Introduction

Housing, Health, and Proximity to Toxicity

Housing discrimination harms health and steals wealth. Residential racial segregation is an economic injustice but also a public health menace. Denying people access to safe, sound, and secure housing imposes artificial impediments to acquiring assets that can appreciate in value and be inherited by future generations. It compels many members of aggrieved racialized groups to live their lives in what Tricia Rose describes as “proximity to toxicity,”1 dwelling in polluted and under-resourced places where life spans are shorter and the burdens of illness are higher. Even relatively high-income and wealthy nonwhite property owners suffer from housing discrimination. They are confined to an artificially limited segment of the market where dwellings are less likely to appreciate in value and more likely to be close to toxic hazards. Moreover, municipal, state, and federal governments have consistently designed, funded, and implemented policies that destroy once-stable neighborhoods inhabited by members of racialized groups in order to replace them with taxpayer-subsidized convention centers, sports arenas, civic centers, office buildings, and luxury housing, and with highways designed to increase home values in areas reserved largely for white residency.2 Whether their incomes or wealth holdings are high or low, members of aggrieved groups targeted for housing discrimination endure arbitrary, irrational, and unnecessary incidents of discrimination, displacement, and dispossession that combine to undermine their individual and collective health, wealth, and well-being.
The Danger Zone Is Everywhere focuses on the factors that make housing insecurity and poor health key components of an unjust, destructive, and even deadly racial order. Residential segregation and group health disparities are usually addressed separately in medical and legal practice, public policy, and academic inquiry. They are treated as discrete and unrelated processes. This book argues that they are mutually constitutive, that health is as much social as it is biological, and that race is a political construction, not a biological entity. The injuries inflicted by housing discrimination have serious medical consequences that produce additional obstacles to accessing education and employment. Unfair access to housing subjects people from aggrieved groups to endless cycles of dispossession, displacement, disinvestment, and debt; to predatory and punitive policing; and to illness, addiction, and incarceration.

EXAMINING HOUSING AND HEALTH CARE TOGETHER

Shortly after the passage of the Fair Housing Act in 1968, Lester Breslow, president of the American Public Health Association, touted the ways in which improving access to safe, stable, and affordable housing could affect the health of the public. “In the long run,” he declared, “housing may be more important to health than hospitals.” Breslow’s acknowledgment of housing as a key social determinant of health marked a clear departure from the long and ignoble history of practices in public health—premised on assumptions that poverty is an inheritable trait and that poor health among racialized groups is caused by their allegedly inferior biological makeup or their dysfunctional behaviors.

Contemporary research documents the continuing salience of Breslow’s formulation. Despite the gradual and continuing expansion of the coverage and remedies enabled by the Fair Housing Act, a collective national failure to implement fully its clear mandate to “affirmatively further fair housing” continues to damage the physical and mental health of the nation. David Williams and Chiquita Collins established nearly two decades ago that residential segregation is the single most important cause of the disproportionate exposure to health hazards among people of color in the United States. In 2019, Williams and other colleagues emphasized segregation’s continuing effects, especially its impediments to education and employment opportunities and its disproportionate exposure of people to physical and emotional stressors, as well as its association with low birth weights and preterm births,
higher risk of myocardial infarction, early onset of sickness, rapid progression of disease, and lower rates of surviving illnesses.6

Examining health in relation to housing reveals the importance of what researchers call the social and structural determinants of health.7 Racial disparities in health are caused by disproportionate exposure to toxic air, water, and land; by residency in places with limited access to fresh food, pharmacies, and physicians; by few opportunities for healthful exercise and recreation; and by the physical and psychic stressors produced by race-based discrimination. These social and structural determinants of poor health do not occur in a vacuum: they are a consequence of racialized subordination structured inside a variety of institutions, some of which at first glance might appear to have little to do with health or housing. This book connects the distribution of determinants of health to discriminatory practices in mortgage lending, insurance risk algorithms, home value appraisals, tax assessments, municipal fines and fees, policing, incarceration, transportation, and urban planning. These structural processes emerge from histories of slavery, Indigenous dispossession, coloniality, labor exploitation, sexism, and misogyny that reproduce and reinforce racism every day in the present. Working together they make up the system of structural racism.

Medical and legal professionals and the public at large generally underestimate the importance of social and structural determinants of health. They most often attribute racially disparate health outcomes to the conduct of individuals in managing personal health care regimes or to immutable genetic characteristics. Both of these attributions underestimate the importance of social and structural factors. In 2011 the Centers for Disease Control, discussing the variables that shape ill and good health, concluded that the elements that most people assume to be decisive in producing physical well-being—such as personal choices about diet, exercise, and use or avoidance of damaging substances—account for only 20 percent of individual health outcomes. The quality and frequency of professional health care shape an additional 20 percent. A mere 5 percent can be traced to genetic inheritance. Significantly, most of the remaining 55 percent comes from the factors most closely related to housing discrimination and the racial wealth gap: from the social determinants of health shaped by racism. An emphasis in medical research and practice on the genetic codes of individuals obscures the significance of the zip codes in which members of aggrieved racialized groups live, work, and play.8

Overemphasis on the genetic makeup or health regimes of individuals directs excess attention to the roles played by medicines and medical
technologies in improving collective well-being while diverting attention away from advances enabled by adjustments to social and structural forces such as safe and affordable housing. Epidemiologists and historians of health generally agree that most of the reasons for increased life expectancy during the past two centuries emerged out of nonmedical advances in public health, advances achieved through measures such as improved sewage management and garbage collection procedures, cleaner air created by the elimination of coal-burning furnaces, removal of lead from gasoline, safer and more abundant foods, improved housing conditions, and more equitable distributions of wealth. Yet responses to surveys indicate that respondents think that 80 percent of the improve-

VARIABLES THAT SHAPE ILL AND GOOD HEALTH OF AGGRIEVED RACIALIZED GROUPS

![Variables that shape health](image_url)

ments in life expectancy should be attributed to “modern medicine,” virtually ignoring how changes in social and structural determinants of health have led to longer lives. As Gordon Lindsay and colleagues conclude, these beliefs contribute to overfunding the sector of the economy that treats health problems medically while underfunding many of the practices that are most effective in preventing illness. Nearly 20 percent of the Gross Domestic Product in the United States goes to technology-dominated health care interventions while proven and cost-effective public health and housing programs remain starved for funds. Misguided beliefs contribute to the underestimation of the importance to health of available, affordable, accessible, safe, and secure housing.

**THE BIOMEDICAL MODEL OF RACE AND DISEASE**

Medical and scientific literature past and present overwhelmingly presents race as a biological category. It also tends to present genetic differences as the most plausible hypothesis for observed racial differences in outcomes. This biomedical model of health combines with the tort model of injury in law to offer single-axis solutions to what are almost always multiple-axis problems.

The biomedical model that dominates health care is an individual model. It posits a healthy body that has been temporarily injured and can be restored to a previous state of good health by treatment. It imagines a specific discrete cause for every illness and treats the body as a machine made up of parts that can be fixed or replaced. In attending largely to health at the scale of individual bodies, the biomedical approach treats symptoms of racial health disparities but does not challenge the causal spatial and racial ecologies that relegate people of different races to different places that are marked by grossly unequal and unjust health hazards. For example, the incursion of COVID-19 has been described as a “pandemic” for the nation as a whole, but for Black and Latinx people it should properly be considered a “syndemic”: a medical crisis that is shaped and exacerbated by a complex confluence of place-based racialized health and housing vulnerabilities.

The biomedical model of disease treats race wrongly and inaccurately as a biological category rather than a political construction and for that reason leads to ineffective, inefficient, and even counterproductive medical practices. People in the United States spend more on health care than people in any other country in the world, yet the health care system produces declining life expectancies, high rates of maternal
childbirth mortality, and stark racial health disparities.\textsuperscript{12} Compared to their peers in Japan, Germany, France, and other well-resourced nations, young people in the United States are twice as likely to die between the ages of fifteen and twenty-four. The infant mortality rate in the United States is three times higher than the rate in similar nations.\textsuperscript{13}

**THE TORT MODEL OF INJURY IN LAW**

The struggle for racial justice is impeded by overemphasis on the individualized biomedical approach to illness and infirmity in medicine, but it is equally undermined by the dominance of the tort model of injury in law. Both of these frameworks privilege individual and domain-specific solutions to social problems. They deny medical and legal practitioners the tools needed to address and redress racist injuries. The tort model focuses on harm done to individuals caused by malevolence, carelessness, or neglect: actions that are presumed to disrupt the normal workings of society. It imagines that the injured party can be “made whole”—that is, restored to the previous state before the injury—by personal punishment of perpetrators or personal compensation awarded to plaintiffs. This premise encourages attorneys to view housing discrimination as largely individual, intentional, and aberrant. Yet the perpetration of discrimination in housing comes not only from individuals but from forces and actors who are dispersed, not acting consciously in concert, and grounded in a fully linked and mutually constitutive network of racist subordination that is systemic, structural, collective, cumulative, and continuing.

The biomedical model of disease and the tort model of injury in law are destructively confined to the level of the individual. They encourage medical providers and attorneys to assume that their fields are not connected to each other, that racial disparities in one sphere do not shape or reflect disparities in others. This one-at-a-time approach occludes the larger system in which racial disparities are located, a system that Barbara Reskin accurately describes as “über” or “meta discrimination.” In this case, the whole is greater than the sum of its parts because injustices that appear in different institutions are mutually reinforcing, as Reskin argues, racism in multiple domains produces effects that none of them in isolation can produce on their own, effects that “implant über discrimination into our minds, culture, and institutions.”\textsuperscript{14}

Systemic and structural problems require systemic and structural solutions. But efforts to litigate and legislate for fair housing generally ignore the health costs of discrimination, while physicians, clinicians,
and public health officials rarely reckon with the ways in which unjust and illegal housing discrimination creates and exacerbates illness and infirmity. This book identifies and endorses ways of seeing and acting upon health and housing intersectionally, structurally, and systemically. Good health and good housing are connected; efforts to promote access to each must attend to the other.

THE DANGER ZONE IS EVERYWHERE

Housing and health care—like nearly every other major social, economic, and educational practice and institution—work as parts of an interconnected network that perpetuates structural and systemic racism. The resulting condition is captured by the title of a Percy Mayfield song recorded by Ray Charles in 1961. The lyrics of that song assert: “The danger zone is everywhere.” Racist danger does reside in the medical clinic and the fair housing courtroom obviously, but it festers as well in places that initially might seem to have little to do with race: in patterns of home value appraisal and tax assessment, in rubrics of risk in property and auto insurance, in predatory policing and mass incarceration, and in practices of urban planning. The economic and social injuries inflicted on members of targeted groups because of racial discrimination in these spheres have deadly medical and economic consequences for them and for society at large.

Yet precisely because the danger zone is everywhere, there is opportunity everywhere to join with others to forge new tactics and strategies for racial justice. Systems and structures created by humans can be dismantled by humans and replaced with better ways of knowing, thinking, and living. This book describes a wide range of work under way where people from many different backgrounds in many different realms of life join together to promote health justice and housing justice in response to the conjunctural crises of our times. Their work evidences the urgency people feel to resist unlivable destinies.

The evidence, ideas, and arguments that I present in this book reflect things that I have learned from my nearly sixty years of participation in organized movements for social change, as well from my forty-five years as an academic researcher, teacher, and writer focused on the forces that skew life chances and opportunities along racial lines. I have participated in struggles for housing and health justice as a member of the board of directors of the National Fair Housing Alliance and the Fair Housing Council of San Diego, as a speaker at fair housing laws and
litigations conferences and continuing legal education courses, and as a researcher and expert witness in court cases. For ten years I served as chair of the board of directors of the African American Policy Forum. I became aware of the importance of arts-based collaborative campaigns for health and housing justice through my work with Latinx activists in the Building Healthy Communities in Boyle Heights project in East Los Angeles staged by the Alliance for California Traditional Arts and the California Endowment, as well as with Black activists in the Free-Dem Foundations and Students at the Center initiatives in New Orleans contesting the effects of mass criminalization and incarceration in that city. Conducting equity-oriented collaborative community-based research and accompanying activist groups in struggles have led me to conversations and collaborations with grassroots activists in Ferguson and Flint, Milwaukee and Memphis, East Austin in Texas and West Palm Beaches in Florida, the inner-ring suburbs of north St. Louis County, and the southern suburbs of Chicago. Much of what appears in this book originated in those activist meetings and mobilizations.

I identify myself and am identified by others as a white, cisgender, heterosexual male. I attempt, however, to situate my ideas and actions inside the generative political and intellectual traditions of Black feminist intersectionality and the Black Radical Tradition. I am not claiming to be an expert on Black feminist theory, but rather see myself as someone who has been educated by it profoundly through my work with Kimberlé Crenshaw and the African American Policy Forum, by a long history of learning from and with Tricia Rose, and by the occasions where I have shared spaces and been in dialogue with Black womanist cultural workers Sunni Patterson and Shana M. griffin. My ideas and analyses have also been shaped by Black men committed to Black feminism, including Robin D. G. Kelley, Luke Harris, Devon Carbado, and Kalamu ya Salaam. My commitment to the Black Radical Tradition emanates from being a colleague, admirer, and dedicated reader of writings by Cedric Robinson, learning from him that the collective consciousness and ontological totality of Black struggles for freedom and justice are generative points of entry into critiquing and contesting all of the forms of dehumanization that turn difference into domination. Robinson’s framework condensed and crystallized intellectually much of what I had previously learned experientially from interactions with my friend and teacher Ivory Perry, an organic intellectual whose years of dedicated direct action protests and community organization in St. Louis produced my earliest education on matters of race and justice.
Nearly everything I think, say, and write about social justice draws on the profound wisdom that I have observed in accompaniment with activists from aggrieved racialized groups. The restorative cultural arts practice/praxis projects of East Los Angeles artivistas, especially Rosanna Esparza Ahrens, Ofelia Esparza, Quetzal Flores, Martha Gonzales, and Omar G. Ramirez, guide the arguments and analyses I make throughout this book, but especially in chapter 7. My work with Asian Immigrant Women Advocates in Oakland opened my eyes to the importance of intersectionality as a social movement strategy and to the value of democratic discussions and deliberations for cultivating capacities for solidarity and self-activity among working people.

As a white person drawing on the profound wisdom of activists from aggrieved racialized communities, I inhabit a particularly perilous danger zone. Being ascribed and treated as white can create intellectual enfeeblement because it relies on living with evil and being taught to lie about it. The privileges and preferences allocated to me because of my whiteness no doubt lead me to miss particular practices and ramifications of white supremacy that are important to understand. This makes it likely that any foray I make into writing about race or acting against racism runs the risks of replicating and reinforcing rather than reducing the calculated cruelties of white supremacy. But mistakes can be corrected, while silence about injustice is inexcusable.

Meaningful change cannot be formulated abstractly or forecast prophetically by me or anyone else. Instead it must be forged collectively inside social movement mobilizations: in the work of fair housing councils and public health collectives, in alternative learning circles and arts-based community-building projects, in community gardens and community land trusts, and in all the other diverse and dispersed circles of mutual respect, accountability, and accompaniment that are emerging from many different but interconnected crises.

Struggles for housing and health justice have the potential to revitalize civil society, to replace isolation and atomization with a rich, interactive, responsible, and accountable public life. The radical revolution in values and practices that is emerging is not the province of any one profession, discipline, or social group. It requires the full participation of the greatest possible number of people from the broadest possible range of social positions. This book is aimed at physicians, clinicians, and other health care professionals, at attorneys, advocates, and academic legal researchers, at social workers and urban planners. Yet the changes that are needed cannot emanate exclusively from people
credentialed by social institutions as specialists and experts. This book highlights the actions of neighborhood community-building and development activists, environmental justice advocates, campaigners for livable wages, prison abolitionists, and activists insisting on the dignity and democratic rights of people deemed disabled. It shows how health and housing justice alike are impeded by hate crimes, police violence, and draconian immigration surveillance, incarceration, and deportation policies.

FAIR HOUSING ADVOCACY AND ACTIVISM

The people who perpetrate and benefit most from racial housing discrimination reap unearned gains and unfair material rewards that enable them to accumulate wealth and to hoard for themselves a wide range of resources, opportunities, amenities, and advantages. The Fair Housing Act of 1968 was structured to solve this problem by mandating all entities receiving government funds to take steps “to affirmatively further fair housing” and to provide individuals and groups with access to forms of litigation set up to secure justice and to compensate victims. As amended in 1988 and expanded by creative litigation, this law provides an indispensable mechanism for promoting housing and health justice. Its existence has enabled the creation of local nonprofit fair housing agencies mobilized together through the National Fair Housing Alliance. Fair housing advocacy has helped millions of people to acquire assets that appreciate in value and can be passed down across generations, and to secure better living conditions in the present.

Yet despite decades of litigation, legislation, administration, organization, mobilization, education, and agitation, most instances of housing discrimination remain unchallenged and unimpeded. Even when fair housing litigation is successful, judgments and settlements generally secure relief that is inadequate for rectifying the devastating damages to health and wealth caused by discrimination. There is an urgent need for those who see themselves as bystanders—disconnected from struggles for meaningful change—to become upstanders, to become educated and impelled to take action. Full enforcement of existing municipal, state, and federal fair housing laws would help, as would new forms of creative litigation and legislation to increase damage awards and expand the range of protected categories.

This legal realm is important for fair housing. Law sets the rules by which society operates. Racial subordination in the United States has