

UVA LAW | The Civil Rights of Health, With Angela P. Harris

DAYNA BOWEN MATTHEW: I have to introduce Angela Harris, and it is an honor and a pleasure to do so. I want to say that the accolades that are in the program, the information about her scholarship and her work that are easily accessible are not where I would like to focus my few words of introduction. I want to tell you that the first time that I heard of Angela's work reinvigorating civil rights or medical civil rights was at a workshop at the ChangeLab Solutions-- at ChangeLab Solutions office in Oakland, California.

Angela was holding forth. She was creating a new paradigm. She was thinking aloud and working with people who were funders, who were think tank workers, who were community organizers, who were lawyers, who were clinicians, and she was creating from scratch a new way to think and a new way to attack inequality and inequality that produces health inequities.

I left that meeting thinking, I have to know more about what she does with this germ of an idea that I saw start on that day. Well, what she's done is create something that will be, in frankness, going across the country like wildfire. We are quite lucky to have Angela here to present the idea of medical civil rights. I think we're the first academic institution that gets the pleasure of hearing this new paradigm in combination with the ChangeLab Solutions folks, who will also show us the blueprint for bringing it to life.

After this, I know she'll be in Washington DC at the American University. She'll be at several universities, and our hope is that what you hear today is the start of something big and something new. I thank you very much for helping me to welcome a creative thought leader and change agent, Professor Angela Harris.

[APPLAUSE]

ANGELA P. HARRIS: Thank you so much. Thanks to all of you for being here. And I do need a little bit of tech help, because I don't know how to make my slides appear. Does anyone know how to-- oh, there they are. Perfect. It was like magic.

All right, so first, please join me in acknowledging and paying respect to the traditional custodians of the land we're on today, the Monocan people. So just take a moment and remember that there were stewards who are still here who have endured for centuries. Thank you.

So I also have a few personal thanks before we get going. Thank you to Dayna for that amazing introduction, for really taking us into the feeling of where we want to go, what we want to do with this time together. I appreciate that. Thank you to all the organizers, to Dean Goluboff for inviting me to be part of this amazing event, and all of you for putting your time

and energy into being here.

A few personal shout-outs, I want to thank the amazing people at ChangeLab who are over there. Marice Ashe, who is the founding ED of that organization, was a former student of mine from Berkeley Law. And a couple of months after I retired, I ran into her at the Berkeley Y, and she said, oh, you're retired. I have a project for you. And that was the beginning of my journey into this work, which I'm still a novice at and I'm still learning, and I'm so looking forward to learning more from all of you, the experts.

I want to thank my amazing co-author on this article, Aysha, who is both a lawyer and a public health expert. I'm really sorry that she couldn't be here today, because this work is 100% hers as well as 100% mine. And finally, I want to thank and acknowledge a couple of the supporting institutions that have made this project possible. The Robert Wood Johnson Foundation for supporting ChangeLab and allowing me to come onto the team, and the American Bar Foundation for supporting me this year while I continue to work with Aysha on making this article better.

OK, so I want to start with this quote from the sociologist Ruthie Gilmore, who created this definition of racism for the purpose of talking about the political economy of mass incarceration in California. And this definition has become popular in the academy among people who write and talk about race, because it rejects our conventional, legal, moral, psychological understandings of racism as either something that's in the mind or something that's in the heart. Racism, she says, specifically is the state sanctioned or extra legal production and exploitation of group differentiated vulnerability to premature death. And this definition is especially useful for our purposes in the next couple of days, because it starts to orient us to the life and death impacts of racism and other forms of subordination.

Healing Hate is a wonderful title for this conference, but the change is that we're not just talking about hate. We're not just talking about morality and who's a good or bad person, we're also talking about structures and institutions that create this group differentiated vulnerability to premature death. So here's the takeaway of the talk. First, new research on disparities in public health has begun to recognize that to fully eliminate those disparities, we have to uproot all forms of subordination, by which we mean in our article, all unjust forms of caste, from the personal to the structural, whether perpetrated by private or public action. And although most of my examples in this talk for reasons of time are focused on race, you'll be hearing in the next couple of days the many different directions and dimensions along which subordination

operates.

And secondly, in order to uproot all forms of subordination, we need to build strong alliances, as Dayna was telling us about, alliances in particular that we talk about in our article between three kinds of actors, public health advocates, civil rights lawyers, and advocates for social justice. So here's what the talk's going to look like. I'll first give you a little taste of the new public health research on how political and social inequalities are written on the body with a focus on racialized health disparities, but I won't spend very much time on this because I am not an expert, and there are people in this room who know far more about all of the details and will tell you more as the days continue. Secondly, I'll talk about some of the legal strategies that Aysha and I have begun to imagine, with help from many of you in this room, as ways to address health disparities, and more broadly, to make structural and institutional discrimination more visible.

And this is one of those points where we need the help, particularly of those of you who are law students and lawyers in the room. We need your creativity to make this part of the project real. I'm so glad that we have time to make this a real conversation. Third, I'll lift up the health justice model as a framework for pursuing the civil rights of health and explain why we think social movements are a key third partner in the initiative. And then finally, I'll acknowledge some of the political challenges to doing this kind of work, and I'll suggest that the best strategy to overcome these challenges is John Powell's notion of targeted universalism.

So for those of you who are like me and don't know very much about the public health literature, and I apologize to those of you who are deeply steeped in this, just a couple of definitions. The first definition or first term that you may hear is the social determinants of health, and this definition that I put up on the slide comes from the Centers for Disease Control. The social determinants of health, the CDC tells us, are shaped by the distribution of money, power, and resources which come to rest through the social environment, the physical environment, health services, and structural and societal factors, and these structural factors drive health disparities, the second term, defined as groups of people who have systematically experienced greater obstacles to health based on their race, ethnicity, religion, socioeconomic status, gender, age, mental or physical disability, sexual orientation or gender identity, or geographic location when compared with majority populations. So now, we think back to Gilmore's definition of racism, but note that these disparities are not just racialized, but reflect almost every form of social stigma that we're familiar with.

And finally, nirvana for public health advocates would be health equity. That's where we want to get to, a world in which everyone has a fair and just opportunity to be healthy. So in our article, Aysha and I used the literature on the social determinants of health to identify three broad pathways through which socially constructed group differences come to be written on the body, population, place, and power. These pathways are overlapping and somewhat intertwined, as you'll see, but they're also somewhat distinct. So I'm going to give just one example of each, and again, you'll be hearing from experts in the field who can give you many, many more.

So first, population. So last week-- I'm living in Chicago this year at the American Bar while I'm at the American Bar Foundation, and I read last week in *The Chicago Tribune* that a black woman or a Latina in Chicago is almost three times more likely to die of cervical cancer than a white woman in the same city, even though cervical cancer is almost 100% preventable. This chart, which is probably too small for you to see all the details of, uses CDC data from the 2000s to illustrate the black-white health gap in general. The blue circle is the white incidence of ill health, and the red circle is the black incidence of ill health, so farther to the right means bad. And these are statistics for childhood obesity, infant mortality, childhood asthma, female breast cancer mortality, and adult HIV infection diagnosis.

And the question is, what's the source of these population-based health disparities? Is it bad choices, bad genes, disparate poverty or education rates, lack of access to health insurance, lack of access to primary care? I will let the researchers in this room give you much more detail about each of those answers, but the piece of the puzzle that I want to identify right now is the biological impact of social discrimination.

So here's a questionnaire developed by a public health researcher to investigate the physiological effects of interpersonal discrimination as reported by its targets. These questions look like questions a civil rights lawyer might ask their client, but it turns out that a doctor might have reason to ask the same questions. For unfair reasons, have you ever not been hired for a job? Have you ever been unfairly stopped, searched, questioned, physically threatened, or abused by the police? Have you ever unfairly been denied a bank loan?

So how does discrimination get written into our bodies? There are a number of ways. One mechanism seems to be overwhelming and chronic physiological stress without adequate supports and a chance to come back to baseline, such as that caused by daily life as a person subject to interpersonal, institutional, and structural discrimination. This chart just illustrates

some of the many organ systems that can be harmed by chronic stress.

Another mechanism is discrimination within the health care system itself, another driver of population-based health disparities. This is an influential paper that found that black Americans are systematically undertreated for pain relative to white Americans. The authors found first that half of a sample of white medical students and residents endorse false beliefs about biological differences among the races, such as black people's skin is thicker than white people's.

Second, the study also found that participants who more strongly endorse such false beliefs about biological differences reported lower pain ratings for a black versus white target. And third, participants who endorse these beliefs rated the black versus the white patient's pain as lower and made less accurate treatment recommendations. So that's another pathway for these population health disparities.

And then a third way in which population-based health disparities can be written on the body is through transgenerational biological transmission. The new research on epigenetics demonstrates that environmental insults can create biological changes not only in the person who's exposed, but sometimes even in that person's children or grandchildren. This research has implications, for instance, for the children and grandchildren of people exposed to toxins, such as lead, which notoriously remains rampant in low-income housing, and was involved in the Flint water crisis, as well as agricultural fungicides which disproportionately affect farm workers, who also happen to be disproportionately poor and Latinx.

The next pathway through which health disparities are transmitted that we talk about is place. And here's a slogan that's become popular in the public health community, your zip code determines your health more than your genetic code. It's some such research showing that even putting group identity aside, where people live can produce a life expectancy differential of decades.

Here's something else, another factoid that I read in *The Chicago Tribune* last week, residents of Englewood, a poor, mostly black Chicago neighborhood, have an average life expectancy of about 60 years compared to about 90 years for residents of Streeterville, a wealthy, but predominantly white neighborhood. These neighborhoods are about 9 miles apart.

Of course, in many places, what place represents is subordination, again, but now operating at a structural rather than an interpersonal level. Here's a list of some of the factors that create

place-based health disparities. Many of them are related to past or present race and class dynamics that have now been written into the built environment and endure for generations. Unsafe or unhealthy housing that exposes residents to allergens and other hazards, opportunities for residents to exercise, walk, or cycle, proximity to highways, factories, other sources of toxic agents, unreliable or expensive public transit, and of course, residential segregation, and features that can isolate communities from social cohesion, stifle economic growth, and perpetuate cycles of poverty.

The trouble here, of course, is that we tend to think that systematic racial subordination is in the past, and so no longer is a problem, because now it's illegal. But I want to introduce you to work being done by the Seattle Civil Rights and Labor History Project at the University of Washington on the after life of redlining that shows how outlawing a practice doesn't necessarily make its effects disappear. So this project surveyed deeds and cataloged 416 racial restrictive covenants still present in deeds in the Seattle area, and in fact, the project estimates that tens of thousands of Seattle homeowners still have restrictive covenants in their deeds, even though, as you all know, these were made illegal by the Supreme Court decades ago. The researchers found that Seattle neighborhoods that had been redlined in the 1950s today still have the most infant deaths per year, the lowest life expectancy, and the highest rates of low birth weight infants. For example, they found that a 10% increase in the percent of a health reporting area considered a redline neighborhood was associated with a 6.7% increase in the risk of low birth weight babies.

And the third pathway that we discussed in our article from structural inequality, to differential vulnerability, to illness and death is power. And here, we mean good power in the sense of capacity rather than their ability to restrict other people's choices. Here, the fascinating evidence from the public health literature is that powerlessness is bad for your physical and mental health. Lack of personal and collective agency, whether caused by trauma, toxic stress, discrimination, poverty, political marginalization or disenfranchisement, increases both the risk of mental illness, and the risk of chronic physical disease.

Conversely, the experience of exercising self-determination, believing that you have the power to control your life, whether at the individual or collective level, has a protective effect on health. Sadly, a fair amount of this evidence comes from literature on child abuse. One way that individuals experience power in this positive sense is by being able to exercise enough control over their environment to meet the basic human need for a sense of safety. Children

who are exposed to physical violence or emotional abuse without the ability to affect or change their situation are vulnerable to the long-lasting set of changes that we call trauma, and trauma is associated with mental and emotional distress, as well as vulnerability to mental and physical illness.

One well-known measure for the risk of trauma is ACEs, Adverse Childhood Experiences. ACEs include physical and emotional abuse, neglect, exposure to intimate partner violence, and parental incarceration. The idea is that the more ACEs a child has, the more of these experiences a child encounters, the more likely that child is to suffer as an adult from conditions such as heart disease, obesity, depression, and substance abuse.

ACEs also appear to alter brain development in young children, leading to a host of other negative outcomes. Once again, of course, this pathway is only partly distinct from the other pathways. So children who are exposed to racial discrimination, along with adults, are also collecting more ACEs. Researchers building on the original ACEs framework look at discrimination alongside family violence and divorce as a risk factor for developmental disparities. And you can see here on the left and comparing to the right how researchers are starting to build on the ACEs model to look at social conditions and local context, and even to look at historical trauma as part of the ACEs framework.

One of the projects at ChangeLab that's really exciting is studying the health effects of what they call serial forced displacement, repetitive coercive upheavals in neighborhoods, including evictions, arrests, and gentrification that break up communities and scatter the residents. And we know something about the health effects of displacement from New Orleans post Hurricane Katrina.

OK, so we have this incredibly interesting evidence base of how systematic inequalities create health disparities, and I'm looking forward to learning more from those of you who do this work. Researchers and policymakers in public health have increasingly been looking to law to address these disparities. And of course, law has always been relevant to public health, as in campaigns for mandatory vaccination. But in the past, public health advocates have concentrated on universal campaigns, like vaccination, hoping that a rising tide would lift all boats rather than targeting the distinctive vulnerabilities of subordinated groups.

Now, they're starting to look at anti-subordination legal initiatives as a critical piece of the health disparity puzzle. Of course, from a legal perspective, as the civil rights advocates here

know, although we're well aware of the need to combat subordination, a problem in doing this work is how to attack structural and institutional subordination, indeed, how to even make it visible. So it's not only the view of many individuals, but to a great extent, the view of the US Supreme Court that racism is just that tiny little triangle at the top, the interpersonal explicit bias, the hate that people feel for one another in their hearts.

The law is pretty good at recognizing and challenging this kind of bias, but existing civil rights law is terrible at recognizing and uprooting implicit bias, institutional bias, structural bias. Nevertheless, even if the legal tools still need to be developed, part of the force of this new public health research that I've described is the possibility of measuring and documenting large-scale health effects of subordination as a way to make visible the bottom of this pyramid. And it's mind-blowing to me to be able to show that just because slavery ended or restrictive covenants were made illegal does not mean that the health consequences of those injustices have disappeared. So bringing public health and legal advocates together can help us have a much more realistic conversation about subordination and its implications, conversations that's informed not only by morality, but by medical research, informed by history, geography, and social context.

So later today, we'll have a chance to brainstorm together about specific ways to bring public health and civil rights law into one. I'll only mention a couple of possibilities to pique the interest, perhaps, of some of the students who are here. Litigation, what role, for example, might the Americans with Disabilities Act and other related civil rights statutes play in helping litigators frame the health harms caused by systemic discrimination as disabilities that require accommodation?

State and local level litigation. An increasing number of law school clinics have formed medical-legal partnerships between law students and medical students or public health graduate students. Some of these clinics use state and local law to adjust to health concerns of low-income families, such as sanitary or housing codes, specific laws focused on health threats like lead paint, asbestos, pests, mold, and adequate heat.

State constitutions. At least 12 state constitutions address either the state's role with regard to public health in general, or health care for the poor specifically, but lawyers haven't really built out these provisions. What might be done with some of these laws?

Legal and administrative law. State statutory law, municipal ordinances are a rich source of

innovative health-related protections. Cities have done a lot to establish universal protections for public health, such as smoke-free environments, safe and affordable housing, paid leave, minimum wage increases.

And what about vulnerable groups? You'll hear more later this morning about impact assessments that focus on race, the idea being that before agencies approve new projects, the project has to undergo a health assessment to find out what will be the disparate consequences of this change. And then with respect to policy, we don't necessarily need litigation or new legislation to use the civil rights of health to affect policymaking. Being able to simply see the consequences of discrimination over time, as in the afterlife of redlining project, can be a powerful way to get policymakers and lawmakers to understand institutional and structural discrimination better and to act accordingly.

Sometimes a picture is worth a thousand words, and data-driven policymaking is more informed policymaking. For example, Legal Services of Northern California has been successful in its race equity project by just showing government policymakers the disparate effects of their current policies on different communities. Once the data are accessible and visible for all to see, ignoring the effects becomes much harder.

However, I do want to acknowledge some of the big challenges to this project, even beyond the poor job that US civil rights law does with institutional and structural discrimination. First, with the exception of some of the state constitutional provisions that I've mentioned, here in the US, we just don't have a lot of legal rights that are specifically attached to health. Our federal constitution tends to enshrine negative rights to be let alone rather than positive rights to support.

Second, in terms of existing civil rights, not all the groups that suffer health disparities have sufficient legal protection. For example, poverty is a powerful driver of poor health. Discrimination against the poor is common, and economic mobility in the United States is quite limited, but the Supreme Court has not recognized poverty as a status that uniformly receives anti-discrimination protection.

Third, presently existing civil rights law has an increasing number of procedural and substantive limitations that make it hard to use, particularly with respect to class actions, and that even might be a threat to legislative, administrative, and policy initiatives that attempt to target stigmatized groups. And finally, I want to touch on the possibility that an alliance

between public health and civil rights law might not just be ineffective, it might cause more harm. We have to move carefully when we think about this.

We increasingly live in a surveillance society. Most of us already carry our mobile tracking devices with us 24/7. Private companies and public actors in the criminal justice system collect and consolidate data at scale.

Now, suppose we imagine that a city decides to go big on protecting its black and brown citizens from chronic health risk caused by years of discrimination. The first thing it's going to need is data on them, lots and lots of data. And because we've seen how the health effects of discrimination compound through multiple pathways and through multiple forms of discrimination, the most useful data would be drawn from multiple sources and interconnected so that we could measure and visualize the health impacts of housing stock, employment rates, employment discrimination, preschool quality, exposure to neighborhood violence, water quality, drug use, family violence.

But we have a huge privacy and security problem already, and now add to it the problem of stigma. The hope of public health advocates is that by documenting the impact of unjust inequality on vulnerable populations, policymakers will be moved towards helping. But what if the overall result is instead, that black and brown people in this imaginary city are stigmatized as biologically broken or even dangerous?

Some of you may remember the panic in the 1980s over crack babies. Public health research then suggested that babies born to crack-addicted mothers faced distinctive health risks, but the overall reaction in the public wasn't a compassionate one to provide more and better health care to mothers and babies, it was overall a punitive response, such as using the criminal law to threaten addicted mothers with prison time for harming their babies, even charging women under laws meant to punish drug dealers for transmitting illegal substances to their fetuses. There was a wholesale panic, which turned out to be completely unfounded, about how these babies were going to grow up to be monsters who were destined for the criminal justice system.

Another historical example is the early days of the HIV-AIDS crisis, when some public policymakers called for immigration restrictions against Haitians, and quarantine policies for gay people and prostitutes as a public health measure. So how do we respond to these are obstacles? So Aysha and I argue in our paper that for this reason in particular, we need not

just a two-way partnership of law and public health, but a three-way partnership, engaging social movements, community people, frontline communities on behalf of vulnerable groups so that these groups can be active partners in law and policymaking. And this is the kind of alliance exemplified by justice movements, such as environmental justice, climate justice, water justice.

Specifically, we can look at the example of environmental justice, where community advocates, public health researchers, and government officials both work together, but also sometimes challenge one another and check one another, resulting in policy and legal advances that are both innovative and more likely to be socially just. So in my home state of California, environmental justice advocates have been very active in state legislative lobbying and policymaking. As a result, the state's climate change initiatives are sensitive to the disproportionate health burdens and vulnerabilities of poor and minority communities.

The environmental justice framework focuses on building power for the most vulnerable in health-challenged communities. EJ advocacy in the state has been robust, often quite adversarial with respect to both public health research initiatives and vulnerable communities, and state law and policymakers, but the result of this checks and balances system has been climate policy that fosters the overall health of Californians without unfairly burdening certain communities, those with the least money and political power. In similar fashion, engaging not just law and public health, but also social movements on behalf of vulnerable communities, which might include economic justice, environmental justice, children's rights, elder rights, LGBTQ rights, and other groups in the quest to recognize health as a civil right can increase the positive potential of this initiative while decreasing its risks to these very vulnerable populations. So our model for the civil rights of health is this triangle of social actors.

But before I close, I would be remiss if I didn't acknowledge one other challenge, in some ways, the most difficult one of all. Evidence of health disparities has been around for a really long time, and those disparities still have not been fixed. And one reason why is that, as Derrick Bell spent a lifetime arguing, these disparities aren't a system bug, they're a feature. Subordination is pervasive in political and economic life because it works for those at the top.

Consider the research on social inequality, finding that the more unequal the income distribution in a country, state, or city, the lower the life expectancies for people at all income levels. So we should expect lots of support for equality if it helps everybody. And yet, some research also indicates that the bigger the income gap between the rich and the poor, the less

inclined the well-off are to pay taxes for public services that they either do not intend to use or that they use in low proportion to the taxes that they pay, and that's because under conditions of extreme inequality, societies get divided into us and them, and if we're us, we don't want to pay for them.

It gets even sadder. Sociologist Jonathan Metzl recently did focus groups and interviews among people in politically conservative areas on their policy preferences. And I'm quoting him here. "I found that if you lived in a state that rejected the Medicaid expansion and blocked the full passage of the Affordable Care Act, you lived about a 21 to 28 day shorter lifespan on the aggregate, so it was costing people about three to four weeks of life in those states. When I looked at states that made it incredibly easy for people to buy and carry guns pretty much anywhere they wanted, I found that this correlated with hundreds of deaths that wouldn't have happened otherwise, particularly in white populations, because gun suicide rose dramatically. And I found that if you lived in a state that cut away infrastructure in schools and funding, that correlated with higher high school dropout rates," unquote.

But Metzl also found, of course, that support for policies like getting rid of Obamacare, cutting food stamps, rejecting Medicaid expansion was also highest in these areas, and so Metzl's provocative conclusion is that people in these areas were dying of whiteness. Not because of hatred in their hearts, because they're worried about the policy implications of paying for those people. So we, as legal and policy experts, as public health advocates, have to grapple with the fact that simply presenting good data and constructing sound policy is not necessarily going to make fundamental structural change possible, not unless we struggle with the political legacy of subordination.

And that's another reason why we need social movements to be part of the civil rights of health. It's only social movements that can change a culture. Professional expertise, no matter how impressive the research or how well-qualified the expert, can never do that.

So what do we do? In terms of strategies going forward, Aysha and I see the civil rights of health as being a campaign that embraces what my former Berkeley colleague, John Powell, calls targeted universalism. His insight is that neither universal nor targeted approaches alone are sufficient to bring about equity in an unjust world.

In the public health space, universal approaches, like campaigns to stop smoking, have improved overall health, but left health disparities in place. Targeted approaches alone, like

focusing on prostitutes or gay people in the AIDS crisis, create political obstacles, foster accusations of special interests, and at worst, create greater stigmatization. So we need to combine universal and targeted approaches in thoughtful ways.

On the one hand, we need universal campaigns for more positive legal rights and policies that center human health and flourishing as the goal of our political and economic systems for everybody, and we also need targeted strategies that seek to close the unjust disparities that will persist unless we take account of them. So only by combining universal strategies, targeted strategies, and campaigns for social change by and on behalf of subordinated groups, only by combining all of these can all of us get to health equity, that world in which everyone has a fair and just opportunity to be healthy. So I thank you very much for your time and attention. I'm looking forward to a wonderful conversation, and thanks again for letting me be here.

[APPLAUSE]