

A Human Rights Framework to Address Racial Inequalities Undermining Health in the U.S.

NICOLLETTE LEVI*

“I’ve never experienced anything in my life where my social media timeline looks like an obituary,” said Tara Liberty Smith from Detroit, Michigan, in April 2020. “You cannot scroll [through social media] . . . [without] knowing someone who has been attacked by the virus or who has experienced death from the virus.”¹ Smith’s account, although horrific, is not unique; people across the United States, especially those of people living in Black communities, have been living through similar experiences. Michigan recorded nearly 5,500 deaths by the end of May 2020.² Metrics reflect that Detroit, where nearly 80% of the population is Black,³ suffered the highest impact.⁴

As of August 18, 2020, COVID-19 deaths among Black, non-Hispanic persons are 2.8 times higher than white, non-Hispanic

* JD Candidate 2022, University of Miami School of Law; B.S. 2019, Florida State University. I am grateful for Tamar Ezer, my former supervisor at the University of Miami Human Rights Clinic. Further, I would like to thank David Stuzin for his help and encouragement during the writing process of this article.

¹ Gus Burns, *Michigan’s Black Communities Devastated by the Coronavirus*, GOV’T TECH. (Apr. 29, 2020), <https://www.govtech.com/em/safety/Michigans-Black-Communities-Devastated-by-the-Coronavirus.html>.

² Craig Mauger, *New Michigan COVID-19 Deaths in May Less Than Half April Total*, DETROIT NEWS (May 31, 2020), <https://www.detroitnews.com/story/news/local/michigan/2020/05/31/new-michigan-covid-19-deaths-may-less-than-half-april-total/5300588002/>.

³ *Quick Facts: Detroit City, Michigan; United States*, U.S. CENSUS BUREAU, <https://www.census.gov/quickfacts/fact/table/detroitcitymichigan,US/PST045219> (last visited May 7, 2021).

⁴ Mauger, *supra* note 2.

persons.⁵ The data is clear: the pandemic kills more Black Americans than white Americans. However, this disproportionate effect on Black Americans is not because of the virus; rather, the disparity in deaths is due to the systemic inequality in the U.S.'s healthcare system. This includes both inequalities in health services, as well as inequalities in the underlying determinants of health, such as access to adequate housing, food, and decent work conditions. International human rights law provides a powerful normative framework for addressing the current severe racial impacts of the COVID-19 pandemic in the U.S. This framework requires the U.S. to ensure a right to health that includes both providing access to health services and addressing the underlying determinants of health. Additionally, such a framework requires the U.S. to adopt a more robust right to equality that challenges disproportionate impacts based on race.

This paper relies on several core international human rights instruments, which provide both a legal and normative framework for protecting human rights: the Universal Declaration of Human Rights (the "UDHR");⁶ International Covenant on Civil and Political Rights (the "ICCPR");⁷ International Covenant on Economic, Social and Cultural Rights (the "ICESCR");⁸ and International Convention on the Elimination of All Forms of Racial Discrimination (the "ICERD").⁹ While the U.S. has a complicated relationship with international human rights law, the U.S. has played an important role in international human rights law's development. The

⁵ *COVID-19 Hospitalization and Death by Race/Ethnicity*, CTR. FOR DISEASE CONTROL, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html> (last updated Nov. 30, 2020).

⁶ G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948) [hereinafter UDHR].

⁷ International Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR] (ratified by the U.S. June 8, 1992).

⁸ International Covenant Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR] (signed Oct. 5, 1977).

⁹ International Covenant on the Elimination of All Forms of Racial Discrimination, *opened for signature* March 7, 1966, 660 U.N.T.S. 211 [hereinafter ICERD] (ratified by U.S. Oct. 21, 1994).

UDHR is the foundational document of the U.N. human rights system, and the U.S. chaired the commission that drafted it under First Lady Eleanor Roosevelt's leadership.¹⁰ Although the UDHR is a declaration rather than a legally binding treaty, it has as important normative authority and at least parts of it have, arguably, attained the status of international customary law.¹¹ In fact, courts in the U.S. have discussed the UDHR more frequently than in any other country.¹² The U.S. ratified the ICCPR on June 8, 1992, and the ICERD on October 21, 1994, and is bound by their provisions. However, the U.S. has declared these treaties "not self-executing," meaning that, unless Congress passes implementing legislation, those treaties alone cannot serve as a cause of action in domestic courts.¹³ Nevertheless, these treaties are binding¹⁴ and can be used in court as an interpretive aid or in advocacy with other branches of government. In addition, the U.S. has not yet ratified, but signed, the ICESCR on October 5, 1977. While the U.S. is not legally bound by provisions in this treaty and need not take positive steps to realize them, in signing, the U.S. has indicated its "consent to be bound" and, therefore, carries the obligation per the terms of the ICESCR to "avoid actions which could render impossible the entry into force and implementation [the agreement], or defeat its

¹⁰ *The Foundation of International Human Rights Law*, UNITED NATIONS, <https://www.un.org/en/sections/universal-declaration/foundation-international-human-rights-law/index.html> (last visited May 7, 2021); see *Women Who Shaped The Universal Declaration*, UNITED NATIONS, https://www.un.org/sites/un2.un.org/files/women_who_shaped_the_udhr.pdf (last visited May 7, 2021).

¹¹ George J. Andreopoulos, *Universal Declaration of Human Rights*, ENCY. BRITANNICA, <https://www.britannica.com/topic/Universal-Declaration-of-Human-Rights> (last updated Jan. 2, 2020).

¹² Hurst Hannum, *The Status of the Universal Declaration of Human Rights in National and International Law*, 25 GA. J. INT'L & COMP. L. 287, 304 (1998).

¹³ Robin H. Gise, *Rethinking McClesky v. Kemp: How U.S. Ratification of the International Convention on the Elimination of All Forms of Racial Discrimination Provides a Remedy for Claims of Racial Disparity in Death Penalty Cases*, FORDHAM INT'L. L.J. 2270, 2272 (1998).

¹⁴ Human Rights Comm., *Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: International Covenant on Civil and Political Rights*, U.N. Doc. CCPR/C/81/Add.4 (Aug. 24, 1994).

basic purpose and value to the other party or parties.”¹⁵ In any case, these international instruments provide important normative standards that can be used to determine whether a government is adequately promoting the general welfare.

International human rights instruments provide a powerful framework for addressing the current severe racial impacts of the COVID-19 pandemic within the U.S. International law recognizes that a government’s failure to protect the health and lives of its residents is a human rights violation. Article 12(1) of the ICESCR sets out “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹⁶ This elaborates on article 25(1) of the UDHR, which recognizes that “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.”¹⁷ The Committee on Cultural, Economic, and Social Rights (the “CESCR”), which monitors compliance with the ICESCR, defines the

right to health . . . as an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and 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.¹⁸

Furthermore, article 6(1) of the ICCPR recognizes a right to life.¹⁹ This elaborates on article 3 of the UDHR, which recognizes

¹⁵ RESTATEMENT (FOURTH) OF THE FOREIGN RELATIONS LAW OF THE UNITED STATES § 304 cmt. d (AM. L. INST. 2017).

¹⁶ ICESCR, *supra* note 9, at 8.

¹⁷ UDHR, *supra* note 6, at 5.

¹⁸ Comm. on Cultural, Econ. And Soc. Rts., Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 14 (2000), ¶ 11, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR GC 14].

¹⁹ Hum. Rts. Comm., Article 6: Right to Life, ¶ 26, U.N. Doc. CCPR/C/GC/36 (Sept. 3, 2019) [hereinafter HRC GC 36].

that “everyone has the right to life, liberty, and security of the person.”²⁰ The Human Rights Committee, which monitors compliance with the ICCPR, defines the right to life expansively as the right to a life with dignity.²¹ Therefore, “the right to life include[s], where necessary, measures designed to ensure access without delay by individuals to essential goods and services such as . . . health care . . . and effective emergency health services”²²

The COVID-19 pandemic exposes the U.S.’s failure to equally protect the rights to health and life of all people by its disproportionate impact on people of color, specifically Black Americans. A study that looked at “county-level health outcomes, comparing counties with disproportionately Black populations to all other counties” concluded that, “while disproportionately Black counties account for only 30% of the U.S. population, they were the location of 56% of COVID-19 deaths.”²³ Additionally, the Centers for Disease Control and Prevention (the “CDC”) has reported that, “Racial and ethnic minority groups have disproportionately higher hospitalization rates among every age group, including children aged younger than 18 years.”²⁴ Additionally, the CDC notes that

“Non-Hispanic American Indian or Alaska Native persons have an age-adjusted hospitalization rate approximately 5.5 times that of non-Hispanic White persons, non-Hispanic Black persons have a rate approximately 4.5 times that of non-Hispanic White persons, while Hispanic or Latino persons have a

²⁰ UDHR, *supra* note 6, at art. 3.

²¹ HRC GC 36, *supra* note 19, at ¶ 26.

²² *Id.*

²³ Maria Godoy & Daniel Wood, *What Do Coronavirus Disparities Look Like State by State*, NPR (May 30, 2020 6:00 A.M.), <https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state>.

²⁴ *COVID-19 Racial and Ethnic Health Disparities*, CTR. DISEASE CONTROL (Dec. 10, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/disparities-hospitalization.html>.

rate approximately 4 times that of non-Hispanic White persons.”²⁵

The impact of COVID-19, thus, differs sharply by race and ethnicity.

The disproportionate impact of COVID-19 based on race, further, stems from the U.S.’s violation of the right to equality and non-discrimination, which is a right that is foundational to all human rights, including health, and espoused in every human rights instrument. The first article of the UDHR sets out that “All human beings are born free and equal in dignity and rights.”²⁶ Article 2 follows by recognizing freedom from discrimination with regards to all rights in the UDHR, including the right to health, on the basis of “race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”²⁷ Both the ICCPR and ICESCR echo this with regards to the rights set out in these treaties,²⁸ and the ICCPR sets out a stand-alone right to non-discrimination and equality.²⁹ Furthermore, the ICERD links the

²⁵ *COVIDView Summary ending on June 13, 2020*, CTR. DISEASE CONTROL (June 19, 2020) [hereinafter *COVIDView*], <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/past-reports/06192020.html>.

²⁶ UDHR, *supra* note 6, at art.1

²⁷ *Id.* at art. 2.

²⁸ ICCPR, *supra* note 7, at art. 2; ICESCR, *supra* note 9, at art. 3. (“The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.”). In pertinent part, the ICCPR reads as follows:

Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

ICCPR, *supra* note 8, at art. 2.

²⁹ ICCPR, *supra* note 7, at art. 26. Article 26 of the ICCPR states that

All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language,

rights to health and equality by requiring State parties “to eliminate racial discrimination in all its forms and to guarantee the right of everyone . . . to equality before the law, notably in the enjoyment of . . . the right to public health [and] medical care.”³⁰ While domestic law in the U.S. only focuses on rectifying intentional discrimination,³¹ international human rights law has a much broader approach to equality, calling for substantive equality and addressing disparate impacts.³² The failure in the U.S. to eliminate racial discrimination in health services and the underlying determinants of health is highlighted by the disproportionate infection rates among the Black American community.³³

Inequalities in health services include inferior and biased care, as well as disparate access to health care services. Inferior and biased care is a direct violation of the right to health, which requires that health facilities and goods be scientifically and medically appropriate and of good quality.³⁴ In 2005, a National Academy of Medicine (the “NAM”) study concluded that “racial and ethnic minorities receive lower-quality health care than white people—even when insurance status, income, age, and severity of conditions are comparable.”³⁵ In addition, the study showed that minori-

religion, political or other opinion, national or social origin, property, birth or other status.

Id.

³⁰ ICERD, *supra* note 9, at art. 5(e)(iv).

³¹ *Vill. of Arlington Heights v. Metro. Hous. Dev. Corp.*, 429 U.S. 252, 269–271 (1977); Jennifer M. Hesch, *Village of Arlington Heights v. Metropolitan Housing Development Corp.*, BRITANNICA ONLINE ENCYC., <https://www.britannica.com/topic/Village-of-Arlington-Heights-v-Metropolitan-Housing-Development-Corp> (last visited May 7, 2021). (noting that United States Supreme Court held that racial discriminatory intent or purpose must be the motivating factor of a government action for there to be a violation of Fourteenth’s Amendment’s equal protection clause).

³² Hum. Rts. Comm., General Comment 18: Non-discrimination (Thirty-seventh session, 1989), U.N. Doc. HRI/GEN/1/Rev. 1, at 26 (July 29, 1994).

³³ Godoy & Wood, *supra* note 23; *see* COVIDView, *supra* note 25.

³⁴ CDESCR GC 14, *supra* note 18, at ¶ 12(d).

³⁵ Khiara M. Bridges, *Implicit Bias and Racial Disparities in Health Care*, AM. BAR ASS’N, https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/racial-disparities-in-health-care/ (last visited May 7, 2021).

ties in the U.S. are less likely than white Americans to receive appropriate cardiac care, kidney dialysis or transplants and that minorities are less likely than white Americans to be given the best treatments for cancer, stroke, or AIDS.³⁶ The NAM study also showed that Black Americans were less likely to be given coronary bypass operations and angiography, and are discharged earlier than white Americans after surgery—“at a stage when discharge is inappropriate.”³⁷ The NAM study has been corroborated in recent years with new studies that show that “providers are less likely to deliver effective treatments to people of color when compared to their white counterparts—even after controlling for characteristics like class, health behaviors, comorbidities, and access to health insurance and health care services.”³⁸ For instance, one study of 400 hospitals in the U.S. found that Black Americans with heart disease were given “older, cheaper, and more conservative treatments” than white Americans.³⁹

Additionally, the disproportionate effect of the coronavirus on the Black American community exemplifies the physical and economic inaccessibility of health care services. The right to health requires that “[h]ealth facilities, goods and services must be accessible to everyone without discrimination, within the jurisdiction of the State party.”⁴⁰ A 2014 National Institutes of Health study found that hospitals in predominantly Black American neighborhoods are more likely to close down than those in predominantly white neighborhoods.⁴¹ However, the right to health requires that “health facilities, goods and services be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities.”⁴² Therefore, the lack of physical

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ CESCR GC 14, *supra* note 18, at ¶ 12(b)(ii).

⁴¹ Eugene Scott, *4 Reasons Coronavirus is Hitting Black Communities So Hard*, WASH. POST (Apr. 10, 2020, 3:10 PM), <https://www.washingtonpost.com/politics/2020/04/10/4-reasons-coronavirus-is-hitting-black-communities-so-hard/>.

⁴² CESCR GC 14, *supra* note 18, at ¶ 12(b)(iii).

accessibility to hospitals in predominantly Black American communities is a violation of the right to health.

The high expense of health care in the U.S. and lack of a public option further serve to bar access for Black and Hispanic Americans. The right to health requires States to ensure that “payment for health-care services, as well services related to the underlying determinants of health” are “based on the principles of equity,” meaning that “socially disadvantaged groups” and “poorer households should not be disproportionately burdened with health expenses as compared to richer households.”⁴³ The U.S. is one of the only industrialized countries in the world that does not have a universal healthcare system, requiring Americans to either have private health insurance or directly pay for health care.⁴⁴ Instead of a healthcare system, the U.S. is more accurately described as having a health insurance system, in which most Americans get health insurance through their employers.⁴⁵ However, Black and Hispanic Americans are overrepresented in low-income jobs that lack benefits like health insurance.⁴⁶ These low-income jobs include agricultural, domestic, and service vocations.⁴⁷ The devaluation of these low-income jobs are the results of intentional government policy and is the legacy of slavery, Jim Crow, and the New Deal.⁴⁸ As a result, only 55% of Black Americans have private health insurance compared to 75% of white Americans, according to the U.S. De-

⁴³ *Id.*

⁴⁴ Timothy Callaghan, *3 Reasons the U.S. Doesn't Have Universal Health Coverage*, U.S. NEWS (Oct. 26, 2016, 12:22 P.M.), <https://www.usnews.com/news/national-news/articles/2016-10-26/3-reasons-the-us-doesnt-have-universal-health-coverage>.

⁴⁵ *How Do Most Americans Get Their Health Insurance?*, USA Facts (Mar. 23, 2020, 4:41 PM), <https://usafacts.org/articles/how-most-americans-get-their-health-insurance-medicare-employers/>.

⁴⁶ Courtney Connley, *Racial Health Disparities Already Existed in America—The Coronavirus Just Exacerbated Them*, CNBC (June 3, 2020, 10:29 AM), www.cnbc.com/2020/05/14/how-covid-19-exacerbated-americas-racial-health-disparities.html.

⁴⁷ Danyelle Solomon, Connor Maxwell & Abril Castro, *Systematic Inequality and Economic Opportunity*, CTR. AM. PROGRESS (Aug. 7, 2019, 7:00 AM), <https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/>.

⁴⁸ *Id.*

partment of Health and Human Services.⁴⁹ This is a violation of the right to access health care, requiring “health facilities, goods and services [to] be affordable for all.”⁵⁰

Black and Hispanic American workers disproportionately earn lower wages than white American workers, violating both their right to work in decent conditions and to an adequate standard of living. The U.S. violations of these rights further impede on the rights of Black and Hispanic American workers to health and a life with dignity. A 2019 report by the Brookings Institution highlights the disparity in income faced by many Black and Hispanic workers: “63% of Latino or Hispanic workers and 54% of Black workers earn low wages, compared to 40% of Asian American workers and 37% of white workers,” and even in these low-income jobs, Black and Hispanic employees “earn less than white workers with the same education level and experience.”⁵¹ This is a violation of the right to equal pay for equal work, outlined in article 5(e)(i) of the ICERD, which requires States Parties to prohibit and eliminate racial discrimination in all its forms.⁵²

The 2019 Brookings report, further, categorized “low wages,” as “jobs that pay a median salary of \$10.22 per hour or \$17,950 per year.”⁵³ Paying such low wages to workers is a violation of the right to work. Article 23(3) of the UDHR sets out the right to work as the “right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.”⁵⁴ Article 7(a)(ii) of the ICESCR sets out the “right of everyone to the enjoyment of just and favorable conditions of work which ensure, in particular: remuneration which provides all workers, as a minimum with . . . a decent living for themselves and their families.”⁵⁵

Moreover, a salary that is insufficient to enable access to health care violates the right to an adequate standard of living, outlined in

⁴⁹ Connley, *supra* note 46.

⁵⁰ CDESCR GC 14, *supra* note 18, at ¶ 12(b)(iii).

⁵¹ Connley, *supra* note 46.

⁵² ICERD, *supra* note 9, at art. 5(e)(i).

⁵³ Connley, *supra* note 46.

⁵⁴ UDHR, *supra* note 6, at art. 23(3).

⁵⁵ ICESCR, *supra* note 9, at art. 7(a)(ii).

article 11(1) of the ICESCR and article 25(1) of the UDHR. Article 11(1) of the ICESCR states that everyone has the “right to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions.”⁵⁶ This elaborates on article 25(1) of the UDHR, which states that “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”⁵⁷ Allowing employers to remunerate workers with low wages that makes access to basic health services an impossibility and further violates the right to a life with dignity. As the Human Rights Committee General Comment no. 36 explains:

The duty to protect life also implies that States parties should take appropriate measures to address general conditions in society that may . . . prevent individuals from enjoying their right to life with dignity The measures called for to address adequate conditions for protecting the right to life include . . . measures designed to ensure access . . . to health care.⁵⁸

In addition to the stark inequalities in quality and access to health care based on race, inequalities in the underlying determinants of health have also resulted in the racially skewed impact of COVID-19. Specifically, this consists of housing discrimination, poor access to healthy foods, and dangerous work conditions for many Black Americans. Housing conditions are an influential factor in determining the likelihood of contracting the coronavirus. The CDC has stated that

Crowded living conditions and unstable housing contribute to transmission of infectious diseases and can hinder COVID-19 prevention strategies like hygiene measures, self-isolation, or self-quarantine Among people with COVID-19,

⁵⁶ *Id.* at art. 11(1).

⁵⁷ UDHR, *supra* note 6, at art. 25(1).

⁵⁸ HRC GC 36, *supra* note 19, at ¶ 26.

people in racial and ethnic minority groups were more likely to live in areas with higher population density and more housing units or inadequate housing (such as lack of indoor plumbing).⁵⁹

Adequate housing is both an underlying determinant of health and a component of the right to an adequate standard of living.⁶⁰ Furthermore, a component of the right to adequate housing is habitability, which includes “providing the inhabitants with adequate space and protecting them from . . . threats to health,” further linking the right to adequate housing to the right to health.⁶¹

Furthermore, housing discrimination and redlining, “the systemic practice of refusing government resources to predominantly black neighborhoods because they’ve been deemed a financial risk,” has resulted in many Black Americans living in what is known as “food deserts,” with implications for health, as well as the right to food.⁶² Food deserts are neighborhoods that lack access

⁵⁹ *COVID-19 Racial and Ethnic Health Disparities*, CTR. FOR DISEASE CONTROL, <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/increased-risk-exposure.html> (last updated Dec. 10, 2020).

⁶⁰ CESCR GC 14, *supra* note 18, at ¶ 11. (“The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and 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.”); UDHR, *supra* note 6, at art. 25(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.”); ICESCR, *supra* note 9, at art. 11(1). (“The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions.”).

⁶¹ Comm. on Cultural, Econ. and Soc. Rts., General Comment No. 4: The Right to Adequate Housing (Art. 11), ¶ 8(d), U.N. Doc. E/1992/23 (Dec. 13, 1991).

⁶² Connley, *supra* note 46.

to affordable and good-quality, healthy options.⁶³ Clinical pharmacist Jessica Caporuscio noted that “this may be due to having a limited income or living far away from sources of healthful and affordable food.”⁶⁴ Access to adequate food is both an underlying determinant of health, as well as a component of an adequate standard of living.⁶⁵ However, for many Black Americans living in food deserts, the food decisions they make are the result of a survival mindset in which they do not have the luxury of considering the long term effect of their diet.⁶⁶ Black Americans living in food deserts “tend to rely on high calorie foods that are cheaper and more accessible,” and result in chronic diseases that raise the risk of death from COVID-19.⁶⁷ This has also resulted in a disproportionate number of Black Americans with underlying health prob-

⁶³ *Id.*

⁶⁴ Jessica Caporuscio, *What Are Food Deserts, and How Do They Impact Health?*, MED. NEWS TODAY (June 22, 2020), <https://www.medicalnewstoday.com/articles/what-are-food-deserts>.

⁶⁵ CESCR GC 14, *supra* note 18, at ¶ 11. (“The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and 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.”); UDHR, *supra* note 6, at art. 25(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.”); ICESCR, *supra* note 9, at art. 11(1). (“The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions.”). Comm. on. Cultural, Econ. & Soc. Rts., Article 11: the Right to Adequate Food, ¶ 6, U.N. Doc. E/C.12/1999/5 (May 12, 1999) (“The right to adequate food is realized when every man, woman, and child, alone or in a community with others, have physical and economic access at all times to adequate food or means for procurement.”); *id.* at ¶ 8 (“The availability of food in quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture.”).

⁶⁶ Connley, *supra* note 46.

⁶⁷ *Id.*

lems, such as heart disease, diabetes, and hypertension, which raise the risk of death from COVID-19.⁶⁸

The COVID-19 pandemic serves as a fatal awakening that the U.S. must change the way it views human rights, specifically the right to health. Currently, the U.S. is disinclined to acknowledge positive rights as legitimate, including health care.⁶⁹ While negative rights “prevent the state from violating individual autonomy,” positive rights “impose a duty on the state to provide certain goods and services.”⁷⁰ If the U.S. can work towards actively realizing “the highest attainable standard of physical and mental health” as a right to which all Americans are entitled, this would be a big step towards ensuring the health and well-being of all Americans.⁷¹ Only by adopting the ICESCR can the U.S. truly claim to be a leader in promoting human rights and a country that guarantees basic rights for all. Furthermore, the U.S. must adopt a more robust right to equality that seeks to address disproportionate impacts based on race. The first step is to acknowledge that the playing field is systematically unequal for racial minorities.

The COVID-19 pandemic has exposed severe structural inequalities in the U.S., which disproportionately impact racial and ethnic minorities. The U.S. has failed to ensure the rights to equality and health with regard to both health care quality and access, as well as with regard to the underlying determinants of health, including access to adequate housing and food and to decent working conditions. Moreover, with the COVID-19 pandemic leading to premature deaths, these breaches have had fatal consequences, further violating the right to life.

⁶⁸ *Id.*

⁶⁹ Tamar Ezer, *A Positive Right to Protection for Children*, 7 YALE HUM. RTS. & DEV. L.J. 1, 4 (2004).

⁷⁰ *Id.*

⁷¹ ICESCR, *supra* note 9, at art. 12(1).