Using Civil Rights Tools to Address Health Disparities

Michael Rodriguez, MD, MPH; Marc Brenman; Marianne Engelman Lado, JD; and Robert García, JD
ABOUT THE CITY PROJECT

The City Project believes that all people should have access to healthy, livable communities. Our multicultural, Latino-led team works with diverse allies to ensure equal access to (1) healthy green land use through planning by and for the community; (2) physical education and schools of hope as centers of their communities; (3) health equity and wellness; and (4) economic vitality for all, including jobs and avoiding displacement as communities become greener and more desirable. The mission of The City Project is to achieve equal justice, democracy, and livability for all.

“Of all the forms of inequality, injustice in health care is the most shocking and inhuman.”
- Dr. Martin Luther King, Jr.

On the cover: Los Angeles State Historic Park and the greening of the L.A. River
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Policy Report
The City Project
2014

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ABSTRACT

Ethnic and racial health and health care disparities are persistent and pervasive. Despite a wide range of approaches to address these disparities, they remain largely intact. The Affordable Care Act of 2010 (ACA) is expected to reduce disparities in access to health care and addresses health discrimination. In addition, the Civil Rights Act of 1964, the cornerstone legislation that prohibits discrimination based on race, color, and national origin by recipients of federal funding, and Executive Order 12898 on environmental justice and health can be used to address health disparities. If utilized consistently and applied with renewed efforts, civil rights laws can continue to address health care issues and reduce health disparities. These legal tools cut across diverse federally funded programs and activities. This article examines four health-related areas with disparities based on race, color, or national origin: (1) food stamp programs; (2) physical education in public schools; (3) parks and healthy green land use; and (4) access to health care services for limited English proficiency (LEP) populations. Civil rights laws including Title VI offer tools that attorneys and other stakeholders working with public health professionals, community groups, government agencies, and recipients of federal funds can use to alleviate health disparities. These legal tools are not limited to a litigation strategy. Voluntary compliance with civil rights laws is the preferred means to achieve equal justice goals. Civil rights attorneys continue the struggle to uphold and strengthen these laws.

1. INTRODUCTION

Extensive literature documents widespread ethnic and racial health disparities in the United States today. These disparities are persistent and pervasive, prompting a need for multifaceted approaches to reduce and eliminate them. Federal dollars support programs that promote the health and welfare of US residents. Some of these programs or activities include food stamp programs (FSP), physical education classes in public schools, parks and healthy green land use, and translator and interpreter services for limited English proficient (LEP) populations. Civil rights laws including Title VI offer tools that attorneys and other stakeholders working with public health professionals, community groups, government agencies, and recipients of federal funds can use to alleviate health disparities. These legal tools exist in access to these programs or activities.

Civil rights tools are available to address health disparities. The tools analyzed here include: Title VI of the Civil Rights Act of 1964 and its regulations, which prohibit discrimination based on race, color, or national origin in programs or activities of recipients of federal funding; Executive Order 12898 addressing environmental justice and health; and the antidiscrimination provisions of the Affordable Care Act. These authorities are analyzed in more detail below.

While public health officials working with civil rights attorneys and federal officials in and out of court have historically addressed many health discrimination issues, more remains to be done. For example, the federal Hill-Burton Act enacted in 1944 provided more than $100 million per year in direct aid to states for health and hospitals. The act explicitly provided for “separate but equal” health services and facilities. Ten years later, the U.S. Supreme Court in Brown v. Board of Education in 1954 held that segregated public schools are inherently unequal and violate the Equal Protection Clause of the 14th Amendment. The National Medical Association and NAACP Legal Defense Fund lawyers worked together, with support from U.S. Justice Department, to challenge the “separate but equal” provision. In 1963, a federal court of appeals struck down the “separate but equal” provision of the Hill-Burton Act in Simkins v. Moses H. Cone Memorial Hospital. The court ruled in favor of a class that included Black physicians, dentists and patients who were excluded from private White hospitals that received federal funding. Soon after, Congress passed Title VI of the Civil Rights Act of 1964, and federal agencies enacted regulations under Title VI. Congress then passed the Medicare Act in 1965. Medicare funding, coupled with the Title VI prohibition against discrimination by recipients of federal funding, has helped end discrimination in health services and facilities. In the 50 years since its passage, Title VI has been used to challenge hospital closures and relocations and other discriminatory health care practices. Title VI has been used to address discriminatory programs and activities in other areas that affect health, including education, park access, and transportation. The ACA reflects a renewed commitment by Congress and the President to eliminate health discrimination.

Lessons from the Civil Rights Movement are especially appropriate in light of the 20th anniversary of the Executive Order 12898 on environmental justice and health, the 50th anniversary of the Civil Rights Act of 1964, and the 60th anniversary of Brown v Board of Education in 2014. In addition, Civil Rights advocates are fighting to uphold the disparate impact standard of discrimination under the Fair Housing Act in the US Supreme Court in 2015. In the Inclusive Communities Project case, opponents are challenging the right to fight unfair and unjustified discriminatory impacts, even where there are less discriminatory alternatives, absent proof of intentional discrimination. This reflects a general attack on civil rights tools to combat discrimination.
Racial and ethnic discrimination in health care persists. In 2003, the Institute of Medicine published a landmark study of health care disparities. The book includes a chapter on the civil rights dimension of racial and ethnic health disparities by Tom Perez, who later served as Assistant Attorney General for Civil Rights in the U.S. Department of Justice and Secretary of Labor. In this chapter, Perez notes that “discrimination is a root cause of health disparities, and a comprehensive strategy to eliminate disparities must incorporate a strong civil rights component.” The chapter further outlined a host of civil rights interventions to address these widespread and persistent disparities.

Why are civil rights protections necessary to protect health and life itself? The documented costs of health inequalities are great. Between 2003 and 2006, for example:

- The combined costs of health inequalities and premature death in the U.S. were $1.24 trillion.
- Eliminating health disparities for people of color would have reduced direct medical care expenditures by $229.4 billion.
- 30.6% of direct medical care expenditures for African Americans, Asians, and Hispanics were excess costs due to health inequalities.
- Eliminating health inequalities for people of color would have reduced indirect costs associated with illness and premature death by more than one trillion dollars.

The World Health Organization defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” WHO recognizes that the social determinants of health – the conditions in which people live, learn, play, pray, work, and age – are significant factors in health equity and disparities, and calls for health in all policies. The WHO definition of health is consistent with the broad view of health under the Affordable Care Act.

This report examines how civil rights tools, including Title VI and Executive Order 12898, can be used to promote health equity through programs or activities by recipients of federal funding. We explore health equity and disparities in four programs or activities: (1) food stamp programs; (2) physical education classes in public schools; (3) parks and healthy green land use; and (4) translator and interpreter services for limited English proficient populations in the health care setting. Finally, we discuss civil rights laws and tools that attorneys and other stakeholders can use to alleviate health disparities beyond litigation.

2. EXAMPLES OF FEDERALLY FUNDED PROGRAMS AND ACTIVITIES

Food stamps

The federal food stamp program, now known as the Supplemental Nutrition Assistance Program (SNAP), provides federal financial assistance to increase the food purchasing power and nutrition of low-income households. Food stamps are considered by the US government to be a “first line of defense against hunger” and a central component of US policy to alleviate hunger and poverty. Food stamps are a valuable tool in reducing household food insecurity and improving nutrition in the US. Household food insecurity is defined as “when the availability of or ability to acquire safe and adequate food is limited or uncertain.” Reducing food insecurity contributes to increased academic achievement in children, lowers body mass index (BMI) and reduces the severity of metabolic syndrome conditions.
Food stamp eligibility is based on two main requirements: household income lower than 135% of the federal poverty line (FPL) and at least five years as a legal resident of the United States. Currently, 15% of the US population receives food stamp benefits averaging $134/person per month. During fiscal year 2012, the program served more than 46 million people in an average month at a total annual cost of over $74 billion in benefits.

Despite the proven success of this program with seemingly neutral eligibility criterion, only 57% of eligible households that experience food insecurity received some form of federal food or nutritional assistance in 2011. In 2010 in California, only 55% of the people eligible (5,840,000) participated in the food stamp program, whereas the United States had a 75% average participation rate for those eligible.

Nationally, limited availability and access to food is 2.5 times as prevalent among Latinos and non-Latino Blacks compared with their White counterparts. Twice as many households headed by Latinos or Blacks are food insecure compared with households headed by Whites. In California, Latinos suffer the worst levels of food insecurity: 44% of low income (at or below 185% of the FPL) Latinos are considered food insecure, the highest level of any race or ethnicity in the state.

Despite suffering high food insecurity, eligible Latinos have lower participation rates in using food stamps than the national average. For Latinos, limitations to food stamp access have been attributed to transportation costs, the process required to complete forms and determine eligibility, and language barriers. Anecdotal information indicates that many eligible Latinos are discouraged from applying for food stamps due to unequally applied practices by agencies that provide food stamps.

Children of immigrants (93% of whom are US citizens) are less than half as likely as children of US-born parents to receive food stamp benefits, despite the higher poverty rates that children of immigrants have. Two of the major predictors of a family not participating in food stamps are working more than 40 hours per week and immigration status. Children of immigrant families were more likely to live in families with difficulties affording food and without food stamp benefits (20% of immigrant families vs. 40% of US-born families utilizing federal food stamps benefits).

Physical education programs in public schools

Physical education in K-12 has great potential to promote the health of students attending schools in the US. School environments are an efficient and effective way to best promote healthy lifestyles through physical education. No other institution has as much contact with or influence on youth during the first two decades of their lives in terms of continuity and intensity. In fact, federal guidelines recommend that elementary school students receive 150 minutes of school physical education per week and that middle and high school students receive 225 minutes of school physical education per week. Of the 50 states, 41 have instituted physical education mandates for the elementary school level, but only six states meet the 150 minute per week recommended guidelines. In addition, 37 states have mandated middle school physical education with only two adhering to the 225 minute per week guideline. Forty-one states mandated high school physical education, but no state meets the 225 minute per week guidelines for physical education.

Physical education and regular opportunities for physical activity are important components in the fight against obesity and other related chronic conditions. Obesity and related conditions disproportionately affect communities of color. In 2005 in California, Samoan children had the largest percentage (54%) of all children in the state whose BMI was not within the California public school Healthy Fitness Zone standard. Latino children (38.9%), Native American children (36.1%), and Black children (32.4%) also had significant percentages outside of the Healthy Fitness Zone in comparison to 23.1% of non-Hispanic white children. This trend is seen in adults as well, where 32% of Black, 28% of Latino, and 32% of Native Hawaiian Pacific Islander adults were obese, in comparison to 19% of non-Hispanic white adults.
Access to physical education is a right under California law. The California Court of Appeal has held that the State Education Code requires an average of 20 minutes of physical education per day in elementary schools, and that parents and students have the right to sue a school district for failure to comply with that law. Yet, half the public school districts audited in California from 2005 to 2009 did not comply with the physical education minutes requirements. A 2013 study of San Francisco public schools revealed a substantial gap between reported compliance and actual compliance with state law. Eighty-three percent of elementary schools reported they met the minutes requirements for physical education, but when the schools were monitored, only 5% met the requirements. Unfortunately, this is a nationwide trend. A 2013 study found that states with school physical education policies which required a certain number of minutes or percentage of time engaged in physical activity were monitored only through schools self-reporting progress to the state, resulting in biased reports and insufficient opportunities for physical activity. A separate study showed that noncompliant districts had a higher percentage of Black and Latino students than districts that were compliant. The Los Angeles Unified School District, the second largest in the nation, has adopted a plan to comply voluntarily with state physical education and federal and state civil rights requirements, in response to an organizing campaign and administrative complaints.

The Institute of Medicine recommends monitoring compliance in providing physical education minutes, addressing disparities, improving teacher education, making physical education a core subject, and addressing physical activity in the whole school environment. Failure to provide physical education in school may adversely impact health outcomes, as well as academic achievement. Studies have shown that: (1) physical education has either a neutral or positive effect on testing; (2) cognitive function may be linked positively with physical activity in elementary and middle school students; (3) physical education may be associated with reduced overweight or obesity, lower blood pressure and improved bone health; and (4) physical education is an important component in the fight against obesity and other related chronic conditions.

Parks and healthy green land use

In a historic moment, President Barack Obama recognized that there are disparities in park access for people of color, that this contributes to health disparities, and that agencies need to address these social justice issues.

Too many children . . . especially children of color, don’t have access to parks where they can run free, breathe fresh air, experience nature, and learn about their environment. . . . This is an issue of social justice. Because it’s not enough to have this awesome natural wonder within your sight – you have to be able to access it.

President Barack Obama’s words ring true in communities across the nation. He was speaking of L.A. County when he dedicated the San Gabriel Mountains National Monument in Southern California in 2014. According to the White House, improving public access and recreational opportunities will help address the region’s public health challenges. Studies have shown that increasing recreational access to public lands translates to higher levels of youth activity and lower youth obesity rates.
Park Poor, Income Poor and People of Color

Demographics - American Community Survey (ACS) 5-year blockgroup estimates 2006-2010, US Census Bureau
census.gov/acs/www/data_documentation/summary_file/
*348,706 is 60% of the statewide average and is used to define a disadvantaged community in California. Cal. Pub. Res. Code §§ 5642(f), 75005(g).
Existing Park/Green Space - California Protected Areas Database (CPAD) v1.8 July 2012, GreenInfo Network calandals.org. All parks and open space are used to calculate acres of parkland per 1000 people, including Forest Service, Bureau of Land Management and large state/regional parks.
State Parks are defined as lands owned by The California Department of Parks and Recreation. This includes: state beaches, state recreation areas, state vehicular recreation areas, and state historical parks.
Map and analyses by The City Project and GreenInfo Network, September 2013, cityprojectca.org and greeninfo.org. CC BY NC SA
The State Parks logo does not imply editorial content has been authored by or represents the views or opinions of the Department.
The preceding map shows communities that are disproportionately park poor, income poor, and of color in California. Numerical disparities are a starting point for analyses under civil rights and environmental justice standards. GIS and demographic analyses provide important tools for this purpose.

In 2011, the National Park Service (NPS) published a Healthy Parks, Healthy People US Strategic Action Plan and Science Plan. NPS recognizes that people of color and low-income people face disparities in access to parks and recreation, and these disparities can impede their health. Park agencies have an obligation to alleviate these disparities. For example, 36% of Black and 35% of Latino high school students nationwide are overweight or obese, while 24% of non-Hispanic White high school students suffer from these conditions. Evidence-based social science research shows that parks can play an important role in alleviating socioeconomic health disparities. Yet, non-Hispanic Whites have disproportionately greater access to parks, with 12 to 15 times more park acreage per capita than Latinos and African-Americans in Los Angeles County. This reflects disparities nationwide. Communities with the least amount of green access tend to have higher rates of obesity and diabetes. The National Parks Service relies on the WHO definition.

NPS recommends a new national recreation area in the San Gabriel Mountains, where the population is disproportionately Hispanic (64%) and Asian Pacific Islander (16%), citing civil rights and environmental justice protections. According to NPS, economically disadvantaged people in the study area lack access and the ability to enjoy existing green space due to lack of close-to-home open space, lack of effective transportation, lack of culturally advantageous facilities or opportunities, and lack of knowledge about recreation and natural resources. Diversifying access to and support for the San Gabriels, including recommendations to improve transit for underserved communities, will benefit the diverse local population and the greater Los Angeles region.

Furthermore, access to parks and green space has a profound effect on human health and psychological wellbeing. In 2010, a National Recreation and Park Association (NRPA) report found that green environments fostered greater mental health, with lower susceptibility to stress, anxiety disorders, depression, and aggression, as well as greater resiliency and cognitive functioning. Urban communities of color without access to green space, however, are particularly subject to mental health disorders. A 2001 study of Chicago’s Robert Taylor Homes, one of the poorest neighborhoods in America, revealed that residents with views of only asphalt and concrete reported systematically higher levels of aggression and violence than residents living in identical buildings with views of trees and grass. A follow-up study in the Ida B. Wells low-rise apartment development found that buildings with high levels of vegetation had 52% fewer total crimes, 48% fewer property crimes, and 56% fewer violent crimes than buildings with low levels of vegetation. Ultimately, the studies found that “more green translates to less aggression, less transgression, more socializing, and more acts of caring.” Furthermore, studies of 7- to 11-year old children diagnosed with attention deficit/hyperactivity disorder have found that children’s concentration performance was better after 20-minute walks in an urban park than after walks of equal length in a neighborhood or downtown area. Thus, park poor communities of color with limited or no access to green space are unjustly subject to mental and physical health disparities that can affect length and quality of life.

The following map shows ParkIndex scores for Los Angeles County. ParkIndex measures access to green space on a scale of 0 to 100, with 100 being best access. ParkIndex offers a tool for analyzing disparities in park access.
**Limited English Proficient (LEP) programs**

A LEP person is defined as someone who “does not speak English as their primary language and who has a limited ability to read, write, speak or understand English.”65 More than one sixth of the US population speaks a language other than English at home, and this number is increasing.66 The fastest-growing non-English speaking groups are Latinos and Asian Americans.67 In 2006 in California, 40% and 36% of the Latino and Asian American population respectively had limited English proficiency.68 Furthermore, Latinos and Asian Americans comprise 78% of the foreign-born population nationwide since 2000.69 Health-related challenges for LEP patients include: (1) conversing with their health care professional; (2) reading health-related materials; (3) taking an active role in their own health care decisions; and (4) following instructions for care in English.70

![People’s March for Climate Action, New York City, 2014](image)

Legal tools are available to address the needs of LEP patients. Discrimination on the basis of national origin includes discrimination on the basis of language. In *Lau v. Nichols*, the US Supreme Court held that public schools in San Francisco discriminated against non-English speaking Chinese American children and deprived them of effective educational services when they did not provide materials in the children’s native language.71 In 2000, Executive Order 13166 directed federal agencies to develop guidelines for providing services and removing language barriers for persons who are LEP.72 Forty-three states have laws addressing national origin and language discrimination in health care settings.73 In addition, hospital guidelines, including the National Culturally and Linguistically Appropriate Services (CLAS), follow joint commission standards that recommend the routine use of professional interpreters.74

Despite these laws and recommendations, professional interpreters, language assistance tools and translations continue to be underutilized and provided at an insufficient rate to meet demand and need.75 LEP patients are frequently not provided the necessary resources to improve their quality of care.76 Failure to provide appropriate and effective language assistance to LEP persons compromises the quality of care that they receive.77 Yet, in a national study examining hospitals and their level of compliance with the National Culturally and Linguistically Appropriate Services (CLAS) standards, which include culturally and linguistically competent care, 19% of hospitals surveyed did not comply with any of the standards.78

LEP status contributes to ethnic and racial disparities in certain dimensions of access to care, such as preventative services and usual source of care, and contributes to higher utilization of emergency room services and delayed service related to lower health knowledge in emergency situations.79 When patients have difficulty communicating with their physicians, they are also more likely to receive inappropriate diagnoses and treatment and lower quality of care, have lower comprehension and adherence to medication regimens, lower patient satisfaction, and lower overall health outcomes.80 Limited English proficiency status can contribute to a lack of awareness of health conditions, creating a barrier to recognizing services and treatment that are necessary.81 In addition, reduced access to care has been shown for the LEP population even when adjusting for ethnicity and socioeconomic status.82

LEP patients were also less likely to receive preventative health services such as cervical and breast cancer screenings as well as cancer-preventable vaccines, compared to their English-speaking counterparts.83
Americans are the only racial/ethnic group for whom the leading cause of death is cancer – total deaths caused by cancer is 27.7% in Asian Americans in comparison to 23.3% for non-Hispanic whites. Furthermore, 29% of Asian American women are noncompliant with cervical cancer screening guidelines, in comparison to 14% non-Hispanic white women. Twenty-six percent of Asian American women are noncompliant with breast cancer screening guidelines, in comparison to 21% of non-Hispanic white women. Finally, 53% of Asian Americans were noncompliant with colorectal cancer screening guidelines, in comparison to 42% of non-Hispanic whites. A similar finding was found among Mexican American men, who were 1.32 times, and those with LEP 1.68 times, more likely to have never had colorectal cancer screening tests despite having a higher prevalence of diagnosis in advanced stages.

Patients with LEP who did not receive effective language assistance services were also more likely to have poor glycemic control as compared with those who received assistance in their native language. This was also observed with asthma when LEP patients demonstrated poor asthma control, lower access to inpatient services, and poorer overall quality of life compared with their English-proficient counterparts.

Spanish and Cantonese speakers were the least likely to access mental health services as compared with English-speaking Latino and non-Latino White people. Individuals with LEP were more likely to forego necessary medical care and less likely to have a health care visit, compared with individuals who were proficient in English. LEP disparities also translate into lack of services that LEP patients seek for their children, with LEP patients having greater odds of not seeking necessary care for their children, resulting in fair or poor health status.

LEP Latino patients report fewer services and less satisfaction with health provider communication than do other patients. In studies examining whether clinicians provided health advisement, researchers found that obese, English-proficient Latino patients were about 50% more likely to report having received advice for physical activity and/or diet compared with LEP Latino, obese patients. Moreover, a 2006 study of adult patients in California found that 11% of Latinos and 7% of Asian Americans—groups with large percentages of LEP populations—perceived race-based discrimination in medical care, in comparison to 3% of non-Hispanic whites.

Patients who had both Medicare and Medicaid had better health outcomes compared to the elderly with Medicare alone. This may be partially due to the federal mandate that requires Medicaid to supply interpreting services to LEP patients. Also, when language policies were implemented, there was greater utilization of mental health services within that population.

Despite the federal mandate to provide LEP services, these mandates are enforced weakly, if at all. Patients can make a complaint with the U.S. Department of Health & Human Services, Office for Civil Rights (OCR) to initiate an investigation. However, LEP status presents added challenges in navigating the system for filing a complaint, underscoring the importance of greater compliance, implementation and enforcement of existing laws, as well as how LEP services should be provided for the complaint process itself.

3. WHAT ARE THE CIVIL RIGHTS AUTHORITIES?

Health disparities raise concerns about potential intentional discrimination, and unjustified and unnecessary discriminatory impacts. The discriminatory impact standard can ferret out subtle and structural practices that have demonstrably discriminatory effects. A thoughtless policy can be as unfair as, and functionally equivalent to, intentional discrimination. As a matter of common sense, discriminatory programs or activities should be avoided in favor of those that serve everyone's interests fairly, effectively, and without discrimination. This section will discuss the legal authorities to address health inequities and will present an analytic framework.
Title VI of the Civil Rights Act of 1964 prohibits intentional discrimination by recipients of federal financial assistance based on race, color, or national origin, including LEP. Title VI regulations adopted by federal agencies prohibit unjustified and unnecessary discriminatory impacts. According to President John F. Kennedy in his message to Congress on Title VI, “Simple justice requires that public funds, to which all taxpayers of all races contribute, not be spent in any fashion which encourages, entrenches, subsidizes, or results in racial discrimination.” Recipients of federal financial assistance sign contracts to comply with Title VI as a condition of receiving federal funds. California and other states have similar laws prohibiting intentional and disparate impact discrimination.

The Affordable Care Act provides important protections against health discrimination based on race, color, national origin, LEP, and other characteristics. Specifically, ACA section 1557 states that no individual, on the basis of race, color, national origin, or other characteristics shall "be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance." Section 1557 also applies to any program or activity administered by a federal executive agency. Section 1557 references prior laws that protect against health discrimination, including Title VI. The ACA includes more than 60 provisions to advance health justice through a broad range of actions, sectors and actors. Thus, the ACA includes physical activity, healthy land use, and infrastructure projects as part of its mandate. This underscores how equal access to wellness and prevention programs is an important component of the ACA and health promotion.

Executive Order 12898 on environmental justice and health requires each federal agency to “make achieving environmental justice part of its mission by identifying and addressing, as appropriate, disproportionately high and adverse human health or environmental effects of its programs, policies, and activities on minority populations and low-income populations.” The accompanying Presidential Memorandum identifies Title VI as one of several federal laws to be applied to prevent these communities from being subject to discriminatory effects. Environmental justice embraces the principle that all people and communities are entitled to equal protection of our environmental, health, employment, education, housing, transportation, and Civil Rights laws, according to Dr. Robert Bullard.

These civil rights laws may facilitate the use of health impact assessments (HIAs). A compliance analysis may require an HIA, and an HIA may inform the compliance and equity review. "Recognizing and addressing the effects of a proposal on health equity (or health disparities) between various groups has been seen as a core task of HIA, although HIA practice has sometimes been criticized for a lack of attention to health equity." The major steps of an HIA are consistent with, and complementary to, the legal framework described later in this article.

4. WHAT IS THE CIVIL RIGHTS ANALYSIS?

Voluntary compliance is the preferred means to achieve health equity and other civil rights goals. Planning, funding, and administrative processes offer opportunities for public agencies and other stakeholders to improve the health and lives of people of color and low-income people without litigation. Collecting, analyzing, and publishing data on health disparities is an important step of any comprehensive effort to eliminate health inequities. Numerical disparities are an important starting point for analyzing compliance with civil rights and environmental justice standards under both the disparate impact and intentional discrimination standards. GIS and demographic analyses, as illustrated in the maps in this report, provide invaluable tools to understand disparities in access to public resources. Although statistical disparities alone are seldom sufficient to prove discrimination, data collection and analysis provides necessary information and can inform strategies to eliminate health disparities. In addition, even if the factual disparities are based on race and ethnicity, race-neutral solutions can be provided. For example, parks in underserved communities improve park access for all people.
Compliance Analysis

A compliance and equity analysis for a program or activity by a recipient of federal financial assistance includes the following steps under Title VI and its regulations, and Executive Order 12898 addressing environmental justice and health.\(^{117}\)

1. Describe the program or activity.
2. Analyze the burdens and benefits for all people.
3. Analyze alternatives.
4. Include people of color and low-income people in the decision-making process.
5. Implement a plan to address equity concerns and avoid discrimination.

A best practice example of how funding agencies can use a compliance analysis is the development of what is now the Los Angeles State Historic Park.

This site could have been warehouses in downtown L.A. Instead, it is now a park. Andrew Cuomo, who was then-secretary of the U.S. Department of Housing and Urban Development, withheld federal subsidies for a proposed warehouse project at the site unless a full environmental study was conducted to consider the park alternative and the impact on people who were of color or low-income. As a result, the state bought the land and created the park. HUD relied on Title VI and Executive Order 12898 on environmental justice in response to an administrative complaint filed by diverse allies.\(^{118}\)

Unjustified Discriminatory Impacts

A compliance and equity analysis helps guard against discriminatory impacts. The disparate impact framework includes an analysis that seeks answers to the following questions:\(^{119}\)

1. Are there numerical health disparities? Disparities can be shown through statistical or social science evidence, or anecdotally. Data collection and analyses is relevant here.
2. Are the disparities justified by business necessity? Alternatively, is there a substantial legitimate justification for the disparities?
3. Even if so, are there less discriminatory alternatives to promote similar goals?

The federal court of appeals decision in *Larry P. v. Riles* illustrates how to apply the disparate impact analysis. The court held that the use of IQ tests to place Black students in classes for the “educable mentally retarded” violated the disparate impact standard under Title VI and its regulations using the framework shown above.\(^{120}\)

1. The tests disproportionately placed Black students in those classes.
2. The disparities were unnecessary and unjustified because the tests were not validated for the purpose used.
3. Schools have less discriminatory alternatives to evaluate students, such as considering the full background of the child.
Following this framework, thumbnail disparate impact analyses of the health inequities discussed in this article are shown below. These examples are presented here only for purposes of illustration, recognizing that a complete analysis would be much more thorough and fact-based.

**Food stamps**

1. Data show disparities in food stamp participation, especially among Latinos. Collecting and analyzing data to disaggregate participation rates by race and ethnicity at the state and county level, where food stamp programs are administered, is necessary to understand disparities.
2. Are such disparities justified by business necessity? Or is there a substantial legitimate justification for the disparities?
3. Are there less discriminatory alternatives to promote food security and health? Researchers have called for increasing awareness of food stamps, streamlining the application process, and making food stamp applications available via phone or online. Indeed, failure to provide Spanish speakers with information about food stamps in Spanish can be a form of intentional discrimination, as discussed below.

**Physical education**

1. Black and Latino students are disproportionately denied physical education, as discussed above.
2. The disparities are unnecessary and unjustified. School districts can eliminate the disparities by complying with the legislative and judicial mandates to provide physical education, as many districts do.
3. There are less discriminatory alternatives, as many school districts do comply with the minutes requirement.

**Parks and healthy green land use**

As one example, disparate impact questions for improving green access to the San Gabriel Mountains and along the Los Angeles River would be:

1. Are there numerical disparities in green access and health? Planning studies by NPS and Army Corps of Engineers document such disparities.\(^{121}\)
2. Are these disparities justified by business necessity? Or is there a substantial legitimate justification for these disparities? Disparities in green access in Los Angeles are not the result of unplanned growth or an efficient market. Disparities are the result of a history of discriminatory land use, mortgage and housing policies, and segregated parks.\(^{122}\)
3. Even if so, are there less discriminatory alternatives to promote healthy green access? Proper planning, including compliance with civil rights laws, can provide equitable, sustainable alternatives that promote green access for all.

The following map shows that people of color disproportionately live in areas that are the most burdened for pollution and toxics, are the most vulnerable to health risks, and live in the most park poor communities. Thus:

1. In the areas with the 10% highest CalEnviroScreen (CES) score (most burdened) for pollution burden and vulnerability, fully 89% of the people are of color; only 11% are non-Hispanic white people. Statewide, the population average is 58% people of color.
2. In the areas with the 10% lowest CES score (least burdened) for pollution burden and vulnerability, only 31% of the people are of color; fully 69% are non-Hispanic white people.
3. 64% of people of color in the state live in areas with the 50% highest CES scores (most burdened) for pollution burden and vulnerability; only 31% of non-Hispanic white people live in those areas.
4. Only 36% of people of color in the state live in areas with the 50% lowest CES scores for pollution burden and vulnerability; fully 69% of non-Hispanic white people live in those areas.\(^{123}\)
Intentional Discrimination

A compliance and equity analysis also guards against intentional discrimination. The U.S. Supreme Court has described the kinds of evidence that are relevant to assess claims of intentional discrimination, including the following:

1. An important starting point for assessing intent is the impact of the action, and whether it bears more heavily on one racial or ethnic group than another. This is similar to the numerical inquiry under the disparate impact standard.
2. Whether there is a history of discrimination.
3. Compliance with, or departures from, substantive norms in reaching the decision.
4. Compliance with, or departures from, normal procedures.
5. Whether decision makers know of the impact of their actions.
6. Whether there is a pattern of discrimination.

The intentional discrimination standard remains an important tool in the 21st Century. Research supports evidence of numerical health disparities, as discussed above. The scientific literature demonstrates the history and legacy of discrimination that has existed in the US health care system since its inception, most frequently studied among African Americans. The federal Hill-Burton Act discussed above funded "separate but equal" health services and facilities until 1963, for example. In Tuskegee, public health officials diagnosed Black men with syphilis and left them uninformed and untreated for decades. In Guatemala, US public health officials intentionally infected Guatemalan victims beginning in the 1940s and left them untreated and uncompensated to the present day. False and discriminatory diagnoses persist. For example, Susan Matsuko Shinagawa in 1991 was told by her doctor after a sonogram revealing a solid mass in her breasts that she was "too young to have cancer, [had] no family history of cancer, and besides, Asian women don’t get breast cancer." Fortunately, Shinagawa obtained a second opinion, which determined that the lump was indeed breast cancer. Substantive norms generally support equal access to publicly funded resources, including health care and wellness programs. Departures from substantive norms and normal procedures may be evidence of intent. Failure to collect, analyze, and publish data necessary to understand the impact of a program or activity, where there is evidence of disparities, may be evidence of intent. Examples of intentional discrimination and evidence demonstrating it appear below.

Food stamps and LEP

The district court in *Almendares v. Palmer* held that failure to provide bilingual information to Spanish-speaking Latino food stamp recipients can constitute intentional discrimination based on national origin, in violation of Title VI. Plaintiff Spanish-speaking recipients of food stamps alleged that defendant food stamp agencies purposefully discriminated against them when defendants chose to continue a policy of failing to provide bilingual services, knowing that Spanish-speaking applicants and recipients of food stamps were being harmed as the consequence. The court held that if this were proven at trial, this evidence would support a finding that the policy constituted intentional discrimination because of the numeric impact on LEP Spanish speakers. The subsequent settlement agreement included a provision requiring the state and county to conduct a demographic analysis of food stamp recipients and engage in other outreach efforts.

Physical education

For physical education concerns, the following is evidence of intentional discrimination.

1. Evidence shows that failure to provide physical education disproportionately impacts Latino and Black students, as discussed above.
2. There is a history of discrimination in public education in California. Additional research could be necessary at the individual school district level.
3. There are substantive irregularities in failing to provide physical education. Substantive quality education and health standards require physical education.
4. There are procedural irregularities in failing to provide physical education. Procedurally, districts do not seek exemptions; they simply do not provide physical education.
5. Decision makers know the impact that the failure to provide physical education has on students. Social science and advocacy can be used to establish this knowledge.
6. There is a pattern of discrimination in education in California, including the factors above.
Evidence of intentional discrimination for park access would include the following:

1. People of color face disparities in access to parks, as demonstrated by the studies by NPS and Army Corps of Engineers, among others.
2. Disparities in green access in Los Angeles are not the result of unplanned growth or an efficient market. Disparities are the result of a history of discriminatory land use, mortgage and housing policies, and segregated parks.  
3. Departures from substantive norms and (4) departures from normal procedures. Substantive norms support equal access to parks and public resources. Advocates argued that the city’s failure to conduct an environmental review that considered the park alternative and the impact on people who were of color and low income was a substantive and procedural irregularity in the HUD matter discussed above.
4. Proper planning includes data collection and analysis to inform decision makers and stakeholders of the impact of public actions. Disparities in health and green access are well-documented.
5. There is a pattern of discrimination in the distribution of environmental benefits and burdens, as evidenced by the CalEnviroScreen map and analyses above.

HOW CAN CIVIL RIGHTS COMPLIANCE AND ENFORCEMENT ADDRESS HEALTH INEQUITIES?

Many avenues are available to alleviate health inequities through civil rights laws and international principles. For example, the US Department of Health and Human Services (US DHHS), which is primarily responsible for implementing the ACA, and other federal agencies can guard against health discrimination through planning, regulations, data collection and analyses, review of federal funding applications, contractual assurances of compliance by recipients of federal financial assistance, compulsory self-evaluations by recipients, compliance reviews after funding, investigation of administrative complaints, full and fair public participation in the compliance and enforcement process, and termination and deferral of funding. The Department of Justice has civil rights coordinating responsibility with federal agencies and can enforce civil rights laws in court.

The US DHHS issued a request for information in the process of drafting regulations to implement the antidiscrimination provisions of the Affordable Care Act. This is a best practice example of using the planning and regulatory process.  

The NPS and Army Corps studies for park access in the San Gabriels and along the Los Angeles River discussed above are best practice examples of using the planning process to include civil rights compliance.

Private individuals and groups can file administrative complaints with funding agencies. They should have a fair say in the investigation and resolution of those complaints. The administrative complaint process and funding decision in the HUD matter above resulting in the creation of LA State Historic Park are best practice examples. The administrative complaint and voluntary compliance with physical education and civil rights laws in the Los Angeles Unified School District cited above is a best practice example.

Private individuals and groups can seek access to justice through the courts, including individual, class, and third party complaints for injunctive and declaratory relief and money damages. Examples of successful Title VI cases include Larry P. on IQ tests, Lau on bilingual education, and Almendares on food stamps and LEP. In addition, successful cases filed in court are often settled through mediation and before trial without resulting in a published opinion.

There are many avenues to achieve compliance with civil rights laws. The courtroom is only one of many venues where justice can be won. Voluntary compliance should be the preferred means to achieve civil rights goals including health equity. Voluntary compliance can eliminate costly, time consuming, and risky litigation, for example, and can bring people together to support common values through democratic governance.

Often, one’s perceptions of the law, lawyers, and health may be limited to litigation to resolve poor surgical or other dissatisfactory health outcomes. Yet, creative civil rights lawyers can help create broader constituencies for equitable policies in health care, wellness and prevention, community planning and revitalization, data collection and analysis, and democratic participation. The planning, funding, and administrative processes offer opportunities to advance the cause of justice and improve the health and lives of people of color and low-income people, in addition to access to justice through the courts.

Today's civil rights and racial justice lawyers are problem solvers who use many of the same strategies that corporate or transactional lawyers use on behalf of their clients: planning, data collection and analysis, media, negotiation, policy advocacy, and coalition building are all part of a comprehensive problem solving strategy. Civil rights lawyers work with
clients, experts, and broader coalitions to seek racial equity and overcome discrimination and structural barriers to a more equitable society. This view of civil rights and racial justice seeks to change structures and practices that perpetuate racial and ethnic disparities.

A few important lessons can guide the change needed to improve health equity. The history of health discrimination assists in understanding continued health inequities. Civil rights attorneys, public health experts, agencies, recipients of federal funding, foundations, and other stakeholders need to work together to address health inequities.

The Civil Rights Revolution has used multiple strategies to address health discrimination. The Movement includes attorneys taking cases to court, ground breaking judicial decisions, grass roots organizing in the streets, legislation by Congress, action by the President, implementation by administrative agencies, and people providing a mandate to support civil rights through the right to vote.

While Brown v Board of Education in 1954 is often seen as the starting point of the modern Civil Rights Revolution, in fact civil rights attorneys and community organizers began the struggle for equal justice culminating in Brown and its progeny decades earlier. In the first half of the twentieth century, beginning in the 1920s, African American and Mexican American parents and civil rights attorneys challenged racial segregation in schools across the United States, often working with civil rights organizations, including the NAACP, the American Civil Liberties Union (ACLU), and League of United Latin American Citizens (LULAC). Plaintiffs’ lawyers used social science research to contest segregation, a strategy pioneered in Mendez v. Westminster School District of Orange County (1946), which successfully challenged the segregation of Mexican American students in Southern California. Thurgood Marshall and the NAACP Legal Defense Fund, Inc. (LDF) adopted and developed this approach in their school segregation cases, including Brown v Board of Education.

In Brown in 1954, the US Supreme Court struck down “separate but equal” schools. Also in 1954, the US Supreme Court held that the Equal Protection Clause protects against discrimination based on race, color, national origin, ancestry, or descent in Hernandez v Texas. Martin Luther King, the Student Nonviolent Coordinating Committee, the March on Washington, and other organizing efforts of the Movement in the streets led to the passage of the Civil Rights Act of 1964. President Lyndon Johnson led Congress in passing that Act and Medicare in 1965. Civil rights attorneys and government agencies have used Title VI and Medicare funding to help dismantle discrimination in health care administratively, as well as through litigation, as discussed above.

Today, these lessons should guide a health justice movement to seek racial and ethnic equity and overcome discrimination and structural barriers to a more equitable society. Research studies and policy prescriptions are important, but they are not enough without the force of law. The ACA creates enforceable rights; an Affordable Care "policy" would not. Finally, access to justice through the courts, as well as research, legislation, planning and funding decisions, and administrative procedures are necessary to alleviate health inequities.

Foundations have a significant role to play in supporting civil rights advocacy to address health disparities. There are structural obstacles to fund health justice through foundations and government. Foundations should fund legal advocacy and access to justice through the courts, which is a First Amendment right, but many will not fund advocacy or litigation. The more committed to the environment, the less likely a foundation will fund social justice. While environmental funders spent $10 billion between 2000 and 2009, just 15% of those dollars benefited marginalized communities, and only 11% went to advancing social justice. Foundations should invest at least 20% to benefit marginalized communities, and 25% to
advance social justice - policy advocacy and community organizing that works toward structural change on behalf of those who are the least well off politically, economically and socially.\textsuperscript{142} Foundations and government funding exacerbate rather than alleviate inequities in health and green access in Southern California, according to two recent peer reviewed studies. Public and nonprofit expenditures are most strongly associated with race and ethnicity. Black and Latino communities suffer from lower expenditure levels for parks and recreation by both the public and nonprofit sector.\textsuperscript{143} Some mainstream environmental organizations are now trying to increase the diversity of their staffs and boards. That is good, but it is not enough. Nonprofits that receive federal funding should comply with civil rights requirements as discussed above.

The disparate impact standard of discrimination is a lynchpin for addressing health and environmental justice. Civil rights attorneys continue the struggle to uphold and strengthen these laws. The disparate impact standard is being challenged in the US Supreme Court in 2015. Opponents are challenging the right to fight unfair and unjustified discriminatory impacts, even where there are less discriminatory alternatives, absent proof of intentional discrimination. While that case involves the Fair Housing Act, the disparate impact standard applies in other contexts including, for example, health disparities and employment discrimination. The challenge to the disparate impact standard reflects a general attack on civil rights tools to combat discrimination. Disparate impact is a long standing safeguard for civil rights. Disparate impact is a legacy of the Civil Right Movement. Freedom from discrimination benefits everyone.\textsuperscript{145}

6. WHAT’S NEXT?

The following recommendations can help civil rights attorneys, public health professionals, community groups, public agencies, recipients of public funding, foundations and other stakeholders alleviate health inequities through compliance with civil rights laws. Framing the issues can vary depending on the context (e.g., wellness and prevention, social determinants of health, environmental and health justice and civil rights compliance, sustainable development, equitable ecosystem services,\textsuperscript{146} smart growth) but the principles and goals are similar.
1. Of the many avenues to achieve compliance with civil rights laws, voluntary compliance is the preferred means to achieve civil rights goals including health equity.

2. Discrimination is a root cause of health disparities, and a comprehensive strategy to eliminate disparities must incorporate a strong civil rights component.

3. Stakeholders should work together on a compliance and equity plan for each program or activity by recipients of federal funding that describes what is to be done, analyzes the impact on all communities, analyzes alternatives, includes full and fair participation by diverse communities, and alleviates health inequities.

4. Compliance and equity plans should guard against unjustified and unnecessary discriminatory impacts, as well as intentional discrimination, in health programs and activities.

5. Federal agencies should ensure compliance with civil rights laws through the many avenues they have available. This includes data collection, analyses, and publication, planning, regulations and guidance documents, review of federal funding applications, contractual assurances of compliance by recipients, compulsory self-evaluations by recipients, compliance reviews after funding, investigation of administrative complaints, full and fair public participation in the compliance and enforcement process, and denial or termination of funding. State and local agencies have similar tools to ensure compliance with federal and parallel state laws.

6. Civil rights lawyers should use comprehensive problem-solving strategies: coalition building, planning, data collection and analysis, media, negotiation, policy and legal advocacy out of court, and access to justice through the courts.

7. Foundations should support compliance with civil rights laws to ensure health equity, and support organizations for whom racial and ethnic justice is a core value. This can strengthen philanthropic efforts across a range of programs. Funding for organizational capacity is needed. Strategic funding of national, regional or local civil rights and environmental justice groups can have a significant impact.

8. Attorneys and public health experts should work together to promote better understanding of the civil rights dimension of the challenge of health disparities, and to show how to address these civil rights concerns.

9. Civil rights laws against discrimination in health and other publicly funded programs and activities should be strengthened and not rolled back. This includes the prohibition against unjustified and unnecessary discriminatory impacts, and intentional discrimination.

10. It takes a movement. The myriad of strategies of the Civil Rights Movement started the process of dismantling the most egregious forms of Jim Crow health discrimination. A continued health justice movement, drawing on the lessons of history, is needed to seek racial equity and overcome discrimination and structural barriers to a more equitable society.
ACKNOWLEDGEMENTS

This work is made possible in part through the financial support of The California Endowment. Dr. Michael Rodriguez is also supported by UCLA/ DREW Project EXPORT, NIMHD, 2P20MD000182. The City Project also received the support of the Kresge Foundation and the Rosalinde and Arthur Gilbert Foundation. Robert Garcia is also supported by NIH-NIMHD grant U54MD007598 (formerly U54RR026138), CDU-AXIS, Grant# U54MD007598 from NIMHD.

The authors are grateful to City Project staff attorney Daphne Hsu and Anne M. Dubois for insightful comments and edits on earlier drafts; to City Project Policy Analyst Ariel Collins for research, editing, and layout; and to City Project Intern Michelle Kao and Kevin O’Fee for research and editing assistance.

We thank the following colleagues for their comments:

Professor Jason Bocarro, Ph.D., Dept. of Parks, Recreation & Tourism Management, College of Natural Resources, North Carolina State University
Brian Cole, UCLA Adjunct Assistant Professor, Department of Environmental Health Sciences, UCLA Fielding School of Public Health
Leslie Fields, Director, Environmental Justice and Community Outreach Programs, Sierra Club
Professor Lisa Ikemoto, UC Davis, Martin Luther King, Jr., School of Law
Kay Jowers Senior Policy Associate, State Policy Program, Nicholas Institute for Environmental Policy Solutions Duke University
Amy Pickle, Director, State Policy Program, Nicholas Institute for Environmental Policy Solutions, Duke University
Dr. David Martins, MD, Assistant Dean, Clinical and Community Affairs, Charles Drew University
Daniel A. Mazmanian, Professor of Public Policy, USC Sol Price School of Public Policy
Professor Miguel Mendez, Stanford Law School and UC Davis, Martin Luther King, Jr., School of Law
Professor Gerald Torres, Cornell University Law School, and primary author of Executive Order 12898 on environmental justice and health
Omega Wilson, West End Revitalization Association (Mebane, NC)

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