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

Angela P. Harris & Aysha Pamukcu

ABSTRACT

An emerging literature on the social determinants of health reveals that subordination is a major driver of public health disparities. 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. Conversely, understanding social injustice as a health issue as well as a moral issue has the potential to reinvigorate civil rights advocacy. But given the history of law-and-public health initiatives that have reflected and even reinforced subordination, social movements are an essential advocacy partner and watchdog. 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.

AUTHORS

Angela P. Harris, JD, Professor Emerita, University of California, Davis School of Law (King Hall). Angela is Professor Emerita at the University of California, Davis School of Law, and most recently was the 2019–20 Visiting William H. Neukom Fellows Research Chair in Diversity and Law at the American Bar Foundation. She is the author of numerous influential books, articles, and essays in critical race feminism, and is Coeditor-in-Chief of the new peer reviewed, interdisciplinary journal, the Journal of Law and Political Economy.

Aysha Pamukcu, JD, Founder, Movement Praxis. Aysha is an attorney who specializes in equitable policy and philanthropy. She is the founder of Movement Praxis and the 2019–20 Fulcrum Fellow at ChangeLab Solutions, where she previously led the organization’s health equity practice. She was recognized for her health justice innovations as one of the de Beaumont Foundation’s “40 under 40 in Public Health.” In addition to public health, Aysha’s research and advocacy addresses civil and human rights, economic justice, and climate justice. She currently leads the Policy Fund at the San Francisco Foundation.

The authors wish to thank Katie Hannon Michel and Tucker Culbertson for their invaluable research assistance. Thank you as well to ChangeLab Solutions staff who contributed to this
Article’s development, including: Marice Ashe, Erik Calloway, Sarah de Guia, Cesar De La Vega, Saneta deVuono-powell, Alexis Etow, Kimberly Libman, Katie Hannon Michel, Pratima Musburger, Shauneequa Owusu, Hannah Sheehy, and Ben Winig. Many thanks to Ajay K. Mehotra and the staff, fellows, and board of the American Bar Foundation for their comments on presentations of this Article and for their research support. We would also like to thank Claudia Center, Nancy Dowd, Thalia Gonzalez, Lisa Ikemoto, Amy Kapczynski, Dayna Bowen Matthew, Alice Miller, Michael Stein, Joel Teitelbaum, Elizabeth Tobin-Tyler, and Ruqaiijah A. Yearby 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.

Finally, the authors wish to acknowledge that this Article was completed before the rapid spread of the COVID-19 global pandemic and before the widespread civil rights actions against police brutality and racism. In other work now in progress, we discuss the relevance of our framework to the fight against COVID-19 and systemic and institutional racism.

TABLE OF CONTENTS

Introduction ..................................................................................................................................................762
I. Public Health Research and the Social Determinants of Health: Toward a Civil Rights of Health ..................................................................................................................................................766
   A. Three Pathways of Health Disparities: Population, Place, and Power .......................................770
      1. Health Disparities Based on Population..................................................................................771
      2. Health Disparities Based on Place..........................................................................................774
      3. Health Disparities Based on Access to Power ........................................................................777
   B. The Root of the Problem: Subordination and the Need for Civil Rights of Health .................782
      1. The Relative Invisibility of Institutional and Structural Discrimination ...........................784
      2. The Problem of Affirmative Action Remedies .......................................................................789
II. Challenges to the Civil Rights of Health Initiative .........................................................................792
   A. Limitations of Public Health Advocacy in Addressing Persistent Health Disparities ............793
      1. Universal Solutions Focused on Behavior Change Obscure Subordination's Impact on Health..................................................................................................................................................793
      2. Subordination Influences Public Health Assumptions, Methods, and Research Priorities..................................................................................................................................................795
   B. Limitations of Civil Rights Law ........................................................................................................798
      1. The Risk of Evidence-Based Subordination............................................................................802
III. A Way Forward: The Health Justice Framework .............................................................................806
   A. The Emerging Health Justice Frame ...............................................................................................807
      1. [X] Justice Movements and the Centrality and Complexity of Subordination...............808
      2. [X] Justice Movements and the Limits of Professional Expertise ........................................810
B. An Agenda for Promoting the Civil Rights of Health ................................................................. 813
   1. Advancing the Civil Rights of Health via the Population Pathway ........................................ 814
      a. Expanding Litigation Possibilities: Beyond the Intent Requirement ............................... 814
      b. Litigation-Aware Policy: Building an Intent Record ......................................................... 818
   2. Advancing the Civil Rights of Health Through the Place Pathway ....................................... 819
   3. Advancing the Civil Rights of Health Through the Power Pathway ...................................... 824
      a. Litigation and Policy Advocacy: Building Power-To for Children and Families ................ 824
      b. State Legislative and Constitutional Law: Protecting State and Local Government’s Ability to Promote Collective Power-To ................................................................. 826
C. The Big Picture: Toward New Rights and “Targeted Universalism” in Health Justice ........... 829
CONCLUSION ........................................................................................................................................ 831
INTRODUCTION

We live in a time of increasingly steep inequalities, not only in income and wealth, but also in access to basic public goods like healthy food, clean water, and adequate housing. 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 a moral and constitutional issue with serious consequences for our health. 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.” 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.

Subordination based on markers of social stigma such as race, gender, sexuality, and class is chief among the structural forces creating unjust access to health-promoting opportunities and resources. In this Article, we—a critical race

---

4. For the 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 refer to subordination rather than oppression in recognition of the legal literature distinguishing antisubordination from anticlassification approaches to the Equal Protection Clause. See, e.g., Jack M. Balkin & Reva B. Siegel, The American Civil Rights Tradition: Anticlassification or Antisubordination?, 58 U. Miami L. Rev. 9 (2003). For explication of the difference between the anticlassification and antisubordination approach, see infra Part II.B.

With DiAngelo, we hold that subordination is institutional, historical, and ideological, and results in systematic dominant group privilege. DiAngelo, supra, at 67–70. Moreover, the forces of subordination are always intersectional, as Kimberlé Crenshaw has defined that term: that is, race, gender, sexuality, disability, and other systems of subordination overlap and interact. See Kimberlé Crenshaw, Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, 1989 U. Chi. Legal F. 139 [hereinafter Crenshaw, Demarginalizing the Intersection]; Kimberlé Crenshaw, Mapping the Margins: Intersectionality, Identity Politics,
theorist and a health justice lawyer—argue that subordination is a public health problem. Understanding subordination to be at the root of social determinants of health holds the potential to transform both public health and civil rights advocacy.

Recognizing subordination as a driver of health is essential to solving the puzzle of persistent health disparities linked to group status. Despite public health advocates’ longstanding awareness of how social context affects health,5 and many gains in improving population health outcomes overall,6 advocates have been unable to close the gap in these disparities. 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 health gains 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,7 and these same population groups


6. 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. NAT’L CANCER INST., 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, Elizabeth M. Ward & Rebecca L. Siegel, 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).

7. 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 based on race, income, and other subordination factors. See CAL. TOBACCO CONTROL PROGRAM, CAL. DEP’T OF PUB. HEALTH, CALIFORNIA TOBACCO FACTS AND FIGURES: A RETROSPECTIVE LOOK AT 2017, at 1, 5 (2018). A 2014–2015 California survey found that 29.5 percent of all Native American and Alaska Native adults reported smoking, compared with 17.8 percent of all Black and African American adults, 13.4 percent of Whites, 11.1 percent of Hispanics, and 8.9 percent 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 percent) of low-income Native
disproportionately bear the burden of tobacco-related harm.\textsuperscript{8} These disparities are not solely the product of individual choices to smoke. They are also 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.\textsuperscript{9}

As the tobacco example shows, eliminating disparities in health is a different task than improving public health overall. Eliminating disparities means: (1) eliminating discrimination against stigmatized groups; (2) changing the spatial distribution of healthy environments, economic resources, and opportunity; and (3) 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 order to address “the causes of the causes” behind health disparities, public health advocates should add civil rights law to their toolkit.

For their part, civil rights lawyers and scholars are well accustomed to framing social inequalities as failures of justice. Time and again, however, civil

\begin{itemize}
\item American and Alaska Native adults reported smoking compared with 24.4 percent of low-income Black and 23.7 percent of low-income White adults. \textit{Id.} at 6.


\item CHANGELAB SOLS., TOBACCO RETAILER DENSITY: PLACE-BASED STRATEGIES TO ADVANCE HEALTH AND 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 SOLS., supra note 8, at 8 (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 SOLS., 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).
\end{itemize}
rights advocacy has been stymied by resistance to institutional and structural approaches to subordination. The belief that racism, for example, is an individual character flaw or a moral failing rather than a system woven over generations into politics, economics, history, and culture, overshadows civil rights jurisprudence as well as popular conversation. Indeed, efforts to fight racism and its effects systematically are commonly decried as themselves racist, precisely because they tackle group disparities rather than individual intent. For civil rights advocates, the literature on the social determinants of health puts the force of scientific research behind the insight that subordination is not about correct thinking, but rather about human flourishing. We believe that the literature on the social determinants of health presents an opportunity to revive and expand civil rights law, not just in the courts, but through legislation, policy, and other tools of good governance.

Combining these insights, we argue for collaboration among public health and legal advocates to promote “the civil rights of health.” Yet, we also recognize that the history of alliances between public health actors and the state is not consistently benign. Thus, we situate our proposed initiative within the emergent health justice movement, a framework that places the empowerment of marginalized populations at the center of action. As in other “[x] justice” movements—such as the grandmother of them all, environmental justice—the health justice framework treats public health, law, and social movement advocacy as collaborative and potentially counteracting forces, creating a system of checks and balances against abuses of power.

Framing the civil rights approach to health in terms of health justice allows for many possible combinations of legal power, scientific power, and people power. Some partnerships may be preventive in nature, such as participatory budgeting and community-based comprehensive planning; others will be

10. See Kendall Thomas, Racial Justice: Moral or Political?, 17 NAT’L BLACK L.J. 222, 227 (2002) (“[T]he felt necessity to defend or attack color-blindness and color-consciousness in terms of the morality of race has increasingly become one of the more striking features of the dominant discourse.”).

11. Our call builds on the work of others who have already seen the possibilities of collaboration between law and public health. See, e.g., 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); CHANGE Lab SOLS, Tools for Change: A Resource Catalog for Community Health (2019); Dayna Bowen Mathew, Just Medicine: A Cure for Racial Inequality in American Health Care (2015); see also infra note 206 (listing sources).

necessarily reactive, such as collaborations among public health and immigrant justice advocates to provide flu shots to detained migrants at the U.S.–Mexico border or to protect communities against a coronavirus without reinforcing racial and ethnic discrimination. The ultimate goal, however, is what public health advocates call health equity: a world in which your wealth, social status, access to power, and zip code are irrelevant to your life expectancy or vulnerability to illness.13

Part I of this Article 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 proposes an alliance of interest between public health and civil rights advocates to treat antisubordination law and policy as a health intervention. Part II acknowledges a series of challenges to this proposed alliance, including the limitations of conventional public health advocacy in fully confronting subordination, the retrenchment in civil rights law that makes it increasingly difficult to effectively uproot subordination, and the dark history of some previous alliances between law and public health that have harmed rather than helped marginalized social groups. Part III argues for a health justice approach to our proposed initiative, and provides examples of what this work could look like. We conclude that a civil rights of health initiative that embraces grassroots organizing 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 while also, in Mari Matsuda’s famous words, “looking to the bottom.”14

I. PUBLIC HEALTH RESEARCH AND THE SOCIAL DETERMINANTS OF HEALTH: TOWARD A CIVIL RIGHTS OF HEALTH

People often think of health as the product of individual choices.15 Indeed, as Scott Burris observes, even opinion elites tend to discuss health and illness “in

13. Health equity is also sometimes equated with the abolition of all health disparities. See, e.g., Paula Braveman, What Are Health Disparities and Health Equity? We Need to Be Clear, 129 PUB. HEALTH REP. 5 (Supp. 2 2014), https://doi.org/10.1177/00333549141291S203.
15. 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 poor 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
medical terms, as something that starts at the doctor’s office, the hospital, or the pharmacy.” In this view, the most important determinants of health are the catastrophes, genetic inheritances, and disease agents that cause illness or injury, and the individual patient’s responsible or irresponsible reaction to these challenges.

Yet, while individual choices do play a part in determining how healthy people are, it is now well documented that health outcomes are also highly dependent on the individual’s social background and environmental context, such as whether they are rich or poor, a person of color or white, living in a violent neighborhood or a peaceful one, living in substandard or quality housing,

primarily through the modification of life styles”); Julie Guthman, Weighing In: Obesity, Food Justice, and the Limits of Capitalism (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, Alistair Woodward, Boyd Swinburn & William H. Dietz, Prevalence Trends Tell Us What Did Not Precipitate the U.S. Obesity Epidemic, 3 LANCET e162, e162 (2018) (citation omitted). 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. See id.

19. See, e.g., Katherine P. Theall, Elizabeth A. Shirtcliff, Andrew Dismukes & Maeye Wallace, Association Between Neighborhood Violence and Biological Stress in Children, 171 JAMA PEDIATRICS 53 (2017); Anna W. Wright, Makeda Austin, Carolyn Booth & Wendy Kliwer,
experiencing strong social relationships or isolation, breathing polluted or clean air, surrounded by healthy food options or junk food, or inundated by health-promoting or health-harming advertising. Individual 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.

In the last few decades, public health advocates have documented the “social determinants of health.” These are the cultural, social, economic, environmental, 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.

Mindful of the social determinants of health, public health advocates have focused on population-wide interventions to prevent disease or injury as well as on encouraging individuals to make healthy choices. For example, recent public health efforts have sought to prevent obesity and heart disease by creating environments that support physical activity and provide access to healthy food, especially for children, and also by disseminating information to the public about healthy eating and exercise.


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).


An example is the “Let’s Move” campaign launched in 2010 by first lady Michelle Obama. See White House Task Force on Childhood Obesity Report to the President, LET’S MOVE (May 2010), https://letsmove.obamawhitehouse.archives.gov/white-house-task-force-childhood-obesity-report-president [https://perma.cc/CX5L-A9SE]. In 2011, the White House released a one-year report identifying the goals of the Let’s Move campaign as “(1)
But despite many successes, public health advocates have been dogged by the stubborn persistence of health disparities.\textsuperscript{25} Healthy People 2020, an initiative promulgated by the U.S. 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.”\textsuperscript{26}

In our view, the stubborn persistence of myriad health disparities in the United States, despite longstanding recognition of the problem\textsuperscript{27} is linked to the empowering parents and caregivers to make healthy choices for their families; (2) serving healthier food in schools; (3) ensuring access to healthy, affordable food; and (4) increasing physical activity.” \textit{White House Task Force on Childhood Obesity, One Year Progress Report 1} (2011), \url{https://letsmove.obamawhitehouse.archives.gov/sites/letsmove.gov/files/Obesity_update_report.pdf} [https://perma.cc/6MS3-QYBU].


fact that conventional public health advocacy has yet to fully confront the centrality of subordination in creating and perpetuating disparities. While there is a strong body of research on the health effects of subordination, less attention is paid to how to directly confront subordination itself. Health disparities are closely associated with “social, economic, and/or environmental disadvantage” because they result from historic and ongoing injustices against stigmatized or vulnerable groups.28 By definition, then, health disparities are “avoidable, unnecessary, and unjust.”29 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 the historical public health approach to eliminating them.

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

Understanding that health is socially determined has led some public health advocates even further “upstream”30 to examine political factors such as the “inequitable distribution of power, money, and resources.”31 In accordance with this move, we argue that subordination on the basis of race, gender, class, citizenship, sexuality, and other power and privilege differentials is a central driver of health disparities. We will discuss three interrelated but analytically distinct pathways through which subordination produces health disparities: population, place, and access to power.

include, for example, AGENCY FOR HEALTHCARE RSCH. & QUALITY, U.S. DEP’T OF HEALTH & HUMAN SERVS., NATIONAL HEALTHCARE DISPARITIES REPORT 2011 (2012) (finding that African Americans, American Indians and Alaska Natives, and Hispanics/Latinos receive lower quality and less accessible health care than Whites); 60 CTRS. FOR DISEASE CONTROL & PREVENTION, U.S. DEP’T HEALTH & HUMAN SERVS., CDC HEALTH DISPARITIES AND INEQUALITIES REPORT—UNITED STATES, 2011, at 1–2 (2011) (reporting 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).


29. Braveman, supra note 13, at 7 (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)).

30. This term is commonly used in the public health literature in reference to denote the social determinants of health, in contrast to the individual determinants of health. See, e.g., David R. Williams, Manuela V. Costa, Adebola O. Odunlami & Selina A. Mohammed, Moving Upstream: How Interventions that Address the Social Determinants of Health can Improve Health and Reduce Disparities, 14 J. PUB. HEALTH MGMT. & PRACT. S8 (2008).

I. Health Disparities Based on Population

The public health community’s attention to health disparities began with the recognition that, despite overall advances in health in the last few generations, certain social groups are burdened more than others by disease, illness, and premature death. The burden of poor health—from preventable chronic conditions to “deaths of despair”—falls disproportionately on people of color, children, low-income families, and individuals with a low level of education. Other groups with disproportionately poor health outcomes include the elderly, sexual minorities, and people with disabilities. In other words, who you are and the social building blocks of your identity are predictive of your health and longevity.

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. Yet throughout this period, disparities in deaths from cardiovascular disease based on race, income, and education have persisted. In 2013, Black Americans were 30 percent more likely to die from cardiovascular disease than white Americans, and 113 percent more likely to die from cardiovascular disease than Asians/Pacific Islanders. Individuals with low income and education levels were 46 to 76 percent more likely to die from cardiovascular disease than those with high levels of income and education. Another example is the disparity in health outcomes and mortality rates for Black mothers and babies, described in the New York Times as a “life-or-death crisis.” 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.

32. See ANNE CASE & ANGUS DEATON, DEATHS OF DESPAIR AND THE FUTURE OF CAPITALISM (2020) (noting an increase in mortality among middle-aged American, white adults without bachelor’s degrees).
33. See TOBIN-TYLER & TEITELBAUM, supra note 3, at 34.
35. Id.
36. Id.
38. See, e.g., DIV. OF REPROD. HEALTH, CTRS. FOR DISEASE CONTROL & PREVENTION, PREGNANCY MORTALITY SURVEILLANCE SYSTEM, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm#trends [https://perma.cc/Q4X3-3AE4] (last updated Feb. 4, 2020) (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...
children as a group experience more illness and death related to childbirth neither because they are distinctively 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,\textsuperscript{39} institutional discrimination in the provision of health care,\textsuperscript{40} medical research that

\begin{itemize}
\item \textsuperscript{39} Martha Lang and Chloe Bird explain that the experience of societal discrimination produces chronic stress, which in turn creates systemic dysregulation:
\begin{quote}
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.
\end{quote}

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

\item \textsuperscript{40} According to health law scholar Dayna Bowen Matthew, for instance, “[t]wenty-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). Khiara Bridges’s qualitative research on the treatment of poor pregnant women of color at a hospital in New York City suggested that their bodies were considered “unruly.” Khiara M. Bridges, Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization 74 (2011). Sexual minorities also experience discrimination in the patient-provider relationship and in insurance coverage. See Valarie K. Blake, Remediying Stigma-Driven Health Disparities in Sexual Minorities, 17 HOUS. J. HEALTH L. & POL’Y 183, 210–11 (2017).
\end{itemize}
prioritizes white male bodies, and even transgenerational biological transmission of the effects of discrimination.

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.” 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.”

Today’s discrimination occurs, moreover, against a backdrop of recent policy decisions to shift the risk of catastrophic events onto individuals and their families, and a longstanding 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,” treating substance abuse, homelessness, and mental illness as

41. See Lisa C. Ikemoto, Bioprivilege, 42 WASH. U. J.L. & POL’Y 61, 64 (2013); Michelle Oberman & 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).

42. 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 CLEVE. 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 & Christopher W. Kuzawa, Biological Memories of Past Environments: Epigenetic Pathways to Health Disparities, 6 EPIGENETICS 798 (2011).

43. See TOBIN-TYLER & TEITELBAUM, supra note 3, at 34–56 (summarizing research on health disparities affecting the following vulnerable populations: low socioeconomic 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).

44. Id. at 35 (quoting Kevin Grumbach et al., Vulnerable Populations and Health Disparities: An Overview, in Medical Management of Vulnerable and Underserved Populations: Principles, Practice, and Populations 3 (T. E. King et al. eds., 2007)).


46. See TOBIN-TYLER & TEITELBAUM, supra note 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. at xv (emphasis omitted).
individual problems or even as crimes, rather than problems to be addressed at an institutional level. Population vulnerability is made, not born.

2. Health Disparities Based on Place

A popular saying among public health practitioners is that “your zip code can tell more about your health than your genetic code.” This expression 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, today in Alameda County, California, “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.” 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. 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 twenty years.

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. Some communities enjoy well-funded schools, parks, and other

47. See id.; 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”).

48. PAULA BRAVEMAN & SUSAN EGERTER, CTR. ON SOC. DISPARITIES IN HEALTH, RWJF COMMISSION TO BUILD A HEALTHIER AMERICA, OVERCOMING OBSTACLES TO HEALTH IN 2013 AND BEYOND 12 (2013).


51. Mapping Life Expectancy, supra note 50.

52. See TOBIN-TYLER & TEITELBAUM, supra note 3, at 73–82 (discussing these physical characteristics of neighborhoods 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 NAGUIB PELLOW, THE SLUMS OF ASPEN: IMMIGRANTS VS. THE ENVIRONMENT IN AMERICA’S DEN (2011). Iton and Shrimali explain:
green spaces, full-service grocery stores, safe and affordable housing, and well-connected transportation.53 Other neighborhoods are burdened with concentrated poverty, poor-quality housing, rundown streets, dilapidated infrastructure and “brownfields,” low-performing schools, and exposure to crime and violence.54 These characteristics of the natural and built environment pave the way for predictable and persistent health disparities.55

A second place-based factor shaping the geography of health is the multigenerational interaction of racism, capital, and political power.56 How this interaction manifests depends on a variety of factors, like whether a neighborhood is rural, urban, or suburban, incorporated or unincorporated, or isolated or part of a strong regional identity.

To illustrate the geography of health, we turn to an urban example. In the 1950s and 1960s, federal government policy encouraged and subsidized the building of residential suburbs.57 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.58 Meanwhile, the concept of urban blight convinced courts and policymakers that the use of

---

[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 segregatist 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, supra note 49, at 1754 (citations omitted).


54. Id. at 801.


56. Christopher Tyson argues that “[f]or 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, 54 Harv. J. Racial & Ethnic Just. 1, 2 (2018).


eminent domain was appropriate to demolish neighborhoods seen as physically rundown or dangerous.\(^5\) 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.’\(^6\)

Land use policy in this period both fostered and entrenched racial segregation and systematically directed economic subsidies to homeowners in all-white communities, exacerbating white flight from cities.\(^6\) Left-behind urban neighborhoods, starved of capital investment, indeed became physically decrepit. The poverty of neighborhood residents weakened their political voices, leaving these areas open for demolition or the placement of locally-unwanted land uses such as highways and hazardous waste facilities.\(^6\)

Today, the number of upper-income, white professionals living in the formerly disinvested 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 . . . .\(^6\)


\(^{6}\) Id. at 47.

\(^{6}\) See Barbara Bezdek, To Attain “The Just Rewards of So Much Struggle”: Local-Resident Equity Participation in Urban Revitalization, 35 HOFSTRA L. REV. 37, 51 (2006) (“The indelible remaking of the landscape is now widely recognized as rooted in the massively funded federal policies of the twentieth century: the federal government’s unparalleled investment in interstate highways, the explicit racism of the Federal Housing Administration’s redlining that funded white flight from cities to suburbs, and the immense (and racially skewed) federal subsidy of homeownership through the federal mortgage interest deduction.”); 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, 18 (2006) (discussing “public policies that endorsed and supported private racism”).


\(^{6}\) McFarlane, supra note 61, at 5.
Public and private economic investment in places formerly classified as low-value is known as gentrification. Rather than healing the ills of segregation and blight, however, gentrification brings complex benefits and burdens. Gentrification brings amenities associated with good public health: new parks, produce-filled supermarkets, and improvements in housing quality. Residents often appreciate these changes, yet as McFarlane observes, poorer residents may also recognize that these health-promoting improvements may result in their being priced out.64 At the same time, gentrification often means a dramatic change in the racial and ethnic character of a neighborhood. Although this new form of “Negro removal” appears on the surface to be the result of pure “market forces,” law-driven public policy plays a central role in shaping economic development.65 Cash-strapped cities are making policy choices that perpetuate racial and class segregation and the health disparities that follow.66

Today, some public health researchers conclude that “racial residential segregation is the cornerstone on which Black-white disparities in health have been built in the U.S.”67 Despite the end of de jure segregation, public and private land use decisions have ensured that place-based factors, from access to educational and employment opportunities, to exposures to pollution and toxic substances like lead paint, continue to geographically distribute health outcomes.

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, we rely

64. Id. at 29.
65. See Bezdek, supra note 61, at 51 (“The market account masks the hefty hand that government has played in current land use allocations.”); McFarlane, supra note 61, at 33 (“Through the redevelopment process, the governmental body that is supposed to represent all people is judging the value of different groups of people and through the government’s administration of land use and development, discriminating against and subordinating some groups, regardless of the merits of competing claims to land use.”).  
66. As McFarlane explains, “[c]ity, 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.” McFarlane, supra note 61, at 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., The Opportunity Atlas: Mapping Childhood Roots of Social Mobility (Ctr. for Econ. Studies, Working Paper No. 18-42, 2018).
on its other meaning as “related to asserting individual and collective will.”68 what
the political science literature calls “power-to,” as opposed to “power-over,”69 and
what activists refer to as “empowerment.”70 One formulation of power-to comes
from the psychology literature and concerns an individual’s ability to exercise
agency.71 A second aspect of power-to relates to collective power and control, and
is reflected in civic engagement and participation in public decisionmaking.

In the public health literature, power-to means control over one’s destiny, and
a growing group of scholars and practitioners see it as a fundamental social
determinant of health.72 Evidence suggests that lack of personal or collective
agency—whether caused by trauma, toxic stress, discrimination, poverty, political
marginalization, or disenfranchisement—increases the risk of mental illness and
chronic disease.73 Conversely, the experience of exercising self-
determination, whether at the individual or collective level, has a protective effect
on health.74

68. Marjory Givens, David Kindig, Paula Tran Inzio & Victoria Faust, Power: The Most
Fundamental Cause of Health Inequity?, HEALTH AFF. BLOG (Feb. 1, 2018), https://
www.healthaffairs.org/do/10.1377/hblog20180129.731387/full [https://perma.cc/G3LE-
EQB2].
69. 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).
70. See, e.g. Jo Rowlands, Empowerment Examined, 5 DEV. PRAC. 101, 103 (1995) (adopting
a definition of “empowerment” as having three dimensions: personal, in close
relationships, and collective).
71. See, e.g., James W. Moore, What Is the Sense of Agency and Why Does It Matter?, 7 FRONTIERS
PSYCH. 1272, 1272 (2016) (explaining that a “[s]ense of agency refers to the feeling of control
over actions and their consequences”).
72. See generally Whitehead et al., supra note 29.
73. See, e.g., Brian D. Christens, Targeting Empowerment in Community Development: A
Community Psychology Approach to Enhancing Local Power and Well-Being, 47 CMTY. DEV. J.
538 (2012) (discussing importance of empowerment to mental health); Glen Laverack,
Improving Health Outcomes through Community Empowerment: A Review of the Literature, 24
J. HEALTH POPULATION & NUTRITION 113 (2006) (identifying nine “empowerment domains”
in which greater individual and community control over resources is associated with better
physical and mental health); Nina Wallerstein, Empowerment and Health: The Theory and
Practice of Community Change, 28 CMTY. DEV. J. 218, 219 (1993) (“Powerlessness as a
broad-based variable of disease risk is supported by research in poverty versus non-poverty
areas; by occupational setting studies where people have worse heart disease rates if they are
lower in the hierarchy, or have high work demands in combination with low levels of
decision-making control; and by the stress literature which indicates an association between
chronic stress and various physical, behavioral, and psychological health problems.”
(citations omitted)).
74. See sources cited in supra note 73; see also, e.g., A. O’Mara Eves et al., Community Engagement
to Reduce Inequalities in Health: A Systematic Review, Meta-Analysis and Economic Analysis, 1
PUB. HEALTH RSCH. v, xvii (2013) (“Overall, community engagement interventions are
effective in improving health behaviours, health consequences, participant self-efficacy and
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. 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. Trauma is associated with mental and emotional distress, as well as vulnerability to mental and physical illness.

Public health advocates have identified a specific kind of trauma, adverse childhood experiences (ACEs), as a powerful predictor of later health. ACEs include physical and emotional abuse, neglect, exposure to intimate partner violence, and parental incarceration. The more adverse 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. It also appears that ACEs alter young children’s brain development, leading to other negative outcomes.

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, sexual abuse, family violence, poverty, or forced migration. All of these are experiences of extreme powerlessness and lack perceived social support for disadvantaged groups.}; Nina Wallerstein, Empowerment to Reduce Health Disparities, 30 SCANDINAVIAN J. PUB. HEALTH 72, 74 (2002) (summarizing the research on individual and collective empowerment and finding that both are correlated with improved health outcomes).


77. Id.


79. See id.

80. See TOBIN-TYLER & TEITELBAUM, supra note 3, at 84–85 (reviewing ACE studies).

81. See, e.g., Sabina Palic et al., Evidence of Complex Posttraumatic Stress Disorder CPTSD Across Populations with Prolonged Trauma of Varying Interpersonal Intensity and Ages of Exposure, 246 PSYCHIATRY RSCH. 692, 696 (2016) (“[H]igh probability of CPTSD was found in both the childhood prolonged trauma . . . and the adulthood prolonged trauma samples with severe interpersonal intensity (i.e. the refugees, and the ex-POWs).”); KATHRYN COLLINS ET AL., FAMILY-INFOR MED. TRAUMA TREATMENT CTR., UNDERSTANDING THE IMPACT OF TRAUMA AND
of physical security, and like ACEs they produce a host of vulnerabilities to poor physical and mental health. Additional 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. Poverty is a striking example. The chronic inability of poor people to control their circumstances appears to contribute to negative health outcomes even over and above the obvious correlation between poverty and lack of access to resources like nutritious food, clean water, and adequate health care.

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 chronically overloaded, rendering the body vulnerable to a host of negative consequences. Disempowerment stems not only from individual family or life circumstances but also from social and economic status and geography. Toxic stress, therefore, may attack the body through multiple vectors, as in the example of poor children of color growing up in polluted and chronically disinvested neighborhoods.

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.” Just as strong social and

---


83. See Clancy Blair & C. Cybele Raver, Poverty, Stress, and Brain Development: New Directions for Prevention and Intervention, 16 ACAD. PEDIATRIC S30, S30 (Supp. 2016) (“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”).


85. See Howard Pinderhughes, Rachel A. Davis & Myesha Williams, Prevention Inst., Adverse Community Experiences and Resilience: A Framework for Addressing and
community bonds support resilience, damage to a social network can threaten it. Adverse community experiences may be constant and unrelenting, such as the dignity harms imposed on marginalized communities by racialized policing practices.\(^8\) Adverse community experiences also include instances in which a supportive social network is abruptly destroyed, through climate disaster (as in the wake of catastrophic hurricanes, tornadoes, fires, or floods) or human causes (as in urban renewal policies that physically destroy neighborhoods). Through the loss of personal ties, the erosion of positive social norms, marginalization or exclusion from collective decisionmaking, physical upheaval, and the loss of community-building third places like churches, bars, and schools, adverse community experiences are associated with negative health outcomes.\(^8\)

Conversely, a growing body of literature looks to personal and collective efficacy as having a protective effect on health at individual and community levels.\(^8\) A pioneering study on violence prevention defines collective efficacy as “social cohesion among neighbors combined with their willingness to intervene

\(^{86}\) See generally Susan A. Bandes, Marie Pryor, Erin M. Kerrison & Phillip Atiba Goff, *The Mismeasure of Terry Stops: Assessing the Psychological and Emotional Harms of Stop and Frisk to Individuals and Communities*, 37 BEHAV. SCI. LAW. 176 (2019). As 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 law.” Purtle, *supra* note 82, at 636 (citations omitted).

One commentator speculates that the lack of a sense of social and political solidarity lies behind the white “deaths of despair,” see *Case & Deaton*, *supra* note 32. Helen Epstein observes that although African American and Latino communities endure racial discrimination in addition to poverty, these communities gain resilience by acknowledging the institutional and structural causes of their situation. Middle-aged poor whites, in contrast, tend to be bewildered by economic failure and blame themselves for their own plight. Helen Epstein, *Left Behind*, N.Y. REV. BOOKS (Mar. 26, 2020), https://www.nybooks.com/articles/2020/03/26/left-behind-life-expectancy-crises [https://perma.cc/K9NP-FFSP] (describing white informants' self-perceptions in one study as "lonely warriors facing strange, undefined threats to their community").


\(^{88}\) See Whitehead et al., *supra* note 29, at 52.
on behalf of the common good." 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. As Michael Marmot concludes, “[a]utonomy—how much control you have over your life—and the opportunities you have for full social engagement and participation are crucial for health, well-being and longevity.”

B. The Root of the Problem: Subordination and the Need for Civil Rights of Health

The three pathways we have identified 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 immigration status are critical risk factors for interpersonal violence—a power pathway— because they create significant barriers to individuals trying to leave an abusive relationship or avoid street violence inflicted by strangers or authorities. Similarly, the place-based factor of racial segregation etches social discrimination against marginalized communities into the built environment, leaving people of color to live in neighborhoods that have more locally unwanted land uses and fewer amenities.


92. TOBIN-TYLER & TEITELBAUM, supra note 3, at 83.

93. 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).
These pathways are intertwined because they share a common origin: subordination. From the colonial period to the present United States, dispossession, labor exploitation, and political domination on the basis of race have affected the distribution of political power and economic resources. 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.

This interconnection suggests that addressing the social determinants of health and persistent health disparities requires grappling directly with subordination. Public health advocates increasingly acknowledge that law offers an indispensable tool for addressing the social determinants of health. We argue in this Part that, conversely, civil rights advocates can and should use the public health literature on disparities and the social determinants of health to establish the civil rights of health.

Antidiscrimination law was expressly designed to dismantle subordination by prohibiting discrimination by public and private actors in specified areas of concern—employment, education, housing, public accommodation, voting—and by rejecting social relations of caste. Moreover, antidiscrimination law draws on moral traditions that run deep in U.S. history and continue 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 antidiscrimination law has been vital to people seeking to alter systemic social inequality.


95 We recognize that antidiscrimination law is not capable of dismantling all forms of subordination that create health disparities. For instance, as Margaret Moss points out, Native Americans 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 HAMLIN J. PUB. L. & POL’Y 59, 79–80 (2010). Federal statutory and administrative law directed specifically at Native health have an important role to play in reducing these health disparities, as do tribal laws and rules of
Together, public health and civil rights advocates can confront two obstacles to effective antisubordination law and policy. The first obstacle is the relative invisibility of institutional and structural discrimination compared to interpersonal discrimination. The second is the proscription on using group membership as a proxy for discrimination in the formulation of legal remedies.

1. The Relative Invisibility of Institutional and Structural Discrimination

Despite its proud history, current civil rights advocacy labors under a number of challenges. One of the most serious problems facing civil rights advocates is the fixation many Americans have on an individual, intent-based understanding of discrimination. Although explicit individual discrimination is real, it is not the only or even the most insidious form of discrimination. Subordination also includes institutional and structural discrimination, as well as interpersonal bias.96

Take, for example, racial discrimination. Some Americans believe that racial differences are biologically based and determine an individual’s worth. This is explicit interpersonal bias, also known as prejudice. Many more individuals 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 interpersonal bias, an unconscious tendency to perceive and act according to cultural stereotypes about social groups, whether those

jurisdiction and procedure. See Starla Kay Roels, HIPAA and Patient Privacy: Tribal Policies as Added Means for 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 U.S. Supreme Court decision acknowledging tribal jurisdiction as an inherent attribute of sovereignty will help indigenous women and children at risk for sexual violence) (the authors wish to thank Michelle Gutierrez for raising this point). A full account of federal Indian law and tribal law as a health justice initiative is beyond the scope of this Article; however, this gap comports with our position that the participation of social movements is necessary to bring about health equity. See infra Part III.

96. Cf. 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, Levels of Racism: A Theoretic Framework and a Gardener’s Tale, 90 AM. J. PUB. HEALTH 1212, 1213 (2000). But see DIANGELO, supra note 4, at 76–77 (discussing internalized oppression). Because civil rights law is not an appropriate tool for addressing internalized racism, we do not discuss it further in this Article.
stereotypes are benign or malign.\textsuperscript{97} 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 on whether to prescribe pain medication for a patient asking for it.\textsuperscript{98}

Even more insidious than interpersonal discrimination, however, are institutional and structural discrimination. Institutional discrimination as we define 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 education, employment, and the legal system.\textsuperscript{99} Institutional discrimination cannot necessarily be 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 inclusion and exclusion, or exploitation and privilege.\textsuperscript{100} Consider, for instance, the recent discovery that some computer algorithms designed to assist decisionmaking in employment and criminal justice reflect the racial biases
and blind spots of their designers, as well as bias in the data on which these algorithms rely.\textsuperscript{101}

Finally, structural discrimination refers to the interaction of discriminatory institutions, which results in the intensification and perpetuation of subordination across many spheres of social life.\textsuperscript{102} For example, journalist Ta-Nehisi Coates has explored the history and legacy of government and private redlining in Chicago.\textsuperscript{103} Residential racial discrimination may have originated as interpersonal discrimination, as individual white homeowners refused to live next to Black people. It became institutional, however, when racial segregation became official government policy, affecting mortgage loan eligibility.\textsuperscript{104} As a form of institutional racism, residential segregation became embedded in the logic of the housing market. 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.\textsuperscript{105}

Then, residential segregation became structural, and as such it endures today. For example, because public education is tied to neighborhoods, families in poor neighborhoods have reduced access to better-resourced schools. Lower educational achievement adversely affects the employment prospects of young adults, which makes it less likely that they will be able to amass the wealth to buy

\textsuperscript{101} See Anupam Chander, The Racist Algorithm?, 115 MICH. L. REV. 1023, 1036 (2017) ("Ostensibly neutral algorithms can produce results that reflect the prejudices of society. Thus, even if algorithms are less likely than the human decisionmakers they replace to be afflicted by prejudice, algorithms can still further entrench discrimination through other means. Even facially neutral algorithms will produce discriminatory results because they train and operate on the real world of pervasive discrimination."); Margaret Hu, Algorithmic Jim Crow, 86 FORDHAM L. REV. 633, 645 (2017) ("[C]urrent algorithm-driven vetting and biometric-biographic identification screening, especially once deployed across the entire citizenry, will likely lead to discriminatory profiling and surveillance on the basis of suspicious data as well as classification-based discrimination. These vetting and screening systems are likely to result in both direct and disparate discrimination, particularly based on race, color, ethnicity, national origin, and religion."); 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).

\textsuperscript{102} See powell, supra note 53, at 796 ("Structural racism shifts our attention from the single, intra-institutional setting to inter-institutional arrangements and interactions."); Wieck, supra note 96, at 5 (defining structural racism as comprising "cultural beliefs, historical legacies, and institutional policies within and among public and private organizations that interweave to create drastic racial disparities in life outcomes").


\textsuperscript{104} See infra Part I (discussing the place pathway of health disparities).

\textsuperscript{105} See Coates, supra note 103.
into a more expensive neighborhood with better amenities. Additionally, because most families’ greatest source of wealth is their home, white families have for generations enjoyed dramatically more wealth than Black families—even after controlling for household income—which provides white young adults a cushion against economic shocks and a resource for investments in education and housing. This racial wealth gap is large and shows no sign of closing.

The net result of structural racism is “differential access to the goods, services, and opportunities of society by race.” This form of racism is particularly insidious. As the example of residential segregation shows, the structural dimension of racial subordination is persistent over time. Moreover, structural discrimination is difficult to dislodge because it is embedded in institutions and processes that appear fair and colorblind, such as housing markets, employment decisions, educational admissions, and medical research and treatment.

Unfortunately, today’s U.S. Supreme Court has absorbed the popular view that explicit interpersonal bias is the sine qua non of discrimination. According to the Court, the Fourteenth Amendment’s Equal Protection Clause prohibits actions taken by state actors with the conscious “intent” to harm someone on the basis of race, but not state action with a mere racial “impact.” 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 nonintentional mechanisms. Nevertheless, the Court has not only read the intent requirement into the U.S. Constitution, but

106. Race and class are intermingled here: All-white communities continue to enjoy higher property values and more amenities, while mixed and Black neighborhoods experience lower property values and fewer amenities. See generally Sheryll Cashin, The Failures of Integration: How Race and Class Are Undermining the American Dream (2005).


108. See, e.g., William Darity Jr. et al., Samuel DuBois Cook Ctr. on Social Equity, What We Get Wrong About Closing the Racial Wealth Gap 2 (2018), https://socialequity.duke.edu/wp-content/uploads/2019/10/what-we-get-wrong.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.”).


110. See Daria Rothmayr, 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).

has also applied the intent requirement to an expanding range of nonconstitutional antidiscrimination doctrines.\textsuperscript{112}

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 or tend to deprive any individual of employment opportunities . . . because of” a protected classification: race, color, religion, sex, or national origin.\textsuperscript{113} 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.\textsuperscript{114} Under disparate impact theory, in contrast, “the use of employment practices that have a disparate impact on groups with protected characteristics is unlawful unless the employer can show that the practices are job related and justified by business necessity.”\textsuperscript{115} The disparate treatment standard makes it difficult to hold employers responsible for nonintentional, subtle forms of bias in


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.”


\textsuperscript{115} Green, \textit{supra} note 114, at 136.
the workplace, such as implicit bias.\textsuperscript{116} As a result, employment disparities on the basis of race and sex have persisted.\textsuperscript{117}

Americans tend to see individual agency, but not the institutional and structural context within which individuals make choices. As we have seen, this individualist bias affects Americans’ approach to health. It also affects our legal approach to discrimination. In the popular imagination, and in the Supreme Court, interpersonal bias is the root of racism.

The public health literature, however, provides a way to see that interpersonal discrimination is only one facet of subordination. Confronting facts such as the stubbornly high rates of African American maternal and infant mortality leads us to understand that condemning hate groups cannot comprise the whole of antiracist public policy.\textsuperscript{118} The literature on the social determinants of health can also help us see how racism interacts with other forms of subordination, such as gender, sexuality, disability, and citizenship.\textsuperscript{119} Like the cognitive psychology literature on implicit bias, the public health literature on health disparities offers civil rights advocates a glimpse of hope and new directions for advocacy.

2. The Problem of Affirmative Action Remedies

Perhaps the most important substantive limitation on contemporary civil rights law relates to the scope of legal remedies for discrimination. Because the Supreme Court has absorbed an individualist definition of discrimination, it has also set strict limits on what state and private actors may do to remedy the effects of discrimination. In short, attempts at affirmative action—policies meant to ameliorate the harms of discrimination by targeting aid to those groups that have been historically discriminated against—are today considered reverse discrimination and treated as presumptively illegal.

Taking again the example of racial discrimination, the 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.\textsuperscript{120} For example, in \textit{Parents Involved in Community Schools v. Seattle Sch. Dist. No. 1} (1954)
Seattle School Dist. 1, 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 percent 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 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.”

In other words, the district’s actions were taken to address institutional and structural discrimination. Nonetheless, the Court struck down the plan because it employed racial classifications. According to Justice Roberts’s plurality opinion: “The way to stop discrimination on the basis of race is to stop discriminating on the basis of race.”

Similarly, in Ricci v. DeStefano, white and Hispanic firefighters in New Haven, Connecticut objected when city officials refused to promote them based on a civil service exam. The officials 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 motion for summary judgment at trial, a decision that was affirmed...
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 relying on 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 Ian Haney López argues, “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.”

The Court has rejected an approach to equal protection that would examine government use of racial categories in the context of those categories’ history, function, design, and effect: the so-called antisubordination approach. Instead, the Court has embraced an anticlassification approach, which upholds formal equality—the view that all citizens should be treated the same regardless of morally irrelevant social statuses such as race—but also invalidates most attempts by government actors to uproot institutional and structural discrimination.

The literature on the social determinants of health offers a lifeline to civil rights advocates and policymakers struggling to steer between the Scylla of subordination and the Charybdis of so-called “reverse discrimination.”

130. Id. at 587.
132. See, e.g., Owen M. Fiss, Groups and the Equal Protection Clause, 5 PHIL. & PUB. AFF. 107 (1976) (articulating the difference between anticlassification and antisubordination approaches); Balkin & Siegel, supra note 4, at 9 (noting that the antisubordination principle is also called “the antinubjugation principle, the equal citizenship principle, or the anticaaste principle”).
133. 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 (2002) (“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 percent 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, 833–34 (2006). The “overwhelming” majority of these laws, according to the study, were attempts to generate opportunities for discriminated-against racialized minorities. Id. at 834.
Consider, for example, a state public health department that notices abnormally high levels of HIV-related deaths among Black and Puerto Rican men. A policy that subsidized access to drug cocktails for some racialized groups but not others would surely constitute illegal discrimination. Armed with public health data, however, lawmakers and public health officials could tailor a response to unevenly distributed deaths without using broad and stigmatizing racial classifications. At the same time, investigating the causes of the disparities could shine a light for policymakers and the public on the complex dynamics of subordination.

Our call for a civil rights of health initiative has other possible benefits beyond overcoming the impasses of current civil rights jurisprudence. First, health is not just an individual good; it is distinctively a public good, too. As public health advocates have long made clear, we each have a stake in everyone else’s health: infectious diseases, for example, do not respect neighborhood or international borders. The literature on health disparities explains why subordination should be considered a problem for everybody, not just for society’s most vulnerable groups. Second, health is not a zero-sum game: good health for one group does not require poor health for another. A civil rights of health initiative may thus produce less political friction and divisiveness than civil rights campaigns in other areas such as employment and education.

In Part III, we begin to describe the kinds of campaigns we believe might be part of a civil rights of health initiative. First, however, we must address some of the challenges we see to such an initiative, and why public health and law need a third partner in the form of social movements.

II. CHALLENGES TO THE CIVIL RIGHTS OF HEALTH INITIATIVE

We have argued that an alliance between civil rights and public health advocates will help address subordination as a public health intervention and that

135. As this Article was being edited, the COVID-19 global pandemic was revealing layer upon layer of health disparities manifested through population, place, and power pathways. See, e.g., Anna North, Every Aspect of the Coronavirus Pandemic Exposes America’s Devastating Inequalities, Vox (Apr. 10, 2020), https://www.vox.com/2020/4/10/21207520/coronavirus-deaths-economy-layoffs-inequality-covid-pandemic [https://perma.cc/8V2S-47NV] (“[I]t is exacerbating the inequalities in American society, taking a disproportionate toll on low-income Americans, people of color, and others who were already marginalized before the crisis hit.”).

The legal language of justice can strengthen the public health quest to eliminate health disparities. Conversely, research on the social determinants of health has the potential to reinvigorate civil rights advocacy by exposing the health consequences of structural discrimination. Despite the promise of an initiative to promote the civil rights of health, however, we see some serious challenges such an initiative would need to surmount to be effective and just. Some of these challenges are internal to public health and civil rights advocacy, respectively. Another challenge is the risk that an alliance between law and public health could actually exacerbate, rather than ameliorate, subordination. In this Part, we describe these challenges; in Part III, we suggest a means of addressing them.

A. Limitations of Public Health Advocacy in Addressing Persistent Health Disparities

Two key limitations of public health advocacy continue to hinder its ability to adequately address the role of subordination in shaping the social determinants of health. First, many public health advocates have focused on universal health interventions designed to benefit as many people as possible. Under this approach, however, health disparities may persist or even widen, and the systems that constrain individuals' choices remain 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 a reluctance to fully acknowledge and take action against subordination, perhaps in part out of fear of tainting scientific research with the stain of "politics."137

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

The traditional approach to improving public health has been premised on universalism: a focus on solutions that apply broadly across all social groups.

137. For example, one team of public health researchers discusses the difficulty in arriving at a definition of health disparities that uses a justice lens:

Previous official approaches to defining health disparities in the United States have avoided being explicit about values and principles, perhaps for fear of stirring political opposition, because of genuine differences in values or because of the prevailing ethos that enjoins researchers to avoid the realm of values that might compromise the integrity of their science.

Although public health advocates have increasingly recognized its limitations, universalism is reflected in important public health policy initiatives of the last few decades, such as ensuring access to affordable and high-quality health care, encouraging healthier behavior choices, and fostering healthier communities. For example, the campaign to reduce obesity and related chronic diseases, especially among children, combines all three universalist initiatives. Despite concerted and sustained public health campaigns to address 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.

Public health advocates have also focused many of their campaigns on promoting individual behavior change. This focus, however, can obscure the

---

138. For examples of emerging public health and social justice theories that acknowledge the limitations of a universalist approach, see, for example, John A. Powell, Stephen Menendian & Jason Reece, The Importance of Targeted Universalism, POVERTY & RACE RSCH. ACTION COUNCIL, Mar./Apr. 2009, 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”); John A. Powell, Post-Racialism or Targeted Universalism?, 86 DENV. U. L. REV. 785, 791 (2009) (identifying problems with “false universalism”); 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 gradient [in health outcomes], programs and policies must include a range of responses for different levels of disadvantage experienced within the population”).

139. Wiley, supra note 25, at 75.


142. See Nicholas Freudenberg, Emily Franzosa, Janice Chisholm & Kimberly Libman, 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 ‘downstream’ behavioral risks”); Fran Baum & Matthew Fisher, Why Behavioural Health Promotion Endures Despite Its Failure to Reduce Health Inequalities, 36 SOCIO. HEALTH & ILLNESS 213, 217–18 (2014) (offering several reasons why promoting individual behavior change has dominated governmental initiatives despite the limitations of this approach).
role that structural and systemic forces play in causing health disparities.\textsuperscript{143} Taking the obesity example again, researchers have pointed out that personal responsibility did not suddenly decline in the last few decades; rather, the availability and affordability of calorie-dense food and the environments in which we consume it have changed.\textsuperscript{144} Under these circumstances, Mary T. Basset and Jasmine D. Graves argue that attributing differences in health to lifestyle choices perpetuates 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.”\textsuperscript{145} Thus, even when targeted approaches are used, like a campaign directed at populations based on perceived lifestyle differences, there is risk that they will focus on the consequences of subordination rather than subordination itself.

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 population, place, and power.\textsuperscript{146}

\section*{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 history and dynamics of subordination that have shaped biomedical 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

\textsuperscript{143} See Wiley, supra note 25, at 10; Baum & Fisher, supra note 142, at 215 (observing that interventions targeted at individual behavior “tend to generate significantly less or little improvement with low SES [socioeconomic status] or other disadvantaged groups” and that the overall effect “may be to entrench or exacerbate inequality in health behavior and so in health outcomes”).

\textsuperscript{144} For an argument that a combination of corporate power, income inequality, and racial subordination have led to higher levels of obesity and obesity-related disease in Black and brown communities, see Andrea Freeman, \textit{Fast Food: Oppression Through Poor Nutrition}, 95 CALIF. L. REV. 2221 (2007).


\textsuperscript{146} See Wiley, supra note 25, at 48–49 (acknowledging lingering health disparities connected to race, ethnicity, gender, and poverty).
research, such as the use of the white male body as the standard yardstick for testing medical interventions.\textsuperscript{147} Public health researchers, similarly, must grapple with the influence of subordination on the field’s research and interventions.

Public health research has tended to shy away from acknowledging subordination. As an historical example, in 1851, American physician Samuel A. Cartwright notoriously hypothesized that the reason so many enslaved Africans fled captivity was because they were uniquely susceptible to a fictional mental illness called “drapetomania.”\textsuperscript{148} Failing to take account of racism while accounting for race reinforces the notion that an individual’s race is somehow biologically disabling.

Such thinking, unfortunately, did not end in the nineteenth century. In the 1990s for example, the Federal Violence Initiative adopted a public health approach to violence in inner cities.\textsuperscript{149} The leaders of the initiative, however, framed a key research question as, “Do male and Black persons have a higher potential for violence than others and, if so, why?”\textsuperscript{150} This research question assumed that the causes of inner-city violence were to be found in the physiology or mentality of Black men, rather than in the interactions of interpersonal, institutional, and structural discrimination that make poor and Black neighborhoods dangerous.\textsuperscript{151}

\textsuperscript{147} As Lisa Ikemoto explains:

\begin{quote}
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.”
\end{quote}

Ikemoto, supra note 41, at 64. (quoting Kathleen D. Mendelsohn et al., \textit{Sex and Gender Bias in Anatomy and Physical Diagnosis Text Illustrations}, 272 JAMA 1267, 1269 (1994)).

\textsuperscript{148} Samuel A. Cartwright, \textit{Report on the Diseases and Physical Peculiarities of the Negro Race}, 1851 NEW ORLEANS MED. & SURGICAL J. 691. 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 Black people 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. See Dykes, supra note 27, at 1135.


\textsuperscript{150} \textit{Id.} at 945 (quoting Peter R. Breggin & Ginger Ross Breggin, \textit{The War Against Children} 25 (1997)). 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.’” \textit{Id.} (quoting Breggin & Breggin, supra, at 8).

\textsuperscript{151} 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
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, public health researchers Chandra Ford and Collins Airhihenbuwa argue that epidemiological models of disease commonly treat race as “a population characteristic that predisposes one toward particular behaviors.”\(^{152}\) A better approach, they argue, is to recognize that race is a socially constructed category whose connection to physical health is mediated through social and political systems.\(^{153}\) Race, in this conception, is “less a risk factor itself than a marker of risk for racism-related exposures.”\(^{154}\)

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.”\(^{155}\) Confusing the two means that public health researchers may too readily accept explanations for racial disparities that fail to recognize the role of subordination in producing the differential vulnerability.

Even the conventional comparative method of investigating health disparities—comparing the health outcomes of people of color to those of whites—fails to sufficiently take account of subordination. As Shawn Bediako and Derek Griffith point out, although the comparative approach is descriptively 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.” Katie M. Saulnier & 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 challenge it, this time by stigmatizing minority cultures instead of minority bodies. For example, this initiative might encourage researchers to identify biological “abnormalit[ies]” 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, 353 (2012) (arguing that governmental measures to prevent methylmercury toxicity in fetuses by issuing warnings to women of childbearing age not to eat fish may have harmful racializing effects by framing the problem as women of color making bad personal choices).


\(^{153}\) Id.

\(^{154}\) Id.

\(^{155}\) As Krieger explains, the biological expression of race relations “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,” while racialized expressions of biology “refers to how arbitrary biological traits are erroneously construed as markers of innate ‘racial’ distinctions.” Nancy Krieger, *Does Racism Harm Health? Did Child Abuse Exist Before 1962? On Explicit Questions, Critical Science, and Current Controversies: An Ecosocial Perspective*, 93 AM. J. PUB. HEALTH 194, 195 (2003).
useful, it fails to identify “specific causal factors that produce disproportionately poor health outcomes for racial and ethnic minorities.” In this view, the public health research agenda needs to shift from simply describing and measuring the problem of health disparities to crafting solutions to address it. Relatedly, the comparison model also raises the question of which populations’ health outcomes are repeatedly implied to be the desirable standard of good health. Comparing marginalized peoples’ health outcomes to those of socially advantaged populations is indeed descriptively useful; but public health advocates must take care not to inadvertently conflate, for example, whiteness with ideal health outcomes.

In summary, many public health approaches remain hindered by a universalist and individualist focus and insufficient critical self-consciousness about the impact of subordination on research directions and methods, and interventions. The vulnerabilities transmitted through populations, places, and lack of power are not natural, but rather created, often by law, and sometimes deliberately. Although much progress has been made, the public health field has work to do to consistently acknowledge and effectively address this.

B. Limitations of Civil Rights Law

In the previous Subpart we noted the conceptual limitations of civil rights law, which we believe the social determinants of health literature begins to address. This Subpart acknowledges, in addition, the procedural obstacles to addressing subordination in present-day civil rights litigation.

Legal advocates have long recognized the role of subordination in creating and sustaining inequalities. What the public 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


157. 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 (Supp. 2 2014). They explain, “[u]ntil 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.

158. 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, 1 (2017) (concluding that “law creates and perpetuates the health problems of the urban poor more than it eliminates or ameliorates them”).
body of law developed to remedy discrimination, should thus logically be an important component of public health advocacy. Unfortunately, antidiscrimination law is in the throes of a decades-long retrenchment. Indeed, many legal scholars argue that today’s civil rights laws more often accommodate than challenge subordination.

Before addressing the obstacles specific to antidiscrimination litigation, we note two practical challenges in using American civil rights 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 antidiscrimination protection under the U.S. Constitution. Rather, the Court has recognized only a few scattered constitutional rights for poor people, such as the right to be represented by a lawyer at no cost in a criminal trial. Other targets of subordination, such as people under the LGBTQ umbrella, have similarly incomplete legal protections against discrimination.

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 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.

Setting these problems aside, a host of judicially-imposed procedural obstacles make it difficult for today’s federal civil rights litigators to achieve

159. See Tobin-Tyler & Teitelbaum, supra note 3, at 6–10; see also Cary Franklin, The New Class Blindness, 128 YALE L.J. 2, 2 (2018) (arguing that recent judicial decisions interpreting federal antidiscrimination law wrongly presume that equal protection law contains no protections based on poverty).
traction.163 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.”164 Some of the obstacles are longstanding. For example, Karlan argues that the Court has been unable to effectively guarantee equality in areas such as voting because it has focused solely on harms to individuals rather than harms to democratic representation as a whole.165

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,166 as well as new rules concerning qualified immunity that make it harder for plaintiffs challenging government violations of the Constitution to find someone to sue.167 The procedural barriers facing litigants who seek to bring class actions have also increased.168 Finally, new judicially-imposed pleading rules compel plaintiffs bringing antidiscrimination claims to submit detailed facts about their case at the


164. Karlan, supra note 163, at 877.

165. See id. at 877–79.

166. Id. at 881–82 (noting that Hein held taxpayers lack standing to challenge discretionary executive branch decisions); see Hein v. Freedom From Religion Found., Inc., 551 U.S. 587, 603–09 (2007) (plurality opinion).


earliest stages of litigation, or else see their claims thrown out as implausible.169 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.170

Meanwhile, some areas of civil rights litigation have been shut down entirely by recent Supreme Court rulings.171 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.172 Even when government agencies do

169. See, e.g., Ashcroft v. Iqbal, 556 U.S. 662, 677 (2009) (“[T]o 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 (arguing that the Court’s recent pleading decisions threaten claims of employment 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).

170. See Green, supra note 97, at 984–97 (giving examples of judges’ reluctance to acknowledge the impact of racist conduct in the workplace); see also Wal-Mart Stores, Inc., v. Dukes, 564 U.S. 338, 355 (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”); Marcia L. McCormick, Implausible Injuries: Wal-Mart v. Dukes and the Future of Class Actions and Employment Discrimination Cases, 62 DEPAUL L. REV. 711, 728 (2013) (arguing that “the decision in Dukes will stand for the principle that only decisions made with the fully self-aware goal of penalizing a person because of her sex, race, or other protected status is discrimination under Title VII”); 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) (asserting that “the new Dukes class certification standard jeopardizes potentially meritorious challenges to systemic discrimination”).

171. For example, Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d-7 (2018), forbids discrimination based on race, color, or national origin by any program or activity that receives federal financial assistance. In Alexander v. Sandoval, the Supreme Court held that private individuals may not bring suit based on violations of this provision. 532 U.S. 275 (2004). 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).

172. Legal scholars have decried, for example, the lethargic response of the Environmental Protection Agency’s Office of Civil Rights to environmental justice complaints. See, e.g., 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 [the EPA’s Office of Civil Rights], only 30 were accepted for
take action to enforce civil rights, the range of evidence they may introduce is limited. For example, 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 based on its apparent belief that racial discrimination is a thing of the past.173

As Part III explores, while courthouse doors have been closing at the federal level, new innovations in civil rights law have emerged at the state and local level.174 Nevertheless, it must be acknowledged that these procedural developments pose a challenge to pursuing the civil rights of health in federal courts.

1. The Risk of Evidence-Based Subordination

The first two challenges to a civil rights of health initiative we have identified are internal to public health research and legal advocacy. A third problem has to do with how an alliance between public health researchers and legal actors might play out in practice despite good intentions. If history is any indication, linking public health and the law has the potential to facilitate the surveillance and control of people and populations identified as dangerous or defective, thus deepening subordination rather than ameliorating it.

Consider, for instance, the treatment of people with disabilities in the United States. The so-called medical model of disability treats persons with disabilities as inherently defective, requiring rehabilitation in order to fit into society.175 Disability rights advocates argue that the medical model makes subordination invisible and have embraced instead a social model of disability, which treats 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.”). Rosenbaum and Teitelbaum argue that the failure of the executive and legislative branches to respond to Sandoval “threatens to deepen a crisis of confidence regarding the willingness of society at large to decisively address one of the most fundamental problems in United States health policy—that of racial and ethnic discrimination.” Rosenbaum & Teitelbaum, supra note 171, at 218.

173. 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, 551 U.S. 701 (2007), to overrule the judgment of a democratically-elected 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, 360–61 (2013) (criticizing the Court’s assertion in Shelby County v. Holder, 133 S. Ct. 2612 (2013), 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”).


disability as “a relationship between people with impairments and a
discriminatory society.” The Americans with Disabilities Act (ADA) is based on
a congressional finding that “individuals with disabilities are a discrete and insular
minority who have been faced with restrictions and limitations, subjected to a
history of purposeful unequal treatment, and relegated to a position of political
powerlessness in our society.”

Why did the language of health and illness fail to aid people with disabilities?
The answer lies in what sociologist Erving Goffman termed “stigma:” people
identified as abnormal in a negative way not only become the targets of
interpersonal prejudice and cultural stereotyping, but their needs are also
excluded from consideration in the design of mainstream social and built
environments. The experience of disability rights advocates suggests that
without vigorous advocacy to disrupt social stigma, documenting the ill health of
a stigmatized group may simply encourage policymakers to treat that group as
irredeemably broken or damaged, only now with the justification of science.

Public health panics can inflame stigma, leading to punitive rather than
supportive law and public policy. An example is the panic that took hold in the
1980s over so-called “crack babies,” infants supposed to be permanently hampered
by physical and cognitive disabilities because of their mothers’ drug abuse. Although the crack baby phenomenon proved not to be real after continued
medical and public health research, the panic led to widespread criminal and
administrative sanctions against pregnant women, especially poor Black and
brown women, and the effects of this stigmatizing public policy are still being
felt today.

176. Tom Shakespeare, Disability, Identity and Difference, in EXPLORING THE DIVIDE: ILLNESS AND
DISABILITY 94, 96 (Colin Barnes & Geof Mercer eds., 1996).
Adler, Benjamin D. Winig & Jennifer Karas Montez, Equity First: Conceptualizing a
Normative Framework to Assess the Role of Preemption in Public Health, 98 MILBANK Q.
131 (2020) (noting that preemption can also promote public health and proposing an
“equity first” framework for evaluating preemption).
179. Michele Goodwin, Fetal Protection Laws: Moral Panic and the New Constitutional Battlefront,
102 CALIF. L. REV. 781, 809 (2014) (“[P]regnant addicts endured a particularly unique attack
not only as intensified targets of the drug war, but also as ‘bad mothers’ on the path toward
swamping the United States with crack babies, who develop into uneducable, disabled, and
malformed children.”).
180. Id. at 786, 794 (arguing that the United States is experiencing a new wave of criminal
prosecutions of pregnant women despite the dubious public health benefits of such
prosecutions).
The most chilling cautionary tale in this regard is the history of American eugenics. Beginning in the early twentieth century, policymakers and legislators distressed about the future of the “white race” used scientific and public health research to support immigration restrictions, arguing that immigrants from southern and eastern Europe carried corrupted “bloodlines” that threatened the American body politic. ¹⁸¹ Public health concerns couched in the supposedly scientific language of eugenics, as well as concerns for the public fisc, also supported public and private initiatives to sterilize poor women, especially Black and brown women. This policy was upheld by the Supreme Court with the infamous words of Justice Holmes: “Three generations of imbeciles are enough.” ¹⁸² A similar legal and public health campaign against LGBTQ and gender-nonconforming persons, including women who were or suspected to be prostitutes, was helped along by the official classification of homosexuality as a medical disorder. ¹⁸³ The lesson is that public awareness of differential health does not necessarily stir compassion, indeed, it may do the opposite when the group is already stigmatized.

Moreover, raising awareness about the health consequences of subordination carries a new risk in today’s data-driven society. Governmental institutions, such as the criminal justice system, the family law system, public schools, and social benefits administration, increasingly collect and share data on individuals, and with the help of computerized algorithms, these data can be used for predictive purposes. ¹⁸⁴ Legal administration and public policymaking increasingly rely on these algorithms, which promise accuracy and efficiency. Researchers have, however, sounded an alarm about algorithms that reflect and magnify existing stigma. ¹⁸⁵ Meanwhile, civil rights scholars warn that big data can

¹⁸² Buck v. Bell, 274 U.S. 200, 207 (1927); see id. at 146.
¹⁸³ See Ordover, supra note 181, at 70 (campaigns against homosexual persons); Wendy Kline, Building a Better Race: Gender, Sexuality, and Eugenics from the Turn of the Century to the Baby Boom 44–48 (2001) (discussing the convergence between public health and eugenics language to justify institutionalizing sexually active women in California in the early days of the twentieth century); id. at 134–40 (discussing the use of a psychological personality test to pathologize homosexual and gender-nonconforming persons).
be used not only in service of greater health and safety, but also as tools of surveillance and discipline. 186 Although lawmakers and regulators have attempted to keep health data from being used for discriminatory purposes by imposing privacy restrictions, some commentators doubt whether these restrictions will be effective. 187

Scholars of poverty law and the welfare state argue that government assistance for stigmatized populations comes at the steep price of what Wendy Bach calls "hyperregulation." 188 Because existing programs of economic assistance and health care directed to marginalized groups like poor women of color already subject these groups to privacy intrusions and punitive regulation, the risk is great that big data initiatives will further entrench hyperregulation even while purporting to improve public health. 189

Despite the promise of better law and public policy offered by the civil rights of health, this practice also faces serious challenges. Public health advocacy has yet to fully reckon with the pervasiveness of subordination. Civil rights advocacy has been hampered by retrenchments in antidiscrimination law. Finally, an unreflective law and public health approach to health disparities could reinforce rather than ameliorate subordination.

One way to address these challenges is to adopt a model pioneered by justice-centered social movements, referred to here as [x] justice movements. Rather than envisioning a two-party partnership between public health and legal elites, a health justice model brings frontline communities and their representatives into the partnership as leaders. This three-way alliance can address the limitations of public health and legal advocacy, and also provide a check on elite abuses of power. The next Part sets forth the health justice model for which we advocate, and outlines an agenda for the civil rights of health within this model.

concluded that Black patients were healthier than equally sick white patients, because less money is spent on Black patients who have the same level of need).

186. See generally Valentine, supra note 184 (describing dangers of surveillance and discipline to stigmatized groups).


188. See Wendy A. Bach, The Hyperregulatory State: Women, Race, Poverty and Support, 25 YALE J.L. & FEMINISM 319, 322 (2014) (defining the hyperregulatory state as one whose mechanisms are "targeted by race, class, gender, and place to exert punitive social control over poor, African-American women, their families, and their communities").

189. See KAARYN S. GUSTAFSON, CHEATING WELFARE: PUBLIC ASSISTANCE AND THE CRIMINALIZATION OF POVERTY 1 (2011) ("Today’s welfare system treats those who use public benefits, or who even apply for benefits, as latent criminals."); BRIDGES, supra note 40, at 16 ("Medicaid mandates an intrusion into women’s private lives and produces pregnancy as an opportunity for state supervision, management, and regulation of poor, otherwise uninsured women.").
III. A WAY FORWARD: THE HEALTH JUSTICE FRAMEWORK

As Part I described, research on the social determinants of health makes plain the impacts of subordination on human health through the pathways of population, place, and power. Using this data, public health advocates have been increasingly drawn upstream to see law as a key tool for promoting health and well-being. The time is now for an alliance between public health and civil rights advocates to promote and develop the civil rights of health. This alliance recognizes the centrality of attacking subordination head-on in order to abolish health disparities, and it provides civil rights advocates with a powerful new tool for exposing, understanding, and addressing institutional and structural discrimination. The civil rights of health initiative recognizes that subordination is not only a moral issue, but also an issue of life and death.

But, as we saw in Part II, such an alliance is not without its challenges. Public health as a field has been reluctant to directly address subordination, and has tended to adopt universalist solutions while overlooking the impact of subordination on research frameworks. Meanwhile, legal scholars and advocates are comfortable with identifying and targeting subordination but are hampered by the limitations of current antidiscrimination law. And history warns that alliances between public health and law can turn ugly when public panic arises about stigmatized groups: a warning heightened in today’s culture of poorly-regulated, large-scale data collection and surveillance.

In this Part, we argue that one way to move forward while addressing these challenges is to place the civil rights of health initiative within the emerging framework of health justice. Like environmental justice, reproductive justice, and other [x] justice movements, health justice not only places subordination at the center of the problem of health disparities, it also calls for subordinated communities to speak and advocate for themselves. Embracing social movements as equal partners in the civil rights of health initiative acknowledges the internal limitations of public health and law. Moreover, allowing marginalized groups an equal voice empowers them against the possibility of abusive alliances of public health and law.

Subpart III.A explains the health justice framework, arguing that it provides a set of commitments that speak to the goals and limitations of public health and law. Subpart III.III.B sketches out an advocacy agenda and issues an invitation to build out the civil rights of health as a health justice initiative.
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. For example, Dayna Bowen Matthew calls for an approach to health disparities that begins with the recognition of structural inequality. 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.” Tobin-Tyler and Teitelbaum explain that they adopted “health justice” for their primer rather than “health equity” because the word “justice” resonates with a broader range of people, and immediately brings the legal system to mind. In our view the health justice paradigm involves another essential component: the vigorous engagement and leadership of frontline communities, the targets of subordination.

In the last few decades, North America has seen the proliferation of social movements that incorporate the word justice: “environmental justice,”


191. See Matthew, supra note 11, at 186. 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.” Matthew, supra note 93, at 83.

192. Benfer, Health Justice, supra note 190, at 278.

193. TOBIN-TYLER & TEITELBAUM, supra note 3, at x.

194. 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, supra note 25, at 104–05.
“reproductive justice,” “climate justice,” “energy justice,” “food justice,” “land justice,” and “water justice,” to name a few. 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 are committed to the empowerment of stigmatized communities, a commitment encapsulated in the disability rights movement slogan, “Nothing about us without us.”

Substantively, [x] justice movements share three basic commitments reflected in their analyses and their organizing: (1) a commitment to acknowledging the centrality and complexity of subordination; (2) an understanding of the necessity yet insufficiency of legal advocacy and technical knowledge alone to redress subordination; and (3) a commitment to, through social movement organizing, centering state and market governance around broadly-articulated “life rights.” These commitments, discussed in turn below, help to address the limitations of public health and civil rights advocacy identified in Part II. They thus provide an apt grounding for a health justice framework.

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

Central to [x] justice movements is the recognition that universalist-individualist approaches to disparities 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. Environmentalists in this period appealed to all Americans to recognize pollution as a gravely important policy issue, but in the process of seeking universal appeal, the movement tended to ignore the particular environmental burdens

---

195. The account that follows builds on Harris, supra note 12.
198. Harris, supra note 12, at 568.
faced by marginalized groups. In contrast, the environmental justice movement emerged from the recognition that addressing problems of pollution, waste, and environmental health required attention to disparities created by race, sex, indigeneity, poverty, disability, and other systems of caste.

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 every woman’s right to choose whether to conceive and bear a child. In the view of reproductive justice advocates, this universalist approach, with its focus on protecting the individual right to 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 institutional and structural forms of discrimination that prevent all women from equally enjoying the right to bear and raise healthy children, in addition to the right to choose not to have a child.

In addition to identifying subordination as the root of unjust disparities, justice movements have embraced a coalition-based, multifaceted approach to challenging that subordination. The idea that status-based forms of subordination

200. See Luke W. Cole, Empowerment as the Key to Environmental Protection: The Need for Environmental Poverty Law, 19 ECOLOGY L.Q. 619, 620 (1992) (arguing that “mainstream environmental groups have not focused on the environmental problems faced by low-income communities”); Robert D. Bullard, Environmental Justice in the Twenty-First Century, in THE QUEST FOR ENVIRONMENTAL JUSTICE: HUMAN RIGHTS AND THE POLITICS OF POLLUTION 19, 30 (Robert D. Bullard ed., 2005) (noting that the origin of the environmental justice movement was “a loose alliance of grassroots and national environmental and civil rights leaders who questioned the foundation of the current environmental protection paradigm”).

201. See, e.g., Cole, supra note 200, at 620–21 (arguing that the struggle for environmental justice is inherently entwined with antipoverty advocacy); COLE & FOSTER, supra note 199, at 32 (describing alliances among indigenous activists, people of color, women, and other interest groups at the founding of the movement).

202. For a discussion tracing the mobilization of women of color in response to the narrow abortion frame of the mainstream women’s rights movement, see generally LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION (2017); JENNIFER NELSON, WOMEN OF COLOR AND THE REPRODUCTIVE RIGHTS MOVEMENT (2003); JAEL SILLMAN, MARLENE GERBER FRIED, LORETTA ROSS & ELENA R. GUTÍERREZ, UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE (2004).

203. See, e.g., Reproductive Justice, SISTERSONG, https://www.sistersong.net/reproductive-justice [https://perma.cc/8FT2-VTEE] (last visited Feb. 23, 2019) (“To achieve Reproductive Justice, we must . . . [a]nalyze power systems. Reproductive politics in the US is based on gendered, sexualized, and racialized acts of dominance that occur on a daily basis. [Reproductive Justice] works to understand and eradicate these nuanced dynamics.”). As the reproductive justice movement has evolved, it has come to recognize the needs of trans and nonbinary people as well as cisgender women. See id.
are overlapping and mutually interactive is known in the United States as intersectionality, in acknowledgment of Kimberlé Williams Crenshaw’s pioneering theoretical interventions in legal scholarship in the late 1980s.\textsuperscript{204} [X] justice movements have consistently placed intersectionality at the center of their analyses and their organizing.\textsuperscript{205} This approach aligns with the public health recognition of the multiple, overlapping pathways through which health disparities emerge, as well as with the civil rights recognition that historical and current forms of discrimination, from the interpersonal to the structural, shape the choices that people make and the life chances they experience in complex and interactive ways.

2. [X] Justice Movements and the Limits of Professional Expertise

A second commitment of [x] justice movements—the view that professional expertise is necessary but insufficient to end subordination—both aligns with research on the health-enhancing effects of empowerment, and potentially addresses the limitations of both current public health advocacy and current civil rights advocacy.\textsuperscript{206}

[X] justice movements use empowerment as their touchstone, prioritizing community rights to participation in decisionmaking and policymaking. This priority aligns with the new public health research on the importance of individual and collective power-to in human flourishing.\textsuperscript{207} Public health, civil rights, and community advocates can easily agree on the benefits of participation, whether that means community participation in envisioning healthy neighborhoods in cities, lay participation in developing and directing resources for wellness, or community education as a tool to promote healthy eating.\textsuperscript{208}

More crucially, however, [x] justice movements’ insistence on leadership from the bottom—engaging frontline communities in shaping policy and

\textsuperscript{204} See generally Crenshaw, Demarginalizing the Intersection, supra note 4 (discussing concept of intersectionality); Crenshaw, Mapping the Margins, supra note 4 (further discussing concept of intersectionality).

\textsuperscript{205} See, e.g., Reproductive Justice, supra note 203 (“To achieve Reproductive Justice, we must . . . [a]dress intersecting oppressions. Audre Lorde said, ‘There is no such thing as a single-issue 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.”).

\textsuperscript{206} See Harris, supra note 12, at 588–89.

\textsuperscript{207} See infra Part I.A.3.

\textsuperscript{208} See infra Part III.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. Wiley, supra note 190, at 223.
selecting priorities—can serve as a check on expert-driven policies and majoritarian legal initiatives that reinforce subordination. A good example is the California environmental justice movement. Environmental justice advocates have consistently fought to use the law as a tool, but with “lawyers on tap, not lawyers on top.” This means that lawsuits, for example, should be designed with community engagement in mind. Using this framework, environmental justice community groups in California have bypassed the many pitfalls of civil rights litigation gaining “relatively unprecedented access to insider participation in the environmental decisionmaking processes that impact its members’ and constituents’ lives at the regional and statewide levels.”

Working within, alongside, and sometimes against state and local agencies, environmental justice organizers and activists have not only enjoyed the right to comment on proposals, but have proactively shaped the path of environmental policy in the state. Aware that law on the books does not automatically translate into law on the street, environmental justice advocates have also championed vigorous enforcement of existing legal protections and relied on media appeals as well as legal action. This insistence on frontline leadership counters the tendency for lawyers’ voices to eclipse the voices of their subordinated clients.

A similar checks-and-balances relationship holds between environmental justice advocates and scientific researchers. Marginalized communities often find themselves the targets of academic researchers who seek to extract data for

---


210. See id. at 1065–66.


213. See Benfer, *Health Justice, supra* note 190, 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”).
their projects but do not share their results with the community. In addition, research projects driven from outside the community may overlook “local knowledge” held by community members or make requests of residents using unfamiliar concepts. In response to these problems, “participatory action research” seeks to make research programs into collaborations among communities and researchers.

214. See Christopher Bacon et al., Introduction to Empowered Partnerships: Community-Based Participatory Action Research for Environmental Justice, 6 ENV'T. JUST. 1, 2 (2013) (“Rather than involving communities in the research process or consult on the results of a study, traditional academic research embraces an ‘arms-length’ relationship with community members, viewing studied communities as potential sources of ‘contamination’ to data that is gathered and later analyzed.”).


216. See, e.g., Ikemoto, supra note 149, 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: COMMUNITY KNOWLEDGE AND ENVIRONMENTAL HEALTH JUSTICE 3–4 (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).

217. This approach to research goes under many names; other commonly used terms are “community-based research” and “community-based participatory research.” Bacon et al., supra note 214, at 3 (discussing the terms “participatory action research,” “community-based participatory research,” and “community-based participatory action research”). For an overview of the principles of community-based research in a public health context, see Lawrence Green, Mark Daniel & Lloyd Novick, Partnerships and Coalitions for Community-Based Research, 116 PUB. HEALTH REP. 20 (Supp. 1 2001), https://journals.sagepub.com/doi/pdf/10.1093/phr/116.S1.20 [https://perma.cc/AC34-BDV3]; see also Carolina L. Balazs & Rachel Morello-Frosch, The Three R’s: How Community-Based Participatory Research Strengthens the Rigor, Relevance and Reach of Science, 6 ENV'T. JUST. 1 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3832061/pdf/nihms524103.pdf [https://perma.cc/KFG6-BM8C] (arguing, in the environmental justice context, that community-based research improves the “rigor, relevance, and reach” of scientific study). Principles of PAR have spread to the legal context as well. See Bacon et al., supra note 214, at 6; Emily M.S. Houh & Kristin Kalsem, It's Critical: Legal Participatory Action Research, 19 MICH. J. RACE & L. 287, 342 (2014).
Similarly, “citizen science” or “street science” projects permit nonscientists to contribute to data gathering.\(^{218}\)

Finally, another potential contribution of a health justice frame to the civil rights of health project is the ability, through people power, to expand the limits of what is possible through, for example, the development of new legal rights. Americans enjoy very few positive legal rights, including rights relevant to health, and civil rights law has fallen on hard times in the courts. Politics—by which we broadly include cultural change and movement work as well as electoral behavior—is the source of new rights, new cultural understandings, and new policy priorities.\(^{219}\) Social movements shape the collective imagination and social narratives, thereby giving content to new ideas that can take the shape of policy. Ordinary people can extend the capacities of professionals.

**B. An Agenda for Promoting the Civil Rights of Health**

Elizabeth Tobin-Tyler and Joel B. Teitelbaum identify three levels of health justice advocacy: (1) individual advocacy, on behalf of an individual patient or family; (2) health systems advocacy, focused on the institutional provision of medical care; and (3) local, state, and federal policy advocacy.\(^{220}\) Collaborations between lawyers and public health professionals through “medical-legal partnership[s]”\(^{221}\) (MLPs) and organizational initiatives have already begun to advance the first two types of advocacy.

This Article focuses on the third type of advocacy, which involves partnerships among civil rights advocates, community advocates, and public health advocates to use litigation, administrative action, planning, and policymaking to connect the fight against health disparities with the fight against

\(^{218}\) See generally Corburn, supra note 216 (describing four instances in the Greenpoint/Williamsburg neighborhoods in New York City in which community members and professionals combined forces to address the risks of subsistence fishing from the polluted East River, the asthma epidemic in the Latino community, childhood lead poisoning, and local sources of air pollution).

\(^{219}\) An example is the advocacy by LGBT social movements that changed the practices of HIV/AIDS treatment. Lewis Grossman, examining this history, concludes that “the AIDS social movement spurred changes in the agency’s implementation of the Food, Drug, and Cosmetic Act (FDCA) and, eventually, in the language of the statute itself. The resulting reforms have made access to potentially life-saving drugs a fundamental goal of the Act, alongside the protection of consumers from unsafe and ineffective products.” Lewis A. Grossman, AIDS Activists, FDA Regulation, and the Amendment of America’s Drug Constitution, 42 AM. J. L. & MED. 687, 690 (2016).

\(^{220}\) Tobin-Tyler & Teitelbaum, supra note 3, at 150.

\(^{221}\) Id. at 138–39.
subordination. 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—and that not every example involves all three partners we envision—we offer some suggestions for assembling a civil rights of health toolkit.

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

a. Expanding Litigation Possibilities: Beyond the Intent Requirement

The public health effects of subordination are multiple, compounding, and often institutional and structural in nature, making it difficult or impossible to identify a given intentional action as the cause of a particular health outcome. Antidiscrimination 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, giving judges discretion to move between various definitions and to allow different evidentiary methods depending on their inclinations.

Even under existing jurisprudence the intent requirement does not always require an evidentiary smoking gun of explicit bias. For instance, in Village of Arlington Heights v. Metropolitan Housing Development Corporation, the Court.

---


223. This problem has stymied environmental justice litigation based on civil rights theories. See Wyatt G. Sassman, Environmental Justice as Civil Rights, 18 RICH. J.L. & PUB. INT. 441, 449 (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”).

224. Huq, supra note 112, at 1214; see also Zatz, supra note 112 (arguing that disparate impact theories of litigation are consistent with the Court’s focus on harm to individuals).

explained how circumstantial evidence can be used to prove intent to discriminate. 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 have permitted evidence of “deliberate indifference” in the face of actual knowledge of discrimination to count as “intent.” Two student authors have suggested that this standard could be used in cases involving government agency decisions that result in environmental harm to marginalized groups. Meanwhile, legal scholars are preparing for this

226. 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 decisionmaking process; and (5) whether the “legislative or administrative history” behind the decision reveals discriminatory purpose. Id. at 252, 266–68. This analysis remains good law. See, e.g., Abbott v. Perez, 138 S. Ct. 2305, 2325 (2018) (citing Arlington Heights for the proposition that the historical background of a legislative enactment is “one evidentiary source relevant to the question of intent”).

A recent federal circuit court decision interpreting the Fourteenth Amendment intent requirement in light of Arlington Heights briefly brought hope to advocates challenging a state’s preemption of local civil rights laws. In Lewis v. Governor of Alabama, 896 F.3d 1282 (11th Cir. 2018), a panel of the Eleventh Circuit held that Birmingham, Alabama’s Black residents stated an equal protection claim 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. Id. at 1294–97. Unfortunately, the full court subsequently granted the defendants’ motion for a rehearing en banc and vacated the panel’s decision. Lewis v. Governor of Alabama, 944 F.3d 1287 (11th Cir. 2019).


228. See Gebser v. Lago Vista Indep. Sch. Dist., 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 ex rel. LaShonda D. v. Monroe Cnty. Bd. of Educ., 526 U.S. 629, 643 (1999) (holding that a school board may be liable for damages on the “deliberate indifference” theory).

229. See Faerstein, supra note 227, at 584–85 (arguing that as state environmental justice initiatives mature, inaction in the face of documented inequities begins to provide evidence of litigable “deliberate indifference”); see also 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, 388–89 (2002) (providing an example of deliberate indifference in an educational discrimination context).
opening door with new conceptions of intent such as “reckless discrimination” and “negligent discrimination.”

There are also still some antidiscrimination causes of action that do not require proof of intent. For example, in Texas Department of Housing and Community Affairs v. Inclusive Communities Project, the 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 in this decision 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 majority opinion an erosion of the longstanding dichotomy between “disparate treatment” and “disparate impact” discrimination, with implications for employment law.

One federal antidiscrimination provision that embraces an impact standard within the health care system is § 1557 of the Affordable Care Act, which prohibits health insurers and health care providers from discriminating on the basis of race, ethnicity, gender, disability, and age. Sidney Watson argues that this provision “offers an important new anti-discrimination tool for identifying and dismantling health care segregation.”

---

230. Bornstein, supra note 116, at 1055 (arguing for Title VII liability “where an employer acts with reckless disregard for the consequences of implicit bias and stereotyping in employment decisions”).
232. 135 S. Ct. 2507 (2015). This case was a housing discrimination action brought under the federal Fair Housing Act (FHA) alleging that the defendant state agency had allocated housing tax credits in a way that disproportionately harmed African American residents. The Supreme Court held that disparate impact suits are cognizable under the FHA. Writing for the Court, Justice Kennedy explained, “Recognition of disparate-impact liability under the FHA also plays a role in uncovering discriminatory intent: It permits plaintiffs to counteract unconscious prejudices and disguised animus that escape easy classification as disparate treatment. In this way disparate-impact liability may prevent segregated housing patterns that might otherwise result from covert and illicit stereotyping.” Id. at 2522.
233. See infra Subpart III.B.2.
234. Sandra S. F. Sperino, Justice Kennedy’s Big New Idea, 96 B.U. L. Rev. 1789, 1792 (2016) (“Breaking down the perceived sharp line between disparate impact and disparate treatment cases opens up new theoretical and practical possibilities for Title VII.”).
236. Sidney D. Watson, Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity, 55 How. L.J. 855, 859 (2012); see also Matthew, supra note 10, at 225–27 (discussing § 1557 as a tool for addressing institutional bias and discrimination in health care). On June 12, 2020, the Office for Civil Rights (OCR) of the Department of Health and Human Services (HHS) issued a new final rule on § 1557, rejecting protections against discrimination based on sex stereotyping and gender identity that the Obama Administration had established in 2016. See Katie Keith, HHS Strips Gender Identity, Sex Stereotyping, Language Access Protections From ACA Anti-Discrimination Rule, HEALTH AFF. BLOG (June 13, 2020), https://www.healthaffairs.org/do/10.1377/
Perhaps most promisingly, the Americans with Disabilities Act (ADA)\textsuperscript{237} is organized around the concept of “accommodation” rather than proof of intentional discrimination, recognizing that, in Justice Kennedy’s words, “persons with mental or physical impairments are confronted with prejudice which can stem from indifference or insecurity as well as from malicious ill will.”\textsuperscript{238} Both the ADA and its predecessor statute, the Rehabilitation Act of 1973,\textsuperscript{239} require that programs and policies in employment, public accommodations, telecommunications, and public services seek to include people with disabilities, not just refrain from discriminating against them. The ADA adopted the view of disability rights activists that disability is a social construct, and requires that covered entities that exclude people with disabilities change to incorporate them.\textsuperscript{240}

This accommodation-focused structure of the ADA is sometimes perceived as setting it apart from the rest of civil rights law. As Michael Stein and others have argued, however:

> The divisions between race-based, sex-based, and disability-based workplace discrimination are not decisively sharp…. The biases fueling all three kinds of wrong, as well as the pretexts implementing them, arise from discomfort about lack of fit with whatever workplace practices are normative at the time and thereby result in refutable attributions of incapability. Such stigmatization has precluded racial minorities and women, as well as work-capable people who depart in other ways from idealized worker paradigms, from productive and rewarding employment.\textsuperscript{241}

The ADA, then, offers an opportunity to shift civil rights protections for many different groups toward an accommodation model.\textsuperscript{242}

\hspace{1em}\hspace{1em} hblog20200613.671888/full [https://perma.cc/5MUS-GUZ6]. The Trump Administration’s position on this point, however, seems to be contradicted by the Supreme Court’s recent ruling in \textit{Bostock v. Clayton County} that the plain language of Title VII prohibits discrimination against LBGT individuals based on “sex.” Bostock v. Clayton County, 140 S. Ct. 1731 (2020).

\textsuperscript{238} Bd. of Trs. of Univ. of Ala. v. Garrett, 531 U.S. 356, 375 (2001) (Kennedy, J., concurring).
\textsuperscript{240} See Michael Ashley Stein \\& Penelope J. S. Stein, \textit{Beyond Disability Civil Rights}, 58 HASTINGS L.J. 1203, 1208-09 (2007) (arguing that Congress premised the ADA on the belief that society had to be redesigned to allow the full integration of people with disabilities).
\textsuperscript{242} See, e.g., Kimani Paul-Emile, \textit{Blackness as Disability?}, 106 GEO. L.J. 293, 293 (2018) (arguing that the ADA 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”).
Finally, looking toward legislative action to open up litigation opportunities, Dayna Matthew Bowen advocates amending Title VI of the Civil Rights Act of 1964, which prohibits federally funded organizations, including health care organizations, from discriminating on the basis of race, color, or national origin.243 Alexander v. Sandoval allows only federal agencies to enforce this provision; Bowen proposes that Congress create a private right of action.244 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 particular cases; it also provides an important forum for public education and organizing. By playing the long game and continuing to argue against explicit interpersonal discrimination as the sine qua non of subordination in the media, in education, and in policy forums, advocates with an understanding of the social determinants of health can open pathways for legal change in antidiscrimination law.

b. Litigation-Aware Policy: Building an Intent Record

Even in the absence of any changes in antidiscrimination law, 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.245 A racial impact statement is designed to document or anticipate the effects of particular policies or decisions on racialized communities. An 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.246

Racial impact statements help make visible the dynamics of institutional and structural racism.247 The attorneys at LSNC argue that a racial impact statement can also lay a foundation for a legal challenge to state action based on intentional

---

243. Matthew, supra note 11, at 208–11 (setting forth a proposed revision of the statutory language).
244. See id.; supra Part II.
246. Id. at 157.
247. 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”).
The environmental justice movement has been a leader in challenging negative health impacts caused by the unequal geographic 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, but two examples are suggestive.

The complaint in *D.R. v Michigan Department of Education* 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. The class action suit sought communitywide early screening, referrals for evaluations of disability, provisions of special education and related services, and procedural safeguards against disciplinary measures related to disability for 30,000 school-age children residing in Flint, based on the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), and related statutes. In April 2018, the district court approved a

248. Kennedy et al., supra note 245, at 159.
249. Id.
251. 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).
settlement allowing the screening process to go forward, calling it a “win-win” for all sides.\textsuperscript{254}

A second example of place-based advocacy where environmental justice and health justice meet relates to housing quality. Some MLPs use landlord-tenant law and local administrative law to address the health concerns of low-income families. As Diana Hernández 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 prevention measures such as smoke and carbon-monoxide detectors.”\textsuperscript{255} Enforcing these laws and regulations can protect families from health conditions caused by substandard housing.

Working together, health professionals and lawyers can expand this individual advocacy into large-scale group advocacy addressing place-based health harms. For example, in East Chicago, Indiana, residents of the West Calumet Housing Complex, a public housing complex, lived for over forty years without knowing the soil they were living on was contaminated with lead and arsenic.\textsuperscript{256} 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 maximum permitted level.\textsuperscript{257} 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.\textsuperscript{258}

A more ambitious civil rights of health project is to move “upstream” to the structural drivers of poor housing quality and locally-unwanted land uses, drivers that include racial segregation and economic disinvestment. As discussed above,


\textsuperscript{255} Diana Hernández, ‘Extra Oomph:’ Addressing Housing Disparities Through Medical Legal Partnership Interventions, 31 HOUS. STUD. 871, 872 (2016).

\textsuperscript{256} Kate Walz & Emily Coffey, Public Housing, Environmental Health, and Racism: The West Calumet Story, in \textsc{Strategies for Health Justice: Lessons from the Field}, 9, 10 (Megan Haberle & Heidi Kumiawan eds., 2018), https://prrac.org/pdf/health_justice_rpt.pdf [https://perma.cc/2MP5-6GXN].

\textsuperscript{257} \textit{Id.} at 11.

\textsuperscript{258} \textit{Id.} at 15.
the Court’s decision in *Inclusive Communities*\(^2\) represents a ray of hope for fair housing litigators, upholding the impact standard for fair housing actions. According to Andrea Boyack, the decision means more broadly that “[l]ocal governments no longer have discretion to decide whether to overcome segregation, only how to do so.”\(^3\) 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.

Litigation aside, the federal government can play a role in incentivizing communities to undo segregation and its effects. 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.”\(^4\) 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].”\(^5\)

Although this promising federal initiative lost its momentum once President Donald Trump took office, state and local communities committed to disrupting the ongoing place-based health effects of discrimination are still developing their own goals and strategies. One example is New York City, which under Mayor Bill De Blasio recently issued a comprehensive draft fair housing plan and included the following as one of its six goals: “Make equitable investments to address the neighborhood-based legacy of discrimination, segregation, and concentrated poverty.”\(^6\)

Research on the social determinants of health can also help housing advocates highlight the health effects of inadequate housing. Noting that families

---


\(^3\) Tyson, *supra* note 56, at 35.

\(^4\) Id. at 36.

facing a lack of available housing must face tradeoffs such as skimping on food and other necessities, accepting low-quality housing, or becoming homeless, Dayna Bowen Matthew argues that the affordability crisis in housing ought to be understood as a public health crisis.264 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.”265 One example of a legislative remedy is the passage of “source of income” laws.266 These state statutes and municipal ordinances prohibit discrimination against renters and homebuyers based on the source of their income, thus making it unlawful, for example, to refuse to rent to a household on the grounds that it participates in the “Section 8” federal voucher program for low-income families.267 Opening up more housing for poor people is, as we have seen, a health intervention; what is more, the recent proliferation of shelter-in-place orders to combat the spread of COVID-19 has vividly demonstrated that housing is a necessary public good to safeguard everyone’s health.

State and local governments have been founts of innovation around the civil rights of health outside the housing context as well, with local governments being especially well-positioned to respond to issues of health justice.268 Policies such as sugary drink taxes and cigarette taxes, for example, have followed a “bottom-up federalism” trajectory, moving from municipal to state governments.269 Armed with public health data, state and local governments have begun to view built environment through an equity lens for planning and administrative purposes.270

264. Matthew, supra note 93.
265. Id. at 194.
267. One report found that as of 2017, twelve states, the District of Columbia, and many localities had such laws in place. Source of Income Laws, supra note 266.
270. Such policymaking need not be radical or controversial. For instance, the city of Seattle, Washington, after launching a “Race and Social Justice Initiative” in 2002, realized that streetlight bulbs should be changed on the basis of the bulbs’ life expectancy rather than on reported complaints after an “equity impact analysis” revealed that low-income communities, communities of color, recent immigrants, and people with limited English proficiency were less likely to report broken streetlights. CHANGELAB SOLS., LONG-RANGE PLANNING FOR HEALTH, EQUITY & PROSPERITY: A PRIMER FOR LOCAL GOVERNMENTS 51 (2019), https://www.changelabsolutions.org/sites/default/files/2020-01/CLS-BG217-Long_Range_Planning_Primer_FINAL_20200115.pdf [https://perma.cc/M8BC-NGVD].
Because “our localism”\textsuperscript{271} gives states and municipalities broad police powers with which to govern, state and local advocacy also offers the opportunity to connect public health advocates and civil rights lawyers through addressing disparate and selective enforcement of laws affecting the health of people of color and other marginalized populations. This is an area ripe for partnership, and 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 wellbeing.\textsuperscript{272}

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.\textsuperscript{273} Christopher Tyson argues for a policy of mandatory race audits as a condition for qualifying for federal grant-in-aid programs.\textsuperscript{274} 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.”\textsuperscript{275}

Meanwhile, frontline communities can be leaders in promoting the civil rights of health both by organizing to identify and publicize place-based inequities, and by building literacy in data production and interpretation.\textsuperscript{276} Grassroots environmental justice organizations have been active in this regard, using


\textsuperscript{273}See Lenhardt, \textit{supra} note 247.

\textsuperscript{274}Tyson, \textit{supra} note 56, at 52.

\textsuperscript{275}Id. at 54.

scientific and public health data in advocacy.\textsuperscript{277} The strongest and most effective campaigns have united community leaders, public health experts, and law and policymakers, though, tragically, such alliances sometimes succeed only after longstanding, needless harms to life and health.\textsuperscript{278} Working within a health justice framework, social movements, public health advocates, and civil rights advocates can come together to challenge the health disparities that arise through the place pathway.

3. Advancing the Civil Rights of Health Through the Power Pathway

a. Litigation and Policy Advocacy: Building Power-To for Children and Families

Building on the emergent ACEs research, various harms that befall children often build cumulative momentum into poor adult health outcomes that then can ripple out into families and communities. Therefore, public health interventions that specifically benefit children and families hold great promise for illness and disease prevention. 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 civil rights law on behalf of children who are suffering from trauma and disempowerment.

For example, in \textit{Peter P. v. Compton Unified School District},\textsuperscript{279} 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, which students had been subjected

\textsuperscript{277} For example, community-based participatory research initiatives have enabled communities to play a key role in environmental justice campaigns. See, e.g., Meredith Minkler et al., \textit{Si Se Puede: Using Participatory Research to Promote Environmental Justice in a Latino Community in San Diego, California}, 87 J. URB. HEALTH 796 (2010) (describing the translation of research findings as part of a policy advocacy effort, called the Toxic Free Neighborhoods Campaign, in the Old Town neighborhood of San Diego, California).

\textsuperscript{278} A notorious example is the Flint water crisis, which did not produce effective action until long after community members recognized the problems with their drinking water. For one account of this crisis written by a pediatrician who found herself “politicized” by witnessing the lead poisoning of young black and brown children in the area, see \textit{Hanna-Aitishia}, supra note 251.

to, 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.280

In a similar suit, Stephen C. v. Bureau of Indian Education,281 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.”282

Although these suits are hampered by some familiar limitations of civil rights law, they also represent a creative way to infuse disability civil rights protections with the social determinants of health research.283 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.”284

Beyond litigation, policy advocacy on the civil rights of health can engage school districts as partners to develop proactive responses to the risk of trauma.285 State policymakers, school districts, and individual schools 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

280. The complaint in this case survived the defendants’ motion to dismiss, although as of this writing a decision has not yet been issued on the merits. See 135 F. Supp. 3d at 1126.
282. Id. at *1.
283. One problem with which advocates for the civil rights of health have to wrestle when they take up disability jurisprudence is—as elsewhere in antidiscrimination law—a focus on individual harms and remedies. See Dowd, supra note 279, at 235 (“[T]he disability framework . . . may tend toward identifying causes or laying blame on the individual or their family, rather than on structural harm.”). For other scholars, however, 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.” Paul-Emile, supra note 242.
284. Dowd, supra note 279, at 201.
285. See, e.g., Yael Cannon & 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 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”).
schools.286 Until recently, public health advocates have been largely absent from the conversation around school discipline reform;287 the civil rights of health represents an opportunity to bridge that gap.

b. State Legislative and Constitutional Law: Protecting State and Local Government’s Ability to Promote Collective Power-To

As we saw in the context of place-based civil rights of health initiatives, state and local law is in many ways a more promising resource for the civil rights of health than federal law. The primacy of state and local law holds when we turn to the power pathway of the civil rights of health. For example, while the U.S. Constitution recognizes no economic and social rights, all fifty states’ constitutions guarantee some degree of protection for economic and social rights.288 Some of these rights explicitly concern health and health care, such as Alaska’s declaration that its legislature “shall provide for the promotion and protection of public health.”289 Other state constitutions contain broad but as yet undefined obligations that are relevant to the civil rights of health.290

State statutes and municipal ordinances are also a rich resource for health-related protections. In recent years, cities have been especially active in designing protections for public health, addressing such issues as smoke-free environments, safe and affordable housing, paid leave, and minimum wage increases.291 The literature on empowerment and health, however, also puts community engagement practices such as participatory budgeting and legislative initiatives protecting the right to vote in a new light.292 From the perspective of the

---

289. Jeffrey Omar Usman, Good Enough for Government Work: The Interpretation of Positive Constitutional Rights in State Constitutions, 73 ALB. L. REV. 1459, 1473 (2010) (“At least twelve state constitutions address either the state’s role with regard to public health in general or healthcare for the poor specifically.”).
290. Id.
291. See text accompanying supra note 270.
292. Participatory budgeting allows community members to “influence their local budget by prioritizing local government spending and the allocation of public resources.” Patricia E. Salkin & Charles Gottlieb, Engaging Deliberative Democracy at the Grassroots: Prioritizing the
civil rights of health, promoting democratic participation and political voice is a positive health intervention.293

A potential danger to such innovations in collective self-determination, however, is the preemption doctrine.294 Some state legislatures have used preemption doctrine to block local innovations aimed at eliminating health disparities.295 According to some public health scholars, this intergovernmental conflict goes beyond the judicial nullification of municipal actions here and there; in some cases private industries have used their economic and political power to enact state laws preempting local regulation, while some states have begun adopting punishments—including criminal penalties—for localities and individual local officials who act outside the confines of preemption.296 In response to this threat, some scholars and public health advocates have begun to develop ways to assess preemption itself from a health equity perspective.297


294. See Paul Diller, The Political Process of Preemption, 54 U. RICH. L. REV. 343, 346 (2020) (defining the term as “any override of pre-existing local power or prerogative by statute or constitutional amendment”). Diller explains:

Such preemption may impose a new regulatory regime from above, displacing the locality’s previously governing regime, or it may impose a regulatory regime when none such existed previously at the local level. . . . [P]reemption may also simply deprive the locality of the authority to implement a regulatory regime or fiscal choice, such as its preferred level of taxation, without providing any new regime or supplementary revenue in its place.

Id.
297. See Carr et al., supra note 177.
Finally, at the policy level, public health and legal advocates have developed tools for reorienting governmental action generally around the core value of protecting and fostering health. For example, Health in All Policies (HiAP) is “a collaborative approach to improve health by incorporating health considerations into decision making in all sectors and policy areas.”\footnote{298} HiAP recognizes that “[e]nvironments in which people live, work, study, and play impact health by influencing available opportunities” and that “[p]olicy decisions made by ‘non-health’ agencies play a major role in shaping [those] environments.”\footnote{299} Lindsay Wiley argues that coalitions among public health, environmental, antihunger groups, and others have successfully used the HiAP framework to convince the U.S. Department of Agriculture to give more weight to its health mandate, and she suggests that this story offers a model for campaigns engaging other agencies.\footnote{300}

One method of incorporating HiAP into the administrative state is the health impact assessment (HIA).\footnote{301} Like the racial audit discussed earlier, health impact assessments provide a means of taking health into account before new initiatives move forward, as opposed to litigation, which is usually backward-looking. Christina Ho argues that HIAs should be required for all federal legislation and regulation, noting that policies involving housing, education, transportation, incarceration, taxation, employment, agricultural, energy, gun safety, and trade all have potential health effects.\footnote{302}

Meanwhile, this framework is already being adopted at the municipal level. Seattle, Washington, Richmond, California, and Minneapolis, Minnesota have each incorporated the HiAP model into their governance policies and, according to one study, have “made significant progress operationalizing health and equity in all policies.”\footnote{303} Denver, Colorado’s Departments of Public Health and Environment and Community Planning and Development have used the HiAP framework to develop an “equity index” for prioritizing planning and investment

\begin{footnotes}
\footnotetext[299]{Id.}
\footnotetext[300]{Id.}
\footnotetext[301]{Christina S. Ho, Legislating a Negative Right to Health: Health Impact Assessments, 30 SETON HALL L. REV. 643 (2020).}
\footnotetext[302]{Id.}
\footnotetext[303]{Erik Calloway, The Long Road to the “All” of HiAP, 4 CHRONS. HEALTH IMPACT ASSESSMENT 45 (2019).}
\end{footnotes}
The Civil Rights of Health

activities. California describes its HiAP program as “the first state-level initiative of its kind in the United States,” and boasts of its “national and international model for promoting policies that improve health outcomes.”

C. The Big Picture: Toward New Rights and “Targeted Universalism” in Health Justice

As John A. Powell has observed, resistance to civil rights initiatives often takes the form of calls to abandon “identity politics” and to instead seek universal solutions. In the field of public health, as we have seen, universal approaches have failed to eliminate health disparities, indeed, universal approaches have sometimes intensified such disparities. We have argued that the necessity of a civil rights of health initiative stems from its unique ability to address the subordination that lies at the root of health disparities. The civil rights of health protect stigmatized and vulnerable communities where universal solutions fail by creating targeted solutions.

In the long run, however, we see targeted antisubordination advocacy as insufficient for true health equity. In order for people in the United States to truly enjoy health equity, we also need to advocate for universal positive rights relevant to health. Although such a campaign is not the focus of this Article, we note that social movements aware of the social determinants of health can help pave the way for new rights and new government responsibilities beyond the current limits of American law.

The United States has inherited an eighteenth-century constitution that, with scattered exceptions, recognizes negative but not positive rights. Furthermore, the United States has been reluctant to sign or ratify international human rights conventions that recognize social and economic rights relevant to public health, such as the right to housing, the right to education, and the right to health itself. A shared commitment of [x] justice movements, however, is their interest in establishing new rights connected to the material fundamentals of life, such as

306. See powell, supra note 138; powell et al., supra note 138.
307. See supra Part I.
308. See supra Part II.A.
309. Christina Ho argues, however, that American courts already implicitly recognize a right to health, although they are loath to say so. Christina S. Ho, Are We Suffering From an Undiagnosed Health Right?, 42 AM. J.L. & MED. 743 (2016).
land, water, energy, health, food, and reproduction. Indeed, these movements sometimes use international human rights discourse as an organizing tool.

Social movement organizing to develop new universal health-related rights challenges subordination in two ways. First, the grand goals of equality law have been historically stymied in the United States in part because redistributions of wealth, resources, and opportunity are conventionally considered off the table. Calling for positive rights, especially economic rights, recognizes that economic injustice—including land dispossession, labor exploitation, racialized wealth accumulation, and opportunity hoarding—has been one of the central mechanisms of subordination in the United States. Without economic redistribution, it is difficult to see how subordination can ever be fully redressed. Calling for positive rights seeks to restore the economic component to civil rights battles. The campaign to establish universal positive rights related to health has also provided an opportunity to bring the sustainability of ecological systems into the human health conversation in a time of global climate crisis. As the climate justice movement recognizes, global warming, deforestation, habitat destruction, soil degradation, and pollution are all likely to wreak the earliest and most intense damage on subordinated populations.

Second, new universal rights make new targeted 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 antisubordination

310. Harris, supra note 12.
311. See, e.g., Reproductive Justice, supra note 203 (“[Reproductive justice] 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.”); see infra Subpart III.A.III.1.
312. See OLIVER & SHAPIRO, supra note 107 (discussing the intergenerational “sedimentation” of racialized wealth inequality); ROTHSTEIN, supra note 57 (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) (arguing that neoclassical ideology has limited the struggle for economic justice).
advocacy, universal rights—such as the right to equal treatment itself—can support rather than stymie the fight against unjust disparities.

The universalist side of targeted universalism speaks to the work of critical legal theorists who seek to establish human flourishing—not maximizing individual wealth or defending personal autonomy—as the end goal of governance.316 As powell argues, although targeted approaches are indispensable to ending unjust health disparities, ultimately targeted and universal approaches must be combined in order to achieve a world in which all persons truly have the capacity to live the fullest life possible.317 The civil rights of health, in our view, comprises one piece of powell’s “targeted universalism” strategy. The other piece—which is best accomplished through people power—is the development of robust positive and universal rights to the public goods that help all of us survive and thrive.

CONCLUSION

As a joint project of public health, social justice, and frontline community 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 partnerships.

Public health research demonstrates how even policies that seem far from the health arena have significant and often measurable health implications and impacts. Moreover, public health data can be incredibly powerful and even predictive, 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 combined social, political, and legal strategies, 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 conventionally 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 on the


317. See powell, supra note 138, at 802 (arguing that targeted universalism ensures that “our institutions do the work we want them to do”).
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.318

Finally, we note that alliances among social justice advocates and civil rights advocates have made surprising recent gains in a time of retrenchment and pessimism. Campaigns such as “Ban the Box” and the “Fight for $15” have succeeded in moving the needle on mass incarceration and economic justice. The #MeToo and Time’s Up initiatives have similarly reinvigorated the battle against sexual violence, harassment, and exploitation. LGBTQ advocates have established same-sex marriage as the law of the land and called attention to the distinctive subordination of trans and gender-nonconforming people, despite legal setbacks. Health justice builds on the work of [x] justice movements that have come before, and carries the potential to unite them in an overall concern for human flourishing.

The geographer Ruth Gilmore famously defined racism as “the state-sanctioned or extralegal production and exploitation of group-differentiated vulnerability to premature death.”319 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 advocacy. We hope this Article will be read not as a summation, but as a call to action.

---

318. Courses that could incorporate 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.