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released report from the U.S. Commission on Civil Rights, has almost never made a finding of discrimination, denied, or withdrawn financial assistance from a recipient.[88]

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

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

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

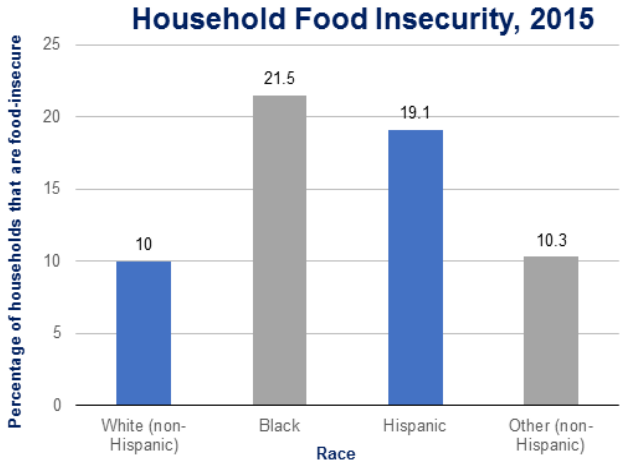
89. *See, e.g.*, Angela Hilmers et al., *Neighborhood Disparities in Access to Healthy Foods and Their Effects on Environmental Justice*, 102 AM. J. PUB. HEALTH 1644, 1649–51 (2012).

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

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

healthy food sources, exposing those populations to greater social, psychological, and physiological health risks of food insecurity.[92]

Figure 5[93]



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

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

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

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

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

that African Americans are nearly nine times more likely to experience racial discrimination at work than their white co-workers.[96]

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

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

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

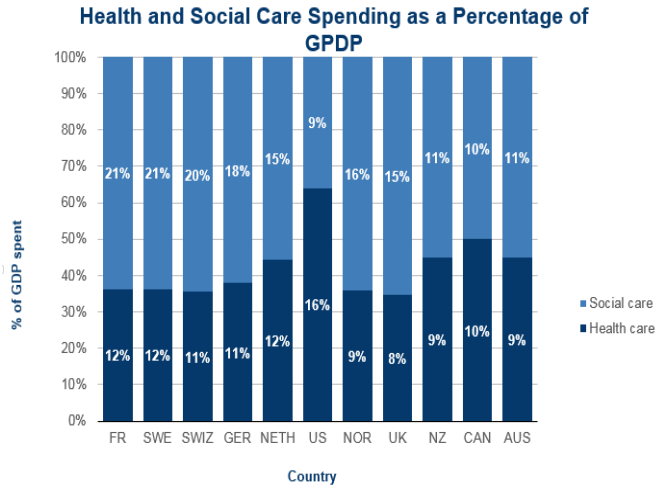
97. *See* OFFICE ON SMOKING & HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVS., PREVENTING TOBACCO USE AMONG YOUTH AND YOUNG ADULTS 8 (2012), https://www.ncbi.nlm.nih.gov/books/NBK99237/pdf/Bookshelf_NBK99237.pdf.

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

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

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

Figure 6[100]



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

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

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

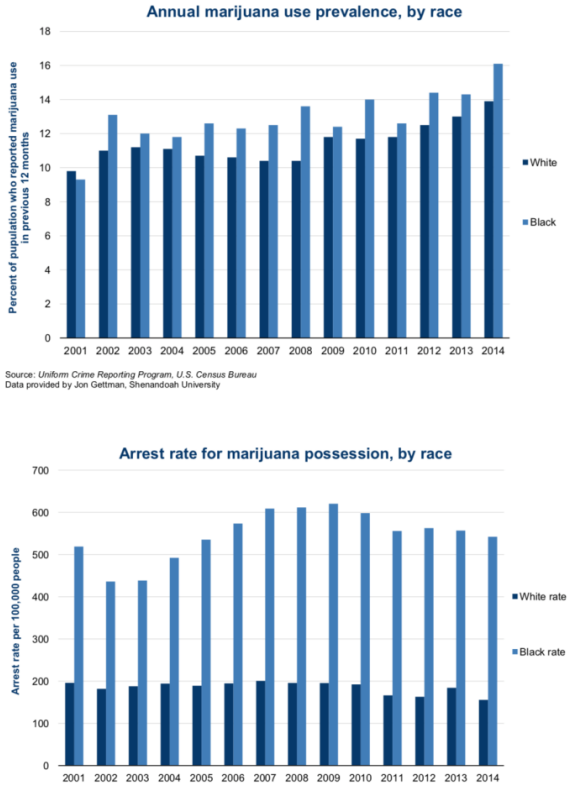
predominately black urban communities.[102] Black men and women are more likely to be arrested, charged, and convicted than whites who commit the same crimes.[103] Once convicted, the U.S. Sentencing Commission found that black men are given prison sentences nearly 20% longer than white men for similar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

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

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

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

Figure 7[105]



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

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

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

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

Figure 8[108]

Incarcerated populations are also at greater risk for transmission of infectious disease such as tuberculosis, viral hepatitis, and sexually transmitted diseases.[109] Moreover, the prevalence of mental illness and injection drug use among incarcerated populations is significantly higher than in the communities at large.[110] 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.[111] Because the majority of people in prison today are black, the public health harms associated with imprisonment are disproportionately visited on black communities and represent a formidable cause of health disparities.

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

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

110. *See id.*

111. *See id.*

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

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

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

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

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

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

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

117. *Id.* at 2580–81.

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

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

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

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

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

121. *Id.*

122. *Id.*

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

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

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

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

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

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

127. THOMAS A. LAVEIST ET AL., JOINT CTR. FOR POLITICAL & ECON. STUDIES, THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES 1 (2009), https://www.hhnmag.com/ext/resources/inc-hhn/pdfs/resources/Burden_Of_Health_FINAL_0.pdf.

128. *Id.* at 4–5.

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

130. *Id.* at 1.

131. *Id.*

132. *Id.*

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

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

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

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

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

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

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

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

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

137. *Id*. at 531.

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

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

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

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

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

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

> We are seeking to make America *one nation*, indivisible, with liberty and justice for all. . . . [T]he struggle for civil rights and the struggle to make these two Americas one America, is much more difficult today than it was five or ten years ago. For about a decade or maybe twelve years, we've struggled all across the South to get rid of legal, overt segregation and all of the humiliation that surrounded that system of segregation.
>
> In a sense this was a struggle for decency; we could not go to a lunch counter in so many instances and get a hamburger or a cup of coffee. We could not make use

141. *Id.* at 23–24.

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

143. *Id.*

144. *Id.*

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

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

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145. *Id.* at 3–4 (emphasis added).

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

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

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

III. CONCLUSION

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

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

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

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