

The Most Shocking and Inhuman Inequality: Thinking Structurally About Poverty, Racism, and Health Inequities

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I. INTRODUCTION

In 1966, Dr. Martin Luther King, Jr. singled out one form of inequality as especially egregious: “Of all the forms of inequality, injustice in health is the most shocking and inhuman.”¹ A year later, Dr. King launched the Poor People’s Campaign, which connected the ongoing movement for black people’s civil rights to a new call for the

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1. *Dr. Martin Luther King on Health Care Injustice*, PHYSICIANS FOR A NAT’L HEALTH PROGRAM (Oct. 14, 2014), <http://www.pnhp.org/news/2014/october/dr-martin-luther-king-on-health-care-injustice> (providing the wire story the Associated Press printed the day after Dr. King’s March 25, 1966 press conference that included this quote).

radical redistribution of political and economic power.² He identified racism, poverty, and militarism as related evils that systematically fueled an unjust social order and that had to be fought together to build a better world.³ By highlighting injustice in health, Dr. King recognized the relationship between gaps in health among populations living in the United States and the institutionalized racism and economic inequality that were at the heart of a widening civil rights struggle.⁴

Today, health disparities continue to be the focus of scientific and policy debates. Biological scientists are investigating whether gaps in health between social groups result from differing social environments or from differing genetic predispositions.⁵ Congress is deciding whether to treat health care as a human right or to cut funding for medical services for the poor and allow discriminatory restrictions on their receipt of benefits.⁶ Dr. King indicated these questions concerning health, along with debates about inequality in criminal justice, education, employment, and voting, were critical to his dream of a Beloved Community—a society based on justice, equal opportunity,

2. *Dr. King's Vision: The Poor People's Campaign of 1967-68: Why a Poor People's Campaign?*, POOR PEOPLE'S CAMPAIGN, <https://www.poorpeoplescampaign.org/history/> (last visited Oct. 15, 2018).

3. *See id.* (summarizing Dr. King's last sermon where he proposed a revolution of technology, weaponry, and human rights).

4. *Dr. Martin Luther King on Health Care Injustice*, *supra* note 1 (giving a presentation on March 25, 1966, at a Chicago press conference regarding the Medical Committee for Human Rights, Dr. Martin Luther King, Jr. stated, "[o]f all the forms of inequality, injustice in healthcare is the most shocking and inhuman.").

5. *See generally* DOROTHY ROBERTS, *FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY* 104-46 (2011) (discussing the inclusion of race as a variable in health and biomedical research, beginning in the mid-1980s, and critically analyzing its impact).

6. *See* Ed Kilgore, *3 States Are Pushing Medicaid Reforms that Discriminate Against Black People*, N.Y. MAG.: INTELLIGENCER (May 14, 2018), <http://nymag.com/daily/intelligencer/2018/05/discriminatory-medicaid-work-requirements-spread-to-3-states.html>; *see also* Erica Werner, *House GOP Plan Would Cut Medicare, Medicaid to Balance Budget*, WASH. POST: BUS. (June 19, 2018), https://www.washingtonpost.com/news/business/wp/2018/06/19/house-gop-plan-would-cut-medicare-social-security-to-balance-budget/?noredirect=on&utm_term=.110b908f776d (discussing the ramifications of the proposed budget entitled "A Brighter American Future").

and love of one's fellow human beings.⁷ According to Dr. King, affirming our equal humanity required guarantees of certain basic human rights, including adequate income, food, shelter, and health care.⁸

This Essay interrogates Dr. King's attention to health inequality to illuminate three aspects of the structural relationship between poverty, racism, and health, with a focus on Black Americans. First, health disparities are structured according to political hierarchies in our society. Health status tracks social status. Striking gaps exist in health between black people and white people, poor people and wealthy people, and other socially disadvantaged and socially privileged people in the United States.⁹ Health inequality is especially shocking and inhuman because these gaps are so large and cause so much suffering to the most marginalized people in our society. Second, health inequities are structured by the intersection of poverty and racism. Because institutionalized racism has excluded Black Americans from equal participation in the national economy, concentrating poverty and discrimination in their communities, their higher rates of mortality and morbidity are caused by racism and poverty combined. Finally, biological explanations for racial gaps in health that obscure the role of poverty and racism help to more broadly support structural injustice. This Essay concludes by recommending strategies to dismantle structural impediments to good health as well as to reject biological explanations for social inequality.

7. See JAMES H. CONE, *MARTIN & MALCOLM & AMERICA: A DREAM OR A NIGHTMARE* 19, 293, 297 (1991); MARTIN LUTHER KING, JR., *WHERE DO WE GO FROM HERE: CHAOS OR COMMUNITY?* 133, 164, 170, 173 (1968); KENNETH L. SMITH & IRA G. ZEPP, JR., *SEARCH FOR THE BELOVED COMMUNITY: THE THINKING OF MARTIN LUTHER KING, JR.* 120–23 (1974).

8. See Joseph Fishkin & William E. Forbath, *The Great Society and the Constitution of Opportunity*, 62 *DRAKE L. REV.* 1017, 1046–47 (2014) (internal citations omitted); William E. Forbath, *Caste, Class, and Equal Citizenship*, 98 *MICH. L. REV.* 1, 87 (1999).

9. See generally DONALD A. BARR, *HEALTH DISPARITIES IN THE UNITED STATES: SOCIAL CLASS, RACE, ETHNICITY, AND HEALTH* 124–48 (2008) (summarizing research investigating disparities in specific health outcomes, such as low birth weight, among racial groups and further analyzing these disparities by socioeconomic status).

II. SOCIAL INEQUALITY AND THE STRUCTURE OF HEALTH DISPARITIES

Health disparities are not just a biological reality; they are a form of social inequality because they are structured according to unjust power arrangements. Social stratification drives group disparities in health, so health status reflects social status.¹⁰ Public health advocates use the term “health inequities” to describe these differences in health because they result from the systemic, unjust, and avoidable distribution of social, economic, political, and environmental resources needed for health and well-being.¹¹ Numerous studies have established that the best predictor of health is an individual’s position in the social order.¹² Poor health is a function of occupying a disadvantaged position in our society, while having better health is a benefit of being socially privileged.¹³ The classic Whitehall Study of British Civil Servants, lasting for more than two decades, compared heart disease and mortality in employees at four civil service levels: administrators, professional and executive employees, clerical staff, and

10. See COMM’N ON SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 1 (2008), http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf (“[T]he marked health inequities . . . are caused by the unequal distribution of power, income, goods, and services . . .”).

11. *Id.* (“[H]ealth inequities . . . are caused by the unequal distribution of power, income, goods, and services, . . . access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities . . .”).

12. See, e.g., BARR, *supra* note 9, at 45–47 (citations omitted); Nancy E. Adler & David H. Rehkopf, *U.S. Disparities in Health: Descriptions, Causes, and Mechanisms*, 29 ANN. REV. PUB. HEALTH 235, 242–43 (2008).

13. See BARR, *supra* note 9, at 42 (citation omitted) (discussing that with each step down the employment hierarchy, health deteriorates and death rates increase).

menial workers.¹⁴ The study found that health got worse and mortality increased with each step down the occupational hierarchy.¹⁵

Similarly, people of color in the United States experience greater rates of morbidity and mortality than whites.¹⁶ A growing field of empirical research demonstrates that racism negatively affects the health of Black Americans through a variety of pathways.¹⁷ Scientists are now uncovering the biological pathways that translate inequities in wealth, employment, health care, housing, incarceration, and education, along with experiences of stigma and discrimination, into disparate health outcomes.¹⁸ Institutionalized racism in these systems restricts access to resources required for health and well-being.¹⁹ For example, a 2014 study using novel measures of structural racism—political participation, employment status, educational attainment, and judicial treatment—found that blacks living in states with high levels of structural racism were more likely to report past-

14. M. G. Marmot et al., *Employment Grade and Coronary Heart Disease in British Civil Servants*, 32 J. EPIDEMIOLOGY & COMMUNITY HEALTH 244, 244 (1978); see generally M. G. Marmot et al., *Inequalities in Death: Specific Explanations of a General Pattern?*, 323 THE LANCET 1003 (1984) (establishing over a ten year span an observed inverse relationship between hierarchal employment level and mortality).

15. M. G. Marmot et al., *supra* note 14, at 245–46 (reporting results and providing a table of findings showing mortality differences between different employment levels).

16. See NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTH, UNITED STATES 2015: WITH SPECIAL FEATURE ON RACIAL AND ETHNIC HEALTH DISPARITIES 37–38, 100–01 (2016), <http://www.cdc.gov/nchs/data/hus/hus15.pdf>; Robert S. Levine et al., *Black-White Inequalities in Mortality and Life Expectancy, 1933–1999: Implications for Health People 2010*, 116 PUB. HEALTH REP. 474, 480 (2001); David R. Williams, *Miles to Go Before We Sleep: Racial Inequities in Health*, 53 J. HEALTH & SOC. BEHAV. 279, 280 (2012).

17. See, e.g., Elizabeth Brondolo, Linda C. Gallo & Hector F. Myers, *Race, Racism and Health: Disparities, Mechanisms, and Interventions*, 32 J. BEHAV. MED. 1 (2009) (examining the state of research surrounding race, racism, and health disparities in the United States); David R. Williams & Selina A. Mohammed, *Racism and Health I: Pathways and Scientific Evidence*, 57 AM. BEHAV. SCI. 1152 (2013) (reviewing the scientific research that indicates institutional racism, cultural racism, and racial discrimination adversely affect the health status of racial populations).

18. Zinzi D. Bailey et al., *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 THE LANCET 1453, 1456–58 (2017).

19. *Id.*

year myocardial infarction²⁰ than those living in low-structural racism states.²¹

In addition, experiencing racial discrimination causes chronic stress and other negative psychological responses that are related to disease.²² Recent studies indicate that red blood cell oxidative stress,²³ sleep deprivation,²⁴ allostatic load,²⁵ and cortisol dysregulation²⁶ are pathways by which racial discrimination increases cardiovascular disease, diabetes, and premature aging. A 2007 study showed that experiencing daily racial microaggressions, which often has been dismissed as benign,²⁷ actually has biological consequences that gravely damage black and Latino adolescents' health.²⁸ A 2018 study found that police killings of unarmed Black Americans had an adverse effect on self-reported mental health of other Black Americans in the general population.²⁹ Thus, gaps in health between social

20. A myocardial infarction is a heart attack. *Myocardial infarction*, OXFORD ENGLISH DICTIONARY (3d ed. 2003).

21. Alicia Lukachko, Mark L. Hatzenbuehler & Katherine M. Keyes, *Structural Racism and Myocardial Infarction in the United States*, 103 SOC. SCI. & MED. 42, 46–47 (2014).

22. Camara Jules P. Harrell et al., *Multiple Pathways Linking Racism to Health Outcomes*, 8 DU BOIS REV. 143, 143–44 (2011); Nancy Krieger, *Discrimination and Health Inequities*, 44 INT'L J. HEALTH SERVS. 643, 644 (2014); Williams & Mohammed, *supra* note 17, at 1163.

23. Sarah L. Szanton et al., *Racial Discrimination Is Associated with a Measure of Red Blood Cell Oxidative Stress: A Potential Pathway for Racial Health Disparities*, 19 INT'L J. BEHAV. MED. 489, 490 (2012).

24. Bridget J. Goosby et al., *Discrimination, Sleep, and Stress Reactivity: Pathways to African American-White Cardiometabolic Risk Inequities*, 36 POPULATION RES. POL'Y REV. 699, 700 (2017).

25. Adler & Rehkopf, *supra* note 12, at 245–46.

26. Amy S. DeSantis et al., *Racial/Ethnic Differences in Cortisol Diurnal Rhythms in a Community Sample of Adolescents*, 41 J. ADOLESCENT HEALTH 3, 4 (2007).

27. Derald Wing Sue et al., *Racial Microaggressions in Everyday Life: Implications for Clinical Practice*, 62 AM. PSYCHOLOGIST 271, 273 (2007).

28. DeSantis et al., *supra* note 26, at 11–12 (measuring cortisol levels of African American and Latino adolescents as they are experiencing discrimination).

29. Jacob Bor et al., *Police Killings and Their Spillover Effects on the Mental Health of Black Americans: A Population-Based, Quasi-Experimental Study*, 392 THE LANCET 302, 307–08 (2018).

groups in the United States can be viewed as a measure of structural injustice.

Using health disparities as a measure of injustice reveals that the United States is a very unjust society. Imagine if every single day a jumbo jet loaded with 230 black passengers took off into the sky, reached a cruising altitude, and then crashed to the ground killing all aboard. According to former Surgeon General David Satcher, that is the impact caused by racial health disparities in the United States.³⁰ That image represents the number of Black Americans—totaling 83,570—who would still have been alive in 2002 when he gathered the statistics, if their life expectancy was the same as that of whites.³¹ In one generation, between 1940 and 1999, more than four million Black Americans died prematurely relative to whites.³²

Race matters at the beginning of life, too. Black infants are more than two times as likely as white infants to die before their first birthday and more than three times as likely as white infants to die from complications related to low birth weight.³³ Recent research shows that the maternal mortality rate is actually *increasing* in the United States, unlike in any other developed nation, departing even from most of the developing world.³⁴ Black women in the United States are almost four times more likely than white women to die

30. 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).

31. *Id.* at 459–60.

32. Levine et al., *supra* note 16, at 474–75.

33. NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTH, UNITED STATES, 2016: WITH CHARTBOOK ON LONG-TERM TRENDS IN HEALTH 107 (2017), <https://www.cdc.gov/nchs/data/hus/hus16.pdf> (finding that in 2014 African American infants died at a rate of 10.7 per 1,000 live births, compared to only 4.9 white infants per 1,000 live births, translating into African American infants dying at a frequency 2.2 times more often than white infants); *Infant Mortality and African Americans*, HHS.GOV, <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23> (last visited Oct. 15, 2018) (finding that African American infants were 3.2 times as likely to die from low birth weight than white infants).

34. Marian F. MacDorman et al., *Is the United States Maternal Mortality Rate Increasing? Disentangling Trends from Measurement Issues*, 128 OBSTETRICS & GYNECOLOGY 447, 450 (2016).

from pregnancy-related causes.³⁵ For black women, Chickasaw County, Mississippi, is a deadlier place to be pregnant than Kenya or Rwanda.³⁶

A 2007 study conducted in Chicago found that white women were slightly more likely than black women to get breast cancer, but black women were twice as likely to die from it.³⁷ The researchers discovered that in 1980, Chicago's black and white breast cancer mortality rates were identical: black and white women died at exactly the same rate.³⁸ Between 1980 and 2003, the death rate from breast cancer among black women remained the same while the death rate among white women fell about forty percent.³⁹ During Dr. Steven Whitman's interview about this trend, he explained, "[w]hite women were able to take advantage of . . . improvements [in early detection and treatment over those 25 years] and black women not at all. . . . [B]lack women have gained nothing, not one iota, in terms of breast cancer mortality from any of our advances."⁴⁰

Spotlighting these enormous gaps in health caused by economic inequities and racism illuminates why Dr. King identified injustice in health as the most shocking and inhuman form of inequality. These gaps reflect different degrees of suffering from illness, disability, and death experienced by individuals because of their position in society. Ultimately, health disparities give a striking account of how much those in power value different people's lives.

35. *Pregnancy Mortality Surveillance System*, CTRS. FOR DISEASE CONTROL AND PREVENTION, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm> (last updated Aug. 7, 2018).

36. Miriam Zoila Pérez, *New Report Says U.S. Health Care Violates U.N. Convention on Racism*, COLORLINES (Aug. 28, 2014, 11:00 AM), <https://www.colorlines.com/articles/new-report-says-us-health-care-violates-un-convention-racism>.

37. Jocelyn Hirschman, Steven Whitman & David Ansell, *The Black:White Disparity in Breast Cancer Mortality: The Example of Chicago*, 18 *CANCER CAUSES & CONTROL* 323, 325–26 (2007).

38. *Id.* at 323.

39. *See id.* at 323, 325–26 (finding the divergence between the rates which black and white women die of breast cancer began in the 1990s and continued through the 2000s).

40. ROBERTS, *supra* note 5, at 125.

III. HOW POVERTY AND RACISM INTERSECT TO PRODUCE HEALTH INJUSTICE

The prior section discussed how both poverty and racism create health disparities; however, a second dimension of injustice raised by Dr. King's words is that health disparities are structured by the *intersection* of poverty and racism. Black Americans are especially at risk for poor health because they experience high rates of poverty.⁴¹ Yet, observing that black people have poorer health either because they experience racial discrimination and are disadvantaged by structural racism, or they are disproportionately poor misses the way that economic deprivation and racism work together to harm their health.

The disproportionate impoverishment of Black Americans today stems from a history of institutionalized racism. The enslavement of Africans in the United States for almost three centuries established a deeply unequal foundation for the economic welfare of their descendants.⁴² Slavery unjustly created both wealth for white people and unjustly denied it to black people.⁴³ During the decades that followed the abolition of slavery, institutionalized racism continued to deny equal economic opportunities to black people and affirmatively confiscated significant amounts of property and wealth black people were able to amass.⁴⁴

41. Ann Chih Lin & David R. Harris, *Why is American Poverty Still Colored in the Twenty-First Century*, in *THE COLORS OF POVERTY: WHY RACIAL AND ETHNIC DISPARITIES PERSIST* 1, 1–2 (Ann Chih Lin & David R. Harris eds., 2010).

42. *See generally* EDWARD E. BAPTIST, *THE HALF HAS NEVER BEEN TOLD: SLAVERY AND THE MAKING OF AMERICAN CAPITALISM* 245–46 (2014) (describing the total wealth in the United States in comparison to enslaved people and their share of this wealth).

43. *See* Anthony E. Cook, *King and the Beloved Community: A Communitarian Defense of Black Reparations*, 68 *GEO. WASH. L. REV.* 959, 986 (“Slavery . . . [was] designed to exclude blacks from the great wealth created by their labor and by the increasing wealth generated by American capitalism.”).

44. *See generally* MICHELLE ALEXANDER, *THE NEW JIM CROW: MASS INCARCERATION IN THE AGE OF COLORBLINDNESS* 27–35 (2012) (discussing the immediate reaction by whites after the abolition of slavery giving rise to the Jim Crow era); ANDREA FLYNN ET AL., *THE HIDDEN RULES OF RACE: BARRIERS TO AN INCLUSIVE ECONOMY* 21–23 (2017) (noting the first period of reconstruction led to the Supreme Court narrowing the reach of the Fourteenth Amendment, opening the door for the Jim Crow era); IRA KATZNELSON, *WHEN AFFIRMATIVE ACTION WAS WHITE* 30–33 (2005) (reporting the economic situations of African American work-

Residential segregation—resulting from the forcible exclusion of black people from white neighborhoods by private terror, government housing policies, and state-sponsored legal mechanisms, such as restrictive covenants—is one of the most potent mechanisms of persistent racial disadvantage.⁴⁵ Numerous studies have identified racially segregated housing as a key contributor to health disparities because it concentrates poverty and minimizes resources needed for good health in predominantly black areas.⁴⁶ As a group of health researchers recently summarized, racial residential segregation harms health through multiple pathways, including “the high concentration of dilapidated housing in neighbourhoods that people of colour reside in, the substandard quality of the social and built environment, exposure to pollutants and toxins, limited opportunities for high-quality education and decent employment, and restricted access to health care.”⁴⁷

Racial disparities in low birthweight, for example, have been attributed to combinations of residential segregation and neighbor-

ers in the South prior to World War II); MELVIN L. OLIVER & THOMAS M. SHAPIRO, *BLACK WEALTH/WHITE WEALTH: A NEW PERSPECTIVE ON RACIAL INEQUALITY* 13–23 (1995) (discussing how reconstruction, the suburbanization of America, and contemporary racism contributed to economic inequality).

45. See DOUGLAS S. MASSEY & NANCY A. DENTON, *AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE UNDERCLASS* 35–37 (1993); RICHARD ROTHSTEIN, *THE COLOR OF LAW: A FORGOTTEN HISTORY OF HOW OUR GOVERNMENT SEGREGATED AMERICA* vii–xv (2017).

46. See Joy Rayanne Piontak & Michael D. Schulman, *School Context Matters: The Impacts of Concentrated Poverty and Racial Segregation on Childhood Obesity*, 86 J. SCH. HEALTH 864, 865 (2016) (reporting that previous research established residential segregation is associated with higher levels of obesity); David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 410–11 (2001) (summarizing previous research linking minority communities with diminished access to healthier options in grocery stores and increased levels of alcohol and tobacco marketing); Williams & Mohammed, *supra* note 17, at 1158–59 (detailing research on residential segregation and exposure to toxic chemicals, psychological stressors, and poorer quality preventative care).

47. Bailey et al., *supra* note 18, at 1456 (internal citations omitted); see also Williams & Mohammed, *supra* note 17, at 1159 (noting residential segregation is “associated with residence in poorer-quality housing and in neighborhood environments that are deficient in a broad range of resources that enhance health and well-being, including medical care”).

hood poverty.⁴⁸ Merging data from the 1994 Home Mortgage Disclosure Act and Neighborhood Change Database with data from the Project on Human Development in Chicago Neighborhoods, Emory sociologist Abigail A. Sewell found a connection between the dual mortgage market, residential segregation, and childhood health inequalities.⁴⁹ Harvard sociologists Robert Sampson and Alix Winter graphically showed the racial ecology of lead poisoning by empirically mapping the link between the spatial isolation of African Americans in segregated neighborhoods and the prevalence of lead poisoning in Chicago.⁵⁰ Using the term “toxic inequality,” they confirm what black activists have charged as environmental racism for decades: predominantly black neighborhoods comprise the vast majority of neighborhoods in the top quintile of Chicago’s lead toxicity rates in each year from 1996 through 2012.⁵¹ Lead poisoning of black children, they conclude, is “a form of biosocial stratification.”⁵²

In addition, the psychosocial stressors related to living in a high-poverty neighborhood are intensified by stress stemming from racial discrimination in health care, schools, employment, foster care, prisons, and policing that prevails in these same areas.⁵³ Thus, by geographically concentrating racism and poverty, residential segregation creates neighborhood environments for black residents that are extraordinarily destructive to their health.

48. Sue C. Grady, *Racial Disparities in Low Birthweight and the Contribution of Residential Segregation: A Multilevel Analysis*, 63 SOC. SCI. & MED. 3013, 3014 (2006); see also James W. Collins Jr. et al., *Very Low Birthweight in African American Infants: The Role of Maternal Exposure to Interpersonal Racial Discrimination*, 94 AM. J. PUB. HEALTH 2132, 2132 (2004).

49. See generally Abigail A. Sewell, *The Racism-Race Reification Process: A Mesolevel Political Economic Framework for Understanding Racial Health Disparities*, 2 SOC. RACE & ETHNICITY 402, 414 (2016) (proposing that a racism-race reification analysis can delineate how institutional conditions influence the health of racially marginalized individuals).

50. Robert J. Sampson & Alix S. Winter, *The Racial Ecology of Lead Poisoning: Toxic Inequality in Chicago Neighborhoods, 1995–2013*, 13 DU BOIS REV. 261, 264–65, 268 (2016).

51. *Id.* at 264, 270.

52. See *id.* at 279 (internal citations omitted).

53. See Harrell et al., *supra* note 22, at 153; Krieger, *supra* note 22, at 652, 654; Williams & Mohammed, *supra* note 17, at 1163–64.

IV. HEALTH DISPARITIES AND BIOLOGICAL V. STRUCTURAL
EXPLANATIONS OF INEQUALITY

Finally, Dr. King's interpretation of health disparities as a form of structural inequality is crucial because biological explanations for racial gaps in health, which obscure the role of poverty and racism, help to more broadly support structural injustice. Researchers are still at odds over whether the racial gaps in health, described above, result from unequal social conditions, political structures, and access to health care, or from innate racial differences in predisposition to disease.⁵⁴ Dr. King may have recognized that health inequities in America today are deeply rooted in a longstanding relationship between the very concept of race as a natural division of human beings and white supremacy. European scientists claimed race was a biological trait rather than a political relationship to justify Europeans' subjugation of other peoples through conquest, slavery, and colonialism.⁵⁵ Transported to revolutionary America, scientific claims of biological distinctions between races became essential to justifying the enslavement of Africans in a nation founded on a radical commitment to liberty, equality, and natural rights.⁵⁶

During the slavery era, medical researchers sought to prove the inheritability of race by investigating racial differences in health. They developed the racial concept of disease—that people of different races suffer from different diseases and experience common diseases differently—as proof not only that race was biological but also that black pathology caused racial inequality.⁵⁷ They argued that the bio-

54. See ROBERTS, *supra* note 5, at 104–22 (summarizing previous research on health disparities focused on biological concepts of race).

55. See IBRAM X. KENDI, *STAMPED FROM THE BEGINNING: THE DEFINITIVE HISTORY OF RACIST IDEAS IN AMERICA* 28–29 (2016); NELL IRVIN PAINTER, *THE HISTORY OF WHITE PEOPLE* 43–44, 65–67, 75–79 (2010).

56. Barbara J. Fields, *Ideology and Race in American History*, in *REGION, RACE, AND RECONSTRUCTION: ESSAYS IN HONOR OF C. VANN WOODWARD* 143, 148–49 (J. Morgan Kousser & James M. McPherson eds., 1982).

57. LUNDY BRAUN, *BREATHING RACE INTO THE MACHINE: THE SURPRISING CAREER OF THE SPIROMETER FROM PLANTATION TO GENETICS* 28 (2014); 1 W. MICHAEL BYRD & LINDA A. CLAYTON, *AN AMERICAN HEALTH DILEMMA: A MEDICAL HISTORY OF AFRICAN AMERICANS AND THE PROBLEM OF RACE, BEGINNINGS TO 1900*, at 222 (2000); RANA A. HOGARTH, *MEDICALIZING BLACKNESS: MAKING RACIAL DIFFERENCE IN THE ATLANTIC WORLD, 1780–1840*, at 106 (2017);

logical peculiarities of black people made enslavement the only condition that allowed them to be productive, disciplined, and even healthy. White scientists asserted that black people benefitted from slavery for medical reasons. Dr. Samuel Cartwright, a well-known expert on “Negro medicine,” claimed that because black people had lower lung capacity than whites, forced labor was good for them.⁵⁸ He explained in a medical journal: “[I]t is the red, vital blood, sent to the brain, that liberates their mind when under the white man’s control; and it is the want of a sufficiency of red, vital blood, that chains their mind to ignorance and barbarism, when in freedom.”⁵⁹

After slavery ended, white scientists blamed black people’s deteriorating health on a biological incapacity to adjust to freedom.⁶⁰ Locating blacks’ subordinated status in biological susceptibility provided an excuse to retain white supremacy instead of dismantling the social order inherited from slavery. The great black intellectual, sociologist, and civil rights leader W.E.B. Du Bois pioneered the first academic challenge to these oppressive explanations for racial gaps in health, and he attributed health inequities instead to unequal social and political conditions.⁶¹ In 1899, Du Bois wrote: “Particularly with regard to consumption it must be remembered that the Negroes are not the first people who have been claimed as its particular victims; the Irish were once thought to be doomed by that disease—but that was when Irishmen were unpopular.”⁶²

The biological concept of race and racial health disparities continues to shape ideas and practices in biomedical research and

HARRIET A. WASHINGTON, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT* 36–37 (2006).

58. BRAUN, *supra* note 57, at 28.

59. Samuel A. Cartwright, *Report on the Diseases and Physical Peculiarities of the Negro Race*, in *HEALTH, DISEASE, AND ILLNESS: CONCEPTS IN MEDICINE* 28, 30 (Arthur L. Caplan et al. eds., 2004).

60. See SAMUEL KELTON ROBERTS JR., *INFECTIOUS FEAR: POLITICS, DISEASE, AND THE HEALTH EFFECTS OF SEGREGATION* 50 (2009).

61. ALDON D. MORRIS, *THE SCHOLAR DENIED: W.E.B. DU BOIS AND THE BIRTH OF MODERN SOCIOLOGY* 3 (2015).

62. W.E.B. DU BOIS, *THE PHILADELPHIA NEGRO: A SOCIAL STUDY* 160 (1899).

medicine today.⁶³ Black patients are especially vulnerable to harmful biases and stereotypes, including the undertreatment of their pain based on commonly held myths that black people as a race feel less pain, exaggerate their pain, or are predisposed to drug addiction.⁶⁴ A 2016 study conducted at the University of Virginia Medical School confirmed the association between doctors' false beliefs about race-based biological differences and the undertreatment of black patients' pain.⁶⁵ The researchers found "a substantial number of white . . . medical students and residents hold false beliefs about biological differences between blacks and whites"—beliefs such as black people have thicker skin and less sensitive nerve endings than white people—and "these beliefs predict racial bias in pain perception and treatment."⁶⁶

Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century documents a resurgence of the dangerous myth that human beings are naturally divided into biological races in scientific research, pharmaceutical development, and politics.⁶⁷ A striking example is the Food & Drug Administration's ("FDA") 2005 approval of a race-specific drug to treat heart failure in self-identified African American patients.⁶⁸ The FDA speculated that race served as a proxy for some unknown genetic difference that affects heart failure or drug response despite lacking any evidence for

63. BRAUN, *supra* note 57, at 164; JOHN HOBERMAN, BLACK & BLUE: THE ORIGINS AND CONSEQUENCES OF MEDICAL RACISM 32–37 (2012). *See generally* KENDI, *supra* note 55, at 474–76 (discussing the Human Genome Project); ROBERTS, *supra* note 5, at 57–80, 104–22 (exploring the resurgence of biological concepts of race in genomic and biomedical research).

64. *See* Monika K. Goyal et al., *Racial Disparities in Pain Management of Children with Appendicitis in Emergency Departments*, 169 JAMA PEDIATRICS 996, 998–99 (2015); Kelly M. Hoffman et al., *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Blacks and Whites*, 113 PNAS 4296, 4297–4300 (2016); Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS OF EMERGENCY MED. 11, 13 (2000).

65. Hoffman et al., *supra* note 64, at 4296–4300.

66. *Id.* at 4296.

67. *See generally* ROBERTS, *supra* note 5 (making the case that humans should be bound by the struggle for equal dignity, not just innate genetic, political, or ancestral links).

68. *Id.* at 168–201; JONATHAN KAHN, RACE IN A BOTTLE: THE STORY OF BiDiL AND RACIALIZED MEDICINE IN A POST-GENOMIC AGE 48 (2013).

it.⁶⁹ Moreover, the FDA's approval sent the harmful message that black people's bodies are so substandard there is no guarantee a drug tested on them will work in other patients.

More generally, the search for innate racial differences in disease as explanations for health disparities diverts attention and resources from ending health disparities' structural causes and perpetuates the false belief that social inequality stems from biological differences. Using biological terms to define social inequities makes them seem natural—the result of inherent racial differences that can't be changed instead of unjust societal structures that must be dismantled. In the current political climate, this view is especially toxic as increasingly vocal and influential white nationalists rely on racial science to support their claims of a separate and superior white race, and scientists increasingly call for more research on genetic differences between races to explain black people's underachievement.⁷⁰

V. CONCLUSION

Dr. King's identification of health inequalities as a key human rights issue calls us to think structurally about the relationship between poverty, racism, and health. To close the appalling racial gaps in health, we must develop strategies to end the structural impediments to good health that are grounded in intersecting economic and racial inequities and supported by biological explanations for social inequality.

These structural interventions occur at many levels.⁷¹ First, to achieve the Beloved Community Dr. King worked for, we must recognize health care as a human right by guaranteeing universal, state-supported, high-quality health care. This includes not only maintaining and generously funding Medicaid, Medicare, and the Affordable

69. ROBERTS, *supra* note 5, at 178.

70. CATHERINE BLISS, SOCIAL BY NATURE: THE PROMISE AND PERIL OF SOCIOGENOMICS 85–86 (2018); Gavin Evans, *The Unwelcome Revival of 'Race Science,'* THE GUARDIAN (Mar. 2, 2018, 1:00 PM), <https://www.theguardian.com/news/2018/mar/02/the-unwelcome-revival-of-race-science>.

71. *See generally* Bailey et al., *supra* note 18, at 1458–61 (addressing structural racism in a variety of contexts and providing interventions to eliminate issues faced by minorities).

Care Act but also working to transform government provision of medical care to ensure coverage for all residents of the United States.

Second, ending health inequities requires eliminating the living conditions that unjustly damage the health of socially disadvantaged communities. This means enacting policies aimed at changing the structures, systems, and institutions that unequally distribute resources that affect people's health. For example, understanding the relationship between lead toxicity and residential segregation led researchers to recommend policies addressing "landlord neglect of private housing conditions and institutional neglect of the indoor environments of daycare centers and schools," "neighborhood reinvestment," and "city infrastructure projects."⁷² At the same time, we must end carceral approaches that lock up and punish people for having health problems, such as drug addiction and trauma from experiencing violence.⁷³ Efforts directed at ending mass incarceration and police violence, which disproportionately involve black people, are critical to achieving health equality in the United States.⁷⁴

Finally, health inequities should be addressed by training health professionals to be more structurally competent.⁷⁵ Medical education in the United States typically perpetuates biological concepts of race, the racial concept of disease, and stereotypes about racial differences that contribute to inferior treatment of black patients.⁷⁶ Ra-

72. Sampson & Winter, *supra* note 50, at 279.

73. BETH E. RICHIE, *ARRESTED JUSTICE: BLACK WOMEN, VIOLENCE, AND AMERICA'S PRISON NATION* 127 (2012); Dora M. Dumont et al., *Public Health and the Epidemic of Incarceration*, 33 *ANN. REV. PUB. HEALTH* 325, 328–29 (2012).

74. Michael Massoglia, *Incarceration, Health, and Racial Disparities in Health*, 42 *LAW & SOC'Y REV.* 275, 280–81 (2008). *See generally* David Cloud, *On Life Support: Public Health in the Age of Mass Incarceration*, VERA INST. JUST. (Nov. 2014), <https://www.vera.org/publications/on-life-support-public-health-in-the-age-of-mass-incarceration> (analyzing mass incarceration as a social determinant of health and its effect on health disparities in the United States).

75. Jonathan M. Metzl & Dorothy E. Roberts, *Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge*, 16 *AM. MED. ASS'N. J. OF ETHICS* 674, 683–84 (2014), <https://journalofethics.ama-assn.org/article/structural-competency-meets-structural-racism-race-politics-and-structure-medical-knowledge>.

76. ROBERTS, *supra* note 5, at 99–100. *See generally* HOBBERMAN, *supra* note 63, at 198–233 (describing inadequate attempts to change racial thinking by medical students through curricular reform).

ther than grapple with racist ideas embedded in the curriculum, medical schools have sought to address physician bias by requiring students to be trained in “cultural competency” to better understand patient lifestyles and attitudes.⁷⁷ A growing movement called “structural competency” radically departs from these biological and cultural approaches by contending that “many health-related factors previously attributed to culture or ethnicity also represent the downstream consequences of decisions about larger structural contexts, including health care and food delivery systems, zoning laws, local politics, urban and rural infrastructures, structural racisms, or even the very definitions of illness and health.”⁷⁸ Health-care providers need to be more competent at recognizing and addressing these upstream structural factors that determine patients’ health and create health disparities.

In 1967, a year before his death, Dr. King reflected on the issues of science, racial injustice, and poverty of the spirit. He stated:

When we look at modern man, we have to face the fact that modern man suffers from a kind of poverty of the spirit, which stands in glaring contrast to his scientific and technological abundance. We’ve learned to fly the air like birds, we’ve learned to swim the seas like fish, and yet we haven’t learned to walk the Earth as brothers and sisters.⁷⁹

Dr. King was not speaking against science and technology but against a society that promotes science and technology without concern for the equal humanity of all people. A more just society would be healthier for everyone.

77. Sunil Kripalani et al., *A Prescription for Cultural Competence in Medical Education*, 21 J. GEN. INTERNAL MED. 1116, 1116–17 (2006).

78. Metzler & Roberts, *supra* note 75, at 674.

79. *Rev. Dr. Martin Luther King, Jr. on Racial Segregation* (KPIX-TV television broadcast Feb. 27, 1967), <https://diva.sfsu.edu/collections/sfbatv/bundles/190080>.