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Alichia McIntosh

Northwestern Pritzker School of Law, alichia.mcintosh@law.northwestern.edu

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Healthcare Inequities in the United States and Beyond Are Taking Black Women's Lives

Alichia McIntosh*

ABSTRACT

Black women have been dying at devastating rates due to health complications at the hands of the United States' healthcare and legal systems. This Note explores these distressing rates and how they compare to White women while analyzing the fatalities and diagnoses among several health complications and diseases. These fatalities persist due to the United States' history of racism—such as the institution of slavery and over 100 years of Black bodies experiencing Jim Crow laws—and the socioeconomic disadvantages Black women disproportionately face. This Note emphasizes that these disparities continue because the United States has failed to implement treaties—which it has ratified—and to ratify treaties that recognize health care as a human right and prohibit de facto and de jure discrimination. Instead, the United States' legal system ignores the de facto discrimination that Black women face since the Supreme Court has held that the United States Constitution prohibits only de jure discrimination. Still, the question remains: how can the United States navigate out of the horrific disparities resulting from de facto discrimination and provide Black women a more equitable medical experience in U.S. society? This Note recommends the United States combat these disparities by investing in Black communities, recruiting and training more Black doctors, providing proper medical bias training, performing its obligations under the international treaties it has ratified, and ratifying the treaties it has enacted.

Keywords: Black, women, discrimination, inequity, health, care, disparities, access, doctor, international, right

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INTRODUCTION

“Equal rights, fair play, justice, are all like the air: we all have it, or none has it. That is the truth of it.” —*Maya Angelou*.¹

Serena Williams, one of the most well-known tennis players in the world with a net-worth of 200 million dollars, had an “easy” pregnancy.² Unfortunately, her delivery and post-delivery were not as easy. After Serena’s contractions caused her daughter’s heart rate to drop, the baby was born by emergency C-section.³ A day after the birth, Serena’s health complications started to spiral when she began to experience shortness of breath—a symptom she had experienced before.⁴ See, Serena had complications with pulmonary embolism, a life threatening condition where arteries in the lungs are blocked by a blood clot and cause shortness of breath.⁵ Aware of her medical history, Serena alerted the nurse when she started to feel shortness of breath, and while gasping for air, stated she “needed a CT scan with contrast and IV heparin right away.”⁶

The nurse ignored Serena’s requests for treatment, believing her medicine was making her confused.⁷ After further insistence, a doctor performed an unnecessary ultrasound of her legs, which revealed nothing.⁸ As Serena’s complications continued, she

* Author—Alichia McIntosh Esq.; J.D., Northwestern Pritzker School of Law, 2022; B.A., Southern Illinois University, Carbondale, 2019. Alichia McIntosh authored this article during law school. The views and opinions expressed in this article are solely those of the author. They do not purport to reflect the views or opinions of any entities or individuals she is affiliated with or represents. I dedicate this note to Black women who have felt ignored while advocating for their health and livelihood in the United States’ society. May we all fight for equity for all women. A huge thanks to the Northwestern Journal of Law and Social Policy editorial board for their work on this piece and prioritizing the importance of giving diverse perspectives a platform.

¹ Interview by the Acad. of Achievement with Maya Angelou, (Jan. 22, 1997).

² Serena Williams, *Serena Williams: What My Life-Threatening Experience Taught Me About Giving Birth*, CNN (Feb. 20, 2018, 3:32 PM), <https://www.cnn.com/2018/02/20/opinions/protect-mother-pregnancy-williams-opinion>.

³ *Id.*

⁴ P.R. Lockhart, *What Serena Williams’s Scary Childbirth Story Says About Medical Treatment of Black Women*, VOX (Jan. 11, 2018, 4:40 PM), <https://www.vox.com/identities/2018/1/11/16879984/serena-williams-childbirth-scare-black-women>.

⁵ *Id.* See also *Pulmonary embolism*, MAYO CLINIC (Dec. 1, 2022), <https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc-20354647>.

⁶ *Id.* Heparin is a blood thinner.

⁷ *Id.*

⁸ *Id.*

forcefully coughed, due to the embolisms, and ruptured her C-section incision.⁹ She finally received the CT scan she begged for, which indicated “several small blood clots [had] settled in her lungs.”¹⁰ While such an experience might seem like an extreme case of doctors navigating a complicated medical system, Serena’s experience is not an isolated incident. Her experience is symptomatic of a much larger issue: the U.S. healthcare system’s disparate treatment of Black women. As a result of this disparate treatment, the health struggles of Black women are systematically minimized or dismissed. Thus, the color of their skin is “the difference between life and death.”¹¹

Serena’s story, and the stories that follow, highlight how Black women must fight to receive appropriate health care in the United States. These stories show that stereotypes, biases, and the lack of access to sufficient care negatively impact Black women’s medical treatment. Moreover, a Black woman’s financial and educational resources—as shown by Serena’s case—are not dispositive. These stories demonstrate that many doctors do not recognize their patients’ pain when their patients are Black women, and studies, which will be discussed in Part II, have confirmed this conclusion.¹²

Amira Lewally, a Black woman in the United States, lost hearing in her left ear.¹³ After attempting to treat the ear on her own, she sought a primary care doctor for help.¹⁴ However, at every step, she had to fight for her health when the doctors did not.¹⁵ A doctor first told her the muffled hearing was probably due to allergies.¹⁶ Her symptoms continued for months and eventually a clear fluid started leaking from her nose.¹⁷ She asked her doctor whether her previous diagnosis, pseudotumor cerebri,¹⁸ might be causing her symptoms.¹⁹ However, the doctor stayed firm on the first diagnosis: allergies.²⁰ A year later, Amira returned to the doctor after finding an article supporting her hypothesis that her symptoms may be due to brain leakage.²¹ Amira insisted on seeing an ear, nose, and throat specialist.²²

⁹ *Id.*

¹⁰ *Id.*

¹¹ Joanne Spataro, *Doctors Don’t Always Believe You When You’re a Black Woman*, VICE: HEALTH (Feb. 2, 2018, 9:00 AM), <https://www.vice.com/en/article/qvedxd/doctors-dont-always-believe-you-when-youre-a-black-woman> (summarizing stories of everyday Black women advocating for their health in regard to pregnancies, adequate birth control for their particular bodies, brain injuries, orthopedic injuries, etc.).

¹² *Id.*; for instance, a 2019 study found that doctors more readily recognized White participants’ pain than Black participants. This phenomenon is further discussed in Part II. *See generally* Peter Mende-Siedlecki, Jennie Qu-Lee, Robert Backer, & Jay J. Van Bavel, *Perceptual Contributions to Racial Bias in Pain Recognition*, 148 J. EXPERIMENTAL PSYCH.: GEN. 863 (2019).

¹³ Amira Lewally, *As a Black Woman, I Had to Beg Doctors to Take Me Seriously When My Brain Was Leaking*, L.A. TIMES (Oct. 30, 2020, 6:30 AM), <https://www.latimes.com/lifestyle/story/2020-10-30/amira-lewally-i-begged-doctors-to-take-me-seriously-when-my-brain-was-leaking>.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ Pseudotumor cerebri is a pressure buildup in the brain that causes headaches and eyesight issues. *Pseudotumor Cerebri*, JOHNS HOPKINS MED., <https://www.hopkinsmedicine.org/health/conditions-and-diseases/pseudotumor-cerebri> (last visited Nov. 6, 2022).

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.* This symptom is caused by a cerebrospinal fluid leak. *Cerebrospinal Fluid (CSF) Leak*, JOHNS HOPKINS MED., <https://www.hopkinsmedicine.org/health/conditions-and-diseases/cerebrospinal-fluid-csf-leak> (last visited Aug. 17, 2022).

²² *Id.*

Three years and three doctors later, she finally received an accurate diagnosis confirming a cerebrospinal fluid leak.²³ It took three years of self-advocacy for Amira to get the appropriate diagnosis.²⁴ Amira ensured her health, not the doctors who were paid to do so.

Not every Black woman's self-advocacy results in proper care; Dr. Susan Moore died on December 18, 2020, due to COVID-19 complications.²⁵ She died two weeks after posting a video on social media stating her White doctor was ignoring her continuous complaints of pain and requests for medication because she was Black, even though *she was a doctor herself*.²⁶ In the video, Dr. Moore explained her doctor brushed off her symptoms, telling her, “[y]ou’re not even short of breath.”²⁷ Despite her severe and evident pain, the doctor told her he might send her home without more medication.²⁸ Dr. Moore stated the doctor made her feel like a drug addict, even though the medication she asked for “would support her recovery by making it easier for her to breathe” and was “part of standard treatment for COVID-19.”²⁹ In a press review after Dr. Moore's passing, the President and CEO of the hospital admitted to her mistreatment while she was under their care.³⁰

This Note explores conceivable reasons for the mistreatment exhibited in these stories and why Black women are dying at disproportionate rates compared to their White counterparts. Part I compares health disparities and causes of death among Black and White women. Part II explores explanations for these health and death disparities, such as doctors ignoring Black women's pain, the impact of one's socioeconomic background, and the effects of racism and stereotypes. Part III compares the U.S. healthcare experience with its international equivalents. Specifically, this Note discusses the right to health care emphasized in the United Nations' (U.N.) treaties, the United States' unwillingness to ratify the treaties it has enacted and abide by the ones it has ratified, and how U.S. constitutional interpretation affects the right to health care. Finally, Part IV offers recommendations to combat these race-based disparities. These suggestions include the United States joining and enforcing U.N. treaties, investing in Black low-income communities, and pushing for more diverse medical practitioners. Each of these actions would constitute a significant step toward a more equitable medical experience for Black women in U.S. society.

²³ *Id.* A cerebrospinal leak, left untreated “can lead to life-threatening meningitis, brain infections, or stroke.” *What Happens if a CSF Leak Goes Untreated?* HEALTHY J., <https://www.thehealthyjournal.com/faq/what-happens-if-a-csf-leak-goes-untreated> (last visited Aug. 17, 2022).

²⁴ See *What Happens if a CSF Leak Goes Untreated?*, *supra* note 23 (explaining that “[p]atients may have a CFS leak for years or decades before it is diagnosed” since it is “often mysterious where the leak is and what is causing it”).

²⁵ Dakin Andone, *A Black Doctor Died of Covid-19 Weeks After Accusing Hospital Staff of Racist Treatment*, CNN (Dec. 25, 2020, 7:33 AM), <https://www.cnn.com/2020/12/24/us/black-doctor-susan-moore-covid-19/index.html>.

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ *Id.*

I. HEALTH DISPARITIES BETWEEN BLACK AND WHITE WOMEN

Disparities in outcomes across health conditions, such as breast cancer, heart disease, pregnancy-related complications, and HIV, show that Black and White women live two different realities in the United States. Most Black women are affected by poor quality health care and environmental conditions that do not have the same effect on most White women. This Part discusses the statistical difference in death and diagnosis among these conditions between the two demographics.

A. Breast Cancer Disparities

Breast cancer used to be the second leading cause of cancer deaths among Black women, following lung cancer.³¹ However, a 2022 report by the American Cancer Society found that breast cancer now surpasses lung cancer as the leading cause of cancer death in Black women.³² Black women are more likely than any other racial group to die from breast cancer.³³ In fact, Black women are 40% more likely to die from breast cancer than their White counterparts.³⁴ Although it is true that women in the United States, at large, have a 13% chance of developing breast cancer,³⁵ fatal breast cancer is most common among Black women.³⁶

Researchers have identified that hormonal, lifestyle (obesity and health behaviors), and environmental factors—such as barriers to quality healthcare access—increase a person’s risk of breast cancer.³⁷ The explanation for this disparity, which will be discussed in Part III, is analogous to explanations for the disparities seen among many other diseases and health complications. The common causes among a wide range of diseases and medical conditions reflect that there may also be a common solution. But instead, these issues remain unresolved among the United States’ medical, legal, and political systems.

³¹ *Black Women in U.S. Most Likely To Die from Breast Cancer*, SUSAN G. KOMEN BLOG (Feb. 12, 2020), <https://blog.komen.org/blog/black-women-in-us-most-likely-to-die-from-breast-cancer/>; Sandy McDowell, *Breast Cancer Death Rates Are Highest for Black Women—Again*, AM. CANCER SOC’Y (Oct. 3, 2022), <https://www.cancer.org/latest-news/breast-cancer-death-rates-are-highest-for-black-women-again.html>.

³² Angela N. Giaquinto, Hyuna Sung, Kimberly D. Miller, Joan L. Kramer, Lisa A. Newman, Adair Minihan, Ahmedin Jemal, & Rebecca L. Siegel, *Breast Cancer Statistics, 2022*, 72 CA: A CANCER J. FOR CLINICIANS 524–41 (2022).

³³ *Black Women in U.S. Most Likely To Die from Breast Cancer*, *supra* note 31.

³⁴ *Id.*

³⁵ *Key Statistics for Breast Cancer*, AM. CANCER SOC’Y, <https://www.cancer.org/cancer/breast-cancer/about/how-common-is-breast-cancer.html> (last visited Jan. 28, 2023).

³⁶ *Black Women in U.S. Most Likely to Die from Breast Cancer*, *supra* note 31.

³⁷ Doctors estimate between five and ten percent of breast cancers result from a genetic mutation. It is logical to assume, due to Black women being at higher risk of being diagnosed with cancer, that their offspring may also face similar health complications. Judy C. Boughey, *Breast Cancer*, MAYO CLINIC (Dec. 14, 2022), <https://www.mayoclinic.org/diseases-conditions/breast-cancer/symptoms-causes/syc-20352470>. However, this estimate would not limit the analysis that environments and inadequate healthcare impact these statistics—since the estimate does not account for why Black women are more likely to have genetic mutations that develop into breast cancer. If anything, doctors’ assessments offer support that the historical mistreatment of Black women’s bodies, whether from lack of medical care or from environmental impacts, has continued to affect Black women’s bodies; this is the idea of “weathering,” which Part II explains.

B. Heart Disease Disparities

Outcomes in heart diseases also reflect a significant health gap between Black and White women.³⁸ Just considering disparities among races, and not the intersectionality of race and sex, in 2018, Black people were 30% more likely to die of heart disease than White people.³⁹ Currently, less is “known . . . on sex-based disparities;”⁴⁰ however, a 2009 comparative study reviewed the status of cardiovascular disease (CVD) in Black women compared to White women.⁴¹ The study found Black women have a greater chance of death for coronary artery disease, hypertension, stroke, and congestive heart failure.⁴² Coronary artery disease death was “69% higher in [B]lack women than in [W]hite women.”⁴³ Stroke deaths were 54% higher in Black women.⁴⁴ Together, these findings demonstrate Black women have a significantly higher death risk for CVD than White women.⁴⁵

C. Pregnancy Related Deaths and Abortion

There is also a racial disparity in pregnancy-related deaths.⁴⁶ In any given year, 50,000 women in the United States experience “dangerous or life-threatening pregnancy-related complications.”⁴⁷ However, Black women are more likely to “fall victim to the United States’ ongoing maternal mortality crisis.”⁴⁸ Black women are three to four times more likely to die from pregnancy-related complications than White women.⁴⁹ Put another way, Black women are 243% more likely than White women to die from pregnancy-related complications, making these complications one of the “largest racial disparities in women’s

³⁸ *Id.*

³⁹ *Heart Disease and African Americans*, U.S. DEP’T OF HEALTH & HUM. SERVS.: OMH (Feb. 17, 2023, 3:38 PM), <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=19>.

⁴⁰ Ashley N. Kyalwazi, Emefah C. Loccoh, LaPrincess C. Brewer, Elizabeth O. Ofili, Jiaman Xu, Yang Song, Karen E. Joynt Maddox, Robert W. Yeh, & Rishi K. Wadhera, *Disparities in Cardiovascular Mortality Between Black and White Adults in the U.S., 1999 to 2019*, 146 *CIRCULATION: AM. HEART ASS’N* 211–28 (2022).

⁴¹ Richard Allen Williams, *Cardiovascular Disease in African American Women: A Health Care Disparities Issue*, 101 *J. NAT’L MED. ASS’N*. 536, 536 (June 2009).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.* CVD is a term that refers to several diseases that affect the heart and blood vessels, which include coronary heart disease and stroke. NAT’L HEART, LUNG, & BLOOD INST., KNOW THE DIFFERENCE: CARDIOVASCULAR DISEASE, HEART DISEASE, CORONARY HEART DISEASE (2020), <https://www.nhlbi.nih.gov/sites/default/files/publications/FactSheetKnowDiffDesign2020V4a.pdf>. Coronary artery disease takes a toll on the heart when waxy substances build up in the coronary arteries, which overtime can lead to a heart attack or heart failure. A stroke damages the brain when either a blood clot or buildup of plaque blocks arteries that lead to the brain, which causes brain damage such as weakness or paralysis. Evan Starkman, *Is it Coronary Artery Disease (CAD) or a Stroke?*, WEDMD (Oct. 26, 2021), <https://www.webmd.com/heart-disease/coronary-artery-disease-or-stroke>.

⁴⁶ Lockhart, *supra* note 4.

⁴⁷ *Id.* Pregnancy related deaths are a significant health crisis for all women in the world, and “most pregnancy related deaths are preventable.” *Pregnancy-Related Deaths in the United States*, CTRS. FOR DISEASE CONTROL & PREVENTION (Nov. 16, 2022), <https://www.cdc.gov/hearher/pregnancy-related-deaths/index.html>.

⁴⁸ *Id.*

⁴⁹ *Id.*

health.”⁵⁰ Variations in healthcare quality, underlying medical conditions, racism, and bias all factor into this disparity, as will be discussed in Part II.⁵¹

The number of Black women losing their lives to pregnancy-related complications could climb after the *Dobbs v. Jackson Women’s Health Organization* decision, which held that the United States Constitution does not confer the right to an abortion.⁵² *Dobbs* overruled *Roe v. Wade* and *Planned Parenthood v. Casey*, which, together, recognized that the right to privacy protects a woman’s ability to exercise liberty over her body and the decision to get an abortion (within limitations).⁵³

However, *Dobbs* completely obliterated *Roe* and *Casey*. In *Dobbs*, the Court emphasized numerous times that abortion is not a constitutional right while analyzing if abortion falls under one of the first eight Amendments or if it is a fundamental right “deeply rooted in [U.S.] history and tradition’ and . . . essential to [United States]’ ‘scheme of ordered liberty.’”⁵⁴ The Court held abortion does not fall under either.⁵⁵

One dire consequence of *Dobbs* is that fatalities from pregnancy complications will increase as states bar medical providers from conducting necessary abortions.⁵⁶ Because Black women are more likely to face life-threatening pregnancy complications, they are more likely to need a lifesaving abortion, and the *Dobbs* decision will cause severely damaging and dangerous consequences for Black women.⁵⁷ A 2021 study by sociologist Amanda Stevenson found that banning abortions nationwide would lead to a 21% increase in pregnancy-related deaths for all women and 33% among Black women.⁵⁸ Although

⁵⁰ *Id.* “According to the CDC, Black women are 22 percent more likely to die from heart disease and 71 percent more likely to die from cervical cancer.” Nina Martin & Renee Montagne, *Lost Mothers: Nothing Protects Black Women From Dying in Pregnancy and Childbirth*, PROPUBLICA (Dec. 7, 2017, 8:00 AM), <https://www.propublica.org/article/nothing-protects-black-women-from-dying-in-pregnancy-and-childbirth>.

⁵¹ *Working Together to Reduce Black Maternal Mortality*, CTRS. FOR DISEASE CONTROL & PREVENTION (Apr. 6, 2022), <https://www.cdc.gov/healthequity/features/maternal-mortality/index.html>.

⁵² *Dobbs v. Jackson Women's Health Org.*, 142 S. Ct. 2228, 2242 (2022).

⁵³ *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

⁵⁴ *Dobbs*, 142 S. Ct. at 2244; *Timbs v. Indiana*, 139 S. Ct. 682, 689 (2019).

⁵⁵ *See generally Dobbs*, 142 S. Ct. at 2257–59.

⁵⁶ There is a lack of data concerning deaths that result from abortions, both legal and illegal, due to stigmas related to abortion. However, the CDC’s limited research shows that after *Roe*, deaths relating to illegal abortions decreased from nineteen in 1973 to six in 1974. Further, from 1979 to 2017, no more than two women died a year from unlawful abortions (the ethnicity of these women was undetermined). “Mortality rates for legal abortions have seemed to decline over the same period.” Madison Czopek, *Fact Check: Did Roe v. Wade Mark ‘the End of Women Dying From Abortions’?*, AUSTIN AM.-STATESMAN (Oct. 17, 2021, 2:21 PM), <https://www.statesman.com/story/news/politics/2021/10/17/fact-check-roe-v-wade-texas-abortion-law-women-deaths/8468747002/>.

⁵⁷ Fabiola Cineas, *Black Women Will Suffer the Most Without Roe*, VOX (June 29, 2022, 1:20 PM), <https://www.vox.com/2022/6/29/23187002/black-women-abortion-access-roe>. For instance, Black women born in the U.S. are at a higher risk for preeclampsia (a blood pressure condition that can lead to fatal conditions) than other Black women who are not born in the U.S. Hence, race alone is not the only explanation for U.S.-born Black women’s health disparities, but includes a combination of biological, social, and cultural factors, which suggests there is something unique about the U.S. experience that causes health complications. *U.S.-Born Black Women at Higher Risk of Preeclampsia Than Foreign-Born Counterparts; Race Alone Does Not Explain Disparity*, JOHNS HOPKINS MED. (Dec. 29, 2021), <https://www.hopkinsmedicine.org/news/newsroom/news-releases/us-born-black-women-at-higher-risk-of-preeclampsia-than-foreign-born-counterparts-race-alone-does-not-explain-disparity>.

⁵⁸ Amanda Jean Stevenson, *The Pregnancy-Related Mortality Impact of a Total Abortion Ban in the United States: A Research Note on Increased Deaths Due to Remaining Pregnant*, 58 DEMOGRAPHY 2019 (Oct. 25, 2021).

abortion bans put all women at greater risk of death, Stevenson’s research indicates “the additional mortality burden is estimated to be greatest among non-Hispanic Black women.”⁵⁹

The *Dobbs* decision does not ban women from getting an abortion and instead allows states to interfere with a woman exercising autonomy over her body. But society should not ignore which states have abortion bans and how this affects Black women disproportionately. Thirteen states with trigger bans, which prohibited abortion within thirty days of the *Dobbs* decision, are primarily located in the South, where half of the United States’ Black population resides.⁶⁰ For instance, in 2019, in Mississippi alone, the state that initially filed *Dobbs*, 74% of abortions were performed for Black women.⁶¹ Alabama similarly had a high percentage of Black women getting abortions: 62% of abortions were performed for Black women. In Georgia, the rate was 65%.⁶²

Because many of these states (like Mississippi and Alabama) have a complete ban or a ban after six weeks of pregnancy (as in Georgia), more Black women will have to travel out of these Southern states to receive proper health care.⁶³ Of course, traveling out of state to get an abortion is not an experience unique to Black women; all women in these states will have to travel. What is unique to the experience of Black women is the lack of resources. Black women are less likely to have the financial means to travel out of state.⁶⁴ Just by analyzing the affordability of contraceptives, one can assume that travel costs are not readily available for Black women. For example, about four in ten Black women of ages 18-44 could not afford more than \$10 for contraceptives such as birth control.⁶⁵ If these women face the challenge of having to go out of state to get an abortion, they will likely not be able to because of financial restraints—which may lead to higher pregnancy-related deaths and intensify the maternal mortality disparity.⁶⁶

D. Human Immunodeficiency Virus Infection

Statistics from 2008 show that human immunodeficiency virus infection (HIV) is another area where Black women are substantially and disparately impacted compared to White women. HIV is among the top ten leading causes of death for Black women between the ages of 20-54.⁶⁷ However, it does not rank among the top ten leading causes of death for White women in any age bracket.⁶⁸ By contrast, the mortality rates of Black women with HIV between the ages of 25-64 were 8.2 times greater than White women in the same

⁵⁹ *Id.*

⁶⁰ Cineas, *supra* note 57.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ Carlos O. Nesbeth, Rajiv Kandala, & Syed Najeeb, *HIV Mortality Difference Between Black and White Women*, 11 J. HEALTH DISPARITIES RES. & PRAC., 179, 179 (2011).

⁶⁸ *Id.*

age bracket.⁶⁹ Overall, Black women are seventeen times more likely to die from HIV than their White counterparts.⁷⁰

These disparities are disappointing and shameful to the U.S. healthcare system. It is important to note that the categories of Black women dying are not limited to the diseases and circumstances discussed above. The question remains: Why are these disparities recurring among different health complications and what does this say about U.S. society?

II. WHY THESE HEALTH DISPARITIES EXIST

To analyze why these health disparities exist, one needs to explore the inherently racist history of the United States and how this history impacts U.S. society today. It is also essential to explore how socioeconomic obstacles affect one's health in various ways by influencing access to healthcare facilities or the opportunity to see a doctor who looks like the patient. This Part discusses these hurdles and suggests racism, stereotypes, access, and poverty are why Black women in the United States experience these disparities.

A. U.S. History: Slavery and Jim Crow's Impact on Health Care in the 21st Century

The disparities in the medical treatment and outcomes Black women experience are rooted in U.S. history. Looking back to the Jim Crow Era, which lasted over 100 years, legalizing and enforcing racial segregation and discrimination took an immense toll on Black people's health.⁷¹ Nancy Krieger, a professor at Harvard University's T.H. Chan School of Public Health, "found an association between Jim Crow laws and premature mortality rates for [Black] Americans born under those laws."⁷² The study focuses on the changes in estrogen receptor (ER) status in breast cancer patients, specifically women born in states that had Jim Crow laws.⁷³ Krieger reviewed 46,417 Black and 339,830 White U.S.-born women and found that among women diagnosed with breast cancer before age 55, the percentage of ER cases rose among each 4-year birth cohort (from 1915–1919 to 1975–1979).⁷⁴ Also, the percentage increase in ER tumors was greater in Black women

⁶⁹ *Id.*

⁷⁰ *Id.* at 188; see also Kristen Tillerson, *Explaining Racial Disparities in HIV/AIDS Incidence Among Women in the U.S.: A Systematic Review*, 27 *STATS. IN MED.* 4132 (Sept. 10, 2008) (discussing that there has not been a clear showing of whether Black women engage in more risky sexual behavior or are more likely to use drugs with needles. Instead, Tillerson suggests that states' studies need to focus on other explanatory factors such as child abuse, socioeconomic background, social behavior, and education. Tillerson further explains that these studies would provide scientifically rigorous information and a measure of the potential effectiveness of interventions in targeting these specific sources).

⁷¹ Erika Stallings, *This Is How the American Healthcare System Is Failing Black Women*, *OPRAH DAILY* (Aug. 1, 2018), <https://www.oprahdaily.com/life/health/a23100351/racial-bias-in-healthcare-black-women/> (discussing that Black women feel unheard by doctors and lack access to medical attention, such as receiving proper recommendations, which adds another layer to the common Black woman experience).

⁷² *Id.*; Nancy Krieger, Jaquelyn L. Jahn, Pamela D. Waterman, & Jarvis T. Chen, *Breast Cancer Estrogen Receptor Status According to Biological Generation: US Black and White Women Born 1915-1979*, 187 *AM. J. EPIDEMIOLOGY* 960 (2018).

⁷³ *Id.*

⁷⁴ Karen Feldscher, *Jim Crow Laws: A Contributing Factor to More Lethal Breast Cancer Among U.S. Black Women Now?*, *HARV. T.H. CHAN: SCH. PUB. HEALTH* (Nov. 1, 2017), <https://www.hsph.harvard.edu/news/features/jim-crow-breast-cancer-black-women/>.

than White women.⁷⁵ Among Black women, the increased rate of ER tumors was greatest for those born in Jim Crow law-abiding states compared to non-Jim Crow law states.⁷⁶ The results imply the impact of Jim Crow laws contributed to the higher percentage of ER tumors among Black women.⁷⁷ Though Jim Crow laws were abolished in the mid-1960s,⁷⁸ Krieger's research showed Black people's bodies suffered from the discriminatory treatment through the 1970s.⁷⁹

Krieger's research results align with the concept of "weathering," the toxic stress of dealing with discrimination over time that leads to poorer health outcomes—such as premature aging, which can shorten individuals' protective caps at the end of their chromosomes.⁸⁰ These protective caps, called telomeres, protect the DNA sequence.⁸¹ Due to the protective nature of telomere, proteins have evolved to preserve the protective cap's length and structure.⁸² Once this protective cap is damaged or not maintained, it can lead to cancer, which explains the higher ER tumors Krieger's research found in Black women as compared to White women—who experience discrimination in *different ways* during the Jim Crow Era.⁸³

Slavery is also embedded in the medical experience of Black women. For instance, gynecology practice advanced because of the oppression of Black women's bodies through the institution of slavery.⁸⁴ In 1808, the United States Congress prohibited participation in the international African slave trade.⁸⁵ As a result of the ban, enslavers looked elsewhere to maintain and grow the system of profiting off of Black bodies.⁸⁶ Enslavers pressured enslaved women to have children and ensured those children lived past the age of one.⁸⁷ Consequently, Black women procreating during slavery had little to do with "liberty" and instead was an additional bondage and result of oppression.⁸⁸ Therefore, doctors in the South, many of whom enslaved people, "had access to black bodies, particularly black women's bodies, to experiment on, to examine, and to, in their words, 'cure' or 'fix' diseases and disorders" of other demographic groups.⁸⁹ Black women were seen as "medical super bodies"—a term coined by Deirdre Owens to

⁷⁵ *Id.*

⁷⁶ *Id.*

⁷⁷ Krieger, Jahn, Waterman, & Chen, *supra* note 72, at 964.

⁷⁸ Stallings, *supra* note 71.

⁷⁹ Krieger, Jahn, Waterman, & Chen, *supra* note 72, at 964.

⁸⁰ Stallings, *supra* note 71; Jason A. Stewart, Mary F. Chaiken, Feng Wang, & Carolyn M. Price, *Maintaining the End: Roles of Telomere Proteins in End-Protection, Telomere Replication and Length Regulation*, 730 MUTATION RSCH. 12 (2012).

⁸¹ Stewart, Chaiken, Wang, & Price, *supra* note 80, at 12.

⁸² *Id.*

⁸³ *Id.* It should be acknowledged that all women have and do face sexual discrimination and discrimination unique to that person, i.e., disability, age, etc.; however, women of color experience discrimination based on the intersectionality of race and sex. Hence, Black and White women experience discrimination in different ways.

⁸⁴ Kara Manke, *Historian Uncovers Gynecology's Brutal Roots in Slavery*, BERKELEY NEWS (Feb. 17, 2020), <https://news.berkeley.edu/2020/02/17/historian-uncovers-gynecologys-brutal-roots-in-slavery/>.

⁸⁵ *The Slave Trade*, NAT'L ARCHIVES (Jan. 7, 2022), <https://www.archives.gov/education/lessons/slave-trade.html>.

⁸⁶ Manke, *supra* note 84.

⁸⁷ *Id.*

⁸⁸ DOROTHY ROBERTS, *KILLING THE BLACK BODY* 23 (1997).

⁸⁹ Manke, *supra* note 84.

describe how White male doctors saw Black women in the 19th century.⁹⁰ Deidre Owens explains in her book that Black women stood at a “crossroads of being the norm for healing—because [White] doctors [believed they] could use these women to cure any woman.”⁹¹ However, these doctors still held “racialized fiction that Black women were more hypersexual, did not experience pain, and were immodest.”⁹² These falsities led to a societal belief that Black women are “intellectually inferior to [W]hite women, but . . . physically stronger.”⁹³ Some medical professionals today hold the same falsities, which the subpart below discusses, demonstrating the connection between the institution of slavery and the medical treatment Black women receive today.

The disparities previously discussed in Part II are no accident; they are rooted in structural inequities and the mistreatment of Black women’s bodies since the beginning of U.S. society. Serena Williams, Amira Lewally, and Dr. Susan Moore’s experiences indicate that those racist myths, such as the “medical super body,” continue to persist.

B. *Racism and Stereotypes in the Medical Profession*

Racial bias is corroding the health of Black people in the United States.⁹⁴ Half of medical trainees in the United States hold one or more of the following beliefs: “Black people’s nerve endings are less sensitive than White people’s;”⁹⁵ “Black people’s skin is thicker than White people’s;”⁹⁶ “Black people’s blood coagulates more quickly than White people’s;”⁹⁷ “Black people have less sensitive nerve endings than White people.”⁹⁸ These are all myths that are pervasive in the medical field and which have emanated from 19th century medical doctors, as the term “medical super bodies” explains above.⁹⁹ In other words, medical professionals-in-training truly believe Black people feel less pain than White people. Thus, the trainees who hold these beliefs become doctors who do not appropriately treat Black people’s pain.¹⁰⁰

One explanation for medical professionals’ abhorrent beliefs is in-group bias. In-group bias, or identifying more with one’s group, influences providers’ ability to assess pain.¹⁰¹ A 2019 experimental psychology study asked “subjects to identify pain expressed . . . in photos,” and “found that [W]hite participants more readily recognized pain on [W]hite faces than on [B]lack faces.”¹⁰²

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ Stallings, *supra* note 71.

⁹⁵ Janice A. Sabin, *How We Fail Black Patients in Pain*, ASS’N AM. MED. COLLS., (Jan. 6, 2020), <https://www.aamc.org/news-insights/how-we-fail-black-patients-pain>.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ Kelly M. Hoffman, Sophie Trawalter, Jordan R. Axt, & M. Norman Oliver, *Racial Bias in Pain Assessment and Treatment Recommendations, and False Beliefs About Biological Differences Between Black and Whites*, PROC. NAT’L ACAD. OF SCIS. 4296, 4298 (2016).

⁹⁹ *Id.*

¹⁰⁰ Sabin, *supra* note 95.

¹⁰¹ See generally Mende-Siedlecki, Qu-Lee, Backer, & Van Bavel, *supra* note 12.

¹⁰² *Id.* at 868; Sabin, *supra* note 95.

Further, “[p]roviders are not immune to stereotypes and images portrayed in the media, which tend to associate African Americans with substance abuse.”¹⁰³ These stereotypes lead to inadequate treatment,¹⁰⁴ as discussed above in Dr. Moore’s case, who felt that her doctors treated her as a drug addict.

Ultimately, healthcare providers’ racial biases are endangering their patients’ lives.¹⁰⁵ “In 2005, the Institute of Medicine (IOM) released a report finding that people of color receive lower-quality”—meaning materially inferior—“health care than White people, even when controlling for insurance status, income, age, and severity of conditions.”¹⁰⁶ The IOM found that “racial minorities are less likely than White people to be given appropriate cardiac care, receive kidney dialysis or transplants.”¹⁰⁷ There is an “uncomfortable reality” that “some people in the United States [are] more likely to die from cancer, heart disease, and diabetes simply because of their race or ethnicity, not just because they lack access to health care.”¹⁰⁸ IOM’s findings discredit any argument that race is not a significant factor in the inferior care Black women receive. IOM’s study controls for common critical ideas such as Black women not having medical insurance, which may result in inferior quality of care, or that Black women are complacent in their degrading health. Instead, the ignorance of Black women’s medical providers, in part, determines the health care Black women receive.

C. Access and Poverty

Not only are there issues with the care Black women receive from providers, but there are also significant problems with *accessing* a provider in the first place. This difficulty stems from disparate socioeconomic situations, such as diet, economic stressors, and physically inaccessible health care. Issues of quality of care and acceptability of insurance compound problems of availability and accessibility for minorities.¹⁰⁹ All in all, “poverty has a deleterious effect on health.”¹¹⁰

Because people of color, specifically Black people, are disproportionately affected by poverty in the United States, consequential poor health is a reality for many.¹¹¹ Poor

¹⁰³ Sabin, *supra* note 95.

¹⁰⁴ *Id.*

¹⁰⁵ Khiara M. Bridges, *Racial Disparities in Maternal Mortality*, 95 N.Y.U. L. REV. 1229, 1262 (2020).

¹⁰⁶ *Id.* (citing *About: Health and Medicine Division*, NAT’L ACADS., <https://www.nationalacademies.org/hmd/about> (last visited June 19, 2020); INST. OF MED. OF THE NAT’L ACADS., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 5 (2003).

¹⁰⁷ Bridges, *supra* note 105, at 1263.

¹⁰⁸ *Id.* (citing INST. OF MED. OF THE NAT’L ACADS., *ADDRESSING RACIAL AND ETHNIC HEALTH CARE DISPARITIES: WHERE DO WE GO FROM HERE?* 3 (2005), http://cretscmhd.psych.ucla.edu/healthfair/PDF%20articles%20for%20fact%20sheet%20linking/Addressing_health_disparities.pdf).

¹⁰⁹ Jean Connolly Carmalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. CITY L. REV. 359, 385–87.

¹¹⁰ Bridges, *supra* note 105, at 1258 (citing SHELLEY PHIPPS, *CANADIAN POPULATION HEALTH INITIATIVE, THE IMPACT OF POVERTY ON HEALTH: A SCAN OF RESEARCH LITERATURE* 13 (2003) (“[T]here is little doubt that poverty leads to ill health.”)).

¹¹¹ Bridges, *supra* note 105, at 1250; see *Poverty in America Continues to Affect People of Colour Most*, *ECONOMIST* (Sept. 26, 2019), <https://www.economist.com/special-report/2019/09/26/poverty-in->

Black Americans are more likely than poor White Americans to live in areas of concentrated poverty, and poor people have more exposure to stressors that negatively affect their health.¹¹² For example, “one of five Black households are situated in a food desert,”¹¹³ a geographic area where access to affordable healthy food is limited.¹¹⁴ Elements of food deserts, combined with high prices for healthy food items, leave individuals in impoverished communities with “high-sodium, high-fat, high-sugar, low-nutritional-value foods” (inexpensive and readily available in poor neighborhoods) as their main diet source, leading to health complications.¹¹⁵

Low-income people not only struggle with being able to maintain a healthy diet to prevent health complications, but also struggle with accessing healthcare facilities once health complications arise. Low-income individuals, even those with insurance, may find health care physically inaccessible, which prevents them from taking precautionary measures to protect their health or monitor pre-existing medical conditions.¹¹⁶ Moreover, poor people have difficulty accessing health care when physically proximate providers “refuse to accept the Medicaid insurance on which poor people rely.”¹¹⁷

Further, health insurance does not necessarily allow people to afford health care.¹¹⁸ Black people in the United States have about the same access to health insurance as White people, but they face additional financial burdens accessing care.¹¹⁹ Affordability means different things for different groups of people and includes the principle of proportionality: poorer households should not be “disproportionately burdened with health expenses as compared to richer households.”¹²⁰ The actual cost of medical care is subservient to the percentage cost for households.¹²¹ “For example, if a household earning \$500,000 per year pays \$5,000 in medical expenses, then a household earning \$50,000 per year should only pay \$500 in medical expenses.”¹²² The difference in the meaning of “affordability” reflects the problem of underinsurance in the United States, which transpires when people hold

america-continues-to-affect-people-of-colour-most (“Across America, black people remain disproportionately poor. More than 20% live in poverty, twice the rate of whites.”); *see also* AMNESTY INT’L, DEADLY DELIVERY: THE MATERNAL HEALTH CARE CRISIS IN THE USA 25 (2010), <https://www.hsph.harvard.edu/wp-content/uploads/sites/2413/2016/12/deadlydelivery.pdf> (“Women of color are at least twice as likely as white women to be living in poverty; approximately a quarter of black and Latina women have incomes below the Federal Poverty Level.”).

¹¹² Carmalt, *supra* note 109, at 386 (2008); Bridges, *supra* note 105, at 1258.

¹¹³ *Too Many Black Americans Live in Food Deserts*, MCKINSEY & CO. (Sept. 9, 2021), <https://www.mckinsey.com/featured-insights/coronavirus-leading-through-the-crisis/charting-the-path-to-the-next-normal/too-many-black-americans-live-in-food-deserts>.

¹¹⁴ 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>.

¹¹⁵ Bridges, *supra* note 105, at 1258; *see generally* Angela Hilmers, David C. Hilmers, & Jayna Dave, *Neighborhood Disparities in Access to Healthy Foods and Their Effects on Environmental Justice*, 102 AM. J. PUB. HEALTH 1644, 1644 (2012).

¹¹⁶ Carmalt, *supra* note 109, at 386, 392.

¹¹⁷ Bridges, *supra* note 105, at 1259.

¹¹⁸ Carmalt, *supra* note 109, at 386.

¹¹⁹ *Id.*

¹²⁰ *Id.* at 368 (quoting U.N. Comm. on Econ., Soc. and Cultural Rts. (CESCR), *General Comment 14: The Right to the Highest Attainable Standard of Health* (Art. 12), ¶ 33(b), U.N. Doc. E/CN.12/2000/4 (Aug. 11, 2000)).

¹²¹ *Id.*

¹²² *Id.*

health insurance policies that provide insufficient coverage.¹²³ Thus, when a group of insured individuals continue to face significant financial barriers to accessing health care, insurance availability alone does not account for adequate healthcare needs.¹²⁴

Moreover, researchers have identified a connection between racial segregation and the quality of care a patient receives.¹²⁵ A Black person who lives in a segregated community and undergoes surgery is more likely to do so at a hospital with higher mortality rates because health facilities in those communities often lack resources compared to those in predominantly White areas.¹²⁶

Appropriate healthcare access does not only consist of having facilities for obtaining care or health insurance to cover costs, but it also encompasses the *quality* of health care, which is impacted by the doctors in these facilities. Only 5.7% of U.S. physicians are Black, out of a population that is 13% Black.¹²⁷ Because Black patients are likely to receive treatment from White doctors, since White doctors make up 56.2% of active physicians,¹²⁸ issues of racism and stereotypes negatively impact the quality of their care. It is *not* an assumption that only or all White doctors hold racial biases. Instead, because White doctors make up most of medical practitioners, and it is established that bias is a problem in the medical profession, one can infer that at least some White doctors hold negative biases, which impacts a Black woman's care.

Continuous disparities are not solely due to racism, poverty, or accessibility but a combination of these factors intertwined throughout the entire healthcare infrastructure. The health disparities Black women experience transpire from the societal hardships Black women are more likely to face than White women. However, according to the various U.N. treaties to which the United States is a party, these unfair conditions—which essentially constitute de facto discrimination—should not be occurring, as discussed in the following Part.

III. INTERNATIONAL HUMAN RIGHTS: HEALTH CARE IS A HUMAN RIGHT

The U.N. is an established leader in recognizing that the right to health is an international human right.¹²⁹ The major U.N. treaties addressing the right to health are the Constitution of the World Health Organization (WHO), the Universal Declaration of Human Rights (UDHR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR).¹³⁰ However, the healthcare conditions Black women in the United States face defy the U.N.'s recognition that states should provide equal access to health care, eliminate discrimination, and offer their citizens a holistically healthy life. Although the U.N. designed these international treaties to combat disparities and discrimination in health

¹²³ *Id.* at 386.

¹²⁴ *Id.* at 386–87.

¹²⁵ *Id.*

¹²⁶ Stallings, *supra* note 71.

¹²⁷ *Id.*

¹²⁸ *Diversity in Medicine: Facts and Figures 2019: Figure 18. Percentage of All Active Physicians by Race/ethnicity, 2018*, ASS'N AM. MED. COLLS., <https://www.aamc.org/data-reports/workforce/interactive-data/figure-18-percentage-all-active-physicians-race/ethnicity-2018> (last visited Sept. 9, 2022).

¹²⁹ Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 338 (2008).

¹³⁰ *See generally id.*

care around the world, these treaties have not had their intended effect on the United States. The racial disparities outlined in Parts I and II show the United States treats health care as a privilege instead of a right.

Since WHO's constitution adopted the first right to health provision in 1946, the world has increasingly recognized health rights.¹³¹ WHO's constitution commits state parties to promoting the following principles:

Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

...

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.¹³²

The significance of WHO's constitution is that the governments of State Parties must take social measures to ensure their citizens are receiving health care, beyond the mere standard of living. State Parties should ensure their people have a holistically healthy life—whether that be enforcing access to healthy living conditions and diets or proper medical treatment and access.

In 1948, the U.N. adopted the UDHR, recognizing an international consensus that all people have certain inalienable rights to the protection and advancement of their lives by virtue of their status as human beings.¹³³ The UDHR provides, “everyone has the right to a standard of living adequate for health and wellbeing of [them]self and of [their] family, including . . . medical care.”¹³⁴ However, since the UDHR is a declaration, it did not set out obligations for State Parties to further the right.¹³⁵ Subsequently, the U.N. adopted two covenants to implement health care as a human right: the ICESCR and the International Covenant on Civil and Political Rights (ICCPR).¹³⁶

¹³¹ Elisavet Athanasia Alexiadou, *Health Care Reforms and the Challenge of Inequality from A Human Rights Lens: Lessons from Europe*, 17 *IND. HEALTH L. REV.* 63, 67–68 (2020) (citing WORLD HEALTH ORG., CONSTITUTION OF THE WORLD HEALTH ORGANIZATION (July 22, 1946), <https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>).

¹³² WORLD HEALTH ORG., CONSTITUTION OF THE WORLD HEALTH ORGANIZATION (July 22, 1946), <https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

¹³³ Kinney, *supra* note 129, at 335 (citing G.A. Res. 217 (III) A, Universal Declaration of Human Rights (Dec. 10, 1948)).

¹³⁴ *Id.* at 338–39.

¹³⁵ *Id.* at 339.

¹³⁶ *Id.*

The U.N. legally affirmed health as a human right under the right to health provision in the ICESCR, which the United States has enacted, meaning it has been negotiated by the president and approved by a two-thirds vote of the Senate. The United States, however, has not ratified the ICESCR, meaning it is not binding on the United States.¹³⁷ ICESCR sets out three levels of responsibility among States to enforce the right to health: the duty to respect, the duty to protect, and the duty to fulfill.¹³⁸ These “duties exist for all human rights under international law.”¹³⁹ The duty to respect means that parties must respect the right to health by ensuring everyone has equal access to “preventative, curative and palliative health services.”¹⁴⁰ That is, States must “ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for . . . marginalized groups.”¹⁴¹ States’ duty to protect the right to health requires measures preventing third parties from interfering with a person’s “enjoyment of the highest attainable standard of physical and mental health.”¹⁴² The obligation to fulfill involves the “full realization of rights,” which requires each State Party to the treaty to adopt substantive legislative measures and all other appropriate means, including administrative and judicial, to enforce the right to health.¹⁴³

Additionally, as a State Party to the ICCPR and as a country that has ratified the treaty, the United States is obligated to uphold the right to health as necessary to prevent arbitrary deprivation of life.¹⁴⁴ Under that agreement, the United States must eliminate discriminatory practices affecting the right to public health and medical care.¹⁴⁵

U.N. treaties addressing the needs of individuals historically subject to discrimination also recognize the right to health.¹⁴⁶ These treaties include the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)—which requires members to commit to the elimination of racial discrimination—and the Convention on the Elimination of All Forms of Discrimination against Women—which requires members to eliminate discrimination against women and girls.¹⁴⁷ Each treaty specifies rights to health for the different groups: “First, each prohibits discrimination in the provision of healthcare services. Second, they often state affirmative rights to types of healthcare services of special importance to the relevant population, such as the obstetrical and gynecological services for women.”¹⁴⁸

The United States has, in fact, ratified the ICERD and is bound by its terms to prohibit racial discrimination in all its forms, which includes both de facto and de jure discrimination.¹⁴⁹ De facto discrimination results from discriminatory actions and not systemic laws, while de jure discrimination is when overt, explicit, and systemic laws

¹³⁷ Alexiadou, *supra* note 131, at 68.

¹³⁸ Carmalt, *supra* note 109, at 361.

¹³⁹ *Id.*

¹⁴⁰ Alexiadou, *supra* note 131, at 69.

¹⁴¹ *Id.*

¹⁴² International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.

¹⁴³ *Id.* at art. 2.

¹⁴⁴ Carmalt, *supra* note 109, at 362, 372; *See* Kinney, *supra* note 129, at 363.

¹⁴⁵ Carmalt, *supra* note 109, at 372.

¹⁴⁶ *See* Kinney, *supra* note 129, at 342–43.

¹⁴⁷ Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13.

¹⁴⁸ *See* Kinney, *supra* note 129, at 342–43.

¹⁴⁹ Carmalt, *supra* note 109, at 376.

formalize discrimination.¹⁵⁰ The Convention requires State Parties to “take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists.”¹⁵¹ Thus, under international law, the United States is legally obligated to respect the right to health insofar as it relates to the prohibition against discrimination.¹⁵² In other words, the United States is obligated to address many of the issues discussed above such as medical providers accepting health care, food deserts, and physical access to health facilities. However, the disparities in Part I and the possible explanations in Part II reveal that politicians of communities with a majority Black population continue to fail to address the circumstances that perpetuate, at minimum, de facto racial discrimination.

Although the United States has enacted these treaties, it has failed to ratify any of the treaties that recognize the international human right to health, except for the UDHR and the ICERD.¹⁵³ Additionally, U.S. regional treaties have not recognized the international human right to health.¹⁵⁴

Many of the world’s nation-states recognize the international human right to health through international treaties and their independent constitutions.¹⁵⁵ However, the United States Constitution, as interpreted by the United States Supreme Court, neither addresses the international human right to health nor recognizes a duty of the federal government to provide or guarantee healthcare services to the United States’ population.¹⁵⁶ Also, domestic law in the United States prohibits only intentional de jure discrimination, such as pro-segregation laws.¹⁵⁷ The Supreme Court interpreted the Due Process Clause of the Fifth Amendment prohibition of discrimination to include the “intent doctrine.”¹⁵⁸ *Washington v. Davis* articulates how the “intent doctrine” provides that “a law or other official act, without regard to whether it reflects a racial discriminatory purpose, is [not] unconstitutional solely because it has a racially disproportionate impact.”¹⁵⁹ This doctrine clashes with the United States’ “obligations under the ICERD and ICCPR”¹⁶⁰ as both the ICERD and ICCPR “include de facto discrimination as part of the overall prohibition

¹⁵⁰ Yifat Bitton, *The Limits of Equality and the Virtues of Discrimination*, 2006 MICH. ST. L. REV. 593, 599 (2006).

¹⁵¹ Carmalt, *supra* note 109, at 376–77; International Convention on the Elimination of All Forms of Racial Discrimination art. 2, ¶1(c), Dec. 21, 1965, 660 U.N.T.S. 195 [hereinafter ICERD].

¹⁵² Carmalt, *supra* note 109, at 378.

¹⁵³ See Kinney, *supra* note 129, at 363.

¹⁵⁴ *Id.* at 363–64.

¹⁵⁵ *Id.* at 364. There are several examples. Afghanistan’s Constitution states: “it is the duty of the State to provide, within the limits of its means, balanced facilities for the prevention and treatment of diseases for all Afghans. The aim of the State in this respect is to reach a stage where suitable medical facilities will be made available to all Afghans.” Afghanistan’s Constitution is one of many that recognize health rights; in fact, 67.5% of constitutions of the world address health or health care. Eleanor D. Kinney & Brian A. Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT’L L.J. 285, 305 (2004) (analyzing all countries’ Constitutions that acknowledge health as a human right).

¹⁵⁶ Kinney, *supra* note 129, at 364.

¹⁵⁷ See Carmalt, *supra* note 109, at 384.

¹⁵⁸ *Washington v. Davis*, 426 U.S. 229, 239 (1976).

¹⁵⁹ Carmalt, *supra* note 109, at 384; *Davis*, 426 U.S. at 239.

¹⁶⁰ See Carmalt, *supra* note 109, at 384; *Davis*, 426 U.S. at 239.

against discrimination;” *Davis*’ holding, however, effectively allows for de facto discrimination.¹⁶¹

The Supreme Court’s interpretation that the Constitution allows for de facto discrimination, the United States’ failure to implement and ratify U.N. treaties, and local politicians’ failure to implement appropriate policies have allowed the U.S. healthcare system to remain discriminatory based on race and class. Thus, the United States falls behind many other countries who recognize a fundamental human right to health.

IV. SUGGESTIONS

The socioeconomic and health-based disparities described in Parts I and II demonstrate that the United States’ healthcare system is detrimentally impacted by inequity and racism and is taking the lives of Black women. Although the healthcare issues discussed in this Note are multifaceted, this Part discusses actions the United States can take to help overcome such disparities and save Black women’s lives. These suggestions include implementing and ratifying U.N. treaties that recognize health care as a human right, studying Black and medical history, investing in and allocating resources to low-income minority communities, and urging medical professionals to acknowledge their biases.

A. *Implement and Ratify Treaties*

The inequities that Black women experience can be partially attributed to the United States’ legal system’s failure to recognize the human right to health care. Further, Black women’s experiences make obvious that the United States does not abide by the ICCPR or the ICERD’s mission since many Black women in the United States cannot afford adequate treatment, do not live near a medical provider, and are denied treatment by medical providers to which they can get access. The fact that Black women disparately experience these things is discriminatory—a violation of the ICERD—and indicates Black women are experiencing “arbitrary deprivation of life”—a violation of the ICCPR.¹⁶² To remedy this discriminatory impact, the United States should uphold its obligations under the ICCPR and ICERD.

To address its obligations under the ICCPR, the United States can take steps to prevent Black women from experiencing deprivation by investing in Black communities and experiences. If Black women are receiving preventative care, resources to maintain a healthy diet, and interacting with medical professionals who properly care for them, the gap between the health disparities of Black and White women will likely shrink.

Further, the United States can start fulfilling its obligations under ICERD by taking more “effective measures” in legislation and local policies. Legislation needs to exceed the basics of having medical insurance for Black women to having a more equitable healthcare experience. As explained above, the disparities are not primarily attributed to a lack of insurance; instead, a more considerable concern is affordability, which disproportionately affects Black women. If legislators can find a way to apportion medical costs to income, this would allow Black women to afford medicine, treatments, and preventative care.

¹⁶¹ See Carmalt, *supra* note 109, at 384.

¹⁶² International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171.

Moreover, the United States should ratify and implement the ICESCR, which requires states to enforce the right to health at three levels: the duty to respect, the duty to protect, and the duty to fulfill. Again, the United States can start fulfilling these levels in ways that would similarly satisfy ICCPR and ICERD: legislators creating more comprehensive laws and investing in Black communities and resources that affect Black people's health, as the subpart below explains.

B. Investing in Communities to Combat the Disparities: Resources, Representation, and Education

Complying with its obligations under the ICERD and ICCPR and ratifying the ICESCR would require the United States to affirmatively combat health disparities between Black and White women. To combat health disparities between Black women and White women is to invest in resources for the Black community, acknowledge how these disparities are rooted in U.S. racial history, and reform the medical field. As stated above, to solve the issues in the healthcare system (racism, poverty, and access), each element needs to be addressed individually for a comprehensive resolution.

1. Investment in Healthy Lifestyles

Greater investment in healthy food options, recreation facilities, and healthcare facilities in Black communities would help alleviate disparities. Local government officials need to put more effort in addressing communities that live in food deserts. Government officials can establish bus stop farmers' markets, which are pop-up farmers' markets that provide healthy and affordable food options to impoverished communities.¹⁶³ Additionally, officials can open government-run grocery stores and recreation facilities in low-income neighborhoods.¹⁶⁴ Since a healthier diet and exercise deter health issues, such as heart disease and diabetes, and lead to a longer life span, these actions will help shrink the many mortality gaps between Black and White women discussed in Part I.¹⁶⁵ Also, investment in proper healthcare facilities for Black people so they can receive adequate care closer to their homes will improve access to the healthcare system by helping to overcome financial barriers connected with travel. These healthcare offices will need to accept all health insurance. These improvements will allow Black women to have more control over their health and have a greater chance of a healthier lifestyle, preventing the fatality statistics discussed in Part I.

2. Investment in Representation in the Medical Field

As discussed above, facilities and insurance do not solve all issues of inadequate care because racial biases and stereotypes cloud some medical practitioners' judgment when caring for Black patients. Thus, there must be more Black doctors that can care for Black patients. There is a small percentage of Black doctors in the United States

¹⁶³ Aria Dailee, *5 Solutions that Alleviate Food Insecurity in the U.S.*, MEDIUM (Dec. 7, 2020), <https://heated.medium.com/5-solutions-that-alleviate-food-insecurity-in-the-u-s-767ba03fcb94>.

¹⁶⁴ *Id.*

¹⁶⁵ *Poor Nutrition*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 8, 2022), <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm>.

compared to the Black population. To combat health provider representation issues in the United States, the U.S. medical education system must invest in and better support Black medical students. Having more Black doctors in the United States is essential because patients seeing a doctor with a similar racial background helps combat their chances of being discriminated against and stereotyped; instead, Black patients would be more likely to receive proper care and have trust in their medical providers.

Research supports the above conclusion. For instance, although the study focused on Black men, Stanford University found Black men paired with Black physicians were more engaged with those doctors than those paired with non-Black doctors.¹⁶⁶ Further, Black doctors wrote more detailed notes than White doctors.¹⁶⁷ The study results showed that Black men with the least trust and exposure to the medical system benefited the most from the racial pairing.¹⁶⁸ “The study estimates that racial pairing of Black patients and Black physicians could reduce the [B]lack-[W]hite mortality gap due to heart disease by 19%.”¹⁶⁹ Although the study did not focus on stereotypes doctors may hold, one can infer that the Black doctors were more engaged with Black patients than the White doctors; meaning, the Black doctors were better positioned to correctly treat their Black patients’ needs and hear their concerns. Hence, the racial pairing can help diminish health disparities.

3. Investment in Racial Bias Education

Lastly, medical professionals must recognize and work to combat their racial biases. Racism is deeply rooted in the medical field, and older medical professionals may cling to their racial prejudices due to indoctrination through education and practice. However, new generations of doctors provide opportunities to address racial biases in early training. Thus, medical schools can provide training on racism and in-group biases for medical students. This training should not be a one-time seminar on anti-racism; instead, schools should have the training integrated at every level of a student’s education. Improved training on pain assessment for all races will lessen the discriminatory impact on Black people. Further, training on communication between medical practitioners and patients to provide a correct diagnosis, as in Amira Lewally’s case, will also help abate the routine stereotyping of Black patients.

CONCLUSION

The health disparities between Black women and their White counterparts are grim. They reflect the reality that the health care Black women receive in the United States is inequitable and Black women are denied or prevented from accessing health care because of their skin color. De facto discrimination—that is, racism, and the lack of access to health care, resources, and adequate nutrition—and the United States’ forbearance from

¹⁶⁶ Ryan Huerto, *Minority Patients Benefit from Having Minority Doctors, But That’s a Hard Match to Make*, MICHIGAN MED.: U. MICH., (Mar. 31, 2020, 1:46 PM), <https://labblog.uofmhealth.org/rounds/minority-patients-benefit-from-having-minority-doctors-but-thats-a-hard-match-to-make-0>.

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

implementing the ICERD and ICCPR and ratifying the ICESAR, influence such health disparities. The United States needs to change its approach regarding Black Americans' health and specifically Black women's. It needs to recognize how broken the healthcare system is to fix it and treat everyone equitably and adequately. When a person goes to the doctor, they should not have to fight for their life. However, without firmly implementing and ratifying these treaties—which recognize health rights and prohibit de facto discrimination—and investing in communities, the current system will continue perpetuating inequities in the healthcare system that takes Black women's lives. The United States needs to actively remedy the root causes of health disparities so Black women can receive the health care they deserve.