

# Tremors Along the Fault Line: A Critical Perspective on Covid-19 and the Right to Health in the United States<sup>1</sup>

## I. STRUCTURAL RACISM IN US HEALTH CARE BEFORE COVID-19

Almost a year into the coronavirus outbreak, the United States continues to lead the world in infections and deaths from COVID-19. The incidence of the disease disproportionately affects Black, Indigenous, Latinx<sup>2</sup> and other people of color<sup>3</sup> because of structural injustices in the U.S.<sup>4</sup> To make matters worse, the Trump Administration has exacerbated the crisis through a chaotic, mismanaged and politicized response replete with accusations, denials, lies, refusals to follow scientific data and recommendations, attempts to manipulate responses, and pressures on scientific bodies to change their guidelines to fit the Administration's political ends. As of November 1, 2020, there were over 9.2 million reported COVID-19 cases and 230,000 deaths in the United States, leading to one of the highest rates in the world (70 deaths per 100,000 people)<sup>5</sup>. How did we get here? What did the United States do wrong to produce such grave and catastrophic effects?

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<sup>1</sup> Mara González Souto, Grace Carson and Joseph Berra, Promise Institute for Human Rights. This is the English translation of a chapter for a forthcoming edited volume, *“El derecho a la salud en Estados Unidos, México, Centroamérica y Panamá en el contexto del COVID-19,”* Joaquín A. Mejía Rivera editor. The chapter was submitted in November of 2020, and contains data current only to that date. The chapter was written primarily for a non-US, Spanish-speaking audience.

<sup>2</sup> “Latinx” is a gender-neutral term to refer to people of Latin American descent in the United States.

<sup>3</sup> In the United States, the terms “people of color” or “communities of color” refer to racialized, non-white communities. These can include African American, Latinx, Asian American, Arab American and Native American and Indigenous communities. Another way of referring to the non-white population in the United States is as Black, Indigenous and people of color or BIPOC.

<sup>4</sup> In this chapter, we take a critical race perspective on the impact of COVID-19 and the right to health in the United States. Not all groups are racialized in the same way in the United States, but the underlying structures of settler colonialism and anti-black racism have created a racial hierarchy anchored in white privilege and white supremacy. We analyze here the disparate impact of the right to health and health access before the crisis in order to evaluate the impact of COVID-19 and its stark revelation of these structural inequalities.

<sup>5</sup> Covid in the U.S.: Latest Map and Case Count”. *The New York Times*. November 29, 2020. Retrieved on November 29, 2020. Accessed from [https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?name=styln-coronavirus&region=TOP\\_BANNER&block=storyline\\_menu\\_recirc&action=click&pgtype=LegacyCollection&impression\\_id=17648811-327c-11eb-980b-55781a7260ff&variant=1\\_Show](https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html?name=styln-coronavirus&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=LegacyCollection&impression_id=17648811-327c-11eb-980b-55781a7260ff&variant=1_Show)

In many respects, COVID-19 has re-exposed the prevalence of structural and institutional racism in health care across the United States, in both apparent and understated ways. Understanding how we got here requires diving into the underlying social and institutional structures that define and continue to shape access to quality health care. We will see that structural racism, which refers to the many “ways in which societies foster [racial] discrimination”<sup>6</sup> in areas like health care, has enabled a broad range of stressors, comorbidities and negative outcomes for racial, ethnic and Indigenous minorities.<sup>7</sup> Likewise, we will see that institutional racism, which refers to racially discriminatory practices implemented by state and non-state institutions<sup>8</sup>, is a central way of perpetuating the stratifications of wealth, opportunity and access to resources on the basis of race, ethnicity and Indigenous identity. As outlined by social epidemiologist Nancy Krieger,<sup>9</sup> racism is causally connected with negative health outcomes through five pathways, namely economic and social deprivation; distribution of hazardous materials and waste; socially inflicted trauma; targeted marketing of injurious commodities; and inadequate health care access, care, and treatment. This chapter will draw from public health literature and data to explore each of these pathways of structural racism and their negative outcomes both before and after the COVID-19 crisis.

The U.S., despite being one of the wealthiest nations on Earth, has a deep inequality penetrating its institutions, rooted in the history of settler colonialism<sup>10</sup> and slavery. The country is founded upon the dispossession and genocide of Native

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<sup>6</sup> KRIEGER, Nancy. “Discrimination and health inequities”. *International Journal of Health Services: Planning, Administration, Evaluation*. Year 2014. Vol. 44,4, p. 643-710. Retrieved on September 24, 2020. Accessed from <https://www.jstor.org/stable/45140862>

<sup>7</sup> *Public Health Reports. Unequal Treatment: The Institute of Medicine Report and Its Public Health Implications Source*. Sage Publications, Inc., Vol. 118, No. 4., pp. 287-292. July – August 2003. Retrieved on September 24, 2020. Accessed from <https://www.jstor.org/stable/4598854>

<sup>8</sup> Id.

<sup>9</sup> HARDIMON, Michael O. “Health, Race, Medicine”. *Rethinking Race: The Case for Deflationary Realism*. Harvard University Press. 2017. Retrieved on September 24, 2020. Accessed from <https://www.jstor.org/stable/j.ctvncw0jx.12>

<sup>10</sup> “Settler colonialism” is a concept that seeks to capture the fact that some forms of colonialism, particularly in the Americas, were marked by the fact that the colonizers came to stay, implying the assertion of foreign sovereignty, dispossession of indigenous lands, and policies of extermination, genocide, and invisibilization of Indigenous peoples.

Americans and chattel slavery of Black Americans. This foundation created a racial hierarchy that remains in many ways intransigent, leading to persisting inequalities, in spite of formal recognition of equality under the law regardless of race. It is present in the economic disparity, educational barriers, cultural racism, over-policing and incarceration disproportionately affecting Black, Indigenous, Latinx and other communities of color. This structural and institutional racism is also the source of resurgent xenophobia in the U.S., where non-white immigrants, particularly from Latin America, are racialized and demonized as the “other.” This history and structure of racism is reproduced within the structures and institutions of the U.S. health care system.

Critical race theory (CRT) seeks to better understand how this history affects all aspects of U.S. institutions, including the health care system. CRT is concerned with studying and transforming the relationship between race, racism, and power. “Unlike traditional civil rights, which embraces incrementalism and step-by-step progress, critical race theory questions the very foundations of the liberal order, including equality theory, legal reasoning, Enlightenment rationalism, and neutral principles of constitutional law.”<sup>11</sup> CRT understands that structural racism is implemented in every aspect of U.S. institutions, and is an underlying reason for every inequality.<sup>12</sup>

At the same time, neoliberal policies form an interlocking structure with both racism and settler colonialism to exacerbate inequalities and inequities in the health care system. Unlike most developed countries in the world, the United States does not have a universal health care system. Health care is operated primarily by the private sector with some participation by the public sector, through a mix of for-profit, non-profit and government-run organizations and institutions. In order to access that health care, the majority of individuals in the United States have to obtain health insurance through

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<sup>11</sup> Richard Delgado and Jean Stefancic. “Critical Race Theory: An Introduction.” Retrieved on September 24, 2020. Accessed from [https://uniteyouthdublin.files.wordpress.com/2015/01/richard\\_delgado\\_jean\\_stefancic\\_critical\\_race\\_thboo kfi-org-1.pdf](https://uniteyouthdublin.files.wordpress.com/2015/01/richard_delgado_jean_stefancic_critical_race_thboo kfi-org-1.pdf)

<sup>12</sup> Id.

the private insurance market. Those with stable employment with mid-to large-scale employers access health insurance through their employment, but still see a significant portion of their wages go to paying premiums, deductibles and other health care costs not covered by their plans, which themselves exhibit wide disparities in the level of coverage. The poorest individuals may be covered by Medicaid, the public health insurance option, but eligibility is limited and generally does not include immigrants. The cost of health care in the United States is the highest in the world, but health outcomes in the U.S. are poorer than other developed countries with universal coverage. Because of its high price and concessions to corporate interests in the pharmaceutical and insurance industries, health care is not considered or treated as a right in the United States, but a commodity accessed unevenly depending on one's resources.

In a nation where health care access depends on income and resources, socioeconomic status is a critical determinant of health. In a study of the relationship between health insurance disparities and race, ethnicity and socioeconomic status, researchers first found an inverse relationship between the level of educational attainment and the likelihood of not having health insurance. Individuals with less than a high school education were 9.68 times as likely to be uninsured as those with a graduate degree. Meanwhile, individuals with a Bachelor's degree were 1.94 times as likely to be uninsured as those with a graduate degree.<sup>13</sup> In turn, individuals with at least a high school diploma lived almost a decade longer than those without one, while men and women who graduated college lived an additional four and two years, respectively.<sup>14</sup> At the extreme end, men with the highest incomes lived almost 15 years longer than those with the lowest income.<sup>15</sup>

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<sup>13</sup> HEGENAUER, Christa L. "ARE WE COVERED? HEALTH INSURANCE DISPARITIES IN THE AFFORDABLE CARE ACT ERA" In Michigan Sociological Review. Fall 2016. Vol. 30, pp. 100-101. Retrieved on September 24, 2020. Accessed from <http://www.jstor.com/stable/43940349>

<sup>14</sup> GOSTIN, Lawrence O., WILEY, Lindsay F. "Health Justice". Public Health Law and Ethics: A Reader. University of California Press. 2018. Retrieved on September 26, 2020. Accessed from <http://www.jstor.com/stable/10.1525/j.ctv5j024v.18>

<sup>15</sup> Id.

These numbers are striking given the way income is directly related to educational attainment and inversely related to health outcomes. In 2016, the median annual income for non-Latinx<sup>16</sup> whites was already higher than that of racial and ethnic minorities, standing at \$47,958, while that of Blacks trailed at \$31,082 and that of Latinxs at \$30,400. That contrast is even greater when comparing income at the bottom tenth percentile for each group, with low-income whites at this level making \$15,094 and low-income Blacks and Latinxs making \$8,201 and \$9,900, respectively.<sup>17</sup> Racial disparities in education and income lead to similar disparities in access to health care, health outcomes and life expectancy.

In many ways, socioeconomic status also influences where racial, ethnic and Indigenous groups can live. There is extensive literature on environmental racism in the United States. One example is the predominance of garbage and toxic waste sites strategically placed near the homes of marginalized, racial, ethnic and Indigenous groups.<sup>18</sup> Like the notorious and well-publicized example of the government's selective failure to prevent lead from leaking into drinking water in predominantly-minority Flint, Michigan, the story of waste facilities in Chester, Pennsylvania is an emblematic illustration of the way environmental hazards cripple the health of communities of color.

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<sup>16</sup> While census data and corresponding demographic data in many studies use the category "Hispanic," we will use the term "Latinx". In the U.S. data, Hispanic or Latinx is an ethnic rather than a racial category, hence the use of the term "non-Latinx whites," since Latinx people can be of any race. However, Latinx people have themselves been racialized within the U.S. racial hierarchy and color spectrum based on white supremacy. See Laura E. *Inventing Latinos: A New Story of American Racism*, The New Press, 2020, for a discussion of the evolution of racism and racialization of Latinx in the United States.

<sup>17</sup> KOCHHAR, Rakesh, CILLUFFO, Anthony. "Income Inequality in the U.S. Is Rising Most Rapidly Among Asians: Asians displace blacks as the most economically divided group in the U.S." Pew Research Center Social & Demographic Trends. July 12, 2018. Retrieved on September 27, 2020. Accessed from <https://www.pewsocialtrends.org/2018/07/12/income-inequality-in-the-u-s-is-rising-most-rapidly-among-asians/>

<sup>18</sup> KRIEGER, Nancy. "Discrimination and health inequities"... op. cit., p. 643-710; BRAVO, Mercedes A., ANTHOPOLOS, Rebecca, BELL, Michelle L., et al. "Racial Isolation And Exposure To Airborne Particulate Matter And Ozone In Understudied U.S. Populations: Environmental Justice Applications Of Downscaled Numerical Model Output". *Environment International*. 2016. Vol. 92-93, pp. 247-255. Retrieved on September 27, 2020. Accessed from <https://doi.org/10.1016/j.envint.2016.04.008>; BAILEY, Zinzi D., KRIEGER, Nancy, AGENOR, Madina, et al. "Structural Racism and Health Inequities in the United States of America: Evidence and Interventions". In OBERLANDER, Jonathan, BUCHBINDER, Mara, CHURCHILL, Larry R., et al. *The Social Medicine Reader: Differences and Inequalities, Volume II*, Third Edition. Duke University Press. 2019. Retrieved on September 27, 2020. Accessed from <https://www.jstor.org/stable/j.ctv11smxmw.29>

For decades, Chester was home to multiple toxic waste facilities and, in 1988, it was set to also become home to the largest incinerator in the country. These facilities were strategically placed in and around Chester, which is majority low-income and Black. Despite its proximity to racially diverse Delaware County, Chester is 65% African American and 45% less affluent, with a poverty rate triple that of Delaware County. Further, unemployment and crime are much higher, on top of a mortality rate 40% higher than that of Delaware county.<sup>19</sup>

These negative consequences emanate to a large degree from the toxins in the air and the constant vibration and rumbling of garbage trucks around the neighborhoods, which cause the foundations of many houses to crack, driving property values down and engendering decreasing investment into these communities.<sup>20</sup> To make matters worse, in 1988, the city granted a permit for the building of the largest incinerator in the country, which until 1997 burned all of Delaware's waste, in addition to that of the state of New Jersey and New York. Over time, conditions for Chester residents worsened as the waste, odor and noise grew, causing respiratory problems and other illnesses.<sup>21</sup> Unfortunately, the story of Chester, Pennsylvania is not unique. Across the country, incinerators and toxic waste facilities have been disproportionality placed in or near communities of color.<sup>22</sup> These residents are then forced to *internalize* their living conditions, in ways that negatively impact their health.

In fact, the public health literature has examined very closely how structural racism and its resulting residential segregation forces communities of color into conditions that lead to poorer health outcomes.<sup>23</sup> Racial residential segregation leads to conditions of sub-standard housing in areas beset by pollutants and far away from high-

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<sup>19</sup> GOSTIN, Lawrence O., WILEY, Lindsay F. "Health Justice"... op. cit., p. 593.

<sup>20</sup> Id.

<sup>21</sup> Id.

<sup>22</sup> BRAVO, Mercedes A., ANTHOPOLOS, Rebecca, BELL, Michelle L., et al. "Racial Isolation And Exposure To Airborne Particulate Matter And Ozone In Understudied U.S. Populations: Environmental Justice Applications Of Downscaled Numerical Model Output"...op. cit., pp. 247–255

<sup>23</sup> BAILEY, Zinzi D., KRIEGER, Nancy, AGENOR, Madina, et al. "Structural Racism and Health Inequities in the United States of America: Evidence and Interventions"...op. cit., p. 220

quality education and decent employment.<sup>24</sup> In these conditions, communities of color increasingly suffer from higher levels of infant mortality,<sup>25</sup> lower life expectancy<sup>26</sup> and higher risks of chronic disease.<sup>27</sup> Structural racism subjects Black, Indigenous and communities of color to social determinants that render them vulnerable to poor health. Poverty, unhealthy environments, greater exposure to risks in the workplace, poor diet, and the added stressors of everyday life at the margins contribute to poorer health. Once vulnerable, lack of access to health care exacerbates these conditions.

The United States has failed in two critical ways to ensure the right to health. On the one hand, it has failed to implement universal health insurance coverage. On the other, it has failed to implement appropriate interventions that might minimize health risks to vulnerable populations and ameliorate the structural determinants of poor health.<sup>28</sup> By refusing to adequately address racial and social inequality, and failing to ensure universal health care coverage, the U.S. has exacerbated harms to communities of color.<sup>29</sup>

On top of these social determinants of health, communities of color must also cope with the stresses and threats of ongoing structures of racism, settler colonialism and xenophobia, which influence the distribution of power and resources, further propelling a vicious cycle. Black lives are devalued, Indigenous people continue to be

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<sup>24</sup> WILLIAMS, David R., COLLINS, Chiquita. "Racial Residential Segregation: A Fundamental Cause Of Racial Disparities In Health". In *Public Health Reports*. 2001. Vol. 116. No. 5, pp. 404-416. Retrieved on September 27, 2020. Accessed from <https://www.jstor.org/stable/4598675>

<sup>25</sup> ACEVEDO-GARCIA, Dolores, LOCHNER, Kimberly A., OSYPUK, Theresa L., et al. "Future Directions in Residential Segregation and Health Research: A Multilevel Approach". *American Journal of Public Health*. 2003. Vol. 93. No. 2, pp. 215-221. C Retrieved on September 27, 2020. Accessed from <https://doi.org/10.2105/AJPH.93.2.215>

<sup>26</sup> FRANKS, Peter, MUENNIG, Peter, LUBETKIN, Erica, et al. "The Burden of Disease Associated with being African-American in the United States and the Contribution of Socio-economic Status." *Social Science and Medicine*. 2006. 65. Vol. 62. No. 10. pp. 2469-78. Retrieved on September 27, 2020. Accessed from <https://doi.org/10.1016/j.socscimed.2005.10.035>

<sup>27</sup> ACEVEDO-GARCIA, Dolores, LOCHNER, Kimberly A., OSYPUK, Theresa L., et al. "Future Directions in Residential Segregation and Health Research: A Multilevel Approach"... op. cit., pp. 215-221; KERSHAW, Kiarri N., DIEZ, Ana V., ROUX, Sarah A., et al. "Metropolitan-level racial residential segregation and black-white disparities in hypertension". *American Journal of Epidemiology*. Oxford University Press on behalf of the Johns Hopkins Bloomberg School of Public Health. 2011. Vol. 174. No. 5, pp. 537–545. Retrieved on September 27, 2020. Accessed from <https://doi.org/10.1093/aje/kwr116>

<sup>28</sup> Id.

<sup>29</sup> Id.

dispossessed and their indigenous identity erased, and immigrants performing essential labor are racialized, criminalized, and demonized in a situation where their legal status strips them of full rights in U.S. society. These stresses and comorbidities are also known as social determinants of *inequity*.<sup>30</sup>

These stressors produce a range of biochemical, physiological, mental and behavioral responses that harm the health of communities of color.<sup>31</sup> These responses then trigger physical or psychological responses like high blood pressure and higher levels of stress hormones.<sup>32</sup> Overproduced hormones like cortisol can then lead to suppressed immune functions and changes in heart rate and blood pressure, in ways that over time may lead to psychiatric disorders, hypertension and cardiac failure.<sup>33</sup> This societal rejection and exclusion can be extremely stressful and cause physical pain.<sup>34</sup> Coupled with the race-related stressors of (un)employment, difficult life events and discrimination, systematic rejection and exclusion means that communities of color are increasingly exposed to these biochemical and physiological stressors. Whereas Blacks are the most likely group to experience a “clustering” of stressors, Latinxs born in the US experience patterns similar to those of African Americans.<sup>35</sup>

Over time, chronic exposure to these stressors translates into trauma and posttraumatic stress disorder, further impacting health. For instance, traumatic race-related experience are found to disrupt the anatomy of children’s brain, resulting in structural changes associated with the development of anxiety and depression.<sup>36</sup> Given

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<sup>30</sup> *Ibíd*, pp. 71-73.

<sup>31</sup> CARTER, Robert T., PIETERSE, Alex L. “UNDERSTANDING REACTIONS TO STRESS: TRAUMA, TRAUMATIC STRESS, AND POSTTRAUMATIC STRESS DISORDER”. *Measuring the Effects of Racism: Guidelines for the Assessment and Treatment of Race-Based Traumatic Stress Injury*. Columbia University Press. 2020. Retrieved on September 24, 2020. Accessed from <https://www.jstor.org/stable/10.7312/cart19306>

<sup>32</sup> *Ibíd*, p. 28.

<sup>33</sup> *Ibíd*, p. 26.

<sup>34</sup> *Ibíd*, p. 28.

<sup>35</sup> *Id.*; It is worth noting that Native Americans are largely absent from the data.

<sup>36</sup> CARTER, Robert T., PIETERSE, Alex. “EMERGING ISSUES IN PRACTICE AND RESEARCH”. *Measuring the Effects of Racism: Guidelines for the Assessment and Treatment of Race-Based Traumatic Stress Injury*. Columbia University Press. 2020. Retrieved on September 24, 2020. Accessed from <https://www.jstor.org/stable/10.7312/cart19306.16>



the connection between these experiences and the neurobiology of children and adolescents of color, more research must be done to understand the resulting long-lasting, traumatic effects.

What happens when health worsens and the time comes to seek medical care? Where there is health care coverage, quality of care may be absent. Conversely, where there is quality of health care, there may not be access to it. These barriers for racial, Indigenous and ethnic communities, commonly known as health inequities, have existed for decades. In fact, all racial minority variables, when compared to those of whites, show positive associations with a lack of health insurance coverage; the same is true of Latinxs, even when controlling for gender, age, marital status and employment status.<sup>37</sup> Unfortunately, this is true even in the age of the Patient Protection and Affordable Care Act (ACA), the most significant federal effort to reduce health disparities in the United States.<sup>38</sup>

More concretely, while the United States is spending the highest per-capita health care expenditures in the world, tens of millions of people continue to be un- and under-insured.<sup>39</sup> For comparison, before the passage of the ACA, In 2008, the Centers for Disease Control and Prevention (CDC) found that African Americans were nearly twice as likely to be uninsured than non-Latinx whites, while Latinxs were more than three times as likely to be uninsured.<sup>40</sup> It is estimated that the cost of these disparities in direct medical costs and lost productivity exceeded 1.24 trillion dollars between 2003 and 2006.<sup>41</sup> According to the CDC, "inequalities in health status and access to care - as

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<sup>37</sup> HEGENAUER, Christa L. "ARE WE COVERED? HEALTH INSURANCE DISPARITIES IN THE AFFORDABLE CARE ACT ERA"... op. cit., pp. 103; 105.

<sup>38</sup> United States Department of Health and Human Services. Strategic Goal 1: Strengthen Health Care. HHS. 2015. Retrieved on September 26, 2020. Accessed from <http://www.hhs.gov/about/strategic-plan/strategic-goal-1/index.html>

<sup>39</sup> TODD, Susan R., SOMMERS, Benjamin D. "Overview of the Uninsured in the United States: A Summary of the 2012 Current Population Survey Report". Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE). Issue Brief. 2012. Retrieved on September 30, 2020. Accessed from <http://aspe.hhs.gov/health/reports/2012/uninsuredintheus/ib.cfm>

<sup>40</sup> HEGENAUER, Christa L. "ARE WE COVERED? HEALTH INSURANCE DISPARITIES IN THE AFFORDABLE CARE ACT ERA"... op. cit., p. 94.

<sup>41</sup> Id.

well as the unequal burden of morbidity and mortality - for some racial and ethnic groups in the United States have made race and Hispanic [sic] origin among the most important demographic characteristics of interest to users of the National Health Interview Survey (NHIS)".<sup>42</sup> Nevertheless, greater access to health care coverage has not solved the problem for the un- and underinsured. This is because the current health financing system reinforces and institutionalizes inequality.

To illustrate this, it is worth examining the actual monetary cost of health care in the United States. In 2014, the new private plans of the ACA were found to carry high deductibles and co-payments, with the bronze and silver plans averaging over \$5000 and \$2900, respectively, for single coverage, and over \$10,000 and \$6,000, for family coverage.<sup>43</sup> By contrast, the median net worth of black and Latinx householders was \$6,314 and \$7,683, respectively, vs. \$110,500 for non-Latinx whites, a 15-fold difference.<sup>44</sup> Therefore, the average family deductibles for bronze and silver plans "would bring financial ruin to most African American and Latinx households".<sup>45</sup> Thus, while the ACA expands access to health care at a national level, it still fails at materializing that access to millions of racial, ethnic and Indigenous communities.

As with inadequate access to health care, the quality of care also exhibits institutional racism and health inequities. In a number of studies, experts found that health care providers contribute to racial and ethnic disparities through their role in the patient-provider relationship, the diagnosis and the delivery of services.<sup>46</sup> This type of

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<sup>42</sup> Centers for Disease Control and Prevention (CDC). Race and Hispanic Origin Information. CDC National Center for Health Statistics. 2010. Retrieved on September 30, 2020. Accessed from [https://www.cdc.gov/nchs/nhis/rhoi/rhoi\\_history.htm](https://www.cdc.gov/nchs/nhis/rhoi/rhoi_history.htm)

<sup>43</sup> GOODNOUGH, Abby, PEAR, Robert. "Unable to meet the deductible or the doctor". *The New York Times*. October 17, 2014. Retrieved on September 30, 2020. Accessed from <https://www.nytimes.com/2014/10/18/us/unable-to-meet-the-deductible-or-the-doctor.html>

<sup>44</sup> United States Census Bureau. Net worth and asset ownership of households: 2011.2014. U.S. Census Bureau. Retrieved on September 30, 2020. Accessed from <https://www.census.gov/newsroom/press-releases/2014/cb14-156.html>

<sup>45</sup> CARUSO, Dominic F., HIMMELSTEIN, David U., WOOLHANDLER, Steffie. "Single-Payer Health Reform". *Harvard Public Health Review*. 2015. Vol. 7., pp. 1-4. Retrieved on September 30, 2020. Accessed from <https://www.jstor.org/stable/10.2307/48503129>

<sup>46</sup> HAVES, Betsy E., YONAS, Michael A., MASON, Mondy A., et al. "Eliminating Inequities in Health Care: Understanding Perceptions and Participation in an Antiracism Initiative". *Health Promotion Practice*. 2011.

racism comes to light through an institution's organizational infrastructure and allocation of resources, such as a lack of client outreach, direct services provision, culturally and linguistically inappropriate services, and the absence of systems for ensuring provider accountability.<sup>47</sup> Considering the social determinants of inequity and health described above, it is no surprise that the webs of structural racism, settler colonialism and xenophobia, coupled with a capitalist health care model, undermine efforts of health care reform to remedy or dismantle these systems.

## II. A CRITIQUE OF THE US HEALTH CARE SYSTEM

Reflecting on the health inequities described above, how does the United States perceive its obligation to protect and guarantee the health of its people? What exactly is the status of the right to health in the United States? As this section will elucidate, the right to health is not legally recognized constitutionally or statutorily at the national level or state level, and this failure of recognition means that protections and guarantees are inadequate and disparate across the country. Absent a clear, federal or international recognition of the right to health in the United States, efforts like the enactment of the Affordable Care Act (ACA) and state laws, like those of Massachusetts and Vermont, continue to fall short of appropriate and equitable protections.

As a preliminary matter, it is worth recalling the meaning and guarantees of the right to health. The World Health Organization (WHO) defined the right to health as “the enjoyment of the highest attainable standard of health... without distinction of race, religion, political belief, economic or social condition”, where health is the “state of complete physical, mental and social well-being and not merely the absence of disease

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<sup>47</sup> JONES, Camara P. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health*. 2000. Vol. 90. No. 8, pp. 1212-1215. Retrieved on September 30, 2020. Accessed from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446334/pdf/10936998.pdf>

or infirmity.”<sup>48</sup> Echoing the social determinants of health discussed above, the Committee on Economic, Social and Cultural Rights also recognized "underlying determinants of health", such as access to health care and hospitals; safe drinking water and adequate sanitation; safe food; adequate nutrition and housing; healthy working and environmental conditions; health-related education and information; and gender equality.<sup>49</sup>

Under the International Covenant on Economic, Social and Cultural Rights (ICESCR), states commit to recognizing the right to health and honoring its entitlements, including providing a system of health protection that provides equal opportunity for everyone to enjoy the highest attainable level of health; access to prevention, treatment and control of diseases; maternal, child and reproductive health; equal and timely access to basic health services; health-related education and information; and participation of the population in health-related decision-making at the national and community levels.<sup>50</sup> And while some of these obligations are “subject to progressive realization”, at a minimum States have to show they are making every possible effort, within available resources, to better protect and promote the right to health.<sup>51</sup>

As such, a State’s obligations with respect to the right to health can be summarized as an obligation to protect, by preventing third parties from interfering with the right; to respect, by refraining from directly or indirectly interfering with that right; and to fulfill, by adopting a national health policy or plan to cover all sectors and all populations within its jurisdiction.<sup>52</sup> Further, these treaties and the WHO are explicit in pointing out that the right to health must be non-discriminatory, rejecting “any distinction, exclusion or restriction made on the basis of various grounds which [have] the effect or

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<sup>48</sup> United Nations Office of the High Commissioner for Human Rights (OHCHR). Fact Sheet No. 31: The Right to Health. June 2008. No. 31. Retrieved on November 15, 2020. Accessed from <https://www.refworld.org/docid/48625a742.html>

<sup>49</sup> *Ibíd*, p. 3.

<sup>50</sup> *Ibíd*, p. 1, 3-4.

<sup>51</sup> *Ibíd*, p. 23.

<sup>52</sup> *Ibíd*, p. 25-27.

purpose of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms.<sup>53</sup> Unsurprisingly, these obligations are echoed and reemphasized in related treaties like the International Convention on the Elimination of all forms of Racial Discrimination (ICERD), which requires states to address differential access to health care.

Where does the United States stand with respect to these and other treaties recognizing the right to health? Has it made an international, and therefore national, commitment to respect the right to health? On the one hand, the United States is not a party to ICESCR, for it has yet to ratify it, or most other international legal instruments in which a right to health is declared or defined. Further, it has not recognized a right to health in the U.S. Constitution. In fact, even when supporters of the right to health have sought to obtain its recognition through the theory of economic discrimination under the Fourteenth Amendment of the U.S. Constitution, which requires the government to provide welfare benefits without discrimination, that has not gained traction.<sup>54</sup> This lack of recognition under the Constitution or a binding international convention has left individuals in the United States with no legally-cognizable or actionable right to health.<sup>55</sup>

However, U.S. adherence to treaties like ICERD appears to suggest it has made an international and national commitment to recognize the right: not only did the United States sign ICERD in 1966 and ratify it in 1994, but in 2007 it also provided a periodic report to the UN Committee on the Elimination of Racial Discrimination addressing concerns about its racial profiling, residential segregation, disproportionate incarceration, differential access to health care, and the achievement gap in education, all of which directly and indirectly impact the right to health.<sup>56</sup> In particular, the United

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<sup>53</sup> *Ibid*, p. 7.

<sup>54</sup> SANDHU, Puneet K. "COMMENT: A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?". In 95 *Calif. L. Rev.* 1151. 2007.

<sup>55</sup> MCGILL, Mariah, MACNAUGHTON, Gillian. "ARTICLE: THE STRUGGLE TO ACHIEVE THE HUMAN RIGHT TO HEALTH CARE IN THE UNITED STATES". In 25 *S. Cal. Interdis. L.J.* 625

<sup>56</sup> United Nations Office of the High Commissioner for Human Rights (OHCHR). Reports Submitted by States Parties Under Article 9 of the Convention: Seventh to Ninth Periodic Reports of States Parties Due in 2011: United States of America. CERD/C/USA/7-9. October 3, 2013. Retrieved on October 23, 2020. Accessed from

States emphasized that it prohibits discrimination in hospitals and health care facilities, adding that it has been tracking access to health care for racial and ethnic minorities since 2003 through the National Healthcare Quality Report (NHQR) and the National Healthcare Disparities Report (NHDR) and that “HHS [the U.S. Department of Health and Human Services] and DOJ vigorously enforc[e] these laws”.<sup>57</sup> Interestingly, in this same report, the United States recognized that the data it has collected through NHQR and NHDR indicates that “health care quality in America could be improved”.<sup>58</sup>

In response to its periodic report from the United States, the Committee on the Elimination of Racial Discrimination expressed concern that “individuals belonging to racial and ethnic minorities, as well as indigenous [sic] peoples, continue to be disproportionately affected by the negative health impact of pollution caused by the extractive and manufacturing industries”.<sup>59</sup> It also expressed concern about the exclusion of undocumented immigrants from coverage under the Affordable Care Act, as well as worry about states with significant racial and ethnic minorities opting out of the Medicaid expansion program, both of which have resulted in a failure to “address racial disparities in access to affordable and quality health care”.<sup>60</sup> The Committee then recommended the United States take steps to “ensure that all individuals, in particular those belonging to racial and ethnic minorities who reside in states that have opted out of the Affordable Care Act, undocumented immigrants and immigrants and their families [...] have effective access to affordable and adequate health-care services”.<sup>61</sup>

In addition to these findings and recommendations under ICERD, the United States expressed a commitment to the right to health in September 2015, when it

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[https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2f7-9&Lang=en](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2f7-9&Lang=en)

<sup>57</sup> *Ibíd*, p. 45.

<sup>58</sup> *Id.*

<sup>59</sup> United Nations Office of the High Commissioner for Human Rights (OHCHR). Concluding observations on the combined seventh to ninth periodic reports of the United States of America. CERD/C/USA/CO/7-9. 25 de septiembre de 2014. Consultado el 23 de octubre de 2020. Recuperado de [https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2fCO%2f7-9&Lang=en](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fUSA%2fCO%2f7-9&Lang=en)

<sup>60</sup> *Ibíd*, p. 7.

<sup>61</sup> *Id.*

endorsed the United Nations General Assembly's 2030 Agenda for Sustainable Development, which outlined the 17 Sustainable Development Goals (SDGs) and 169 targets, including efforts to achieve universal health coverage and access to quality essential health care services, by 2030.<sup>62</sup> These goals apply to all members of the United Nations, including the United States, thereby enshrining a commitment to achieving universal health coverage.

Despite these two express commitments, the United States has continued to fail to recognize a right to health. Instead, it has moved toward advancing laws that commoditize health care and privatize its provision. The most recent case-in-point is the Patient Protection and Affordable Care Act (ACA), which was signed into law in March of 2010 and was subsequently upheld by the Supreme Court in June of 2012. The ACA created subsidized programs for low- and middle-income people, provided support for states to expand Medicaid, which is designed to support low-income people, and mandated that all individuals maintain health insurance unless there was no other affordable option.<sup>63</sup> The U.S. Department of Health and Human Services (HHS) has argued that the ACA represents the most significant federal effort to reduce health disparities in our country's history.<sup>64</sup> According to HHS, it seeks to address health disparities experienced by underserved populations who have historically had poorer access and health outcomes through "improve[d] quality, increase[d] access, and protect[i]ons for] consumers of health care".<sup>65</sup> Further, the ACA contains provisions that clearly aim at reducing disparities among low income and disadvantaged racial and ethnic populations, although the HHS finds that targeted efforts are still necessary to ensure that they are receiving these new benefits.<sup>66</sup>

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<sup>62</sup> United Nations General Assembly. Resolution adopted by the General Assembly on 25 September 2015. A/RES/70/1. 21 de octubre del 2015. Retrieved on October 23, 2020. Accessed from [https://www.un.org/ga/search/view\\_doc.asp?symbol=A/RES/70/1&Lang=E](https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E)

<sup>63</sup> The Henry J. Kaiser Family Foundation. "Summary of the Affordable Care Act". The Henry J. Kaiser Family Foundation. 2013. Menlo Park, CA. Retrieved on October 23, 2020. Accessed from <http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act>

<sup>64</sup> United States Department of Health and Human Services. Strategic Goal 1: Strengthen Health Care. HHS. 2015. Retrieved on September 26, 2020. Accessed from <http://www.hhs.gov/about/strategic-plan/strategic-goal-1/index.html>

<sup>65</sup> Id.

<sup>66</sup> Id.

While the ACA might suggest that the United States considers health a human right, the very framework of the ACA indicates that it is instead a commodity reserved for those with resources and access to that system. For one, the ACA incorporated major concessions to corporate health interests, the pharmaceutical and insurance industries, which lobbied lawmakers extensively.<sup>67</sup> For instance, a two-year delay in the implementation of Medicare price controls for dialysis drug Sensipar allowed biotechnology company Amgen to cash in approximately \$500 million, while maintaining for two years the already high price of Sensipar for dialysis patients.<sup>68</sup> Further, it also preserved Accountable Care Organizations (ACOs), which are modified versions of the corporate managed care organizations (MCOs) behind many of the corporate interests of the 1970's through today.<sup>69</sup> Thus, by relying on private, for-profit insurers to fund health care, the ACA's drafters gave the key to this system to for-profit insurers primarily concerned with maximizing shareholders' profits through higher premiums and denial of coverage for preexisting conditions of expensive enrollees, more commonly known as cherry picking. While the ACA technically bans these tactics, there is evidence already that insurers are finding ways to get around these regulations.<sup>70</sup> To make matters worse, the very topic of health care continues to be a divisive political issue. While the country's federalist structure demands leaving the issue to the states' discretion, the two-party system forces the parties and voters to choose one side of the debate or the other.

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<sup>67</sup> YOUNG, Kevin, SCHWARTZ, Michael. "Healthy, Wealthy, and Wise: How Corporate Power Shaped the Affordable Care Act". *New Labor Forum*. 2014. Vol. 23, No. 2, pp. 30-40. Retrieved on November 19, 2020. Accessed from <https://www.jstor.org/stable/24718508>

<sup>68</sup> LIPTON, Eric, SACK, Kevin. "Fiscal Footnote: Big Senate Gift to Drug Maker". *The New York Times*. January 20, 2013. Retrieved on November 19, 2020. Accessed from <https://www.nytimes.com/2013/01/20/us/medicare-pricing-delay-is-political-win-for-amgen-drug-maker.html>

<sup>69</sup> GAFFNEY, Adam, HIMMELSTEIN, David, WOOLHANDLER, Steffie. "The Failure of Obamacare and a Revision of the Single-Payer Proposal after a Quarter-Century of Struggle". WAITZKIN, Howard. *Health Care Under the Knife: Moving Beyond Capitalism for Our Health*. NYU Press. Retrieved on October 23, 2020. Accessed from <https://www.jstor.org/stable/j.ctt1pwt8bd.15>

<sup>70</sup> JACOBS, Douglas B., SOMMERS, Benjamin D. "Using Drugs to Discriminate—Adverse Selection in the Insurance Marketplace". *New England Journal of Medicine*. 2015. Vol. 372, No.5, pp. 399-402. Retrieved on October 23, 2020. Accessed from <https://www.nejm.org/doi/pdf/10.1056/NEJMp1411376?articleTools=true>



On top of these problematic, structural underpinnings, the ACA's individual mandate to purchase insurance or pay a fine is still facing long-standing coverage issues. Recent studies show that a quarter of adults with private insurance still cannot afford health care when adding premiums, deductibles, and out-of-pocket costs.<sup>71</sup> Likewise, millions of people remained uninsured as of 2016.<sup>72</sup> In fact, in analyzing data before and after the passage of ACA, researchers found that low levels of educational attainment, non-white race, and Hispanic ethnicity were all associated with an increased likelihood of not being covered by health insurance.<sup>73</sup> As expected, the success and failure of the ACA has varied from state to state<sup>74</sup>, as each has taken its own approach at implementation.

In fact, in the face of disparate implementation and a national failure to recognize the right to health, a few states have taken the matter in their own hands. Massachusetts is one key example: the state went from 86% of adults aged 19–64 having health insurance in 2006 to over 96% of these adults having insurance in 2017, all as a result of An Act Providing Access to Affordable, Quality, Accountable Health Care, more commonly known as Chapter 58.<sup>75</sup> This health reform effort sought to recognize health care as a human right and resolve the crisis of uninsurance and high medical costs. But while it was successful at increasing coverage, Chapter 58 still gave way to a crisis of underinsurance, where in spite of having health insurance people were still unable to access necessary or adequate health care.<sup>76</sup> Further, while it pushed for

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<sup>71</sup>TOLBERT, Jennifer, YOUNG, Katherine. Paying for health coverage: The challenge of affording health insurance among marketplace enrollees. The Henry J. Kaiser Family Foundation. 2016. Menlo Park, CA. Retrieved on October 23, 2020. Accessed from <http://files.kff.org/attachment/issue-brief-paying-for-health-coverage-the-challenge-of-affording-health-insurance-among-marketplace-enrollees>

<sup>72</sup> GAFFNEY, Adam, HIMMELSTEIN, David, WOOLHANDLER, Steffie. "The Failure of Obamacare and a Revision of the Single-Payer Proposal after a Quarter-Century of Struggle"... op. cit., p. 205.

<sup>73</sup> HEGENAUER, Christa L. "ARE WE COVERED? HEALTH INSURANCE DISPARITIES IN THE AFFORDABLE CARE ACT ERA"... op. cit., p. 99.

<sup>74</sup> The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. The Henry J. Kaiser Family Foundation. December 2019. Retrieved on October 23, 2020. Accessed from <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>

<sup>75</sup> SKOPEC, Laura, LONG, Sharon K., SHERR, Susan et al. Findings from the 2017 Massachusetts health information survey. Center for Health Information and Analysis; Urban Institute; SSRS. December 2017. Retrieved on October 23, 2020. Accessed from <http://www.chiamass.gov/assets/docs/r/survey/mhis-2017/2017-MHIS-Report.pdf>

<sup>76</sup> MACNAUGHTON, Gillian, MCGILL, Mariah, JAKUBEC, April, et al. "Engaging Human Rights Norms to Realize Universal Health Care in Massachusetts, USA". Health and Human Rights. 2018. Vol. 20. No. 2,

recognition of health care as a human right through a strong grassroots campaign, the state failed at passing an amendment to the Massachusetts's Constitution and was not able to increase understanding among residents regarding the actual meaning of that right.<sup>77</sup> Nevertheless, over ten years after the passage of Chapter 58, Massachusetts has one of the highest rates of health insurance coverage in the United States. While not perfect, the law's achievements were part of the reason President Obama modeled the ACA after Chapter 58.<sup>78</sup>

A second illustrative example is that of the state of Vermont, home to Senator and recent presidential candidate, Bernie Sanders. Like Massachusetts, Vermont also had a portion of its population uninsured, with almost 10% of Vermonters, or approximately 66,000 residents, remaining uninsured.<sup>79</sup> The state adopted two laws, Act 128 and Act 48, in 2010 and 2011, whereby it recognized health care as a "public good" and embraced human rights principles as guidelines for a new universal health care system covering all residents of Vermont.<sup>80</sup> This was the first effort in the United States to frame a health care reform in the context of recognition of the right to health. Since then, Senator Bernie Sanders has continued to push for federal recognition of that right. In 2013, he took that one step farther by introducing a bill in US Congress to establish a universal health care system. And while that effort had no co-sponsors and failed<sup>81</sup>, it has recently gained more traction, with 17 co-sponsors in the US Senate, through a new "Medicare for All" bill designed to improve and broaden health care coverage.<sup>82</sup>

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pp. 93-104. Retrieved on September 30, 2020. Accessed from <https://www.jstor.org/stable/10.2307/26542063>

<sup>77</sup> *Ibid*, p. 93.

<sup>78</sup> *Ibid*, p. 94.

<sup>79</sup> MCGILL, Mariah. "Using human rights to move beyond the politically possible". *Clearinghouse Review Journal of Poverty Law and Policy*. 2011. Vol. 44, pp. 459–460. Retrieved on September 30, 2020. Accessed from [https://www.northeastern.edu/law/pdfs/academics/phrge-mcgill\\_clearinghouse\\_janfeb2011.pdf](https://www.northeastern.edu/law/pdfs/academics/phrge-mcgill_clearinghouse_janfeb2011.pdf)

<sup>80</sup> MACNAUGHTON, Gillian, MCGILL, Mariah, JAKUBEC, April, et al. "Engaging Human Rights Norms to Realize Universal Health Care in Massachusetts, USA"... *op. cit.*, p. 83.

<sup>81</sup> The Nation. "The political genius of Bernie's 'Medicare for All' bill". *The Nation*. September 20, 2017. Retrieved on September 30, 2020. Accessed from <https://www.thenation.com/article/archive/the-political-genius-of-bernies-medicare-for-all-bill/>

<sup>82</sup> SANDERS, Bernie. A Bill to Establish a Medicare for All National Health Insurance Program: S. 1804. 115th Congress, 1st Session. Retrieved on September 30, 2020. Accessed from

Although these state-level reforms are hopeful efforts of recognition of the right to health, the United States continues to demonstrate a broad federal and state commitment to political buy-in from powerful corporate interests. In many ways, the cases of Massachusetts and Vermont are a microcosm of the national problem. On the one hand, individuals continue to lack information and understanding of the right to health, thereby remaining unempowered to demand broader changes. On the other, the absence of a constitutional or statutory recognition of the right to health, less-than-transformational reforms like the ACA will continue to replay the same challenges at the state and federal levels, in ways that continually engender disparate access and quality of health care.

### III. **GROSS FAILURES IN THE AGE OF COVID-19**

Despite the human rights standards in place internationally and the principle of non-discrimination, as well as the U.S. formal health care policy towards expansion of coverage and elimination of inequities, the U.S. has failed to commit to and implement those standards in response to the COVID-19 crisis through a coherent national plan. This, together with cynical leadership, has led to the U.S., as of this writing, leading the world in COVID-19 infections and deaths<sup>83</sup> and those outcomes have disproportionately affected Black, Indigenous, and people of color because of structural injustices expressed in the health care system and social determinants of health in the U.S.<sup>84</sup> This failure itself has been due to both lack of leadership at the national level through a chaotic, mismanaged response, and the politization of the pandemic by Trump and his administration through denial, lies, refusal to follow scientific data and

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<https://www.sanders.senate.gov/download/medicare-for-all-act?id=6CA2351C-6EAE-4A11-BBE4-CE07984813C8&download=1&inline=file>

<sup>83</sup> "Covid world map: which countries have the most coronavirus cases and deaths?" *The Guardian*. October 28, 2020. Retrieved on October 28, 2020. Accessed from <https://www.theguardian.com/world/2020/oct/28/covid-world-map-which-countries-have-the-most-coronavirus-cases-and-deaths>.

<sup>84</sup> "The Fullest Look Yet at the Racial Inequity of Coronavirus." *The New York Times*. July 5, 2020. Retrieved on October 28, 2020. Accessed from <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html>.

recommendations, attempts to manipulate response to conform to political-economic goals that would benefit his reelection, blaming others, and pressuring scientific bodies like the CDC, Food and Drug Administration (FDA), and otherwise non-partisan scientific advisors.

The failed national response to the COVID-19 outbreak led to harm that could have been prevented or subdued with proper leadership. From the beginning of the outbreak, Trump and his administration denied and lied about how serious the outbreak was. At the beginning of the outbreak in the U.S., Trump intentionally downplayed the seriousness of the virus. In January Trump said that the coronavirus was “totally under control” and that there would be only a few U.S. cases before the number would “go down to zero.” In late February, Trump said, “It’s going to disappear. One day it’s like a miracle, it will disappear.” In March, Trump said people would be able to celebrate defeating the coronavirus by going to church on Easter.<sup>85</sup>

Washington Post journalist Bob Woodward interviewed Trump 18 times from January 28th to August 14th for his recently published book “Rage.” Based on those interviews, Woodward asserts that Trump purposefully lied about the risks of COVID-19. During the interviews, Trump revealed that he knew more about the severity of the illness than he had admitted to publicly. According to a tape of the interview, Trump told Woodward in February that the coronavirus was deadlier than the flu. Later that month, however, Trump publicly promised the virus was “very much under control,” and that the case count would soon be close to zero. He also implied the flu was more dangerous than COVID-19. Speaking on Capitol Hill in early March, Trump said, “Just stay calm. It will go away.” Nine days later, after the White House declared the pandemic a national

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<sup>85</sup> Hohmann, James. “The Daily 202: Trump seems to remain in denial about coronavirus dangers, as the coverup continues.” *The Washington Post*. October 5, 2020. Retrieved on October 28, 2020. Accessed from <https://www.washingtonpost.com/politics/2020/10/05/daily-202-trump-seems-remain-denial-about-coronavirus-dangers-coverup-continues/>

emergency, the president told Woodward, "I wanted to always play it down. I still like playing it down, because I don't want to create a panic."<sup>86</sup>

Trump openly refused to recognize science and data, continuously going against CDC recommendations. Not only did Trump deny the seriousness of COVID-19, but he and his administration politicized the issue. In late February, Trump accused Democrats of "politicizing" the COVID-19 outbreak during a campaign rally, claiming that the outbreak was "their new hoax" as he continued to downplay the risk in the U.S.<sup>87</sup>

This politization also suggested to the people of the United States that they should be skeptical of scientists and health experts. Michael R. Caputo, the assistant secretary of public affairs at the Department of Health and Human Services, accused the CDC of harboring a "resistance unit" determined to undermine Trump, and that they inflated the COVID-19 death toll. Both Trump and Caputo have singled out scientists and health experts as disloyal.<sup>88</sup>

The failures mentioned above led to a national public health crisis. From January to August, there were over 4.7 million COVID-19 cases and 150,000 deaths in the United States. Among the 45 countries with more than 50,000 COVID-19 cases, the U.S. has the eighth-highest number of deaths per 100,000 people: 47.93 deaths from the coronavirus for every 100,000 Americans.<sup>89</sup> A new report published in mid-October in the *Journal of the American Medical Association* found that in the past five months,

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<sup>86</sup> "Bob Woodward book Rage: Trump denies lying about risks of coronavirus." *BBC*. September 10, 2020. Retrieved on October 28, 2020. Accessed from <https://www.bbc.com/news/world-us-canada-54107677>.

<sup>87</sup> Egan, Lauren. "Trump calls coronavirus Democrats' 'new hoax'." *NBC*. February 28, 2020. Retrieved on October 28, 2020. Accessed from <https://www.nbcnews.com/politics/donald-trump/trump-calls-coronavirus-democrats-new-hoax-n1145721>.

<sup>88</sup> LaFraniere, Sharon. "Trump Health Aide Pushes Bizarre Conspiracies and Warns of Armed Revolt." *The New York Times*. September 14, 2020. Retrieved on October 28, 2020. Accessed from [https://www.nytimes.com/2020/09/14/us/politics/caputo-virus.html?utm\\_source=newsletter&utm\\_medium=email&utm\\_campaign=newsletter\\_axiosvitals&stream=top](https://www.nytimes.com/2020/09/14/us/politics/caputo-virus.html?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top).

<sup>89</sup> "Charts: How The U.S. Ranks On COVID-19 Deaths Per Capita — And By Case Count." *NPR*. August 5, 2020. Retrieved on October 28, 2020. Accessed from <https://www.npr.org/sections/goatsandsoda/2020/08/05/899365887/charts-how-the-u-s-ranks-on-covid-19-deaths-per-capita-and-by-case-count>.

per capita deaths in the U.S., both from COVID-19 and other causes, have been far greater than in 18 other high-income countries.<sup>90</sup> Even considering only confirmed COVID-19 deaths, the number of people dying since May 10, after adjusting for population size, is on average 50% higher than every other country in the study.<sup>91</sup>

The rate of COVID-19 deaths in the U.S. since June 7 is 27.2 per 100,000 people. In contrast, in Italy, the death rate is down to 3.1 per 100,000.<sup>92</sup> Dr. Ezekiel J. Emanuel, a professor of health policy and medical ethics at the University of Pennsylvania and one of the authors of the study, said that "[Italy has] the same public health measures we've got. They just implemented them effectively and we implemented them poorly."<sup>93</sup> If the U.S. had managed to keep its per capita death rate at the level of Italy's, 79,120 fewer Americans would have died.<sup>94</sup>

These failures, paired with structural injustices within systems (including the health care system) in the U.S., led to Black, Latinx, Indigenous, and people of color suffering disproportionately the brunt of the harm of COVID-19. *The New York Times* reported, based on data from the CDC, that Black and Latinx people have been disproportionately affected by COVID-19 in a widespread manner that spans the country across all age groups in both suburban and rural areas.<sup>95</sup> The CDC now reports the rates in which Black, Indigenous, and people of color contract the virus, are hospitalized for the virus, and die because of the virus compared to white Americans.<sup>96</sup>

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<sup>90</sup> "Americans Are Dying In The Pandemic At Rates Far Higher Than In Other Countries." NPR. October 13, 2020. Retrieved on October 28, 2020. Accessed from <https://www.npr.org/sections/health-shots/2020/10/13/923253681/americans-are-dying-in-the-pandemic-at-rates-far-higher-than-in-other-countries>.

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> The NY Times obtained the data only after suing the Centers for Disease Control and Prevention under the Federal Freedom of Information Act, forcing the agency to release the information about COVID and race. "The Fullest Look Yet at the Racial Inequity of Coronavirus." *The New York Times*. July 5, 2020. Retrieved on October 28, 2020. Accessed from <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html>.

<sup>96</sup> "COVID-19 Hospitalization and Death by Race/Ethnicity." CDC. August 18, 2020. Retrieved on October 28, 2020. Accessed from <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html>.

<b>Rate ratios compared to White, Non-Hispanic Persons</b>	<b>American Indian or Alaska Native, Non-Hispanic persons</b>	<b>Asian, Non-Hispanic persons</b>	<b>Black or African American, Non-Hispanic persons</b>	<b>Hispanic or Latino persons</b>
<b>Cases</b>	2.8x higher	1.1x higher	2.6x higher	2.8x higher
<b>Hospitalization</b>	5.3x higher	1.3x higher	4.7x higher	4.6x higher
<b>Death</b>	1.4x higher	No Increase	2.1x higher	1.1x higher

The CDC also reports that Latinx people between the ages of 40 and 59 have been infected at five times the rate of white people in the same age group. For deaths, more than a quarter of Latinx people who died were younger than 60. Among white people who died, only 6 percent were that young.<sup>97</sup> Black Americans are also disproportionately affected by the virus. In Louisiana alone, although Black Americans make up only 32 percent of the state’s total population, more than 70 percent of those who have died have been Black.<sup>98</sup>

This data is likely incomplete. *The New York Times* states that when the newspaper was finally given this information in early July, the CDC released nearly 1.5 million case records where data on race, ethnicity and county of residence was missing for hundreds of thousands of cases. Even with the missing information, agency

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<sup>97</sup> “The Fullest Look Yet at the Racial Inequity of Coronavirus.” *The New York Times*. July 5, 2020. Retrieved on October 28, 2020. Accessed from <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html>.  
<sup>98</sup> “CDC Hospital Data Point To Racial Disparity In COVID-19 Cases” *NPR*. April 8, 2020. Retrieved on October 28, 2020. Accessed from <https://www.npr.org/sections/coronavirus-live-updates/2020/04/08/830030932/cdc-hospital-data-point-to-racial-disparity-in-covid-19-cases.html>.

scientists said they can still find important patterns in the data when combining the records about individual cases with aggregated data from local agencies.<sup>99</sup>

Experts say that the circumstances that have made Black and Latinx people more likely than white people to be exposed to the virus is that many people in these communities have low-wage, front-line jobs that keep them from working at home, rely on public transportation, or live in cramped apartments or multigenerational homes.<sup>100</sup> Low wage workers who work closely around others, including those working at factories, farms, grocery stores, meatpacking and poultry plants, etc., are disproportionately Latinx or Black. Likewise, nearly one in ten low-wage workers reports that they are in fair or poor health, putting them at an increased risk for serious illness, hospitalization, or death if they contract COVID-19.<sup>101</sup>

Native Americans are one of the ethnic groups most at risk of contracting COVID-19.<sup>102</sup> Although non-Hispanic Native persons account for 0.7% of the U.S. population, a recent analysis found that 1.3% of COVID-19 cases reported to CDC with known race and ethnicity were among Native persons.<sup>103</sup> This data is likely not complete and fails to capture the full impact on “Indian Country”<sup>104</sup>, as Native Americans have been structurally invisibilized and consistently left out of data collection.<sup>105</sup> This is

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<sup>99</sup> “The Fullest Look Yet at the Racial Inequity of Coronavirus.” *The New York Times*. July 5, 2020. Retrieved on October 28, 2020. Accessed from <https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html>.

<sup>100</sup> Id.

<sup>101</sup> “Double Jeopardy: Low Wage Workers at Risk for Health and Financial Implications of COVID-19.” KFF. April 29, 2020. Retrieved on October 28, 2020. Accessed from <https://www.kff.org/coronavirus-covid-19/issue-brief/double-jeopardy-low-wage-workers-at-risk-for-health-and-financial-implications-of-covid-19/>.

<sup>102</sup> “CDC data show disproportionate COVID-19 impact in American Indian/Alaska Native populations.” CDC. August 19, 2020. Retrieved on October 28, 2020. Accessed from <https://www.cdc.gov/media/releases/2020/p0819-covid-19-impact-american-indian-alaska-native.html>.

<sup>103</sup> “The COVID-19 Response in Indian Country.” Center for American Progress. June 18, 2020. Retrieved on October 28, 2020. Accessed from <https://www.americanprogress.org/issues/green/reports/2020/06/18/486480/covid-19-response-indian-country/>.

<sup>104</sup> “Indian Country” is an American legal concept that formalizes a territory where Native American groups can exercise their own jurisdiction and sovereignty..

<sup>105</sup> Id.



an ongoing example of settler colonial structures consistently impacting the lives and well-being of Native Americans in the U.S.

Reservations, such as the Navajo Nation, became hotspots for COVID-19. In June, the Navajo Nation had the highest infection rate in the country, greater than that of New York, which was the most affected state, and greater than that of Wuhan at the height of the outbreak in China. The need for Native people to travel to towns bordering the reservation increases their risk of contracting the virus. Native people make up approximately one-tenth of New Mexico's population, but more than 55 percent of its coronavirus cases. In Wyoming, they are less than 3 percent of the state's population, but make up more than one-third of its cases. As the Center for American Progress states, "This crisis—and the underlying conditions tribal communities face—are the result of centuries of colonial violence and neglect that continue to this day."<sup>106</sup>

There is also a vulnerability for the immigrant community. Undocumented immigrants perform essential jobs in many different sectors of the workforce, from farming to healthcare. About 389,000 undocumented people are working on farms and in food processing plants. Food processing plants have become epicenters of COVID-19 outbreaks and agricultural areas have experienced some of the highest concentrations. There are also an estimated 225,000 undocumented health care workers, such as doctors, nurses and home health aides. There are an additional 190,000 undocumented individuals working as necessary custodial and administrative roles within health care settings. Millions of other undocumented people are working at grocery stores, warehouses and cleaning businesses — all workplaces where there is a larger risk for contracting the coronavirus.<sup>107</sup>

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<sup>106</sup> Id.

<sup>107</sup> "Immigrants as Essential Workers During COVID-19." Center for American Progress. September 28, 2020. Retrieved on October 28, 2020. Accessed from <https://www.americanprogress.org/issues/immigration/reports/2020/09/28/490919/immigrants-essential-workers-covid-19/>.

There is a particular vulnerability for those detained and incarcerated, which is a product of the carceral state and especially affects Black, Indigenous and people of color. For instance, Black Americans are more likely than white Americans to be arrested; once arrested, they are more likely to be convicted; and once convicted, and they are more likely to experience lengthy prison sentences. Black adults are 5.9 times as likely to be incarcerated than white adults and Latinx adults are 3.1 times as likely.<sup>108</sup> Harmful conditions and inadequate health care within jails, prisons and detention facilities have taken on new urgency during the COVID-19 pandemic. Disease mitigation efforts are minimal or nonexistent in jails, prisons and detention centers. They are crowded, and close quarters make social distancing challenging. These places have unsanitary conditions, which often include a lack of access to hygienic practices such as hand washing. The introduction and spread of COVID-19 in jails, prisons and detention facilities are facilitated by staff who come and go each day across two or three shifts. Once inside a facility, the virus cannot be contained and can then easily spread. The state has unique responsibilities here, since it has deprived these individuals of their liberty and has taken them into its custody.<sup>109</sup> Incarcerated and detained people did not sign up for a death sentence, and that is what is happening to those who are imprisoned during this pandemic.

#### **IV. CONCLUSION**

The COVID-19 pandemic has been a sober wake-up call for the United States. On the one hand, it has evoked the lack of recognition of the right to health under the U.S. Constitution or binding international instruments, despite broad recognition internationally. This omission has been compounded by structural failures in the health care system, which continues to reflect the legacies of slavery, genocide, and

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<sup>108</sup> "Report to the United Nations on Racial Disparities in the U.S. Criminal Justice System." The Sentencing Project. April 19, 2018. Retrieved on November 18, 2020. Accessed from <https://www.sentencingproject.org/publications/un-report-on-racial-disparities/>.

<sup>109</sup> "A State-by-State Look at Coronavirus in Prisons." The Marshall Project. October 23, 2020. Retrieved on October 28, 2020. Accessed from <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>.

colonialism, and continues to be motivated by corporate interests from the pharmaceutical and insurance industries, even under the umbrella of the Affordable Care Act. At the community-level, these structural failures have meant that Black, Latinx and Indigenous communities experience greater risks and harms, with concerning higher cases of hospitalizations and deaths than their white counterparts.

On the other hand, the COVID-19 pandemic has exposed the importance of political leadership (or lack thereof) and effective policy implementation in the face of crisis. The grave, failed response of the U.S. government to the pandemic has cost communities of color additional, unnecessary harms, in addition to reinforcing the same structural, racist, xenophobic and settler colonialist power systems that have been present all along. If the U.S. hopes to remedy their past and present harms, it must invest in undoing the structural racism, xenophobia, settler colonialism and classism that upholds white supremacy and harms the country's most vulnerable.