178] The grand goals of equality law have been historically stymied in the United States in part because redistributions of wealth and opportunity are conventionally considered "off the table." Yet without such redistribution, it is difficult to see how subordination can ever be fully redressed. Calling for positive rights counters the dynamics through which the economic component of anti-subordination rights has been lost.[179] From a health justice perspective, equal economic opportunity and economic security are key to equal health.

Second, new universal rights make new equality claims possible. If there is no "right to food" or "right to health care," for instance, there can be no cause of action for the unequal realization of that right. When combined with anti-subordination advocacy, universal rights – such as the right to equal treatment itself – can support rather than stymie the fight against unjust disparities.

B. An Agenda for Promoting the Civil Rights of Health

Elizabeth Tobin-Tyler and Joel Teitelbaum identify three levels of health justice advocacy: individual advocacy (on behalf of an individual patient or family); health systems advocacy (focused on the institutional provision of medical care); and local, state, and federal policy advocacy.[180] Collaborations between lawyers and public health professionals, through "medical-legal partnerships"[181] and

---

[178] *See* OLIVER & SHAPIRO, BLACK WEALTH/WHITE WEALTH, *supra* n. 137 (discussing the intergenerational "sedimentation" of racialized wealth inequality); ROTHSTEIN, THE COLOR OF LAW, *supra* n. 56 (discussing the twentieth-century uses of law to accumulate economic and political privilege for white people as a group); GEORGE LIPSITZ, THE POSSESSIVE INVESTMENT IN WHITENESS: HOW WHITE PEOPLE PROFIT FROM IDENTITY POLITICS (2006) (same); *see also* Charles R.P. Pouncy, Economic Justice and Economic Theory: Limiting the Reach of Neoclassical Ideology, 14 U. FLA. J.L. & PUB. POL'Y 11 (2002).

[179] *See generally* Llezlie Green Coleman, *Disrupting the Discrimination Narrative: An Argument for Wage and Hour Laws' Inclusion in Antisubordination Advocacy*, 14 STAN. J. CIV. RTS. & CIV. LIBERTIES 49 (2018); Noah D. Zatz, *The Minimum Wage as a Civil Rights Protection: An Alternative to Antipoverty Arguments*, 2009 U. CHI. LEGAL F. 1, 1 (2009); *see also* RISA GOLUBOFF, THE LOST PROMISE OF CIVIL RIGHTS (2010) (noting the disappearance of black worker rights from Thirteenth Amendment advocacy in the twentieth century).

[180] Tobin-Tyler & Teitelbaum, *supra* n. 3, at 150.

[181] *See* Tobin-Tyler & Teitelbaum, *supra* n. 3, at 138-139; Charity Scott, *Incorporating Lawyers on the Interprofessional Team to Promote Health and Health Equity*, 14 IND. HEALTH L. REV. 54 (2017); Bharath Krishnamurthy et al., *What We Know and What We Need to Know About Medical-Legal Partnership*, 67 S.C. L. REV. 377 (2016); Ellen Lawton & Megan Sandel, *Investing in Legal Prevention: Connecting Access to Civil Justice and Healthcare Through Medical-Legal Partnership*, 35 J. LEG. MEDICINE 29 (2014), available at https://doi.org/10.1080/01947648.2014.884430; Ellen Cohen et al., *Medical-Legal Partnership: Collaborating with Lawyers to Identify and Address Health Disparities*, 25 J. GEN. INTERNAL MED. 136 (Suppl 2) (2010), available at https://doi.org/10.1007/s11606-009-1239-7.;

organizational initiatives, have already begun to advance the first two types of advocacy. This Article focuses on the third type of advocacy, involving partnerships between civil rights advocates and public health advocates to use litigation, administrative actions, and policymaking to connect the fight against health disparities with the fight against subordination. [182] We believe that advocating for the "civil rights of health," especially at the local and state level, has the potential to foster an understanding of subordination as a key cause of health disparities, and ultimately to expand the capacity of civil rights law to challenge all forms of discrimination. With the acknowledgement that this initiative is still in its infancy, we offer some examples of what this work might look like.

1. Advancing the Civil Rights of Health Via the Population Pathway

a) Beyond the intent requirement

As we have seen, the public health effects of subordination are multiple, cumulative, and often institutional and structural in nature, meaning that it is difficult or impossible to identify a given intentional action as the cause of a particular health outcome.[183] Anti-discrimination law would therefore be more effective in eliminating health disparities manifested in populations if the courts could move beyond the intent requirement. Because it is so embedded in current jurisprudence, this will be a difficult task. Nevertheless, there are glimmers of possibility in current law and advocacy. For instance, Aziz Huq argues that, looking closely, the judicial meaning of "intent" is more various (and incoherent) than it seems, allowing judges

---

Emily A. Benfer, *Educating the Next Generation of Health Leaders: Medical-Legal Partnership and Interprofessional Graduate Education, supra* n. 157; Yael Cannon, *A Mental Health Checkup for Children at the Doctor's Office: Lessons from the Medical-Legal Partnership Movement to Fulfill Medicaid's Promise, supra* n. 157; Diana Hernandez, *"Extra Oomph:" Addressing Housing Disparities through Medical Legal Partnerships*, 31 HOUS. STUD. 871 (2016).

[182] Public health advocates have also looked increasingly to a fourth approach, "policy-systems-environment" (PSE) change, that is inclusive of all three levels. *See generally, e.g.*, *Sally Honeycutt et al., Evaluating Policy, Systems, and Environmental Change Interventions: Lessons Learned from CDC's Prevention Research Centers*, 12 PREVENTING CHRONIC DISEASE, E174, Oct. 15, 2015, *available at* http://dx.doi.org/10.5888/pcd12.150281; The Food Trust, What Is Policy, Systems and Environmental (PSE) Change? (2012), http://healthtrust.org/wp-content/uploads/2013/11/2012-12-28-Policy_Systems_and_Environmental_Change.pdf.

[183] This problem has stymied environmental justice litigation based on civil rights theories. *See* Wyatt Sassman, *Environmental Justice as Civil Rights*, 18 RICH. J.L. & PUB. INT. 441 (2015) (arguing that "[t]he strategy of harnessing civil rights to solve environmental justice problems has largely failed," and blaming "the overall limiting of civil rights remedies across American law").

discretion to move between various definitions and to allow different evidentiary methods, depending on their inclinations.[184]

For instance, in *Village of Arlington Heights v. Metropolitan Housing Development Corporation*,[185] the Supreme Court upheld the use of circumstantial evidence to prove intent to discriminate.[186] A recent federal circuit court decision interpreting the Fourteenth Amendment intent requirement in light of *Arlington Heights* brought hope (briefly) to advocates challenging a state's preemption of local civil rights laws.[187] In *Lewis v. Governor of Alabama*,[188] a panel of the Eleventh Circuit held that Birmingham, Alabama's black residents stated a claim for violation of the federal equal protection clause when they argued that a state statute preempting all local labor and employment regulation and mandating a uniform minimum wage throughout Alabama was motivated by racial animus. The panel's reasoning followed the outlines of *Arlington Heights*.[189] Unfortunately, the full court subsequently granted the defendants' motion for a rehearing *en banc* and vacated the panel's decision.[190]

In addition to the *Arlington Heights* method of proving intent through circumstantial evidence, several cases decided on the basis of Title IX of the Education Amendments of 1972[191] have permitted evidence of "deliberate

---

[184] Aziz Huq, *What Is Discriminatory Intent? supra* n. 143; see also Noah Zatz, *Disparate Impact and the Unity of Equality Law*, *supra* n. 143.

[185] 429 U.S. 252 (1977); *see Lewis*, 896 F.3d at 1294 (quoting *Arlington Heights*, 429 U.S. at 266); *see also Equal Protection--Race Discrimination--Eleventh Circuit Reverses Dismissal of Discrimination Claim Relying on Historical and Statistical Evidence*, 132 HARV. L. REV. 771, 774-77 (2018).

[186] Under *Arlington Heights*, the following factors, among others, can be introduced as evidence of intent: (1) "[t]he impact of the official action[,] whether it 'bears more heavily on one race than another;'"(2) whether "a clear pattern, unexplainable on grounds other than race, emerges from the effect of the state action even when the governing legislation appears neutral on its face;" (3) whether "[t]he historical background of the decision . . . reveals a series of official actions taken for invidious purposes;" (4) whether there were "[d]epartures from the normal procedural sequence" or "[s]ubstantive departures" in the decision-making process; and (5) whether the "legislative or administrative history" behind the decision reveals discriminatory purpose. *Arlington Heights*, 429 U.S. at 267-68.

[187] We discuss the "power-to" implications of preemption law *infra*.

[188] 896 F.3d 1282, 1294-97 (11th Cir. 2018).

[189] Under *Arlington Heights*, the following factors, among others, can be introduced as evidence of intent: (1) the impact of the challenged action, (2) "[t]he specific sequence of events leading up to the challenged decision," and (3) "the historical background." 429 U.S. at 267. For a careful look at the potential of *Arlington Heights* for environmental justice claims (which frequently implicate health), see Alice Kaswan, *Environmental Laws: Grist for the Equal Protection Mill*, 70 U. COLO. L. REV. 387 (1999).

[190] Lewis v. Governor of Ala., 914 F.3d 1291 (2019) (mem.).

[191] 20 U.S.C. §1681 (2004). Title IX forbids gender discrimination in programs that receive federal funding; Brian Faerstein points out that Congress modeled Title IX after Title VI of the Civil Rights Act of 1964, which forbids racial discrimination in programs that receive federal funding. Brian

indifference" in the face of actual knowledge of discrimination to count as "intent."[192] Two student authors have suggested that this standard could be used in cases involving government agency decisions that result in environmental harm to vulnerable groups.[193]

There are also still some anti-discrimination causes of action that do not require proof of intent. For example, in *Texas Department of Housing and Community Affairs v. Inclusive Communities Project*,[194] the Supreme Court upheld a "discriminatory impact" standard for the 1968 Fair Housing Act. In addition to its potential usefulness in addressing the "place" pathway for health disparities, discussed below, some scholars see a loosening of the intent framework that makes room for more capacious and realistic approaches to discrimination. Sandra Sperino, for instance, sees in Justice Kennedy's opinion for the majority an erosion of the long-standing dichotomy between "disparate treatment" and "disparate impact" discrimination, with implications for employment law.[195] Legal scholars are ready for this opening door with new conceptions of intent such as "reckless discrimination"[196] and "negligent discrimination."[197]

Finally, looking toward legislative action, Dayna Matthew Bowen advocates amending Title VI of the federal Civil Rights Act of 1964, which prohibits federally funded organizations, including health care organizations, from discriminating.[198] At present, the Supreme Court decision in *Alexander v. Sandoval* allows only federal agencies to enforce this provision; Bowen proposes that Congress create a private right of action.[199] At present, this change in civil rights law is not politically feasible. One of the lessons of [x] justice movements, however, is that judicial and legislative advocacy does not only serve the purpose of winning in particular cases; it also provides an important forum for public education and organizing. By playing the long

---

Faerstein, *Resurrecting Equal Protection Challenges to Environmental Inequity: A Deliberately Indifferent Optimistic Approach*, 7 U. PA. J. CONST. L. 561, n. 104 (2004).

[192] *See* Gebser v. Lago Vista Independent School District, 524 U.S. 274 (1998) (holding that a school district official who has authority to institute corrective measures on the district's behalf, has actual notice of a teacher's misconduct, and is deliberately indifferent to the misconduct, may be held in violation of Title IX); Davis v. Monroe County Board of Education, 526 U.S. 629 (1999) (holding a school board liable for damages on the "deliberate indifference" theory).

[193] Brian Faerstein, *Resurrecting Equal Protection Challenges, supra* n. 192; Derek Black, Picking Up the Pieces after Alexander v. Sandoval: Resurrecting a Private Cause of Action for Disparate Impact, 81 N.C. L. REV. 356 (2002).

[194] 135 S.Ct. 2507 (2015).

[195] Sandra Sperino, *Justice Kennedy's Big Idea*, 96 BOSTON U. L.REV. 1789 (2016).

[196] Stephanie Bornstein, *Reckless Discrimination*, *supra* n. 147 (arguing for Title VII liability "where an employer acts with reckless disregard for the consequences of implicit bias and stereotyping in employment decisions.").

[197] David Benjamin Oppenheimer, *Negligent Discrimination*, 141 U. PA. L. REV. 899 (1992).

[198] MATTHEW, JUST MEDICINE, *supra* n. 5.

[199] *See* Part II *infra.*

game, greater understanding of the social determinants of health can open a pathway for legal change in anti-discrimination law.

b) Building an "intent" record

Even in the absence of any changes in the law of intent, health justice advocates can work with government agencies to educate them about health disparities and build a record of "intent" at the same time. Lawyers in the Racial Equity Project at Legal Services of Northern California (LSNC), for example, argue for the use of "racial impact statements" as a way to combat racial disparities.[200] A racial impact statement may take several forms. It may operate as a prospective tool for policy development and decisionmaking; it may be a tool for retrospective review and analysis of existing policy; or it may be required across the board for all agency actions as part of a broader mandate to eliminate unlawful discrimination.[201] In any of these forms, it is designed to document or anticipate the effects of particular policies or decisions on racialized communities.

Racial impact statements, of course, are useful in and of themselves as guides for making visible the dynamics of institutional and structural racism.[202] The attorneys at LSNC argue that a racial impact statement can also lay a foundation for a legal challenge based on intentional discrimination. For instance, they recount how one LSNC attorney conducted a survey of Medicaid fee-for-services benefits paid out for psychiatric illnesses in a rural county, and discovered that "white families received benefits at a rate double that paid to families of color. When confronted with the disparity, the county could not defend the outcomes. . . . [N]ot long after being confronted with the disparities, the county hired outreach and bilingual staff under a 'new program.'"[203] LSNC boasts that it has used racial impact statements in its advocacy for seven years, with the goal of creating an actionable complaint -- but the statements have been so successful in changing behavior that litigation has not yet been necessary.[204]

---

[200] William Kennedy, Gillian Sonnad, & Sharon Hing, *Putting Race Back on the Table: Racial Impact Statements*, 47 CLEARINGHOUSE REV. 154 (2013).
[201] Kennedy et al., *supra* n. 200, at 157.
[202] See R. A. Lenhardt, *Race Audits,* 62 HASTINGS L.J. 1527, 1527 (2011) (arguing that, used at the local level, race audits can "uncover the specific structural mechanisms that create cumulative racial disadvantage across domains, time, and generations by, inter alia, being attuned to the spatial dimensions, meaning, and operation of race in the United States.").
[203] *Id.* at 159.
[204] *Id.*

2. Advancing the civil rights of health through the place pathway

Undoing the health disparities that result from subordination "baked into" geography is no easy feat. Nonetheless, there are many opportunities for a civil rights of health initiative to begin to address the problem.

The environmental justice movement has been a leader in challenging negative health impacts caused by the unequal distribution of environmental hazards, and alliances between health justice and environmental justice advocates are a natural next step. A full account of environmental justice advocacy as it pertains to health is beyond the scope of this Article; two suggestive examples will have to suffice.

The complaint in *D.R. v Michigan Department of Education*[205] used disability law to articulate environmental justice concerns. In September, 2016, the American Civil Liberties Union of Michigan and the New Jersey-based Education Law Center sued the Michigan Department of Education, the Flint Community Schools, and the Genesee Intermediate School District in the wake of the contamination of Flint's water.[206] The class action suit sought community-wide early screening, referral for evaluations of disability, provision of special education and related services, and procedural safeguards against disciplinary measures based on disability for 30,000 school-age children residing in Flint, based on the Individuals with Disabilities Education Improvement Act of 2004 (IDEA),[207] and related statutes. In April, 2018, U.S. District Judge Arnold Tarnow approved a settlement allowing the screening process to go forward, calling it a "win-win" for all sides.[208]

A second example of place-based advocacy where environmental justice and health justice meet has to do with housing quality. Some medical-legal partnerships (MLPs) use landlord-tenant law and local administrative law to address the health concerns of low-income families. As Diana Hernandez notes, "State and municipal laws ordinarily include sanitary or housing codes governing the construction and conditions of residential properties as well as specific laws focused on certain health threats such as lead paint, asbestos, pests, mold, and adequate heat and injury

[205] 2016 WL 6080952 (E.D.Mich.) (class action complaint).
[206] For an account of the crisis by a pediatrician whose advocacy was crucial to uncovering this public health crisis, *see* MONA HANNA-ATTISHA, WHAT THE EYES DON'T SEE: A STORY OF CRISIS, RESISTANCE, AND HOPE IN AN AMERICAN CITY (2018).
[207] 20 U.S. §1400 et seq.
[208] Lori Higgins, *Federal judge OKs 'win-win' settlement to help up to 30,000 Flint kids,* DETROIT FREE PRESS, April 12, 2018, available at https://www.freep.com/story/news/education/2018/04/12/flint-aclu-lead-testing-settlement/510750002/.

prevention measures such as smoke and carbon-monoxide detectors."[209] Working together, health professionals and lawyers can expand this individual advocacy into large-scale group advocacy. For example, in East Chicago, Indiana, residents of the West Calumet Housing Complex, a public housing complex, lived for over forty years without knowing that the soil they were living on was contaminated with lead and arsenic.[210] In 2016, seven years after the area was declared a federal Superfund site, the Environmental Protection Agency reported to the city of East Chicago that it had found lead levels in the soil as high as 91,000 parts per million, 228 times the minimum permitted level.[211] Working with a collective of current and former residents and a local community organization, a coalition of organizations, including Loyola University Chicago School of Law's Health Justice Project, environmental law clinics at Northwestern University Law School and the University of Chicago Law School, and the Shriver Center, helped the residents obtain a declaration of emergency from the city and the state of Indiana to release federal and state resources to respond to the lead crisis.[212]

A more ambitious civil rights of health project is to go "upstream" to the structural drivers of poor housing quality and environmental harm, including racial segregation and economic disinvestment. As we saw above, the Supreme Court's decision in *Inclusive Communities*[213] represents a ray of hope for fair housing litigators, upholding the impact standard for fair housing actions. According to Andrea Boyack, the decision means "[l]ocal governments no longer have discretion to decide whether to overcome segregation, only *how* to do so."[214] Within the *Inclusive Communities* framework, litigators may be able to use research on the health impacts of racial segregation in order to seek remedies with municipality-wide or even statewide application. Housing advocates and poverty advocates may benefit from research on the social determinants of health in such litigation.

Housing policy efforts may also benefit from a public health framing. Noting that families facing a lack of available housing must choose tradeoffs such as skimping on food and other necessities, accepting low-quality housing, or becoming

---

[209] Diana Hernandez, *"Extra Oomph:" Addressing Housing Disparities through Medical Legal Partnerships*, *supra* n. 181, at 872.

[210] POVERTY & RACE RESEARCH ACTION COUNCIL (MEGAN HABERLE & HEIDI KUMIAWAN, EDS)., STRATEGIES FOR HEALTH JUSTICE: LESSONS FROM THE FIELD 10 (November 2018), available at https://prrac.org/pdf/health_justice_rpt.pdf.

[211] STRATEGIES FOR HEALTH JUSTICE, *supra* n. 210 at 11.

[212] *Id.* at 15.

[213] 135 S.Ct. 2507 (2015).

[214] Andrea J. Boyack, *Side by Side: Revitalizing Urban Cores and Ensuring Residential Diversity*, 92 CHI.-KENT L. REV. 435, 464 (2017); *see* Jonathan Zasloff, *The Price of Equality: Fair Housing, Land Use, and Disparate Impact*, 48 COLUM. HUM. RTS. L. REV. 98 (2017) (suggesting a path for courts to take in the wake of *Inclusive Communities* in balancing fair housing and local public policy considerations).

homeless, Dayna Bowen Matthew argues that the affordability crisis in housing ought to be understood as a public health crisis.[215] In her view, centering housing policy around health would reflect "the communal altruism that has historically motivated American housing policy, while also being more effective, efficient, and equitable than current approaches."[216]

Research from the social determinants of health literature can help inform new policy and legislative initiatives and promote this re-centering. For example, Christopher Tyson notes that in July 2015, the federal Department of Housing and Urban Development (HUD) raised standards for localities receiving federal money: its new rule requires grantees to take "meaningful actions" to end segregation and foster inclusive communities.[217] In theory, HUD has a reciprocal commitment to provide states, municipalities, housing agencies, and the public with "local and regional data on integrated and segregated living patterns, racially or ethnically concentrated areas of poverty, the location of certain publicly supported housing, access to opportunity afforded by key community assets and disproportionate housing needs based on classes protected by the [Fair Housing Act]."[218] Public health advocates could aid in this effort by augmenting this data with data on the place pathway of health disparities.

Tyson notes, however, that prospects for a rapid and robust fulfillment of this commitment are dim given the weak civil rights history of HUD and the current presidential administration's hostility to the principles underlying this initiative. Another way forward relies on the innovation capacities of government below the federal level. In recent years, state and local governments have been founts of innovation around the civil rights of health, with local governments, in particular, being especially well-positioned to respond to issues of health justice.[219] Ideas such as sugary drink taxes and cigarette taxes, for example, have followed a "bottom-up federalism" trajectory, moving from municipal to state governments.[220]

Because "our localism"[221] gives states and municipalities broad police powers with which to govern, state and local advocacy also offers the opportunity to connect

---

[215] Dayna Bowen Matthew, *Health and Housing: Altruistic Medicalization of America's Affordability Crisis*, *supra* n. 86.
[216] *Id.* at 194.
[217] Christopher Tyson, *From Ferguson to Flint*, *supra* n. 55, at 35.
[218] *Id.* at 36.
[219] *See* Paul A. Diller, *Why Do Cities Innovate in Public Health? Implications of Scale and Structure*, 91 WASH. U. L. REV. 1219. 1254-71 (2014).
[220] *See* Charles R. Shipan & Craig Volden, *Bottom-up Federalism: The Diffusion of Antismoking Policies from U.S. Cities to States*, 50 AM. J. POL. SCI. 825 (2006); Olatunde C. A. Johnson, *The Local Turn: Innovation and Diffusion in Civil Rights Law*, 79 L. & CONTEMP. PROB. 115 (2016).
[221] *See* Richard Briffault, *Our Localism: Part I – The Structure of Local Government Law*, 90 COLUM. L. REV. 1 (1990).

public health advocates and civil rights lawyers through addressing disparate and selective enforcement of laws affecting the health of people of color and other vulnerable populations. This is an area ripe for partnership, one that also points to the link between the social determinants of health and subordination. For example, failing to enforce housing codes can have a snowball effect on residents' health and well-being.[222]

As we saw above, racial impact statements, or "race audits," may also play a role in challenging the racial subordination incorporated into state and local government practices. Christopher Tyson argues for a policy of mandatory race audits as a condition for qualifying for federal grant-in-aid programs.[223] This policy, too, awaits a friendlier federal environment, but if implemented, Tyson argues, it is potentially "one of the most potent tools for identifying and mapping the anatomy of black subordination in cities and structural racism generally."[224]

3. Advancing the civil rights of health through the power pathway

a) Building power-to for individuals

Children as a class are defined by their lack of access to power, and accordingly they are uniquely vulnerable to trauma and the health harms of disempowerment. Research on the social determinants of health can assist legal advocates in using and potentially expanding the tools of anti-discrimination law on behalf of children who are suffering from trauma and disempowerment.

For example, in *Peter P. v. Compton Unified School District*,[225] a putative class of current and future students who grew up in high poverty neighborhoods along with three teachers sued the Compton Unified School District, its superintendent, and school board members in their official capacities. The plaintiffs alleged that the neurobiological effects of complex trauma to which students had been subjected

[222] *See* CHRISTINA STACY, JOSEPH SCHILLING, & STEVE BARLOW, STRATEGIC HOUSING CODE ENFORCEMENT AND PUBLIC HEALTH 4-8 (2018); CHANGELAB SOLUTIONS, UP TO CODE: CODE ENFORCEMENT STRATEGIES FOR HEALTHY HOUSING 5 (2015). *See generally* ASSOCIATION FOR NEIGHBORHOOD AND HOUSING DEVELOPMENT & THE CITY OF NEW YORK OFFICE OF THE PUBLIC ADVOCATE, INEQUITABLE ENFORCEMENT: THE CRISIS OF HOUSING CODE ENFORCEMENT IN NEW YORK CITY (2008).

[223] Tyson, *supra* n. 55, at 52.

[224] Id. at 54.

[225] 135 F.Supp.3d 1098 (United States District Court, C.D. Cal). See Aaron Lawson, *Straight Outta Compton: Witness the Strength of Disability Rights Taking One Last Stand for Education Reform*, 67 SYRACUSE L. REV. 551 (2017); Nancy Dowd, *Straight Out of Compton: Developmental Equality and a Critique of the Compton School Litigation*, 45 CAP. U. L. REV. 199 (2017).

constituted a disability under the federal Rehabilitation Act and the Americans with Disabilities Act (ADA), because the effects impaired the students' ability to perform activities essential to education, including but not limited to learning, thinking, and concentrating. In a similar suit, *Stephen C. v. Bureau of Indian Education*,[226] nine Havasupai students and the Native American Disability Law Center sued the Bureau of Indian Education, the secretary of the Department of the Interior, and other officials. The plaintiffs used disability law to argue that the defendants "knowingly failed to provide basic general education, a system of special education, and necessary wellness and mental health support to Havasupai students, resulting in indefensible deficits in academic achievement and educational attainment." Although these suits are hampered by structural and philosophical problems, they also represent a creative way to infuse disability civil rights protections with the social determinants of health research.[227] As Nancy Dowd argues, the goal is "to trigger an obligation by the state to eliminate its role in supporting, directly or indirectly, identifiable challenges that create or exacerbate developmental inequality for children that perpetuate their potential for, or reality of, subordination."[228] Beyond litigation, policy advocacy on the civil rights of health can work with school districts as partners to develop proactive responses to the risk of trauma.[229]

---

[226] 2018 WL 1871457 (United States District Court, D. Arizona).

[227] First, federal disability law, like other civil rights tools, is focused on harms to individuals, rather than the institutional and structural causes of the harms. *See* Dowd, *Straight Out of Compton, supra* n. 226, at 235 ("the disability framework may render invisible the causes of incapability, difficulty, delay, or behavior. Or it may tend toward identifying causes or laying blame on the individual or their family, rather than on structural harm."). Second, the disability model risks deepening stigma against disfavored groups, such as racial minorities, by marking them as essentially inferior. *Id*.; *but see* Kimani Paul-Emile, *Blackness as Disability?* 106 GEO. L.J. 293 (2018) (arguing that the disability law framework "allows for serious engagement with the reality of structural inequality, opening new possibilities for social reform foreclosed by current race jurisprudence, and offers a meaningful legal path to advancing racial equality.").

Third, and related, disability law itself has a vexed relationship with social stigma. Disability rights advocates are aware that the policy path of least resistance is often to pursue medical and technological means of eliminating disability in individual bodies. In contrast, advocates often prefer that policy interventions target the built and social environments, so that institutions are more inclusive of people with a wide range of abilities. The Americans with Disabilities Act clearly embraces the "social model" of disability, requiring institutions to accommodate people with disabilities. Yet, some courts continue to assume that people with disabilities are living inferior lives. *See* Samuel R. Bagenstos, *Subordination, Stigma, and "Disability,"* 86 VA. L. REV. 397, 472 (2000) (arguing that some judicial approaches to disability law seem premised on the notion that people with disabilities are living lives inferior to those of non-disabled people, and advocating instead for an anti-subordination approach). A fourth problem relevant to education litigation generally is that public schools are already vulnerable and resource-poor institutions, which means that they are not the best target for litigation. Thanks to Claudia Center for these points.

[228] Dowd, *supra* n. 157, at 201.

[229] *See, e.g.,* Yael Cannon & Dr. Andrew Hsi, *Disrupting the Path from Childhood Trauma to Juvenile Justice: An Upstream Health and Justice Approach,* 43 FORDHAM URB. L.J. 425, 475 (2016) (describing

Where existing school policies or practices are found to unjustly contribute to health disparities, courts would do well to seek remedies in evidence-based strategies that strengthen student empowerment, safety, and learning. State policymakers, school districts, and individual schools also have an important role to play by replacing punitive and racially disproportionate discipline policies with more supportive and healing-centered strategies, like restorative justice and social-emotional learning, that can start closing the gap in health disparities in schools.[230] Until recently, public health advocates have been largely absent from the conversation around school discipline reform, and the civil rights of health represents an opportunity to bridge that gap.

b) Protecting state and local government's ability to advance health justice and community efficacy

Scholars and advocates of the last generation have concentrated on federal anti-discrimination law, but in many ways a more promising resource for the civil rights of health is state and local law. For example, while the U.S. Constitution recognizes no economic and social rights, all fifty state constitutions guarantee some degree of protection for economic and social rights.[231] Some of these rights directly concern health and health care. Jeffrey Usman observes:

> At least twelve state constitutions address either the state's role with regard to public health in general or healthcare for the poor specifically. The Alaska Constitution declares that "[t]he legislature shall provide for the promotion and protection of public health." The constitutions of Hawaii, Michigan, New York, South Carolina, and Wyoming also set forth a similarly broad, but undefined duty to provide for the protection and promotion of the public health. The Hawaii, Georgia, Mississippi, and Texas Constitutions expressly authorize the state to assist the needy in obtaining healthcare. Missouri's Constitution creates a Department of Social Services and charges the director thereof with

---

the University of New Mexico Medical-Legal Alliance (MLA), which seeks to identify children with high ACES early and offer their families a "multi-generational, multidisciplinary, upstream system of care.").

[230] CHANGELAB SOLUTIONS, SCHOOL DISCIPLINE PRACTICES: A PUBLIC HEALTH CRISIS AND AN OPPORTUNITY FOR REFORM 5-7 (2019).

[231] See Helen Hershkoff, *Positive Rights and State Constitutions: The Limits of Federal Rationality Review*, 112 HARV. L. REV. 1131 (1999); Helen Hershkoff, *"Just Words": Common Law and the Enforcement of State Constitutional Social and Economic Rights*, 62 STAN. L. REV. 1521 (2010); Helen Hershkoff & Stephen Loffredo, *State Courts and Constitutional Socio-Economic Rights: Exploring the Underutilization Thesis*, 115 PENN ST. L. REV. 923 (2011); see also ROBERT F. WILLIAMS, THE LAW OF AMERICAN STATE CONSTITUTIONS (2009).

"promoting improved health." The Alabama Constitution authorizes the state to "acquire, build, establish, own, operate and maintain hospitals . . . and other health facilities" and to appropriate funds for this purpose, while the Louisiana Constitution authorizes the establishment of a public health system.[232]

In addition to state constitutional law, statutory law and municipal ordinances are a rich source of innovative health-related protections. Cities have been particularly active in designing protections for public health, such as smoke-free environments, safe and affordable housing, paid leave, and minimum wage increases.[233] The danger here is preemption by hostile federal and state government. The literature of health disparities, however, places the preemption issue in an intriguing new light. Could the right to have one's voice heard in local government be conceived of not only as a right of democratic participation, but a health right?[234]

IV. CONCLUSION

As a joint project of public health and legal advocates, promoting the civil rights of health holds the potential to foster public and elite awareness of the systems of subordination that produce and perpetuate health disparities. We end with a word about the alliance of health justice with social justice efforts more generally.

Public health research demonstrates how even policies that seem far from the health arena have significant health implications and impacts. Moreover, public health data is incredibly powerful and even predictive on a population basis -- something which has yet to be effectively harnessed by the legal field, including civil rights advocates. Fully realizing the civil rights of health will require interdisciplinary and cross-sector collaboration to strategize and leverage collective resources. This work will require a combined political and legal strategy, and much remains to be done.

One natural place to begin this collaboration is in our law schools. Within legal education, public health law is considered a "niche" subject; few faculty teach it and relatively few students are exposed to it. Properly understood, however, public health law is deeply integral to social justice, as the literature on the social determinants of health makes clear. Introducing the literature of the social determinants of health, not just to public health law faculty and students, but more broadly to students and faculty in a range of civil rights-related courses will help make clear the importance of health justice to the social justice mission. Courses that could incorporate

---

[232] Jeffrey Omar Usman, *Good Enough for Government Work: The Interpretation of Positive Constitutional Rights in State Constitutions*, 73 ALB. L. REV. 1459, 1473 (2010).

[233] See Part III *infra*.

[234] *Compare* Michelle Wilde Anderson, *Mapped Out of Local Democracy*, 62 STAN. L. REV. 931 (2010) (describing the political powerlessness of residents of unincorporated urban areas).

information about the social determinants of health include poverty law, civil rights law, constitutional law, critical race theory, gender, sexuality and the law, environmental law, and international human rights law, as well as practice-related courses like legislative advocacy, public interest practice, and policy advocacy.

It is perhaps fitting, and unsurprising, that justice makes us healthy and injustice makes us ill. With this recognition bolstered by science as well as law, we are at an important beginning of new scholarship and practice. We hope this Article will be read not as a summation, but a call to action.