

Structural Inequality: The Real COVID-19 Threat to America’s Health and How Strengthening the Affordable Care Act Can Help

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INTRODUCTION

“Health equity” is all the rage. Health systems, hospitals, clinics, and even insurers have bought into the proposition that achieving health equity—eliminating health disparities that grow out of persistently systemic inequality¹—is a top

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1. Paula Braveman, *Health Disparities and Health Equity: Concepts and Measurement*, 27 ANN. REV. PUB. HEALTH 167, 167, 180–81 (2006).

priority for delivering cost-effective, high-quality healthcare. Thousands of dollars are being spent to hire specialists, promote campaigns, and create new initiatives across the country that address the persistent prevalence of racially disparate health outcomes.² And yet, as the tragically disproportionate morbidity and mortality rates suffered by African-Americans in this country during the global COVID-19 pandemic demonstrated, America is still far from achieving health equity.

Gradually, healthcare providers, ranging from individual clinicians to the largest hospitals and integrated healthcare systems, have recognized that it is pervasive social inequality, which denies marginalized populations equal access to the social determinants of health—housing, employment, education, food security, and the environment, for example—that drives disparate health outcomes. This Essay addresses two lessons America must learn from the COVID-19 pandemic in order to survive. Both lessons are about structural equality. The first is that structural inequality threatens the health of our entire population, not just the health of the poor. The COVID-19 pandemic laid bare the fallacy of imagining that inequality is only a problem for the marginalized among us. Although it is all too true that the pandemic did disproportionately ravage poor neighborhoods as compared to wealthy ones, killed more blacks than it did whites, and afflicted the elderly more severely than the young, by attacking the most vulnerable, it crippled us all. The virus shut down at least one-quarter of the U.S. economy. And no community was isolated from the dangers the disease presented to “essential” workers who delivered groceries, taught and cared for children, or provided healthcare for everyone. The threat of death and economic destruction touched all. We will ignore the disproportionate devastation suffered by the least wealthy among us to our collective peril. The second lesson is that the greatest threat to our health as a society is the inequality that characterizes our social infrastructure. The virus ripped through neighborhoods where good food is scarce, decent housing is limited, and people work for substandard wages. Our public transportation systems corralled those disproportionately exposed populations together daily as they traveled throughout cities and neighborhoods to keep food on the shelves and garbage out of the streets. Our collective health depends upon addressing the structural inequities that plague the social determinants of health for us all. Moreover, I argue here that the key to overcoming these challenges lies in health providers and lawmakers uniting to dismantle structural inequality.

This Essay focuses first on the provider’s role in addressing public health inequities caused by inequities in social determinants. Some innovators are notable. Kaiser Permanente, the nation’s largest integrated health system, is investing \$200 million in Oakland, California, toward supportive housing for the homeless. This provider is also investing in affordable housing development for people

2. Ernest Moy & William Freeman, *Federal Investments to Eliminate Racial/Ethnic Health-Care Disparities*, 129 PUB. HEALTH REP. (SUPPLEMENT 2) 62, 62–70 (2014), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863704/> [<https://perma.cc/ZH59-CBQA>].

displaced by gentrification because, Kaiser explains, “[h]ousing stability is a key factor in a person’s overall health and well-being.”³ In another example, a Brockton, Massachusetts, federally qualified health center that serves a Cape Verdean community has co-located with a supermarket that specializes in tropical foods to improve health. Together, they serve patients in one building.⁴ This cooperation allows residents of the low-income neighborhood to have access to a full-time nutritionist, who works with chronically ill clinic patients who have diabetes, while using the facility’s teaching kitchen to learn how to prepare and eat healthy foods that appeal to the immigrant community.⁵ With food prescriptions from the clinic, and shopping lists from the nutrition expert, patients can walk next door to the grocer to shop for culturally appropriate food. The safety-net clinic⁶ moreover brings 100 full-time jobs to a neighborhood where over twenty-five percent of residents live below the poverty line.⁷ This partnership of medical and food services “will make it that much easier for residents to access these critical services, improve their health, and start to transform their quality of life.”⁸ In a third example, the largest safety-net hospital in Denver, Colorado combines healthcare with an intervention aimed at reducing street violence. Denver Health provides trauma-informed care to “interrupt the cycle of violence among Denver’s at-risk youth and young adults.”⁹ Patients leave the hospital with mentoring, counseling, and home visits during and after a hospital stay because, according to Denver’s Public Health Department, “violence is a health issue.”¹⁰

These healthcare innovations share several important features in common. First, by enlarging their scope beyond healthcare, they adopt a public-health approach to improving population health rather than simply delivering care to individuals. The providers have designed interventions that address the underlying social causes of disease rather than just the diseases themselves. Second, the

3. *Housing Security*, KAISER PERMANENTE, <https://about.kaiserpermanente.org/community-health/improving-community-conditions/housing-security> [<https://perma.cc/74U9-V8UE>] (last visited Mar. 8, 2020); see Susan Morse, *How Kaiser Permanente and Enterprise Are Investing in Affordable Housing*, HEALTHCARE FIN. (Sept. 16, 2019), <https://www.healthcarefinancenews.com/node/139162> [<https://perma.cc/57L3-6J7D>].

4. See *Success Story: Vicente’s Tropical Supermarket*, REINVESTMENT FUND, <https://www.reinvestment.com/success-story/vicentes-tropical-supermarket/> [<https://perma.cc/8V58-DXZK>] (last visited Nov. 13, 2019).

5. See *id.*

6. INST. OF MED., *AMERICA’S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED 1* (2000) (defining safety-net providers as “providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients”).

7. See *Success Story: Vicente’s Tropical Supermarket*, *supra* note 4.

8. Press Release, Local Initiatives Support Corp., Brockton Neighborhood Health Center to Open (Aug. 31, 2015), <https://www.pnewsire.com/news-releases/brockton-neighborhood-health-center-to-open-300135160.html> [<https://perma.cc/94FK-HSU5>].

9. *Pre-Health Programs*, DENVER HEALTH, <https://www.denverhealth.org/for-professionals/office-of-education/health-professions-and-pre-health-programs/pre-health-programs> [<https://perma.cc/W5D6-G732>] (last visited Nov. 3, 2019).

10. *Youth Violence Prevention*, DENVER PUB. HEALTH, <http://www.denverpublichealth.org/community-health-promotion/youth-health/violence-prevention> [<https://perma.cc/G482-3347>] (last visited Nov. 3, 2019).

health services are delivered through collaborative partnerships. Traditional healthcare providers—a health system, clinic, and hospital—have joined with nonmedical partners—housing developers, a grocer, and law enforcement—to increase the quality and effectiveness of their medical services. And third, these providers’ interventions treat the health impacts of inequality that are at the root of the disparate medical problems their vulnerable patient populations face. Inequitable access to decent, affordable housing;¹¹ inequitable distribution of healthy food;¹² education disparities;¹³ and disproportionate exposure to violence and childhood trauma¹⁴ are four examples of the inequalities that these health providers have confronted in order to promote good health. Together, the aggregate effect of inequity in each of these social domains combines so that adversity becomes cumulative and structural.¹⁵ Sociologists have defined structural inequality as “an inequality in the distribution of a valued resource, such as wealth, information, or technology, that brings social power.”¹⁶ Structural inequality

11. See Samiya A. Bashir, *Home Is Where the Harm Is: Inadequate Housing as a Public Health Crisis*, 92 AM. J. PUB. HEALTH 733 (2002) (noting that overcrowded neighborhoods and dangerous housing conditions like mold, lead, and vermin are associated with childhood asthma and many other illnesses); James Krieger & Donna L. Higgins, *Housing and Health: Time Again for Public Health Action*, 92 AM. J. PUB. HEALTH 758 (2002) (discussing epidemiological studies linking substandard housing to increased chronic illness, infectious disease, injuries, and mental illness); Jaime Raymond, William Wheeler & Mary Jean Brown, *Inadequate and Unhealthy Housing: 2007 and 2009*, 60 CTRS. DISEASE CONTROL & PREVENTION: MORBIDITY & MORTALITY WKLY. REP. 21 (2011) (noting that healthy housing can help throughout life stages supporting mental, physical, and emotional health); LAUREN TAYLOR, HEALTH AFF., HOUSING AND HEALTH: AN OVERVIEW OF THE LITERATURE, (June 7, 2018) (noting that some housing interventions have been found to improve health outcomes and reduce healthcare costs), <https://www.healthaffairs.org/doi/10.1377/hpb20180313.396577/full/> [https://perma.cc/Q2UB-DV2D].

12. Heather D’Angelo et al., *Access to Food Source and Food Source Use Are Associated with Healthy and Unhealthy Food-Purchasing Behaviours Among Low-Income African-American Adults in Baltimore City*, 14 PUB. HEALTH NUTRITION 1632, 1637–38 (2011) (Baltimore study finding healthier food purchases in areas with supermarkets rather than convenience stores and where transportation was more readily available); Craig Gundersen & James P. Ziliak, *Food Insecurity and Health Outcomes*, 34 HEALTH AFF. 1830 (2015) (examining studies showing that food insecurity is associated with poor health in children and elderly but can be relieved by the SNAP food stamp program).

13. Emily B. Zimmerman, Steven H. Woolf & Amber Haley, *Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives*, in POPULATION HEALTH: BEHAVIORAL AND SOCIAL SCIENCE INSIGHTS 347 (Robert M. Kaplan, Michael L. Spittel & Daryn H. David eds., 2015) (arguing that education is a key filtering mechanism to situate individuals within ecological contexts where there are differing opportunities and resources, and therefore health and health behaviors are affected by accessibility of education).

14. ANITA CHANDRA ET AL., RAND CORP. TOWARD AN INITIAL CONCEPTUAL FRAMEWORK TO ASSESS COMMUNITY ALLOSTATIC LOAD: EARLY THEMES FROM LITERATURE REVIEW AND COMMUNITY ANALYSES ON THE ROLE OF CUMULATIVE COMMUNITY STRESS (2018); James A. Mercy et al., *Public Health Policy for Preventing Violence*, 12 HEALTH AFF. 7, 10, 19, 39 (1993) (noting that violence and other community disadvantages are associated with stress and resultant illness).

15. See generally Stephani L. Hatch, *Conceptualizing and Identifying Cumulative Adversity and Protective Resources: Implications for Understanding Health Inequalities*, 60 J. GERONTOLOGY (SPECIAL ISSUE) 130, 130 (2005) (focusing on “cumulative adversity and protective resources” in evaluating health inequalities across the life course).

16. Cecilia L. Ridgeway, *The Emergence of Status Beliefs: From Structural Inequality to Legitimizing Ideology*, in THE PSYCHOLOGY OF LEGITIMACY: EMERGING PERSPECTIVES ON IDEOLOGY, JUSTICE, AND INTERGROUP RELATIONS 257, 259 (John T. Jost & Brenda Major eds., 2001).

delivers cumulative advantage to the affluent—and cumulative disadvantage to others—by disparately allocating access to education, employment, housing, food, healthcare, political power, and legal representation.¹⁷

The empirical evidence of growing structural inequalities is compelling. By all measures, inequalities that separate the advantaged from the disadvantaged in America are severe and worsening to levels not seen since the Great Depression.¹⁸ The top one percent of earners take home twenty percent of the nation's income, while the bottom fifty percent of the population earns less than thirteen percent of national income. Wealth inequity is even more concentrated; the top one percent of households hold nearly forty percent of all wealth, while the bottom ninety percent share less than a quarter of the nation's wealth.¹⁹ Middle-class families are suffering the most from the widening inequity gaps,²⁰ especially racial and ethnic minorities as compared to white families.²¹ As a result, social and economic inequity characterizes all sectors of society. Educational inequity is particularly pernicious. It not only limits current life choices, but also constrains social mobility for generations,²² confining a perpetual underclass into neighborhoods characterized by concentrated poverty, discriminatory policing, food insecurity, and tragically disparate poor health outcomes.

Structural inequality is directly associated with poor health in the United States and globally.²³ Sir Michael Marmot convincingly demonstrated this correlation by empirically describing an inverse linear relationship between relative wealth

17. See generally EDWARD ROYCE, *POVERTY AND POWER: THE PROBLEM OF STRUCTURAL INEQUALITY* (3d ed. 2019) (asserting that poverty is a structural, not individualistic moral problem, stemming from economic, political, and power inequalities that favor the affluent and cumulatively disfavor the impoverished in America, more than any other industrialized nation).

18. 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>.

19. See Thomas Piketty, Emmanuel Saez & Gabriel Zucman, *Distributional National Accounts: Methods and Estimates for the United States* 25, 46 (Washington Ctr. for Equitable Growth, 2016), <http://equitablegrowth.org/working-papers/distributional-national-accounts/> [<https://perma.cc/7SDZ-B9MZ>].

20. See Chad Stone et al., *A Guide to Statistics on Historical Trends in Income Inequality*, CTR. ON BUDGET & POL'Y PRIORITIES 10–12, <https://www.cbpp.org/research/poverty-and-inequality/a-guide-to-statistics-on-historical-trends-in-income-inequality> [<https://perma.cc/ME3S-KMBZ>] (last updated Jan. 13, 2020).

21. See 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. (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/> [<https://perma.cc/44VV-X2Q3>].

22. See 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 THE HEALTH PROFESSIONS* 208 (Nat'l Acad. Press 2001).

23. See Richard G.A. Feachem, *Poverty and Inequity: A Proper Focus for the New Century*, 78 BULL. WORLD HEALTH ORG. 1 (2000); see also *Inequality and Health*, INEQUALITY.ORG, <https://inequality.org/facts/inequality-and-health/#us-inequality-health> [<https://perma.cc/CL98-UQ8R>] (last visited Nov. 3, 2019).

and health which he called, “the social gradient.”²⁴ In Great Britain, its national health-insurance system notwithstanding, Sir Marmot’s Whitehall Studies showed that social-class differences drive differences in health status.²⁵ Nancy Scheper-Hughes’ qualitative research carefully illustrated the desperate correlation between abject poverty and children’s dismal health outcomes in her heart-wrenching ethnography about life in Brazil’s slums.²⁶ Similarly, in the United States, research shows that widening gaps in income inequality predict increasing differences in life expectancy;²⁷ and differences in life expectancy are directly related to gaps in educational attainment.²⁸ However, these vast social inequities are well beyond the capacity of the healthcare industry to address on its own.

The global COVID-19 pandemic provides the most recent and disturbing proof that structural inequality is a causal factor in producing deadly health disparities, and that a massive legal intervention will be required to correct it. First reported as a pneumonia of unknown cause in Wuhan, China, by January 30, 2020, the World Health Organization declared the coronavirus outbreak a Public Health Emergency of International Concern. Worldwide, the poor in developing nations, especially where populations live in densely populated areas with limited public health infrastructure, were likely to be the most severely affected by the crisis.²⁹ In the United States, the earliest data showed that African-Americans contracted and died from COVID-19 at disproportionately high rates.³⁰ In “hotspot” areas such as New York City,³¹ Milwaukee, Louisiana,³² and Chicago,³³ black and

24. Michael Marmot & Eric Brunner, *Cohort Profile: The Whitehall II Study*, 34 INT’L J. EPIDEMIOLOGY 251, 251 (2005).

25. *See id.*

26. *See generally* NANCY SCHEPER-HUGHES, DEATH WITHOUT WEeping: THE VIOLENCE OF EVERYDAY LIFE IN BRAZIL (1992) (identifying poverty that leads to malnutrition and dehydration as “new” childhood killer for babies of shantytowns’ poor working mothers).

27. *See* John Lynch et al., *Income Inequality, the Psychosocial Environment, and Health: Comparisons of Wealthy Nations*, 358 LANCET 194, 194, 198 (2001).

28. *See* Ellen R. Meara, Seth Richards & David M. Cutler, *The Gap Gets Bigger: Changes in Mortality and Life Expectancy, by Education, 1981–2000*, 27 HEALTH AFF. 350, 353–55 (2008).

29. Adam Vaughan, *Coronavirus Will Play Out Very Differently in World’s Poorest Nations*, NEWSIDENTIST (Apr. 3, 2020), <https://www.newscientist.com/article/2239612-coronavirus-will-play-out-very-differently-in-worlds-poorest-nations/> [<https://perma.cc/6C3H-AK8P>].

30. *See* Akilah Johnson & Talia Buford, *Early Data Shows African Americans Have Contracted and Died of Coronavirus at an Alarming Rate*, PROPUBLICA (Apr. 3, 2020, 1:21 PM), <https://www.propublica.org/article/early-data-shows-african-americans-have-contracted-and-died-of-coronavirus-at-an-alarming-rate> [<https://perma.cc/AB7V-UT9H>].

31. *See* Sanya Mansoor, *Data Suggests Many New York City Neighborhoods Hardest Hit by COVID-19 Are Also Low-Income Areas*, TIME (Apr. 5, 2020, 3:36 PM), <https://time.com/5815820/data-new-york-low-income-neighborhoods-coronavirus/> [<https://perma.cc/4VMB-9FHZ>].

32. *See* Reis Thebault, Andrew Ba Tran & Vanessa Williams, *The Coronavirus Is Infecting and Killing Black Americans at an Alarmingly High Rate*, WASH. POST (Apr. 7, 2020), <https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows/?arc404=true>.

33. *See* Samantha Michaels, *70 Percent of People by the Coronavirus Are Black*, MOTHER JONES (Apr. 5, 2020), <https://www.motherjones.com/coronavirus-updates/2020/04/70-percent-of-people-killed-in-chicago-by-the-coronavirus-are-black/> [<https://perma.cc/63AN-NQBS>].

LatinX³⁴ populations were decimated because they are over-exposed to several structural risk factors for COVID-19. They are overrepresented among low-wage workers whose jobs do not allow them to stay home and shelter in place to avoid exposure. Moreover, these communities are more likely to live in densely populated urban neighborhoods and communities traumatized by violence and poverty. African-American and LatinX neighborhoods typically have inferior access to quality healthcare; are more likely located proximate to environmental pollution hazards; and are less likely to contain ample green and recreational spaces. In addition, these populations have inferior access to early diagnostic and aggressive therapeutic care, and therefore, are susceptible to underlying comorbidity risks such as diabetes. The temptation is to cast these disproportionalities as individual-level failings of health behavior or heredity. Although individual factors are not irrelevant, the most powerful explanation for minority populations' susceptibility to the COVID-19 disease and its devastation is the structural inequality that characterizes their lives and historic experiences in this country. In short, inequitable societies are the most vulnerable, least safe,³⁵ and least healthy in the world.³⁶ That is why healthcare providers, public health professionals, and sociologists have become preoccupied with addressing structural inequality. This Essay invites legal scholars to join this life-and-death conversation.

Some legal scholars have acknowledged the ethical and moral contradiction to our nation's founding principles that vast social inequality represents.³⁷ However, the fact that the relationship between legally enabled social inequality and poor population health is underappreciated is far more than an intellectual oversight. The nation's Declaration of Independence begins with the pronouncement that all lives have equal, intrinsic worth.³⁸ The Fourteenth Amendment embeds this equality principle into our Constitution as a foundation of American law.³⁹ As stated by Justice Brennan, "[T]he rock upon which our Constitution rests. . . the judicial pursuit of equality is . . . properly regarded to be the noblest mission of judges."⁴⁰ Even the late Justice Antonin Scalia cheered for the equality principle

34. There is considerable diversity within populations of African descent in the United States. This Essay does not ignore that richness, but instead will acknowledge and embrace it despite the discriminatory burdens that are imposed on this heterogeneous group based on skin color by the social construct of race. To reflect the constitutionally driven focus of my analysis, I use the terms "black" and "African-American" interchangeably. Similarly, from a population health perspective, the term I use here—"Latino/a/X"—describes a diverse ethnic group from Latin and Central America.

35. See Martin Daly, Margo Wilson & Shawn Vasdev, *Income Inequality and Homicide Rates in Canada and the United States*, 43 CANADIAN J. CRIMINOLOGY 219, 231 (2001).

36. See Ichiro Kawachi & Bruce P. Kennedy, *Income Inequality and Health: Pathways and Mechanisms*, 34 HEALTH SERVS. RES. 215, 215, 216–17 (1999).

37. See, e.g., CHARLES POSTEL, EQUALITY: AN AMERICAN DILEMMA 1866–1896, at 8 (2019) ("Equality, of course, had been a potent idea in American affairs since the country's founding.").

38. See generally Clarence Thomas, *Toward a "Plain Reading" of the Constitution—The Declaration of Independence in Constitutional Interpretation*, 30 HOW. L.J. 983 (1987) (examining the principles of the founding documents in light of policies toward African-Americans).

39. See U.S. CONST. amend. XIV, § 2; see also U.S. CONST. amend. V.

40. William J. Brennan, Jr., *The Equality Principle: A Foundation of American Law*, 20 U.C. DAVIS L. REV. 673, 673–74 (1987).

when he praised its legal articulation, saying, “The Equal Protection Clause epitomizes justice more than any other provision of the Constitution.”⁴¹ However, it must be admitted that “[e]quality remain[s] an unresolved and multipronged dilemma”⁴² in this country.

Equality can conceptually confound even the most astute analysts, as this theorist’s internally inconsistent distinction between equality and rights evinces:

Equality is commonly perceived to differ from rights and liberties. Rights are diverse; equality is singular. Rights are complicated; equality is simple. Rights are noncomparative in nature, having their source and their justification in a person’s individual well-being; equality is comparative, deriving its source and its limits from the treatment of others. Rights are concerned with absolute deprivation; equality is concerned with relative deprivation. Rights mean variety, creativity, differentiation; equality means uniformity. Rights are individualistic; equality is social. Or so it is said.⁴³

Unable to decide whether equality is “singular” or “comparative,” “simple” or “relative,” Peter Westen concludes that equality is a substantively “empty idea” that “should be banished from moral and legal discourse as an explanatory norm.”⁴⁴ He is wrong.⁴⁵ However, this likely explains some of the judicial lack of commitment to the equality principle that has adversely affected the lives of those the constitutional doctrine was intended to protect. Enforcing the equality principle necessarily confronts a strong opposition. For example, equality claims can compete with a set of principles that protect individual liberty and autonomy.⁴⁶ Thus, courts often have turned to liberty-based analysis to replace old-fashioned equal protection for civil rights claims, as Kenji Yoshino explains.⁴⁷ Equality and liberty must be linked in order to find, in his account, a new form of hybrid claim that accounts for the exhaustion that has resulted from seemingly endless equal protection claims from aggrieved groups. Yoshino calls this, “pluralism anxiety,” and argues it warrants limiting traditional conceptualizations of equality.⁴⁸ Thus, lamenting the Supreme Court’s decreasing appetite for enforcing the Equal Protection Clause, Yoshino has pronounced the “end of equality doctrine as we

41. Antonin Scalia, *The Rule of Law as a Law of Rules*, 56 U. CHI. L. REV. 1175, 1178 (1989).

42. POSTEL, *supra* note 37, at 311.

43. Peter Westen, *The Empty Idea of Equality*, 95 HARV. L. REV. 537, 537 (1982).

44. *Id.* at 542.

45. In his classic apologetic of sufficiency to replace the notion of equality, even Harry Frankfurt admitted that although “[m]y claim that equality in itself lacks moral importance does not entail that equality is to be avoided. . . . Even if equality is not as such morally important. . . . it might turn out that the most feasible approach to the achievement of sufficiency would be the pursuit of equality.” Harry Frankfurt, *Equality as a Moral Ideal*, 98 ETHICS 21, 22 (1987).

46. See Cass R. Sunstein, *The Anticaste Principle*, 92 MICH. L. REV. 2410, 2410 (1994).

47. Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747, 776 (2011).

48. *Id.* at 749.

have known it.”⁴⁹ He is not wrong. Although Yoshino properly identifies the salient change to be a jurisprudential shift in how courts enforce the equality principle, he does not make the mistake that Westen does by improperly presuming the Court’s irreconcilable interpretations of equal protection,⁵⁰ or that changing public opinion⁵¹ has the power to eliminate the transcendent morality of the equality principle.⁵²

This Essay sounds an urgent alarm, calling for the equality principle embodied in the Fourteenth Amendment’s Equal Protection Clause to be revived, and put to work. This Essay posits that a continued jurisprudential failure will ensure that structural inequality will continue to threaten the health of America’s populations and institutions. Indeed, a primary reason America’s progress toward health equity has been slow and uneven is because our legal conceptualization of equality has lost its way. As a consequence, antidiscrimination law—provisions enacted to prohibit actions that destroy equality based on race, nationality, gender, sexuality, and other protected statuses—has been neutralized. As a result, discrimination has been allowed to create, maintain, and even strengthen the structural inequalities that lie at the root of all health disparities. Moreover, I argue that the jurisprudential contributor to this failing and progressive abandonment of the commonsense meaning of equality has corrupted our Constitution’s equal protection guarantee. From a public health standpoint, returning the equality principle to American jurisprudence is vital to ensuring equitable access to the social determinants of health.⁵³ Indeed, I argue that finally living up to this nation’s promise of laws that protect the equality of all is the imperative required to reverse the structural inequality that threatens us all.

The premise of this Essay is that to eradicate health disparities, America’s equal protection jurisprudence must once again become a useful tool in the fight to reverse the systemic discrimination that characterizes the major social determinants of health. Inequitable access to housing, education, and community safety

49. *Id.* at 748.

50. *Compare Swann v. Charlotte-Mecklenburg Bd. of Educ.*, 402 U.S. 1, 16 (1971) (finding that school authorities’ powers are broad, flexible, and plenary), with *Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1*, 551 U.S. 701 (2007) (striking down school districts’ voluntarily adopted desegregation plans).

51. *See, e.g.,* Reva Seigel, *Why Equal Protection No Longer Protects: The Evolving Forms of Status-Enforcing State Action*, 49 STAN. L. REV. 1111, 1112 (1997) (explaining that transcontextual moral certainty does not attach even to public opinion about the evil of slavery).

52. I think Westen goes wrong from the outset by relying upon a proceduralist notion of equality. “By ‘equality’ I mean the proposition that in law and morals that ‘people who are alike should be treated alike’ and its correlative, that ‘people who are unlike should be treated unlike.’” Westen, *supra* note 43, at 539–40 (footnotes omitted).

53. *See, e.g.,* NORMAN DANIELS, BRUCE KENNEDY & ICHIRO KAWACHI, IS INEQUALITY BAD FOR OUR HEALTH? 6 (2000) (suggesting that establishing equal liberties, opportunity, and fair distribution of resources would eliminate most injustices in health outcomes); James Y. Nazroo, *The Structuring of Ethnic Inequalities in Health: Economic Position, Racial Discrimination, and Racism*, 93 AM. J. PUB. HEALTH 277, 383 (finding convincing evidence that ethnic inequalities in health are likely due in large part to socioeconomic differences) (2003); Larry S. Temkin, *Inequality and Health*, in INEQUALITIES IN HEALTH: CONCEPTS, MEASURES, AND ETHICS 13, 24–25 (Nir Eyal et al. eds., 2013) (suggesting that the inequalities that matter most may be inequalities of food, health, safety, and wages, requiring a profound shift in approach to public health).

are at the root of the health injustices that we politely call “health disparities.” Health inequity is due primarily to our nation’s disregard for the equal humanity of minorities with white populations. This disregard, it turns out, is an adverse indicator for the health of both majority and minority populations. Indeed, the departure from an equality principle that protects the inalienable right of every member of society to enjoy an opportunity to pursue a healthy life does damage to the shared moral fiber of the nation, as well as to its collective health and well-being.

I make this argument in three Parts. In Part I, I outline the conceptual framework of the equality principle that animated the drafters of the Equal Protection Clause when it was ratified. I contend this same principle should drive antidiscrimination law today. Unfortunately, it does not. The first Part highlights the departure from “equal protection of the laws” in theory to the current unequal protection of the laws that prevails in the United States today. In Part II, I show the effect of this departure on equal access to decent and affordable housing, safety, recreation, food security, education, and wealth for minority populations. I connect these inequities to the disparate health outcomes that minority populations suffer. Part III suggests building upon the steps toward implementing a public health agenda to address health inequality taken by drafters of the Patient Protection and Affordable Care Act (the Affordable Care Act or ACA).⁵⁴ The ACA allowed some demonstrable progress toward an equitable distribution of healthcare, and thereby began to move the needle toward reducing structural inequality. Moreover, the ACA contains a healthcare civil rights provision, which represents one of the most significant course corrections in the nation’s departure from true equal protection of the laws since the 1965 Civil Rights Act. Section 1557 of the ACA prohibits discrimination by health programs and activities that receive federal financial assistance.⁵⁵ I argue that if properly enforced, this section of the Affordable Care Act could disrupt the progressively widening gap between the haves and have-nots that threatens our national health, and that has proved deadly to African-American, LatinX, and low-wealth people disproportionately.

54. *See, e.g.*, Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10501(k), 124 Stat. 119, 1004 (2010) (codified as amended at 42 U.S.C. § 254b-1 (2012)).

55. *See id.* § 1557. The relevant text provides:

Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

Id. § 1557(a).

I. A BRIEF OVERVIEW OF EQUAL PROTECTION JURISPRUDENCE

The proposition that all are created equal and therefore enjoy equal protection under the law remains a vision that has never been fully realized in America. Because nothing like equality for all was intended in 1776 when the Declaration of Independence was adopted,⁵⁶ I choose July 28, 1868—the date the Secretary of State declared that three-fourths of the states had ratified the Fourteenth Amendment⁵⁷—as the starting point of our country’s struggle to live up to the equality principle. Section 1 of the Fourteenth Amendment forbids any state to “deny to any person within its jurisdiction the equal protection of the laws.”⁵⁸ Known as one of the three “Reconstruction Amendments,”⁵⁹ this Amendment granted citizenship to enslaved Americans and “[a]ll persons born or naturalized in the United States,”⁶⁰ thereby including the formerly enslaved as fully equal participants in the benefits and burdens of the American polity. Following ratification, the Fourteenth Amendment presented the hope that equality would mean dignity, in every sense that a government could offer or withhold equal status, representation, respect, and opportunity to all its citizens. The hope was grounded in the commonsense meaning of the word “equal.” Indeed, the entry for the word “equal” in Samuel Johnson’s 1755 classic dictionary of the English language is

E’qual. *adj.* . . .

1. Like another in bulk, excellence, or any other quality that admits comparison; neither greater nor less; neither worse nor better. . . .
3. Even; uniform. . . .
5. Impartial; neutral. . . .
6. Indifferent. . . .
7. Equitable; advantageous alike to both parties. . . .
8. Upon the same terms. . . .

E’qual. *n.* . . .

1. One not inferiour or superiour to another⁶¹

This plain language meaning likely created an expectation that the Constitution would become useful to remedy America’s unjust systems of white supremacy. The hope was further supported by the surmise that the unparalleled carnage of

56. Any number of marginalized groups could be the subject of this paper. Native Americans, women, the disabled, members of the queer community, and a host of others have sought fulfillment of the promise of equal social status in America. Here, however, I focus on our nation’s still-unfulfilled promise of racial equality, both because it is the foundation upon which all other efforts for equality have been built and because racial equality has proved the most elusive ideal.

57. See Douglas H. Bryant, *Unorthodox and Paradox: Revisiting the Ratification of the Fourteenth Amendment*, 53 ALA. L. REV. 555, 575 (2002).

58. U.S. CONST. amend. XIV.

59. See *id.* amends. XIII, XIV, XV.

60. *Id.* amend. XIV.

61. *E’qual*, A DICTIONARY OF THE ENGLISH LANGUAGE (Samuel Johnson ed., 1997), <https://johnsonsdictionaryonline.com/page-view/?i=713> [<https://perma.cc/MB3S-9EE8>].

the Civil War and the three constitutional Amendments—the Thirteenth, Fourteenth, and Fifteenth—that followed ushered in a new era in which America would be able to finally live up to the equality ideal it espoused in its founding documents. In short, the hope was that a Civil War and three Constitutional Amendments might finally spell the end of American racism. They have not. The tortured struggle to give meaning to the equality principle in our laws is proof.

Legal philosophers have wrestled to define the philosophical meaning of equality in the political sense. Ronald Dworkin, for example, famously examined what he called two aspects of “distributional equality”—a theory in which society treats all people as equals politically and economically either to the point that no one has greater *welfare* than others, which requires taking respective differences into account, or to the point that society treats all equally by ensuring that none have greater *resources* than others, which simply requires equal division of all available resources.⁶² Exploring such abstract theoretical conceptualizations is beyond the scope of my Essay. Instead, I take a more pragmatic approach, focusing on the essential purpose that the equality principle serves in American law. The starting place here is in keeping with Elizabeth Anderson’s exposition of “democratic equality.”⁶³ In Professor Anderson’s words, this Essay assumes “[t]he proper negative aim of egalitarian justice is . . . to end oppression, which by definition is socially imposed. Its proper positive aim is not to ensure that everyone gets what they morally deserve, but to create a community in which people stand in relations of equality to others.”⁶⁴ I remain committed to the power of law to incentivize equal respect, treatment, valuation, and concern for the relationship among all people and the state. I remain determined to see the end of the law’s role in perpetuating racism as a system that assigns power and resources to some, while withholding resources and opportunity from others, based on loathsome, socially constructed notions of inferior and superior races. In service of this goal, this Part takes a brief look at the theoretical ideal of equality that underlies equal protection, and then contrasts the inequality that has resulted because that equality ideal has failed to operationalize.

A. EQUAL PROTECTION IN THEORY

The meaning an ordinary person would ascribe to the word “equal” contained in the Fourteenth Amendment at the time that it became effective would have been straightforward as Samuel Johnson’s dictionary entry reveals. There would be no question about the meaning of “equal protection” to any objective listener, as Representative Thaddeus Stevens made plain when he introduced the Fourteenth Amendment for debate in Congress:

62. Ronald Dworkin, *What Is Equality? Part 1: Equality of Welfare*, 10 PHIL. & PUB. AFF. 185, 186 (1981).

63. Elizabeth S. Anderson, *What Is the Point of Equality?*, 109 ETHICS 287, 289 (1999).

64. *Id.* at 288–89.

This amendment . . . allows Congress to correct the unjust legislation of the States, so far that the law which operates upon one man shall operate *equally* upon all. Whatever law punishes a white man for a crime shall punish the black man precisely in the same way and to the same degree. Whatever law protects the white man shall afford “equal” protection to the black man. Whatever means of redress is afforded to one shall be afforded to all. Whatever law allows the white man to testify in court shall allow the man of color to do the same. These are great advantages over their present codes. Now different degrees of punishment are inflicted, not on account of the magnitude of the crime, but according to the color of the skin. Now color disqualifies a man from testifying in courts, or being tried in the same way as white men. I need not enumerate these partial and oppressive laws. Unless the Constitution should restrain them those States will all, I fear, keep up this discrimination, and crush to death the hated freedmen.⁶⁵

According to Professor Charles Postel, the dominant definition of equality post-Civil War was an ideal described as “equality of opportunity.”⁶⁶ He stated, “[t]he starting point or common denominator was often Lincoln’s free-labor ideal of an ‘open field and a fair chance’ with ‘equal privileges in the race of life.’”⁶⁷ Republicans who dominated the post-Civil War Congress “pursued . . . ‘the utopian vision of a nation whose citizens enjoyed equality of civil and political rights, secured by a powerful and beneficent national state.’”⁶⁸ In summary, Professor Postel explains the common sense equality principle that captured law and culture at the time of the Fourteenth Amendment’s ratification:

[M]illions of men and women who joined voluntary associations understood the problem of equality in their historical moment. Associations reflected shared moral commitments and common responses to the intellectual and political world in which they were formed. The people who made up these post-bellum collective efforts mainly believed in the idea of freedom and opposed the idea of slavery. They often harked back to an idealized republican past and looked forward to an idealized republican future. They tended to embrace visions of progress, modernity, and the advance of civilization. And they understood that the pursuit of equality served as a lever for the realization of freedom, good government, and progress.⁶⁹

65. CONG. GLOBE, 39th Cong., 1st Sess. 2459 (1866) (introducing H.R. RES. 127, which became the Fourteenth Amendment).

66. POSTEL, *supra* note 37, at 10.

67. *Id.*

68. *Id.* at 9.

69. *Id.* at 10 (footnotes omitted).

The unambiguous goal of protecting “equality” under the constitutional Amendment was then, and must today be understood as putting a stop to the oppressive use of law to distinguish the societal participation of one group of people from that of another on the basis of skin color. The meaning of “equal” then and now can only be understood as prohibiting any use of law that operates to distinguish one group’s legal status from another on a basis that could not be supported by differences in their essential humanity. According to Professor Michael McConnell, “[t]he Fourteenth Amendment, at its heart, embraces the principle of equality of civil rights: any civil right to which a white person would be entitled must be extended to all citizens on exactly the same terms.”⁷⁰

Professor Michael Klarman explains that before *Brown v. Board of Education*, “the dominant intention of the Fourteenth Amendment’s drafters . . . had been to protect blacks in the exercise of certain fundamental rights.”⁷¹ However, even Klarman’s analysis stops short of understanding the full breadth of the equality that the Constitution’s provisions must ensure. The meaning of “equal” must be understood to refer to essential, equal humanity of all people who in that organic document are now included in the principle that “all are created equal” before God. America has yet to realize this plain meaning of equality. Instead, America has flouted the Constitution’s guarantee of equality. Not long after the Fourteenth Amendment’s passage, courts showed open disregard for this notion of equality. This using law to defeat the Constitution’s aspirational goal of protecting the essential equality of all humanity has produced the untenable racial health disparities that plague America today.

Professor Alan Freeman cites the disheartening speed with which the courts repeatedly departed from the concept of equality Representative Stevens espoused:

During [the post-Civil War Reconstruction] era, it took thirty-three years to go from the promise of the Emancipation Proclamation in 1863 to the bleak reality of the “separate but equal” doctrine endorsed by *Plessy v. Ferguson* in 1896. More recently, it has taken thirty-five years to go from the glowing promise of *Brown v. Board of Education* in 1954 to the “Civil Rights Cases” of 1989, which seem to enshrine the principle of “unequal but irrelevant.”⁷²

The next section identifies the impact of these swift departures upon the health of American sub-populations.

70. Michael W. McConnell, *The Originalist Case for Brown v. Board of Education*, 19 HARV. J.L. & PUB. POL’Y 457, 461 (1996).

71. Michael Klarman, *An Interpretive History of Modern Equal Protection*, 90 MICH. L. REV. 213, 220 (1991). But Klarman also identifies the tension between the Fourteenth Amendment’s Equal Protection Clause, and Section 2’s clear tolerance of racial discrimination in voting. *Id.* at 228–29.

72. Alan Freeman, *Antidiscrimination Law: The View from 1989*, 64 TUL. L. REV. 1407, 1407–08 (1990) (footnotes omitted).

B. UNEQUAL PROTECTION IN PRACTICE

In the 152 years since its passage, the Fourteenth Amendment has continued to tolerate interpretations that make some people more equal than others. Borrowing from Professor Freeman's famous analysis that divided the period from 1954 to 1990 into "four 'eras' of Supreme Court decisionmaking,"⁷³ in this section, I divide the history of the Court's equal protection jurisprudence into five distinct eras of American legal history that describe the Court's varying commitments to the Constitution's equality principle as applied to African-Americans in the United States. I focus on the Supreme Court's equal protection jurisprudence in each era to conclude, as Professor Freedman did, that "[t]he eras add up to a story of promise, intervention, retreat, and surrender."⁷⁴ To analyze the equality principle, I divide the time from the close of the Civil War to the present into five periods. The first is the Reconstruction Era, which began immediately at the conclusion of the Civil War in 1865 and lasted until the Compromise of 1877 when the federal government withdrew its troops from the southern states. During Reconstruction's brief twelve years, Congress repeatedly attempted to codify the equality principle in legislative language that was almost immediately nullified by the United States Supreme Court. For example, the Civil Rights Act of 1875 declared:

[W]e recognize the equality of all men before the law, and hold that it is the duty of government in its dealings with the people to mete out equal and exact justice to all, of whatever nativity, race, color, or persuasion, religious or political; and it being the appropriate object of legislation to enact great fundamental principles into law.⁷⁵

But in 1883, the Court held that Act unconstitutional;⁷⁶ then in 1896, the *Plessy* Court infamously constitutionalized the Jim Crow Era's "separate but equal" laws—but not before the thirty-ninth Congress succeeded in constitutionalizing the equality principle in the Fourteenth Amendment, which was ratified in 1868. For most of the Jim Crow Era, the Amendment lay dormant and underutilized as the Supreme Court sanctioned racist state and local actions that plainly violated the equality principle.⁷⁷ The "Civil Rights Era" began in earnest in 1954 when the Court decided *Brown v. Board of Education*⁷⁸ and *Hernandez v. Texas*.⁷⁹ I mark the end of that era as 1976, when the Supreme Court significantly

73. *Id.* at 1413.

74. *Id.*

75. Civil Rights Act of 1875, ch. 114, 18 Stat. 335.

76. *The Civil Rights Cases*, 109 U.S. 3 (1883).

77. *See, e.g.*, *Cumming v. Richmond Cty. Bd. of Educ.*, 175 U.S. 528, 545 (1899) (approving de jure segregation in schools); *Lum v. Rice*, 275 U.S. 78, 87 (1927) (approving exclusion of Chinese children from high schools). *But see, e.g.*, *Sweatt v. Painter*, 339 U.S. 629, 633 (1950) (holding that separate law school created for blacks to avoid integration failed to provide "substantial equality").

78. 347 U.S. 483 (1954).

79. 347 U.S. 475 (1954).

retreated from *Brown*'s equality promise in *Washington v. Davis*.⁸⁰ *Davis* began the "Post-Civil Rights Era" by introducing the purposeful intent requirement, which operates to deny efforts to reverse systemic racial inequality unless plaintiffs show the defendant's discrimination was intentional.⁸¹ I distinguish what I call the "Post-Civil Rights Era," which lasted from *Washington v. Davis* in 1976 to 2001, from the "Sandoval Era," which began when the Court departed from precedent that had established a private cause of action in disparate impact cases. The *Sandoval* Era was ushered in by *Alexander v. Sandoval*⁸² in 2001 and continues through to the present day. During these five periods, the nation's courts, legislatures, and local governments waxed and waned in the extent to which the prohibition against legalized discrimination was enforced. And the health of minority communities vis-à-vis white communities also rose and fell over these five periods.

The first era followed the abolition of slavery, reached a zenith with the ratification of the Fourteenth Amendment in July 1868, and marked a paradigm shift toward enforcing racial equality. It was during this period when Congress enacted a flurry of Civil Rights Acts in 1870,⁸³ 1871,⁸⁴ and 1875.⁸⁵ During the brief twelve-year period that marked Reconstruction, the federal government attempted to vigorously enforce the Constitution's Reconstruction amendments and congressional legislation, and pursued equality among the races under the law. Yet, by 1883, the United States Supreme Court had reversed congressional efforts to ensure that states would uphold equal rights for African-Americans and instead acquiesced to the segregationist interpretation that constitutional equality did not mean social equality. In the *Civil Rights Cases*, the Supreme Court interpreted the Fourteenth Amendment to allow racial segregation and discrimination by private actors.⁸⁶ In those cases, even a dissenting Justice John Marshall Harlan could not help but reveal that the Court's equal protection interpretation did not presume black Americans were of equal value to whites. Instead, he quoted cases with approbation that described whites as the "superior race."⁸⁷ Similarly, in 1896, when, in *Plessy v. Ferguson*, the Supreme Court upheld the constitutionality of state laws that enforced racial segregation in public spaces, Justice Harlan preceded his declaration that "[o]ur Constitution is color-blind" with this reminder of the Court's, and indeed society's, presumption of racial inequality:

80. 426 U.S. 229 (1976).

81. *See, e.g.*, *McCleskey v. Kemp*, 481 U.S. 279 (1987) (approving Georgia death penalty process where the rate of sentencing in a white-victim case was shown to be 120% greater than in a black-victim case).

82. 532 U.S. 275 (2001).

83. *See* Civil Rights Act of 1870, Pub. L. No. 41-114, 16 Stat. 140.

84. *See* Civil Rights Acts of 1871, Pub. L. No. 41-99, 16 Stat. 433; Civil Rights Act of 1871, Pub. L. No. 42-22, 17 Stat. 13.

85. *See* Civil Rights Act of 1875, ch. 114, 18 Stat. 335.

86. *See* 109 U.S. 3, 11-12 (1883).

87. *Id.* at 49 (Harlan, J., dissenting) (internal quotation marks omitted).

The white race deems itself to be the dominant race in this country. And so it is, in prestige, in achievements, in education, in wealth and in power. So, I doubt not, it will continue to be for all time, if it remains true to its great heritage, and holds fast to the principles of constitutional liberty.⁸⁸

By declaring the Constitution of the United States powerless to put the “inferior” colored race on the same social plane as the white race, the *Plessy v. Ferguson* Court halted all progress toward racial equality and ended the Reconstruction Era in 1896.

The *Plessy* decision began the Jim Crow Era. This was a period of segregation using Jim Crow laws to reassert white supremacy and institutionalize racial inequality throughout all societal domains. Thus, during this second era, lasting from 1877 to 1954, legal segregation enabled an American version of apartheid. At the heart of this era was a collective belief that blacks were inferior beings. During this period, President Woodrow Wilson declared that “[r]econstruction was nothing more than a host of dusky children untimely put out of school”⁸⁹ and a period when “the dominance of an ignorant and inferior race was justly dreaded.”⁹⁰ State legislatures throughout the nation enacted “Jim Crow”⁹¹ laws, promulgated to physically separate whites from blacks in places of education,⁹² recreation,⁹³ transportation,⁹⁴ and public accommodations.⁹⁵ “Separate but equal” meant anything but equality for African-Americans, who were deemed legally unfit to mingle with whites in

88. *Plessy v. Ferguson*, 163 U.S. 537, 559 (1896) (Harlan, J., dissenting).

89. Kenneth O’Reilly, *The Jim Crow Policies of Woodrow Wilson*, 17 J. BLACKS HIGHER EDUC. 117, 117 (1997).

90. Michael Dennis, *Looking Backward: Woodrow Wilson, the New South, and the Question of Race*, 3 AM. NINETEENTH CENTURY HIST. 77, 82 (2002) (internal quotation marks omitted) (emphasis omitted) (noting Wilson’s views that black voting was politically illegitimate, restoration of southern white control by “real citizens” was desirable, and Reconstruction was a “tragic era”); see also BERNARD M. BARUCH, WAR INDUS. BD., AMERICAN INDUSTRY IN THE WAR: A REPORT OF THE WAR INDUSTRIES BOARD (1921) (also quoting Wilson as saying Reconstruction was a period when “the dominance of an ignorant and inferior race was justly dreaded”); John S. Ezell, *Woodrow Wilson as Southerner, 1856–1885: A Review Essay*, 15 CIV. WAR HIST. 160, 162 (1969).

91. See MICHAEL J. KLARMAN, FROM JIM CROW TO CIVIL RIGHTS: THE SUPREME COURT AND THE STRUGGLE FOR RACIAL EQUALITY (2004) (discussing the “Jim Crow” laws, which were statutes enforcing segregation).

92. See, e.g., *Griffin v. Cty. Sch. Bd. of Prince Edward Cty.*, 377 U.S. 218, 232 (1964) (reversing Virginia Supreme Court’s approval of public funds to support private schools opened in resistance to desegregation of public schools).

93. See, e.g., *Brown v. City of Richmond*, 132 S.E.2d 495, 495–96, 501 (Va. 1963) (reversing lower court decree upholding Virginia statutes segregating baseball fields and theaters).

94. See, e.g., VA. CODE ANN. § 4097(z)–4097(dd) (1942); *Morgan v. Commonwealth*, 34 S.E.2d 491, 497 (Va. 1945) (upholding constitutionality of Virginia statute segregating public motor carrier passengers by race), *rev’d*, 328 U.S. 373, 386 (1946).

95. See, e.g., *Randolph v. Commonwealth*, 119 S.E.2d 817, 820 820 (Va. 1961) (holding that refusal to serve Negro in restaurant and subsequent arrest did not violate Constitution), *vacated*, 374 U.S. 97 (1961).

matrimony,⁹⁶ in medicine,⁹⁷ or even after death.⁹⁸

In 1954, *Brown v. Board of Education* and *Hernandez v. Texas* returned the nation's jurisprudence to an era of striving toward racial equality, introducing the third era—the Civil Rights Era—which extended approximately twenty-two years. In the *Brown* decision, the Supreme Court articulated a commitment to the equality principle, holding “that in the field of public education the doctrine of ‘separate but equal’ has no place. Separate educational facilities are inherently unequal.”⁹⁹ Landmark Supreme Court decisions followed, such as *Garner v. Louisiana*,¹⁰⁰ *McLaughlin v. Florida*,¹⁰¹ and *Loving v. Virginia*,¹⁰² that established a presumptive rule against racial classifications and set the tone for state courts to prohibit racial inequality. Congress enacted a series of civil rights laws including the Civil Rights Act of 1964,¹⁰³ the Voting Rights Act of 1965,¹⁰⁴ and the Fair Housing Act of 1968¹⁰⁵ to once again pursue the national ideal of racial equality as embedded in the Constitution. During the Civil Rights Era, equal protection was interpreted to impose an affirmative duty on governments to transform institutions steeped in discriminatory practices and guarantee the removal of roadblocks to equality. This accounted for significant progress toward the equality ideal. But by 1976, the Court's view of Equal Protection again retreated from a plain understanding of equality.

Washington v. Davis introduced the Post-Civil Rights Era, when the Supreme Court rejected the notion that the Fourteenth Amendment imposes an affirmative duty of government to ensure racial equality, and instead viewed the Amendment as a mere prohibition against deliberate state acts of intentional discrimination.¹⁰⁶ The resulting discriminatory intent doctrine meant that equal protection challengers would only prevail if they could demonstrate that a state action intended to discriminate.¹⁰⁷ Once again, using the appealing sound of a “colorblind constitution,” the law became an instrument to defeat rather than defend all persons' right to equal protection. Finally, the Court decided *Alexander v. Sandoval* in

96. See *Loving v. Virginia*, 388 U.S. 1, 2 (1967).

97. See generally Charles E. Wynes, *The Evolution of Jim Crow Laws in Twentieth Century Virginia*, 28 *PHYLON* 416 (1960); see also EDWARD H. BEARDSLEY, *A HISTORY OF NEGLECT: HEALTH CARE FOR BLACKS AND MILL WORKERS IN THE TWENTIETH-CENTURY SOUTH* 245 (1987) (discussing “the fight aimed at discriminatory practices in American medicine and health care,” which “had as principal targets the all-white medical society and school and the rigidly segregated Southern hospital”).

98. See, e.g., CHARLOTTESVILLE, VA., REVISED ORDINANCES, ch. 15, § 5 (1894) (reserving entire cemeteries for “exclusive[]” use “for the burial or internment of white persons,” except for limited sections “set apart for colored persons”).

99. *Brown v. Bd. of Educ.*, 347 U.S. 483, 494–95 (1954).

100. 368 U.S. 157, 174 (1961) (holding that states cannot criminally prosecute nonviolent protesters staging a sit-in to express opposition to segregation).

101. 379 U.S. 184, 184 (1964) (invalidating criminal law banning interracial cohabitation).

102. 388 U.S. 1, 12 (1967) (invalidating state miscegenation law).

103. 42 U.S.C. § 2000(d) (2012).

104. Pub. L. No. 89-110, 79 Stat. 437 (codified at 42 U.S.C. §§ 1973–1973aa-6 (2012)).

105. Pub. L. No. 90-284, Title VIII, § 801, 82 Stat. 81 (codified at 42 U.S.C. § 3601 (2012)).

106. 426 U.S. 229 (1976).

107. *Id.* at 240–41.

2001, further weakening equal protection and beginning the fifth and current era—the *Sandoval* Era.¹⁰⁸ During this era, individual litigants may not pursue a private right of action to enforce Title VI of the 1964 Civil Rights Act. The point of identifying five eras of Equal Protection Clause law is to link the real-life consequences of historically choosing to protect or disregard constitutional equality to contemporary disparate health outcomes.

I suggest two conclusions from the waxing and waning of equal protection under the law. First, the epidemic of racial inequality is driving avoidable sickness and preventable deaths in America's minority communities. Second, errant interpretations of constitutionally mandated equality are driving these inequalities by enabling increasingly inequitable access to the social determinants that allow people to live healthy lives. In the next Part, I outline areas in which anti-discrimination laws are associated with health-harming social outcomes to show that our errant equality doctrines have life-and-death consequences.

II. HOW LEGAL INEQUALITY AFFECTS HEALTH INEQUITY

The thesis set forth in this Essay is straightforward: racial inequality thrives when laws designed to limit it are not enforced. The resulting freedom to discriminate in housing, education, employment, civil, and criminal justice systems is the essence of structural racism and affects population health in three ways. First, during periods in our history when lax legal prohibition left discrimination unchecked, ethnic and racial minority communities lacked access to the basic building blocks of a healthy life. It is estimated that only ten to fifteen percent of health outcomes are determined by access to healthcare and genetic make-up of individuals respectively.¹⁰⁹ In contrast, social determinants—the environments in which people live, work, and play—are estimated to represent forty percent of the influences that determine health outcomes. Another forty percent of health outcomes are related to health behaviors that occur within a social context and are therefore also susceptible to environmental influences. To the extent that racial discrimination affects access to, and the quality of these social determinants, health outcomes for blacks relative to whites are disproportionately and adversely impacted. Second, uncontrolled discrimination not only leads to systemic and structural inequalities; these burdens disproportionately increase exposure to social stressors that produce anxiety, depression, suicide, and unhealthy behaviors. Without question, increased exposure to racial discrimination has a profoundly adverse impact on minorities' mental health.¹¹⁰ Taken together, these first two health-harming effects comprise what has been termed "structural" or "institutionalized racism."¹¹¹

108. 532 U.S. 275 (2001).

109. See Paula Braveman & Laura Gottlieb, *The Social Determinants of Health: It's Time to Consider the Causes of the Causes*, 129 PUB. HEALTH REP. 19, 20 (2014).

110. See David R. Williams & Ruth Williams-Morris, *Racism and Mental Health: The African American Experience*, 5 ETHNICITY & HEALTH 243, 251–52 (2000).

111. See David R. Williams et al., *Racism and Health: Evidence and Needed Research*, 40 ANN. REV. PUB. HEALTH 105, 106 (2019) ("Racism is an organized social system in which the dominant racial

The third harm caused by the systemic inequality associated with unchecked discrimination defies the prevailing fallacy that discrimination is only a problem for those who are discriminated against. Data and experience tell us this one-sided account is untrue. Pervasive racial discrimination harms the health of majority and minority populations. Moreover, I argue here that the health harms flowing from discriminatory inequity reach further still. Systemic racial inequality leads to societal polarization that increases isolation, stigmatization, stereotyping, fear, and resentment, all of which breed the kind of racial violence that is tragically on the rise in the United States and worldwide. These outcomes challenge the health of populations and violate the foundational notions of equality on which America's democracy depends. Several examples are instructive.

A. UNEQUAL PROTECTION FROM HOUSING DISCRIMINATION

In 1968, Congress enacted, and President Lyndon Johnson signed, the Fair Housing Act (FHA) to outlaw housing discrimination and extend legal protection to all Americans for the opportunity to enjoy equal access to housing.¹¹² The FHA made it unlawful to “discriminate against any person in the terms, conditions, or privileges of sale or rental of a dwelling, or in the provision of services or facilities in connection therewith, because of race, color, religion, sex, familial status, or national origin.”¹¹³ As a general rule, the law applies to all levels of local, state, and federal government, as well as to private defendants.¹¹⁴ Lest there be any doubt that the Act's sponsors intended to serve the equality principle in its passage, Walter Mondale, one of the FHA's original co-sponsors, wrote:

The law was Congress's effort to remedy a great historical evil: the large-scale exclusion and isolation of blacks from white communities. In the Jim Crow South, white and black citizens were kept apart to confirm and reinforce the idea of white superiority. Residential segregation accomplished the same result elsewhere, but on a much larger scale. The Fair Housing Act was intended to prevent and reverse all this. . . . It remains a bulwark for advocates of justice and equality, as they advance, inch by inch, toward a fairer, more integrated nation.¹¹⁵

group, based on an ideology of inferiority, categorizes and ranks people into social groups called ‘races’ and uses its power to devalue, disempower, and differentially allocate valued societal resources and opportunities to groups defined as inferior.”).

112. See 42 U.S.C. § 3604 (2012).

113. *Id.* § 3604(a).

114. ROBERT G. SCHWEMM, HOUSING DISCRIMINATION LAW AND LITIGATION § 12B:4 (July 2019 Update); see, e.g., *Meyer v. Holley*, 537 U.S. 280, 283 (2003) (finding that the Fair Housing Act imposed vicarious liability on corporation for unlawful acts of its employees); see also, e.g., *City of Chicago v. Matchmaker Real Estate Sales Ctr., Inc.*, 982 F.2d 1086, 1099 (7th Cir. 1992) (finding realty corporation and its sales agents liable for compensatory damages where agent consistently steered white testers toward white areas and black testers toward black areas, and denied information to black testers readily given to similarly situated white testers).

115. Walter F. Mondale, *Walter Mondale: The Civil Rights Law We Ignored*, N.Y. TIMES (Apr. 10, 2018), <https://www.nytimes.com/2018/04/10/opinion/walter-mondale-fair-housing-act.html>.

In short, the law sought to replace segregation inspired by white supremacy with integration as evidence of racial equality.¹¹⁶ Instead, the law faced what Mondale called fifty years of “gradual progress and frequent setbacks.”¹¹⁷ According to the bill’s author, the agency charged with enforcing the FHA remained mired in bureaucracy so that segregation was not effectively challenged under the law. A significant body of research confirms the connection between racially segregated housing and poor population health.¹¹⁸ In its recent study on health equity, the National Academy of Medicine drew attention to the adverse health effects of segregation and racial disparities.¹¹⁹ Minorities living in cities with higher rates of residential segregation¹²⁰ experience higher infant mortality rates,¹²¹ lower birth weights,¹²² shorter life expectancy,¹²³ poorer mental health,¹²⁴ more coronary heart disease,¹²⁵ and greater prevalence of infectious diseases such as tuberculosis,¹²⁶ even after controlling for poverty.¹²⁷

Two reasons are commonly cited: first, residential segregation increases exposure to health hazards such as air pollution;¹²⁸ and second, segregation decreases access to health-related resources. For example, segregation is associated with inferior access to healthcare providers; lower quality pharmacies; clinicians with inferior training;¹²⁹ and hospitals with worse outcomes, older physical plants, and less medical equipment.¹³⁰ The association between racial isolation and poor health also affects affluent minority families, not just low-income minorities,

116. *Id.*

117. *Id.*

118. See Jing Fang et al., *Residential Segregation and Mortality in New York City*, 47 SOC. SCI. & MED. 469, 474 (1998); David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 407–08 (2011).

119. See JAMES N. WEINSTEIN ET AL., COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 8 (2017).

120. See Douglas S. Massey, *Residential Segregation Is the Linchpin of Racial Stratification*, 15 CITY & COMMUNITY 4, 6 (2016).

121. See Thomas A. LaVeist, *Segregation, Poverty, and Empowerment: Health Consequences for African Americans*, 71 MILBANK Q. 41, 42–43 (1993).

122. See Sue C. Grady, *Racial Disparities in Low Birthweight and the Contribution of Residential Segregation: A Multilevel Analysis*, 63 SOC. SCI. & MED. 3013, 3014, 3026 (2006).

123. See Thomas A. LaVeist, *Racial Segregation and Longevity Among African Americans: An Individual-Level Analysis*, 38 HEALTH SERVS. RES. 1719, 1719 (2003).

124. See Carol S. Aneshensel & Clea A. Sucoff, *The Neighborhood Context of Adolescent Mental Health*, 37 J. HEALTH & SOC. BEHAV. 293, 305 (1996).

125. See Ana V. Diez Roux et al., *Neighborhood of Residence and Incidence of Coronary Heart Disease*, 345 NEW ENG. J. MED. 99, 103 (2001).

126. See Dolores Acevedo-Garcia, *Residential Segregation and the Epidemiology of Infectious Diseases*, 51 SOC. SCI. & MED. 1143, 1144 (2000).

127. See Michael R. Kramer & Carol R. Hogue, *Is Segregation Bad for Your Health?*, 31 EPIDEMIOLOGIC REV. 178, 189 (2004).

128. See Rachel Morello-Frosch & Bill M. Jesdale, *Separate and Unequal: Residential Segregation and Estimated Cancer Risks Associated with Ambient Air Toxins in U.S. Metropolitan Areas*, 114 ENVTL. HEALTH PERSP. 386, 392 (2006).

129. See Peter B. Bach et al., *Primary Care Physicians Who Treat Blacks and Whites*, 351 NEW ENG. J. MED. 575, 579 (2004).

130. See Jonathan Skinner et al., *Mortality After Acute Myocardial Infarction in Hospitals That Disproportionately Treat Black Patients*, 112 CIRCULATION 2634, 2639 (2005).

more frequently than white families. This is because black and Latinx households are, on average, located in neighborhoods where poverty and segregation rates are significantly higher than white households, regardless of the family's socioeconomic status.¹³¹

The public health issues in housing have long been exacerbated by the significant extent to which illegal discrimination is either practiced or ignored by state and local governments, and even the federal government, which is obligated to enforce the Equal Protection Clause. The historic record of the U.S. federal government's discriminatory housing policies, beginning during Reconstruction and continuing during the New Deal Era, World War II, and the post-Civil Rights urban renewal is well known.¹³² Familiar too are the wholesale displacements of minority communities as a result of both urban renewal during the latter half of the twentieth century and the inaptly named process of "gentrification" that continues to this day. Researchers also distinguish between exclusionary discrimination intended to prevent minorities from obtaining housing and nonexclusionary discrimination that occurs when landlords, neighbors, or real estate agents harass and mistreat minority tenants and homeowners who have already obtained housing.¹³³ During the first half of the twentieth century, discriminatory federal lending practices and destructive displacement from urban areas sought to remove minority residents from communities where they were unwelcome. This is exclusionary discrimination. Later in the twentieth and twenty-first centuries, minority families felt the effects of "gentrification," aggressive evictions, and foreclosures that most often resulted from nonexclusionary discrimination.

Private racial discrimination against blacks, and to a slightly lesser extent the Latinx community, has been declining over the last thirty-five years but continues to represent a significant factor in preserving residential segregation in America. Studies show that racial harassment and opposition by homeowner and tenant associations, steering by real estate agents, and discriminatory banking practices persist, all in violation of antidiscrimination laws.¹³⁴ A 2012 National Audit Study used in-person paired and Internet correspondence testing to compare

131. See Sean F. Reardon et al., *Neighborhood Income Composition by Household Race and Income, 1990–2009*, 660 ANNALS AM. ACAD. 78, 94 (2015).

132. See generally RICHARD ROTHSTEIN, *THE COLOR OF LAW: A FORGOTTEN HISTORY OF HOW OUR GOVERNMENT SEGREGATED AMERICA* (2017) (outlining the system of racially explicit federal laws, regulations, and government practices that were consistently employed throughout the twentieth century to enforce residential racial segregation).

133. See Vincent Roscigno et al., *The Complexities and Processes of Racial Housing Discrimination*, 56 SOC. PROBS. 49, 49 (2009).

134. See, e.g., Vincent J. Roscigno, Diana L. Karfin & Griff Tester, *The Complexities and Processes of Racial Housing Discrimination*, 56 SOC. PROBS. 49 (2009); Anne-Marie G. Harris, Geraldine R. Henderson & Jerome D. Williams, *Courting Customers: Assessing Consumer Racial Profiling and Other Marketplace Discrimination*, 24 J. PUB. POL'Y & MARKETING 163 (2005); Samantha Friedman, *Commentary: Housing Discrimination Research in the 21st Century*, 17 CITYSCAPE: J. POL'Y DEV. & RES. 143 (2015).

discriminatory sales and rental practices.¹³⁵ The study found that white home-buyers were shown nine percent more available houses than equally qualified black home-buyers.¹³⁶ White home-seekers were told about more available units in 13.4% of inquiries than black home-seekers.¹³⁷ In the rental market, white renters experienced more favorable treatment than equally qualified black and Latinx renters in 28.4% and 28.9% of inquires respectively, while white renters were treated less favorably in 19.6% and 18.9% of inquiries respectively.¹³⁸ Social media has also proved a fertile ground for discriminatory housing practices. For example, ProPublica found in 2016 and 2017 that Facebook permits housing advertisers to exclude ads from being seen by selected racial groups and to exclude anyone with an “affinity” for blacks, Latinx, or Asians from viewing the ad.¹³⁹ It is true that in recent decades, the extent of residential segregation by race has declined. But the decline has been modest and from a high starting point. Black Americans are much more segregated in U.S. metro areas than in those in other nations.¹⁴⁰

More than half of the black or white residents of some of the largest U.S. metro areas would have to move to a different census tract in order to fully integrate those cities.¹⁴¹ White Americans are also more segregated from black Americans than from either Asian or Latinx Americans.¹⁴² Importantly, some researchers have demonstrated that poverty confounds the relationship between segregated housing and poor health. Dr. Thomas A. LaVeist found that concentrated poverty, which characterizes segregated neighborhoods, is a more influential risk factor for poor self-reported health than race alone.¹⁴³ LaVeist’s results suggest that segregated populations experience poor health because they are impoverished rather than because of their race. However, Dr. Kiarri Kershaw showed that race differences in hypertension rates were largest in segregated, high-poverty areas, and

135. See Sun Jung Oh & John Yinger, *What Have We Learned from Paired Testing in Housing Markets?*, 17 CITYSCAPE 15 (2015).

136. See *id.* at 25.

137. See *id.* at 23.

138. See *id.*

139. See Julia Angwin & Terry Parris Jr., *Facebook Lets Advertisers Exclude Users by Race*, PROPUBLICA (Oct. 28, 2016, 1:00 PM), <https://www.propublica.org/article/facebook-lets-advertisers-exclude-users-by-race#> [<https://perma.cc/HR4S-MA2D>].

140. See JOHN ICELAND, RESIDENTIAL SEGREGATION: TRANSATLANTIC ANALYSIS 6 (2014) <http://www.migrationpolicy.org/research/residential-segregation-transatlantic-analysis> [<https://perma.cc/3Z3X-7DKB>].

141. See Tara Bahrapour, *Large Cities Still Segregated Even as Nation Becoming More Diverse*, WASH. POST (Dec. 6, 2018, 7:00 AM), https://www.washingtonpost.com/local/social-issues/large-cities-still-segregated-even-as-nation-becoming-more-diverse/2018/12/06/4d7e98b2-f8d8-11e8-863c-9e2f864d47e7_story.html.

142. See WILLIAM H. FREY, BROOKINGS INSTITUTION AND UNIVERSITY OF MICHIGAN SOCIAL SCIENCE DATA ANALYSIS NETWORK’S ANALYSIS OF 1990, 2000, AND 2010 CENSUS DECENNIAL CENSUS TRACT DATA (2001) https://www.brookings.edu/wp-content/uploads/2016/06/0406_census_diversity_frey.pdf [<https://perma.cc/348H-G5RE>].

143. See THOMAS A. LAVEIST ET AL., SEGREGATED SPACES, RISKY PLACES: THE EFFECTS OF RACIAL SEGREGATION ON HEALTH INEQUALITIES (2011), <https://perma.cc/W76P-UHVB>.

smallest in integrated (i.e. nonsegregated), high-poverty areas.¹⁴⁴ In sum, although poverty explains some but not all of the association between segregated housing and poor health, families who live in housing that is both racially isolated and located in high-poverty communities could benefit from increased social spending to improve health and housing. Discrimination in housing that concentrates minority communities further affects health disparities by overburdening these communities with neighborhood-level health risks, which also thrive when antidiscrimination laws are not enforced.

B. UNEQUAL PROTECTION FROM POLLUTION

Racial discrimination in housing concentrates minority populations in geographic spaces that are structurally harmful to health. This is called the “built environment” threat to minority health.¹⁴⁵ It means simply that the physical features of a neighborhood can directly and adversely impact a community’s health. An important example is concentrated exposure to environmental pollutants¹⁴⁶ that disproportionately harms the health of residents in black communities as compared to white communities.¹⁴⁷ Black Americans are significantly more likely to live within a mile of a polluting facility.¹⁴⁸ Black children are more likely than white children to attend schools located near polluting facilities¹⁴⁹ resulting in poorer student health and academic performance.¹⁵⁰ 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.¹⁵¹

144. See Kiarri N. Kershaw et al., *Metropolitan-Level Racial Residential Segregation and Black-White Disparities in Hypertension*, 174 AM. J. EPIDEMIOLOGY 537, 540 (2011). Kershaw’s results reflect the fact that increased segregation and poverty had differing impacts on white and black health outcomes. More whites had hypertension in less segregated areas, but the reverse was true for blacks. Whites experienced greater hypertension in areas of greater poverty, while blacks had no similar association.

145. See, e.g., Penny Gordon-Larsen, *Inequality in the Built Environment Underlies Key Health Disparities in Physical Activity and Obesity*, 117 PEDIATRICS 417, 418, 421–22 (2006).

146. See Liam Downey & Brian Hawkins, *Race, Income, and Environmental Inequality in the United States*, 51 SOC. PERSP. 759, 760 (2008).

147. See *id.* at 775; Gilbert C. Gee & Devon C. Payne-Sturges, *Environmental Health Disparities: A Framework Integrating Psychosocial and Environmental Concepts*, 112 ENVTL. HEALTH PERSP. 1645, 1645 (2004).

148. See 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, S649 (2009).

149. See Robert Bullard, *New Report Tracks Environmental Justice Movement Over Five Decades*, DR. ROBERT BULLARD (Feb. 9, 2014), <https://drrobertbullard.com/new-report-tracks-environmental-justice-movement-over-five-decades/> [https://perma.cc/4LHZ-ABXY].

150. See Paul Mohai et al., *Air Pollution Around Schools Is Linked to Poorer Student Health and Academic Performance*, 30 HEALTH AFF. 852, 858 (2011).

151. See ROBERT D. BULLARD, *DUMPING IN DIXIE: RACE, CLASS, AND ENVIRONMENTAL QUALITY* (3d ed. 2000).

Title VI of the Civil Rights Act of 1964 ostensibly provides the government a legal weapon against the inequitable distribution of environmental pollution on minority communities. However, the administrative record of protecting minority community health from pollution is dismal. The Environmental Protection Agency (EPA) dismisses or rejects over ninety percent of Title VI complaints filed and takes an average of 350 days to determine whether it will investigate civil rights complaints.¹⁵² In addition, according to a recently released report from the U.S. Commission on Civil Rights, the EPA had not ever in its history, prior to 2017, made a formal finding of discrimination or denied or withdrawn financial assistance from a recipient.¹⁵³ In fact, on January 19, 2017, the EPA made a rare finding of environmental discrimination in a case involving a Michigan power station, but the decision came twenty-five years after the initial complaint was filed.¹⁵⁴

C. UNEQUAL PROTECTION FROM INCARCERATION

Morbidity and mortality in minority communities are adversely affected when criminal law is inequitably enforced in African-American and Latinx communities as compared to white neighborhoods. Black men and women are more likely to be arrested, charged, and convicted than whites who commit the same crimes.¹⁵⁵ Once convicted, the U.S. Sentencing Commission found that black men are given prison sentences that are nearly twenty percent longer than white men for similar crimes.¹⁵⁶ The public health impact on black communities of disparate criminal law enforcement is significant. Incarceration affects the mental and physical health of communities left behind. Family members experience increased incidence of mental illness such as depression and anxiety disorders, as well as an increased risk of poverty and homelessness.¹⁵⁷ Growing evidence documents that these health consequences are multi-generational; incarceration, for example, is associated with a thirty percent increase in infant mortality.¹⁵⁸

152. See Editorial, *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.

153. See 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, at 50 (2016), https://www.usccr.gov/pubs/2016/Statutory_Enforcement_Report2016.pdf [<https://perma.cc/GE67-PL5L>].

154. See Letter from Lilian S. Dorca, Dir., External Civil Rights Compliance Office, Office of Gen. Counsel, EPA, to Heidi Grether, Dir., Mich. Dep't of Env'tl. Quality (Jan. 19, 2017), <https://www.epa.gov/sites/production/files/2017-01/documents/final-genesee-complaint-letter-to-director-grether-1-19-2017.pdf> [<https://perma.cc/4NBJ-72FX>].

155. See David S. Abrams et al., *Do Judges Vary in Their Treatment of Race?*, 41 J. LEGAL STUD. 347, 350 (2012); Dylan Matthews, *The Black/White Marijuana Arrest Gap, in Nine Charts*, WASH. POST (June 4, 2013, 12:41 PM), <https://www.washingtonpost.com/news/wonk/wp/2013/06/04/the-black-white-marijuana-arrest-gap-in-nine-charts/>.

156. See Joe Palazzolo, *Racial Gap in Men's Sentencing*, WALL ST. J. (Feb. 14, 2013, 5:36 PM), <http://www.wsj.com/articles/SB10001424127887324432004578304463789858002>.

157. See Editorial, *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>.

158. See Christopher Wildeman, *Imprisonment and (Inequality In) Population Health*, 41 SOC. SCI. RES. 74, 84 (2012).

Incarcerated populations are also at greater risk for transmission of infectious disease such as tuberculosis, viral hepatitis, and sexually transmitted diseases.¹⁵⁹ Moreover, the prevalence of mental illness and injection drug use among incarcerated populations is significantly higher than in the communities at large.¹⁶⁰ 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.¹⁶¹ Because blacks outnumber whites in U.S. prisons, the public health harms associated with imprisonment are disproportionately visited on black communities and represent a formidable cause of health disparities.

Disproportionality in arrests, sentencing, plea-bargaining, and overall incarceration violates the equality principle because the incidence of criminal behavior—especially for nonviolent drug offenses—does not differ in proportion to criminal justice involvement by race. In a 2000 study, Jamie Fellner wrote:

It is difficult to assess the extent to which racial bias or sheer indifference to the fate of black communities has contributed to the development and persistence of the nation's punitive anti-drug strategies. . . . Cocaine use by white Americans in all social classes increased in the late 1970s and early 1980s, but it did not engender the "orgy of media and political attention" that catalyzed the war on drugs in the mid-1980s when smokable cocaine in the form of crack spread throughout low income minority neighborhoods that were already seen as dangerous and threatening. Even though far more whites used both powder cocaine and crack cocaine than blacks, the image of the drug offender that has dominated media stories is a black man slouching in an alleyway, not a white man in his home.¹⁶²

At every stage of the criminal justice system—including stops, searches, arrests, pleas, jury selection, sentencing, and incarceration—empirical evidence supports the conclusion that similarly situated people of different races are not treated equally in this country. For example, Gelman, Fagan, and Kiss analyzed the racially disparate impact of policing practices in New York City to find that members of minority racial groups were stopped more often than whites, in comparison to the overall population, and in comparison, to their estimated rates of

159. See Sandra Galeo, *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/> [<https://perma.cc/C48G-5F78>].

160. See *id.*

161. See *id.*

162. JAMIE FELLNER, HUMAN RIGHTS WATCH, PUNISHMENT AND PREJUDICE: RACIAL DISPARITIES IN THE WAR ON DRUGS (2000) (footnotes omitted), <https://www.hrw.org/reports/2000/usa/> [<https://perma.cc/L5HX-ET4V>].

engaging in criminal behavior.¹⁶³ In fact, evidence supports the conclusion that minority motorists are disproportionately stopped by police and that, once stopped, black and LatinX motorists are more likely to be searched and arrested by police.¹⁶⁴ This is the phenomenon African-American communities call “Driving While Black.” In a 2015 study of records from over 300 trials over a ten-year period, researchers found that a Louisiana District Attorney used peremptory challenges to strike prospective black jurors more than three times as often as they used peremptory challenges against white prospective jurors for felony jury trials.¹⁶⁵ The District Attorney’s office struck black jurors forty-six percent of the time, but white jurors fifteen percent of the time.¹⁶⁶ In 1987, the Supreme Court in *McCleskey v. Kemp* upheld a death sentence and ignored the great weight of statistical evidence showing the sentence had been infected by pervasive racial discrimination throughout Georgia’s criminal justice system.¹⁶⁷ Since then, the courts have approved racial discrimination in criminal justice, constitutionalizing violations of the Equal Protection Clause. David Rudovsky explains:

The Supreme Court has placed significant obstacles to the pursuit of racial justice and equality in the criminal justice system. These decisions have operated on two levels. First, as a procedural matter, the decisions have made it very difficult and, in some case, impossible to obtain judicial review of challenged practices. . . . Second, the Supreme Court’s decisions have established substantive constitutional standards that fail to address racial bias and other documented unfair practices in the criminal justice system.¹⁶⁸

The health data reveal that the absence of legal equality is a proximate cause of health disparities by race and ethnicity in America.

D. UNEQUAL ACCESS TO EDUCATION

Neighborhood schools are the most obvious way in which geography matters for black and LatinX children’s life chances. But there is considerable evidence that educational disparities can have a deleterious effect on minorities’ health outcomes.¹⁶⁹ The exact extent of the impact and the direction of causation remain

163. Andrew Gelman, Jeffrey Fagan & Alex Kiss, *An Analysis of the New York City Police Department’s “Stop-and-Frisk” Policy in the Context of Claims of Racial Bias*, 102 J. AM. STAT. ASS’N 813 (2007).

164. *Id.* at 814.

165. See Ursula Noye, *Blackstrikes: A Study of the Racially Disparate Use of Peremptory Challenges by the Caddo Parish District Attorney’s Office* (Aug. 2005) (unpublished manuscript), <https://doksi.net/get.php?lid=29391> [<https://perma.cc/JLB2-JMLZ>].

166. See *id.* (manuscript at 8).

167. 481 U.S. 279, 292 (1987).

168. David Rudovsky, *Litigating Civil Rights Cases to Reform Racially Biased Criminal Justice Practices*, 39 COLUM. HUM. RTS. L. REV. 97–98 (2007) (footnotes omitted).

169. See Zimmerman, Woolf & Haley, *supra* note 13, at 348.

issues for further empirical study. This section is dedicated to outlining the evidence that discrimination in education withholds one of the most important social determinants of health: education.

Education has been widely recognized as an important function of government, a public good to which children are entitled access. Many developmental and social skills gleaned from education are critical for health, and the benefits of education in health are experienced at the individual level and more broadly in population health measures.¹⁷⁰ Education is intimately related to other community characteristics that have implications for health, from neighborhood context and housing segregation to access to economic resources and opportunities.¹⁷¹ Health literacy¹⁷² and stress exposure¹⁷³ are examples of the more direct effects education can have on health. With the understanding that education is an important social determinant of health, this section will argue that inequity in education contributes to inequity in health, and that educational inequity is the result of state action and law.

Despite the importance of education as a social determinant of health, public schooling remains highly segregated,¹⁷⁴ and this in turn leads to gross racial health disparities. Minority children still face educational discrimination in a variety of forms. The racial segregation of public schooling means that inequitable school funding results in racial disparities in educational resources. Localized school funding streams exacerbate these educational divides. In twenty-three states, according to 2012 data, richer school districts get more state and local funding than poor districts.¹⁷⁵ Federal funding helps bring most of these states to parity, but as former Education Secretary Arne Duncan noted, the “point of [the federal] money was to supplement [rather than equalize funding], recognizing that poor children . . . come to school with additional challenges.”¹⁷⁶ “What it says very clearly,” he told the *Washington Post*, “is that we have, in many places, school systems that are separate and unequal.”¹⁷⁷ Evidence also shows that racial minorities are often subject to disproportionate disciplinary action and are exposed to disproportionate violence while in school.¹⁷⁸ Resources and

170. See Robert A. Hahn & Benedict I. Truman, *Education Improves Public Health and Promotes Health Equity*, 45 INT’L J. HEALTH SERVS. 657, 659–60, 671 (2015).

171. See Zimmerman, Woolf & Haley, *supra* note 13, at 353, 358.

172. See *id.* at 353.

173. See *id.* at 413.

174. See Keith Meatto, *Still Separate, Still Unequal: Teaching About School Segregation and Educational Inequality*, N.Y. TIMES (May 2, 2019), <https://www.nytimes.com/2019/05/02/learning/lesson-plans/still-separate-still-unequal-teaching-about-school-segregation-and-educational-inequality.html>.

175. Emma Brown, *In 23 States, Richer School Districts Get More Local Funding than Poorer Districts*, WASH. POST (Mar. 12, 2015, 8:00 AM), <https://www.washingtonpost.com/news/local/wp/2015/03/12/in-23-states-richer-school-districts-get-more-local-funding-than-poorer-districts/>.

176. *Id.*

177. *Id.*

178. See Kathy Sanders-Phillips, *Racial Discrimination: A Continuum of Violence Exposure for Children of Color*, 12 CLINICAL CHILD & FAM. PSYCHOL. REV. 174, 180 (2009); David Simson,

environment are critical factors in determining the quality of a child's education, and disparities in access to quality educational opportunities still have strikingly harmful effects on racial minorities. Discrimination in education directly translates to higher health risks for vulnerable populations.

Indeed, educational inequity in America has been constructed and mediated by law, in clear violation of the Fourteenth Amendment's Equal Protection guarantee. Even though *Brown* was decided in 1954, desegregation of schools did not begin in earnest until a decade later, when the Court ruled that closing public schools for the purpose of denying black children an education violated the Equal Protection Clause.¹⁷⁹ The Civil Rights Act of 1964 and *Griffin v. County School Board* brought the beginnings of progress, but the desegregation of schools that followed was short-lived. Soon thereafter, the Supreme Court began to systematically dismantle equal protection against discrimination in education when it decided that multi-district desegregation remedies were unconstitutional,¹⁸⁰ and that desegregation plans could be abandoned after a "reasonable period of time," even where schools were still segregated.¹⁸¹ Legal scholar Erwin Chemerinsky points to a number of key Supreme Court decisions in the 1970s and 1990s that led to the "re-segregation" of schools.¹⁸² Chemerinsky traces the Supreme Court's role in re-segregating American public schools, and argues the Court neutralized the considerable gains in school desegregation that had been achieved despite massive resistance.¹⁸³

In the time since *Brown*, the law has repeatedly failed in its constitutional duty to guarantee equal protection in education. Desegregation was slow and incomplete, and Supreme Court decisions allowed re-segregation to occur with little regard for the unequal educational outcomes that followed. Inequities in education lead to inequities in health, and the law must protect vulnerable populations against the harms of segregated schooling.

The U.S. Constitution codifies the equality principle in the Fourteenth Amendment's Equal Protection Clause. This Amendment, as well as the statutes and regulations that operationalize it, should be potent and primary weapons against the institutionalized inequality that I have shown is associated with the primary social determinants of health. The Fourteenth Amendment to the Constitution prohibits any state from denying to any person within its jurisdiction the equal protection of the laws. And yet, states regularly deny equal protection of the laws to persons who are not white or wealthy, and this systemic discrimination

Exclusion, Punishment, Racism and Our Schools: A Critical Race Theory Perspective on School Discipline, 61 UCLA L. REV. 506, 509 (2014).

179. See *Griffin v. Cty. Sch. Bd. of Prince Edward Cty.*, 377 U.S. 218, 225 (1964); see also *Brown v. Bd. of Educ.*, 349 U.S. 294, 301 (1955) (ordering the desegregation of public schools to take place with "all deliberate speed").

180. See *Milliken v. Bradley*, 418 U.S. 717, 745 (1974).

181. *Bd. of Educ. v. Dowell*, 498 U.S. 237, 248 (1991).

182. Erwin Chemerinsky, *The Segregation and Resegregation of American Public Education: The Courts' Role*, 81 N.C. L. Rev. 1597, 1600 (2003).

183. *Id.* at 1603.

produces structural inequities. Discrimination in housing, education, environmental pollution, and law enforcement cumulatively erect structural barriers to an equal opportunity to achieve good health. Therefore, whenever constitutional prohibitions against discrimination are ignored, structural inequities are institutionalized and result in unequal health outcomes. In contrast, whenever our legal institutions strengthen constitutional protections of equality, specifically within the social determinants, health disparities decrease. In 2010, Congress enacted the Patient Protection and Affordable Care Act—the “Affordable Care Act” for short—in an effort to equalize access to healthcare. The Act also contained provisions to introduce some flexibility to also equalize access to social determinants. The next Part of this Essay reviews the 2010 Act’s impact on the direct relationship between social inequality and population health.

III. THE AFFORDABLE CARE ACT AND EQUALITY

On March 30, 2010, the Affordable Care Act (ACA) was signed into law. Despite seventy-one attempts at legislative repeal, and numerous constitutional threats, the ACA continues to endure. Furthermore, the evidence suggests the law has had a modestly positive impact on reducing inequality. This Part begins by summarizing the egalitarian impact the Affordable Care Act has had on public health. Then it suggests specific steps that could be taken, strengthening the ACA, to further advance the equality principle in health outcomes throughout the United States.

A. REDUCTION IN DISPARITIES SINCE THE AFFORDABLE CARE ACT

The ACA has increased access to health-insurance coverage for at-risk populations. Studies from late 2018 through June 2019 find that the ACA increased access to health-insurance coverage across the board, but more specifically among minority populations who had suffered disproportionate exclusion from the healthcare insurance market.¹⁸⁴ Since its passage, the ACA has registered large reductions in uninsured rates—the percentage of nonelderly adults lacking health insurance fell from 16.8% in 2013 to 10.2% in 2017, a nearly 65% drop.¹⁸⁵ All racial groups showed gains in health-insurance coverage after the passage of the ACA, but gains were especially strong for minority groups¹⁸⁶ and low-income groups below 200% of the federal poverty level.¹⁸⁷ The coverage gap between

184. See Stacey McMorro & Daniel Polsky, *Insurance Coverage and Access to Care Under the Affordable Care Act*, U. PA. LEONARD DAVIS INST. HEALTH ECON.: ISSUE BRIEF, Dec. 2016, at 1; see also Thomas C. Buchmueller et al., *Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage*, 106 AM. J. PUB. HEALTH 1416, 1416 (2016).

185. See Jennifer Tolbert et al., *Key Facts About the Uninsured Population*, KAISER FAM. FOUND. 2 fig.1 (2019), <http://files.kff.org/attachment/Issue-Brief-Key-Facts-about-the-Uninsured-Population> [<https://perma.cc/P6MB-WLU6>].

186. See Samantha Artiga et al., *Changes in Health Coverage by Race and Ethnicity Since Implementation of the ACA 2013-2017*, KAISER FAM. FOUND. 2–6 (2019), <https://perma.cc/X5M5-G8TL>.

187. See Gerald F. Kominski et al., *The Affordable Care Act’s Impacts on Access to Insurance and Health Care for Low-Income Populations*, 38 ANN. REV. PUB. HEALTH 489, 492–93 (2016).

blacks and whites declined from 4.1 percentage points between 2013 and 2016, and by 9.4 percentage points between Latinx and whites during the same period.¹⁸⁸ In 2017, gains for minority groups flattened and began increasing again among whites and blacks.¹⁸⁹ In short, the ACA reduced health-insurance coverage disparities between whites and racial and ethnic minorities in the United States. The COVID-19 crisis hit hardest in states where the ACA did not expand insurance coverage—states that rejected the Medicaid expansion. In these states, low-income populations lacked access to preventive care, heightening their risk of contracting and dying from the virus. The cost of testing and treating patients in these states was not shared by the federal government.¹⁹⁰

Evidence also indicates that the Affordable Care Act improved some quality-of-care indicators for patient outcomes. Specifically, the ACA's Medicaid expansion is associated with increases in cancer diagnosis rates, especially early-stage diagnosis rates.¹⁹¹ In addition, access to and utilization of cancer surgery has increased,¹⁹² and patients have found increased access to medication-assisted treatment for opioid-use disorder and opioid overdose.¹⁹³ Overall, the ACA's Medicaid expansion increased access to services and medications for behavioral health among the most vulnerable members of American society.¹⁹⁴ During the pandemic, the Trump Administration signed the Families First Coronavirus Response Act (FFCRA).¹⁹⁵ These funds provided by the Act directly improved the quality of care to qualifying states, for example by giving rural patients access to telemedicine and increasing support for continued opioid recovery treatment during the pandemic.¹⁹⁶

188. See Jesse C. Baumgartner et al., *How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Health Care*, COMMONWEALTH FUND (Jan. 16, 2020), <https://www.commonwealthfund.org/publications/2020/jan/how-ACA-narrowed-racial-ethnic-disparities-access> [<https://perma.cc/M8DE-MSEF>].

189. See *id.*

190. See Robin Rudowitz, *COVID-19: Expected Implication for Medicaid and State Budgets*, KAISER FAM. FOUND. (Apr. 3, 2020), <https://www.kff.org/coronavirus-policy-watch/covid-19-expected-implications-medicare-state-budgets/> [<https://perma.cc/YJ8X-PVJR>]; see also CTRS. FOR MEDICARE & MEDICAID SERVS., *COVERAGE AND BENEFITS RELATED TO COVID-19 MEDICAID AND CHIP* (2020), <https://www.cms.gov/files/document/03052020-medicare-covid-19-fact-sheet.pdf> [<https://perma.cc/79JC-USJ5>].

191. See LARISA ANTONISSE ET AL., KAISER FAMILY FOUND., *THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW* 5 (2019), <http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review> [<https://perma.cc/48UQ-78PX>].

192. See *id.*

193. See *id.*

194. See *id.*

195. Pub. L. No. 116-127, § 6008, 134 Stat. 178 (2020); see MEDICAID.GOV, *FAMILIES FIRST RESPONSE ACT—INCREASED FMAP FAQs* (2020), <https://www.medicare.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html> [<https://perma.cc/HDR6-9NFC>].

196. Pub. L. No. 115-271, § 1009, 132 Stat. 3894 (2018); see RURAL HEALTH CARE AND MEDICAID TELEHEALTH FLEXIBILITIES, AND GUIDANCE REGARDING SECTION 1009 OF THE SUBSTANCE USE-DISORDER PREVENTION THAT PROMOTES OPIOID RECOVERY AND TREATMENT (SUPPORT) FOR PATIENTS AND COMMUNITIES ACT (Pub. L. No. 115-271), CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T HEALTH & HUMAN SERVS., *ENTITLED MEDICAID SUBSTANCE USE DISORDER TREATMENT VIA*

The Affordable Care Act also contained provisions that allowed its funding to address natural disasters in regions where vulnerable populations live. For example, on February 9, 2018, the President signed into law the Bipartisan Budget Act of 2018 (BBA), which includes Medicaid disaster-relief funding for Puerto Rico and the U.S. Virgin Islands (USVI).¹⁹⁷ The BBA provides \$3.6 billion in additional Medicaid funding to Puerto Rico and approximately \$106.9 million in additional Medicaid funding to USVI from January 1, 2018, through September 30, 2019.¹⁹⁸ The law provides an additional \$1.2 billion to Puerto Rico and approximately \$35.6 million to USVI if the U.S. Department of Health and Human Services (HHS) Secretary certifies that each territory, respectively, has taken reasonable and appropriate steps to implement methods for collecting and reporting reliable data for Transformed Medicaid Statistical Information System (T-MSIS) and has demonstrated progress in establishing a Medicaid Fraud Control Unit (MFCU).¹⁹⁹

The ACA has had direct and some indirect impact on reducing health inequality. Under the ACA, racial and ethnic minorities “experienced large gains in coverage . . . that narrowed longstanding disparities.”²⁰⁰ Prior to the ACA, people of color were significantly more likely to be uninsured than whites:

In 2013, just before the major ACA coverage expansions went into effect, 44 million people or 16.8% of the total nonelderly population were uninsured. People of color were at a much higher risk of being uninsured compared to Whites, with Hispanics and American Indians and Alaska Natives (AIANs) at the highest risk of lacking coverage²⁰¹

However, the most direct impact on increasing equality could have come from the Health Care Civil Rights Act—also known as “section 1557.”

B. ENHANCING HEALTH EQUALITY UNDER SECTION 1557

The purpose of the ACA’s section 1557 was to advance health equity by prohibiting discrimination,²⁰² covering a number of different healthcare entities and

TELEHEALTH (2020), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib040220.pdf> [<https://perma.cc/AFA7-JENK>].

197. See Bipartisan Budget Act of 2018, Pub. L. No. 115-123, 132 Stat. 64.

198. *Id.* at 118.

199. *Id.* at 119.

200. See Artiga et al., *supra* note 186, at 1.

201. *Id.* at 2.

202. See DANIEL E. DAWES, 150 YEARS OF OBAMACARE (2016); Valarie K. Blake, *Civil Rights as Treatment for Health Insurance Discrimination*, 2016 WIS. L. REV. FORWARD 37, 42–44; Mary L. Heen, *Nondiscrimination in Insurance: The Next Chapter*, 49 GA. L. REV. 1, 60 (2014); Elizabeth Pendo, *Reducing Disparities Through Health Care Reform: Disability and Accessible Medical Equipment*, 2010 UTAH L. REV. 1057, 1077; Sidney D. Watson, *Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity*, 55 HOW. L.J. 855 (2012); Ruqaiyah Yearby, *Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1313 (2012); Sarah G. Steege, Note, *Finding a Cure in the Courts: A Private Right of Action for Disparate Impact in Health Care*, 16 MICH. J. RACE & L. 439, 455–59 (2011).

health-insurance products, and applying section 1557 to all healthcare entities and insurers.²⁰³ Section 1557 states that an individual (based on race, color, national origin, sex, age, or disability) shall not

be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments).²⁰⁴

Section 1557 is intentionally broad in its coverage and scope.²⁰⁵ The entities covered under section 1557 were any and all health programs and activities that receive federal financial assistance through HHS, including Medicaid, most of Medicare, student-health plans, Basic Health Program, and CHIP funds; meaningful-use payments; the advance-premium tax credit; and many other programs.²⁰⁶ The provision restored the right of individuals to bring a cause of action (COA) but also enhanced the administrative grievance and other procedures available to help make healthcare more equitable.

Arguably, the Medicaid expansion also gave new options for addressing the inequities that characterize the social determinants of health. The primary types of Medicaid waivers might have been used to infuse further equity into the American healthcare landscape.²⁰⁷ However, neither section 1557 nor Medicaid waivers have been effectively used to encourage or enforce “equal protection of the laws.” Seven states have received a section 1115 waiver to implement the Medicaid expansion, and some have experimented with reimbursing nonmedical costs. These states have the potential to influence the social determinants of health and begin to equalize access to the social determinants. For example, North Carolina and Louisiana have used Medicaid’s flexibility to invest in supportive housing.²⁰⁸ Other states have used the waivers to introduce work requirements and various levels of work requirements under supervision. When the

203. 42 U.S.C. § 18116 (2012).

204. *Id.* § 18116(a) (footnote omitted).

205. See Timothy Jost, *HHS Issues Health Equity Final Rule*, HEALTH AFF. BLOG (May 14, 2016), <https://www.healthaffairs.org/doi/10.1377/hblog20160514.054868/full> [<https://perma.cc/JA5Z-P9TJ>].

206. *See id.*

207. For example, one of the four primary types of Medicaid waivers—section 1115 Research and Demonstration Projects—creates program flexibility to test new approaches to deliver and finance integrated care. *See* 42 U.S.C. § 1315. Similarly, the section 1915(b) Managed Care Waivers allow states to create managed care entities to provide integrated care. *See id.* § 1396n.

208. *See Evaluation of the Louisiana Permanent Supportive Housing Initiative*, HUM. SERVS. RES. INST., <https://www.hsri.org/project/evaluation-of-the-louisiana-permanent-supportive-housing-initiative> [<https://perma.cc/XNT6-2H3F>] (last visited Feb. 25, 2020); *Healthy Opportunities Pilots Overview*, N.C. DEP’T HEALTH & HUM. SERVS., <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots/healthy-0> [<https://perma.cc/4SQB-WRFH>] (last visited Feb. 25, 2020).

public has been polled about the goal of work requirements, forty-two percent of Democrats and forty-five percent of independents say it is to reduce government spending by limiting the people enrolled in the program, whereas forty percent of Republicans say it is to reduce government spending and forty-two percent say it is to lift people out of poverty as proponents say.²⁰⁹ Similarly, the promise of section 1557 from an equality standpoint has yet to be realized. Enforcement under the regulation has focused on opposing gender discrimination; few actions were filed to develop the law as it pertains to race or ethnicity enforcement.²¹⁰ These examples represent yet another important missed opportunity to realize the vision and promise of the American equality principle.

When the ACA was enacted, many government reports and industry insiders believed that the ACA not only “represent[ed] the most significant federal effort to reduce disparities in the country’s history.”²¹¹ By its fifth year anniversary, a Rand Corporation study found that the law had caused the uninsured rates to drop and that the Act was working, by and large, as intended.²¹² Yet, since its enactment, challenges to section 1557 have sought to weaken the equality that the law might bring to racial and ethnic minorities. The government has proposed rules to strip notice provisions so that minorities are not apprised of their rights to challenge discrimination preventing their access to care and utilization of care. As a result, the over 66 million people in the United States who speak a language other than English at home, as well as the approximately 25 million who do not speak English “very well” and may be considered Limited English Proficiency (LEP), would be vulnerable to discrimination in direct contradiction of the law’s nondiscrimination purpose and plain language.²¹³ Another proposed

209. See Ashley Kirzinger, Bryan Wu & Mollyann Brodie, *Kaiser Health Tracking Poll-February 2018: Health Care and the 2018 Midterms, Attitudes Towards Proposed Changes to Medicaid*, KAISER FAM. FOUND. (Mar. 1, 2018), https://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2018-health-care-2018-midterms-proposed-changes-to-medicaid/?utm_campaign=KFF-2018-February-Tracking-Poll&utm_source=hs_email&utm_medium=email&utm_content=2&_hsenc=p2ANqtz-rGDvidfxe_LmfsXS2ECGWM8lypNIT-yGfrOXwFyZpdmJ9KYFpYIVGE76yoYkcMh53-gwz2Q8mHY4WyhOfvFgunDAINA [https://perma.cc/Q9E6-4SR4].

210. The HHS enforcement website has a separate section dedicated to sex discrimination cases but makes no similar mention of race discrimination enforcement. See *OCR Enforcement Under Section 1557 of the Affordable Care Act Sex Discrimination Cases*, U.S. DEP’T HEALTH & HUM. SERVS., <https://www.hhs.gov/civil-rights/for-individuals/section-1557/ocr-enforcement-section-1557-aca-sex-discrimination/index.html> [https://perma.cc/J7U9-RXUQ] (last visited Feb. 25, 2020).

211. U.S. DEP’T HEALTH & HUMAN SERVS., HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES: A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE 35 (2011), http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf [https://perma.cc/Y9LU-5SBL].

212. *The Affordable Care Act in Depth*, RAND HEALTH CARE, <https://www.rand.org/health-care/key-topics/health-policy/aca/in-depth.html> [https://perma.cc/CJ3W-2QN3] (last visited Apr. 13, 2020).

213. See *S1601, Language Spoken at Home: 2017 American Community Survey 1-Year Estimates*, U.S. CENSUS BUREAU (2017), <https://perma.cc/N23G-7SJF>.

rule would eliminate the right of private individuals and entities to file lawsuits in federal court to challenge any and all alleged violations of section 1557.²¹⁴

Eliminating this right to sue ignores the Supreme Court's determination that a private right of action is available as an enforcement mechanism for each of the civil rights statutes enforced by the Department.²¹⁵ The Supreme Court even found a private right of action in *Alexander v. Sandoval*, which HHS uses as a reason to no longer recognize a private right of individuals to file disparate impact lawsuits in federal court to challenge alleged violations of section 1557.²¹⁶ Additionally, HHS's decision ignores the conclusion of seven courts that have all reviewed section 1557 and found that it provides a private right of action.²¹⁷ HHS's proposal to eliminate provisions that recognize the right of private individuals and entities to file lawsuits in federal court to challenge alleged violations of section 1557 violates the purpose and language of section 1557. Specifically, section 1557 states that the "enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection."²¹⁸ A private right of action is available as an enforcement mechanism for each of these civil rights statutes.²¹⁹ Thus, by eliminating provisions that recognize the right of private individuals and entities to file lawsuits in federal court to challenge alleged violations of section 1557, HHS establishes section 1557 as different than every other civil rights statute referred to in the law and further weakens equal access to healthcare equity.

214. Nondiscrimination in Health and Health Education Programs or Activities, 84 Fed. Reg. 27,846, 27,883–84 (proposed June 14, 2019) (to be codified in scattered parts of 42 C.F.R.).

215. See *Gonzaga Univ. v. Doe*, 536 U.S. 273, 284 (2002) (explaining that Title VI and Title IX "create individual rights because those statutes are phrased 'with an *unmistakable focus* on the benefited class"); *Barnes v. Gorman*, 536 U.S. 181, 185 (2002) (finding that section 504 of the Rehabilitation Act is "enforceable through [a] private cause[] of action" because the statutory language of section 504 mirrors Title VI); *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001) (finding a private right of action to challenge intentional discrimination under Title VI); *Cannon v. Univ. of Chi.*, 441 U.S. 677, 717 (1979) (finding a private right of action in Title IX of the Education Amendments of 1972); see also 42 U.S.C. § 6104(e)(1) (2012) ("[A]ny interested person [may] bring[] an action in any United States district court for the district in which the defendant is found or transacts business to enjoin a violation of [the Age Discrimination Act of 1975] . . . [and that] interested person may elect, by a demand for such relief in his complaint, to recover reasonable attorney's fees, in which case the court shall award the costs of suit, including a reasonable attorney's fee, to the prevailing plaintiff.").

216. *Alexander*, 532 U.S. at 280.

217. See *Weinreb v. Xerox Bus. Servs.*, 323 F. Supp. 3d 501, 521 n.18 (S.D.N.Y. 2018); *Doe v. BlueCross BlueShield of Tenn.*, No. 2:17-cv-02793-TLP-cgc, 2018 WL 3625012, at *6 (W.D. Tenn. July 30, 2018); *Condry v. UnitedHealth Grp.*, No. 17-cv-00183-VC, 2018 WL 3203046, at *4 (N.D. Cal. June 27, 2018); *Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 737 (N.D. Ill. 2017); *York v. Wellmark, Inc.*, No. 4:16-cv-00627-RGE-CFB, 2017 WL 11261026, at *16 (S.D. Iowa Sept. 6, 2017); *Se. Pa. Transp. Auth. v. Gilead*, 102 F. Supp. 3d 688, 698 (E.D. Pa. 2015); *Rumble v. Fairview Health Serv.*, No. 14-cv-2037, 2015 WL 1197415, at *7 n.3 (D. Minn. Mar. 6, 2015).

218. 42 U.S.C. § 18116(a).

219. See 42 U.S.C. § 6104(e)(1) (establishing that the Age Discrimination Act creates a private right of action); *Gonzaga Univ.*, 536 U.S. at 284 (explaining that Title VI and Title IX create private rights of action); *Barnes*, 536 U.S. at 185 (finding that section 504 of the Rehabilitation Act creates a private right of action); *Cannon*, 441 U.S. at 717 (finding a private right of action under Title IX); *Alexander*, 532 U.S. at 280 (finding a private right of action for claims of intentional discrimination under Title VI).

CONCLUSION

The COVID-19 pandemic has robbed us of the luxury of ignoring structural inequality. More specifically, the pandemic demonstrated that structural racism threatens the health and well-being of the entire American population and economy. In the past, we could afford to leave the matter to academic debate. Some scholars take the position that the Equal Protection Clause was never intended to achieve racial equality.²²⁰ Others rely upon the debates following ratification of the Fourteenth Amendment to conclude that the originalist interpretation would have enforced equal educational opportunity as evinced during the Reconstruction Era debates.²²¹ In this Essay, I have argued that the moral and ethical underpinning of the Constitution's Equal Protection Clause, and of antidiscrimination law more generally, is an egalitarianism principle that must be used to eradicate unjust and avoidable health disparities today. I have examined the recent and compelling evidence of the deadly health impacts of the systemic discrimination that pervade the leading social determinants of health in housing, education, and criminal justice systems. I conclude that systemic racial inequality harms population health in three ways. First, discrimination disrupts access to the basic building blocks known as the social determinants of a healthy life. Social determinants of health are the conditions in which Americans live, work, and play; these are the societal causes behind the causes of health inequity. Differences in social and environmental factors account for an estimated forty percent of health outcomes. Another thirty percent of health outcomes are related to health behaviors that occur within a social context and are therefore also susceptible to environmental influences.²²² Thus, to the extent that racial discrimination affects access to and the quality of these social determinants, health outcomes for blacks and Latinos relative to whites are disproportionately and adversely impacted.

Second, discrimination that violates the equality principle of the Fourteenth Amendment leads to systemic and structural inequalities that disproportionately increase exposure to the stressors that produce anxiety, depression, suicide, and unhealthy behaviors. Taken together, these first two health-harming effects comprise what has been termed "structural inequality" or "institutionalized racism."²²³

220. See, e.g., Klarman, *supra* note 71, at 228.

221. See, e.g., McConnell, *supra* note 70, at 457.

222. See Alvin R. Tarlov, *Social Determinants of Health: The Sociobiological Translation*, in *HEALTH AND SOCIAL ORGANIZATION: TOWARD A HEALTH POLICY FOR THE 21ST CENTURY* 87–109 (David Blane et al., eds. 2002).

223. See Williams et al., *supra* note 111, at 106 ("Racism is an organized social system in which the dominant racial group, based on an ideology of inferiority, categorizes and ranks people into social groups called 'races' and uses its power to devalue, disempower, and differentially allocate valued societal resources and opportunities to groups defined as inferior.").

The third harm caused by structural inequality defies the prevailing fallacy that discrimination is only a problem for those who are discriminated against. Data and experience tell us this one-sided account is untrue. Pervasive discrimination harms the health of majority and minority populations.²²⁴ Moreover, the health harms flowing from discriminatory inequity reach further still. Systemic racial inequality leads to societal polarization that increases isolation, stigmatization, stereotyping, fear, and resentment, all of which breed the kind of racial violence that is tragically on the rise in the United States and worldwide. These outcomes challenge the health of populations and violate the foundational notions of equality on which America's democracy depends.

Despite its challenges, the Affordable Care Act must be strengthened to increase equality in access to healthcare, social determinants of health, and reduce exposure to catastrophic health outcomes that threaten us all. The Affordable Care Act has grown in the public's esteem. As of September 2019, the Kaiser Family Foundation reported that fifty-three percent of Americans had a generally favorable opinion of the ACA (climbing steadily as compared to a low in March 2014) and forty-one percent had an unfavorable opinion (steadily declining from a high in March 2014). The most unfavorably viewed provision of the Act—the individual mandate—maintained high disapproval rates, hovering at sixty-three percent until 2017 when Congress effectively eliminated it by reducing the penalty to \$0 in 2019.²²⁵ As a result, of the COVID-19 pandemic, finding a way to replace even this most unpopular provision in order to universalize healthcare coverage in the United States, might become one of our most viable equality tools of all.

This Essay begins a conversation in which legislators and policymakers may be challenged not merely to return to the “original intent” of the Constitution or its Fourteenth Amendment, but to the “original, original intent” of the Equal Protection Clause aspiration that the law would value all people as their Creator does. The Amendment was then and must today be understood to put a stop to the oppressive use of law to distinguish one group of people from another on the basis of skin color or national origin. The meaning of “equal” then and now requires that any law that operates to distinguish the life chances of one group from another be corrected. The meaning of “equal” in the Amendment must be understood to refer to essential, equal humanity of all people who in that organic

224. See Yeonjin Lee et al., *Effects of Racial Prejudice on the Health of Communities: A Multilevel Survival Analysis*, 105 AM. J. PUB. HEALTH 2349, 2355 (2015) (finding that community-level racial prejudice may reduce social capital associated with increased mortality for both blacks and whites).

225. Ashley Kirzinger, Cailey Muñana & Mollyann Brodie, *6 Charts About Public Opinion on the Affordable Care Act*, KAISER FAM. FOUND. (Nov. 27, 2019), <https://www.kff.org/health-reform/poll-finding/6-charts-about-public-opinion-on-the-affordable-care-act/> [https://perma.cc/3MDC-PX9H].

document are now to include “all who are created equal” before God. During the COVID-19 crisis, healthcare workers stood on America’s frontlines and fought for victims’ health and lives at the expense of their own. By February 2020, fifty percent of those exposed to the virus were healthcare workers.²²⁶ It is fitting that lawmakers join healthcare providers to realize this plain meaning of equality and eliminate unequal protection of the laws for the good of us all.

226. Adam L. Beckman, Suhas Gondi & Howard P. Forman, *How to Stand Behind Frontline Health Care Workers Fighting Coronavirus*, HEALTH AFF. BLOG (Mar. 18, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200316.393860/full/> [<https://perma.cc/G53H-KQC4>] (“According to data last week from the Centers for Disease Control and Prevention (CDC), 50 percent of people (222 of 445) exposed to confirmed COVID-19 cases as of February 26 were health care personnel.”).