REDEFINING HEALTHCARE TO ADDRESS RACIAL HEALTH DISPARITIES & INEQUITIES

Abdur Rahman Amin[*]

TABLE OF CONTENTS

[*] Abdur Rahman Amin, MBA, BS in Public Health, J.D. Candidate 2023 at Mitchell Hamline School of Law. The author is a second-year law student and a food safety and public health professional. He is a credentialed Registered Environmental Health Specialist and advocate for healthcare transformation in the United States.

INTRODUCTION

On May 25, 2020, Minneapolis police officers detained George Floyd, a 46-year-old Black male, when he was suspected of using a counterfeit $20 bill at a neighborhood convenience store.[1] Mr. Floyd was pinned to the ground by Derek Chauvin, a white male police officer with a known history of excessive force.[2] Chauvin kept his knee on Mr. Floyd's neck for over seven minutes resulting in Mr. Floyd losing consciousness and ultimately succumbing to his death.[3] Mr. Floyd screamed "I can't breathe!" while being physically pinned down in a chokehold.[4] This rallying cry has been the catalyst for a locally-inspired but globally-impactful social movement, as witnessed through worldwide demonstrations, to address the racial and social injustices prevalent in our society from the root causes of individual racist attitudes to the role of institutional and systematic racism.[5]

The current calls for reform have focused primarily on reviewing police tactics, exploring implicit racism in the criminal justice system, addressing the intricacies of racism found in the prison industrial complex, and protecting individual liberties of disadvantaged citizens.[6] While these reformative actions are a step in the right direction, healthcare reform is at the core of guaranteeing an equitable right to life. The "I Can't Breathe!" chant encompasses a call to action

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[1] Evan Hill et al., *How George Floyd was Killed in Police Custody*, N.Y. TIMES, https://www.nytimes.com/2020/05/31/us/george-floyd-investigation.html/ (last updated Apr. 6, 2021).

[2] *Id. See also*, Michelle Mark, *18 Complaints in 19 Years, and a Murder Charge: What We Know About Ex-Minneapolis Police Officer Derek Chauvin*, BUS. INSIDER AUSTL. (June 10, 2020), https://www.businessinsider.com.au/derek-chauvin-minneapolis-police-background-life-2020-6.

[3] Hill et al., *supra* note 1.

[4] Katie Wedell et al., *George Floyd is Not Alone. 'I Can't Breathe' Uttered by Dozens in Fatal Police Holds Across U.S.*, USA TODAY, https://www.usatoday.com/in-depth/news/investigations/2020/06/13/george-floyd-not-alone-dozens-said-cant-breathe-police-holds/3137373001/ (last updated June 25, 2020, 8:58 AM).

[5] *How George Floyd's Death Sparked Protests Around the World*, THE WASH. POST (June 10, 2020), https://www.washingtonpost.com/graphics/world/2020/06/10/how-george-floyds-death-sparked-protests-around-world/.

[6] Elizabeth Hinton & DeAnza Cook, *The Mass Criminalization of Black Americans: A Historical Overview*, 4 ANN. REV. CRIMINOLOGY 261 (2021), https://www.annualreviews.org/doi/pdf/10.1146/annurev-criminol-060520-033306.

for a greater problem that requires our society's immediate attention: the right of each person to access healthcare. The right to access healthcare is paramount to the right to life itself which required aspiring towards a standard quality of living for all citizens regardless of their race or socioeconomic status. This article focuses on addressing some of the current challenges affecting our nation's healthcare system. Strategies are then proposed for building a framework for sustaining long-term reforms addressing health and racial disparities, particularly those of Black citizens.

I. BACKGROUND: HEALTH DISPARITIES AMONGST MINORITY COMMUNITIES: SHORT-TERM AND LONG-TERM EFFECTS

A. COVID-19: A Snapshot of Racial Health Inequity

The COVID-19 global pandemic uncovered a well-known fact amongst professionals in the healthcare industry: the burden of disease disproportionately and negatively affects minorities, such as those in Black and Brown neighborhoods, more than the population writ large.[7] Current evidence suggests a disproportionate burden of COVID-related illness and mortality amongst racial and ethnic minority groups.[8] Inequities in social determinants are factors attributed to increased COVID-19 related mortalities, hospitalizations, and co-morbidities in areas where racial and ethnic groups interact and live.[9] Data extrapolated finds that Black patients have

[7] THOMAS BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 28 (6th ed. 2012).

[8] *Health Equity Considerations and Racial and Ethnic Minority Groups*, CTR. FOR DISEASE CONTROL & PREVENTION (Feb. 21, 2021), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html (last reviewed June 4, 2020).

[9] *Id.*

almost 1.4 times the death rate of their White counterparts.[10] In general, COVID-19 affected Black, Indigenous, Latinx, and people of color more so than other groups.[11]

The CDC's MMWR reporting on the race, ethnicity, and age trends of COVID-19 related deaths from May-August 2020 found that members of ethnic groups and minority races are disproportionately represented amongst COV1D-19 deaths.[12] This corroborated the initial observations from the earliest datasets during the early stages of COVID-19 regarding the disproportionate burden of this disease on minority populations.[13] For example, out of 114,4111 deaths reported to the National Vital Statistics System during May-August 2020, 24.2% were Hispanic or Latino and 18.7% were non-Hispanic Blacks.[14] High representations of minorities' deaths are present even though Blacks represent only 12.5% of the entire U.S. population and Hispanics only account for 18.5%.[15] This data confirms that mere coincidence, chance, or routine randomness are not the driving factors for these findings. Rather, the correlation between race and negative health outcomes associated with COVID-19 suggest a causal relationship for these abhorrent statistics.

B. Future Impact: Chronic Conditions & Mental Health

COVID-19's direct impact on minorities cannot be viewed in a vacuum or as a snapshot in time. It must be viewed holistically by coupling its short-term impacts with the long-term

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[10] *The COVID Racial Data Tracker,* THE COVID TRACKING PROJECT AT THE ATLANTIC, https://covidtracking.com/race (last viewed Apr. 12, 2021).

[11] *Id.*

[12] JEREMY A.W. GOLD ET AL., RACE, ETHNICITY, AND AGE TRENDS IN PERSONS WHO DIED FROM COVID-19—UNITED STATES, MAY–AUGUST 2020, 69(42) CDC: MORBIDITY & MORTALITY WKLY. REP. 1517 (Oct. 23, 2020) http://dx.doi.org/10.15585/mmwr.mm6942e1.

[13] ERIN K. STOKES ET AL., CORONAVIRUS DISEASE 2019 CASE SURVEILLANCE—UNITED STATES, JANUARY 22–MAY 30, 2020, 69(24) CDC: MORBIDITY & MORTALITY WKLY. REP. 759 (June 19, 2020) https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm?s_cid=mm6924e2_w.

[14] GOLD ET AL., *supra* note 11.

[15] STOKES ET AL., *supra* note 12.

afflictions that have continuously plagued underrepresented communities. Specifically, chronic diseases and mental health disparities are concerning problems which require the immediate attention of policy problem-solving. Underlying chronic conditions compound the negative effects of a short-term disease impact because they further exacerbate a continuously vulnerable population's susceptibility to a disease outbreak.[16]

Chronic diseases disproportionately affect Blacks more than others in this country. Nearly 14% of Black patients reported having fair or poor health compared to only 8% of White patients.[17] There was an approximately fifteen perfect increase in obesity or overweight reporting for Black female patients compared to their White counterparts.[18] Hypertension rates for Black adults are 42% compared to nearly 29% for White adults.[19] Black patients also have the highest mortality rate for all cancers combined compared with any other racial or ethnic population.[20]

The mental health statistics for Blacks are similarly alarming. In 2018, nearly 4% of Black adults reported having serious psychological distress.[21] Suicide was the second leading cause of death for Black youth and young adults between the ages of fifteen and twenty-four in 2017.[22] Suicide attempts by Black adolescents rose 73% from 1991 to 2017.[23] Injuries from attempted

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[16] *See* Nita Madhav et al., *Pandemics: Risks, Impacts, and Mitigation*, *in* 9 DISEASE CONTROL PRIORITIES: IMPROVING HEALTH AND REDUCING POVERTY 323–24 (Dean T. Jamison et al. eds., 3d ed. 2017), https://www.ncbi.nlm.nih.gov/books/NBK525302/.

[17] Sofia Carratala & Connor Maxwell, *Health Disparities by Race and Ethnicity*, CTR. FOR AM. PROGRESS (May 7, 2020, 9:04 AM), https://www.americanprogress.org/issues/race/reports/2020/05/07/484742/health-disparities-race-ethnicity.

[18] *Id.*

[19] *Id.*

[20] *Id.*

[21] *Id.*

[22] *Mental and Behavioral Health—African Americans*, U.S. DEP'T. OF HEALTH & HUM. SERVS. OFF. OF MINORITY HEALTH, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=24 (last updated Sept. 25, 2019).

[23] Jayne O'Donnell, *'We're Losing Our Kids': Black Youth Suicide Rate Rising Far Faster than for Whites; Coronavirus, Police Violence Deepen Trauma*, USA TODAY, https://www.usatoday.com/story/news/health/2020/06/07/coronavirus-police-violence-boost-risks-rising-black-youth-suicide/2300765001/ (last updated June 20, 2020, 12:15AM).

suicides increased 122 % for Black youth and their rate of suicide was increasing faster than any other ethnic group.[24] Black youth under thirteen were twice as likely to die by suicide than white youth.[25]

II. SOLUTION FRAMEWORK: PRIORITIZING HEALTHCARE ACCESS AND ADDRESSING RACIAL HEALTH DISPARITIES TO IMPROVE THE CURRENT HEALTHCARE SYSTEM

A. Defining Social Determinants of Health

Social determinants of health address the non-direct environmental and social factors that affects one's health outside of physical factors that are typically accounted for in a clinical setting.[26] Determinants are conditions in the environment in which people are born, live, learn, work, play, worship, and age, which affect health, functioning, quality-of-life, and risk.[27] These determinants can further be classified into five conditions which include the social, economic, and physical attributes in one's environmental setting.[28] Public health experts and government officials have articulated relevant examples of social determinants of health to include: access to resources to meet one's daily needs, safe housing, educational access, job opportunities, economic stability, quality of education, public safety, social support, social norms, exposure to crime, transportation, residential segregation, language, literacy, communication access, and access to health care services.[29] A "placed-based approach" focuses on five key areas where these determinants impact

[24] *Id.*
[25] *Id.*
[26] *Social Determinants of Health*, HEALTHY PEOPLE, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health (last visited June 20, 2020).
[27] *Id.*
[28] *Id.*
[29] *Id.*

change include addressing economic stability, education, social and community context, neighborhood and built environment, and health and healthcare.[30] Concentrating on the last key area, healthcare, offers a significant opportunity to not only address improving this relevant social determinant of health, but more importantly, also offers a chance to target solutions which address racial health inequities.

B. A Deeper Dive into Healthcare Access

Access to healthcare and healthcare services is an important factor in determining the health outcome of an individual.[31] Since this factor can be investigated on both an individual and collective level, it provides an opportunity for leaders and policymakers to make sustainable changes to entire communities. By increasing access to healthcare as part of a national policy agenda, swift and impactful changes can quickly be realized. This policy is effective because it addresses the social determinants of health. Therefore, an overview of healthcare service structure and organization is required to identify areas for targeting solutions pertaining to racial inequities and disparities.

The Three Components of the Healthcare Framework

There are three broad components relating to access to healthcare which include insurance coverage, access to health services, and timeliness of care.[32] Each approach to healthcare access provides unique opportunities to address racial disparities in the current healthcare system which provide opportunities and challenges.

First, insurance coverage is often what enables one to enter the healthcare system to access

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[30] *Id.*

[31] *Access to Health Services*, HEALTHY PEOPLE, https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services (lasr visited (Oct. 8, 2020).

[32] *Id.*

needed healthcare services and more specifically preventative care.[33] Inadequate coverage often results in barriers for patients to access care when they need it or being financially burdened with excessive medical bills when they are uninsured.[34] Being underinsured or not insured can also result the higher likelihood that a person is not able to maintain optimal health or standard quality of life. The diagnostic and preventative care often required for having a satisfactory health outcome is not realized due to the barriers and fears of potential financial burdens associated with accessing healthcare services costs. This can result in patients having reduced abilities to access necessary healthcare services.

Second, access to health services ensure that a patient gets the services they need to achieve optimal health and higher quality of life.[35] People with consistent and predictable sources of healthcare services have better outcomes, lower costs, and fewer disparities.[36] Often this takes place in the form of having a primary care provider, who coordinates the access to healthcare services while ensuring consistency, communication, and trust with their patient.[37] This can also result in better diagnostic and preventative care for the patient since the relationship between patient and provider allows for fostering a holistic and contextual partnership to manage care and promote optimal health outcomes for the patient.[38]

Geographic barriers, such as healthcare presence in a particular location, or compatibility barriers, such as finding a compatible healthcare provider for a patient with whom the patient has

[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] INST. OF MED. OF THE NAT'L ACAD., HEALTH PROFESSIONS EDUCATION: A BRIDGE TO QUALITY 45 (Ann C. Greiner & Elisa Knebel eds., 2003), https://www.ncbi.nlm.nih.gov/books/NBK221519/.

open communication and trust to develop a long-term personal relationship, are hindrances which can bar access to healthcare.[39] Individual financial and economic marketplace factors including high costs of care, inadequate or no insurance coverage, high premium costs, and lack of the availability of necessary and culturally relevant services for a specific ethnic or racial group.[40]

Third, timeliness is the final component which is the healthcare service ability to deliver quick and adequate healthcare services after the need is realized by patient and provider.[41] Time delays in providing care can result in worsening health outcomes, increased costs, further health complications, and eroding trust between patient and provider.[42] A healthcare provider's timeliness is the measurement of its efficiency and overall capability.

The three components of the healthcare framework identify points at which failure or reduced ability to function can result in health disparities for a particular population such as Blacks in which drastic health disparities are often observed and require further discussion.

C. Current Status of the U.S. Healthcare System and an Examination of Racial Disparities and Health Inequities

The United States spends more on healthcare than any other high-income country but has the lowest life expectancy.[43] Many people in the United States do not get the healthcare services they need.[44] In fact, about one out of every ten people in the United States do not have health

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[39] *Access to Health Services*, *supra* note 30.
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] Roosa Tikkanen & Melinda K. Abrams, *U.S Health Care from a Global Perspective, 2019: Higher Spending, Worse Outcomes?* THE COMMONWEALTH FUND (Jan 30, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/us-health-care-global-perspective-2019/.
[44] *Health Care Access and Quality*, OFF. OF DISEASE PREVENTION & HEALTH PROMOTION, https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality (last visited Oct. 17, 2020).

insurance.[45] Without accessible healthcare, these patients are at risk of not having access to consistent care with a designated primary care physician or provider who can best treat them.[46] Moreover, barriers to access also result in patients not being able to afford medications and procedures that may be required for their health and overall well-being.[47]

The United States Department of Health and Human Services has long aimed at addressing health disparities involved in lack of access and quality. The Healthy People agenda includes goals and objectives for improving healthcare access.[48] Some health quality goals include: increasing the proportion of adults who receive recommendations for evidence-based preventative care, reducing the proportion of visits to the emergency department with higher wait times than recommended, increasing the number of adolescents who seek care, and increasing access to services such as preventative cancer screening for vulnerable populations.[49] While these specific target objectives attempt to reduce some of the barriers in the healthcare framework, they do put more onus on the provider to reduce disparities. Arguably, this approach could further be enhanced by harmonizing these specific target goals with a greater systems-based solution approach which addresses systemic issues in healthcare access and delivery.

Healthcare access related objectives now include: increasing the number of community organizations that can provide preventative health services, reducing the proportion of people who cannot get medical care when they need it, reducing the percentage of people who cannot procure their prescription medications, increasing the proportion of people who have a regular primary

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[45] *Id.* (citing Edward R. Berchick et al., *Health Insurance Coverage in the United States: 2017*, U.S. CENSUS BUREAU (Sept. 2018), https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf).

[46] *Health Care Access and Quality*, *supra* note 43.

[47] *Id.*

[48] *Id.*

[49] *Id.*

care provider, increasing the proportion of people with health insurance, and reducing the proportion of people under sixty-five (not covered by Medicare) who are underinsured or uninsured.[50] While these goals are important benchmarks, the undercurrents of health policies, laws, and politics cannot be overstated to further affect sustainable and impactful change. Therefore, a reflective inquiry of the current situation regarding United States healthcare access and delivery is required prior to addressing strategies for improvements.

The United States healthcare system is best described as a mixed-model in which components of public and private, for-profit and nonprofit insurance schemes exist to fund the healthcare system.[51] The hallmark federal program, Medicare, provides federal government funding for patients over the age of sixty-five and subsets of patients with disability status.[52] Other government-sponsored programs include Medicaid for low-income populations, the Children's Health Insurance Program, and state-specific programs aimed at reaching desired target populations who lack access to care.[53] Private insurance is the most common form of coverage and accounts for the majority of the system.[54] The United States uninsured rate is 8.5%, which amounts to roughly 27.5 million people.[55]

In 2010, Congress passed the Patient Protection and Affordable Care Act.[56] This bill represented the largest impact of expansion of public funding for healthcare delivery.[57] Key

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[50] *Id.*

[51] Roosa Tikkanen et al., *International Health Care Systems Profiles: United States*, THE COMMONWEALTH FUND (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/united-states.

[52] *Id.*

[53] *Id.*

[54] *Id.*

[55] *Id.*

[56] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111–148, 124 Stat. 119. *See also, Summary of the Affordable Care Act*, KAISER FAM. FOUND. (Apr. 25, 2013), https://www.kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/.

[57] Tikkanen et al., *supra* note 51.

features included: requiring most Americans to obtain health insurance, extending coverage to young adults under twenty-six to retain coverage under their parents' private insurance plans, creating or expanding a health insurance marketplace where individuals are able to procure and choose their desired insurance plans, and expanding Medicaid eligibility and funding options for states that opted into the program.[58] This resulted in twenty million additional people gaining healthcare coverage, which reduced the uninsured rate amongst adults from ages 19–64 from twenty percent in 2010 to twelve percent in 2018.[59]

Considerable changes have been proposed to amend, repeal, or replace the Affordable Care Act (ACA) in recent years.[60] The penalty for the individual mandate requiring everyone to procure insurance was one of the most unpopular provisions and was subsequently reduced to zero dollars.[61] A 2020 literature review of over 400 studies on the effects of Medicaid Expansion under the ACA found that, overall, Medicaid expansion resulted in significant coverage gains and reduction in uninsured rates among low-income populations broadly and within specific vulnerable populations specifically.[62]

Moreover, their research found that Medicaid expansion "improved access to care, utilization of services, the affordability of care, and financial security among the low-income population."[63] "Studies show improved self-reported health following [Medicaid] expansion and

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[58] *Id.*

[59] *Id.*

[60] MaryBeth Musumeci, *Explaining* California v. Texas*: A Guide to the Case Challenging the ACA*¸ KAISER FAM. FOUND. (Sept. 1, 2020), https://www.kff.org/health-reform/issue-brief/explaining-california-v-texas-a-guide-to-the-case-challenging-the-aca/.

[61] *Id.*

[62] Madeline Guth et al., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, KAISER FAM. FOUND. (Mar. 17, 2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.

[63] *Id.*

an association between expansion and certain positive health outcomes."[64] Overall, the percentage of uninsured individuals dropped after the ACA passed but the specific impact on improving access for minorities was not a primary driver of the bill. Therefore, the nuanced correlational roadblocks to healthcare access barriers were not addressed for historically underrepresented populations, particularly Black patients, who historically have worse health outcomes than the rest of the population.

Addressing Racial Disparities and Health Inequities with Black Patients

Black people comprise about 13.4% of the U.S. population.[65] Nearly three million of the twenty million additionally insured patients who gained coverage under the ACA were Black citizens.[66] Despite this fact, in 2018 the uninsured rate of Black people was 9.7%, nearly double that of white people at 5.4%.[67] Proportionally, about 55% of Black people obtained coverage via private insurance while approximately 41% acquired coverage via Medicaid or a state-sponsored program.[68]

A closer examination into the matter shows that the financial burden on Black patients is nearly double that of the rest of the population.[69] On average, the typical Black patient spends one-fifth of their annual household income on healthcare related costs including premiums, bills, and prescriptions.[70] Prohibitive costs also can result in a person deciding not to get insured or being

[64] *Id.*
[65] Jamila Taylor, *Racism, Inequality, and Health Care for African Americans*, THE CENTURY FOUND. (Dec. 19, 2019), https://tcf.org/content/report/racism-inequality-health-care-african-americans/?agreed=1.
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*

underinsured.

The limitations of adopting Medicaid expansion in the southern region of the United States, where a higher proportion of Black Americans reside, also disproportionately burden health outcomes.[71] In 2019, Medicaid, a joint venture between the federal government and individual states, covered 68 million people, with approximately 13.5 million Black patients enrolled in the program.[72] It is estimated in the states that opted out of Medicaid expansion under the Affordable Care Act, Black citizens and other minorities disproportionately suffer because they fall into a coverage gap; they earn too much to be covered by the traditional Medicaid program, but would be eligible if the state had adopted the 138 percent of federal poverty level (FPL) threshold under the ACA.[73]

Disparities in health outcomes also are well-documented between Black people and their white counterparts. Infant mortality, cancer, heart disease, and diabetes rates are more prevalent in Black Americans compared to the population at large.[74] There are more barriers to health services in minority neighborhoods that are predominately Black or Hispanic.[75] Overreliance on community health centers and emergency care visits outweigh utilization of primary care provider services in communities of color.[76] Neighborhood-specific factors such as safety, traffic, and ease of transportation to seek quality care also limit access to healthcare services.[77]

Perhaps the most grievous factor that unduly burdens Black people is systemic racism and

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[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*

its effect on their health.[78] The centuries-long impact of racism on Black people burdens both their mental and physical health.[79] Combined with environmental stressors and exposure to surrounding risks, the culmination of these burdens results in sub-optimal and unfair health outcomes for the individual Black patient and collectively for the communities where they reside. Economic barriers such as income inequality, poverty, lack of access to educational opportunities, inadequate and safe housing, and discrimination further exacerbate the existing stressors previously listed, which results in worsening health outcomes for Black Americans.[80]

Additionally, it is crucial to discuss root causes of heath inequities. Health inequities have two main causes:

> The first is the intrapersonal, interpersonal, institutional, and systemic mechanisms that organize the distribution of power and resources differentially across lines of race, gender, class, sexual orientation, gender expression, and other dimensions of individual and group identity (see the following section on such structural inequities for examples). The second, and more fundamental root cause of health inequity, is the unequal allocation of power and resources—including goods, services, and societal attention—which manifest in unequal social, economic, and environmental conditions, also called the social determinants of health.[81]

Health inequities, social determinants of health, and structural inequalities are all interconnected and have long-term effects.[82] Impacts of structural inequities can be assessed from birth to death.[83] Studies have often reported individuals who experience racism have worse health outcomes.[84] However, the structural manifestations of racism and its relationship to contributing

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[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] COMMUNITIES IN ACTION: PATHWAYS TO HEALTH EQUITY 99 (James N. Weinstein et al., eds., 2017), https://www.ncbi.nlm.nih.gov/books/NBK425845/.
[82] *Id.*
[83] *Id.*
[84] Gilbert C. Gee & Chandra L. Ford, *Structural Racism and Health Inequities: Old Issues, New Directions*, 8(1) DU BOIS REV. 115 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4306458/.

to health inequities are also important factors to consider when addressing the health disparities of vulnerable populations such as Black Americans.

Racism operates on multiple dimensions from individual racism to structural racism.[85] Structural racism is defined as "the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups."[86] Residential segregation is one such example of structural racism.[87] Residential segregation promotes racism and increased health inequities when environmental factors, pollutants, infectious vectors, air pollution, and exposure to carcinogens increase worsening health outcomes for minorities who are implicitly or explicitly forced to live in a certain locale.[88] Workplace and school segregation could have similar effects. Additionally, racism experienced by individual minority members can result in stress which results in worsening health outcomes and increases the health disparity between racial groups.[89]

Structural racism can persist from generation to generation and be passed on cyclically. This concept is defined as intergenerational drag.[90] Worsening health effects can manifest biologically from parent to infant. For example, when the stressors of parents are observed in utero, those same stressors may increase the risk of heart disease or other illnesses throughout the child's life.[91] Historical factors can shape present and future outcomes. Hallmark traits of structural racism include factors that: "(1) persist over time, (2) adapt to new sociopolitical contexts as they unfold,

[85] *Id.*
[86] *Id.*
[87] *Id.*
[88] *Id.*
[89] *Id.*
[90] *Id.*
[91] *Id.*

and (3) impact population level patterns of disease more fundamentally than do proximal factors."[92] The effects of disparities in educational opportunities and employment opportunities create an accumulating effect for each subsequent generation.[93]

III. STRATEGIES AND FRAMEWORKS FOR ADDRESSING HEALTH DISPARITIES TO INCREASE HEALTH OUTCOMES AND REDUCE RACIAL INEQUALITIES

The United States healthcare system symbolizes a diversity of paradoxical objectives. On one hand, there are marketplace drivers and profit incentives for providers to promote the best business strategies, which prioritize profit above all other goals. On the other hand, the notion of providing equitable care and putting the patient's needs first are at the heart and motto of the many healthcare providers and doctors who take the Hippocratic Oath.[94] Each participant in the healthcare system may have differing goals and motives for participating in the healthcare system. This conflict among the various stakeholders persists, which perplexes policymakers and government officials regarding how to best create and manage a national healthcare agenda.

Determining what objectives should be furthered might begin with prioritizing objectives that optimize the health outcomes for all members of a society. Rankings should focus on determining which policies favor healthcare outcomes for all people and further ensure that historically underserved and vulnerable minorities are not forgotten. This does not mean that policies that induce marketplace profits for nonprofit participants of the healthcare industry need to be eliminated, but rather they need to be aligned with a greater national agenda for creating a more equitable healthcare system. A healthcare delivery model should account for the conflicting

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[92] *Id.*

[93] *Id.*

[94] *Greek Medicine*, NAT'L LIBR. OF MED., https://www.nlm.nih.gov/hmd/greek/greek_oath.html (last updated Feb. 7, 2012).

motivations of diverse stakeholders, and achieve goals that are efficient, equitable, and results-oriented. This perspective requires both a political and moral assumption that health and therefore access to healthcare be treated as a universal right for each citizen, which is a concept that may be considered controversial.[95] However, this argument warrants discussion, and a constitutional and ethical basis lends credence for a finding of this justification. In addition, the pursuit of efficient outcomes when comparing the U.S. healthcare system to other global healthcare models may also yield a determination that there is room for improvement for healthcare access and delivery in the United States.

A. U.S. Healthcare Outcomes Compared to Other Countries

A comparison between strategies from other countries' healthcare delivery systems and our complex system offers a launching pad for identifying current strengths, reducing weaknesses, and focusing on opportunities to improve the system. An objective SWOT (strengths, weaknesses, opportunities, and threats) analysis of the United States' healthcare delivery model compared with other models worldwide offers the greatest potential to improve the system and specifically address healthcare disparities associated with race. While expansion of the Affordable Care Act was monumental in increasing health coverage, the mixed-model system is not efficient compared to other healthcare delivery models around the world. Compared to eleven industrialized nations, the United States spends the most on healthcare as a proportion of total GDP at 16.9 percent.[96]

[95] David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21(4) HEALTH CARE FIN. REV. 75 (2000), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/.

[96] Roosa Tikkanen, *Multinational Comparisons of Health Systems Data, 2019* (The Commonwealth Fund, Chartpack), https://www.commonwealthfund.org/sites/default/files/2020-

However, the United States has the worst health outcomes when it comes to life expectancy at birth, suicide rates, adults with multiple chronic conditions, obesity rates, and mortalities amendable to health care.[97] This is compounded with the fact that American individuals, on average, have the highest out-of-pocket expenses and highest percentage of private spending.[98] Both investment and current outcomes produced suggest that improvements to the U.S. system can reduce costs, and therefore may be more profitable and improve health outcomes for its citizens.

B. Federalizing Healthcare

Perhaps the hallmark of nationalized care is Medicaid, which closely resembles an attempt at achieving universal health coverage. Existing federal healthcare programs such as Medicaid have long created a dilemma between states and the federal government regarding a state's autonomy to implement its desired programs and the federal government's agenda to legislate healthcare reform.[99] The Affordable Care Act and the expansion of such programs are no exception. To date, twelve states have failed to adopt Medicaid Expansion despite availability of increased additional federal funding.[100] A principle of dual sovereignty and cooperative federalism addresses this issue and attempts to resolve this tension between the federal government and the state. A dual sovereignty where four ideals persist include:

> This federalist structure of joint sovereigns preserves to the people numerous advantages. It assures a decentralized government that will be more sensitive to the diverse needs of a heterogeneous society; it increases opportunity for citizen involvement in democratic processes; it allows for more innovation and experimentation in government; and it makes government more responsive by putting

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01/Tikkanen_multinational_comparisons_hlt_sys_data_2019_01-30-2020.pdf (last visited Oct. 17, 2020).

[97] *Id.*

[98] *Id.*

[99] Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 432 (2011).

[100] *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAM. FOUND. (Mar. 31, 2021) https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

the States in competition for a mobile citizenry.[101]

The Constitution provides the federal government with several tools to influence state policies and implement its agenda utilizing tools including the Commerce Clause or the Spending Clause for the general welfare when coercion is not found.[102] When a state agrees to take federal funding, it is inherently waiving its rights and acquiescing to a federal program like the expansion of Medicaid.[103] Therefore, a path may exist to legally justify the expansion of healthcare access by federal government subsidy under the Spending Clause, provided that coercion does not take place. It should be a joint venture between the states and the federal government to enact or enhance programs which promote the general well-being of their citizens.

However, the reality of this experimental cooperative federalism relationship between the state and federal governments has not be equitable nor efficient. This is apparent from the lack of expansion of the Affordable Care Act's Medicaid in fourteen states—primarily in the South—where states had the opportunity to opt-in or out of the program.[104] The coverage gap resulted in many Americans, mainly minority populations, not being able to afford healthcare after being disqualified from Medicaid because they exceed the Federal Poverty Line threshold.[105] Fifty-eight percent of the Black population lived in the South in 2017 and were disproportionately affected by these state-specific decisions.[106] As a result, some of the nation's worst health disparities can be observed in the South.[107]

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[101] Huberfeld, *supra* note 98, at 455 (citing Gregory v. Ashcroft, 501 U.S. 452, 458 (1991)).
[102] *Id.* at 456.
[103] *Id.* at 459.
[104] Taylor, *supra* note 64.
[105] *Id.*
[106] *Id.*
[107] *Id.*

C. Strategies Towards Universal Health Coverage

The notion of universal health coverage or a single-payer health delivery model has been discussed at a policy level for many decades and has gained traction in recent years.[108] Universal health coverage ensures that everyone has access to essential healthcare needs.[109] There are many paths to achieving this objective. A predominantly publicly funded system, classically known as a single-payer model, provides healthcare for everyone through government financing of the healthcare system using tax revenues.[110] On the other side of the spectrum, there can be regulated private insurance healthcare systems in which insurance is procured from the private sector but subject to regulation from the legislator and the government agenda.[111] The mixed-model, in which both private and public insurance make up the healthcare system, utilizes both public and private funds.[112] One possible improvement for achieving better outcomes in any healthcare system is to reduce or eliminate the profit incentive.[113]

The momentum for achieving universal health coverage has garnered support internationally, especially with entities such as the United Nations (UN) and the World Health Organization (WHO).[114] There are four driving rationales for achieving universal healthcare.[115] The first one includes a principle of ensuring that everyone's "physical and mental health is just, fair, and

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[108] Dominic F. Caruso et al., *Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care*, 7 HARV. PUB. HEALTH REV. 1 (Summer 2015), https://harvardpublichealthreview.org/wp-content/uploads/2015/07/Dominic-F.-Caruso7.pdf.

[109] Shanoor Seervai et al., *How Other Countries Achieve Universal Coverage*, THE COMMONWEALTH FUND (Oct. 27, 2017), https://www.commonwealthfund.org/blog/2017/how-other-countries-achieve-universal-coverage.

[110] *Id.*

[111] *Id.*

[112] *Id.*

[113] Arnold S. Relman, *Eliminate the Profit Motive in Health Care*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM (Sept. 24, 2009), https://pnhp.org/news/eliminate-the-profit-motive-in-health-care/.

[114] David E. Bloom et al., *The Promise and Peril of Universal Health Care*, 361(6404) SCIENCE 1 (Aug. 24, 2018), https://science.sciencemag.org/content/361/6404/eaat9644.full.

[115] *Id.*

consistent" with the concept of distributive justice.[116] Second, it requires acceptance that health is as a fundamental right is rooted in international law.[117] The third principle is pragmatic and observes that healthier populations correlate with more socially cohesive and politically stable nations.[118] Finally, there are economic and financial considerations which exhibit that investments in healthcare coverage yield higher returns on investments compared to other social programs such as education.[119]

A key challenge in achieving universal health coverage is defining its scope and financing the system. As outlined above, the costs of healthcare have risen in the United States in which almost a fifth of the GDP expenses can be attributed to healthcare.[120] The discussion on how to manage the potential increased costs of adopting a universal coverage system is an important topic.[121] However, the focus needs to shift from simply a cost determination discussion to an inquiry into whether moving to a universal healthcare delivery system is worth the investment.[122] If an objective assessment results in a determination that the added expenses are cost-effective and beneficial in the long run, the prudent choice dictates a shift to a universal healthcare model. A systematic review of twenty single payer plans for US, or individual states, found that "[n]ineteen (86%) of the analyses estimated that health expenditures would fall in the first year, and all suggested the potential for long-term cost savings."[123] "The largest savings were predicted to come

[116] *Id.*
[117] *Id.*
[118] *Id.*
[119] *Id.*
[120] Tikkanen & Abrams, *supra* note 42.
[121] Christopher Cai et al., *Projected Costs of Single-payer Healthcare Financing in the United States: A Systematic Review of Economic Analyses*, 17(1) PLOS MED. 1 (Jan. 15, 2020).
[122] *Id.*
[123] *Id.* at 2.

from simplified billing and lower drug costs."[124] These results were attributed to savings from billing, negotiated drug price reductions, and global budgets control schemes.[125]

Expanding healthcare coverage tends to reduce health disparities because more vulnerable members of society are less likely to receive adequate healthcare than their wealthier counterparts in places where universal healthcare systems are not present.[126] Studies show that increased access to primary care lowers race and wealth-based mortality disparities in various countries.[127] Furthermore, it may be fiscally preferable to spend more on healthcare through a universal healthcare system. Investing in increased access to healthcare to neglected segments of society promotes overall economic growth.

A single-payer health model may also offer an opportunity to reduce structural racism in healthcare and therefore get to a root cause of racial inequity currently observed in healthcare.[128] While healthcare reform often focuses on financing the system, the underlying inequalities are ignored and therefore reinforce a form of structural racism in the healthcare sector.[129] For instance, the higher cost sharing burden from private or public market insurance options disproportionately impact minorities more as they pay a greater proportion of their income on healthcare expenses.[130] This impact stems from societies that perceive health care interactions as a business transaction and not a fundamental right to be provided for all.[131] This interpretation solidifies structural racism in healthcare access and insurance coverage because it is driven by the notion that only those

[124] *Id.*
[125] *Id.*
[126] Bloom et. al, *supra* note 113, at 4.
[127] *Id.*
[128] Caruso et al., *supra* note 107.
[129] *Id.* at 2.
[130] *Id.*
[131] *Id.* at 3.

worthy of healthcare will be able to pay for it.

A nationalized insurance model in which residency, and not employment or income status, drives coverage can reduce barriers and increase access to care for all those who reside in that nation.[132] "A single-payer system would make a clear statement that health care is a human right" and not a rationed good for which only those who pay may benefit.[133] Equitable access to healthcare is fundamental to society's future well-being and for the general welfare of all its citizens. Ensuring equitable access to healthcare for all citizens requires active examination of health care services given to marginalized minority groups.

Medicare for All is a single-payer plan that calls for a single federal program which would replace the current mixture of private and public insurance options.[134] It would be funded by taxes and the current payment scheme and mechanism for insurance would be replaced. Public support for this program varies. However, recent polling suggests higher favorability for a universal health care model in which 63% of people said they would favor some step towards universal health coverage but only 49% would favor a single-payer national health plan.[135]

Creating medical care for all Americans is a policy choice. When the Affordable Care Act was enacted, the existing public market for insurance coverage expanded.[136] Dr. David Rosenbloom, professor at the Boston University School of Public Health, described the realities of healthcare reform:

> Major medical care reforms happen only when one party has dominant control over the White House and both houses of Congress. Medicare, Medicaid, and the

[132] *Id.* at 4.
[133] *Id.*
[134] David Rosenbloom, *The Precarious Path to Universal Health Coverage*, AM. BAR ASS'N (Sept. 08, 2020), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/health-matters-in-elections/the-precarious-path-to-universal-health-coverage/.
[135] *Id.*
[136] *Id.*

> Affordable Care Act passed when Democrats had control of the White House, the House of Representatives, and a filibuster-proof majority in the Senate. The death of Senator Edward Kennedy caused Democrats in the Senate to lose their filibuster-proof majority just as the House was about to pass its version of the ACA. If the House had not accepted the previously passed Senate version, it is unlikely that anything would have become law. Republicans controlled the White House and both houses of Congress in 2017, but their majority in the Senate was not great enough to achieve their primary objective—repeal of the ACA.[137]

The redistributive aspects of Medicare for All are criticized as a form of "socialized medicine."[138] However, the irony lies in the fact that Medicare, in its current form, does the same thing since those who have higher wages pay more in taxes and ultimately receive the same benefits.[139]

President Biden's slightly more moderate approach calls for a public insurance option.[140] It expands upon the current system and "build[s] upon the ACA by adding a new option available to those seeking coverage."[141] Biden's plan provides for a public federal insurance option.[142] This new option would be available for those who are seeking coverage, and may increase access to those who might have fallen into a coverage gap where an individual did not qualify under both private insurance and Medicaid.

President Biden's plan "would retain major components of the ACA including protections for people with pre-existing conditions, premium subsidies, and Medicaid expansion, alone with offering public insurance as an option to anyone who wants it."[143] The Biden plan also reduces prescription drugs costs, enables Medicare to negotiate fee structures for treatments, and offers tax

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[137] *Id.*
[138] *Id.*
[139] *Id.*
[140] Taylor, *supra* note 64.
[141] *Id.*
[142] *Id.*
[143] *Id.*

credits to citizens to offset health insurance costs overall.[144]

The goal of both Medicare for All and a public option insurance plan is to reduce the cost of insurance by providing additional pathways for healthcare coverage. These plans might focus on addressing costs and thus attempt to increase access. However, they might not necessarily address solving health inequalities, racism, and racial disparities currently observed in the U.S. healthcare system.[145] Specifically, to address the disproportionate disparities faced by Black patients, an active effort must be made to promote health equity head on by addressing racism, bias, and the historical and systemic frameworks of race in the healthcare sector.[146] Additionally, the program's goals should include fostering greater equality of care, include strengthening Affordable Care Act benefits to include nondiscrimination guarantees and preserving coverage for patients with pre-existing conditions.[147] Moreover, Medicaid expansion efforts require inducing states, particularly southern states, which have not adopted Medicaid expansion, to adopt the expansion provisions quickly.[148] Furthermore, a proactive effort must be made to increase healthcare services in underrepresented areas where options are limited, and that increase in services should be diverse and culturally competent to meet the needs of underrepresented minorities.[149]

Regardless of which current strategy might seem more politically feasible, the program that results in the greatest expansion of universal health coverage should be pursued. A single-payer nationalized healthcare option offers greater coverage potential but may be politically

[144] *Id.*
[145] *Id.*
[146] *Id.* at nn.43–44.
[147] *Id.*
[148] *Id.* at nn. 17–19.
[149] *Id.*

distasteful to those who prefer more personal choice to attain coverage like that offered by a public insurance option plan. Both options would still require additional safeguards and provisions to target racial and health equity challenges currently burdening minorities and specifically Black patients.

D. Constitutional and Legal Considerations

The notion of health as a universal right is not new. The Declaration of Independence enumerates life as an unalienable right. Both quantitatively and qualitatively, life is best assessed in terms of health. Therefore, the principle that health is a fundamental liberty for every person should resonate in society. While health itself cannot be guaranteed, the opportunity to achieve one's best health outcome can be described by the level of care one has access to at a given time. Health equity should therefore parallel, if not exceed, the importance of other fundamentally recognized rights such as those protected under the Bill of Rights.

Universal human rights have been described as rights that humans are entitled to freely exercise their ability to live a life with dignity.[150] Healthcare access is intersectional to many of these rights.[151] Healthcare access promotes health, which is required to live, a precondition for the right to life itself. The right to healthcare has been recognized internationally by agencies such as the United Nations in Article 25 of the Universal Declaration of Human Rights. Article 25 states that:

> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
> (2) Motherhood and childhood are entitled to special care and assistance. All children,

[150] Mary Gerisch, *Healthcare as a Human Right*, 43(3) HUM. RTS. MAG. 2 (Aug. 1, 2018), https://www.americanbar.org/content/dam/aba/administrative/crsj/human-rights-magazine/hr-v43n3.pdf.
[151] See *Id.*

whether born in or out of wedlock, shall enjoy the same social protection.[152]

This specific assertion to healthcare access in Article as a universal right amplifies the need to consider this a fundamental right.

E. Reinterpreting the Equal Protection Clause: An Active Attempt to Promote Equality as Opposed to a Passive Protection of Individual Liberties

The Equal Protection Clause is a revered symbol of equality in American jurisprudence. The Equal Protection Clause mandates that ". . . nor shall any State . . . deny to any Person within its jurisdiction the equal protections of the laws."[153] The clause must be taken in its historical context to fully appreciate its significance. Since the phrase is part of the Reconstruction Amendments that grant equal rights for all, and specifically for former Black slaves, the Equal Protection Clause has periodically been used to promote equity in addressing inequality issues post-Civil War. Even the conservative-minded Justice Antonin Scalia once argued that the Equal Protection Clause epitomized justice more than any provision in the Constitution.[154]

The Equal Protection Clause can be deployed as a tool to proactively promote equality and fairness rather than as a passive defense for protecting individual liberties and can be used to combat systematic racism and structural inequality.[155] Structural inequalities are the heart of health disparities. Addressing them using this Constitutional tool presents the strongest possibility of attaining healthcare reform that addresses health disparities and improves health outcomes for disadvantaged groups like Black people and other minorities.[156] The Equal Protection Clause

[152] G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948).
[153] U.S. Const. amend. XIV, § 1.
[154] Dayna Bowen Matthew, Structural Inequality: The Real COVID-19 Threat to America's Health and How Strengthening the Affordable Care Act Can Help, 108 GEO. L.J. 1679, 1686 (2020).
[155] See *Id.*
[156] *Id.* at 1688.

offers the greatest potential for legally remedying healthcare disparities since it addresses the root cause: inequality and unequal treatment before the law.

As Dayna Mathew said, the "unambiguous goal of protecting 'equality' under this constitutional Amendment [should be] understood as putting a stop to the oppressive use of law to distinguish the societal participation of one group of people from that of another on the basis of skin color."[157] Rather than treating the Equal Protection Clause as a defense mechanism to ensure that an individual liberty which is already afforded and realized by an individual is protected, it should be deployed as a tool which can actively protects everyone's rights. This is even more important for Black Americans since the legacy and negative ramifications of slavery continue to persist and the Equal Protection Clause was enacted specifically to protect such communities. A passive liberties protection interpretation of the Equal Protection Clause indirectly assures that some people are more equal than others since racial inequality persists and is magnified when legislation enacted does not protect equality.[158]

George Floyd's utterance of "I can't breathe!" unfortunately summarizes the situation of the widening economic and health inequality in the United States. There are thousands of Blacks and other minorities who cannot breathe when the inequality that the Equal Protection Clause seeks to minimize persists despite the momentum to reduce health inequality in the United States. The life expectancy of the wealthiest Americans exceeds the poorest by ten to fifteen years.[159] The richer can literally breathe millions of more times than those who are poor. Inequities are exacerbated since access to coverage does not prevent underinsurance and worsens quality of

[157] *Id.* at 1692.
[158] *Id.* at 1697.
[159] Samuel L Dickman et al., *Inequality and the Health-care System in the USA*, 389 THE LANCET 1431 (2017).

access. Underinsurance remains a problem despite an increase in coverage under the Affordable Care Act due to rising premiums, burdensome cost-sharing mechanisms, lower wages, medical bankruptcies, and debt incurrence.[160]

CONCLUSION

The notion of healthcare as a universal human right needs to be revisited and realized for us as a society. It provides the ethical and moral foundations upon which healthcare functions to promote and protect the right to health. It serves as the basis for evolving and enhancing a healthcare delivery system that is currently plagued with inequities and racial disparities. Healthcare is necessary for disproportionately affected people to live their lives with dignity.[161]

Reform is necessary not only to address the racial injustices but also to achieve better outcomes. The roots of recognizing the right to healthcare can be traced back to President Franklin Delano Roosevelt's draft of the Second Bill of Rights.[162] Eleanor Roosevelt carried on the legacy when she championed for this right as she worked with the United Nations to create the Universal Declaration of Human Rights.[163] The United States adopted these standards, however, it is time to raise the question of whether the United States is still honoring this universal right.

Universal access to care should be considered a fundamental right whose roots are linked back to the Declaration of Independence, where the right to life is considered an unalienable right. Access to healthcare correlates to this right because life outcomes directly correlate to healthcare access. Addressing access to healthcare will not only result in better individual health outcomes in

[160] *Id.* at 1434.
[161] Gerisch, *supra* note 149.
[162] *Id.* at 3.
[163] *Id.*

which optimal use of resources effectively achieve better outcomes, but more importantly, it will serve as a mechanism for reducing health disparities amongst minorities and promoting social justice. Addressing healthcare access from the social determinants of health framework may provide one effective way to combat the dire health outcomes the U.S. collectively faces while also addressing racial inequalities.

The passage of Medicare and the Affordable Care Act in the past one hundred years has created inertia against achieving a higher proportion of health insurance coverage. However, racial disparities and heath inequities experienced by marginalized communities, particularly Black Americans, require that more rigorous and targeted strategies be pursued. This includes reinterpreting our understanding of health as a human right and using the tools that can be gleaned from the Constitution and other policies to make additional headway towards this goal. Current strategies, including expanding upon the Affordable Care Act with increased coverage by a single-payer nationalized system or an expansion of the marketplace option created under the ACA, could both potentially increase coverage for uninsured individuals. However, this expansion could come at the cost of forgetting to address the specific racial disparities, health inequities, and systemically racist inequalities that are currently observed in our healthcare system.

The "I Can't Breathe" rallying cry epitomizes the current situation in the United States healthcare system. A complex healthcare delivery system intended to provide coverage for all people results in persistent inefficiencies. Health equities and disparities present major challenges to ensuring that underrepresented minorities and communities are not forgotten. Their voices should be heard, and equitable access to healthcare should be considered a fundamental right, for it represents, in a way, the right to life itself. Every available option, from learning what other countries' health delivery models do well to creatively crafting political and legal policies that

interpret healthcare as a human right, offers a platform to invigorate effective legislation that should effectively achieve better health outcomes by reducing health inequities and disparities for all people.