HEALING HATE: A PUBLIC HEALTH PERSPECTIVE ON CIVIL RIGHTS IN AMERICA

INTRODUCTION

Dayna Bowen Matthew, J.D., Ph.D. *

INTRODUCTION

Dayna Bowen Matthew, J.D., Ph.D.

As health care providers better understand the social determinants of health, an emerging literature reveals that a major driver of public health disparities is subordination. Inspired by a provocative new approach to addressing population health disparities, this conference gathered scholars and clinicians and policy-makers to explore a "powerful new alliance between public health and civil rights advocates to promote the civil rights of health."[1] For two days we met together—legal, public health, medical, and social science experts—to better understand the health impacts of social injustice generally, and then to equip conference attendees with practical tools to influence policy in their respective spheres. In short, we began the hard work of healing the wounds inflicted on black, brown, and marginalized bodies by racial hatred in America.

In 2017, the FBI reported 7,175 hate crimes, which represents a 17% increase over the crime rate reported in 2016. This marks an upward trend in reported hate crimes over the past five years. Overall, 28% of reported hate crimes were committed against African Americans, who remain among the most vulnerable and targeted groups. Notably, these numbers reflect a 37% spike in crimes targeting Jews and Jewish institutions.

Substantial research demonstrates that health outcomes are distributed unequally among these diverse ethnic groups. For example, rates of hypertension and related complications are significantly higher in Blacks than in non-Hispanic Whites or Asians.[2] Even within broad groupings, there can be substantial differences in health outcomes. Among Latinx populations, Puerto Ricans demonstrate particularly poor health (e.g., relatively high rates of premature mortality), whereas Cubans show better health when compared to other Latinx subgroups.[3] Across ethnic groups, immigrants often evidence better health than their US-born counterparts.[4]

---

[1] Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, U.C.L.A. L. REV., Forthcoming. (Mar. 11, 2019).

[2] American Heart Association, *Heart Disease and Stroke Statistics—2008 Update: A Report from the American Heart Association Statistics Committee and Stroke Statistics Subcommittee*, Circulation, 117, *e25-e146* (2008).

[3] *Health, United States, 2008, with Special Feature on the Health of Young Adults*, National Center for Health Statistics (2009).

[4] Guillermina Jasso et al., *Immigrant Health: Selectivity and Acculturation* (2004); G.K. Singh & M. Siahpush, *Ethnic-Immigrant Differentials in Health Behaviors, Morbidity, and Cause-Specific Mortality in the United States: An Analysis of Two National Data Bases* 74 HUM. BIO. 83-109 (Feb. 2002).

Such disparities run counter to the idea of America as a land of equality, justice, and opportunity for all. Eliminating these inequities is a major goal of the U.S. national health agenda set by Congress in "Healthy People 2010"[5] and is likely to remain a key objective of Healthy People 2020.[6] Despite the increasing public health and research attention focused on health disparities, investigators have yet to fully specify the factors that create and maintain disparities in health status and health care. Consequently, clinicians and researchers have faced limitations in their ability to develop interventions that will effectively target the pathways underlying disparities or offset their effects on health outcomes in affected groups.

In attempting to explain the negative health outcomes experienced by racial and ethnic minorities, researchers have increasingly turned their attention to racial and ethnic discrimination.[7] Racism is a potent psychosocial stressor that is characterized by both social ostracism and blocked economic opportunity. Research from a range of disciplines has clearly demonstrated the harm engendered secondary to all types of social ostracism and isolation.[8] Racism also has led to inequitable access to social, educational, and material resources. These are resources that have both direct effects on health status (i.e., through access to healthy diets and appropriate medical care) and indirect effects on health status (i.e., through their influence on stress, psychosocial resources, and positive and negative emotions).[9]

Despite the clear theoretical rationale for hypothesizing that racism and ethnic discrimination affect health, empirical demonstrations of these effects are still in their early stages. Further work is needed to understand the mechanisms through which racism and ethnic discrimination relate to health. In addition, research is needed to understand how to intervene to reduce the deleterious impact of racism and discrimina-

---

[5] Centers for Disease Control and Prevention, https://www.cdc.gov/nchs/healthy_people/hp2010.htm.

[6] National Center for Health Statistics, Healthy People 2010 Final Review, O-25, https://www.cdc.gov/nchs/data/hpdata2010/hp2010_final_review.pdf.

[7] Vickie Mays et al., *Race, Race-Based Discrimination, and Health Outcomes Among African-Americans*, 58 Ann. Rev. Psychol. 201-25 (Jan. 2007); Vickie Shavers & Brenda S. Shavers, *Racism and Health Inequity Among Americans* (2006).

[8] *See, e.g.,* Roy F. Baumeister et al., *Social Inclusion Impairs Self-Regulation*, 88 J. PERS. SOC. PSYCHOL. 4, 589 (Apr. 2005).

[9] N.E. Adler & D.H. Rehkopf, *U.S. Disparities in Health: Descriptions, Causes, and Mechanisms*, ANN. REV. PUB. HEALTH 235-52 (2008); N.E. Adler & A.C. Snibbe, *The Role of Psychological Processes in Explaining the Gradient Between Socioeconomic Status and Health*, 12 CURRENT DIRECTIONS IN PSYCH. SCIENCE 4, 119 (2003); L.C. Gallo and K.A. Matthews, *Understanding the Association Between Socioeconomic Status & Physical Health: Do Negative Emotions Play a Role*, 129 PSYCHOL. BULL. 10 (Jan. 2003).

tion."[10] Similarly, further work is needed to understand the impact of discrimination and hate crimes on religious minorities such as Muslims[11] and Jews, and on members of LGBTQ+ communities.[12] This conference had three objectives:

- To gather multi-disciplinary scholars, clinicians, policy-makers and community leaders to use a public health approach to explore data and information about the prevalence, severity and incidence of disease and injury due to racism, hate speech, crimes and violence.
- To announce a civil rights framework to combat the health disparities that arise from racism, hate - speech, crimes, and violence
- To generate and disseminate evidenced-based proposals and tools for those wishing to influence policy-makers to translate this knowledge into action that will reduce health disparities.

As the articles in this symposium issue attest, we have begun a vital conversation covering topics ranging from racial profiling to firearm ownership to promoting academic achievement. The goal of the conference, and therefore the aim of the papers in this issue of the *Virginia Journal of Social Policy and Law* is to help build a framework for policymakers and the public to challenge hatred, discrimination, and subordination in pursuit of the elimination of unjust health disparities in America.

---

[10] Elizabeth Brondolo, Linda C. Gallo, & Hector F. Myers, *Race, Racism and Health: Disparities, Mechanisms, and Interventions*, 32 J. OF BEHAVIORAL MED. 1, 1 (2009).

[11] Alyssa E. Rippy, & Elana Newman, *Perceived Religious Discrimination and its Relationship to Anxiety and Paranoia Among Muslim Americans*, 1 J. OF MUSLIM MENTAL HEALTH 1, 5-20 (2006).

[12] Kevin Berrill & Gregory M. Herek, eds. *Hate Crimes: Confronting Violence Against Lesbians and Gay Men*, SAGE PUBLICATIONS (1991).