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Allison K. Hoffman*

How Medicalization of Civil Rights Could Disappoint

Craig Konnoth's article, *Medicalization and the New Civil Rights*,¹ is a carefully crafted and thought-provoking description of the transformation of civil rights claims into medical rights frameworks. The piece compellingly threads together many intellectual traditions—from antidiscrimination law to disability law to health law—to illustrate the pervasiveness of the phenomenon that he describes.

Descriptively, the article is rich. Konnoth shows how medical framing and evidence of physically identifiable and measurable harms have been providing new pathways to vindicate civil rights harms. This insight leads to his normative conclusion that medicalization can be a useful tool for civil rights advocacy. At places, I agreed. At others, I wondered whether the shifting ground Konnoth describes is as solid and productive as he asserts.

From a short-term, utilitarian perspective, Konnoth argues that medical rights-seeking is delivering both antidiscrimination protections and positive rights and benefits at a moment in time when civil rights claims rooted in protected classes and status struggle.² This part of his normative argument seemed plausible.

Longer-term, however, I wonder whether medicalization of civil rights might tell a more ambivalent narrative in at least two ways. First, medicalization could produce a sociological narrowing that could eventually limit how we think about justice. Even though the subordination and trauma people experience can undoubtedly manifest in physical ways and we should recognize these harms, there may be downsides of overly focusing on these physical manifestations of discrimination. Second, and more speculatively, even the utilitarian benefits that medical framing is now producing might diminish as medicalization becomes a new situs for civil rights contests.

Without minimizing Konnoth's thought-provoking insights, this response offers a few reasons why medicalization may not provide a clear civil rights cure in the long run and elaborates on the potential risks of overinvesting in medical rights-seeking. At the end, it considers whether the COVID-19 pandemic, which has produced a dramatic medical manifestation of social inequities and decades of civil rights deprivation, can illuminate the potential benefits or risks of medicalization.

I. Sociological Narrowing

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¹ Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165 (2020).

² See generally Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747 (2011) (describing how the proliferation in identity groups has undermined the Supreme Court's willingness to extend constitutional protection to new groups).

One question the piece raises for me is whether it might be sociologically harmful in the longer term to translate civil rights from social into medical frameworks. I can imagine at least two possible ways in which increased medicalization may undermine civil rights progress, even if that progress seems stalled out in its current modes today. The first concern is whether medicalization may imply ex-post solutions to civil rights harms and in turn diminish the importance of structural solutions. My second, related concern is that medicalization could obscure parts of discrimination altogether, by focusing only on discrimination that manifests in medically meaningful harms.

A. *Too Little, Too Late*

First, medical rights-seeking may draw us further away from thinking about structural solutions that address root causes of racism, sexism, and other discrimination. Medicine tends to deal with fixing individuals, not social structures. Medicalization of discrimination reframes something that is a collective problem into this individualized patient-centric framework. Of course, maybe this is no different from where civil rights law has already gone. It relies increasingly on individual legal claims and harms, and structural interventions have become increasingly difficult in light of shifting affirmative action doctrine.³ Yet, there are moments when big civil rights victories, such as *Obergefell*, can still quickly translate into group-level benefits and social understandings.

Medical rights may tend not to do so as easily. Konnoth discusses how Medicaid, the federal and state matching program that pays for medical assistance for poor people, has begun to allow states to experiment with providing housing services, such as security deposits for leases or lead testing, out of recognition that homelessness can adversely affect health.⁴ Although Medicaid has found creative ways to diagnose and treat housing insecurity, it can do so only at the individual (or family) level since it is a program designed to provide medical assistance to qualifying individuals one at a time. The federal statute also prohibits spending on room and board.⁵ This means that Medicaid can partner with other government programs more specifically focused on housing, but on its own, this program of medical benefits can at best provide a patch on the larger problem of housing insecurity and discrimination.

Even laws like the Americans with Disabilities Act (ADA) and the Rehabilitation Act that demand more structurally oriented reforms can still produce fairly narrow and small-scale remedies. The very example Konnoth cites as a positive signpost in rights recognition for mental disability—the language and reasoning of *Mathews v. Eldridge* as compared to the rights-limiting language in *City of Cleburne*⁶—illustrates how medicalization can produce a framing of rights in individual ways.

³ See *id.* at 748, 767-68, 775 n.198.

⁴ Konnoth, *supra* note 1, at 1196-97.

⁵ *Id.* at 1197.

⁶ *Id.* at 1237-38 (quoting language from *City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 445-46 (1985), about a class-based approach to legal analysis and from *Mathews v. Eldridge*, 424 U.S. 319, 343-44 (1976), about an individual medical approach).

While the *Cleburne* Court struggled to see mental disability as a trait deserving group protection, caught up in “pluralism anxiety,”⁷ or concern about the proliferation of groups seeking legal recognition, the *Mathews* Court recognized mental disability but based on a case-by-case assessment. Konnoth is right that *Mathews* is preferable in terms of recognition of mental disability, but it also entails transforming a legal question about protection for a subordinated group into an individualized inquiry. Civil rights law has more generally been moving in this same direction, with a rejection of group-based claims and anti-subordination principles, but might medicalization sound a death knell to efforts to focus on group-level effects and structural interventions if it requires a case-by-case medical inquiry as in *Mathews*?

Even public health usually falls short of true structural interventions. There is a well-known five-layered pyramid of public health interventions created by Thomas Frieden.⁸ At the top are efforts requiring individual-level effort (for example, counseling and education). At the bottom are interventions with increasing population impact. The public health ideal is to move to the base of the pyramid where socioeconomic factors lie. Even as scholars increasingly focus on these social determinants of health—factors like economic opportunity and infrastructure (transportation, sanitation, clean water) that have the greatest impact on health—public health efforts tend to stall one layer higher on the pyramid, which is about changing the context to encourage healthy decisions. At this layer, we still look to individual behavior to improve outcomes.

Konnoth’s discussion of wellness programs and food deserts illustrates how a medicalized perspective might in fact steer us to this level, where we look to the vulnerable to change their behavior, rather than asking why they are medically vulnerable in the first place. Konnoth suggests that the Affordable Care Act’s Wellness Programs, which allow employers to discount insurance premiums to some employees based on their engagement in healthy behaviors such as attending a gym, change the structural environment for “transforming social practices.”⁹ He offers that these policies might be seen as providing incentives to do better, just as building grocery stores in food deserts—neighborhoods without access to fresh foods—enables people to eat better. There is of course truth to these claims. Incentives and access can shape individual behavior.

Yet, why some people use gyms more than others, or why some buy fresh fruits and veggies and others do not, is only in some small part about having access to gyms and fully-stocked groceries stores. It is more about who has the time and money to exercise and cook, as well as habits developed over generations of poverty. The Healthy Bodegas initiative in New York City discovered the challenge of overcoming all of these barriers in an effort to increase the

⁷ Yoshino, *supra* note 2, at 747-48 (describing aversion to the increase in the number and types of groups who might make civil rights claims and the resulting legal contraction of constitutional protections).

⁸ Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. PUB. HEALTH 590, 591 (2010).

⁹ Konnoth, *supra* note 1, at 1225-26.

availability and uptake of healthier foods in NYC corner stores.¹⁰ Getting healthier food and drinks into corner stores was a significant challenge and yet only the first step in improving communities' health. Focusing on individual health can imply behavioral solutions and place the onus on vulnerable people to do better, rather than casting our collective gaze on the roots of what drives health disparities.

Furthermore, medicine is often reactive. Even what we call preventive care often does not actually prevent disease, but rather screens for and detects disease earlier to speed intervention once someone is already sick. Shifting civil rights claims into a framework that first requires a measurable health harm does little to prevent these harms from recurring one generation to the next.

Take the fact that racism results in disproportionate rates of heart disease in black men. Might the medical civil rights remedy be to provide free Plavix, or aspirin, to black men? If sexism causes depression in women who hit a glass ceiling at work, or who struggle to balance caregiving for children or aging parents with work, the answer might be just as readily to dole out Prozac as to attempt to ameliorate the sexist structures that cause this depression. Targeted treatment is certainly not bad. Angela Harris and Aysha Pamukcu describe in *The Civil Rights of Health* how public health data might enable targeted treatment of this sort that would otherwise be illegal "reverse discrimination."¹¹ This could be progress, for sure, but downstream.

Today's civil rights law may be no more effective at addressing discrimination in structural and transformative ways. Yet medicalization may by definition be forever incapable of doing so because of its granular and belated way of understanding harms and may affirm some of the deepest failings in civil rights law's doctrinal development.

B. Partially Obscuring Discrimination

My second, and greater, sociologically related concern is whether the translation of civil rights harms into medical terms actively obscures part of the social problem, like a scrim curtain over sexism, racism, or homophobia.

Recognizing physical manifestations of discrimination, as Harris and Pamukcu call us to do, is obviously important.¹² However, discrimination is problematic for reasons that reach well beyond the measurable, physical ways it manifests, and medicalization may subtly encourage us not to see racism or sexism as harmful when they fail to manifest in physical ways. Seeing that stress, trauma, and abuse from subordination have physical manifestations that civil rights

¹⁰ Sarah Kliff et al., *Healthy Options—Or Soda Taxes? How Two Cities Are Tackling Obesity*, VOX: THE IMPACT (Nov. 16, 2018, 10:20 AM EST), <https://perma.cc/Q7JM-GXMM> (challenges discussed around minute twelve).

¹¹ Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, UCLA L. REV. (forthcoming 2020).

¹² See *id.* at 17.

law can ameliorate through health interventions is valuable, yet medical rights-seeking risks reducing discrimination to its physical manifestations.

Here, a couple of examples of ways that medicalization within the law can narrow the way we think of a social issue may help. These examples draw from areas of law outside of Konnoth's article to offer analogies that may serve to illustrate what can happen when the law defines or recognizes a social problem or harm too narrowly.

Take tort law and the example of what are sometimes called "pure" emotional harms because they occur in the absence of physical injury. Emotional damages for these harms were long excluded from civil liability.¹³ In fact, until relatively recently, if there were no physical impact and bodily harm, courts were reticent to recognize damages except in a limited set of egregious circumstances, such as the mishandling of a corpse. Even in the modern era, recovery for emotional harms is guided by a circumscribed set of rules that are intended to serve as a proxy for "real" damage.

Even when recognized, the law often requires serious emotional harm or a physical manifestation¹⁴—a medicalization requirement, like a doctor's note to validate the harm. On the frontier of such efforts, legal scholars have considered whether neurological scans might be useful to prove emotional distress.¹⁵ These requirements can imply that someone's harm is not real until attested to by a doctor and measurable in medically recognized ways.

The limiting nature of such requirements can divorce remedy from common sense. On my Torts exam this year, I asked students to consider a mother who used Johnson & Johnson's baby powder that might have been laced with asbestos on her baby boy. Years later as a young adult, he developed mesothelioma—the signature diseases of asbestos exposure. The students quickly saw that the mother's harms didn't fit squarely into the cases where the law most readily awards emotional damages.¹⁶ A progressive court might deem such harm serious enough for recognition nonetheless, but others may not. Tort law looks for certainty and objectivity but in the process diminishes our understanding of emotional harm and undersells the ability of judges or jurors to gauge when it reasonably occurs, even if not medically measurable.

As Konnoth notes, medicalization makes something seem more objective and scientific, but that is not necessarily a good thing. Rather, it is a form of what David Frankford deems

¹³ See Martha Chamallas & Linda K. Kerber, *Women, Mothers, and the Law of Fright: A History*, 88 MICH. L. REV. 814, 816 (1990).

¹⁴ See *id.* at 820; Betsy J. Grey, *The Future of Emotional Harm*, 83 FORDHAM L. REV. 2605, 2611 (2015).

¹⁵ Jean Macchiaroli Eggen & Eric J. Laury, *Toward a Neuroscience Model of Tort Law: How Functional Neuroimaging Will Transform Tort Doctrine*, 13 COLUM. SCI. & TECH. L. REV. 235, 246 (2012).

¹⁶ These include having suffered physical impact or meeting the elements of a bystander cause of action for observing negligent harm to a loved one, which include requirements like proximity, visibility (sensory and contemporaneous observance of an accident), and close familial relationship. Restatement (Third) of Torts §§ 47-48 (2012).

“scientism,” where certain disciplines (law and economics, for example) take on a veneer of exactitude or expertise that is overdetermined.¹⁷ Scientism is especially concerning in the medicalization of civil rights since the “objectivity” of medical opinion has often been on the wrong side of civil rights, from justifying the sterilization of black women to determining who is white for immigration purposes.¹⁸ And medical science can sit on both sides of the law in a problematic way, as illustrated by the fact that two Supreme Court cases decided just seven years apart came to opposite conclusions on the legal necessity of a health exception to a so-called partial birth abortion law, despite the fact that the medical evidence had not changed in that timeframe.¹⁹ The legitimacy that medicine has in court can be harmful to civil rights just as easily as it can advance them. And the very groups that civil rights law aims to protect are those who tend to trust the medical establishment the least, for good reason.²⁰

A second and totally different example of where medicalization under the law has narrowed our vantage draws from my writing on long-term care.²¹ Medicalization in social welfare program design led to an undervaluation of non-medical caregiving that persists to this day.

At the start of the 1900s, public welfare for long-term care was provided locally in almshouses, but most people remained reliant on family care.²² Over the course of the twentieth century, however, public funding for long-term care grew, with federal funding beginning in earnest after the Great Depression. The Social Security Act of 1935 included the Old-Age Assistance program (for poor elderly individuals), Aid to the Blind, and Aid to Dependent Children, which were all programs of cash assistance that paid for care in nursing homes.²³ Simultaneously, home-based care continued with the support of various local, state, and federal efforts including the Works Progress Administration’s “Housekeeping Services.”²⁴ These programs funded everything from nursing care to personal care and even housework and childcare in some cases for ill or disabled mothers.²⁵

¹⁷ See David M. Frankford, *Scientism and Economism in the Regulation of Health Care*, 19 J. HEALTH POL. POL’Y & L. 773, 778 (1994).

¹⁸ See IAN HANEY LOPEZ, *WHITE BY LAW: THE LEGAL CONSTRUCTION OF RACE* 1-2 (2006 ed.); DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 56-57 (2016 ed.).

¹⁹ *Compare* *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000) (holding that a Nebraska law prohibiting “partial-birth abortion,” an intact dilation and extraction procedure, was illegal because it did not include an exception for the health of the pregnant woman), *with* *Gonzales v. Carhart*, 550 U.S. 124, 161-64 (2007) (following *Stenberg* by seven years and upholding the Partial-Birth Abortion Ban Act of 2003 despite no exception for the health of the pregnant woman).

²⁰ Katrina Armstrong et al., *Racial/Ethnic Differences in Physician Distrust in the United States*, 97 AM. J. PUB. HEALTH 1283, 1287 (2007).

²¹ See generally Allison K. Hoffman, *Reimagining the Risk of Long-Term Care*, 16 YALE J. HEALTH POL’Y L. & ETHICS. 147 (2016) (describing the way that social policy has conceived of long-term care risk and arguing that this conception is overly narrow).

²² EILEEN BORIS & JENNIFER KLEIN, *CARING FOR AMERICA: HOME HEALTH WORKERS IN THE SHADOW OF THE WELFARE STATE* 20 (2012).

²³ Sidney D. Watson, *From Almshouses to Nursing Homes and Community Care: Lessons from Medicaid’s History*, 26 GA. ST. U. L. REV. 937, 941-47 (2010).

²⁴ BORIS & KLEIN, *supra* note 22, at 22.

²⁵ *Id.* at 30.

The mid-century rise of private medical insurance, however, began to undermine these home-based care programs. Private health insurance required services to be performed by licensed providers, which relocated medical aspects of caregiving to hospitals and institutions. Care-intensive aspects were excluded and left to underfunded state welfare programs.²⁶ This medicalized model was then replicated in public financing, including in the 1965 creation of the two largest public health insurance programs: Medicare for the elderly and Medicaid for poor families and blind and disabled people.²⁷

These programs perpetuate an exclusion and devaluation of non-medical caregiving to this day. Medicare funds long-term care at best “tangentially,” such as post-acute care after hospitalization, but it does not pay for support with ongoing activities of daily living in home settings.²⁸ Long-term nursing care was excluded from Medicare altogether because it was deemed “more custodial than medical.”²⁹

Medicaid, in contrast, finances over half of all paid long-term care,³⁰ and still bears the mark of medicalization. Medicaid began with an “institutional bias” favoring the provision of long-term care in licensed nursing homes or other licensed institutions.³¹ This institutional care was designated as a mandatory benefit—one that states must cover to receive federal Medicaid matching funds, which pay for over half of the total program costs.³² In contrast, personal care in home settings (for example, bathing, dressing, eating, light housework, or grocery shopping) was made an optional benefit that states may, but do not have to, cover.³³ Even as Medicaid’s institutional bias has receded in favor of home-based care,³⁴ states’ programs do not cover the caregiving services people need at home. After over a half century of Medicaid operating in a manner in which medical care is mandatory and personal or “custodial” care is optional, the notion that social insurance should support the medical but not the social aspects of care endures in a deep way.

Konnoth discusses some institutional objections to medical rights-seeking, such as whether shifting authority from legal to medical institutions may be harmful. The greater institutional

²⁶ *Id.* at 65.

²⁷ See Watson, *supra* note 23, at 953-54.

²⁸ Judith Feder et al., *Long-Term Care in the United States: An Overview*, 19 HEALTH AFF. 40, 44 (2000).

²⁹ Watson, *supra* note 23, at 956.

³⁰ ERICA L. REAVES & MARYBETH MUSUMECI, KAISER FAMILY FOUNDATION, MEDICAID AND LONG-TERM SERVICES AND SUPPORTS: A PRIMER 3 (Dec. 2015).

³¹ See Samuel R. Bagenstos, *The Future of Disability Law*, 114 YALE L.J. 1, 61 (2004).

³² REAVES & MUSUMECI, *supra* note 30, at 5; *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, KAISER FAM. FOUND., <https://perma.cc/R8DN-JPNW> (archived June 6, 2020) (noting that “[b]y law, the FMAP cannot be less than 50%”).

³³ REAVES & MUSUMECI, *supra* note 30, at 5; see also 42 U.S.C. § 1396d(a)(22), 1396d(a)(24) (2018).

³⁴ Moving care into home settings has been called rebalancing in large part in response to the *Olmstead* decision that demanded care in the least restrictive settings possible. See *Olmstead v. L.C.*, 527 U.S. 581, 587 (1999) (holding that people with mental disabilities have the right to live in community-based settings, instead of institutions, if appropriate, desired, and feasible).

harms may be less obvious, sociological effects. The many life experiences that we all have—discriminatory or not—undoubtedly take root in our physical beings, but focusing on the physical manifestations of harms might narrow the way we conceive of the social problem and solutions. Emotional harms that do not manifest in physical measurable ways may be as, or more, damaging than those that do. Non-medical caregiving can contribute more to health and security than medical caregiving. Non-medical manifestations of racism—such as diminished economic inequality and over-criminalization—should concern us as much, or more, than physical manifestations. If the law narrows in on remedying the physical, we may risk losing sight of the full picture and problem.

In his Introduction, Konnoth writes: “In an ideal world, our views on poverty, homelessness, and unemployment would evolve.”³⁵ Might medicalization move us even further from this ideal world by diverting us from this evolution?

II. The Malleability of Medicalization’s Utilitarian Benefits

The second way in which I question Konnoth’s normative conclusions concerns his assertion—albeit an admittedly tentative one—that medicalization may make people more open to civil rights claims because it shifts blame away from individuals and makes them more deserving of support.³⁶ Konnoth recognizes that “[m]edical claims are malleable [and] contingent . . . social phenomena.”³⁷ In light of such malleability, however, it may be possible that the short-term benefits that Konnoth identifies as produced by medicalization could erode if medical rights become the new *situs* of civil rights.

Konnoth plants his normative conclusion in the idea that we have more empathy for medical suffering than suffering due to, for example, poverty, even as he recognizes the paucity of evidence in support of this proposition.³⁸ It is quite possible that we have more empathy for someone else’s suffering when we think of it as being a medical harm outside of her agency. Yet, medical suffering gets sorted both into the category of suffering where we feel empathy and also the category where we do not. These categories vary by country and community and can undoubtedly shift over time. As Konnoth recognizes, some problems like alcoholism, lung cancer caused by smoking, and HIV/AIDS in the early days of the respective diseases failed to garner much empathy.³⁹ Elsewhere like France, however, smoking has a different valence than it does in the United States and, in turn, lung cancer may be less blameworthy. We translate social fixations or idiosyncrasies into medical terms.

³⁵ Konnoth, *supra* note 1, at 1174.

³⁶ *See id.* at 1234-35.

³⁷ *Id.* at 1174.

³⁸ *Id.* at 1222.

³⁹ *See id.*

For instance, Konnoth suggests that the response to opioid addiction was different from the response to crack addiction because the former was framed as a medical problem whereas the latter was seen as mere addiction, a lack of will.⁴⁰ This distinction seems too stark to me.

It is not clear that we cast less blame on opioid addicts. People in towns with high opioid addiction have complained of reversing overdoses and saving lives through the use of naloxone, and have gone so far as to suggest it might be better to let addicts die.⁴¹ Surveys show U.S. adults are just as likely to blame people addicted to prescription painkillers as we are to blame the doctors who overprescribed them.⁴²

To the extent we might blame addicts less in the era of opioids, which is not evident, it is not clearly because of medicalization of the opioid crisis. We may blame doctors more this time around because they did, in fact, contribute significantly to opioid addiction in a way they did not to crack addiction. But the larger difference between the two crises is that crack was disproportionately seen as a “black person” addiction and opioids are a “white person” addiction.⁴³ Race has as much to do with how the crisis is perceived and whether we cast blame on people with addictions or on society at large, as the fact that we call opioid addiction an epidemic.

Even more so, medicalization does not appear to lend much empathy to one of our greatest ongoing civil rights challenges: protections for undocumented immigrants. Quite the opposite: Evidence of medical need could limit someone’s ability to come to the United States legally under public charge rules, which have tightened under the Trump Administration and also predated it.⁴⁴ And while the rise of the coronavirus in the United States could in theory have led to a loosening of immigration restrictions and a reticence to put people into crowded detention centers where their lives are at grave risk, it has not provoked such a response.⁴⁵ Empathy is contingent, even when it comes to medical harms that are no fault of our own.

Conclusion

As I write this response, we live under a cloud of coronavirus, which is unveiling all of our society’s failings through the lens of illness. We see the fractures of our health insurance

⁴⁰ *Id.* at 1234-35.

⁴¹ Ben Haller, *One Way to End the Opioid Epidemic. Let Them Die*, NEWSWEEK (July 21, 2017, 7:10 AM EDT), <https://perma.cc/DLQ4-Z3BJ>.

⁴² BIANCA DIJULIO ET AL., KAISER FAMILY FOUNDATION, THE WASHINGTON POST/KAISER FAMILY FOUNDATION SURVEY OF LONG-TERM PRESCRIPTION PAINKILLER USERS AND THEIR HOUSEHOLD MEMBERS 13 tbl.5 (Dec. 2016).

⁴³ See Andrew Cohen, *How White Users Made Heroin a Public-Health Problem*, THE ATLANTIC (Aug. 12, 2015), <https://perma.cc/V626-N68U>; *Opioid Overdoes Deaths by Race/Ethnicity*, KAISER FAM. FOUND. (2018), <https://perma.cc/V4RS-D676> (showing the racial breakdown of opioid overdose deaths).

⁴⁴ See *Inadmissibility on Public Charge Grounds*, 84 Fed. Reg. 41,292, 41,295 (Aug. 14, 2019) (expanding the interpretation of what constitutes a public charge to include, for example, receipt of benefits through Supplemental Nutrition Assistance Program, food stamps, or Medicaid).

⁴⁵ Ryan Devereaux, *“Burials Are Cheaper than Deportations”: Virus Unleashes Terror in a Troubled ICE Detention Center*, INTERCEPT (Apr. 12, 2020, 8:37 AM), <https://perma.cc/D69F-CUT2>.

system, the instability of our unemployment system, the precariousness caused by our immigration and criminal justice system, and the disparate impact of pandemic by age, income, and race.⁴⁶ Yet, these problems are larger and more complex than their manifestation in this particular medical moment—and the fixes that the medicalization of these problems suggests have so far been short-term and incomplete. Checks of \$1,200, indemnification of the costs of COVID-19 testing, and temporary reduction of jail populations will only go so far.

It is possible that coronavirus will catalyze greater awareness of and empathy for social inequities, as Konnoth's arguments might imply. Some public health experts have indeed gestured in this direction.⁴⁷ If this awareness motivates action, it could mean a monumental unsettling of decades of growing inequality. Yet, true civil rights progress demands reckoning with the deep roots and structural breath of social inequality that, of course, include and also reach well beyond how inequality rears its ugly head in a moment of acute medical crisis.

⁴⁶ See, e.g., Shaun Ossei-Owusu, *Coronavirus and the Politics of Disposability*, Bos. Rev. (Apr. 8, 2020), <https://perma.cc/45FL-5YHU> (describing ways in which COVID-19 disproportionately harms vulnerable populations and linking to articles on this issue across a wide range of social policy topics).

⁴⁷ Eric Levenson, *Why Black Americans Are at Higher Risk for Coronavirus*, CNN (Apr. 7, 2020, 8:16 PM ET) <https://perma.cc/J7KU-YS3D> (describing responses by public health experts that are focused on the underlying social inequities that make black people more susceptible to coronavirus).