PUBLIC HEALTH LIBERATION POSITION STATEMENT

Court Decisions Demonstrate Need for Public Health Economy

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Public Health Liberation (PHL) is a membership nonprofit organization that seeks to accelerate health equity through understanding and affecting the Public Health Economy. **There exist two major distinct but interdependent economies - the traditional growth economy and the Public Health Economy.** The concept of the Public Health Economy is intended to broaden our view of the structural determinants of health through practice-based learning and transdisciplinary synthesis.[1] The inaugural PHL manuscript characterized fundamental features of the Public Health Economy. PHL members represent communities of practice that would most benefit from better performance in this economy. A radical reconceptualization of public health theory-building, training, and research is warranted.

Recently, PHL members gathered in solemn reflection upon the Court's sweeping decisions on reproductive rights, affirmative action, treatment of LGBTQ+ populations, and the Bruen decision in 2022. We are experiencing many heightened fears about our short- and long-term health, safety, and liberty. Chief among them are the diminishing educational and employment opportunities for disadvantaged families of all backgrounds and the immediate health effects on women, particularly women of color. Social division, national disunity, and false narratives on colorblindness are disconcerting. The role of the *Dred Scott* decision in 1857 is instructive of the potential course of the nation. Ideological purity, gun violence, and eroding constitutional protections pose grave threats to the Republic and the Public Health Economy.

The nation's founding documents have helped with understanding this moment in time such as James Madison's *Federalist Paper No.10 (*a faction "united and actuated by some common impulse of passion, or of interest, adversed to the rights of other citizens").[2] For all of their faults, our Founders were attentive to political factionalism ("malicious exultation over its friends and partisans" that "refuted their gloomy sophisms" of liberty).[2]

Equal Protection, Where?

Communities of practice of most interest to Public Health Liberation will shoulder the burden resulting from these decisions — the concomitant "equal protection problem" as Justice Sotomayor characterized in her dissent. The effects are likely to compound suffering and to strengthen aspects of the Public Health Economy that deepen health disparities. The equal protection clause is being used against communities, yet we do not see where it is applied at all. Equal protection means that "a governmental body may not deny people equal protection of its governing laws. The governing body state must treat an individual in the same manner as others in similar conditions and circumstances."[3]

Whether in fair housing, economic development, or environmental justice, we struggle to identify where equal protection is present in our lives and consistently upheld. In our inaugural manuscript, we discussed our personal challenges to environmental racism, gentrification, widening disparities in life expectancy, and government- and landlord-directed slum lording and displacement.[1] Legal action is usually cost-prohibitive, too resource-intensive, and yearslong. Often, we cannot find attorneys who are willing to take on our cases. Government often delays enforcing existing laws, if ever, and irregularly pursues legal action against bad actors.

Growing income inequality is a major social determinant of health in the US. "(T)he gap between the finances of blacks and whites is still as wide in 2020 as it was in 1968".[4] "As of 2016, the most recent year for which data is available, you would have to combine the net worth of 11.5 black households to get the net worth of a typical white U.S. household."[4] "Strong evidence linking income and health suggests that policies promoting economic equity may have broad health

effects."[5] Against this backdrop, poverty is the fourth leading cause of death in the US.[6] The facility of the Public Health Economy to fulfill the public health mission is at stake.

The US is far from perfect, but we need to acknowledge and support its progress, including the role that affirmative action had in rightsizing equal access and opportunity. Affirmative action is much construed as a pejorative in the Court's opinion, but affirmative action was a necessary steppingstone to our professional development and ability to contribute to society as educators, community leaders, and researchers. Despite the new reality, affirmative action is our best hope for equality given the unfinished work of justice and equality. We fear a dark future of regressive decisions and state policies. Although the pace of change in the Public Health Economy is too slow, the nation nonetheless was building on its ideals that were centuries in the making. The amicus briefs in favor of the universities in the affirmative action case were two-to-one to those that opposed.[7] Diversity, equity, and inclusion were moving in the right direction.

There is growing fear that the Court's decision on affirmative action will "discourage corporations from putting in place ambitious diversity policies in hiring and promotion."[8] That is not all. At least one justice suggests revisiting contraception and same-sex marriage that "in future cases, we should reconsider all of this Court's substantive due process precedents."[9] Racial data collection may be threatened and deal a major blow to public health data collection and planning if colorblind posturing follows its logical end point, "the way to stop discrimination on the basis of race is to stop discriminating on the basis of race."[10]

Worsening Public Health Economy

The Public Health Economy is hardly close to equity, which we fear will be more encumbered in the future. US maternal mortality is worsening and nearly three times greater than high-income countries overall.[11] Black maternal mortality is 2.6 times higher rate than that of White women.[11] In the aftermath of the *Dobbs* decision, a majority of surveyed OBGYNs said that its effects have worsened racial and ethnic inequities in maternal health (70%), management of pregnancy related medical emergencies (68%), and pregnancy related mortality (64%).[12] "Regrettably, people who already had poorer-than-average access pre-Dobbs face even greater health burdens and risks."[13]

Education is an overlooked major social determinant of health. Educational attainment is strongly associated with life expectancy, morbidity, and health behaviors.[14] Some groups have been scapegoated and unfairly marginalized in the affirmative action debates. In undergraduate medical education. "Black or African American and Hispanic or Latino medical **students' percentage of U.S. medical school matriculants has hardly changed** since 1980; respectively, 6.0% versus 7.1% and 4.9% versus 6.3%".[15] Justice Sotomayor's dissent portends a dire future based on outcomes in California.

At the University of California, Berkeley, a top public university not just in California but also nationally, the percentage of Black students in the freshman class dropped from 6.32% in 1995 to 3.37% in 1998. Latino representation similarly dropped from 15.57% to 7.28% during that period at Berkeley, even though Latinos represented 31% of California public high school graduates. To this day, the student population at California universities still "reflect[s] a persistent inability to increase opportunities" for all racial groups.[16]

Such a dramatic decline in enrollment of Black and Latino students in US higher education, as in California following voter approval of Proposition 209, is an untenable position.

Admissions practices such as legacy and use of standardized tests have racially disparate impacts that disfavor Black and Latino applicants. Our members discussed the conflation of SAT performance with perceived worth and aptitude. Data from the state of California show that race, family income, and parental education account for 43% of the variance in SAT score.[17] In other words, the influence of these factors, which are outside of the control of individuals, undermine the use and quality of the SAT by suggesting that it may be more affected by social class and family background than affirmative action critics are willing to admit. We have personally experienced the social stigma and emotional harm that poor reasoning on the meaning of SAT performance has caused. These same critics overlook the racially discriminatory practice associated

with legacy as a determinative tipping point in college admissions.

The relevance of the SAT has been closely associated with student outcomes during college. We find that this line of reasoning is fallacious and comes at great emotional and social cost to students from modest income families, regardless of race. In our experiences in the last three decades in higher education as students, administrators, and professors, the institutional culture and student mistreatment within higher education have erected barriers to a positive student learning environment. To justify SAT based on student outcomes minimizes the adversity and added stress that disadvantaged students had to overcome.

The Future of Public Health Economy Study on Race

We also discussed the social and political construction of race. Rather than wish away race and racism, we should lean into it — preserving race and ethnicity while enriching and modernizing analytical approaches. There is much to study and affect for descendants of families of slavery and Jim Crow, families experiencing intergenerational poverty, victims of environmental injustice and racism, those experiencing labor exploitation, income-driven or forced displaced populations, exposure to poverty, and chronically low-resource environments.

Racial identity is central to Black Americans. "A majority of non-Hispanic Black Americans (78%) say being Black is very or extremely important to how they think about themselves."[18] Black Americans are not a monolithic group with an exclusive shared history, culture, or set of beliefs, racial identity. Yet, racial identity shapes cultural, religious, and political expression. The philosophy of colorblindness by "deeming race irrelevant in law does not make it so in life."[16] There is no genetic basis for race, but the racialization of US society cannot be denied, "centuries of racism in this country has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment."[19] Racialization of US society, borne out of slavery and reinforced over centuries, has come at great costs to African Americans. Yet, through their collective struggle and liberation, this racialization has solidified the foundation on which they have sustained and thrived within hostile conditions.

Latinx members of PHL shared that race is not a readily accessible concept. Indeed, the history of racial construction in the US has largely posited a dichotomy between Blacks and Whites and forced a false choice for a sizable share of the Latinx population. Forty-two percent of Hispanic or Latino respondents selected “some other race” in the 2020 US Census.[20] Hispanic and Latinx identity remains strong.

Public Health Liberation is sensitive to all populations most disadvantaged in the Public Health Economy. As such, we must endeavor to understand and define those who are most burdened by and would most benefit from accelerated gains in the Public Health Economy without jettisoning race. Our research should reflect richness and cultural sensitivity to the value of racial identity. For health equity advocates, it will do us no favor to support racial erasure. That is not to say that we cannot conduct subgroups analyses. In fact, a substantial body of evidence has shown public health benefits for examining Hispanic/Latinx ethnicities (e.g., Puerto Rican, Cuban, Mexican) to better explain health disparities.[21]

White ethnicities exist too, as former Virginia Senator Jim Webb reminded us in his book on the Scots-Irish of Appalachia, "Their cultural identity reflected acute individualism, dislike of aristocracy and a military tradition, and, over time, the Scots-Irish defined the attitudes and values of the military, of working class America, and even of the peculiarly populist form of American democracy itself."[22] West Virginia delegates took part in the Poor People's Campaign in 1968. Here in our community of practice in Washington, DC, their interracial contingent was housed right in our neighborhood. They wanted the same as other attendees — economic justice for poor people.

Public Health Liberation strongly believes that the study and effectuation of the Public Health Economy must be the new frontier of public health. Considering recent decisions, public health would strengthen disciplinary training by examining how health inequity is made and reproduced. For example, PHL members considered in our recent meeting how debates over states' right loom large in judicial determinants of

health — a hallmark of US political history from its inception. In Roe v. Wade, the Court decided, "A state criminal abortion statute of the current Texas type, that excepts from criminality only a lifesaving procedure on behalf of the mother, without regard to pregnancy stage and without recognition of the other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment."[23] Essentially, the states' right issue was re-argued under different political and judicial conditions in the *Dobbs* decision. It benefits public health discourse to understand this point — and a broadened view of the Public Health Economy.

Citations

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