Aristotle University of Thessaloníki
European Master's Degree in Human Rights and Democratisation
A.Y. 2019/2020

The Fulfillment of the Rights to Health and Life for Minorities in the U.S. in the era of COVID-19: The Case for Universal Healthcare

Author: Nicole Fulginiti
Supervisor: Dr. Aphrodite Baka

ACKNOWLEDGEMENTS

I would like to offer my gratitude to everyone at Aristotle University. I would also like to thank Dr. Aphrodite Baka, who has been flexible, patient, and supportive throughout this research, despite being on the other side of the world. I want to offer my utmost appreciation to Dr. Desponia Klavandou and Stella Dimitriou for a memorable, warm welcome in Thessaloníki and for being so accommodating the entire semester. I am equally appreciative of the advocates, researchers, and activists who have inspired me to write about this topic. To all of the people in my life, near and far, who encouraged me along the way, I am deeply grateful. A special, sincere thank you to everyone at Global Campus of Human Rights, for the exceptional experience and the resourcefulness, responsiveness, and versatility during this program. Finally, a thank you to all human rights workers, changemakers, and every E.MA graduate; it is with collective effort that our world will become a better place.

ABSTRACT

In the year 2020, the world has experienced a pandemic with catastrophic social and economic implications, yet the United States, the richest country in the world, has exceeded other countries in both the number of COVID-19 cases and deaths. Most of these cases and deaths disproportionately affect marginalized populations, but a contagious virus has illustrated that each person is only as healthy as their most vulnerable neighbor. This research explores the way in which the rights to life and health are understood in various legal and regional contexts, flaws that COVID-19 have revealed in the current institutional structure that oppress communities of color, and analyzes the importance of the implementation of universal healthcare in the US moving forward, for better enjoyment of the rights to health and life. It is concluded that in order to mitigate a crisis of this magnitude and create an equal, non-discriminatory, and inclusive institution surrounding health that protects life, universal healthcare reform in the US is necessary.

TABLE OF CONTENTS

TABLE OF ABBREVIATIONS

ACA - Patient Care and Affordable Care Act

AIDS - Acquired Immune Deficiency Syndrome

CARES Act - Coronavirus Aid, Relief, and Economic Security Act

CDC - Centers for Disease Control and Prevention

CESCR - Committee on Economic, Social, and Cultural Rights

ECHR - European Convention of Human Rights

FFCRA - Families First Coronavirus Response Act

HIV - Human Immunodeficiency Virus

ICCPR - International Covenant for Civil and Political Rights

ICESCR - International Covenant of Economic, Social, and Cultural Rights

IHS - Indian Health Service

OAS - Organization of American States

OECD - Organization for Economic Co-operation and Development

PCP - Primary Care Physician

PHC - Primary Health Care

PPE - Personal Protective Equipment

PPPHCEA - Paycheck Protection Program and Health Care Enhancement Act

SDG - Sustainable Development Goals

SDOH - Social and Environmental Determinants of Health

UDHR - Universal Declaration of Human Rights

UHC - Universal Health Coverage

UN - United Nations

US - United States of America

WHO - World Health Organization

INTRODUCTION

In the context of COVID-19, existing health inequities have been exemplified in a historically unprecedented way. In the US, the populations suffering the most are the vulnerable and marginalized groups. Healthcare reform has been an area of research and policy contention for decades, but until this crisis, the discrepancies in opportunity and health outcomes were not as apparent. What has been viewed as a health issue is also a life issue, and this has also been highlighted during this pandemic.

Therefore, this thesis uses the COVD-19 pandemic as a basis in which to explore the normative legal framework of the rights to health and life. Throughout the first section, it is made clear that the government does have obligations to keep their residents healthy and protected, within their means, especially during an emergency situation where one person's health can hugely impact the health of an entire population. Although all human rights are indivisible, the right to health is clearly necessary for the right to life. These two human rights are interdependent and interrelated, but the right to life is fundamental and is both highly relevant and measurable during this crisis.

The full enjoyment of the human rights to health and life must also take into consideration the needs of minorities and marginalized groups, especially during times of emergency. In particular, this thesis explores the historical and structural challenges and social and environmental determinants of health faced by Black Americans and residents of the Navajo Nation, which are both unequal and disproportionate in nature.

As a means of expanding on the universality of the human rights to health and life, it is imperative to implement universal healthcare coverage in the US. Although other factors contribute to health outcomes, it has never been clearer that the current healthcare system, one that is coupled with employment, is devastating to communities with less economic opportunity. Universal healthcare would not only reduce the rate of uninsured individuals, but it would also increase accessibility as well as provide financial risk protection. In turn, the increased access to care allows for better enjoyment of all human rights, while being inclusive, equitable, and people -centered. The interconnectedness and collective suffering exposed the flaws that exist and persist in the current system; there is now an obligation to act.

1. THE COVID-19 CRISIS

1.1 A Novel Coronavirus Pandemic

The current outbreak of the novel coronavirus, SARS-CoV-2, now known as COVID-19, began in China in 2019 and quickly spread across the globe. This virus was given its scientific name, Severe Acute Respiratory Syndrome Coronavirus 2, by the International Committee on Taxonomy of Viruses.[1] On January 30 2020, the World Health Organization declared SARS-CoV-2 a public health emergency of international concern. As conversations about the emerging virus increased, along with the number of cases throughout the world, the World Health Organization's Director-General, Dr. Tedros Adhanom Ghebreyesus, announced in a media briefing that COVID-19 met all the criteria to be considered a pandemic. This determination was made on March 11 2020, due to the "levels of spread and severity, and by the alarming levels of inaction".[2] A pandemic differs from other types of outbreaks in that a pandemic refers to a disease with worldwide prevalence. The World Health Organization (WHO) Director-General also stated that this is the first pandemic created by a novel coronavirus, yet is also the first controllable pandemic.[3]

Since COVID-19 was a novel coronavirus in humans, nobody is immune, thus making the spread easier. Additionally, since the virus is new, the data and research is constantly evolving, with unknown long term effects.[4] The data listed below evolves with new research, but does reflect the best currently available science.

Cases for this virus continue to exponentially increase. As of May 17 2020, there have been 4,529,027 reported cases of COVID-19 worldwide. Alarmingly, as of August 9 2020, there have been 19,462,111 reported cases worldwide. Of these 19 million cases, the US has accounted

---

[1]Yen-Chin Liu, Rei-Lin Kuo, and Shin-Ru Shih, "COVID-19: The First Documented Coronavirus Pandemic in History," *Biomedical Journal*, May 5, 2020, https://doi.org/10.1016/j.bj.2020.04.007.
[2] World Health Organization, "WHO Characterizes COVID-19 as a Pandemic," Coronavirus Disease (COVID-19) - events as they happen (World Health Organization), accessed April 2020, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen.
[3] Ibid.
[4]A. Peters et al., "Understanding the Emerging Coronavirus: What It Means for Health Security and Infection Prevention," *Journal of Hospital Infection* 104, no. 4 (2020): pp. 440-448, https://doi.org/10.1016/j.jhin.2020.02.023.

for 4,897,958 of them.[5] However, these numbers are probably incorrect, as not everyone who has the virus is included in the numbers of positive cases, and it is likely that only the sickest patients seek and receive tests. The numbers of cases are likely inaccurate because of "differences… between information products published by WHO, national public health authorities, and other sources using different inclusion criteria and different data cut-off times," and "case detection, definitions, testing strategies, reporting practice, and lag times between countries/territories/areas".[6] Due to these factors, it is likely that both the total number of cases are underrepresented, making this pandemic extremely widespread.

Regardless of exact case count, the scientific community agrees that COVID-19 is easily transmissible through human-to-human spread and is transmissible during the incubation period. Although the rate of spread that can stem from one infected person is generally assessed through the *R*0 number, this calculation is influenced by time and place and is not a fixed number. Interventions such as lockdowns and work-from-home measures help mitigate the spread of COVID-19, since transmission is person-to-person. It is estimated that the *R*0, without intervention, has a range from 1.4–6.49, with a mean of 3.28, meaning a single person with the infection will likely infect between 2 to 3 other people, on average. Once the *R*0 is at 1 or below, the spread of the disease is perceived to be controlled at that place and time. Regardless of the rapidly changing calculation, it is clear through the numbers of positive cases that COVID-19 is very contagious. Equally important is the incubation time of COVID-19, which is another dangerous characteristic of this virus. Asymptomatic patients can transmit this virus to others, and the virus takes on average 3-7 days for symptoms to appear. However, there have been cases of symptoms appearing up to 14 days, which gives credence to the suggested active monitoring and quarantine period of 14 days by the WHO. It is also important to note that cases can vary widely in severity, allowing those that do exhibit symptoms to transmit it to others, not knowing

[5] World Health Organization, "Coronavirus Disease (COVID-19) Situation Report – 202," Coronavirus Disease (COVID-19) - events as they happen, August 9, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200809-covid-19-sitrep-202.pdf?sfvrsn=2c7459f6_2.

[6] World Health Organization, "Coronavirus Disease (COVID-19) Situation Report – 118," Coronavirus Disease (COVID-19) - events as they happen, May 17, 2020, https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200517-covid-19-sitrep-118.pdf?sfvrsn=21c0dafe_8.

that they are in fact sick with COVID-19.[7] Understanding the symptoms are hence important to understand the variation in severity and spread.

The symptoms of COVID-19 in some individuals may mimic those of a common cold, making it difficult to identify. In others, it could lead to hospitalization and death. The symptoms of COVID-19 continue to evolve as new scientific research emerges, particularly in regards to possible long term effects. The lack of severe symptoms in some individuals, in addition to the contagious incubation period, allow people to believe they are healthy and are not putting others' health in jeopardy. This makes the virus spread quickly and relatively easily. The most common symptoms are general weakness, fatigue, chills, fever, sore throat, cough, shortness of breath, difficulty breathing, muscle aches, anosmia, and hyposmia. Less common symptoms include diarrhea, vomiting, and nausea.[8]

COVID-19 primarily affects adults, but does infect children too. Children, in general, are less affected by COVID-19 than adults. Despite this, children can still transmit the disease, and in turn, make susceptible adults sick. This disease has claimed so many lives due to the nature of the virus; it can cause cardiovascular problems, acute respiratory distress syndrome, severe pneumonia, as well as sepsis and septic shock, all of which can lead to a COVID-19 related death.[9] These conditions require hospitalization in some patients, but even with treatment can result in premature death. People who are most at risk for severe cases of COVID-19 are those with underlying conditions, such as cancer, diabetes, hypertension, cardiovascular disease, or chronic respiratory disease, or are age 60 or above.[10] COVID-19 also leads to an increased risk of illness with obesity, moderate to severe asthma, liver disease, chronic kidney disease, and anyone else that is immunocompromised. It puts men slightly more at risk than women, and there is an increased risk of severity correlated with age.[11]

---

[7] Peters et al., "Understanding the Emerging Coronavirus," 443-445.
[8] National Center for Immunization and Respiratory Diseases (NCIRD), "Symptoms of Coronavirus," Centers for Disease Control and Prevention (Centers for Disease Control and Prevention, May 13, 2020), https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.
[9] European Centre for Disease Prevention and Control, "Q & A On COVID-19," European Centre for Disease Prevention and Control, May 25, 2020, https://www.ecdc.europa.eu/en/covid-19/questions-answers.
[10] Ibid.
[11] Ibid.

In order to be diagnosed with COVID-19 and appear in the case counts by local, national, and international authorities, one must test positive with a diagnostic laboratory test. Testing is a valuable metric for several reasons. Firstly, it allows identification of positive cases to identify the need for medical services or treatment along with the effects of the illness in different populations. Secondly, it allows for contact tracing to identify who has come into contact with those that have tested positive, and encourages tracking and isolation of those people. Thirdly, testing assists with allocation of resources and medical personnel. At the beginning of the COVID-19 crisis, many countries did not have the necessary resources or capacity to test and treat the disease. Through time, more tests have been produced to meet the increased demand, but in the US, availability of tests vary state by state. As the outbreak has now been occurring for months, testing must increase to provide a reliable picture of the incidence and prevalence. Testing is the most important way to maintain monitoring and surveillance, especially with some asymptomatic cases, and in the US, the country with the most cases, testing is still not adequate, timely, or free for all. As of May 18 2020, there were only 35.75 tests performed per 1,000 people in the US, whereas as of May 17 2020, Portugal performs 64.96 tests per 1000 people, and has reported far fewer cases. This distinction is important because testing reveals a larger sample of people where infection status is known and hence can be studied and supplies can be distributed accordingly.[12]

1.2 Combatting the Virus

As mentioned above, those that test positive for the virus are both very contagious and are at risk of requiring hospitalization. Therefore, personal protective equipment (PPE), respirators, and ventilators are extremely valuable medical resources to help prevail over this illness, which targets the respiratory system. Many countries were unprepared in regards to respirators, ventilators, hospital beds, and PPE when the pandemic began. Respirators and ventilators became the difference between life and death in many circumstances, as severe cases

[12] Ritchie, Hannah et al. “Coronavirus (COVID-19) Testing - Statistics and Research.” Coronavirus (COVID-19) Testing. Our World in Data, May 18, 2020. https://ourworldindata.org/coronavirus-testing.

left patients struggling to breathe and in need of life saving interventions.[13] Likewise, China produced half of the world's masks and while COVID-19 spread across the country, was unable to produce enough to export thus disrupting global PPE production chains. This was notably seen in Italy in February and March, where a combination of underlying conditions, lifestyle factors, and hospital shortages had led the healthcare system to be overwhelmed and ineffective, leading to tens of thousands of deaths.[14] Doctors described having to triage patients and assess not only who is more in need, but who will benefit the most from intervention and services, often prioritizing the healthy and the young to survive. The shortages of PPE also led nurses to contribute an estimated 9% to all COVID-19 cases in Italy as of April 2020. The lack of resources posed questions on medical ethics and furthermore exposed gaps in healthcare supply and preparedness. Medical supplies are not only essential for protecting human life, but also for remaining proactive about this emergency situation and future ones.[15]

Perhaps the most notorious strategies that have been used to prevent the spread of this pandemic have been to "flatten the curve" and "social distance". In fact, flattening the curve specifically refers to extending health care capacity by preventing a spike in infections, so as to avoid the overcapacity seen in Italy. Since there are limited resources as well as medical workers, it was highly recommended by doctors and scientists to isolate oneself in order to flatten the lines or dots that represent the number of infections on a graph. A healthcare system has a certain capacity, and if there were to be a dramatic spike in medical needs, it would surpass the point of capacity on such a graph. The strategy of flattening the curve is intended to prolong the existing health care capacities, to avoid the triaging Italy was doing, where they prioritized some lives over others. In order to achieve this flattening of the curve, many countries around the world instituted strict guidelines, resulting in quarantines and stay at home orders, all

---

[13] Ranney, Megan L., Griffeth, Valerie, and Jha, Ashish. "Critical Supply Shortages — The Need for Ventilators and Personal Protective Equipment during the Covid-19 Pandemic." *New England Journal of Medicine* 382, no. 18 (April 30, 2020). https://doi.org/10.1056/nejmp2006141.

[14] Stefania Boccia, Walter Ricciardi, and John P. A. Ioannidis, "What Other Countries Can Learn From Italy During the COVID-19 Pandemic," *JAMA Internal Medicine*, April 7, 2020, https://doi.org/10.1001/jamainternmed.2020.1447.

[15] International Council of Nurses, "High Proportion of Healthcare Workers with COVID-19 in Italy Is a Stark Warning to the World: Protecting Nurses and Their Colleagues Must Be the Number One Priority," ICN, March 20, 2020, https://www.icn.ch/news/high-proportion-healthcare-workers-covid-19-italy-stark-warning-world-protecting-nurses-and.

encompassing “social distancing”.[16] The United States did not, so the exponential growth in cases and limited health care capacity in some states is not surprising.

Economies shut down while people remained at home. This was done in varying degrees, depending on rules, leadership, and instructions, as well as human behavior.[17] Since COVID-19 has a high likelihood of transmission to others, people around the world were advised to “social distance” themselves from others, by remaining 6 feet or 1.5 meters apart. Hygiene is also highly recommended, such as handwashing, and being mindful of surfaces which can carry the virus for periods of time. Wearing masks is also recommended, although there is not a global mandate at this time. This is because COVID-19 is transmitted by respiratory droplets that can infect by breathing in respiratory droplets or by sticking to surfaces and touching the eyes, nose, or mouth.[18]

1.3 Future Prospects

Currently, there is no way to cure COVID-19. Since the virus is widespread and there is not yet an effective treatment, a vaccine is viewed as the only possible way to help combat the spread of the disease. However, since most effective vaccine development takes between 8-12 years between animal trials, human trials, and long term effects to ensure safety, it is unlikely that a safe vaccine will be produced and then administered to people in a timely manner. Currently, there are several companies, such as Moderna, trying to rush to produce a vaccine to reduce the spread of the virus.[19] However, it is a global effort, so it is likely multiple companies will contribute. Although COVID-19 currently has no cure, it is being treated in a variety of ways, mostly through breathing intervention methods to help aid with respiration. There have been different medications used in different countries and regions, with both Brazil and the US

[16] Nick Romeo, “The Grim Ethical Dilemma of Rationing Medical Care, Explained,” *Vox*, March 31, 2020, https://www.vox.com/coronavirus-covid19/2020/3/31/21199721/coronavirus-covid-19-hospitals-triage-rationing-italy-new-york.
[17] Ranney, Griffeth, Jha, “Critical Supply Shortages”.
[18] Sansonetti, Philippe J. 2020. "COVID‐19, Chronicle Of An Expected Pandemic". *EMBO Molecular Medicine* 12 (5). doi:10.15252/emmm.202012463.
[19] Jeremy Owens. 2020. "Moderna Begins New COVID-19 Vaccine Study". *Marketwatch*. https://www.marketwatch.com/story/moderna-begins-new-covid-19-vaccine-study-2020-05-29.

presidents calling for hydroxychloroquine as a solution, although the WHO disputes this.[20] As science progresses, there have been developments in treatment, but nobody is immune; science is still inconclusive if people can get the virus more than once.

An aim of this thesis is to explore the ways COVID-19 challenges the fundamental rights of life and health especially for the minority populations in the US. Although this virus sees no borders, it predominantly affects the rights of those who are already marginalized. The human rights to health and life are described by the United Nations and other international documents in such a way that acknowledges States have a duty to protect their people. This virus poses challenges for many human rights, but particularly for the enjoyment of the rights to health and life. Since COVID-19 can result in serious complications that require a need for medical intervention, it leaves those that are unable to receive, access, or afford care at a higher risk for premature death. COVID-19 is also easily transmitted, which makes it easier to spread in urban and congregate settings and neighborhoods. It is also combatted through isolation and distancing, putting workers on the front lines at an increased risk of catching the virus. In this case, paid sick leave from work is crucial for workers in order to not spread the virus, as well as be able to afford other conditions of living required for health. Yet, paid sick leave is not guaranteed. Additionally, social and environmental determinants of health contribute to unequal health effects, but rather than mitigate these effects through various policies, the overarching institution of healthcare would be best addressed for better universality of these rights.

2. INTERNATIONAL PERSPECTIVES ON THE RIGHTS TO HEALTH AND LIFE

2.1 Universal Declaration of Human Rights

In order to achieve concurrence on the prevention of any mass violations of human rights again, following the atrocities of World War II, the Universal Declaration of Human Rights (UDHR) still serves a symbolic and pivotal purpose. This document is not legally binding, and is

[20]Jack Goodman and Christopher Giles. 2020. "What Do We Know About Hydroxychloroquine?". *BBC News*. https://www.bbc.com/news/51980731.

hardly as universal as the title implies.[21] Yet, despite the vagueness, historical injustices, and misconstrued interpretation of human rights as political messaging, this fundamental document aimed to make human rights universal by setting standards throughout the world.[22] The UDHR is significant as it "..still constitutes an expression of the fundamental rights and principles that are commonly shared by the vast majority of States worldwide, and in this sense its provisions may reflect customary international law, or may have gained binding character as customary international law at a later stage".[23] The Universal Declaration of Human Rights encompassed an ideological basis in the first two articles, with many related to civil and political rights and others related to economic, social, and cultural rights.[24] According to the UDHR, although the right to life is not absolute, it is a fundamental right that is necessary for the enjoyment of all other human rights.[25] Thus, it is non-derogable, regardless of peacetime, wartime, or other public emergencies. The right to life in the UDHR in Article 3 is described[26] as,

Everyone has the right to life, liberty and the security of person.

The right to health is an equally important right, in fact, the right to health is "inherent to the right to life".[27]Although the right to health is expressed differently in each society, the UDHR has encompassed the framework for this human right that is still relevant today. The UDHR is important in this case as there are countries that are signatories to the UDHR but have not ratified the International Covenant for Economic, Social, and Cultural Rights or the International Covenant for Civil and Political Rights, which explicitly outlines the rights to health and life and makes them legally binding. The UDHR[28] states in Article 25:

---

[21] Only four African countries were able to vote and no indiginious people contributed, possibly due to the lower rate of only 58 UN Member States at the time in 1948. Of these 58, 48 voted in favor, with 0 voting against. There were 8 abstentions and 2 states could not be present.
[22] Filipe Gómes. "The Inter-American System of Human Rights" Slideshow, Lecture, Venice-Lido, 25 September 2019.
[23] Konsta, Marie Anne. "Human Dignity and Social Rights of Refugees in EU Law" Slideshow, Lecture, Thessaloníki, March 24, 2020.
[24] The United Nations. 1948. *Universal Declaration of Human Rights*.
[25] Ibid.
[26] Ibid.
[27] United Nations, "COVID-19 and Human Rights: We Are All in This Together," Victims of Terrorism Support Portal, April 2020, 4 https://www.un.org/victimsofterrorism/sites/www.un.org.victimsofterrorism/files/un_-_human_rights_and_covid_april_2020.pdf.
[28] The United Nations. 1948. *Universal Declaration of Human Rights*.

(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, whether born in or out of wedlock, shall enjoy the same social protection.

In this provision, the language used leaves different implications. First and foremost, it does not specifically refer to the "right to health" but instead uses the term "standard of living adequate for health". The standard of living necessary for health and well-being is then described as including basic essentials such as food, but medical care, social services, and security in the event of circumstances beyond one's control. The provision also specifies that children and mothers have the right to receive specialized medical care, regardless of the marital status of the mother. This phrasing encompasses the different dimensions of public health, including in this case social and physical dimensions, which are necessary to ascertain the right to health but not always recognized as such.[29]

2.2 International Covenant for Civil and Political Rights

The right to life however is also more specifically mentioned in other international human rights documents, such as treaties. In the International Covenant for Civil and Political Rights (ICCPR), a highly ratified human rights treaty,[30] encompasses the right to life[31] as described in Part III, Article 6:

1. Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

2. In countries which have not abolished the death penalty, sentence of death may be imposed only for the most serious crimes in accordance with the law in force at the time of the commission of the crime and not contrary to the provisions of the present Covenant and to the

[29] Ibid.
[30] This includes the United States, which has hesitated to ratify many other human rights treaties.
[31] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171.

Convention on the Prevention and Punishment of the Crime of Genocide. This penalty can only be carried out pursuant to a final judgement rendered by a competent court.

3. When deprivation of life constitutes the crime of genocide, it is understood that nothing in this article shall authorize any State Party to the present Covenant to derogate in any way from any obligation assumed under the provisions of the Convention on the Prevention and Punishment of the Crime of Genocide.

4. Anyone sentenced to death shall have the right to seek pardon or commutation of the sentence. Amnesty, pardon or commutation of the sentence of death may be granted in all cases.

5. Sentences of death shall not be imposed for crimes committed by persons below eighteen years of age and shall not be carried out on pregnant women.

6. Nothing in this article shall be invoked to delay or to prevent the abolition of capital punishment by any State Party to the present Covenant.

The interpretation of the above Article is elaborated upon in General Comment 36 by the treaty body for the ICCPR, the Human Rights Committee[32] and although it addresses six specific affairs, these mostly address the role that states take in encapsulating the right to life.[33]

First and foremost, this Article in the ICCPR specifically refers to the prohibition of deprivation of life. This can be defined as an "intentional or otherwise foreseeable and preventable life-terminating harm or injury, caused by an act or omission."[34] This puts the obligation on the States to protect the right to life in life threatening situations that are reasonably foreseeable and can result in a loss of life.

As previously mentioned, the right to life is fundamental, yet even when deprivation of life is not arbitrary, "it must be applied in a manner which is not arbitrary."[35] This means that arbitrary loss of life is such that the deprivation of life is inconsistent with laws and procedures that protect life, or that it does not have a legal basis. This arbitrary principle must also be consistent with international law and domestic law, and must be assessed with elements including injustice, inappropriateness, due process of law, necessity, reasonability,

[32] General comments are written to serve as interpretations for the legal provisions in UN human rights treaties, and in this matter also provide additional context.
[33] UN Human Rights Committee (HRC), *General comment no. 36, Article 6 (Right to Life)*, 3 September 2019, CCPR/C/GC/35.
[34] Ibid., § 6.
[35] Ibid., § 10.

proportionality, and predictability, or it could qualify as arbitrary. Likewise, to avoid arbitrary deprivation of life, taking someone's life must be strictly necessary for the threat, must be a last resort, cannot involve more force than is strictly needed, and must be carefully directed only to an attacker.[36] Even in situations where States can employ use of force by private parties such as security agencies or other organizations, the State must maintain responsibility to limit the powers given to such actors and ensure that there are effective monitoring, training, and control mechanisms to prevent arbitrary loss of life. Despite State authorization, it still falls on the State and not the private actors if a failure to comply with Article 6 exists and an effective remedy must still be reached regardless of who initiates the violation.[37]

State parties to the ICCPR are expected to take all necessary measures to guarantee that there will be no arbitrary deprivation of life from their authorities. These measures include legislation to control lethal use of force from law enforcement, planned procedures and crowd control for enforcement that is consistent with minimal risk to human life, compulsory reporting, review, and investigation when a lethal incident occurs, and proper protective equipment to reduce the likelihood of resorting to lethal force.[38] In the event an allegation of violation of Article 6 occurs, States must investigate through independent, impartial, prompt, thorough, effective, credible, and transparent means, and if applicable must prosecute and provide full reparation.[39]

The right to life as enshrined in the ICCPR also functions on the basis of non-discrimination. Human rights operate on the basis of non-discrimination as a core principle, meaning that the right to life must be assured without distinction to "race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or any other status, including caste, ethnicity, membership of indigenous group, sexual orientation or gender identity, disability, socioeconomic status, albinism, and age", while stating that deprivation of life based on discrimination is arbitrary, including femicide and other intersectional types of

[36] Ibid., § 12.
[37] Ibid., § 15.
[38] Ibid., § 12-13.
[39] Ibid., § 19.

discrimination.[40] This principle applies to all human rights, and is important considering the outcomes of this pandemic. Some individuals have an easier time getting live-saving treatment, while others have barriers to access.

Genocide is also mentioned in the third provision of Article 6 in the ICCPR, and is described further in the Convention on the Prevention and Punishment of the Crime of Genocide. Genocide is defined in this Convention as committing specific acts "with intent to destroy, in whole or in part, a national, ethnical, racial or religious group."[41] These specific acts, as listed in the Convention on the Prevention and Punishment of the Crime of Genocide include, "killing members of the group, causing serious bodily or mental harm to members of the group, deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part, imposing measures intended to prevent births within the group, or forcibly transferring children of the group to another group."[42] Incitement of genocide, complicity of genocide, and plans to commit genocide are equally illegal, forbidden, and punishable.[43] Genocide is strictly forbidden in times of war or peace and any individual, ruler, private or public individual is subject to effective penalties for committing genocide.[44] Despite the clarity of this definition, it is worth noting that there must also be intent by the perpetrator and it must be clearly provable. As such, widespread or systematic attacks on the right to life are prohibited, and failing to prevent these can result in a failing of the positive obligation on a State to ensure enjoyment of the right to life. This being said, loss of life cannot target specific individuals through discriminatory means, and the death penalty cannot be a genocidal policy meant to target certain members of a group. Genocide is prohibited both in human rights treaties and in customary international law, and States have the duty to prevent genocide as well as to prosecute perpetrators.[45] However, although minorities are dying at disproportionate rates from COVID-19, it is not with the intent to kill, destroy, or inflict conditions that result in death. This

---

[40] UN General Assembly, *Status of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment : resolution / adopted by the General Assembly*, 15 December 1989, A/RES/44/144, 5 § 23.
[41] UN General Assembly, *Prevention and punishment of the crime of genocide*, 9 December 1948, A/RES/260, II.
[42] Ibid.
[43] Ibid., III.
[44] Ibid., V.
[45] Ibid.

is an important distinction to make, as although there are conditions and policies that should be improved, the US government is not acting with intent to do harm on specific groups of people. Rather, the US government should address the effects of COVID-19 and the conditions that have perpetuated the health disparities that have resulted in loss of life.

Also referred to in the ICCPR is the death penalty, which although mentioned in Article 6 is also referred to in the second optional protocol specifically. Discussed in General Comment 36 is the imposition of the death penalty, which is regulated for the countries that have not abolished it. The scope of application is limited only to the states that have not abolished it and also for only the most serious crimes. This indicates that the crimes must have extreme gravity and involve intentional killing and cannot be subjective in nature. Once a State decides to abolish the death penalty, they are not allowed to reconsider and reimplement the death penalty, as well as cannot alter the penalty of a crime to become a capital offence if they have ratified the ICCPR. In order to protect the right to life, States are also forbidden from deporting, extraditing, or otherwise transferring persons to a country where they are facing charges that will result in the death penalty, except if there are "credible and effective assurances against exposing the individual to the death penalty have been obtained."[46] In instances when the death penalty is implemented, only certain methods of execution are permitted without violating Article 7 of the ICCPR, which relates to torture or to cruel, inhuman or degrading treatment or punishment or non consensual medical/scientific experiment participation. Thus, the methods that must be used to execute the death penalty must not render the cause of death arbitrary, and cannot include painful or humiliating method. The trial must be fair, and the premise of innocence until proven guilty must be maintained throughout the process until the conclusion of the trial and sentencing. [47] The Second Optional Protocol to the ICCPR is specifically geared toward universal, international abolishition of the death penalty, but is not mandatory. It goes further than the ICCPR itself in terms of capital punishment in that "the Second Protocol requires State Parties to undertake more ambitious and comprehensive measures than mere abolition," therefore making

[46] UN Human Rights Committee, *General comment no. 36.* § 30.
[47] Ibid., § 40-41.

the ICCPR and accompanying protocols ambitious, relevant legal texts to prohibit the death penalty.[48]

If life is lost while in State custody, it is assumed that the State is guilty and is up to the State to reverse this assumption. Similarly, States must protect individuals lives from other States, international organizations, or other groups that conduct business in their territory or jurisdiction. This positive obligation principle signifies that "States must take reasonable positive measures which do not impose on them disproportionate burdens in response to reasonably foreseeable threats to life originating from private persons and entities, whose conduct is not attributable to the State." Furthermore, States have the responsibility to create and enact legislation or related measures to protect life from all threats, both from private actors and entities. This protection must especially extend to the most vulnerable, including those with "specific threats or pre-existing patterns of violence" including those deprived of liberty as well as marginalized groups and certain sectors of employment, such as journalists or other human rights defenders.[49]

It is important to note that States have the responsibility to take into account underlying issues within their society and address the issues that pose a threat to people's lives. States must consider general conditions within their territory and take adequate steps to ensure that these conditions, which may result in direct threats to life, do not in fact result in a loss of life. These conditions that are referred to in General Comment 36 differ greatly, ranging from high levels of criminal and gun violence, pervasive traffic or industrial accidents, degradation of the environment, to prevalence of life threatening disease. The duty to protect life also extends to taking action to create optimal conditions, specifically to ensure that there are appropriate measures that are taken to protect life, including access to goods and services. These goods or services that States should provide in order to improve general conditions to protect life include "food, water, shelter, health-care, electricity and sanitation."[50] Therefore, the duty to protect life includes the implementation of both proactive and reactive measures that can mitigate poor

[48] Eric Neumayer, "Death Penalty Abolition and the Ratification of the Second Optional Protocol," *The International Journal of Human Rights* 12, no. 1 (2008): 3-5, https://doi.org/10.1080/13642980701725160.
[49] UN Human Rights Committee, *General comment no. 36.*, § 23.
[50] Ibid., § 26.

living conditions that could result in unnecessary death.[51] The Human Rights Committee "considers that it would be desirable for States parties to take all possible measures to … increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics."[52] This obligation to protect life should not be understood narrowly or in a restrictive interpretation; States are expected to be proactive and protective within reason to uphold the right to life.

Therefore, the ICCPR as understood by General Comment 36 indicates that the State should provide access to goods or services to improve general conditions to protect life, and in the COVID-19 crisis, food, water, healthcare, electricity, and sanitation can affect both health and life. States should improve these as much as possible, especially when these factors contribute heavily to susceptibility to COVID-19, which can be fatal. States also have the duty to protect life through access to services, which in this crisis, includes healthcare. During the COVID-19 crisis as well as any other emergency, it is important to prioritize marginalized populations through positive measures to save lives. Additionally, the principle of non-discrimination must be applied to all matters surrounding the right to life.

2.3 International Covenant of Economic, Social, and Cultural Rights

The International Covenant of Economic, Social, and Cultural Rights is intended to function in combination with the ICCPR to more thoroughly cover all human rights set forth in the UDHR as well as make the provisions legally binding. In the International Covenant of Economic, Social, and Cultural Rights (ICESCR),[53] Article 12 establishes:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

[51] Ibid.
[52] UN Human Rights Committee (HRC), *CCPR General Comment No. 6: Article 6 (Right to Life)*, § 5, 30 April 1982.
[53] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The right to health as mentioned in the ICESCR specifically includes the recognition of the right of everyone to the highest attainable standard of health. It is not necessarily the right to be healthy, nor does it specifically state that healthcare is a right. The Committee on Economic, Social, and Cultural Rights (CESCR) has specified that the highest standard of health must consider one's biological and socioeconomic pre-existing conditions as well as the resources that a State has available. This of course does acknowledge that genetic predispositions to disease as well as lifestyle practices may contribute to ill health, but States still have an obligation to take steps to ensure a healthy population nonetheless.[54] In understanding the right to health through General Comment 14, the CESCR has also stated that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health."[55] This may be perceived as vague phrasing, but the right to health is further clarified by the CESCR by describing all applicable elements, such as availability, accessibility, quality, and acceptability.[56]

[54] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, § 37, 11 August 2000, E/C.12/2000/4.
[55] Ibid., § 9.
[56] Ibid., § 12.

Based on the language of Article 12 alone, the right to health dictates that steps must be taken by States in order to ascertain the right to health, including matters related to child development, environment and industry, disease, and medical care.

In all of these matters, however, the "precise application of which will depend on the conditions prevailing in a particular" State.[57] This will soon be discussed further, as progressive realization and utilization of the maximum available resources are key concepts to the enjoyment and fulfillment of this right. The necessity to respect, protect, and fulfill does not equate to optimal health for everyone, but it does emphasize the need to prioritize the vulnerable and marginalized in terms of distribution and management of resources internationally, especially when managing a disease like COVID-19 that is transmissible beyond State borders.[58]

In terms of the right to health, availability is one of the core components. In this sense, "availability" is known as having available health care and other public health facilities, services, and goods in an adequate quantity. Other aspects of health are included in what States should have available, and also include hospitals and other health related buildings, trained medical personnel, and essential drugs.[59] Underlying determinants of health are defined by CESCR as "a wide range of socio-economic factors that promote conditions in which people can lead a healthy life."[60] Since the availability of these facilities, goods, services, and programs may be impacted by these underlying determinants of health, it is important to understand what they include and how they play a role in each of the elements necessary for the realization of this right. Underlying determinants of health, for example, include "potable water, adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health," as well as participation by the population in decisions regarding community, national, and international levels.[61] Although the availability of resources necessary for health may vary depending on a State's development, States must make continuous progress in providing as many resources as possible. This should be a priority especially during a

[57] Ibid.
[58] Ibid., § 40.
[59] Ibid., § 12.
[60] Ibid., § 4.
[61] Ibid., § 1..

pandemic, but should also be a teachable moment for the future as well.

In terms of the "accessibility" element of the right to health, there are four aspects that dictate what accessibility involves. These aspects are non-discrimination, physical accessibility, economic accessibility, and information accessibility. As with all human rights, non-discrimination must be adhered to and thus health facilities, services, and goods must also be accessible to all, in particular to those that are vulnerable and marginalized. In fact, non-discrimination is an immediate obligation and is not subject to being implemented over time.[62] For physical accessibility to be fulfilled, health services, facilities, goods, as well as underlying determinants of health should be within safe distance for all sections of the population, including "vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS".[63] For the economic accessibility aspect, it can easily be summarized by affordability. This means that the aforementioned health resources must be affordable for all, noting that there should be equity; lower income households or other socially disadvantaged groups should not be disproportionately burdened by healthcare expenses. The final aspect of the element of accessibility for the right to health, information accessibility, "includes the right to seek, receive and impart information and ideas concerning health issues."[64] The combination of these four aspects must be prioritized to allow for accessibility, which is another essential element to the enjoyment of the right to health.

Another element that is considered essential to ascertain the right to health is acceptability. In this context, "acceptability" refers to the way in which all health facilities, services, and goods should be medically ethical as well as appropriate toward cultures. Cultures of minorities, peoples, and communities should be respected as well as specific sensitivity to gender and life cycle. Health facilities, services, and goods must be designed in a way which honors confidentiality, as without confidentiality, it would interfere in the elements of accessibility or availability.[65]

---

[62] Ibid., § 30.
[63] Ibid., § 12.
[64] Ibid., § 12.
[65] Ibid.

Although accessibility, availability, and acceptability are all necessary elements for the right to health, quality is also important. If quality is not adhered to, it can also undermine the other necessary elements for the right to health, as these are all interconnected aspects of the application of this right. "Quality" in this context refers to health facilities, services, and goods as being medically and scientifically appropriate and of good quality. Good quality is unclear, but as the CESCR specifies, "good quality...requires inter alia skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation".[66] In regards to all of these elements, they must be understood through the lense of each State's resources.

The efficacy of the right to health is contingent upon the flexibility of the right; it is clear that each State has different levels of development and resources. Thus, the ICESCR uses the phrases "take steps" and "to achieve full realization." This provision reflects the concept of progressive realization, a concept that acknowledges resource constraints but obliges States to take deliberate, concrete, and targeted steps toward the full realization of this right. States have a continuous and specific obligation to work promptly and effectively to best implement the right to health even if it cannot be immediately done.[67] This being said, retrogression of the right to health is not permissible. Violations of the right to health can therefore include omissions, involving not taking steps toward the full realization of health, or retrogressive measures. In the event of omission, "...if resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations…"[68] In the event of retrogressive measures, "the State party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State party's maximum available resources." [69]

In short, the right to health as outlined in the ICESCR is very relevant to COVID-19, as State governments need to adhere to the core concepts of this right in order to meet their

[66] Ibid.
[67] Ibid., § 30-31.
[68] Ibid., § 47.
[69] Ibid., § 32.

obligations. A State should spare no expense in an emergency situation with a virulent disease like COVID-19, and should focus their resource expenditure on improving the right to health as much as within their means. During a pandemic, accessibility to health services and accurate medical information is imperative, as healthcare costs, geographical distance, and lack of affordability of services should not limit the utilization of them. Equally important during a pandemic is availability and adequacy of services, facilities, goods, and other supplies. These are critical not only during an emergency situation, but also beyond it, in order to ensure a better response if such a situation were to occur again. Acceptability of health facilities, services, and goods must also be culturally competent, especially given the range of cultures in diverse States. The CESCR gives equal emphasis to socioeconomic factors of health, which not only increase the risk of severe COVID-19 but also can have a massive impact on all health outcomes. Lastly, an omission of anything mentioned above can also be considered a violation, so violations of the right to health can therefore include omissions, involving not taking targeted and intentional action toward the full realization of the right to health. This is an important distinction to make to ensure governments meet their obligations.

2.4 Sustainable Development Goals

Another important document which emphasizes the importance of the human rights to health and life are the Sustainable Development Goals. These are all interconnected, and encompass seventeen different goals with the aim of being achieved by 2030 globally. These goals are no poverty, zero hunger, good health and well-being, quality education, gender equality, clean water and sanitation, affordable and clean energy, decent work and economic growth, industry, innovation and infrastructure, reduced inequality, sustainable cities and communities, responsible consumption and production, climate action, life below water, life on land, peace and justice strong institutions and partnerships to achieve the goal.[70] All of these goals relate to the rights to health and life in some capacity, and contribute to them, but the most relevant sustainable development goal (SDG) is goal number three, good health and well-being.

[70] United Nations, "Sustainable Development Goals," United Nations Sustainable Development, https://www.un.org/sustainabledevelopment/health/.

The SDGs are enumerated, and the goal of good health and well-being is and will be referred to as SDG 3.

Each SDG has targets and indicators, and these are mostly related and interconnected, like all human rights. For SDG 3, there are thirteen targets which allow monitoring of progress of this goal. Additionally, there are twenty-four indicators to help track progress among each of the thirteen targets. These range from mortality ratios, to treatment interventions, and to communicable disease incidence.[71] Most notable among these targets is 3.8, which is to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all."[72] Of this indication, it is further broken down into those covered by essential services and the number of people covered by health insurance or a health system per one thousand people. The principles of safety, efficacy, quality, and affordability mirror Article 12 in the ICESCR, and the "financial risk protection" language is similar to that of the UN Resolution "Transforming our world: the 2030 Agenda for Sustainable Development", and the related resolutions that follow, as the concept of financial risk protection is a component of universal healthcare.[73] As stated in the SDG 3 infographic relating to COVID-19, healthcare disruptions could reverse decades of improvements.[74] These disruptions could occur globally, but of course, are well documented in the US, where employment is coupled with health insurance coverage. The COVID-19 strategy update regarding SDG 3 is multifaceted. It includes mobilizing communities to engage with prevention, controlling cases by tracing contacts and quarantining, suppressing transmission through distancing and restrictive measures, and developing safe and effective vaccines.[75] Although this strategy reiterates what other important health organizations

[71] Ritchie, Roser, Mispy, Ortiz-Ospina. "Measuring progress towards the Sustainable Development Goals." SDG-Tracker.org, website (2018).
[72] United Nations, "SDG 3: Ensure Healthy Lives and Promote Wellbeing for All at All Ages," The goals within a goal: Health targets for SDG 3 (World Health Organization, February 3, 2017), https://www.who.int/sdg/targets/en/.
[73] General Assembly resolution 70/1. *Transforming our world: the 2030 Agenda for Sustainable Development*, A/70/1 (25 September 2015), 16, available from https://undocs.org/A/RES/70/1.
[74] United Nations Statistics, "Infographic: Good Health and Well-Being," Goal 3: Ensure healthy lives and promote well-being for all at all ages, 2020, https://www.un.org/sustainabledevelopment/wp-content/uploads/2019/07/E_Infographic_03.pdf.
[75] World Health Organization, "COVID-19 Strategy Update," COVID-19 Response, April 14, 2020, https://www.who.int/docs/default-source/coronaviruse/covid-strategy-update-14april2020.pdf?sfvrsn=29da3ba0_19.

have said, it is important to note that future pandemics and emergencies will happen, and it is important to prepare proactively in order to meet the targets and ultimately the goal.[76]

3. ORGANIZATION OF AMERICAN STATES: REGIONAL PERSPECTIVES

3.1 The Right to Life in the Organization of American States

The Organization of American States was founded officially in 1948, as States sought to form relationships with other States in the region through international law, cooperation, and without use of force. The development of the Organization of American States (OAS) Charter established that sovereignty and cooperation regarding obligations from treaties would be prioritized with the creation of the regional organization. There are thirty-five independent States that comprise the OAS along with an additional sixty nine states with observer status, and share the foundational aims of " an order of peace and justice, to promote their solidarity, to strengthen their collaboration, and to defend their sovereignty, their territorial integrity, and their independence." The OAS operates with democracy, human rights, security, and development as the purpose of the organization.[77] The same year that the OAS was established, the American Declaration on the Rights and Duties of Man was also produced (hereinafter, American Declaration).

The American Declaration became a foundational document for the OAS human rights system, which later included the Inter-American Commission, Inter-American Court, and American Convention on Human Rights. Although the American Declaration is non-binding, it has been used by the Inter-American system to hold OAS member States accountable. Together, the American Convention on Human Rights and American Declaration are relied on by the Inter-American system to uphold human rights obligations in member states and parties to the convention. Although the American Convention on Human Rights is legally binding and establishes the Inter-American Court, both contribute value to the governance of OAS states.

[76] World Health Organization, 17, "COVID-19 Strategy Update".
[77] OAS, "Organization of American States: Democracy for Peace, Security, and Development," OAS, August 1, 2009, http://www.oas.org/en/about/who_we_are.asp.

Since the US, for example, is not a signatory to the American Convention on Human Rights but is an OAS member, it is expected to comply with the American Declaration.[78]
The American Declaration states in Article I:

"Every human being has the right to life, liberty and the security of his person."

Though this language is not particularly specific, it allows for the right to life to be emphasized in all OAS member States, and reiterates the same basic concept that is later reflected in other human rights documents and treaties.[79] Likewise, the American Convention affirms this right, by stating in Article 4, the right to life:

1. Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.

2. In countries that have not abolished the death penalty, it may be imposed only for the most serious crimes and pursuant to a final judgment rendered by a competent court and in accordance with a law establishing such punishment, enacted prior to the commission of the crime. The application of such punishment shall not be extended to crimes to which it does not presently apply.

3. The death penalty shall not be reestablished in states that have abolished it.

4. In no case shall capital punishment be inflicted for political offenses or related common crimes.

5. Capital punishment shall not be imposed upon persons who, at the time the crime was committed, were under 18 years of age or over 70 years of age; nor shall it be applied to pregnant women.

6. Every person condemned to death shall have the right to apply for amnesty, pardon, or commutation of sentence, which may be granted in all cases. Capital punishment shall not be imposed while such a petition is pending decision by the competent authority.

The American Convention of Human Rights was established later than the American Declaration, in 1969, and overlaps with many of the previously mentioned standards expressed in other legal documents at the international level. It is worth noting that although these

[78] Ibid.
[79] Centre for Women Peace and Security, "American Declaration on the Rights and Duties of Man," Tackling Violence against Women, September 26, 2016, https://blogs.lse.ac.uk/vaw/regional/the-americas/the-american-declaration-on-the-rights-and-duties-of-man/.

provisions are of equal importance to uphold human rights, the US is not a signatory and thus the American Declaration must be the primary document that is relied upon.[80]

3.2 The Right to Health in the Organization of American States

Also included in the American Convention of Human Rights is Article 26, regarding progressive development[81], which states:

The States Parties undertake to adopt measures, both internally and through international cooperation, especially those of an economic and technical nature, with a view to achieving progressively, by legislation or other appropriate means, the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States as amended by the Protocol of Buenos Aires.

This reiterates the principle of progressive realization, which is also applicable in the ICESCR. The economic, social, and cultural rights are addressed in this system in the Additional Protocol to the American Convention, known as the "Protocol of San Salvador." Similar to the American Charter, the US is not a party to this protocol, yet this treaty still holds significance to all OAS member states and is justiciable to those who have ratified it. The right to health is addressed in Article 10 of the Protocol of San Salvador, which states:

1. Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being.

2. In order to ensure the exercise of the right to health, the States Parties agree to recognize health as a public good and, particularly, to adopt the following measures to ensure that right:

a. Primary health care, that is, essential health care made available to all individuals and families in the community;

b. Extension of the benefits of health services to all individuals subject to the State's jurisdiction;

c. Universal immunization against the principal infectious diseases;

d. Prevention and treatment of endemic, occupational and other diseases;

e. Education of the population on the prevention and treatment of health problems, and

[80] Inter-American Commission on Human Rights (IACHR), American Declaration of the Rights and Duties of Man, 2 May 1948, available at: https://www.refworld.org/docid/3ae6b3710.html [accessed May 2020]

[81] Organization of American States (OAS), American Convention on Human Rights, "Pact of San Jose", Costa Rica, 22 November 1969.

f. Satisfaction of the health needs of the highest risk groups and of those whose poverty makes them the most vulnerable.

This protocol is important, as it is the basis for making economic, social, and cultural rights justiciable in the Inter-American Court.[82] In the case of Pivaral Et Al vs. Guatemala, the court ruled that the inaction to extend essential health care services to people with a transmissible disease, in this case Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), was not progressively achieved for the full realization of the right to health. [83] In this case, the court ruled that the inaction to extend essential health care services to people with HIV/AIDS, a transmissible virus, was progressively achieved for the full realization of the right to health.[84] There were forty-nine applicants who were diagnosed with HIV, and were diagnosed between 1992 and 2004, until 2006 and 2007. At that time, the State started offering minimal assistance to some who had HIV.[85] Prior to that, a nongovernmental organization helped whoever they could, but this was not everyone.[86] The Court noted that socioeconomic status, including limited financial resources and low education, had also worsened their medical condition.[87] The court ruled the State was not competent in providing treatment prior to 2004 and thus violated their right to health.[88] The court also noted that, "The Inter-American Court has consistently interpreted that the right to life and humane treatment are directly and immediately linked to human health care and that 'inadequate medical care' may entail the violation thereof," indicating that the States are responsible for regulating, supervising and monitoring healthcare.[89] This is important in terms of the COVD-19 pandemic, because the spread of a communicable

[82] Organization of American States (OAS), *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador")*, 16 November 1999, A-52.
[83] Pivaral Et Al (Persons Living With HIV/AIDS) vs. Guatemala, Inter-Am. Ct. H.R. No. 2/16 Case 12.484 ¶ 87, 107 (Apr. 6, 2006).
[84] International Justice Resource Center, "Inter-American Court: State Inaction on HIV Violated Progressive Realization Obligation," *IJRC*, February 10, 2020, https://ijrcenter.org/2018/11/06/inter-american-court-state-inaction-on-hiv-violated-progressive-realization-obligation/.
[85] Pivaral Et Al vs. Guatemala, ¶ 34.
[86] International Justice Resource Center, "Inter-American Court: State Inaction on HIV Violated Progressive Realization Obligation," IJRC, February 10, 2020, https://ijrcenter.org/2018/11/06/inter-american-court-state-inaction-on-hiv-violated-progressive-realization-obligation/.
[87] Pivaral Et Al vs. Guatemala, ¶ 63.
[88] Pivaral Et Al vs. Guatemala, ¶ 119, 126-127.
[89] Pivaral Et Al vs. Guatemala, ¶ 87, 107.

disease should be mitigated with proper health insurance coverage, and by the principles set forth in Article 10, should also focus on the needs of those most vulnerable, high risk, and impoverished.

Although the US is not a party to the American Convention of Human Rights or the Additional Protocol of San Salvador, it is important to note that the right to health is in fact mentioned in the American Declaration, as the right to health is not explicit in foundational documents in the US. In the American Declaration, Article XI, right to the preservation of health and well-being, states:

Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.

This article reiterates a progressive realization, and states that everyone has the right to basic necessities, such as medical care, to the extent that is possible by public and community resources.[90] Each State has a duty to protect people within their means, but continue to take measures to improve conditions over time. This is also important in the COVID-19 pandemic, as each State's government must provide basic necessities as much as they can. During a pandemic or emergency situation, this must be prioritized, and the level of resources and care should be equivalent to the State's wealth and capacity.

4. USA PERSPECTIVE ON THE RIGHTS TO HEALTH AND LIFE

4.1 American Foundational Documents

The Declaration of Independence is an important foundational document.[91] It outlines the concept of popular self government as well as a guarantee of individual rights with the inclusion of natural rights principles.[92] It does not have the same legal weight as the US Constitution, but helps to provide useful, guiding principles for other doctrines and for modern interpretations of

[90] IACHR, "American Declaration".
[91] Thomas Jefferson, et al, July 4, 1776, Copy of Declaration of Independence.
[92] Alexander Tsesis, "The Declaration of Independence and Constitutional Interpretation," Southern California Law Review 89, no. 3 (March 2016): 372.

legal concern.[93] However, it is complementary to the US Constitution, and the Declaration of Independence has significance as it is able to render any action, policy, or law contrary to the Declaration unconstitutional. The Declaration of Independence states:

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.

The guarantees of rights are similar in both the Constitution and Declaration of Independence. Together they emphasize that government policies and practices should be weighed with the normative mandates to protect human dignity and common good of society.[94] The Declaration of Independence as a foundational document was aspirational and well-intended, but the argument could be made that it could be improved in practice. This is reflected in regards to the only mention, though indirect, to the right to health in the US Constitution, which in the preamble states:

We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America.

Similarly, the phrase "general welfare" is used in the US Constitution[95] in Article I section 8:

The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States.

Although neither explicit nor direct, the mention of "promoting the general welfare" for the foundational basis of the US is indeed an indication that the US intended to comply with this and that health is considered general welfare. Although this document was produced before modern issues and modern scientific advances, it is established that the founders of the US

[93] Ibid, 369.
[94] Ibid, 375.
[95] U.S. Const. art. 1. sec. 8. cl. 1.

prioritized this principle. Likewise, the fact that it is mentioned in the preamble signifies the importance of it. However, general welfare can be interpreted in various ways, and in fact is not interpreted through case law to be a reference to the right to health. Rather, general welfare is used to create legislation that promotes public welfare, and has been noted when referring to spending in this regard, generally in relation to taxation as authorized by congress. In relation to the right to health, the concept of "general welfare" in the preamble was used to help initiate healthcare reform in the US through the Patient Protection and Affordable Care Act (ACA). In this case, healthcare expansion to the non-elderly living in poverty was an issue of general welfare, yet the Supreme Court ruled that this Medicaid expansion, which would move progressively toward a more universal health system, was voluntary.[96] The current system did not sufficiently cover those living within 133% of the federal poverty level. As a result, and as explained by Justice Roberts in National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012), states were forced to either comply with the ACA requirements or lose all Medicaid funding, violating the Tenth Amendment. Since grants-in-aid such as Medicaid expansion resemble contracts, it is still up to each state to reject or approve of Medicaid expansion, as a loss of all Medicaid funding is over 10% of most states total revenue.[97] Although the ACA progressively took steps in creating a more universal healthcare system, not all aspects are mandatory, nor is it universal.

4.2 Amendments and Interpretation

In the United States of America, the right to life in legal documents is articulated differently than international and regional contexts. The right to life in the US is mostly used in reference to the death penalty or abortion. The right to life is mentioned in this context of the Fifth Amendment[98] to the US Constitution in Section 1:

[96] Legal Information Institute, "Spending for the General Welfare," Cornell Law School, accessed July 29, 2020, https://www.law.cornell.edu/constitution-conan/article-1/section-8/clause-1/spending-for-the-general-welfare.
[97] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).
[98] U.S. Const. amend. art. V, § 1

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a grand jury, except in cases arising in the land or naval forces, or in the militia, when in actual service in time of war or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

It is also mentioned in the Fourteenth Amendment [99], Section 1:

All persons born or naturalized in the United States and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

The US Constitution, like other national constitutions, is the document upon which laws are based on. It originated in 1792, and established the format and function of the federal government. It codified the three branches of government: executive, legislative, and judicial. These separate but equal branches were created to accomplish "checks and balances" to prevent any branch from having too much control. It also contained provisions dictating states rights. Each state has its own constitution, but must still adhere to federal law. Today, it is up to judges to interpret the Constitution in the context of modern day society, making it a "living document". Courts must take note of originalism and the intended meaning by the founding fathers, the operation of the court system in the US allows it to go to the federal court level on the state, then be brought to the specific district court of the US court of appeals, and finally, to the Supreme Court if they agree to take on the case to change the precedent and interpretation for the entire country.[100]

Although it is up to states to create more in depth legislation to protect their residents, the Constitution and the case law surrounding it does not go as far as to protect human life in the

[99] U.S. Const. amend. art. XIV, § 1

[100] Cogan, Neil H.. *The Complete Bill of Rights : The Drafts, Debates, Sources, and Origins*, Oxford University Press, Incorporated, 2015. ProQuest Ebook Central, lxiii-lxvii, https://ebookcentral.proquest.com/lib/worcesteruniv-ebooks/detail.action?docID=2059476.

same way international law explicitly aims to do. The understanding of both of these amendments is instead focused largely on legalities and the notion of the due process of law. Instead, the Fifth Amendment's emphasis and interpretation has been placed on due process and double jeopardy rather than on the right to life, as well as the Fourteenth Amendment which has been interpreted most often on privileges and immunities and equal protection under the law.[101] However, despite the US Supreme Court not often invoking the right to life, the famous case of Roe V Wade, 410 U.S. 113 (1973) is what frequently comes to mind.

4.3 Further Context

In Roe v. Wade, a woman's right to choose to terminate a pregnancy became a right to life debate for the US Supreme Court. The US Supreme Court ruled that a woman's right to privacy contained in the due process clause of the Fourteenth Amendment included the choice to have an abortion, alebit with limitations to be discussed below. This case became a landmark case and granted recognition to the notion that the constitutional right to privacy and liberty encompasses a woman's right, with consultation with her doctor, to decide to terminate her pregnancy. The court made this decision based on the premise of protecting women from severe health risks by noting that mortality rates of abortion are equally or less than as low as that of giving birth. This secured that potential life could not be forced at the expense of a woman's life or health.[102] The Supreme Court also decided that in the first trimester, restrictions on abortion are unconstitutional but that in the second and third semesters, US states could impose restrictions. Despite the Fourteenth Amendment specifying that a State cannot defy life, the Supreme Court noted that they relied on the Fourteenth Amendment's language itself to guarantee individual liberty which encompasses privacy through case law.[103] Although this case established precedent, it is still a ruling that can be overturned. Overturning Roe v. Wade is a focus of the right wing, religious groups, and Republicans today; there is also still a National Right to Life Committee anda popular annual rally year called the "March for Life." These

[101] Ibid.
[102] Roe v. Wade 410 U.S 113 (1973).
[103] Ibid.

various social circles and identities argue that abortions violate the right to life, and use it in this context.[104]

Equally relevant to the US context of the right to life is the death penalty, which is still legal at the federal level but is outlawed in certain states. It has had a inconsistent history of its own on a federal level, and in the early 20th century some US states began outlawing the death penalty. In 1972, following the decision made in Furman v. Georgia, 408 U.S. 238 (1972), the US Supreme Court stated that going through with the death penalty was "to constitute cruel and unusual punishment in violation of Eighth and Fourteenth Amendments" and suspended the practice of capital punishment.[105] Only a few years later, in Gregg v. Georgia 428 U.S. 153 (1976), the death penalty was reinstated with the justification that "the punishment of death for the crime of murder does not, under all circumstances, violate the Eighth and Fourteenth Amendments".[106] Although capital punishment was allowed, case law eventually set standards for the states to do so. Although the execution of insane persons and those with significant cognitive delay eventually became outlawed, through Ford v. Wainwright, 477 U.S. 399 (1986) and Atkins v. Virginia, 536 U.S. 304 (2002) respectively.[107] Despite all of this, the last federal use of the death penalty was in 2003, yet under the current Trump Administration, William Barr under the Department of Justice stated that the Federal Bureau of Prisons must update their protocol for the death penalty to begin reinstating the use. The Supreme Court cleared the way for the death penalty to resume, and on July 14 2020, the first federal execution was made after almost two decades.[108] To date, twenty-two states have outlawed the death penalty since the reinstatement in 1976, while twenty-eight remain supportive and active in implementing capital punishment.[109]

---

[104] Janet Benshoof. "Roe v. Wade." In *The Reader's Companion to U.S. Women's History*, edited by Wilma Pearl Mankiller. Houghton Mifflin, 1998, https://gold.worcester.edu/login?url=https://search.credoreference.com/content/entry/rcuswh/roe_v_wade/0?institutionId=5188.

[105] Furman v. Georgia, 408 U.S. 238 (1972).

[106] Gregg v. Georgia, § 1, 428 U.S. 153 (1976).

[107] Ford v. Wainwright, 477 U.S. 399 (1986). ; Atkins v. Virginia, 536 U.S. 304 (2002).

[108] CNN Editorial Research, "Death Penalty Fast Facts," *CNN*, July 15, 2020, https://www.cnn.com/2013/07/19/us/death-penalty-fast-facts/index.html.

[109] David K. Li, "Colorado Abolishes the Death Penalty," NBC News, March 23, 2020, https://www.nbcnews.com/news/us-news/colorado-abolishes-death-penalty-n1167231?fbclid=IwAR1hjNRTFEBlrRnUkclaRAAE64ap1TYZQ4z6wURJoEizetlgrzqLGzbtyYM

It is clear that the US does not explicitly recognize the right to life and health in the same way it is construed in international and OAS law. However, as members of the UN and OAS, the US does have obligations to protect the health and lives of its residents. The US is a signatory to the ICCPR and recognizes the UDHR as well as ICESCR. During a critical time such as the COVID-19 pandemic, these obligations are only more valuable and necessary. The COVID-19 pandemic should serve as a teachable moment, and States like the US should take appropriate measures moving forward to avoid repeating the catastrophic effects. These effects as well as possible solutions are detailed further in the following chapters.

5. HEALTH INEQUITY IN MINORITIES IN THE USA

5.1 Social Determinants of Health

It is apparent that there are additional boundaries to fighting a pandemic such as COVID-19 such as existing health disparities and inequalities. Although the science behind the spread of a virus is objective, there are numerous factors and forces that contribute to the way human life and human health are protected. The disparities are apparent from one State to another and from one person to another within that State, with data such as life span, chronic disease indicators, and contagious disease rates helping to provide context and a basis for comparison.[110] Poor living conditions, stemming from poverty, climate change, and urbanization perpetuate existing inequalities. Lack of economic regulation, powerful corporate interests, and lobbying significantly impact health promotion and prevention. Lack of effective policies that encompass equity in all spheres only deepen the disparities that contribute to health inequalities, such as poverty, social status, security, and inadequate access to health facilities and services.[111] Health is affected by conditions that are outside of the realm of an individual's immediate control, and "peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity" are all prerequisites of conditions that are needed to achieve optimal

[110] *Health In All Policies: Helsinki Statement. Framework For Country Action*. 2014. Finland: World Health Organization, 1. https://apps.who.int/iris/bitstream/handle/10665/112636/9789241506908_eng.pdf;jsessionid=8E1DB2EBDC6A1CAC46D2B01B50855F96?sequence=1.
[111] Ibid., 2.

health.[112] Although not all of these optimal conditions are attainable through policy solutions all at once, understanding these conditions help set the stage for future policies that can help reinforce the right to health, equitably. Most frequently discussed in the conversation about health inequalities are the social determinants of health, of which the most prominent factor is poverty. In the US, the Organization for Economic Co-operation and Development (OECD) indicators ranked the US 35 out of 37 in terms of poverty and inequality.[113]

Throughout the course of modern history, there have been documented health disparities. In the US, they have been amplified through the Civil Rights Movement, which acknowledged that segregation, discrimination, and non-inclusive policies widened the gap of attaining the highest possible standard of health. This inequality of health is seen not only with Black Americans, but to other racial and ethnic minorities through the lense of social and environmental determinants of health (SDOH). SDOH affects health outcomes, functioning, quality of life, and health risks.[114] Although personal choices do make an impact on health, it is also influenced by external factors that are difficult, impossible, or time consuming to change. Health is needed to enjoy the right to life, and conditions that impact health adversely can result in death. The Centers for Disease Control and Prevention (CDC) have defined the SDOH as, "conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes." Quality of life resources, such as access to education, also play a significant role in SDOH. [115]

In any society where there are disparities in social status, there will likely also be health inequalities that are evident. This is because SDOH are social in nature, and there are numerous determinants of health that reflect social status in society. This leaves already marginalized groups vulnerable, and enhances the inequality of opportunity to the full enjoyment of health. The consequences are often premature deaths from preventable health conditions that are

---

[112] First International Conference on Health Promotion. 1986. "The Ottawa Charter For Health Promotion". Ottawa: World Health Organization.
[113] Phillip Alston. 2020. "Statement On Visit To The USA". https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22533.
[114] Smith, David Barton. 2005. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda". *Health Affairs* 24 (2): 317-324. doi:10.1377/hlthaff.24.2.317.
[115] "Social Determinants Of Health: Know What Affects Health". 2018. *Centers For Disease Control And Prevention*. https://www.cdc.gov/socialdeterminants/index.htm.

disproportionate in prevalence among disadvantaged groups, including minorities. For example, resource distribution, such as safe housing, grocery stores, and transportation options, are often contingent on residence, and it is not the wealthy and the privileged who have difficulty accessing the resources necessary for daily needs. Likewise, public safety or lack thereof, crime, violence, and social unrest all play a role in an individual or community's physical and mental health. The same negative effect on health can be seen with negative social norms and attitudes, such as discrimination, as well as residential segregation and poor socioeconomic conditions. Social support, culture, and access to information through emerging technology also factor into the level of health achievable, generally being helpful factors if the support and culture have positive influence. Likewise, community based resources and recreational/leisurely activities provide positive impacts on people's health, but in the absence of such, can be negative. The same can be said regarding educational and career opportunities and training as well as access to health care services; the more opportunities, the more positively impactful on health attainment.[116]

As explained within the Healthy People 2020 initiative, the five main areas of SDOH include "economic stability, education, social and community context, health and health care, and neighborhood and built environment." These five areas are not irrelevant to each other, as they are interrelated to the rights to health and life. They can be manipulated through policy, which in turn can affect the enjoyment of life, or result in preventable death. The area of economic security includes employment, food instability, housing instability, and poverty. The area of education pertains to early childhood education and development, enrollment in higher education, high school graduation, and language and literacy. In the sector of social and community context, civic participation, discrimination, incarceration, and social cohesion are issues that contribute to the health of individuals and communities. Regarding health and health care, access to health care, primary care, and health literacy also play a role in identifying, treating, or preventing diseases that could result in mortality without adequate care. Lastly, in the area of neighborhood and built environment, crime and violence, quality of housing, and access

[116] "Social Determinants Of Health | Healthy People 2020". 2014. *Office Of Disease Prevention And Health Promotion*. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

to foods that support healthy eating impact those exposed to the particular conditions.[117] The Healthy People 2020 initiative aims to address these SDOH. The Healthy People Initiative recommends utilizing the "Health in All Policies" approach and using health impact assessments to drive policy on local and state levels. The "Health in All Policies" approach is perhaps best understood when reflecting on the aforementioned contributing factors and how each of these are usually determined through laws and policies.[118] Since social determinants of health create an unequal basis for minorities and other marginalized groups, it is necessary to assess how COVID-19 has exacerbated and exposed these disparities.[119]

5.2 Minorities in the USA: The Navajo Nation

One of the minority groups that has been most affected by COVID-19 are the residents of the Navajo Nation. As of June 2020, the Navajo Nation had the highest rates of COVID-19 per capita in the US. This is not easily explained on the surface, as the Navajo reservation is vast yet scarcely populated. The Navajo Nation is the largest Native American reservation in the US, and the residents, known as the Diné people, live across the 27,000 miles (43,452 kilometers) of land within the states of Utah, New Mexico, and Arizona.[120] The last US Census has this number slightly higher, at 286,731 individuals identifying as Navajo, or 332,129 people identifying as Navajo in combination with other races.[121] Today, it accounts for 36% of all Native American lands and is the largest of 278 Native American reservations in the country, completely encircling the Hopi Nation and San Juan Paiute tribes. The government of the Navajo Nation was initiated in 1923, after centuries of dealing with foreign powers, and was given federal political recognition by the US. The government created the Navajo Tribal Council (now the Navajo Nation Council), but is subject to funds and recognition at the behest of the US government.[122]

---

[117] Ibid.
[118] Ibid.
[119] Benjamin Mason Meier, Paul Henry Brodish, and Meri Koivusalo, "Human Rights Provide Justification for the Health in All Policies Approach," Health and Human Rights Journal, June 10, 2013, https://www.hhrjournal.org/2013/06/human-rights-provide-justification-for-the-health-in-all-policies-approach/.
[120] Wilkins, David E.. *The Navajo Political Experience.* (Lanham, MD: Rowman & Littlefield Publishers, 2013). Accessed June 27, 2020. ProQuest Ebook Central, xviii ; Official Site of the Navajo Nation, "Navajo Nation History," Navajo Nation Government , 2011, https://www.navajo-nsn.gov/history.htm.
[121] Wilkins, David E.. *The Navajo Political Experience,* XVII.
[122] Ibid., XVIII.

The Navajo Nation is sovereign enough to have a President and Vice President and a judiciary system with a Supreme Court that uses mostly Fundamental Law. The Navajo Nation itself became federally recognized with the Navajo Nation Treaty of 1868, which established that the Navajo people had sovereign political status.[123] Similarly to US states, there are certain powers delegated to the federal government, while retaining all others, pursuant to treaties and agreements.[124]

5.2.1 Sovereignty and Governance

There are some aspects about the Navajo government that are particularly important to understand the way in which the Navajo Nation functions. The Navajo Treaties establish the "international standing of the Nation, affirm their national sovereignty and right to self-government, provide a series of specific individual rights (e.g., right to hunt), and guarantee the Nation and her members specific property rights as well (e.g., reservation lands)."[125] They are not beholden to the US Constitution due to their specific sovereignty, and they are given power through the Constitution that grants treaty-making power, the power to make war and peace, and the property clause.[126] The Navajo Nation has their own code, but the reserved-rights doctrine protects Native Americans' rights from the US. This doctrine dictates that anything not explicitly ceded to the US was presumed to remain to the Navajo Nation.[127] The US Supreme Court has also adopted principles to interpret Native American treaties, meaning uncertainties in documents must be resolved and construed in favor of Narvie Americans. These principles help to articulate the Navajo Nation's relationship with the US government, as they must still provide certain services and conditions to the Diné to protect their rights to health and life, especially during this crisis.[128]

---

[123] General Records of the United States Government, "Treaty between the United States Government and the Navajo Indians ," National Archives Catalog (National Archives and Records Administration, 1868), https://catalog.archives.gov/id/6173067, XXI.
[124] Wilkins, David E.. *The Navajo Political Experience,* 58.
[125] Ibid.*,* 67.
[126] Ibid., 58.
[127] Ibid.*,* 61.
[128] Ibid., 62.

It should be addressed that the Navajo Nation suffers from extremely disproportionate disparities between the Diné and the vast majority of Americans, and despite the sovereignty of the Navajo Nation, the US Supreme Court establishes that tribes are domestic-dependent nations.[129] Given this, the US government has some responsibility to address the fact that the Navajo Nation suffers significantly and disproportionately from lack of running water, medical deserts, food deserts, and underlying health conditions to protect the human rights to health and life. The Navajo Nation has been the hardest hit area in the COVID-19 pandemic, and the conditions that the Diné people live under only contribute to this. As of June 9 2020, there have been 6,110 cases and 277 deaths. This is about a 3.5% infection rate among the population and a 4.5% death rate, higher than any other part of the country, including the hard hit city of New York.[130] Although Congress has passed three economic relief packages for tribal communities, the $8 billion USD allotted to Native Americans must be shared with 574 federally recognized tribes across 37 states, as well as for-profit Native Alaskan corporations. When asked about this, the President of the Navajo Nation, Jonathan Nez, stated, "We are waiting for resources to come in from the federal government. All fifty states are sovereign entities as well. We agreed through treaties that we would help each other both ways, and when we signed the treaties we gave up some lands, but there was a promise made that the federal government would help with healthcare, education, and many other things, like infrastructure."[131] In an attempt to curb the spread, a 57 hour lockdown was instituted for weekends in addition to an evening curfew, but this did not prevent thousands of Diné people from contracting the virus, leading lives to be lost. As of the beginning of August 2020, this lockdown remains in effect.

5.2.2 Exacerbated Challenges

Since contracting the virus can be deadly, prevention is key. Water is absolutely necessary for the prevention of coronavirus, as handwashing is one of the suggested ways to prevent contagion. It is estimated however that 21-32% of reservation households are not

[129] Ibid., 69-70.
[130] Arlyssa Becenti, "Nation Sees 6,110 Cases, 277 Deaths from COVID-19," Navajo Times, June 9, 2020, https://navajotimes.com/coronavirus-updates/nation-sees-6110-cases-277-deaths-from-covid-19/.
[131] CBSN Originals. 2020. *Coronavirus In Navajo Nation*. https://www.cbsnews.com/news/coronavirus-navajo-nation-running-water-cbsn-originals/.

connected to public water systems. Based on one study conducted, 79% of respondents had public water system connections, 21% did not. Although the majority of people surveyed have running water, the 21% of respondents who reported not having running water is drastically higher than the "0.5% of households nationally and 9% for American Indian tribes overall".[132] This indicates that entire families on the Navajo Nation must leave the household in order to get water from public wells on a frequent basis, posing a challenge with the 57 hour weekend lockdown. Since water is not accessible to the entire population, it is a precious resource. Water supplies must encompass not only handwashing, but cooking food, drinking water, cleaning of surfaces, and bathing, all of which help prevent the spread of COVID-19 by helping to maintain health. In a population with a high contagion rate per capita, lack of running water and public water systems in the household only create barriers for prevention of getting sick. Similarly, with many households choosing to utilize hauled water, it creates the need for families, often traditional and multigenerational, to leave the safety of their homes to seek out water.[133] This obstacle to water clearly poses not only a challenge to the right to health, but since the rights to health and life are linked so clearly during this pandemic, it also creates a challenge for the right to life.

Although healthcare in the US is vastly complex, it is straightforward for Native Americans, who rely on the US Department of Health and Human Services to provide healthcare through the Indian Health Service. The US Department of Health and Human Services has twelve regional units of the Indian Health Service (IHS), including the Navajo Area Indian Health Service. Within these units, the Navajo Area Indian Health Service has five federal units on or near the reservation. There are four hospitals on or near the Navajo Reservation with a total of only 222 beds. Luckily, the Navajo area also has seven full-time health centers providing outpatient services along with five part-time health stations, but these are not useful when dealing with the intense effects of COVID-19 that require medical intervention in order to prevent loss of life. In this case, this amount of beds is not "adequate" as described internationally in the right to health. The 222 beds are insufficient for the population, especially

[132] Grytdal, Scott et al. "Water Quality, Availability, and Acute Gastroenteritis on the Navajo Nation – a Pilot Case-Control Study." *Journal of Water and Health* 16, no. 6 (2018): 1018-1019. https://doi.org/10.2166/wh.2018.007.
[133] CBSN Originals. 2020. *Coronavirus In Navajo Nation*. ; Grytdal, Scott et al. "Water Quality", 1018-1027.

if consideration is given to emergency situations, as it should be under international law obligations.[134] Also notable is that, comparatively, the IHS is not financially prioritized when compared to other public-funded healthcare. A major issue for the functionality for the IHS is their budget, equating to about one-third of the Medicare or Veteran's Affairs budgets per capita. The lack of funding is problematic in that it makes resources more scarce, and during a pandemic, resources like medical personnel, doctors, emergency beds, and intensive care units are essential.[135]

These types of resources are dependent on the budget and are essential for the protection of life; people with severe cases of COVID-19 usually require hospitalization and medical intervention to treat the often fatal effects of the virus. The IHS' efficacy is also limited by budget as reflected in their limited locations. Due to the Navajo Nation's size and inadequate number of facilities, much of the reservation is also a medical desert, meaning that the nearest medical facilities are a notable distance away and therefore are not easy to access. In an area with mostly dirt roads, geographical distance as well as economic status poses a challenge to access of the IHS locations in order to treat COVID-19 or other life threatening illness.[136] The Diné have a median household income only half of the average in the US in general, and "one-third of all households on the Navajo Nation have incomes of less than $15,000 per year," posing another obstacle to geographical distance when transportation is costly and not publicly available.[137]

The spatial distance of health facilities only exacerbated existing accessibility problems during the first peak of COVID-19 in the US, when medical transportation for appointments had stopped, even for life saving interventions like dialysis.[138] Also important is that although the IHS is provided to Native Americans through treaty agreements, they are not covered if they receive health care from external, non-IHS providers. If IHS hospital beds on the reservation were to reach capacity due to COVID-19 and the Diné community had to seek care elsewhere, it

---

[134] US Department of Health and Human Services, "Indian Health Service," Indian Health Service: The Federal Health Program for American Indians and Alaska Natives, 2020, https://www.ihs.gov/navajo.
[135] Alan Mozes, "COVID-19 Ravages the Navajo Nation, But Its People Fight Back." *Consumer HealthDay*, June 9, 2020.
https://consumer.healthday.com/infectious-disease-information-21/coronavirus-1008/covid-19-ravages-the-navajo-nation-but-its-people-fight-back-758365.html.
[136] CBSN Originals. 2020. *Coronavirus In Navajo Nation*.
[137] Grytdal, Scott et al. "Water Quality", 1018-1019.
[138] CBSN Originals. 2020. *Coronavirus In Navajo Nation*.

is not guaranteed that an exorbitant medical bill would not result.[139] This creates not only a barrier to access health services, but also makes it easier to die from a disease like COVID-19 that could be prevented with medical intervention.

Also contributing to the Navajo Nation's dire situation in regards to COVID-19 is the fact that much of the land is a food desert. Although the residents of the Navajo Nation do their best to live off the land, the lack of public water systems has made agriculture a challenge, making adequate nutrition difficult. Water is necessary not only for personal use, but also for livestock and farming. Since lack of public water systems are a challenge for the Diné people, they must often rely on stores to purchase food. Additionally, Westernized agriculture as well as colonization have caused ecological deprivation and have deprived the Diné people of health knowledge and cultural tradition.[140] In the Navajo Nation, a territory that is larger than 10 other US states and is the same size as the state of West Virginia, or Massachusetts, New Hampshire, and Vermont combined, there are only thirteen full grocery stores. This distance creates a reliance on snack foods and fast food restaurants.[141] As Partners in Health has reported, the Navajo Nation is officially classified as a food desert. Similar to a medical desert, the term indicates scarce resources— specifically, an area lacks accessibility to fresh and nutritious foods. [142] This is reflected in the fact that 75% of the Diné people are food insecure. The prevalence of snack foods and fast food restaurants does help to feed the population, but does not help in providing fresh fruit and vegetables, which are necessary to avoid the development of underlying conditions. Throughout the years, initiatives such as the Navajo FVRx Program have been implemented to assist with the problem of food deserts, but initiatives have been unable to eradicate the issue.[143] During COVID-19, it is especially difficult for families to stay in their homes to avoid the spread while also maintaining nutrition. The poverty rate makes stocking up on food even more challenging; lack of electricity at an average rate of 10% and inability to

[139] Aaron Van Dorn, Rebecca E Cooney, and Miriam L Sabin, "COVID-19 Exacerbating Inequalities in the US," *The Lancet* 395, no. 10232 (2020): pp. 1243-1244, https://doi.org/10.1016/s0140-6736(20)30893-x.
[140] COPE, "Community Outreach And Patient Empowerment 2016 Annual Report," PDF. COPE 2016 Annual Report (COPE Project, 2017), https://www.pih.org/sites/default/files/2018-08/COPE-AnnualReport-2016.pdf, 26.
[141] CBSN Originals. 2020. *Coronavirus In Navajo Nation*.
[142] COPE, "Annual Report," 14.
[143] Ibid.

refrigerate food only intensifies this.[144] The lack of access to healthy and fresh food not only poses nutritional obstacles, but also exacerbates health conditions that shorten lifespan and worsen outcomes from COVID-19.

Underlying conditions or conditions that specifically affect cardiovascular or respiratory systems make an individual more susceptible to premature death from COVID-19. In the Navajo Nation, food insecurity only intensifies pre-existing conditions, as "1 in 5 adults has diabetes and 1 in 2 children are overweight or obese."[145] There are also increased rates of hypertension, asthma, cancer, heart and cardiovascular disease which puts residents more at risk. In general, Native Americans are, "600 times more likely to die of tuberculosis and nearly 200 times more likely to die of diabetes than other groups."[146]Access to fresh foods can help to reduce these numbers, as well as access to water and health care. In this case, SDOH visibly factor into the development of these diseases, with poverty, linguistic differences, lack of opportunity, and resource distribution all contributing to poor conditions for the Diné community.[147] The situation in the Navajo Nation revealed itself to be so disproportionate and serious in comparison to the rest of the US, that two teams from Doctors Without Borders have been dispatched to the area from April to at least June of 2020. Since nothing at this point in time can help prevent underlying conditions that increase risk of COVID-19 complications, they aim to suppress the spread of COVID-19. Jean Stowell, head of the Doctors Without Borders COVID-19 team in the US stated she intends to mitigate the spread through, "providing technical guidance to health care facilities and communities with infection prevention and control" by engaging with leaders and other actors in the community to increase health promotion and practical education. Health literacy is important in the prevention of any disease, and lack of internet access only magnifies the barrier to comprehensive information. In this time of crisis, Doctors Without Borders is

---

[144] Laurel Morales, For Many Navajos, Getting Hooked Up To The Power Grid Can Be Life-Changing, *NPR*, May 29, 2019,
https://www.npr.org/sections/health-shots/2019/05/29/726615238/for-many-navajos-getting-hooked-up-to-the-power-grid-can-be-life-changing.
[145] COPE, "Annual Report," 14.
[146] Dana Hedgpeth, Darryl Fears, Gregory Scruggs. "Indian Country, where residents suffer disproportionately from disease, is bracing for coronavirus", *Washington Post*, April 4, 2020,
https://www.washingtonpost.com/climate-environment/2020/04/04/native-american-coronavirus/.
[147] COPE, "Annual Report," 6-19. ; Matthew Raifman and Julia Raifman, "Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income," American Journal of Preventive Medicine 59, no. 1 (2020): 138, https://doi.org/10.1016/j.amepre.2020.04.003.

specifically helping the Diné community to compensate for the lack of assistance from the US government.[148]

5.3 Black Americans

Other marginalized racial groups are also suffering disproportionately from COVID-19. In the US, the structural oppression of Black Americans dating back to the foundation of the country contributes greatly to the high rates of mortality and contagion from COVID-19. In fact, data from April 2020 reveals that Black Americans have died from COVID-19 at nearly double the rate of their share of the US population than their representation in the population overall. [149] In order to understand the reasons behind these high rates, it is important to understand the extent of disadvantages that Blacks have faced in the US for centuries. Many SDOH that affect health outcomes have become more clear during this pandemic.

5.3.1 Historical Context

The US has a well known history of racial inequality, coinciding with the formation of what formerly was not even yet the sovereign US. In British colonial North America in the 1700s, the Transatlantic Slave Trade brought millions of Africans to British colonial North America. Black Americans were stigmatized, separated, and treated like living property. Chattel slavery was widespread, utilized in all 13 original colonies, and was completely legal despite the inhuman and degrading treatment, inequality, and immorality of the practice.[150] The advancement of slavery in this area created a binary across the society "...creating 'white' itself as a social and legal category."[151]

As the US expanded in territory and in economic growth, slavery also spread to all territories. The American Revolution, allowing the US to have sovereignty and independence,

---

[148] Alta Spells, Doctors Without Borders dispatched to New Mexico to help the Navajo Nation, *CNN*, May 11, 2020, https://www.cnn.com/2020/05/11/us/navajo-nation-doctors-without-borders/index.html
[149] Elise Gould and Valerie Wilson, "Black Workers Face Two of the Most Lethal Preexisting Conditions for Coronavirus-Racism and Economic Inequality," Economic Policy Institute, June 1, 2020, https://www.epi.org/publication/black-workers-covid/.
[150] David R. Roediger, *How Race Survived US History: from Settlement and Slavery to the Eclipse of Post-Racialism* (London: Verso, 2019), chap. 1, Kindle.
[151] Ibid.

shifted the ideological, economic, and political dynamics within the country. Particularly in the crop heavy industry in the southern US, slavery was prevalent. The northern US had a far more industrious and less agricultural economic reliance, and therefore mostly outlawed slavery after the American Revolution. Although the North also had this shift, the historical context to which slavery and race was understood did not change the deep ridden, strucutual racism that had prevailed for decades beforehand. Slavery continued to be practiced by most of the South and this did not stop until the end of the Civil War, even with the push a of abolition movement. Even then, the powerful simply brought up new ways to perpetuate racial inequality, exploited labor, mistreatment, and racism—all of which still affect Black Americans today.[152]

Even after the US Civil War, with the Emancipation Proclamation and Thirteenth Amendment freeing most slaves, the rights to health and life of Black Americans were ignored. In fact, Jim Crow laws legalized racial discrimination of the newly freed Black population and reinforced the inequality of African Americans in regards to all areas of rights, including economic, social, political, civil, and cultural rights.[153] Freedom from enslavement did not equate to equality; it simply evolved. The laws put into place during that time maintained the perceived lower status of Black Americans. While being prohibited from education or paid employment, laws were put into place primarily in the previously slave-rich South such as the need to pay poll taxes or take literacy tests to vote to prevent Blacks from participation and representation.[154] This prevented the practice of political participation and greatly affected the socioeconomic situation of Black Americans. As we have seen above, SDOH such as education, political participation, and employment have impacts on health.

5.3.2 Evolution of Obstacles

As progress slowly advanced for the Black and Brown communities through activism, education, and the Civil Rights Movement, the less direct, but still racist "New Jim Crow" laws

[152] Chernoh Sesay Jr., "The American Revolution, Race, and the Failed Beginning of a Nation," AAIHS, December 7 2016, https://www.aaihs.org/the-american-revolution-race-and-the-failed-beginning-of-a-nation/.
[153] Zinzi D Bailey et al., "Structural Racism and Health Inequities in the USA: Evidence and Interventions," *The Lancet* 389, no. 10077 (2017): 1454, https://doi.org/10.1016/s0140-6736(17)30569-x.
[154] Michelle Alexander, *The New Jim Crow* (New York: New Press, 2012), chap. 1, Kindle.

and policies were enacted. Most notable of these is the criminal justice system. Politicians and administrations advanced discriminatory practices through the "war on drugs", mandatory minimum sentences, as well as over-policing. These laws, along with numerous other racially coded laws, were specifically targeted at Black Americans and resulted in the incarceration of many, which then prisons could utilize these prisoners for free labor, restrict freedom, deny public services, and sustain the racist notion that Blacks are inferior, second class citizens. Today, 3% of all Black men in America are serving one year sentences or more, and Black men are incarcerated at 3-10% higher rates than White men, across all age groups.[155] Statistically speaking, as Michelle Alexander states, "the United States imprisons a larger percentage of its Black population than South Africa did at the height of apartheid."[156] With this historical context in mind, institutional racism has paved the way for the continued segregation of Black Americans, adversely affecting their rights to health and life. This is exhibited as "once you're labeled a felon, the old forms of discrimination, denial of the right to vote, denial of educational opportunity, the denial of food stamps and other public benefits, and exclusion from jury service—are suddenly legal. As a criminal, you have scarcely more rights, and arguably less respect..."[157] Needless to say, the criminal justice system also has the power to exercise capital punishment. Thus, it is not possible to separate the criminal justice system from mortality rates, underlying conditions, and overall health of Black Americans; when the criminal justice system disproportionately consists of Blacks, the ramifications of this alone adversely impact the well-being of those communities. The socioeconomic impact of the criminal justice system is also significant in terms of the rights to health and life, as in close quarters and congregate settings like prisons and jails, the spread of a potentially deadly infectious disease such as COVID-19 is rampant. Also, healthcare is not a right for prisoners, and depending on the laws in each US state, utilization of care is not free, even during a pandemic. This can make a prison sentence a death sentence.[158]

---

[155] Zinzi D Bailey et al., "Structural Racism and Health Inequities in the USA," 1455.
[156] Ibid., chap. 5-8.
[157] Ibid., chap. 4.
[158] Brain Wyant and Harner, Holly. (2018) "Financial Barriers and Utilization of Medical Services in Prison: An Examination of Co-payments, Personal Assets, and Individual Characteristics," *Journal for Evidence-based Practice in Correctional Health*: Vol. 2 : Iss. 1 , Article 4.
https://opencommons.uconn.edu/jepch/vol2/iss1/4

Despite decades of attempted progress with racial equity, Black Americans are still subjected to segregated, poor, and/or unequal conditions and services in education, housing, labor, and healthcare. In the Jim Crow era, segregated public schooling was commonplace throughout the country. Despite improvements in making public schooling more inclusive, it is still based upon zip code and tax income, creating an achievement gap in education. School attendance based on residency affects access to quality schools, as funding of schools in lower income areas that are often in communities of color have less resources and are less effective than those in affluent neighborhoods. The lack of quality education then is perpetuated generationally, with achievement gaps resulting in residency in lower income neighborhoods where schools are underfunded and under-resourced. This achievement gap has been persistently documented, as, "administered by the U.S. Department of Education since the 1960's, the National Assessment of Educational Progress shows a clear and persistent discrepancy in educational achievement among student groups, with African American, Latino and American Indian student outcomes at the lowest levels of achievement."[159] This disparity continues well beyond primary and secondary schooling, with comparisons between majority White and majority Black neighborhoods revealing Black neighborhoods tend to have two to three times lower median rates of bachelor's degrees.[160] Since education is supposed to provide purpose, dignity, and also success beyond schooling, poor quality education can be a negative SDOH, and also have impacts on finances, job prospects and advancement, and can further deepen the divide with other resources such as quality food, housing, and healthcare.

The Black American poverty rate impacts housing and residency, and housing is an important SDOH. It also is linked to risk factors of severe cases of COVID-19. More equitable housing policies would help to address this, but housing is also managed at the state and municipal level, making an unequal, unjust condition even more dissimilar with lack of federal

[159] Charisse Cowan Pitre. "Improving African American student outcomes: understanding educational achievement and strategies to close opportunity gaps." *The Western Journal of Black Studies* 38, no. 4 (2014): 209+. *Gale Academic OneFile Select*. https://gold.worcester.edu:3771/apps/doc/A400784999/EAIM?u=mlin_c_worstate&sid=EAIM&xid=b9ef8b23.

[160] Patrick Sharkey, Keeanga-Yamahtta Taylor and Yaryna Serkez, "The Gaps Between White and Black America, in Charts", *NYT*, June 19, 2020, https://www.nytimes.com/interactive/2020/06/19/opinion/politics/opportunity-gaps-race-inequality.html?fbclid=IwAR3PRiJMSTjrMrMTXKnXFtNFg4wTs_WlQKqVhfjwyCq-Wqr2levz4ZFv_Vc.

policy.[161] A major reason that the Black community faces housing injustice and discrimination is redlining, which is the illegal but still relevant discriminatory practice by real estate lenders or insurance companies who deem certain areas high risk investments and refuse to give mortgages to those who want to buy properties in the "high risk" designated areas or to give building improvement loans to the current owners, regardless of strong credit qualifications. This practice allowed housing segregation and legally exclusionary zoning laws and is still embedded in neighborhoods in the US today. Redlining was legally prohibited after the Fair Housing Act of 1968, there is still racial profiling in the banking and insurance industries, widening the racial wealth gap and also ensuring limited mobility of residence.[162] Median homeownership rates remain at about 70%, but among the Black community, the rates are often below 50%.[163]

Not only does housing inequality deepen the divisions of health and wealth, but it also reflects and perpetuates environmental injustice. In Massachusetts for example, a Boston University School of Public Health analysis links communities of color to the highest rates of COVID-19. It is no coincidence that areas with high rates of COVID-19 are the poorest and most polluted.[164] This university also created a tool, identifying risk factors for COVID-19 on a map, reflecting housing and community related risks which include "adults with asthma, living in poverty, quarantine vulnerability, internet access, exposure to air toxins, Superfund sites, polluted waters and other environmental risk factors."[165] When housing segregation, environmental racism, poverty, asthma rates, and employment in essential worker sectors affect Black communities more, this tool will reflect that Black Americans are at a higher risk of getting sick. COVID-19 aside, life expectancy in predominantly Black neighborhoods is several years lower than predominantly White neighborhoods— up to 10 years lower.[166] Black Americans also comprise 40% of the homeless, making social distancing or staying home

---

[161] Chester Hartman, Gregory Squires. *From Foreclosure to Fair Lending : Advocacy, Organizing, Occupy, and the Pursuit of Equitable Credit*. (New York, NY: New Village Press, 2013), foreword, Ebook. http://gold.worcester.edu:2065/login.aspx?direct=true&db=e000xna&AN=1698112&site=ehost-live&scope=site.
[162] Vincent Parrillo 2008. *Encyclopedia of Social Problems*. Thousand Oaks, Calif: SAGE Publications, Inc., 760. http://gold.worcester.edu:2065/login.aspx?direct=true&db=e000xna&AN=474380&site=ehost-live&scope=site.
[163] Sharkey, "White and Black America."
[164] Ibid., 3.
[165] Healey, Maura. "COVID-19's Unequal Effects In Massachusetts," PDF. Office of Attorney General Maura Healey. Mass.gov, May 12, 2020, 6-7. https://www.mass.gov/doc/covid-19s-unequal-effects-in-massachusetts/download.
[166] Sharkey, "White and Black America."

impossible.[167] COVID-19 helps to reveal the existing disparities, but also worsens them. Communities of color tend to live in closer spatial proximities, allowing infectious disease to spread easier, in addition to the environmental factors that also reinforce a disadvantaged, unequal social system for these communities.[168] It is the duty of the State to protect the lives of all people in a non-discriminatory way, and by continuing to allow this injustice, both lives and livelihoods are being lost.

In terms of employment, Black communities are unemployed and underemployed at disproportionately higher rates, and also suffer from poverty more, making communities of color more vulnerable and susceptible to COVID-19.[169] Black workers are more likely to be categorized as workers that can continue employment from home, and are much more likely to fall in the category of "essential workers" thus requiring health risks and endangerment of themselves, their families, and communities, in order to go to the places of employment, outside the safety of their homes.[170] They are also more likely to be front line workers, in the industries of warehouse, trucking, grocery, postal service, convenience and drug stores, public transit, child care, social services, and health care.[171] These sectors of labor are usually less well paid, resulting in a wage gap; Black workers are paid 82.5 cents for every dollar earned by a White worker, on average. [172]Additionally, the median income for Black households is lower, with White households income averaging 70% higher in 2018.[173] Given this, it is unsurprising that Black workers are more likely to face financial insecurity, particularly in the era of COVID-19. This is reflected in data gathered in April 2020 from the Economic Policy Institute, which notes that "the Black unemployment rate is 16.7%, compared with a White unemployment rate of

---

[167] Joy Moses, "Demographic Data Project: Race, Ethnicity, and Homelessness," PDF. Homelessness Research Institute , July 2019, https://endhomelessness.org/wp-content/uploads/2019/07/3rd-Demo-Brief-Race.pdf.
[168] Cato Laurencin and Aneesah Mcclinton, "The COVID-19 Pandemic: a Call to Action to Identify and Address Racial and Ethnic Disparities," *Journal of Racial and Ethnic Health Disparities* 7, no. 3 (April 18, 2020) 398-402, https://doi.org/10.1007/s40615-020-00756-0.
[169] Janelle Jones, "Black Unemployment Is at Least Twice as High as White Unemployment at the National Level and in 12 States and D.C" Economic Policy Institute, October 30, 2018, https://www.epi.org/publication/2018q3_unemployment_state_race_ethnicity/.
[170] Gould, "Black Workers."
[171] Ibid.
[172] General Assembly resolution 63/332, *Report of the Special Rapporteur on extreme poverty and human rights on his mission to the United States of America*, A/63/332 (26 August 2008), 14, available from https://digitallibrary.un.org/record/1629536?ln=en.
[173] Gould, "Black Workers."

14.2%."[174] This disparity is not limited to this time of crisis, as in 2019, the poverty rate was 3.7% in general in the US.[175] However, the White unemployment rate was "3.0% and the Black unemployment rate was twice as high… an average of 6.1% over the year," revealing a stark disparity.[176] All of these factors marginalize Black people and contribute to the experience of higher poverty rates. The US has no shortage of poverty, with an estimated 38.1 million people living in poverty in 2018 [177] — and of this number, it is significant that Black Americans are 2.5 times more likely to experience poverty than White Americans.[178] Poverty is also correlated with a lack of healthcare, since the US healthcare system generally couples full-time employment with health insurance coverage.

Although in the US, health insurance coverage can be used to explain racial or ethnic disparities to an extent, there are several contributing factors that lead Black Americans to be more likely to die from COVID-19. Of these, health insurance coverage, underlying conditions, and the quality of the medical system once founded in slavery and the Jim Crow era can best be used to explain these differences. Firstly, a reliable way to measure efficacy of medical care is to assess whether people have a regular source of medical care, generally through a primary care physician (PCP) in order to receive primary, preventive, and specialty care services. Black communities have lower rates of a regular source of medical care, and this is mostly caused by lack of access to health insurance, but is not the only factor. Black Americans are often uninsured due to unemployment or employment at jobs with low wages or lack of benefits, making health insurance coverage unaffordable or unavailable completely. [179] As of 2016, people that identified as Black in US Census Bureau data revealed a 10.5% uninsurement and a 10.6% uninsurement rate in 2017.[180] Black Americans are more likely to die from cancer, diabetes, or

---

[174] Ibid.
[175] U.S. Bureau of Labor Statistics. "Unemployment Rates for States, Annual Averages." Local Area Unemployment Statistics, March 4, 2020. https://www.bls.gov/lau/lastrk19.htm.
[176] Gould, "Black Workers."
[177] Alston, "Statement On USA."
[178] Alston, "*Special Rapporteur on extreme poverty,"* A/63/332.
[179] Marsha Lillie-Blanton and Catherine Hoffman, "The Role Of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care," *Health Affairs* 24, no. 2 (2005): pp. 398-408, https://doi.org/10.1377/hlthaff.24.2.398.
[180] Edward Berchick, Emily Hood, Jessica Barnett, "Health Insurance Coverage in the United States: 2017," Current Population Reports: U.S Census Bureau, September 2018, 15-18. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.

heart disease; they are less likely to be given cardiac care, stroke, AIDS, or cancer treatment that is appropriate, all of which not only cause death if untreated, but also serve as a risk factor for COVID-19 complications. This health care inequity is due to several things— being less likely to receive the best treatment, being given effective medical supervision in a hospital setting after surgery, or being less likely to receive desirable treatments than White Americans.[181] These healthcare disparities, along with all other structurally discriminatory SDOH that are still prevalent in American society, also explain the underlying conditions more commonly found in Black individuals.

As could be conceived given the above analysis, Black Americans have more underlying conditions that make this population more susceptible to COVID-19 related illness and mortality. Black Americans are more likely than Whites to experience infant mortality, high blood pressure, heart disease, kidney disease, diabetes, stroke, respiratory illness, or HIV.[182] Among these illnesses, respiratory, cardiac related illnesses, and immunocompromised related illnesses are more often experienced among Black Americans, which predispose them to become seriously ill and more likely to die of COVID-19 related complications. It is important to note that due to the discriminatory and unequal economic and social conditions, Black Americans are more likely to die younger from all health related ailments than their White counterparts; in this regard, COVID-19 is no different.[183] To be concise, Black Americans suffer and die disproportionately from many diseases while suffering disproportionately from structural disadvantages, perpetuating the legacy of inequality.

6. TAKING NECESSARY STEPS TO UNIVERSAL HEALTH COVERAGE

It would be optimal, for the sake of a pandemic such as COVID-19 and to protect people's rights to health and life, to promote policy approaches that encompass positive SDOH such as housing, better sanitation, respect for worker's rights, equitable education, and criminal

[181] Khiara M. Bridges, "Implicit Bias and Racial Disparities in Health Care," *Human Rights Magazine*. 43, no. 3 (November 19, 2018).
[182] National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), "African American Health," Centers for Disease Control and Prevention (CDC.gov, July 3, 2017), https://www.cdc.gov/vitalsigns/aahealth/index.html ; Laurencin, "COVID-19 Disparities."
[183] NCCDPHP, "African American Health."

justice reform, policies that are addressed through an equal, inclusive healthcare system. While the previously mentioned factors greatly disadvantage the lives and health of marginalized and vulnerable groups, implementing policies to resolve them involves extensive legislative power. Creating legislation to address all SDOH is significantly more difficult than the implementation of a universal, single-payer healthcare system to help with universality of the rights to health and life. A universal healthcare system contrasts directly to the current US healthcare system. It is therefore imperative to understand the healthcare system as it stands, analyze universal, single-payer healthcare along with a current proposal for it, and evaluate why this policy is crucial for better enjoyment of the rights to health and life, particularly during the COVID-19 pandemic.

6.1 The Current System

As it stands, the US healthcare system is provided either by the public and/or the private sector. Private healthcare is primarily employment-based and is partly paid for by the employer, while the employee has out-of-pocket expenses. This differs from public insurance, which includes Medicare, Medicaid, Tricare, the Veteran's Administration, and the State Children's Health Insurance Program.[184] These public insurance options are available contingent upon meeting the criteria and requirements.[185] The private healthcare system is based on insurance that is primarily employer-based, with the employer paying a portion of a premium, while the employee pays the remainder of the premium, out-of-pocket payments and deductibles for health care services, medical supplies, and pharmaceuticals.[186] The US healthcare expenditure is more than any other country, at 18% of its GDP, yet public health indicators reveal that the US falls

[184] These health insurance options are for those who qualify as military personnel, veterans, disabled, low-income, elderly, and families in need with dependent children. There are onerous conditions, making public options not widely available.
[185] Colton, David. 2019. The Case for Universal Health Care. Atlanta, GA: Clarity Press, 96. http://gold.worcester.edu:2065/login.aspx?direct=true&db=nlebk&AN=2240167&site=ehost-live&scope=site.
[186] Samuel L Dickman, David U Himmelstein, and Steffie Woolhandler, "Inequality and the Health-Care System in the USA," *The Lancet* 389, no. 10077 (2017): 1432-1433. ; Panel on Understanding Cross-National Health Differences Among High-Income Countries, Committee on Population, Division of Behavioral and Social Sciences and Education, National Research Council, Board on Population Health and Public Health Practice, and Institute of Medicine. U. S. Health in International Perspective: *Shorter Lives, Poorer Health*. Washington, D.C.: National Academies Press, 2013. Accessed June 10, 2020. ProQuest Ebook Central, 106. https://ebookcentral.proquest.com/lib/worcesteruniv-ebooks/reader.action?docID=3379143&query=

short compared to other countries in regards to preventable death and overall life expectancy.[187] Although the ACA[188] made progress with healthcare reform, there are numerous shortcomings in the legislation. The ACA expanded Medicaid coverage in the US states that accepted Medicaid expansion, yet there were still 27 million Americans without insurance in 2017.[189] In May, in the midst of the COVID-19 pandemic, there was a 13.3% unemployment rate, 9.7% higher than in May 2019, meaning that the majority of workers that relied on their employers for health insurance.[190] Since COVID-19 requires medical intervention in severe cases, employment-based health insurance has resulted in millions of people without healthcare during a pandemic, and even those who qualify for public insurance will have a gap in coverage. COBRA[191] is an option that allows people who have lost their jobs to continue with health benefits for limited periods of time under certain circumstances, but it is costly at a time when financial security is already in crisis and is only a temporary option.[192]

Since cost is one of the most prohibitive factors in regards to access to care, affordability is an enormous barrier to some people. As it stands, healthcare requires a significantly smaller share of income from the wealthy than the poor, which not only magnifies existing inequalities in disposable income but also leads to forgone care, leading to more serious and costly health conditions in the future.[193] Many of these underlying conditions have proven to worsen COVID-19 and impact health outcomes. In a country with the world's highest healthcare expenditures, the institution of healthcare perpetuates income inequality; the Gini coefficient[194]

---

[187]Alison Galvani et al., "Improving the Prognosis of Health Care in the USA," *The Lancet* 395, no. 10223 (2020): 524, https://doi.org/10.1016/s0140-6736(19)33019-3.

[188] The ACA made it more difficult for insurance providers to deny coverage to people for pre-existing conditions. It created a mandate to expand the insurance risk pool and reduce costs. It set up a marketplace for people to shop for different plans so they weren't stuck only with the plan provided by their employer.

[189] Dickman, Himmelstein, Woolhandler, "Inequality and the Health-Care System," 1433.

[190] US Department of Labor, "State Employment And Unemployment — May 2020," Bureau of Labor Statistics, June 19, 2020, https://www.bls.gov/news.release/pdf/laus.pdf.

[191] COBRA is a healthcare option for those with a gap in coverage, but it is expensive, requiring individuals to pay the entire premium. To qualify, an individual must have been covered by group insurance prior to the qualifying event. An employer does not contribute, meaning the cost burden falls on the individual at a time when there is likely already hardship from reduced hours, unemployment, etc. It is a complex, costly, temporary coverage option.

[192]US Department of Labor, "Continuation of Health Coverage (COBRA)," Health Plans and Benefits, Accessed July 2020, https://www.dol.gov/general/topic/health-plans/cobra.

[193] Galvani et al., "Improving Health Care," 530. ; Dickman, Himmelstein, Woolhandler, "Inequality and the Health-Care System," 1435-1437.

[194] The Gini coefficient is a commonly utilized calculation that provides an index to measure economic inequality.

has revealed the US to be more unequal than all but three other countries in the OECD, making the cost sharing aspect of US healthcare impact the vulnerable the hardest.[195] Though the ACA capped out-of-pocket expenses to an extent[196] medical bills are serious contributors to household debt and bankruptcy and account for half of all unpaid debts that are sent to collection agencies.[197] Costs are exorbitant, and as of 2011, 42% of Americans said they had cost related problems preventing access to care.[198] The current healthcare system and its tendency to create financial catastrophe has been widening the life expectancy gap between the rich and poor since the 1980's, resulting in a doubling of the WHO definition of extreme poverty since the 1990's.[199] Affordable health care would have prevented nearly 10 million Americans from qualifying as below the poverty line.[200] These costs deter people from getting the attention and care necessary to prevent and mitigate underlying conditions, and also serves as a barrier to high quality care as the inconsistency of employment-based healthcare, low physician density, and financial boundaries limit access to primary care doctors and regular health providers.[201] Health care costs are not only burdensome for patients, but also incentivize cheaper, short-term options in private insurance companies; hospital beds per capita is lower in the US than most OECD States as it is cheaper to incentivize outpatient services.[202] In order to mitigate the COVID-19 pandemic, legislation has been signed into law. The Families First Coronavirus Response Act, Paycheck Protection Program and Health Care Enhancement Act, and Coronavirus Aid, Relief, and Economic Security Act (FFCRA, PPPHCEA, and CARES Act) aim to encourage COVID-19 testing by requiring more transparency of costs, especially for diagnostic testing and for health providers. The US government has also allocated some funds for the COVID-19 pandemic, but it is unclear if these funds will be drained or the legislation will expire before the panemic comes to an end. Although there is financial risk protection for those without insurance, this is limited

[195] Ibid, 1431.
[196] For more information, the ACA is available at http://housedocs.house.gov/energycommerce/ppacacon.pdf.
[197] Ibid, 1436-1437.
[198] Panel on Understanding Cross-National Health Differences Among High-Income Countries, "Shorter Lives, Poorer Health", 114.
[199] Dickman, Himmelstein, Woolhandler, "Inequality and the Health-Care System," 1431-1432.
[200] Ibid, 1437.
[201] Panel on Understanding Cross-National Health Differences Among High-Income Countries, "Shorter Lives, Poorer Health", 115.
[202] Ibid, 116.

to only the uninsured and only specifically for COVID-19. Private insurers, in comparison, still have the discretion of which services for COVID-19 they cover and for what out-of-pocket cost.[203] The history of uninsurance and underinsurance discourages utilization of health care, even in a time of crisis and even with the current legislative protections for the uninsured. The legacy of uninsurance and medical debt crises persist, so avoidance of the healthcare system is still prevalent.

In the US, lack of health insurance and underinsurance are commonplace problems. Although underinsurance does not have a standard definition, it is best defined as insufficient insurance coverage that could create financial distress upon receiving care, which in turn may make patients despondent and reluctant to seek care.[204] Those that are uninsured have a greater obstacle to care and often cannot access care when needed. In the case of both uninsured and underinsured Americans, amenable mortality is high, as patients forgo medical visits, tests, treatments, and medications because of cost.[205] Many physicians accept only patients with certain "in-network" insurance. "In-network" care refers to health care providers who have contracts with the insurance company, and have pre-negotiated prices. Depending on the state, an individual could be turned away by a physician depending on their insurance provider, for both private and public insurance sectors. Often, government subsidized insurance companies are among the most limited, with set reimbursement rates for those patients that are less profitable than private insurance.

An example of an individual being turned away did become news at the beginning of the COVID-19 outbreak, when a teenager who had tested positive for the virus sought care for respiratory and cardiac distress was denied care due to lack of health insurance and died as a result.[206] If a patient with a specific private insurer seeks care from a health care provider that is deemed "out of network", the entire payment for the bill will fall onto the patient with no contribution from their insurer, unless there are extraordinary, pre-approved circumstances. For

---

[203] Health Resources and Sources Administration, "COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured," Official website of U.S. Health Resources & Services Administration, June 12, 2020, https://www.hrsa.gov/coviduninsuredclaim.
[204] Dickman, Himmelstein, Woolhandler, "Inequality and the Health-Care System," 1434.
[205] Ibid, 1432.
[206] Janelle Griffith, "Teen whose death may be linked to coronavirus denied care for not having health insurance," *NBC News*, June 9, 2020.

those that seek services without insurance coverage at all, the cost must also be fully covered, forcing Americans to cut back on food and other necessities to life.[207] This restriction of providers is done to reduce premium costs by private plans, despite the barrier to access to care it creates.[208] Equally problematic is that those struggling with health insurance issues are less likely to have a regular or primary care physician, and "coordination of primary care with public health suggests that combinatory efforts can lead to improvements in the management of chronic diseases, control of communicable diseases, and in maternal and child health," all of which are important, but particularly so during a contagious pandemic.[209] Access to primary care also allows for early detection of conditions that would be fatal if left untreated, and in this pandemic, untreated underlying illness directly correlates to deadly complications from COVID-19.[210] All of these disadvantages under the current US healthcare system perpetuate inequality and prioritize the lives of those with economic security and career stability, making the case for universal, single-payer healthcare a more comprehensive, accessible, and proactive policy approach.

6.2 Universal Health Coverage

As it stands in the US, the current healthcare system is not optimal for full enjoyment of the right to life or health, and should be reformed in order to be proactive and prepared for the next emergency situation. Universal healthcare is as straightforward as the name implies. Universal healthcare (UHC) is defined by the WHO as, "ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship".[211] UN experts have noted that during the COVID-19

[207]Dickman, Himmelstein, Woolhandler, "Inequality and the Health-Care System," 1432.
[208] Ibid, 1433.
[209] Leiyu Shi, "The Impact of Primary Care: A Focused Review ," Scientifica (Hindawi Publishing Corporation, September 27, 2012), 6, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/pdf/SCIENTIFICA2012-432892.pdf.
[210] Ryan Barber et al., "Healthcare Access and Quality Index Based on Mortality from Causes Amenable to Personal Health Care in 195 Countries and Territories, 1990–2015: a Novel Analysis from the Global Burden of Disease Study 2015," *The Lancet* 390, no. 10091 (2017): 242, https://doi.org/10.1016/s0140-6736(17)30818-8.
[211] World Health Organization, "Universal Health Coverage," The Global Health Observatory, accessed July 14, 2020, https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major/GHO/universal-health-coverage.

pandemic, private and public insurance as well as scarcity of resources are not valid justifications for ignoring the right to health during this time, and stated that everybody has the right to life saving interventions with the responsibility falling upon the governments. [212] Although there is legislation in the US currently to ensure that any COVID-19 related treatment will protect against financial risk for the uninsured, this is the first time in modern US history that any such legislation has been created for this group of people and a known disease. Additionally, there is no guarantee that the country will not exceed the amount of money designated for such costs, with cases increasing exponentially, and patients may still have mandatory co-payments, deductibles and percentages of the bill. This varies by health insurance provider. Payment for COVID-19 still requires significant bureaucratic obstacles, as one patient that was sent $1.1 million USD in bills must still fight with their insurance company, to ensure as much of the bill is paid as possible. [213]

Importantly, the laws relating to healthcare set forth during the COVID-19 pandemic are aimed to help provide financial relief, in order to not disincentivize people from seeking care against a contagious virus that affects the health of everyone else.[214] Since these laws are intended to provide financial relief and do have bipartisan support, the notion that more affordable medical care, when necessary, allows for financial risk protection is established. However, the connection to having this financial protection always along with a reduction of underlying conditions that make people susceptible to sickness has not been established, although it is clear. Hence, it is important to understand that this financial risk protection would be beneficial at all times, and not just during an emergency. The UN has stated during this pandemic that UHC is imperative to be able to reach those who are vulnerable, prevent discrimination and the spread of the virus, as well as increase preparedness. COVID-19 has

[212] UN Officer of The High Commissioner For Human Rights, "No Exceptions with COVID-19: 'Everyone Has the Right to Life-Saving Interventions' – UN Experts Say," News and Events, accessed July 14, 2020, https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25746.
[213] Ross Barkan, "A $1.1m hospital bill after surviving the coronavirus? That's America for you," *The Guardian,* June 16, 2020, https://www.theguardian.com/commentisfree/2020/jun/16/coronavirus-hospital-bill-healthcare-america.
[214] U.S. Department of the Treasury, "The CARES Act Works for All Americans," The CARES Act Works for All Americans | U.S. Department of the Treasury, July 17, 2020, https://home.treasury.gov/policy-issues/cares.

negatively impacted people's lives and livelihoods, adversely affecting their social and economic situations; to protect the rights to health and life, UHC is of utmost importance.[215]

UHC has been an important goal for many UN representatives and bodies for years. Prior to Michelle Bachelet's role as High Commissioner for Human Rights, she had stated, "UHC would bring a greater focus to the equitable distribution of access to health, with the advantage of it being relevant for all countries, rich and poor. At the same time, it would bring attention to a set of system-level constraints that need to be addressed and the priorities that must be set to scale up access to quality health services with financial protection for all."[216] This quote is indicative of the core argument for UHC; in a country with glaring inequality, there must be systemic reform to help address all challenges that we face as humankind. This pandemic will not be the last emergency or crisis, and therefore, a more universal system will help to counteract many of the unequal policies and legacies that the US is already grappling with. This is why UHC has been a focal point in both Sustainable Development Goals and in UN Resolutions, specifically, UN General Assembly Resolutions 67/81 "Global Health and Foreign Policy", Resolution 70/1 "Transforming our world: the 2030 Agenda for Sustainable Development", Resolution 72/139 "Global Health and Foreign Policy: Addressing the Health of the Most Vulnerable for an Inclusive Society", and Resolution 74/2, "Political Declaration of the High-level Meeting on Universal Health Coverage."

Resolution 67/81 acknowledges that the numerous "underlying determinants of health and risk factors of both non-communicable and communicable diseases" are social and economic policy issues, and recognizes the importance of universal coverage in national health systems through primary health care and social protection mechanisms, to provide access to health services for everyone, in particular for the poorest in the population.[217] This resolution also "recommends to include universal health coverage in the discussions on the post-2015

---

[215] United Nations, "COVID-19 and Human Rights: We Are All in This Together," Victims of Terrorism Support Portal, April 2020, 4 https://www.un.org/victimsofterrorism/sites/www.un.org.victimsofterrorism/files/un_-_human_rights_and_covid_april_2020.pdf.

[216] Julio Frenk, Steven Hoffman, and Michelle Bachelet. "Governance and Leadership for Health." Essay. In *"To Save Humanity": What Matters Most for a Healthy Future*, 22. New York, NY: Oxford University Press, 2015.

[217] General Assembly resolution 67/81. *Global health and foreign policy*, A/63/332 (12 December 2012), 3, available from https://undocs.org/A/RES/67/81.

development agenda in the context of global health challenges."[218] Resolution 70/1 establishes the SDGs and also prioritizes financial risk protection, access to essential health services as well as affordable, safe, effective, and quality essential medicines and vaccines, with the goal of UHC by 2030. This resolution also includes a target to end the epidemics for communicable diseases. [219] Resolution 72/139 focuses on addressing the health of the poor, marginalized, and vulnerable, emphasizing equal access to care, participation of all throughout the UHC process, and a people-centered and community-based health service system based on human rights.[220] This resolution also established a UN High-Level Meeting would be held during the UN General Assembly specifically for UHC, which became very important in light of COVID-19.[221] The UN High-Level Meeting in September 2019 resulted in a political declaration to UHC, Resolution 74/2, which was inspired in part by the UHC2030 movement and SDG 3.

From this Political Declaration of the High-Level Meeting of UHC in combination with UHC2030,[222] there are six key "asks" in order to make UHC a reality.[223] These "asks" reflect both the need for UHC as well as the commitment described in Resolution 74/2.[224] These commitments include ensuring political leadership beyond health, leaving no one behind, regulating and legislating, upholding quality of care, investing more and better, and moving together, with the key targets of access and financial risk protection, resource mobilization, public spending on health, and health workforce.[225] Important in ensuring political leadership

---

[218] Ibid, 6.
[219] General Assembly resolution 70/1. *Transforming our world: the 2030 Agenda for Sustainable Development*, A/70/1 (25 September 2015), 16, available from https://undocs.org/A/RES/70/1.
[220] General Assembly resolution 72/139. *Global health and foreign policy: addressing the health of the most vulnerable for an inclusive society,* A/72/139, (12 December 2017), 8, available from https://undocs.org/A/RES/72/139.
[221] Ibid, 6.
[222] UHC2030 is an international health partnership that aims to achieve UHC worldwide by 2030 as articulated in target 3.8 in SDG 3. Some of their main goals include achieving financial risk protection from health costs, quality services, expansion of primary health care, public financing, and equitable health systems. The WHO and World Bank provide support and coordination globally, regionally, and nationally. The US is a member of UHC2030, as are more than 60 other countries.
[223] UHC 2030, "Key Targets, Commitments & Actions," United Nations High-level Meeting On Universal Health Coverage In 2019, December 2019, 1, https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/UN_HLM/UHC_key_targets_actions_commitments_15_Nov_2019__1_.pdf.
[224] General Assembly resolution 74/2. *Political declaration of the high-level meeting on universal health coverage,* A/RES/74/2, (10 October 2019), 12, available from https://undocs.org/en/A/RES/74/2.
[225] UHC 2030, "Key Targets, Commitments & Actions." 1.

beyond health to transition to UHC is strengthening the capacity of national leadership to prioritize health promotion, disease prevention, health communication and literacy, and strategic leadership and coordination at the highest political level.[226] All of these would certainly be helpful during the COVID-19 pandemic, when language, geographical distance and physical access, literacy, culture, and employment status can prevent access to or advice from a physician providing treatment, testing, or information.[227] These barriers already tend to be seen within vulnerable, marginalized populations and help to explain why this crisis is taking their lives disproportionately. Additionally, the lack of national leadership in regards to health has been devastating. Although the CDC and other governmental health agencies have given proper advice, as of July 2020, the Trump Administration has not issued a nationwide stay-at-home order or quarantine, nor required or exemplified mask-wearing in public. An unenforced social distancing campaign was only launched in mid-March, after ignoring initial security briefings about COVID-19 for months. The administration did not coordinate with US states, nor did it offer clear and consistent messaging, or adjust access barriers or current gaps in the healthcare system to prevent the spread, other than through the aforementioned acts that served as a financial safeguard were passed through Congress, eventually signed into law.[228]

Another classification of commitments from the UHC2030 Movement and Resolution 74/2 is leaving no one behind. Within this goal of equity to quality services with financial protection is to address the physical and mental health needs of the marginalized and eliminate financial barriers to access and reduce financial risk and hardship. Leaving no one behind means equity in responding to unmet needs and training the health workforce to be sensitive to different cultures and specific needs of certain populations, as well as protecting the poor and vulnerable from financial risk. Equitable distribution of and access to quality, safe, affordable, and essential medicines, vaccines, diagnostics, and health technologies are also important parts of the political declaration. During COVID-19, trust in science and the government is imperative in controlling the outbreak, and a culturally competent and diverse workforce under UHC would increase trust

[226] Ibid, 3.
[227] World Health Organization, "Primary Health Care on the Road to Universal Health Coverage," 2019 Monitoring Report, 2019, 86-87, https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1.
[228] Cameron Peters, "A Detailed Timeline of All the Ways Trump Failed to Respond to the Coronavirus," *Vox,* June 8, 2020, https://www.vox.com/2020/6/8/21242003/trump-failed-coronavirus-response.

in the healthcare system, as would clear and consistent messaging.[229] Although health care workers are likely to provide factual messaging, this messaging may be limited to those with insurance and those with regular primary care providers, further marginalizing the unemployed and vulnerable groups, deferring to local, state, and national responses which have been inconsistent and uncoordinated.

In terms of the regulation and legislation aspect to achieve UHC, the goal to "improve availability, affordability, and efficiency of health products by increasing transparency of prices" remains consistently important for anyone that receives health services, especially when out-of-pocket costs per capita averaged $1126 USD in 2017.[230] COVID-19 and any future viral pandemics of this magnitude will likely require vaccine development, production, and distribution. At this time, the development of a COVID-19 vaccine has billions of dollars at stake, and even if the vaccine is free for all, the pharmaceutical industry is known to charge exorbitant prices for life saving health products.[231] An emerging treatment for COVID-19, Remdesivir, has already been priced very high from its producer Gilead Sciences, with apparent distinctions in rates contingent on insurance coverage. Gilead is allowing generic makers to supply the drug for $600 USD in developing countries, but is charging private insurers $3120 USD and $2340 for public insurers in the US; of this, there will be a copay for patients.[232] Another example of the influence of the pharmaceutical industry's excessive pricing is with insulin, costing $300 USD for a vial that is $30 USD in Canada, forcing those in need to dangerously ration or skip doses due to cost sharing, even with insurance coverage. This is common among other prescription drugs as well, and can and does directly or indirectly lead to premature death. Likewise, this example is relevant as diabetes puts people at risk for

[229] UHC 2030. "Living with COVID-19: Time to Get Our Act Together on Health Emergencies and UHC." Discussion Paper, May 27, 2020, 5. https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Health_emergencies_and_UHC/UHC2030_discussion_paper_on_health_emergencies_and_UHC_-_May_2020.pdf.
[230] World Health Organization, "Out-of-Pocket Expenditure per Capita in US$," The Global Health Observatory, 2017, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/out-of-pocket-expenditure-(oop)-per-capita-in-us. ; UHC 2030, "Key Targets" 4.
[231]Elisabeth Rosenthal, "Analysis: How A COVID-19 Vaccine Could Cost Americans Dearly," *Kaiser Health News*, July 8, 2020, https://khn.org/news/analysis-how-a-covid-19-vaccine-could-cost-americans-dearly/.
[232] CBS News, "Gilead's Remdesivir Will Cost $3,120 for Patients with Private Insurance," *CBSN*, June 29, 2020, https://www.cbsnews.com/news/gilead-coronavirus-treatment-remdesivir-private-insurance-cost/.

complications from other illnesses, such as COVID-19.[233] Under the current healthcare system, both out-of-pocket expenses of pharmaceuticals and biopharmaceuticals in general increase faster than inflation, causing 1 in 3 Americans to have skipped a medication due to cost, which could be life threatening. Washington lobbyists and pharmaceutical corporations have fought against drug price regulations and transparency, having been encouraged by the Supreme Court decision Citizens United allowing corporate political expenditures.[234] Regardless of this, twenty-nine states passed legislation in 2019 to protect against rising pharmaceutical prices in some situations.[235] Given that in 2009 the US spent double the average per capita on pharmaceuticals of other OECD countries and prices continue to rise annually, transparency and affordability of health products is vital for the enjoyment of the rights to health and life.[236] These US state laws are a good starting point, but until there is protection and transparency nationwide, it is likely that affordability and efficiency will also be ignored. As of 2021, in order to increase transparency, hospitals will be required to share payer-specific negotiated fees online for 300 medical services. This will reveal some irregularities in healthcare, such as in-network versus out-of-network costs, and can hopefully serve as a motivator for healthcare reform to a universal, affordable system.[237] Health product affordability and transparency will help detect and treat underlying conditions, two things that are often avoided due to cost which can have devastating effects on an individual's health.

Another aspect of UHC aligned with UHC2030 and Resolution 74/2 in order to achieve UHC is upholding the quality of care. Important to note in this area is the expansion and delivery of primary health care (PHC) as a fundamental part of implementing UHC.[238] As is previously mentioned, PHC has a direct impact on health outcomes. PHC interventions are typically offered with greater access and capacity in cities, but geographical access, service capacity, quality, and

---

[233] Galvani et al., "Improving Health Care," 527.
[234] Ibid.
[235] James Campbell. "Congress must Act to Stop Big Pharma Greed," *The Baltimore Sun,* Tribune Publishing Company, August 6, 2019, https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0807-drug-prices-20190806-myjrubuvbbf6ve7yd7erisvbpq-story.html.
[236] Panel on Understanding Cross-National Health Differences Among High-Income Countries, "Shorter Lives, Poorer Health", 122.
[237] "Price Transparency Or Price Gouging: Disclosure of Negotiated Rates Called a 'Tipping Point'." *Hospital Access Management* 39, no. 1 (01, 2020).
[238] UHC 2030, "Key Targets," 4.

trust can affect the supply and demand of these services. Thus, it is important to invest in physical access, infrastructure, process quality, and human resource availability.[239] This is because although coverage is important, other things can also deter or delay people from seeing care. These include too few facilities, particularly in rural areas, inconvenient operating hours, flawed infrastructure, inhospitable staff, or lack of community-based physicians or medical groups. Essential for the transformation of US healthcare to a single-payer, UHC system is PHC centered in equity and high service capacity.[240] In the context of COVID-19, an expansion of PHC would allow individuals to understand if they are at high risk for COVID-19 related complications and mortality, as PHC is crucial for detection and treatment of underlying conditions. Likewise, PHC is a main source of out-of-pocket expenditures but population wide interventions such as communication campaigns and programmatic inerventions that address socioeconomic determinants of health would surely be useful for minorities and marginalized groups.[241] In this crisis, expansion of intensive care beds is equally as important as expansion to PHC, since PHC-led approaches result in a better response.[242] Hence, it is critical to transition to a UHC system in the US that encompasses PHC expansion with particular attention to promotion and prevention to ensure quality.[243] Increasing public spending and reallocating spending to PHC while transitioning to a UHC system would allow improvements in PHC, potentially saving numerous lives.[244]

This being said, "investing more and investing better" must also be a strategy when transitioning to UHC, to improve health outcomes for all, during COVID-19 and beyond.[245] Although the US has the highest rate of healthcare expenditure in the world, bureaucracy

[239] World Health Organization, "On the Road to Universal Health Coverage," 86-87.
[240] Ibid, 87.
[241] Ibid, 97 ; UHC 2030. "Living with COVID-19: Time to Get Our Act Together on Health Emergencies and UHC." Discussion Paper, May 27, 2020, 2. https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Health_emergencies_and_UHC/UHC2030_discussion_paper_on_health_emergencies_and_UHC_-_May_2020.pdf.
[242] Ibid, 3.
[243] Ibid, 2.
[244] World Health Organization, "Countries Must Invest at Least 1% More of GDP on Primary Health Care to Eliminate Glaring Coverage Gaps," News Release, September 22, 2019, https://www.who.int/news-room/detail/22-09-2019-countries-must-invest-at-least-1-more-of-gdp-on-primary-health-care-to-eliminate-glaring-coverage-gaps.
[245] UHC 2030, "Key Targets," 5.

consumes a third of spending.[246] Likewise, there are 2,565 local health departments in the US which fluctuate in budget and resources based on a mixture of federal, state, local, and private sources.[247] This leads to inconsistency and inequality. A more unified approach with decreased bureaucratic costs could allow for resource spending in other SDOH areas, such as education and social services, which would help improve health outcomes and reduce the need for expensive, intensive health care services.[248] In terms of investing better to transition to UHC, moving to a UHC system in the US should also be single-payer in order to reduce these bureaucratic costs to allow more investment to reduce cost sharing and decrease the fragmentation of the current system. Single-payer healthcare refers to "a system in which a single public or quasi-public agency organizes health care financing, but the delivery of care remains largely in private hands."[249] Single-payer healthcare would integrate all providers under a single, unified financial structure, prevent existing disparities in pricing and reimbursement rates— reducing discrimination based on insurer and allow more career freedom. With a universal, single-payer system, the high overhead costs for a multiplicity of insurers would be reduced, so that coverage could be expanded with the money saved.[250]

Lastly, the "move together" aim to transition to UHC in accordance with UHC2030 and Resolution 74/2 aspires to engage all of society to create a healthier world, including all relevant stakeholders. This would encourage collaboration between civil society, academia, and the private sector to provide input in regards to development, implementation, and evaluation of UHC.[251] This is important as it refers to global partnerships, a necessary component of healthcare overhaul to a system that is similar to what is already implemented in much of the world, though varying in each State. Currently, private insurance companies maximize profit by minimizing short-term costs and do not prioritize long-term health, resulting in little expenditure on

[246] Dickman, Himmelstein, Woolhandler, "Inequality and the Health-Care System," 1439.
[247] Panel on Understanding Cross-National Health Differences Among High-Income Countries, "Shorter Lives, Poorer Health", 111.
[248] Ibid.
[249] Physicians for a National Health Program, "About Single Payer," PNHP, August 7, 2019, https://pnhp.org/what-is-single-payer/.
[250] Steffie Woolhandler, Terry Campbell, David U. Himmelstein. "Costs of Health Care Administration in the United States and Canada." *The New England Journal of Medicine* 349, no. 8 (Aug 21, 2003): 773. https://gold.worcester.edu/login?url=https://gold.worcester.edu:3475/docview/223939482?accountid=29121.
[251] UHC 2030, "Key Targets," 5.

prevention which is necessary for protecting life before, during, and after the COVID-19 pandemic.[252] With a universal, single-payer system, the high overhead costs for a multiplicity of insurers would be reduced, so that coverage could be expanded with the money saved.[253]

The UHC service coverage index rate is calculated utilizing indicators relating to reproductive, maternal, newborn, and child health, infectious disease, non-communicable diseases, and service capacity and access.[254] The UHC service coverage index of essential service coverage rate in 2017 in the US was 80%, but this number certainly decreased with the economic recession and unemployment as a result of COVID-19 and the for-profit, employer-based healthcare system in place.[255] In any case, this number may appear to be sufficient, but does not reflect the effects of the current system on the vulnerable and marginalized populations and the devastating institutional flaws. One study using demographic data indicated that at the beginning of the outbreak, 18.2 million individuals at increased risk for severe COVID-19 were uninsured or underinsured in the US, with about 5.7 million of those completely uninsured. This estimate does not take into account the millions who are now unemployed.[256] This study also suggests that Black Americans and Native Americans were significantly more likely to be in the COVID-19 at-risk population compared to Whites. Likewise, those with lower incomes, who reside in US states that did not expand Medicaid through the ACA also were much likely to have an increased risk.[257] In order to meet the needs of the minorities and other marginalized groups, the adoption of universal, single-payer healthcare would allow better enjoyment of the rights to health and life for all. As COVID-19 has shown clearly, the current healthcare system is unequal, fragmented, unaffordable, and inconsistent, which have exacerbated COVID-19 related deaths and illness. For a healthcare policy that would save lives and livelihoods of all people, particularly during this time of crisis, the US government should explore Medicare for All as a policy solution to

---

[252] Galvani et al., "Improving Health Care," 530.
[253] Woolhandler, Campbell, Himmelstein. "Costs of Administration," 773.
[254] Daniel R Hogan et al., "Monitoring Universal Health Coverage within the Sustainable Development Goals: Development and Baseline Data for an Index of Essential Health Services," *The Lancet Global Health* 6, no. 2 (December 13, 2017), https://doi.org/10.1016/s2214-109x(17)30472-2.
[255] Ibid.
[256] Adam W. Gaffney et al., "18.2 Million Individuals at Increased Risk of Severe COVID-19 Illness Are Un- or Underinsured," *Journal of General Internal Medicine*, April 10, 2020, 1, https://doi.org/10.1007/s11606-020-05899-8.
[257] Ibid.

existing socioeconomic inequalities to institute a universally applicable healthcare framework under a single-payer system.

6.3 Medicare For All

The Medicare for All proposal is the emblem of universal, single-payer healthcare in the US and has been a major topic of debate in the Democratic party, mostly since the 2016 presidential election. These discussions were mostly inspired by Senator Bernie Sanders' presidential run, when he championed this proposal, inspiring Medicare for All bills to be introduced in the Senate and House of Representatives. This proposal is an embodiment of the aforementioned principles but has many obstacles before becoming law. However, if signed into law, this proposal aligns better with the enjoyments of the right to health and life, aims to reduce inequality, and encompasses solutions to problems resulting from COVID-19.

Firstly, Medicare for All is based on the principle of non-discrimination, a core component of the rights to health and life, as well as all other human rights. In the first provision of the Medicare for All bill, it indicates that coverage will be inclusive, stating, "every individual who is a resident of the United States is entitled to benefits for health care services under this Act," indicating that coverage will be all inclusive and will not discriminate on the basis of employment status, citizenship, age, or for any other reason.[258] This is contrary to the current healthcare system, which excludes millions of people using certain criteria. This proposal would make employment independent from health insurance, and would help remove the systemic fragmentation that occurs with transitions of employment.[259] Likewise, the proposal specifies that non-discrimination is a foundational principle, and states that nobody shall, "be excluded from participation in, be denied the benefits of, or be subjected to discrimination by any participating provider...or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act."[260] This proposal also addresses the need

[258] U.S. Congress, Senate, *Medicare for All Act of 2019*, S.1129, 116th Congress., introduced in Senate April 10, 2019, https://www.congress.gov/bill/116th-congress/senate-bill/1129 ; U.S. Congress, House, *Medicare for All Act of 2019*, H.R.1384, 116th Congress., introduced in House December 10, 2019, https://www.congress.gov/bill/116th-congress/house-bill/1384/text.
[259] Galvani et al., "Improving Health Care," 530.
[260] S.1129, *Medicare for All Act of 2019* ; H.R.1384, *Medicare for All.*

for a procedure to assess claims of discrimination, aspiring to be truly universal in nature.[261] A pandemic has revealed numerous gaps and inequities in the current system, so a proposal structured around non-discrimination is imperative.

Secondly, Medicare for All is based on access to care and affordability. This proposal, if enacted, eliminates deductibles and copayments and greatly reduces out-of-pocket expenditures. Since cost sharing greatly impacts the poor and vulnerable, accessibility and affordability to medical care would substantially improve and encourage use of care beyond emergency situations.[262] The bills also specifically address healthcare disparities, and aspires to improve data collection on race, ethnicity, gender, geography, and socioeconomic status by means of ongoing, accurate, and timely data collection in medical care services, for increased understanding and efficacy.[263] This approach is important in order to optimize access to care, as even an elimination of a cost barrier does not translate to a perfect system where appropriate adjustments do not need to be made, especially when considering minorities. COVID-19 has exposed the preexisting health disparities among disadvantaged groups, with the virus infecting and causing death at higher rates. Thus, access to care for prevention, promotion, and treatment would be facilitated, and exorbitant fees would not serve as a barrier to care.

Thirdly, Medicare for All is based on quality. The current healthcare system is fragmented and ineffective in many regards, but consolidation of billing into a unified framework has the potential to reduce expenditure for billing and administrative services by billions of dollars.[264] It reduces overwhelming paperwork which is a major factor in physician burnout, and the increased simplicity of the system would allow for easier detection and action of any irregularities and errors.[265] It would also remove barriers to primary and preventative care, which are crucial during a pandemic, but also for life saving interventions, increased health literacy and education, and allows for a more accurate evaluation of quality of services provided.[266]

[261] S.1129, *Medicare for All Act of 2019* ; H.R.1384, *Medicare for All.*
[262] Galvani et al., "Improving Health Care," 529.
[263] S.1129, *Medicare for All Act of 2019* ; H.R.1384, *Medicare for All.*
[264] Galvani et al., "Improving Health Care," 525.
[265] Ibid., 526.
[266] Ibid., "Improving Health Care," 530.

Fourthly, Medicare for All takes steps toward the full realization of the right to health, and utilizes available resources more efficiently. The better utilization of resources would be evident in terms of consolidation of pharmaceutical spending, eliminating unpaid medical bills and hospitalization fees, reducing reimbursement rates for physicians, hospitals, and clinics to more equally reflect a balance of public and private reimbursement, reducing overhead expenditure, massive insurance expansion, and fraud detection, which all would amount to $458 billion USD in savings, even whilst including costs for coverage expansion.[267] The fixed rate of reimbursement as well as significant savings in costs could be reallocated into policies regarding socioeconomic and environmental determinants of health, which would magnify the benefits.

Finally, Medicare for All better protects the right to life. Using a single-payer healthcare interactive financing tool calculation, it is estimated that 68,531 lives in the US, predominantly lives of youth, would be saved. This is in part due to the fact that most individuals older than 64 years are already covered under Medicare, while adults aged 25-45 years are disproportionately uninsured, accounting for 9 million of the 41 million uninsured. These numbers are based on 2019 data, and do not yet reflect the economic recession that resulted from COVID-19. This calculation is based on the age distribution of premature deaths that would be avoided and their corresponding age specific life expectancies. Using the same tool, it is estimated that Medicare for All would save 1.73 million years of life, without incorporating improvements in health status from the uninsured population.[268] Equally important to the quantity of years is quality of years, and Medicare for All would improve quality and productivity of livelihood and economic productivity, reducing absenteeism, premature death and disability. [269] This policy would be very valuable during COVID-19, as in addition to the improvement in quality and quantity of years of life and economic productivity, it also designates a reserve fund for a pandemic or other health emergency, which would be beneficial at this time of crisis.[270]

[267] Ibid., 527-528.
[268] Ibid., 529-530.
[269] Ibid., 530.
[270] S.1129, *Medicare for All Act of 2019* ; H.R.1384, *Medicare for All.*

CONCLUSIONS

The human rights to health and life are very clear in terms of the country's duty to both protect life and take steps to allow better enjoyment of health. Although the context of these rights vary depending on international, national, or regional settings, these human rights still apply universally. In a situation such as COVID-19, the rights to health and life for minority communities in the US have been not accessible and enjoyable in the same way others have benefitted from them. This crisis has laid bare the existing disparities and inequalities in society. Since the US has a duty to protect the rights to health and life of all people, and since these two rights are so heavily intertwined, there is an obligation to act. Addressing the social and environmental determinants of health and structural inequity that have affected these groups is not easily accomplished through bipartisan policy, which is why healthcare reform is necessary to provide a universal institution to manage the effects of the historic and ever-present inequality.

Upon review, it is clear why the rates of COVID-19 cases are so disproportionately high among Black Americans and Native Americans, specifically the Diné. There are challenges and obstacles in regards to education, employment, a healthy environment, healthcare, poverty, housing, underlying health conditions, and access to food, water, and health care, all of which directly affect health outcomes, which in turn, affect quality and enjoyment of life. In a society with glaring social and economic inequality, it is necessary to ensure all human rights can be enjoyed equally with a truly just system. Of course, it is also important to address determinants of health moving forward, but while the crisis continues, it is the healthcare system that should be a priority. The current US healthcare system is deeply flawed in access and affordability and primarily relies on employment in order to receive health insurance coverage. In a crisis wherein millions are now unemployed for the foreseeable future in the US, it is illogical to have a mostly fragmented, for-profit healthcare system that relies on cost sharing and employer contributions for coverage. It is not only minority communities who are affected by this system, but also the

middle class and poor, whose human rights are undermined by limited functionality in society due to lack of healthcare.[271]

It is therefore morally, ethically, and legally sensible to take steps toward a UHC system. Furthermore, transition is needed to a UHC system that is collaborative, inclusive, affordable, accessible, quality, appropriate, and fair. A single-payer, UHC system would progress these principles, as well as eliminate bureaucratic costs, allowing for reallocation of funds.[272] Additionally, considering that the US is the richest country in modern history, it is within the means of the government to reallocate or increase public spending and utilize the US' resources in order to invest in and meet the needs of the people. With the US government already acknowledging that public financing of COVID-19 treatment for the uninsured will help mitigate the spread of COVID-19, it is important to learn from this moment. This pandemic has served as a call to action, as it is now impossible to dismiss the relationship between an affordable, accessible UHC system and the ability for all people to enjoy their rights to health and life. In order to best meet these obligations to fundamental human rights, a true UHC system, such as Medicare for All, should be transitioned to and enacted with all reasonable urgency.

[271] UN General Assembly, Human Rights Council, Report of the Special Rapporteur on extreme poverty and human rights on his mission to the United States of America, 4 May 2018, A/HRC/38/33/Add.1, pp. 12, available at: https://digitallibrary.un.org/record/1629536.
[272] Dickman, Himmelstein, Woolhandler, "Inequality and the Health-Care System," 1439.

References

Alston, Philip. United Nations, General Assembly, Report of the Special Rapporteur on extreme poverty and human rights on his mission to the United States of America, A/63/332 (26 August 2008), available from https://digitallibrary.un.org/record/1629536?ln=en.

Alta Spells, Doctors Without Borders dispatched to New Mexico to help the Navajo Nation, CNN, May 11, 2020, https://www.cnn.com/2020/05/11/us/navajo-nation-doctors-without-borders/index.html

Atkins v. Virginia, 536 U.S. 304 (2002).

Bailey, Zinzi D, Nancy Krieger, Madina Agénor, Jasmine Graves, Natalia Linos, and Mary T Bassett. "Structural Racism and Health Inequities in the USA: Evidence and Interventions." *The Lancet* 389, no. 10077 (2017): 1453–63. https://doi.org/10.1016/s0140-6736(17)30569-x.

Barber, Ryan M, Nancy Fullman, Reed J D Sorensen, Thomas Bollyky, Martin Mckee, Ellen Nolte, Amanuel Alemu Abajobir, et al. "Healthcare Access and Quality Index Based on Mortality from Causes Amenable to Personal Health Care in 195 Countries and Territories, 1990–2015: a Novel Analysis from the Global Burden of Disease Study 2015." The Lancet 390, no. 10091 (2017): pp. 231–66. https://doi.org/10.1016/s0140-6736(17)30818-8.

Barkan, Ross. "A $1.1m hospital bill after surviving the coronavirus? That's America for you," The Guardian, June 16, 2020, https://www.theguardian.com/commentisfree/2020/jun/16/coronavirus-hospital-bill-healthcare-america.

Becenti , Arlyssa. "Nation Sees 6,110 Cases, 277 Deaths from COVID-19." Navajo Times, June 9, 2020. https://navajotimes.com/coronavirus-updates/nation-sees-6110-cases-277-deaths-from-covid-19/.

Benshoof, Janet. "Roe v. Wade." In The Reader's Companion to U.S. Women's History, edited by Wilma Pearl Mankiller. Houghton Mifflin, 1998.

Berchick, Edward, Emily Hood, and Jessica Barnett. "Health Insurance Coverage in the United States: 2017," PDF. Current Population Reports : U.S Census Bureau , September 2018. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf.

Boccia, Stefania, Walter Ricciardi, and John P. A. Ioannidis. “What Other Countries Can Learn From Italy During the COVID-19 Pandemic.” JAMA Internal Medicine, April 7, 2020. https://doi.org/10.1001/jamainternmed.2020.1447.

Bridges, Khiara M. “Implicit Bias and Racial Disparities in Health Care,” Human Rights Magazine. 43, no. 3 (November 19, 2018). https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/.

Wyant, Brian R. PhD and Harner, Holly M. (2018) "Financial Barriers and Utilization of Medical Services in Prison: An Examination of Co-payments, Personal Assets, and Individual Characteristics," *Journal for Evidence-based Practice in Correctional Health*: Vol. 2 : Iss. 1, Article 4. https://opencommons.uconn.edu/jepch/vol2/iss1/4.

Campbell, James. "Congress must Act to Stop Big Pharma Greed," The Baltimore Sun, Tribune Publishing Company, Aug 6, 2019, https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0807-drug-prices-20190806-myjrubuvbbf6ve7yd7erisvbpq-story.html.

CBS News. “Gilead's Remdesivir Will Cost $3,120 for Patients with Private Insurance.” *CBS News*. CBS Interactive, June 29, 2020, https://www.cbsnews.com/news/gilead-coronavirus-treatment-remdesivir-private-insurance-cost/.

CBSN Originals. 2020. Coronavirus In Navajo Nation. Video. https://www.cbsnews.com/news/coronavirus-navajo-nation-running-water-cbsn-originals.

Centre for Women Peace and Security. “American Declaration on the Rights and Duties of Man.” Tackling Violence against Women, September 26, 2016. https://blogs.lse.ac.uk/vaw/regional/the-americas/the-american-declaration-on-the-rights-and-duties-of-man/.

CNN Editorial Research, “Death Penalty Fast Facts,” CNN, July 15, 2020, https://www.cnn.com/2013/07/19/us/death-penalty-fast-facts/index.html.

Cogan, Neil H.. The Complete Bill of Rights : The Drafts, Debates, Sources, and Origins, Oxford University Press, Incorporated, 2015. ProQuest Ebook Central, https://ebookcentral.proquest.com/lib/worcesteruniv-ebooks/detail.action?docID=2059476.

Colton, David. 2019. The Case for Universal Health Care. Atlanta, GA: Clarity Press, pp. 96. http://gold.worcester.edu:2065/login.aspx?direct=true&db=nlebk&AN=2240167&site=ehost-live&scope=site.

COPE. "Community Outreach And Patient Empowerment 2016 Annual Report," PDF. COPE 2016 Annual Report. COPE Project, 2017. https://www.pih.org/sites/default/files/2018-08/COPE-AnnualReport-2016.pdf.

Council of Europe, European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14, 4 November 1950, ETS 5, available at: https://www.refworld.org/docid/3ae6b3b04.html [accessed 19 May 2020]

Dana Hedgpeth, Darryl Fears, Gregory Scruggs. "Indian Country, where residents suffer disproportionately from disease, is bracing for coronavirus", Washington Post, April 4, 2020, https://www.washingtonpost.com/climate-environment/2020/04/04/native-american-coronavirus/.

David R. Roediger, How Race Survived US History: from Settlement and Slavery to the Eclipse of Post-Racialism (London: Verso, 2019), chap. 1, Kindle.

Dickman, Samuel L, David U Himmelstein, and Steffie Woolhandler. "Inequality and the Health-Care System in the USA." The Lancet 389, no. 10077 (2017): 1431–41. https://doi.org/10.1016/s0140-6736(17)30398-7.

Dorn, Aaron Van, Rebecca E Cooney, and Miriam L Sabin. "COVID-19 Exacerbating Inequalities in the US." The Lancet 395, no. 10232 (2020): 1243–44. https://doi.org/10.1016/s0140-6736(20)30893-x.

European Centre for Disease Prevention and Control. "Q & A On COVID-19." European Centre for Disease Prevention and Control, May 25, 2020. https://www.ecdc.europa.eu/en/covid-19/questions-answers.

First International Conference on Health Promotion. 1986. "The Ottawa Charter For Health Promotion". Ottawa: World Health Organization. https://www.who.int/healthpromotion/conferences/previous/ottawa/en/.

Ford v. Wainwright, 477 U.S. 399 (1986).

Frenk, Julio, Hoffman, Steven, Bachelet, Michelle. “Governance and Leadership for Health.” Essay. In "To Save Humanity": What Matters Most for a Healthy Future, 22. New York, NY: Oxford University Press, 2015.

Furman v. Georgia, 408 U.S. 238 (1972).

Gaffney, Adam W., Laura Hawks, David H. Bor, Steffie Woolhandler, David U. Himmelstein, and Danny Mccormick. “18.2 Million Individuals at Increased Risk of Severe COVID-19 Illness Are Un- or Underinsured.” Journal of General Internal Medicine, April 10, 2020. https://doi.org/10.1007/s11606-020-05899-8.

General Assembly resolution 67/81. Global health and foreign policy, A/63/332 (12 December 2012), available from https://undocs.org/A/RES/67/81.

General Assembly resolution 70/1. Transforming our world: the 2030 Agenda for Sustainable Development, A/70/1 (25 September 2015), available from https://undocs.org/A/RES/70/1.

General Assembly resolution 72/139. Global health and foreign policy: addressing the health of the most vulnerable for an inclusive society, A/72/139, (12 December 2017), available from https://undocs.org/A/RES/72/139.

General Records of the United States Government, “Treaty between the United States Government and the Navajo Indians ,” National Archives Catalog (National Archives and Records Administration, 1868), https://catalog.archives.gov/id/6173067, xxi.

Gómes, Filipe. “The Inter-American System of Human Rights” Slideshow, Lecture, Venice-Lido, 25 September 2019.

Goodman, Jack, and Christopher Giles. 2020. "What Do We Know About Hydroxychloroquine?". BBC News. https://www.bbc.com/news/51980731.

Goodman, Jack, and Christopher Giles. 2020. "What Do We Know About Hydroxychloroquine?". BBC News. https://www.bbc.com/news/51980731.

Gould, Elise, and Valerie Wilson. “Black Workers Face Two of the Most Lethal Preexisting Conditions for Coronavirus-Racism and Economic Inequality.” Economic Policy Institute, June 1, 2020. https://www.epi.org/publication/black-workers-covid/.

Griffith, Janelle. “Teen whose death may be linked to coronavirus denied care for not having health insurance,” NBC News, June 9, 2020.

Grytdal, Scott P., Robert Weatherholtz, Douglas H. Esposito, James Campbell, Raymond Reid, Nicole Gregoricus, Chandra Schneeberger, et al. “Water Quality, Availability, and Acute Gastroenteritis on the Navajo Nation – a Pilot Case-Control Study.” Journal of Water and Health 16, no. 6 (2018): 1018–28. https://doi.org/10.2166/wh.2018.007.

Hartman, Chester W., and Gregory D. Squires. From Foreclosure to Fair Lending : Advocacy, Organizing, Occupy, and the Pursuit of Equitable Credit. (New York, NY: New Village Press, 2013), foreword, Ebook. http://gold.worcester.edu:2065/login.aspx?direct=true&db=e000xna&AN=1698112&site=ehost-live&scope=site.

Healey, Maura. “COVID-19’s Unequal Effects In Massachusetts,” PDF. Office of Attorney General Maura Healey. Mass.gov, May 12, 2020. https://www.mass.gov/doc/covid-19s-unequal-effects-in-massachusetts/download.

Health In All Policies: Helsinki Statement. Framework For Country Action. PDF. 2014. Finland: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/112636/9789241506908_eng.pdf;jsessionid=8E1DB2EBDC6A1CAC46D2B01B50855F96?sequence=1.

Health Resources and Sources Administration. “COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured.” Official web site of the U.S. Health Resources & Services Administration, June 12, 2020. https://www.hrsa.gov/coviduninsuredclaim.

Hogan, Daniel R, Gretchen A Stevens, Ahmad Reza Hosseinpoor, and Ties Boerma. “Monitoring Universal Health Coverage within the Sustainable Development Goals: Development and Baseline Data for an Index of Essential Health Services.” The Lancet Global Health 6, no. 2 (December 13, 2017). https://doi.org/10.1016/s2214-109x(17)30472-2.

Inter-American Commission on Human Rights (IACHR), American Declaration of the Rights and Duties of Man, 2 May 1948, available at: https://www.refworld.org/docid/3ae6b3710.html [accessed May 2020].

International Council of Nurses. “High Proportion of Healthcare Workers with COVID-19 in Italy Is a Stark Warning to the World: Protecting Nurses and Their Colleagues Must Be the Number One Priority.” ICN, March 20, 2020. https://www.icn.ch/news/high-proportion-healthcare-workers-covid-19-italy-stark-warning-world-protecting-nurses-and.

International Justice Resource Center, “Inter-American Court: State Inaction on HIV Violated Progressive Realization Obligation,” *IJRC*, February 10, 2020, https://ijrcenter.org/2018/11/06/inter-american-court-state-inaction-on-hiv-violated-progressive-realization-obligation/.

Jones, Janelle. “Black Unemployment Is at Least Twice as High as White Unemployment at the National Level and in 12 States and D.C.: The Highest African American Unemployment Rate Is in the District of Columbia at 12.4 Percent, While the Highest White Unemployment Rate Is in West Virginia at 5.0 Percent.” Economic Policy Institute, October 30, 2018. https://www.epi.org/publication/2018q3_unemployment_state_race_ethnicity/.

Konsta, Marie Anne. “Human Dignity and Social Rights of Refugees in EU Law” Slideshow, Lecture, Thessaloníki, 24 March 2020.

Laurel Morales, For Many Navajos, Getting Hooked Up To The Power Grid Can Be Life-Changing, NPR, May 29, 2019, https://www.npr.org/sections/health-shots/2019/05/29/726615238/for-many-navajos-getting-hooked-up-to-the-power-grid-can-be-life-changing.

Laurencin, Cato, and Aneesah Mcclinton. “The COVID-19 Pandemic: a Call to Action to Identify and Address Racial and Ethnic Disparities.” Journal of Racial and Ethnic Health Disparities 7, no. 3 (April 18, 2020): 398–402. https://doi.org/10.1007/s40615-020-00756-0.

Legal Information Institute. “Spending for the General Welfare.” Cornell Law School. Accessed July 29, 2020. https://www.law.cornell.edu/constitution-conan/article-1/section-8/clause-1/spending-for-the-general-welfare.

Li, David K. “Colorado Abolishes the Death Penalty,” NBC News, March 23, 2020, https://www.nbcnews.com/news/us-news/colorado-abolishes-death-penalty-n1167231?fbclid=IwAR1hjNRTFEBlrRnUkclaRAAE64ap1TYZQ4z6wURJoEizetlgrzqLGzbtyYM.

Lillie-Blanton, Marsha, and Catherine Hoffman. “The Role Of Health Insurance Coverage In Reducing Racial/Ethnic Disparities In Health Care.” Health Affairs 24, no. 2 (2005): 398–408. https://doi.org/10.1377/hlthaff.24.2.398.

Liu, Yen-Chin, Rei-Lin Kuo, and Shin-Ru Shih. “COVID-19: The First Documented Coronavirus Pandemic in History.” Biomedical Journal, May 5, 2020. https://doi.org/10.1016/j.bj.2020.04.007.

Mccann And Others V. The United Kingdom, no. 18984/91, ECHR 1995.

Meier, Benjamin Mason, Paul Henry Brodish, and Meri Koivusalo. “Human Rights Provide Justification for the Health in All Policies Approach.” Health and Human Rights Journal, June 10, 2013. https://www.hhrjournal.org/2013/06/human-rights-provide-justification-for-the-health-in-all-policies-approach/.

Moses, Joy. “Demographic Data Project: Race, Ethnicity, and Homelessness,” PDF. Homelessness Research Institute, July 2019. https://endhomelessness.org/wp-content/uploads/2019/07/3rd-Demo-Brief-Race.pdf.

Mozes, Alan. “COVID-19 Ravages the Navajo Nation, But Its People Fight Back.” Consumer HealthDay, June 9, 2020. https://consumer.healthday.com/infectious-disease-information-21/coronavirus-1008/covid-19-ravages-the-navajo-nation-but-its-people-fight-back-758365.html.

National Center for Chronic Disease Prevention and Health Promotion. “African American Health.” Centers for Disease Control and Prevention. CDC.gov, July 3, 2017. https://www.cdc.gov/vitalsigns/aahealth/index.html.

National Center for Immunization and Respiratory Diseases (NCIRD). “Symptoms of Coronavirus.” Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, May 13, 2020. https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.

National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012)

Neumayer, Eric. “Death Penalty Abolition and the Ratification of the Second Optional Protocol.” The International Journal of Human Rights 12, no. 1 (2008): 3–21. https://doi.org/10.1080/13642980701725160.

OAS. “Organization of American States: Democracy for Peace, Security, and Development.” OAS, August 1, 2009. http://www.oas.org/en/about/who_we_are.asp.

Organization of American States (OAS), Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San

Salvador"), 16 November 1999, A-52, available at: https://www.refworld.org/docid/3ae6b3b90.html [accessed 24 June 2020]

Owens, Jeremy. 2020. "Moderna Begins New COVID-19 Vaccine Study". Marketwatch. https://www.marketwatch.com/story/moderna-begins-new-covid-19-vaccine-study-2020-05-29.

Panel on Understanding Cross-National Health Differences Among High-Income Countries, Committee on Population, Division of Behavioral and Social Sciences and Education, National Research Council, Board on Population Health and Public Health Practice, and Institute of Medicine. U. S. Health in International Perspective: Shorter Lives, Poorer Health. Washington, D.C.: National Academies Press, 2013. Accessed June 10, 2020. ProQuest Ebook Central, pp.106-137.

Parrillo, Vincent N. 2008. Encyclopedia of Social Problems. Thousand Oaks, Calif: SAGE Publications, Inc., 760. http://gold.worcester.edu:2065/login.aspx?direct=true&db=e000xna&AN=474380&site=ehost-live&scope=site.

Patrick Sharkey, Keeanga-Yamahtta Taylor and Yaryna Serkez, The Gaps Between White and Black America, in Charts, NYT, June 19, 2020, https://www.nytimes.com/interactive/2020/06/19/opinion/politics/opportunity-gaps-race-inequality.html?fbclid=IwAR3PRiJMSTjrMrMTXKnXFtNFg4wTs_WlQKqVhfjwyCq-Wqr2levz4ZFv_Vc.

Peters, A., P. Vetter, C. Guitart, N. Lotfinejad, and D. Pittet. “Understanding the Emerging Coronavirus: What It Means for Health Security and Infection Prevention.” *Journal of Hospital Infection* 104, no. 4 (2020): pp. 440–48. https://doi.org/10.1016/j.jhin.2020.02.023.

Peters, Cameron., “A Detailed Timeline of All the Ways Trump Failed to Respond to the Coronavirus,” *Vox,* June 8, 2020, https://www.vox.com/2020/6/8/21242003/trump-failed-coronavirus-response.

Phillip Alston. 2020. "Statement On Visit To The USA." https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=22533.

Physicians for a National Health Program. “About Single Payer.” PNHP, August 7, 2019. https://pnhp.org/what-is-single-payer/.

Pivaral Et Al (Persons Living With HIV/AIDS) vs. Guatemala, Inter-Am. Ct. H.R. No. 2/16 Case 12.484 (Apr. 6, 2006).

Pitre, Charisse Cowan. "Improving African American student outcomes: understanding educational achievement and strategies to close opportunity gaps." *The Western Journal of Black Studies* 38, no. 4 (2014): 209+. *Gale Academic OneFile Select*. https://gold.worcester.edu:3771/apps/doc/A400784999/EAIM?u=mlin_c_worstate&sid=EAIM&xid=b9ef8b23.

"Price Transparency Or Price Gouging: Disclosure of Negotiated Rates Called a 'Tipping Point'." Hospital Access Management 39, no. 1 (01, 2020). https://gold.worcester.edu/login?url=https://gold.worcester.edu:3475/docview/2329683565?accountid=29121/ https://www.reliasmedia.com/articles/145465-price-transparency-or-price-gouging-disclosure-of-negotiated-rates-called-a-tipping-point.

Raifman, Matthew, and Julia Raifman. "Disparities in the Population at Risk of Severe Illness From COVID-19 by Race/Ethnicity and Income." American Journal of Preventive Medicine 59, no. 1 (2020): 137–39. https://doi.org/10.1016/j.amepre.2020.04.003.

Ranney, Megan L., Griffeth, Valerie, and Jha, Ashish. "Critical Supply Shortages — The Need for Ventilators and Personal Protective Equipment during the Covid-19 Pandemic." New England Journal of Medicine 382, no. 18 (April 30, 2020). https://doi.org/10.1056/nejmp2006141.

Ritchie, Hannah, Esteban Ortiz-Ospina, Diana Beltekian, Edouard Mathieu, Joe Hasell, Bobbie Macdonald, Charlie Giattino, and Max Roser. "Coronavirus (COVID-19) Testing - Statistics and Research." Coronavirus (COVID-19) Testing. Our World in Data, May 18, 2020. https://ourworldindata.org/coronavirus-testing.

Ritchie, Roser, Mispy, Ortiz-Ospina. "Measuring progress towards the Sustainable Development Goals." SDG-Tracker.org, website (2018).

Romeo, Nick. "The Grim Ethical Dilemma of Rationing Medical Care, Explained," Vox, March 31, 2020. https://www.vox.com/coronavirus-covid19/2020/3/31/21199721/coronavirus-covid-19-hospitals-triage-rationing-italy-new-york.

Rosenthal, Elisabeth. “Analysis: How A COVID-19 Vaccine Could Cost Americans Dearly.” Kaiser Health News, July 8, 2020. https://khn.org/news/analysis-how-a-covid-19-vaccine-could-cost-americans-dearly/.

Sansonetti, Philippe J. 2020. "COVID‐19, Chronicle Of An Expected Pandemic". EMBO Molecular Medicine 12 (5). doi:10.15252/emmm.202012463.

Sesay Jr., Chernoh. “The American Revolution, Race, and the Failed Beginning of a Nation.” AAIHS, December 7, 2016. https://www.aaihs.org/the-american-revolution-race-and-the-failed-beginning-of-a-nation/.

Shi, Leiyu. “The Impact of Primary Care: A Focused Review .” Scientifica. Hindawi Publishing Corporation, September 27, 2012. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/pdf/SCIENTIFICA2012-432892.pdf.

Smith, David Barton. 2005. "Racial And Ethnic Health Disparities And The Unfinished Civil Rights Agenda". Health Affairs 24 (2): 317-324. doi:10.1377/hlthaff.24.2.317.

"Social Determinants Of Health | Healthy People 2020". 2014. Office Of Disease Prevention And Health Promotion. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health.

"Social Determinants Of Health: Know What Affects Health". 2018. Centers For Disease Control And Prevention. https://www.cdc.gov/socialdeterminants/index.htm.

The United Nations. 1948. Universal Declaration of Human Rights.

Thomas Jefferson, et al, July 4, 1776, Copy of Declaration of Independence.

Tsesis, Alexander , "The Declaration of Independence and Constitutional Interpretation," Southern California Law Review 89, no. 3 (March 2016): pp. 369-398. https://gold.worcester.edu:3396/HOL/Page?collection=journals&handle=hein.journals/scal89&id=409&men_tab=srchresults#.

Gregg v. Georgia, 428 U.S. 153 (1976).

UHC 2030. “Key Targets, Commitments & Actions.” United Nations High-level Meeting On Universal Health Coverage In 2019, December 2019.

https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/UN_HLM/UHC_key_targets_actions_commitments_15_Nov_2019__1_.pdf.

UHC 2030. "Living with COVID-19: Time to Get Our Act Together on Health Emergencies and UHC." Discussion Paper, May 27, 2020. https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/Health_emergencies_and_UHC/UHC2030_discussion_paper_on_health_emergencies_and_UHC_-_May_2020.pdf.

UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: https://www.refworld.org/pdfid/4538838d0.pdf.

UN General Assembly, International Covenant on Civil and Political Rights, 16 December 1966, United Nations, Treaty Series, vol. 999, pp. 171, available at: https://www.refworld.org/docid/3ae6b3aa0.html.

UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, pp. 3, available at: https://www.refworld.org/docid/3ae6b36c0.html [May 2020]

UN General Assembly, Human Rights Council, Report of the Special Rapporteur on extreme poverty and human rights on his mission to the United States of America, 4 May 2018, A/HRC/38/33/Add.1, available at: https://digitallibrary.un.org/record/1629536.

UN General Assembly, Prevention and punishment of the crime of genocide, 9 December 1948, A/RES/260, available at: https://www.refworld.org/docid/3b00f0873.html [accessed 19 July 2020]

UN Human Rights Committee (HRC), General comment no. 36, Article 6 (Right to Life), 3 September 2019, CCPR/C/GC/35, available at: https://www.refworld.org/docid/5e5e75e04.html [accessed 17 May 2020]

United Nations, "COVID-19 and Human Rights: We Are All in This Together," Victims of Terrorism Support Portal, April 2020, pp. 4 https://www.un.org/victimsofterrorism/sites/www.un.org.victimsofterrorism/files/un_-_human_rights_and_covid_april_2020.pdf.

UN Officer of The High Commissioner For Human Rights. “No Exceptions with COVID-19: ‘Everyone Has the Right to Life-Saving Interventions’ – UN Experts Say.” News and Events . Accessed July 14, 2020. https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25746.

United Nations. “SDG 3: Ensure Healthy Lives and Promote Wellbeing for All at All Ages.” The goals within a goal: Health targets for SDG 3. World Health Organization, February 3, 2017. https://www.who.int/sdg/targets/en/.

United Nations. “Sustainable Development Goals.” United Nations Sustainable Development. Accessed July 20, 2020. https://www.un.org/sustainabledevelopment/health/.

United Nations Statistics. “Infographic: Good Health and Well-Being.” Goal 3: Ensure healthy lives and promote well-being for all at all ages, 2020. https://www.un.org/sustainabledevelopment/wp-content/uploads/2019/07/E_Infographic_03.pdf.

U.S. Bureau of Labor Statistics. “Unemployment Rates for States, Annual Averages.” Local Area Unemployment Statistics, March 4, 2020. https://www.bls.gov/lau/lastrk19.htm.

U.S. Congress, House. Medicare for All Act of 2019, H.R.1384, 116th Congress., introduced in House December 10, 2019, https://www.congress.gov/bill/116th-congress/house-bill/1384/text.

U.S. Congress, Senate. Medicare for All Act of 2019, S.1129, 116th Congress., introduced in Senate April 10, 2019, https://www.congress.gov/bill/116th-congress/senate-bill/1129.

US Department of Health and Human Services, “Indian Health Service,” Indian Health Service: The Federal Health Program for American Indians and Alaska Natives, 2020, https://www.ihs.gov/navajo.

US Department of Labor. “Continuation of Health Coverage (COBRA).” Health Plans and Benefits, https://www.dol.gov/general/topic/health-plans/cobra.

US Department of Labor. “State Employment And Unemployment — May 2020.” Bureau of Labor Statistics , June 19, 2020. https://www.bls.gov/news.release/pdf/laus.pdf.

U.S. Department of the Treasury. “The CARES Act Works for All Americans.” The CARES Act Works for All Americans | U.S. Department of the Treasury, July 17, 2020. https://home.treasury.gov/policy-issues/cares.

Wilkins, David E.. The Navajo Political Experience. Lanham, MD: Rowman & Littlefield Publishers, 2013. Accessed June 27, 2020. ProQuest Ebook Central, xviii ; Official Site of the Navajo Nation, “Navajo Nation History,” Navajo Nation Government , 2011, https://www.navajo-nsn.gov/history.htm.

Woolhandler, Steffie,M.D., M.P.H., Terry Campbell M.H.A., and David U. Himmelstein M.D. "Costs of Health Care Administration in the United States and Canada." The New England Journal of Medicine 349, no. 8 (Aug 21, 2003): 768-75. https://gold.worcester.edu/login?url=https://gold.worcester.edu:3475/docview/223939482?accountid=29121.

World Health Organization. “Coronavirus Disease (COVID-19) Situation Report – 118.” Coronavirus Disease (COVID-19) - events as they happen, May 17, 2020. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200517-covid-19-sitrep-118.pdf?sfvrsn=21c0dafe_8.

World Health Organization. “Countries Must Invest at Least 1% More of GDP on Primary Health Care to Eliminate Glaring Coverage Gaps.” News Release , September 22, 2019. https://www.who.int/news-room/detail/22-09-2019-countries-must-invest-at-least-1-more-of-gdp-on-primary-health-care-to-eliminate-glaring-coverage-gaps.

World Health Organization. “COVID-19 Strategy Update.” COVID-19 Response, April 14, 2020. https://www.who.int/docs/default-source/coronaviruse/covid-strategy-update-14april2020.pdf?sfvrsn=29da3ba0_19.

World Health Organization. “Out-of-Pocket Expenditure per Capita in US$.” The Global Health Observatory, 2017. https://www.who.int/data/gho/data/indicators/indicator-details/GHO/out-of-pocket-expenditure-(oop)-per-capita-in-us.

World Health Organization. “Primary Health Care on the Road to Universal Health Coverage.” 2019 Monitoring Report , 2019. https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf?ua=1.

World Health Organization. “Universal Health Coverage.” The Global Health Observatory. Accessed July 14, 2020. https://www.who.int/data/gho/data/major-themes/universal-health-coverage-major/GHO/universal-health-coverage.

World Health Organization. “WHO Characterizes COVID-19 as a Pandemic.” Coronavirus Disease (COVID-19) - events as they happen. World Health Organization. Accessed April 2020. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen.