

# **“Lessons from *The Other America*” Turning a Public Health Lens on Fighting Racism and Poverty**

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## I. INTRODUCTION

It is profoundly important to remember the work that Dr. Martin Luther King, Jr. was doing when he was gunned down in Memphis on April 4, 1968. He had come to support the right of sanitation workers to earn a living wage. In other words, King died fighting against *poverty*. We know that at the time of his death, Dr. King had taken stock of the victories achieved through the civil rights movement he led and had turned to enlarge his vision to address three major priorities: addressing poverty, racism, and militarism. These were his priorities at the time that he came to Memphis. Thus, it is fitting that we focus on eradicating persistent poverty in the fight for equity in America.

By all measures, inequities that separate the advantaged from the disadvantaged in America are severe and worsening to levels not seen in decades.<sup>1</sup> The top 1% of earners took home 20% of the nation's income, while the bottom 50% of the population earned less than 13% of national income in 2014.<sup>2</sup> Wealth inequity is even more concentrated; the top 1% of households hold nearly 40% of all wealth while the bottom 90% share less than a quarter of the nation's wealth.<sup>3</sup> Middle-class families are suffering the worst of the widening inequity gaps,<sup>4</sup> especially racial and ethnic minorities as compared

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1. See Jeremy Ashkenas, *Nine New Findings About Inequality in the United States*, N.Y. TIMES (Dec. 16, 2016), <https://www.nytimes.com/interactive/2016/12/16/business/economy/nine-new-findings-about-income-inequality-piketty.html>.

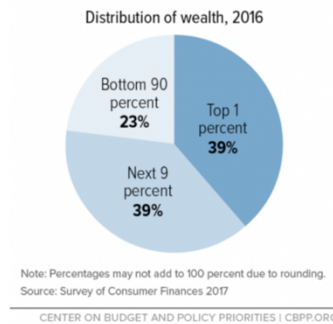
2. Daniel Bachman, *Income Inequality in the United States: What Do We Know and What Does It Mean?*, DELOITTE: DELOITTE INSIGHTS (July 12, 2017), <https://www2.deloitte.com/insights/us/en/economy/issues-by-the-numbers/july-2017/rising-income-inequality-gap-united-states.html>.

3. CHAD STONE ET AL., CTR. ON BUDGET & POLICY PRIORITIES, A GUIDE TO STATISTICS ON HISTORICAL TRENDS IN INCOME INEQUALITY 1 (2018), [https://www.cbpp.org/sites/default/files/atoms/files/11-28-11pov\\_0.pdf](https://www.cbpp.org/sites/default/files/atoms/files/11-28-11pov_0.pdf). See generally Thomas Piketty et al., *Distributional National Accounts: Methods and Estimates for the United States* (Dec. 2016) (working paper) (on file with the Washington Center for Equitable Growth), <http://cdn.equitablegrowth.org/wp-content/uploads/2017/02/24163023/120716-WP-distributional-national-accounts.pdf> (discussing wealth distribution inequities in the U.S.).

4. See STONE ET AL., *supra* note 3, at 9–14.

to white families.<sup>5</sup> As a result, social and economic inequity characterizes all sectors of society. For example, educational inequity constrains social mobility for generations,<sup>6</sup> confining a perpetual underclass into neighborhoods characterized by concentrated poverty, discriminatory policing, food insecurity, and tragically disparate poor health outcomes.<sup>7</sup>

Figure 1<sup>8</sup>



Indeed in Memphis, the city where Dr. King was martyred, the data shows that Memphis remains “ground zero” for Dr. King’s “Poor

5. Rakesh Kochhar & Anthony Cilluffo, *How Wealth Inequality Has Changed in the U.S. Since the Great Recession, by Race, Ethnicity and Income*, PEW RES. CTR.: FACT TANK (Nov. 1, 2017), <http://www.pewresearch.org/fact-tank/2017/11/01/how-wealth-inequality-has-changed-in-the-u-s-since-the-great-recession-by-race-ethnicity-and-income/>.

6. Linda Darling-Hammond, *Inequality in Teaching and Schooling: How Opportunity is Rationed to Students of Color in America*, in *THE RIGHT THING TO DO, THE SMART THING TO DO: ENHANCING DIVERSITY IN HEALTH PROFESSIONS* 208, 208–28 (2001).

7. See generally GARY ORFIELD & CHUNGMEI LEE, CIVIL RIGHTS PROJECT, HARVARD UNIV., *WHY SEGREGATION MATTERS: POVERTY AND EDUCATIONAL INEQUALITY* (2005) (discussing the relationship between race, education, and poverty); David M. Cutler & Adriana Lleras-Muney, *Education and Health: Evaluating Theories and Evidence* (Nat’l Bureau of Econ. Research, Working Paper No. 12352, 2006) (discussing the correlation between education and health).

8. STONE ET AL., *supra* note 3, at 16 fig.4.

People's Campaign.”<sup>9</sup> Poverty and inequity continue to plague this city, fifty years after King's death. Data released in February 2018 found that Memphis is the poorest large metropolitan area in the U.S.<sup>10</sup> Moreover, the wage gap between blacks and whites has remained unchanged with black Memphians earning a median annual income that is only 50% of the median income enjoyed by white Memphians.<sup>11</sup> Tragically, the childhood poverty rate for blacks in Shelby County, where Memphis is located, is more than quadruple the rate for white children.<sup>12</sup> No child should live in poverty. But the disparity among black and white children is especially unjust because inequities established early in childhood mean that over the entire life course, a disproportionate number of blacks in the population will have almost no way to compete on equal footing with whites to achieve the promise of life, liberty, and the pursuit of happiness in America. Memphis, however, is not the only city in America where black children start at a disadvantage. Throughout the country, over one-third of black and Native American children live in poverty, as compared to only 12% of their white and Asian counterparts.<sup>13</sup> This disheartening truth was captured in a speech that Dr. King gave in 1967. The speech was called *The Other America*, and sadly, 50 years after Dr. King's death, still tells the story of the national maladies he

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9. See generally ELENA DELAVEGA, UNIV. OF MEMPHIS, 2017 MEMPHIS POVERTY FACT SHEET (2017), <http://www.memphis.edu/socialwork/research/2017povertyfactsheetwebversion.pdf> (showing data from 2016 American Community Survey); *New Data Finds Memphis Is Poorest Large Metro in America*, WMC ACTION NEWS 5 (Feb. 6, 2018, 9:07 PM), <http://www.wmcactionnews5.com/story/37442278/new-data-finds-memphis-is-poorest-large-metro-in-america>.

10. *New Data Finds Memphis Is Poorest Large Metro in America*, *supra* note 9.

11. NAT'L CIVIL RIGHTS MUSEUM & ELENA DELAVEGA, THE POVERTY REPORT: MEMPHIS SINCE MLK: HOW AFRICAN AMERICANS AND THE POOR HAVE FARED IN MEMPHIS AND SHELBY COUNTY OVER THE PAST 50 YEARS 4 (2018), <https://www.speakcdn.com/assets/2462/nationalcivildrightsourcempovertyreport02152018edrev.pdf?1520286487008>.

12. *Id.*

13. *Children in Poverty by Race and Ethnicity*, KIDS COUNT DATA CENTER, <https://datacenter.kidscount.org> (search “children in poverty by race and ethnicity,” then select first result).

came to Memphis to address. In honor of the work he began then, this Essay highlights three themes from that speech. First, eliminating racism and poverty are separate goals that must not be conflated. Second, the public health framework provides an ideal lens for understanding and mitigating the impacts of poverty and racism. And third, we must reject racial divisions in favor of cooperative and collaborative solutions that are needed to effectively eliminate “The Other America” once and for all.

## II. THE OTHER AMERICA

Dr. King gave an address in 1967 at Stanford University that he titled *The Other America*.<sup>14</sup> And as you might imagine, the theme of that speech recounted data about the disparities that divided and plagued housing, educational opportunity, access to medical care, access to food security, and of course, exposure to violence by police and others.<sup>15</sup> The existence of the “Other America” King said, relied on an essential belief that one group is inferior to the other group.<sup>16</sup> To demonstrate this assumption, in his inimitable way, Dr. King described the Other America as no one else could: “This Other America has a daily ugliness about it that constantly transforms the buoyancy of hope into the fatigue of despair!”<sup>17</sup> He continued the comparison saying that while one America privileges people to live out the promise of life, liberty, and the pursuit of happiness, in the Other America “[l]ittle children . . . are forced to grow up with clouds of inferiority

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14. Dr. Martin Luther King, Jr., Speech at Sanford University: The Other America (Apr. 14, 1967), in Allen Willis et al., *Aurora Forum at Stanford University: Martin Luther King and Economic Justice: The Fortieth Anniversary Commemoration of Dr. King’s “The Other America” Speech at Stanford* (Apr. 15, 2007), at 2, 2–12, [https://auroraforum.stanford.edu/files/transcripts/Aurora\\_Forum\\_Transcript\\_Martin\\_Luther\\_King\\_The\\_Other\\_America\\_Speech\\_at\\_Stanford\\_04.15.07.pdf](https://auroraforum.stanford.edu/files/transcripts/Aurora_Forum_Transcript_Martin_Luther_King_The_Other_America_Speech_at_Stanford_04.15.07.pdf). For a recording of this speech, see Famous History, *Martin Luther King, Jr., “The Other America” Speech*, YOUTUBE (Aug. 27, 2016), <https://www.youtube.com/watch?v=TRI5W95cI4A>.

15. King, *supra* note 14, at 2–12.

16. *Id.* at 2–6.

17. *Id.* at 3.

forming . . . in their mental skies.”<sup>18</sup> But as was always the case, hope and a prescription for action was embedded in this speech about the Other America. The first lesson to take from that speech is that Dr. King identified poverty and racism as separate yet equally pernicious flaws in this nation’s social fabric that needed repair.

*A. Lesson #1: The Fundamental Problem of Racism in America Will Not Be Solved by Addressing Poverty Alone*

Eradicating racism, and all its effects, must remain a central focus of the work to achieve equity in America. Addressing poverty alone, without intentional focus on racial disparities in particular, will not eliminate poverty in Memphis or America. Dr. King referred to the continuing importance of addressing racism saying:

Now the other thing that we’ve gotta come to see now that many of us didn’t see too well during the last ten years—that racism is still alive in American society, and much more wide-spread than we realized. And we must see racism for what it is. It is a myth of the superior and the inferior race. . . . In the final analysis, racism is evil because its ultimate logic is genocide. Hitler was a sick and tragic man who carried racism to its logical conclusion. And He ended up leading a nation to the point of killing about 6 million Jews.<sup>19</sup>

Last summer in Charlottesville, Virginia, the Ku Klux Klan and a group of neo-Nazi, white supremacists violently terrorized the community in hopes of advancing their message of hatred, anti-Semitism, and racism.<sup>20</sup> These acts only serve to remind the nation that Dr. King was right in identifying racism as a problem in 1967, and that racism is sadly still alive and well today. Racism can be de-

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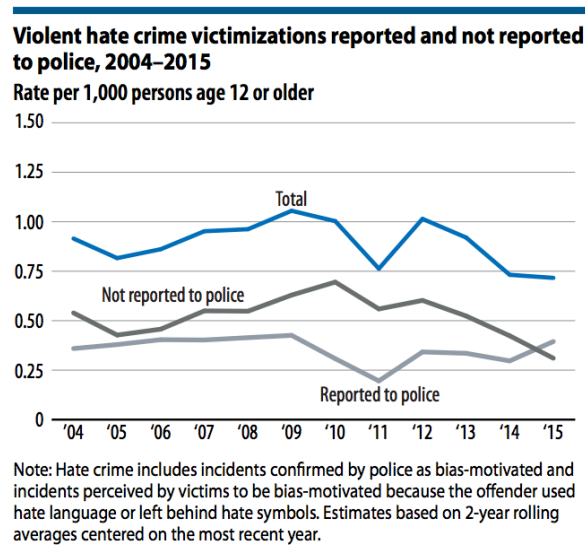
18. *Id.*

19. *Id.* at 5.

20. See Hawes Spencer & Sheryl Gay Stolberg, *White Nationalists March on University of Virginia*, N.Y. TIMES (Aug. 11, 2017), <https://www.nytimes.com/2017/08/11/us/white-nationalists-rally-charlottesville-virginia.html>.

defined as historical, institutionally enabled individual and structural practices that “create and reinforce oppressive systems of race relations whereby people and institutions engaging in discrimination adversely restrict, by judgment and action, the lives of those against whom they discriminate.”<sup>21</sup> The best evidence shows that crimes of racism are on the rise.<sup>22</sup>

Figure 2<sup>23</sup>



21. 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) (citations omitted); see also David R. Williams & Selina A. Mohammed, *Racism and Health I: Pathways and Scientific Evidence*, 57 AM. BEHAV. SCIENTIST 1152, 1153 (2013) (analyzing how racism remains fixed in American society and adversely affects health).

22. For hate crime statistics, see *2016 Hate Crime Statistics*, FED. BUREAU OF INVESTIGATION: UNIFORM CRIME REPORTING PROGRAM, <https://ucr.fbi.gov/hate-crime/2016> (last visited Nov. 14, 2018); see also Brian Levin & John David Reitzel, CTR. FOR THE STUDY OF HATE AND EXTREMISM, CAL. STATE UNIV., SAN BERNARDINO, REPORT TO THE NATION: HATE CRIMES RISE IN U.S. CITIES AND COUNTIES IN TIME OF DIVISION & FOREIGN INTERFERENCE (2018), [https://csbs.csusb.edu/sites/csusb\\_csbs/files/2018%20Hate%20Final%20Report%205-14.pdf](https://csbs.csusb.edu/sites/csusb_csbs/files/2018%20Hate%20Final%20Report%205-14.pdf) (analyzing hate crimes and recent American elections).

23. BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, HATE CRIME VICTIMIZATION, 2004–2015 (June 2017), [https://www.bjs.gov/content/pub/pdf/hcv0415\\_sum.pdf](https://www.bjs.gov/content/pub/pdf/hcv0415_sum.pdf).

We live in an environment where the President of the U.S. exploited social media platforms to share anti-Muslim videos<sup>24</sup> and labeled white supremacist rally organizers as “very fine people.”<sup>25</sup> The result is an unprecedented, national surge in violence and hate crimes, documented by the FBI<sup>26</sup> and the Southern Poverty Law Center,<sup>27</sup> since the presidential election.<sup>28</sup> Now to be sure, the importance of focusing on racism does not render the goal of eradicating poverty any less significant. We must also keep our eye—as Dr. King did—with a laser focus on the evil of racism. Poverty and racism are not one and the same. By addressing one, one cannot fully address the other. Poverty is the product of economic and social deprivation. It affects people of all races. Racism is systemic, institutionalized discrimination based on race or ethnicity—both conscious and unconscious, both intentional and unintentional—and still thrives in America today. This is because racism has deeply entrenched roots in this country.

Racism in America was legally enabled from the day our nation was founded until passage of the Civil Rights Act of 1964; it has persisted, despite explicit anti-discrimination laws and constitutional provisions, to this day. A recent article by sociologists Phelan and Link explains the reason why: racism is what sociologists call “a

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24. Ashley Parker & John Wagner, *Trump Retweets Inflammatory and Unverified Anti-Muslim Videos*, WASH. POST (Nov. 29, 2017), [https://www.washingtonpost.com/news/post-politics/wp/2017/11/29/trump-retweets-inflammatory-and-unverified-anti-muslim-videos/?utm\\_term=.64724abaeb63](https://www.washingtonpost.com/news/post-politics/wp/2017/11/29/trump-retweets-inflammatory-and-unverified-anti-muslim-videos/?utm_term=.64724abaeb63).

25. Michael C. Bender & Peter Nicholas, *Trump Says ‘Both Sides’ to Blame in Charlottesville Violence*, WALL ST. J. (Aug. 15, 2017, 9:28 PM), <https://www.wsj.com/articles/trump-says-both-sides-to-blame-in-charlottesville-violence-reversing-mondays-stance-1502830785>.

26. *Incidents and Offenses, 2016 Hate Crime Statistics*, FED. BUREAU OF INVESTIGATION: UNIFORM CRIME REPORTING PROGRAM, <https://ucr.fbi.gov/hate-crime/2016/topic-pages/incidentsandoffenses> (last visited Nov. 14, 2018).

27. *Ten Days After: Harassment and Intimidation in the Aftermath of the Election*, SOUTHERN POVERTY L. CTR. (Nov. 29, 2016), <https://www.splcenter.org/20161129/ten-days-after-harassment-and-intimidation-aftermath-election>.

28. See BUREAU OF JUSTICE STATISTICS, *supra* note 23, for a comparison on the increase in hate crimes following the 2016 election).



fundamental cause” of health inequality.<sup>29</sup> In lay terms, this means that the discrimination that produces health disparities did not end with slavery; instead, discrimination has reconstituted into structural institutions, from Jim Crow segregation to disproportionate mass incarceration, that continue to impact African American health today.

During the Colonial period of our nation’s history, African Americans were regarded as property not people.<sup>30</sup> They were generally afforded health care befitting that subhuman station and cared for only to the extent that it served white slaveholders’ economic self-interest.<sup>31</sup> The post-Civil War period featured the “black codes”—laws that purported to confer new rights but focused mostly on incentivizing blacks to remain a low-cost source of labor.<sup>32</sup> This task of maintaining a black underclass was made easier by the rampant public health crisis of disease and starvation that claimed an estimated one million African American lives between 1862 and 1870.<sup>33</sup> Documents recording the deaths due to smallpox, also called the “black epidemic” because it killed primarily blacks and Native Americans, are scant while records of deaths from the cholera outbreak in 1866, which claimed white lives primarily, are detailed and, in contrast, reflect a strong public health effort to combat that disease.<sup>34</sup>

From 1865 to 1871, the Freedmen’s Bureau provided food and medical care to an estimated half a million formerly enslaved

29. Jo C. Phelan & Bruce G. Link, *Is Racism a Fundamental Cause of Inequalities in Health?*, 41 ANN. REV. OF SOC. 311, 311–25 (2015) (linking racism as a fundamental cause of racial differences in socioeconomic status, which in turn creates inequities in health).

30. Paul Finkelman, *Slavery in the United States: Persons or Property?*, in THE LEGAL UNDERSTANDING OF SLAVERY: FROM THE HISTORICAL TO THE CONTEMPORARY 105, 105–34 (Jean Allain ed., 2012) (discussing the treatment of African Americans historically in the U.S.).

31. TODD L. SAVITT, MEDICINE AND SLAVERY: THE DISEASES AND HEALTH CARE OF BLACKS IN ANTEBELLUM VIRGINIA 7–12 (2002).

32. *Black Codes*, HIST., <https://www.history.com/topics/black-history/black-codes> (last updated Aug. 21, 2018).

33. See JIM DOWNS, SICK FROM FREEDOM: AFRICAN-AMERICAN ILLNESS AND SUFFERING DURING THE CIVIL WAR AND RECONSTRUCTION 95–116 (2012). The exact number of deaths is difficult to determine because record-keeping was racially skewed. *Id.*

34. *Id.* at 116–19.

blacks.<sup>35</sup> But food rations were discontinued within a year after they began amid worries that this form of relief would make African Americans lazy.<sup>36</sup> Moreover, since hospitals and doctors that served whites did not generally care for blacks, the Freedmen's Bureau performed everything from public health functions like managing the smallpox and cholera outbreaks and inspecting homes to promote sanitation in deplorably poor rural communities, to running the health-care "dispensaries" that provided the majority of basic medical services and pharmaceutical drugs that blacks received during Reconstruction.<sup>37</sup> After Reconstruction, "Pig Laws" began to appear on the books in southern states beginning in 1877 and reversed the gains black communities had seen.<sup>38</sup> These laws imposed harsh criminal penalties on blacks for behaviors that had previously been considered misdemeanors for whites.<sup>39</sup> For example, attempts by blacks to enforce sharecropping contracts or the simple act of being unemployed could lead to jailing.<sup>40</sup> Pig Laws gave way to Jim Crow laws in the late nineteenth century.

Overt bigotry, blessed by the American legal system, ensured separate and unequal access to health care, housing, education, recreation, and every other aspect of life for blacks during the three decades between *Plessy v. Ferguson*<sup>41</sup> and *Brown v. Board of Education*.<sup>42</sup> Then, despite the backlash of massive resistance,<sup>43</sup> access improved for some in black communities as legalized versions of racism gradu-

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35. PAUL A. CIMBALA, *THE FREEDMEN'S BUREAU: RECONSTRUCTING THE AMERICAN SOUTH AFTER THE CIVIL WAR* 3–11 (2005).

36. *Id.*

37. See Gaines M. Foster, *The Limitations of Federal Health Care for Freedmen, 1862–1868*, 48 J. SOUTHERN HIST. 349, 349–72 (1982), for an overview of health care available to formerly enslaved Americans.

38. Christopher R. Adamson, *Punishment After Slavery: Southern State Penal Systems, 1865–1890*, 30 SOC. PROBS. 555, 561–62 (1983).

39. *Id.*

40. *Id.* at 558–65.

41. *Plessy v. Ferguson*, 163 U.S. 537 (1896).

42. *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954).

43. See NUMAN V. BARTLEY, *THE RISE OF MASSIVE RESISTANCE: RACE AND POLITICS IN THE SOUTH DURING THE 1950'S* (1969) (discussing the rise of massive resistance to social changes such as desegregation in public schools).

ally and reluctantly disappeared. Indeed, triumphs of the civil rights era gave way to a new form of racism—implicit and unconscious racial biases against minority communities.<sup>44</sup> Progress towards equality came into tension with ostensibly race-neutral institutions that reasserted the geographic separation of most blacks, regardless of their income or education, from most whites in America. Throughout most of American history, even after slavery ended, racism has been a persistent scourge that continues to recommend the wisdom of Dr. King's commitment to attacking both racism and poverty independently, as well as simultaneously.

*B. Lesson #2: Public Health Provides a Comprehensive Framework for Addressing Persistent Consequences of Racism and Poverty*

The most effective way to attack racism and persistent and concentrated poverty is to address these problems through a public health lens. This framework counsels a comprehensive and integrated approach to social problems that requires simultaneous attacks on all the social determinants of poor health. Dr. King's remarks in *The Other America* evince his understanding of the inter-connectedness of all the social aspects of poverty that must be addressed together rather than piecemeal in order to be effective. He said:

In this [Other] America millions of work-starved men walk the streets daily in search for jobs that do not exist. In this America millions of people find themselves living in rat-infested, vermin-filled slums. In this America people are poor by the millions. They find themselves perishing on a lonely island of poverty in the midst of a vast ocean of material prosperity.<sup>45</sup>

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44. See generally Dayna Bowen Matthew, *Health Care, Title VI, and Racism's New Normal*, 6 GEO. J.L. & MOD. CRITICAL RACE PERSP. 3, 22, 25 (2014) (discussing implicit bias, the new normal of racism, in the American health-care system); Jerry Kang et al., *Implicit Bias in the Courtroom*, 59 UCLA L. REV. 1124, 1126 (2012) (discussing research on the new form of bias, implicit bias, and how it is reshaping the law).

45. King, *supra* note 14, at 3.

Even before it became popular to say, Dr. King realized that “Place Matters,” and he addressed the multiple reasons that one’s zip code is a more important determinant of health than one’s genetic code. Living in a zip code that lacks clean, decent, affordable housing (as 14 million Americans do today) means that people in those neighborhoods cannot find stability or safety.<sup>46</sup> They will spend less on food and health care; they will spend less on their children’s school and enrichment than parents who do not live in poverty. Moreover, at the neighborhood level, concentrated poverty exposes people to increased environmental pollution, violence, and excessive and disparate policing, while disproportionately limiting their access to healthy food, recreational spaces, educational opportunity, and positive social networks.<sup>47</sup>

The advantages of adopting Dr. King’s public health lens include making problems and their solutions: (1) measurable in health outcome terms; (2) comprehensive by including the full breadth of impacts that racism imposes; and (3) universal, bypassing the false racial divides that are being foisted on us by some of our nation’s leaders. This quantifiable, comprehensive, and unifying effect of the public health framework is illustrated by considering one of the most robust expressions of American racism: racial residential segregation.

#### 1. Public Health Analysis of Residential Segregation<sup>48</sup>

Racial residential segregation has been the bedrock of American apartheid since Reconstruction. Richard Rothstein’s important book, *The Color of Law*, tells the disturbing story of how state and federal zoning, lending, contract, and other laws created and pre-

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46. See generally James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758, 758–68 (2002) (discussing the impact that poor housing has on a wide range of health conditions).

47. *Id.*

48. See generally DAYNA BOWEN MATTHEW, RICHARD V. REEVES & EDWARD RODRIGUE, HEALTH, HOUSING, AND RACIAL JUSTICE: AN AGENDA FOR THE TRUMP ADMINISTRATION (2017), <https://www.brookings.edu/research/health-housing-and-racial-justice-an-agenda-for-the-trump-administration/> (discussing the causes and costs of residential segregation and health inequality and offering solutions to overcome these issues).

served the patterns of isolation and separation that continue to characterize many American cities and towns today.<sup>49</sup> Recent census data evinces a decline in residential segregation in America, prompting some to pronounce that 2010 marked “The End of the Segregated Century.”<sup>50</sup> Still, residential segregation—termed by one researcher as “hypersegregation”<sup>51</sup>—doggedly persists,<sup>52</sup> and robust literature links current residential segregation to racial health disparities and poor health outcomes today.<sup>53</sup>

*i. Measuring the Public Health Effects of Residential Segregation*

The magnitude of residential segregation’s injustice may be quantifiably measured by the disproportionate harms that it visits on racial and ethnic minority populations through a variety of pathways. Research confirms the association between racially segregated housing and poor population health.<sup>54</sup> In its recent study on health equity, the National Academy of Medicine outlined the adverse health effects of segregation and racial health disparities.<sup>55</sup> Minorities living in cities with higher rates of residential segregation experience higher in-

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

50. See EDWARD GLAESER & JACOB VIGDOR, *THE END OF THE SEGREGATED CENTURY: RACIAL SEPARATION IN AMERICA’S NEIGHBORHOODS, 1890–2010* (2012), [https://www.manhattan-institute.org/pdf/cr\\_66.pdf](https://www.manhattan-institute.org/pdf/cr_66.pdf) (analyzing census data from 1890 to 2010 and concluding that segregation is declining).

51. NAT’L ACADS. OF SCI., ENG’G & MED., *COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY* 99–164 (James N. Weinstein et al. eds., 2017) (citing Douglas S. Massey & Nancy A. Denton, *Hypersegregation in U.S. Metropolitan Areas: Black and Hispanic Segregation Along Five Dimensions*, 26 *DEMOGRAPHY* 373 (1989)).

52. Thomas A. LaVeist, *Segregation, Poverty, and Empowerment: Health Consequences for African Americans*, 71 *MILBANK Q.* 41, 44 (1993).

53. See *infra* notes 56–65 and accompanying text.

54. See generally Thomas A. LaVeist, *Racial Segregation and Longevity Among African Americans: An Individual-Level Analysis*, 38 *HEALTH SERVS. RES.* 1719, 1719–33 (2003) (finding that segregation and health outcomes are linked).

55. See NAT’L ACADS. OF SCI., ENG’G & MED., *supra* note 51, at 1–26.

fant mortality rates,<sup>56</sup> lower birth weights,<sup>57</sup> shorter life expectancy,<sup>58</sup> poorer mental health,<sup>59</sup> more coronary heart disease,<sup>60</sup> and greater prevalence of infectious disease such as tuberculosis,<sup>61</sup> even after controlling for poverty.<sup>62</sup>

While some health disparities that separate blacks and whites have narrowed, most have remained stagnant, and, tragically, gaps in some of the leading indicators of health are actually widening. The infant mortality rate for black babies remains more than twice the rate for whites.<sup>63</sup> Furthermore, the gap between the rate of black and white infant deaths widens as the mother's education and income increase.<sup>64</sup> Babies born to well-educated, middle-class black mothers are more likely to die before their first birthday than babies born to poor white mothers with less than a high school education.<sup>65</sup>

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56. LaVeist, *Segregation, Poverty, and Empowerment: Health Consequences for African Americans*, *supra* note 52, at 41–44.

57. See Sue C. Grady, *Racial Disparities in Low Birthweight and the Contribution of Residential Segregation: A Multilevel Analysis*, 63 SOC. SCI. & MED. 1303, 1303 (2006).

58. LaVeist, *Racial Segregation and Longevity Among African Americans: An Individual-Level Analysis*, *supra* note 54, at 1719.

59. See Carol S. Aneshensel & Clea A. Sucoff, *The Neighborhood Context of Adolescent Mental Health*, 37 J. HEALTH SOC. BEHAV. 293, 298–307 (1996).

60. See Ana V. Diez Roux et al., *Neighborhood of Residence and Incidence of Coronary Heart Disease*, 345 NEW ENG. J. MED. 99, 101–05 (2001).

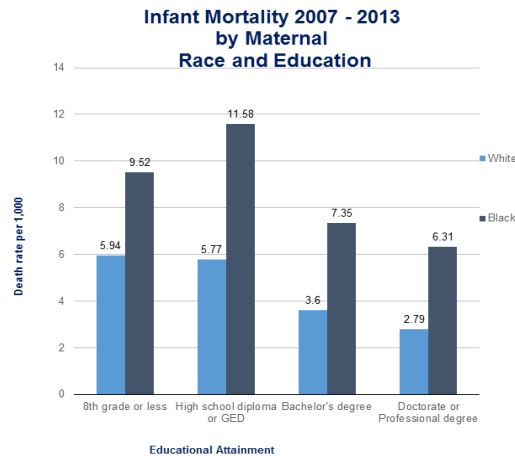
61. See Dolores Acevedo-Garcia, *Residential Segregation and the Epidemiology of Infectious Diseases*, 51 SOC. SCI. & MED. 1143, 1148–51 (2000).

62. See Michael R. Kramer & Carol R. Hogue, *Is Segregation Bad for Your Health?*, 31 EPIDEMIOLOGIC REV. 178, 178 (2009).

63. *Infant Mortality and African Americans*, U.S. DEP'T HEALTH & HUMAN SERVS. OFF. MINORITY HEALTH, <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23> (last visited Nov. 14, 2018).

64. Lindy Washburn, *Medical Mystery Endures: Black Babies at Twice Risk of Whites for Death, Study Indicates*, MED. PRESS (Mar. 2, 2011), <http://medicalxpress.com/news/2011-03-medical-mystery-black-babies-whites.html>.

65. Laudan Y. Aron, *Despite Fifty Years of Improvements in Infant Mortality, Large Black-White Gap Remains Unchanged*, URBAN INST. (Aug. 26, 2013), <http://www.urban.org/urban-wire/despite-fifty-years-improvements-infant-mortality-large-black-white-gap-remains-unchanged>.

Figure 3<sup>66</sup>

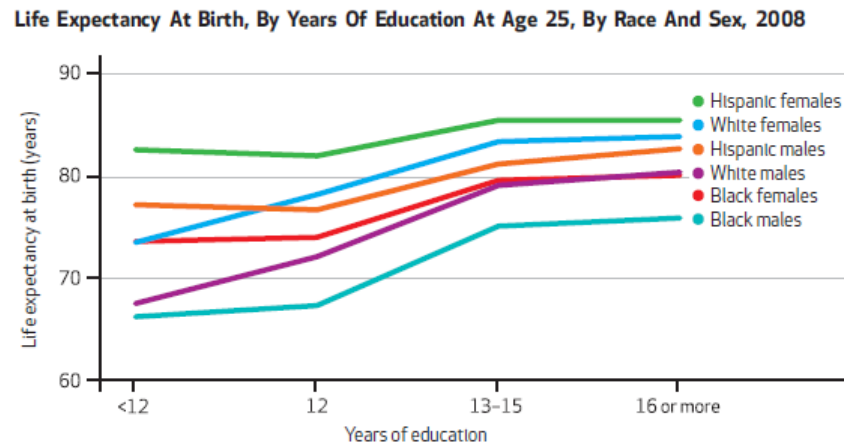
Black men continue to have the shortest life expectancy of any other group in America.<sup>67</sup> Moreover, combining education with race accentuates the mortality gap and underscores the cumulative impact that racial inequities impose on health outcomes.<sup>68</sup> White men and women with college degrees live an average of 14.2 years and 10.3 years longer, respectively, than black men and women with less than a high school education.<sup>69</sup>

66. MATTHEW, REEVES & RODRIGUE, *supra* note 48, at 26.

67. See *Life Expectancy at Birth (in Years), by Race/Ethnicity*, KAISER FAMILY FOUND., <http://kff.org/other/state-indicator/life-expectancy-by-re/?currentTimeframe=0> (last visited Nov. 14, 2018).

68. S. Jay Olshansky et al., *Differences in Life Expectancy Due to Race and Educational Differences Are Widening, and Many May Not Catch Up*, 31 HEALTH AFFAIRS 1803, 1806 (2012).

69. *Id.* at 1805.

Figure 4<sup>70</sup>

Black Americans experience earlier deaths along with more frequent and severe illness due to disparities in several leading causes of death that affect all Americans: cancer, heart disease, and kidney disease.<sup>71</sup> Blacks are also affected by early death rates due to causes that disproportionately impact them such as homicide and HIV.<sup>72</sup> More than thirty years after the Heckler Report first brought national attention to the significant health disparities between black and white Americans,<sup>73</sup> progress has stalled. One reason may be the persistence of residential racial segregation.

70. *Id.* at 1806.

71. See COMM. ON UNDERSTANDING & ELIMINATING RACIAL & ETHNIC DISPARITIES IN HEALTH CARE, INST. OF MED. OF THE NAT'L ACADS., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 80–124 (Brian D. Smedley et al. eds., 2003).

72. U.S. DEP'T OF HEALTH AND HUMAN SERVS., HEALTH, UNITED STATES, 2015, at 21, 99–113 (2016), <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

73. See *History of the Office of Minority Health*, U.S. DEP'T HEALTH & HUMAN SERVS. OFF. MINORITY HEALTH, <http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=1> (last updated Oct. 10, 2018, 9:55 AM), for information on the Heckler Report.



ii. *Considering Seven Risk Factors Comprehensively*

The quantifiable association between residential segregation and the health of minority communities can be traced to at least seven empirically demonstrated risk factors that frequently connect poor health outcomes to segregated neighborhoods. First, segregated neighborhoods have higher concentrations of substandard housing conditions that adversely affect health.<sup>74</sup> Substandard conditions such as pest infestation, lead contamination, faulty plumbing, and overcrowding lead to health problems including asthma, lead poisoning, heart disease, and neurological disorders.<sup>75</sup> Yet our nation has tolerated the fact that blacks are 1.7 times more likely to occupy homes with severe physical problems compared to the rest of the population.<sup>76</sup> Black children who are disproportionately exposed to above average lead exposure suffer developmental delays and depressive disorders, with long-term, irreversible impacts on physical and mental health.<sup>77</sup> The U.S. Department of Housing and Urban Development reports that despite declines in overt racial discrimination, blacks are sold about 11.4% fewer apartments and are shown 4.2% fewer housing units than white renters when they seek apartments to call home.<sup>78</sup> Similarly, blacks learn about 17% fewer homes and get to view 17.7% fewer homes than white prospective buyers.<sup>79</sup> As described earlier, collectively these discriminatory practices constitute racial

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74. Thomas D. Matte & David E. Jacobs, *Housing and Health—Current Issues and Implications for Research and Programs*, 77 J. U. HEALTH 7, 9 (2000).

75. *Id.* at 10–15.

76. David E. Jacobs, *Environmental Health Disparities in Housing*, 101 AM. J. PUB. HEALTH S115, S117 (2011).

77. David E. Jacobs et al., *The Prevalence of Lead-Based Paint Hazards in U.S. Housing*, 110 ENVTL. HEALTH PERSP. A599, A599–603 (2002).

78. U.S. DEP'T OF HOUSING & URBAN DEV., HOUSING DISCRIMINATION AGAINST RACIAL AND ETHNIC MINORITIES 2012, at xi (2013), [https://www.huduser.gov/portal/Publications/pdf/HUD-514\\_HDS2012.pdf](https://www.huduser.gov/portal/Publications/pdf/HUD-514_HDS2012.pdf); see also Stephen L. Ross & Margery Austin Turner, *Housing Discrimination in Metropolitan America: Explaining Changes Between 1989 and 2000*, 52 SOC. PROBS. 152, 165–74 (2005).

79. Ross & Turner, *supra* note 78, at 165–74.

steering that increases the odds of black Americans living in neighborhoods where housing conditions are poor.<sup>80</sup>

Second, in addition to substandard housing conditions, segregation disproportionately exposes black communities to environmental pollutants<sup>81</sup> that are more hazardous to the health of residents in black communities as compared to white communities.<sup>82</sup> Black Americans are significantly more likely to live within a mile of a polluting facility.<sup>83</sup> In addition, black children are more likely than white children to attend schools located near polluting facilities,<sup>84</sup> resulting in poorer student health and academic performance.<sup>85</sup> Dr. Robert Bullard showed that both intentional and unintentional discrimination has led to toxic dumping sites, chemical plants, municipal waste facilities, and other environmental health hazards being disproportionately located in black and low-income communities.<sup>86</sup> Yet the Environmental Protection Agency dismisses or rejects over 90% of Title VI complaints filed that allege a disproportionate pollution burden in minority communities, takes an average of 350 days to determine

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80. *See id.*

81. Liam Downey & Brian Hawkins, *Race, Income, and Environmental Inequality in the United States*, 51 SOC. PERSP. 759, 765–70 (2008); accord Gilbert C. Gee & Devon C. Payne-Sturges, *Environmental Health Disparities: A Framework Integrating Psychosocial and Environmental Concepts*, 112 ENVTL. HEALTH PERSP. 1645, 1647 (2004).

82. Gee & Payne-Sturges, *supra* note 81, at 1647 (citation omitted).

83. Paul Mohai et al., *Racial and Socioeconomic Disparities in Residential Proximity to Polluting Industrial Facilities: Evidence from the Americans' Changing Lives Study*, 99 AM. J. PUB. HEALTH S649, S651–52 (2009).

84. Robert Bullard, *New Report Tracks Environmental Justice Movement Over Five Decades*, DR. ROBERT BULLARD (Feb. 9, 2014), <http://drrobertbullard.com/new-report-tracks-environmental-justice-movement-over-five-decades/>.

85. *See* Paul Mohai et al., *Air Pollution Around Schools Is Linked to Poorer Student Health and Academic Performance*, 30 HEALTH AFF. 852, 852 (2011) (discussing pollution's impact on the health of children and studying the demographic impact of polluting facilities near Michigan schools).

86. ROBERT D. BULLARD, *DUMPING IN DIXIE: RACE, CLASS, AND ENVIRONMENTAL QUALITY* 39–46 (3d ed., 2000).

whether it will investigate civil rights complaints,<sup>87</sup> and, according to the recently released report from the U.S. Commission on Civil Rights, has almost never made a finding of discrimination, denied, or withdrawn financial assistance from a recipient.<sup>88</sup>

A third health-harming factor associated with racially segregated neighborhoods is more limited access to healthy food in black neighborhoods than in white neighborhoods. Several studies show that predominantly African American neighborhoods have a disproportionately higher rate of fast food restaurants and convenience stores but relatively lower access to supermarkets that stock fresh produce and health food options.<sup>89</sup> As a result, African Americans suffer greater food insecurity than other population groups.<sup>90</sup> They have the lowest access to chain grocery stores in the U.S., even after controlling for socioeconomic status.<sup>91</sup> In contrast, black neighborhoods have a disproportionately high number of liquor stores and un-

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87. The Editorial Board, *The E.P.A.'s Civil Rights Problem*, N.Y. TIMES (July 7, 2016), [http://www.nytimes.com/2016/07/07/opinion/the-epas-civil-rights-problem.html?\\_r=0](http://www.nytimes.com/2016/07/07/opinion/the-epas-civil-rights-problem.html?_r=0).

88. U.S. COMM'N ON CIVIL RIGHTS, ENVIRONMENTAL JUSTICE: EXAMINING THE ENVIRONMENTAL PROTECTION AGENCY'S COMPLIANCE AND ENFORCEMENT OF TITLE VI AND EXECUTIVE ORDER 12,898 (2016), [https://www.usccr.gov/pubs/2016/Statutory\\_Enforcement\\_Report2016.pdf](https://www.usccr.gov/pubs/2016/Statutory_Enforcement_Report2016.pdf). *But see* Talia Buford, *Rare Discrimination Finding by EPA Civil-Rights Office*, CTR. FOR PUB. INTEGRITY (Jan. 25, 2017, 12:50 PM), <https://www.publicintegrity.org/2017/01/25/20616/rare-discrimination-finding-epa-civil-rights-office>.

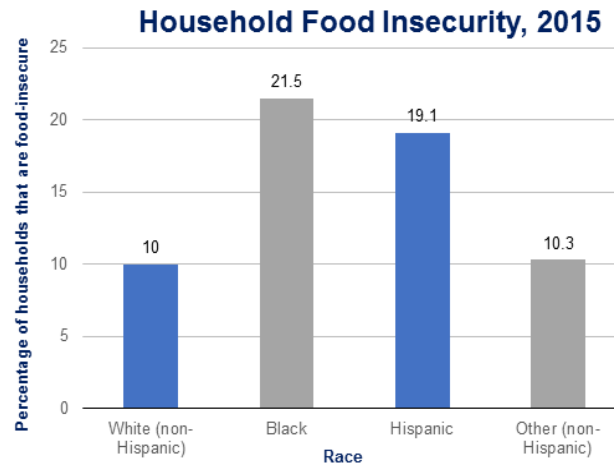
89. *See, e.g.,* Angela Hilmers et al., *Neighborhood Disparities in Access to Healthy Foods and Their Effects on Environmental Justice*, 102 AM. J. PUB. HEALTH 1644, 1649–51 (2012).

90. FEEDING AMERICA, MAP THE MEAL GAP 2017 HIGHLIGHTS OF FINDINGS FOR OVERALL AND CHILD FOOD INSECURITY 18 (2017), <http://www.feedingamerica.org/research/map-the-meal-gap/2015/2015-mapthemealgap-exec-summary.pdf>; *see also* ALISHA COLEMAN-JENSON ET AL., U.S. DEP'T OF AGRIC., STATISTICAL SUPPLEMENT TO HOUSEHOLD FOOD SECURITY IN THE UNITED STATES IN 2016 (2017).

91. *See* Renee E. Walker et al., *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature*, 16 HEALTH & PLACE 876, 878–81.

healthy food sources, exposing those populations to greater social, psychological, and physiological health risks of food insecurity.<sup>92</sup>

Figure 5<sup>93</sup>



A fourth risk is that employment opportunities and workplace conditions are more limited for minority residents of racially segregated neighborhoods than for whites. African Americans are disproportionately represented in low-skill, low-control, and high-stress jobs that have been shown to produce health disparities.<sup>94</sup> Between 2005 and 2015, the U.S. Equal Employment Opportunity Commission reported that new allegations of racial discrimination by employers increased by 16%.<sup>95</sup> This regulatory activity reflects empirical evidence

92. See Thomas A. LaVeist & John M. Wallace, Jr., *Health Risk and Inequitable Distribution of Liquor Stores in African American Neighborhood*, 51 SOC. SCI. & MED. 613, 615–16 (2000).

93. MATTHEW, REEVES & RODRIGUE, *supra* note 48, at 26.

94. See generally David R. Williams, *Race, Socioeconomic Status, and Health: The Added Effects of Racism and Discrimination*, 896 ANNALS N.Y. ACAD. SCI. 173, 173–85 (1999) (analyzing how socioeconomic status and race affect health).

95. *Race-Based Charges (Charges Filed with EEOC) FY 1997–FY 2017*, U.S. EQUAL EMP. OPPORTUNITY COMM’N, <https://www.eeoc.gov/eeoc/statistics/enforcement/race.cfm> (last visited Oct. 31, 2018).

that African Americans are nearly nine times more likely to experience racial discrimination at work than their white co-workers.<sup>96</sup>

A fifth risk factor associated with residentially segregated neighborhoods is the adverse impact on health behaviors that concentrations of African American families in low-income and low-resource neighborhoods endure. Health behaviors occur within a social context. For example, the prevalence of smoking is related to the prominence of tobacco advertising aimed at black youth.<sup>97</sup> Sedentary behaviors are connected to neighborhood violence and inferior-built environments that limit recreation and exercise options. Food consumption is associated with the density of fast food and liquor outlets in black neighborhoods, as compared with the paucity of healthy food options available in predominately white neighborhoods. The health outcomes are as dismal as they are predictable: 38% of African American men and 57.2% of women are obese or overweight as compared with 36.4% of whites.<sup>98</sup>

Together, social and environmental factors, as well as health behaviors that are influenced by them, exert more influence on final health outcomes than medical care alone. Yet the U.S. spends over 80% of its \$3 trillion health budget on medical services and virtually none of its health-care dollars on improving social and environmental influences.<sup>99</sup> But, when compared to other developed nations (as illustrated in Figure 6 below), our health-care spending far outspends the amount we spend on social services. One way in which the U.S. could improve its social and environmental influences is through a new administration. On day one, the new administration must set a

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96. Candice A. Shannon et al., *Race, Racial Discrimination, and the Risk of Work-Related Illness, Injury, or Assault: Findings from a National Study*, 51 J. OCCUPATIONAL & ENVTL. MED 441, 444–46 (2009).

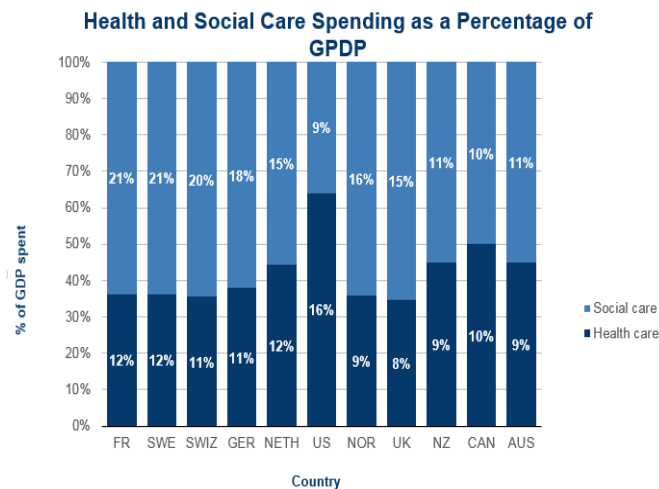
97. See OFFICE ON SMOKING & HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS 8 (2012), [https://www.ncbi.nlm.nih.gov/books/NBK99237/pdf/Bookshelf\\_NBK99237.pdf](https://www.ncbi.nlm.nih.gov/books/NBK99237/pdf/Bookshelf_NBK99237.pdf).

98. *Inequity and Obesity*, THE STATE OF OBESITY, <https://stateofobesity.org/inequity-obesity/> (last visited Nov. 14, 2018).

99. See Jason Millman, *Here's Exactly How the United States Spends \$2.9 Trillion on Health Care*, WASH. POST (Dec. 3, 2014), <https://www.washingtonpost.com/news/wonk/wp/2014/12/03/heres-exactly-how-the-united-states-spends-2-9-trillion-on-health-care/>.

public health agenda that focuses federal, state, and local attention on increasing the nation's investment in the social determinants of health and eliminating the unjustified inequities that characterize them.

Figure 6<sup>100</sup>



Sixth, black residents of segregated neighborhoods experience disproportionate law enforcement patterns.<sup>101</sup> Morbidity and mortality in predominately black communities is adversely affected when criminal law is inequitably enforced in African American neighborhoods as compared to white neighborhoods. For example, in 1968 the federal government commenced a “war on drugs,” though not expressed as a war against the black community, it ultimately led to a 500% increase in incarceration rates, creating a public health crisis in

100. Stuart M. Butler, Dayna Bowen Matthew & Marcela Cabello, *Re-balancing Medical and Social Spending to Promote Health: Increasing State Flexibility to Improve Health Through Housing*, BROOKINGS INST. (Feb. 15, 2017), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2017/02/15/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/> (referencing data in fig. 1).

101. Monica Bell, *The Dynamics of Policing and Segregation by Race and Class*, NYU FURMAN CENTER: THE DREAM REVISITED (July 2017), <http://furmancenter.org/research/iri/essay/the-dynamics-of-policing-and-segregation-by-race-and-class>.

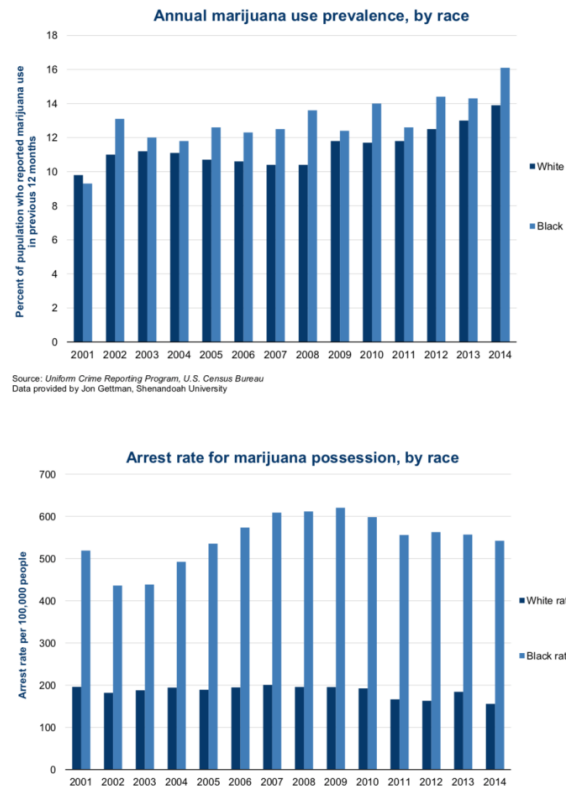
predominately black urban communities.<sup>102</sup> Black men and women are more likely to be arrested, charged, and convicted than whites who commit the same crimes.<sup>103</sup> Once convicted, the U.S. Sentencing Commission found that black men are given prison sentences nearly 20% longer than white men for similar crimes.<sup>104</sup> The public health impact of disparate criminal law enforcement on black communities is staggering.

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102. See generally Lisa D. Moore & Amy Elkavich, *Who's Using and Who's Doing Time: Incarceration, the War on Drugs, and Public Health*, 98 AM. J. PUB. HEALTH 782, 782–86 (2008) (“Since 1972, the number of people incarcerated has increased 5-fold . . .”).

103. See Dylan Matthews, *The Black/White Marijuana Arrest Gap, in Nine Charts*, WASH. POST: WONKBLOG (June 4, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/06/04/the-blackwhite-marijuana-arrest-gap-in-nine-charts/>; see also David S. Abrams et al., *Do Judges Vary in Their Treatment of Race?*, 41 J. LEGAL STUD. 347, 347 (2012).

104. Joe Palazzolo, *Racial Gap in Men's Sentencing*, WALL ST. J. (Feb. 14, 2013, 5:39 PM), <http://www.wsj.com/articles/SB10001424127887324432004578304463789858002>.

Figure 7<sup>105</sup>

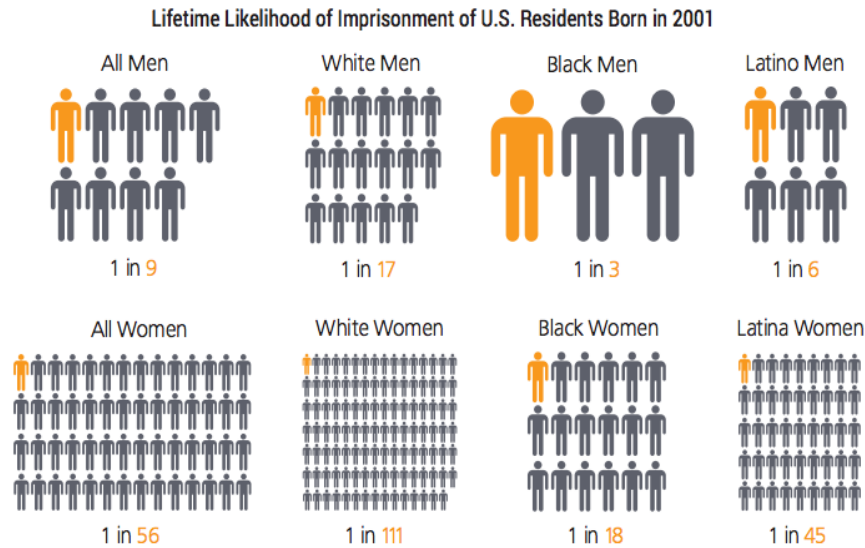
Incarceration adversely affects the mental and physical health of communities left behind. Family members experience increased incidents of mental illness such as depression and anxiety disorders, as well as an increased risk of poverty and homelessness.<sup>106</sup> Growing evidence documents that these health consequences are multi-generational; incarceration, for example, is associated with nearly a 30% increase in infant mortality.<sup>107</sup>

105. MATTHEW, REEVES & RODRIGUE, *supra* note 48, at 36.

106. The Editorial Board, *Mass Imprisonment and Public Health*, N.Y. TIMES (Nov. 26, 2014), <http://www.nytimes.com/2014/11/27/opinion/mass-imprisonment-and-public-health.html>.

107. See Christopher Wildeman, *Imprisonment and (Inequality in) Population Health*, 41 SOC. SCI. RES. 74, 83–4 (2012).



Figure 8<sup>108</sup>

Incarcerated populations are also at greater risk for transmission of infectious disease such as tuberculosis, viral hepatitis, and sexually transmitted diseases.<sup>109</sup> Moreover, the prevalence of mental illness and injection drug use among incarcerated populations is significantly higher than in the communities at large.<sup>110</sup> Importantly, when prisoners are released back into poor and segregated communities, they bring their higher incidence of disease back with them to the detriment of the entire community's health.<sup>111</sup> Because the majority of people in prison today are black, the public health harms associated with imprisonment are disproportionately visited on black communities and represent a formidable cause of health disparities.

108. THE SENTENCING PROJECT, FACT SHEET: TRENDS IN U.S. CORRECTIONS 5 (2018), <https://sentencingproject.org/wp-content/uploads/2016/01/Trends-in-US-Corrections.pdf> (citing THOMAS P. BONCZAR, BUREAU OF JUSTICE STATISTICS, PREVALENCE OF IMPRISONMENT IN THE U.S. POPULATION, 1974–2001 (2003)).

109. See Sandro Galea, *Incarceration and the Health of Populations*, B.U. SCH. PUB. HEALTH (Mar. 22, 2015), <https://www.bu.edu/sph/2015/03/22/incarceration-and-the-health-of-populations/>.

110. See *id.*

111. See *id.*

Finally, the evidence shows that racially segregated neighborhoods with predominately black patient populations host health-care facilities with the fewest technological resources and the least experienced clinicians,<sup>112</sup> while the best equipped health-care institutions and most highly trained professionals serve predominately white communities.<sup>113</sup> This means that African American patients disproportionately receive trauma<sup>114</sup> and surgical care<sup>115</sup> in lower quality hospitals than white patients. Once admitted, black patients receive less intensive hospital care.<sup>116</sup> This is true for multiple diseases and conditions including the two leading causes of death for black Americans—heart disease and cancer.<sup>117</sup>

Blacks receive poorer quality cardiac care in hospitals than whites;<sup>118</sup> they are transferred for revascularization more slowly than white patients.<sup>119</sup> Cancer diagnosis and treatment differ by race for men and women. Studies show that only 59.4% of black men with prostate cancer receive surgery as compared to 69.5% of white

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112. See Justin Dimick et al., *Black Patients Are More Likely to Undergo Surgery at Low-Quality Hospitals in Segregated Regions*, 32 HEALTH AFF. 1046, 1048–51 (2013).

113. Ioana Popescu et al., *Differences in Admitting Hospital Characteristics for Black and White Medicare Beneficiaries with Acute Myocardial Infarction*, 123 CIRCULATION 2710, 2712–14 (2011) (discussing differences in hospital quality, which may be due in part to zip code differences and may contribute to disparities).

114. Laurent G. Glance et al., *Trends in Racial Disparities for Injured Patients Admitted to Trauma Centers*, 48 HEALTH SERVS. RES. 1684, 1691–92 (2013) (concluding that racial disparities in trauma are due to the fact that black patients are more likely to be treated in lower quality hospitals compared with whites).

115. Adil H. Haider et al., *Racial Disparities in Surgical Care and Outcomes in the United States: A Comprehensive Review of Patient, Provider, and Systemic Factors*, 216 J. AM. C. SURGEONS 482, 482 (2013).

116. Kevin Fiscella et al., *Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 J. AM. MED. ASS'N 2579, 2579–80 (2000).

117. *Id.* at 2580–81.

118. Jonathan Skinner et al., *Mortality After Acute Myocardial Infarction in Hospitals that Disproportionately Treat Black Patients*, 112 CIRCULATION 2634, 2638–39 (2005).

119. Colin R. Cooke et al., *Race and Timeliness of Transfer for Revascularization in Patients with Acute Myocardial Infarction*, 49 MED. CARE 662, 664 (2011).

men.<sup>120</sup> Black men wait seven days longer to receive treatment and are less likely to undergo diagnostic node dissection than whites.<sup>121</sup> Partly due to these differences, black men have higher odds of making costly visits to the emergency room within thirty days of prostate surgery and must spend more on their inferior care than white men spend to receive superior care.<sup>122</sup> Similarly, black women receive lower quality treatment than white women for breast cancer.<sup>123</sup> A recent study reports not only that black women are now more likely to die from breast cancer than white women, but also that the disparity is worsening.<sup>124</sup> These deadly disparities, imposed by segregation, are associated with the geographic exclusion from higher quality health-care providers.

While residential segregation cannot be empirically linked to the specific costs of its consequential inequities, the share of costs attributable to this institutionalized racism, both in human and economic terms, is substantial. Former Surgeon General David Satcher examined trends in black-white standardized mortality ratios in order to estimate the cost in terms of lives lost due to racial discrimination in health care. Dr. Satcher's group estimated that over 83,000 African American men and women needlessly lose their lives each year due to the unfair, unjust, and avoidable differences in the quality and quantity of health care provided to minority patients as compared to whites.<sup>125</sup> African Americans not only die earlier than their white counterparts, but also blacks generally suffer from more illnesses than

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120. Marianne Schmid et al., *Racial Differences in the Surgical Care of Medicare Beneficiaries with Localized Prostate Cancer*, 2 JAMA ONCOLOGY 85, 85 (2016).

121. *Id.*

122. *Id.*

123. Claudia R. Baquet et al., *Breast Cancer Epidemiology in Blacks and Whites: Disparities in Incidence, Mortality, Survival Rates and Histology*, 100 J. NAT'L MED. ASS'N 480, 486 (2008).

124. *New Avon Foundation-Funded Breast Cancer Study Finds Black Women Are Dying at Higher Rates than White Women, and the Disparity Is Growing*, AVON FOUND. FOR WOMEN (Oct. 3, 2016), <https://www.avonfoundation.org/new-avon-foundation-funded-breast-cancer-study-finds-black-women-are-dying-at-higher-rates-than-white-women-and-the-disparity-is-growing/>.

125. David Satcher et al., *What if We Were Equal? A Comparison of the Black-White Mortality Gap in 1960 and 2000*, 24 HEALTH AFF. 459, 459 (2005).

white Americans and therefore represent additional and preventable health-care costs that could be eliminated by improving health equity. A CDC study estimated that if black Americans had the same adjusted rate of preventable hospitalizations as non-Hispanic whites from 2004 to 2007, the African American population would have endured 430,000 fewer hospitalizations and enjoyed \$3.4 billion in health-care savings.<sup>126</sup>

The Joint Center for Political and Economic Studies estimated that racial and ethnic disparities have cost Americans \$1.24 trillion between 2003 and 2006.<sup>127</sup> Of these costs, \$229.4 billion are attributable to excessive medical care expenditures and \$1.0 trillion represent the indirect costs of disparities such as lost productivity and unemployment costs.<sup>128</sup> The Urban Institute analyzed the costs of racial and ethnic disparities attributable to diabetes, hypertension, and stroke—three diseases the researchers termed “preventable.”<sup>129</sup> They found that the excess rate of these diseases among black and Latino patients, relative to white patients, would cost \$23.9 billion in 2009.<sup>130</sup> The Medicare program, they estimated, will spend \$15.6 billion of this amount, while private insurers will pay an extra \$5.1 billion.<sup>131</sup> In addition to extra expenditures today, the Urban Institute projected future losses to the American health-care system: “Over the 10-year period from 2009 through 2018, . . . the total cost of these [health] disparities is approximately \$337 billion, including \$220 billion for Medicare.”<sup>132</sup>

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126. Carrie Hanlon & Larry Hinkle, *Assessing the Costs of Racial and Ethnic Health Disparities: State Experience*, HEALTHCARE COST & UTILIZATION PROJECT (Jun. 24, 2011), <https://www.hcup-us.ahrq.gov/reports/race/CostsofDisparitiesIB.jsp>.

127. THOMAS A. LA VEIST ET AL., JOINT CTR. FOR POLITICAL & ECON. STUDIES, THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES 1 (2009), [https://www.hhnmag.com/ext/resources/inc-hhn/pdfs/resources/Burden\\_Of\\_Health\\_FINAL\\_0.pdf](https://www.hhnmag.com/ext/resources/inc-hhn/pdfs/resources/Burden_Of_Health_FINAL_0.pdf).

128. *Id.* at 4–5.

129. TIMOTHY A. WAIDMANN, THE URBAN INSTITUTE, ESTIMATING THE COST OF RACIAL AND ETHNIC HEALTH DISPARITIES 1–3 (2009), <https://www.urban.org/sites/default/files/publication/30666/411962-Estimating-the-Cost-of-Racial-and-Ethnic-Health-Disparities.PDF>.

130. *Id.* at 1.

131. *Id.*

132. *Id.*

Turning a public-health lens on these seven risk factors associated with residential segregation not only allows policy makers to quantify the risks linked to this form of racism, but also this population health perspective allows for a fuller accounting of racism's costs to the people as it targets the greater society. This is an especially important policy tool as the social science evidence of racism's impact on health emerges. Again, the case of residential segregation is illustrative.

Racism has been shown to be harmful to health. It is an important influence that shapes socioeconomic opportunity and status in America. From education, to housing, to employment, and historic access to opportunities that generate wealth, racial discrimination limits access for racial and ethnic minority populations to distribute themselves throughout the American socioeconomic strata. But, the public health perspective has allowed researchers to begin to identify the health impacts of racism and, therefore, allows a more comprehensive accounting of the harms it causes.

The experience of discrimination has been associated with adverse physiological responses in minority populations. For example, in a study of more than 4,000 older adults in Chicago, researchers found that their experiences with discrimination were associated with increased mortality risk.<sup>133</sup> In another study of more than 3,500 African American, Mexican American, Puerto Rican, and other Latino youths, researchers found that perceived discrimination is associated with increased odds of asthma and poorer asthma control among black youths.<sup>134</sup> Racial discrimination is a stressor that can broadly impact mental health, producing psychological distress,<sup>135</sup> blood pressure control, exaggerated cardiovascular responses, and chronic changes in allostatic systems.<sup>136</sup>

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133. Lisa L. Barnes et al., *Perceived Discrimination and Mortality in a Population-Based Study of Older Adults*, 98 AM. J. PUB. HEALTH 1241, 1241 (2008).

134. Neeta Thakur et al., *Perceived Discrimination Associated with Asthma and Related Outcomes in Minority Youth*, 151 CHEST J. 804, 804–06 (2017).

135. See Tiffany Yip et al., *Racial Discrimination and Psychological Distress: The Impact of Ethnic Identity and Age Among Immigrant and United States-Born Asian Adults*, 44 DEVELOPMENTAL PSYCHOL. 787, 787–800 (2008).

136. Elizabeth A. Pascoe & Laura Smart Richman, *Perceived Discrimination and Health: A Meta-Analytic Review*, 135 PSYCHOL. BULL. 531, 531–52 (2009).

Racism has also been shown to be associated with harmful health behaviors<sup>137</sup>: not only as coping methods and as a function of inequalities in knowledge and communication but also as a way to express disapproval of and independence from societal norms perceived as unjust.<sup>138</sup> Finally, just as we have seen that residential segregation can concentrate the impact of discriminatory risk factors from multiple sources such as unemployment and toxic environmental hazards within one neighborhood, residential segregation can also concentrate the impact of racial violence and its sequelae.

Neighborhood segregation can concentrate the impacts of racial violence on the health of minority communities. For example, confrontations between minority residents and the police departments tasked with protecting them are unsurprisingly frequent in segregated neighborhoods. On one hand, advocates cite data that show disproportionate uses of force by police who are 18% more likely to push blacks into a wall than similarly situated whites; 19% more likely to draw weapons against blacks than against whites; and 25% more likely to use pepper spray against blacks than whites in similar situations, while advocates on the other hand cite the same study to argue that police do not shoot black residents more frequently than whites.<sup>139</sup> Indeed, segregated neighborhoods experience high rates of violent crime and homicide apart from police violence. However, the prevalence of hatred and violence directed at minority populations has a distinctive impact on the communities where they live. Dr. Ami Lynch relies on group conflict theory to study this impact in her research related to the role of hate crime in perpetuating black residential segregation.<sup>140</sup> Finding a significant relationship between hate

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137. *Id.* at 531.

138. See Roni Factor et al., *Social Resistance Framework for Understanding High-Risk Behavior Among Nondominant Minorities: Preliminary Evidence*, 103 AM. J. PUB. HEALTH 2245, 2245–50 (2013).

139. Quoc Trung Bui & Amanda Cox, *Surprising New Evidence Shows Bias in Police Use of Force but Not in Shootings*, N.Y. TIMES: THE UPSHOT (July 11, 2016), <https://www.nytimes.com/2016/07/12/upshot/surprising-new-evidence-shows-bias-in-police-use-of-force-but-not-in-shootings.html>.

140. Ami M. Lynch, *Hating the Neighbors: The Role of Hate Crime in the Perpetuation of Black Residential Segregation*, 2 INT'L J. CONFLICT & VIOLENCE 6, 6–8 (2008).

crimes and segregation, Lynch confirms a neighborhood-level effect of race-based violence.<sup>141</sup> It is time, therefore, to consider the neighborhood and population health impacts that increasingly frequent instances of violent and angry racism, such as the deadly demonstrations in Charlottesville, Virginia, have on segregated neighborhoods.

iii. *Lesson #3: Implement Solutions that Defy the False Racist Divides that Politicians and Others Are Peddling*

The final lesson to be taken from Dr. King's Stanford speech may be the most important. Racism and poverty are not "the other guy's problem"; these problems harm victims, perpetrators, and bystanders alike and, therefore, present a challenge that will require all Americans to address. Dr. King said: "Many people of various backgrounds live in this Other America."<sup>142</sup> "Some," he said, "are Mexican Americans, some are Puerto Ricans, some are Indians, some happen to be from other groups. Millions of them are Appalachian whites."<sup>143</sup> He admitted that "probably the largest group in this Other America in proportion to its size in population is the American Negro."<sup>144</sup> But Dr. King was clear-eyed about the goal:

We are seeking to make America *one nation*, indivisible, with liberty and justice for all. . . . [T]he struggle for civil rights and the struggle to make these two Americas one America, is much more difficult today than it was five or ten years ago. For about a decade or maybe twelve years, we've struggled all across the South to get rid of legal, overt segregation and all of the humiliation that surrounded that system of segregation.

In a sense this was a struggle for decency; we could not go to a lunch counter in so many instances and get a hamburger or a cup of coffee. We could not make use

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141. *Id.* at 23–24.

142. King, *supra* note 14, at 3.

143. *Id.*

144. *Id.*

of public accommodations. Public transportation was segregated . . . .

And certainly they were difficult problems, they were humiliating conditions. . . . When they were sitting at those lunch counters they were in reality standing up for the best in the American dream *and seeking to take the whole nation back to those great wells of democracy which were dug deep by the Founding Fathers in the formulation of the Constitution and the Declaration of independence*.<sup>145</sup>

We must remember that racial hatred and divisiveness harms people of all races. We must resist. An example is President Trump's recently announced proposal for dealing with the opioid drug crisis. In it, he called for drug dealers to get the death penalty and for mandatory sentences to increase for possession and distribution of illicit drugs.<sup>146</sup> This is the politics of division at its worst. Poverty and hopelessness are at the core of the opioid epidemic that we are experiencing today. It affects black victims and white victims alike. Moreover, poverty is at its core today as it was in the 1970s and 1980s when it was principally black and brown people dying; there we adopted a criminal justice framework to resolve the drug epidemic and the result was massive incarceration of black and brown people. Today, the President threatens to return to those failed policies again, *but* by focusing on street and not pharmaceutical drug dealers, he targets primarily black and brown *victims of the drug crisis* while excluding equally harmful predominately white corporate drug dealers. In policy proposals to address the nation's opioid crisis, President Trump calls for the death penalty and mandatory minimum sentences for individual drug dealers while turning a blind eye to drug dealing pharmaceutical companies that have substantially contributed to the epidemic.

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145. *Id.* at 3–4 (emphasis added).

146. *See President Donald J. Trump's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand*, WHITE HOUSE (Mar. 19, 2018), <https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand/>.



The President's policy focusing on the death penalty for drug traffickers and increased minimum sentences for possession of illicit drugs, which fails to address the equally deadly trafficking in legal prescription drugs used by white addicts, is pure racism because it employs the privilege and power of the government to systematize and institutionalize disparate treatment of people by race. This is an attempt to divide people who could otherwise fight the poverty roots of the opioid crisis together. I hope to encourage us to look at solutions to poverty that are going to unite people and defeat those who are thriving on the perpetuation of poverty by using racist rhetoric to keep us divided and ineffective.

The hundreds of thousands of activists who were part of the "March for Our Lives" led the way.<sup>147</sup> They addressed a different public health crisis—gun violence—and took a public health approach that resisted the divisive tactics of our current administration. Young people from affluent Parkland, Florida, stood on stage and united against gun violence to advocate for gun safety laws for those who have suffered from gun violence but who have hitherto been ignored in places such as Chicago, New York, and Los Angeles—where gun violence is rampant among black and brown communities. Just as they stood together and would not be divided, so must we in the fight against persistent poverty in Memphis and beyond.

### III. CONCLUSION

The lessons that Dr. Martin Luther King, Jr. taught ring as true today as they did when he was alive. Sadly, the inequality that characterized American society then continues to plague our communities today. The racial schisms that threatened our national productivity, strength, and unity during his day remain stubbornly divisive today.

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147. Crowd estimates range from 200,000 to 800,000. See *About 800,000 Converged on Washington, D.C., for March for Our Lives Rally, Organizers Say*, SUNSENTINEL (Mar. 24, 2018), <http://www.sun-sentinel.com/local/broward/parkland/florida-school-shooting/fl-march-for-our-lives-coverage-20180324-story.html>; *How Many People Attended March for Our Lives? Crowd in D.C. Estimated at 200,000*, CBS NEWS (Mar. 25, 2018), <https://www.cbsnews.com/news/march-for-our-lives-crowd-size-estimated-200000-people-attended-d-c-march/>.

And yet the moral conviction that compelled Dr. King to call for all of America to be held accountable for the plight of poverty and despair in *The Other America* still calls us to action today. Furthermore, today we have the opportunity to examine inequity from a fresh perspective and apply new tools—public health tools—to address disparities. The key will be to preventively address the root social causes of inequity that manifest in disproportionately poor health. These social determinants include the lack of affordable housing and inequitable access to quality education, health care, and employment. No one understood this better than Dr. King. He came to Memphis in 1968 to unite with workers—whether black, white, or brown—in their demand for fair pay and working conditions. His life was cut short here, but his mission must not be. Dr. King acknowledged, when he spoke of “The Other America,” that the struggle for “genuine equality” will be more difficult today than the struggle to integrate lunch counters and buses. And yet, he also declared, “[s]omehow I maintain hope in spite of hope. . . . I still have faith in the future. And I still believe that these problems can be solved.”<sup>148</sup> On this fiftieth Anniversary of Dr. King’s assassination, we honor his legacy best by making his faith, hope, and belief a reality.

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148. King, *supra* note 14, at 11.