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Racial Disparity in Healthcare: Universal Healthcare is not Enough

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Abstract

Racial disparity in the U.S. healthcare system most greatly affects Black and Hispanic people. Many people focus on giving more medical access to this disparaged group, namely through universal healthcare, more doctors, and more hospitals. However, healthcare is more than just doctor visits and insurance. Simple commodities like access to food and water, education, and housing can provide more of an impact than universal healthcare ever can. This article goes in-depth about the impact food and water, education, and housing has and can have on reducing poverty, the greatest factor to consider when it comes to racial disparity in healthcare.

Keywords: Bioethics, Disparity, Healthcare, Housing, Education, Poverty

I. Introduction

Racial disparity in healthcare is an on-going problem that leaves many African-Americans and Hispanics with inadequate medical treatment. However, healthcare is more than just about access to a physician. To address the racial disparities, there would need to be something beyond increased access to healthcare through universal healthcare. To remove the disparity entirely, disparities in other fields of health must first be addressed: homelessness, education, and poverty. In addressing homelessness, those who are homeless must have the structural support they need in order to overcome their hurdles and become self-reliant; in correcting education, generations of families must be given fair access and opportunity to learn, grow, and improve so they will not be bound to low-earning jobs that perpetuate financial restrictions in health choices; and in addressing poverty, society

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must invest in long-term solutions that will tackle the problems that continuously plague low-income people and communities. Solving the racial disparities in healthcare will require looking beyond medical access and universal healthcare to addressing the deeper, underlying issues of housing, education, and poverty.

This article aims to delve into the deeper problems of racial disparity in healthcare by looking beyond medical access. First, the article will define healthcare and how it is more than just physicians, hospitals, and pharmacies by going into a brief history and impact of access to food and water. After defining healthcare, this article will explore the discriminatory policies three key social issues in the United States: homelessness, education, and poverty. I intend to show that those factors cannot be corrected by simply implementing universal healthcare. Thereafter, I propose solutions to the three aforementioned social issues.

II. Defining Healthcare

A. Modern Healthcare

Modern day healthcare is synonymous with physicians, patients, pharmacies, hospitals, and insurance. When discussing healthcare, the trend is to think of the discoveries of penicillin in 1928,[1] the polio vaccine in 1952,[2] and gene therapy in 1985.[3] Even *The New York Times*' health section reveals a majority of discussions on insurance reimbursement, court hearings about the latest disputes in healthcare reform, taxes, and pharmaceutics.[4] Indeed, the very image of modern healthcare revolves around medical research, taxation, and insurance regulations. Yet, there is seldom mention of the issues that underlie problems in healthcare. After all, what good can come of a prescription for penicillin if the patient does not have transportation to the pharmacy, cannot afford the prescription, or could not even afford to see the physician in the first place? Assuming that a patient can afford to travel to and see a physician for diabetes and afford the prescription for insulin, if that person is homeless, where are they to store their insulin, which requires refrigeration?[5] If a child is sick and yet the mother, who was poorly educated due to improper state action,

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[1] Penicillin: Opening the Era of Antibiotics, U.S. Dept. Agric., http://www.ars.usda.gov/Research/docs.htm?docid=12764.

[2] Polio Vaccine, Ctr. Disease Control and Prevention, http://www.cdc.gov/vaccines/vpd-vac/polio/default.htm.

[3] DeWitt Stetten, Gene Therapy, Nat'l Inst. Health, https://history.nih.gov/exhibits/genetics/sect4.htm.

[4] L, The N.Y. Times, http://topics.nytimes.com/top/opinion/health-care/index.html.

[5] *NovoLog*, Food & Drug Admin. (Feb. 2015), http://www.accessdata.fda.gov/drugsatfda_docs/label/2015/020986s082lbl.pdf; *See also* Sanofi U.S., Aug. 2015, http://products.sanofi.us/lantus/lantus.html (all insulin products currently on the market approved by the Food and Drug Administration require some level of refrigeration).

does not know how to measure her child's medication properly, how is the child to get proper care? Healthcare does not simply start and end at the doors of a hospital or doctor's office. Healthcare includes all aspects of public health as well. The term "public health" is used to define other factors that can impact health: infectious diseases, food and water safety, environmental hazards, and so forth.[6] The key difference between the common terms of "healthcare" and "public health" is in the approach to diseases. While modern healthcare will prescribe medication for an illness, public health will look to the reason behind the illness and address the population as a whole.[7] Indeed, rather than focusing on the singular patient, public health looks at all facets of what affects health.

However, looking to either one alone is not enough. What is truly necessary is a combination of both healthcare and public health. This kind of complete healthcare will not only address the immediate issue of treating disease but also look to preventing the underlying root cause of illnesses.

B. A Brief Historical Impact of Food and Water Advancements for Public Health

Improved farming and water treatment greatly changed public life for the better. The actual start of human farming began roughly 12,000 years ago.[8] However, farming evolved around the early 20th century. Between 1900 and 1960, fewer farms were around, but each farm grew larger and more specialized crops.[9] Around 1948, productivity in those farms started growing.[10] This increased productivity and specialized but diverse farming meant food could be available all year round.[11] Year-round supply of proper nutrition and water has been shown to have a strong correlation to healthy pregnant women and men generall y.[12] Around the time farming became more large-scale and productive in the 20th century, many patients started demonstrating better health. Those 50 and up suffered fewer chronic conditions, and those who did suffer from chronic conditions suffered them far later in

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6 *What is Public Health?*, CDC Found. (2015), http://www.cdcfoundation.org/content/what-public-health; *See also What Is the Public Health System?,* U.S. Dep't Health & Hum. Serv. (2015), http://www.hhs.gov/ash/initiatives/quality/system/.

7 *What is Public Health?, supra* note 6.

8 *History of Agriculture*, U. Reading, http://www.ecifm.rdg.ac.uk/history.htm.

9 Carolyn Dimitri, *The 20th Century Transformation of U.S. Agriculture and Farm Policy,* U.S. Dep't Agric., (2005), http://ageconsearch.umn.edu/bitstream/59390/2/eib3.pdf.

10 *Agricultural Productivity*, U.S. Dept' Agric., http://www.ers.usda.gov/topics/farm-economy/agricultural-productivity.aspx.

11 Robert W. Fogel, *Secular Trends in Physiological Capital: implications for equity in healthcare*, 46 Perspectives in Biology and Med. S24, S34 (2003).

12 *Id.* at S32.

life than compared to the 19th century.[13] The age of onset for many diseases came much later; heart disease for all American males increased from around 56 years of age to 65 years; arthritis started at age 64 instead of 53; and respiratory conditions came around the age of 65 instead of 53.[14] These improvements in health were not attributed to direct medical care[15], but rather, these improvements were linked to ample access to proper nutrition and a healthy environment year-round.[16] Further, pregnant women were a strong focus for healthcare concerns as they were their own type of environment for proper fetal growth.

In defining environment, there is the obvious outdoors that house the general population, but also, the environment within the uterus played a key role in determining the baby's health. Analyzing prenatal care here looks to see how the outside environment — the accessibility of year-round nutrition and clean water — affect the environment within the uterus and, ultimately, the baby. For example, pregnant mothers stricken with persistent diarrhea[17] have been shown to have a poor uterine environment that "[retards] the development of the children they are bearing."[18] Food and clean water allowed pregnant women to not only foster their own health but also the health of their children.

Improvements in water also began around the 20th century. Between 1900 and 1936, cities across the nation implemented water filtration and chlorination to purify drinking water; in 1906, efforts went towards nation-wide water filtration; systematic chlorination began in 1907; sewage treatment began in 1910; and sewage chlorination began in 1921.[19] Before filtration and chlorination in the 1900s, the percentage of deaths caused by major infectious diseases was a staggering 39.3%, but 36 years later, as water treatment became more common, that percentage dropped down to 17%.[20] The greatest achievement with water treatment must be the improvement of child health; the percentage of child deaths related to infectious diseases went from 4.5% to 0.5% — near absolute elimination.[21] This increased supply of food and access to cleaner, safer water is one of the more crucial factors of improving health than merely offering medical access.

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13 *Id.* at S33.

14 *Id.*

15 *Id.*

16 *Id.* at S32.

17 Annette Prüss-Üstün et al., *Safer Water, Better Health: Costs, benefits and sustainability of interventions to protect and promote health*, World Health Organization (2008), http://apps.who.int/iris/bitstream/10665/43840/1/9789241596435_eng.pdf (Diarrhea is caused "mainly" by the ingestion of pathogens from unsafe drinking water, contaminated foods, or even from eating from unclean hands).

18 Fogel, *supra* note 11 at S34.

19 David M. Cutler & Grant Miller, *The Role of Public Health Improvements in Health Advances: The Twentieth-Century United States*, 42 Demography 1, 6 (2005).

20 *Id* at 4.

21 *Id.*

Clean water alone led to "nearly half [an] overall reduction in mortality."[22] With the addition of an ample food supply, there was an overall positive trend in public health at the turn of the 20th century. Yet despite how obvious clean water and ample food can affect health, there are still places in the world without access to these necessary resources. In America in 2015, 21.5% of Black non-Hispanic households and 19% of Hispanic households were unable to provide adequate food for their families.[23] There are even cases of unsafe drinking water plaguing America, such as in Flint, Michigan. With a predominantly poverty-stricken Black population[24], Flint suffered a water crisis where its citizens were supplied with water that was not safe for cooking nor drinking as it was filled with high amounts of lead.[25] The problem is not exclusive to Flint, Michigan either; states such as Alabama, Arkansas, Hawaii, Kentucky, Mississippi, Nevada, North Dakota, South Dakota, and Tennessee were also found to have toxic lead levels in their water supply[26] So, despite all previously mentioned advanced in water filtration, chlorination, and purification, access to clean water is still a contemporary problem affecting minority communities throughout the United States.

III. Defining Racial Disparity

A. Overview

Disparity is not always easily defined. Blatantly obvious racial discrimination and its resulting disparity can be easy to see if it is in plain text, like the many discriminatory policies in the late 19th and early 20th century.[27] However, we are no longer in an age where hospitals, food markets, or anything place up "Whites Only" signs. So, in trying to understand what creates disparity — especially in healthcare — statistics are often the only thing available,

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[22] *Id.* at 3.

[23] United States Department of Agriculture Economic Research Service, *Trends in U.S. food security*, http://www.ers.usda.gov/data-products/food-security-in-the-united-states/interactive-chart-food-security-trends.aspx (last visited Oct. 5, 2016) (this is in comparison to White households, of which only 10% are inadequately fed).

[24] United States Census Bureau, *QuickFacts Flint city, Michigan*, http://www.census.gov/quickfacts/table/PST045215/2629000 (last visited Oct. 5, 2016).

[25] Siddhartha Roy, *Test Update: Flint River water 19X more corrosive than Detroit water for Lead Solder; Now What?* (Sept. 11, 2015), http://flintwaterstudy.org/2015/09/test-update-flint-river-water-19x-more-corrosive-than-detroit-water-for-lead-solder-now-what/.

[26] Dina Gusovsky, *America's water crisis goes beyond Flint, Michigan* (Mar. 24, 2016), http://www.cnbc.com/2016/03/24/americas-water-crisis-goes-beyond-flint-michigan.html.

[27] Referring to "Whites Only" signs and the Jim Crow laws that segregated the racial classes in many public facilities.

and yet, statistics alone are often do not offer a complete depiction of disparity. In the courts, a professionally researched statistical study that analyzed the disproportionate imposition of the death sentence on Black people was not enough to establish that there was discrimination.[28] The Supreme Court has ruled that racially disproportionate effects cannot be the sole determinant in deciding whether a government action is racially discriminatory, even if the disparity is a direct result of that act.[29] Outside the court, statistics can often seem positive but fail a truer question. For example, rising trends show increased utilization of hospitals and physician visits.[30] So, people are taking better care of themselves. If it were so simple, the entirety of this article would be moot. Further analysis of those statistics is required. Why is it, then, that the poorer populations have issues of transportation to see physicians or access healthcare?[31] Nearly 51% of the parents of sick children missed appointments with a pediatrician because traveling to the doctor was too great a burden given their socioeconomic status.[32] So, relying on statistics alone may lead to more questions than answers. However, statistics can be the foundation for proper research and logical deductions. Rather than resting solely on statistical data, disparity is best identified through further questioning by understanding what other problems and inquiries the statistics raise. Ultimately, proper analysis must look to social structures and what is causing these disparities.

B. Systemized Racial Stereotyping in Medical Care

In the medical community, there is a certain level of racial association that is permissible. However, these associations are very narrow and based upon a race's particular genetic disposition to certain diseases. For example, African Americans are more prone to sickle cell anemia,[33] Asians are more prone to vitamin D deficiency,[34] and Tay-Sachs is a prominent disease among Jews.[35] This kind of association is an effective means of reducing

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[28] McCleskey v. Kemp, 481 U.S. 279, 279, 107 S. Ct. 1756, 1760, 95 L. Ed. 2d 262 (1987) (referring to the Baldus study).

[29] 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, 384 (2008).

[30] A. B. Bernstein et al., *Health care in America: Trends in utilization*, Center for Disease Control and Prevention (2004), http://www.cdc.gov/nchs/data/misc/healthcare.pdf.

[31] Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 5 J. Community Health 976, 976 (2013).

[32] *Id.*

[33] Nadia Solovieff, *Ancestry of African Americans with sickle cell disease,* 47 Blood Cells, Molecules, and Diseases 41, 41 (2011) (This disease specifically seems to target Sub-Saharan African races and their descendants based on a mutation in the β-hemoglobin gene. This mutation is most frequently occurred in Africa where malaria was most prevalent).

[34] *B. R. Pal, Distribution analysis of vitamin D highlights differences in population subgroups: preliminary observations from a pilot study in UK adults,* 179 J. Endocrinology 119, 122 (2003).

[35] S. L. Perlman, *Tay-Sachs Disease*, 4 Encyclopedia of the Neurological Sciences (2nd ed.) 399, 399 (2014).

healthcare costs; rather than conducting a myriad of testing for each and every patient, it would be more logical for a physician to test and diagnose a patient for what is most statistically likely based on the symptoms. Following that logic, a physician can — and rightly should — be more inclined to test an African American patient for sickle cell anemia than a white patient who has identical symptoms. However, this approach to medicine needs to be carefully taken. There is a slippery slope that doctors have used historically to use science to justify improper discrimination. For example, the classic case of *People v. Hall* shows the court using ethnology — treating it as a science well held by "many scientific writers" — to label a person as part of a "race of people whom nature has marked as inferior" to prevent them from testifying.[36] In 1806, Virginia improperly classified the races into superior and inferior hierarchies based skin color to quantify levels of freedom and privilege.[37] Another example is when states like Virginia[38] and Indiana[39] authorized the sterilization of people they deemed to be "feeble-minded." In the late 19th century, Francis Galton coined the word eugenics, which was a practice that classified how to improve the races by studying racial qualities.[40] While Galton started in Paris, his ideas of eugenics quickly spread to America, and in the 20th century, many alleged scientists justified racial segregation and the demeaning of the black community as scientifically sound. Eugenics gave the excuse that black women were "sexually indiscriminate" and "bad mothers who were constrained by biology to give birth to defective children."[41] Sadly, this is a trend that continues today. A report found that "African-Americans, people of Hispanic origins and American Indians" are less likely to receive certain treatments like advanced cancer treatment, treatment for lung cancer, coronary artery angioplasty, and more as compared with white patients.[42] Further, black women were less likely to receive mammograms than white women.[43] More troubling is that there is reason to believe medical students today may be the reason why minorities are not receiving adequate testing or treatment. In a survey of 222 medical students and residents, around half of them endorsed the false belief

[36] People v. Hall, 4 Cal. 399, 405 (1854)

[37] *Hudgins v. Wright*, 11 Va. 134, 139 (1806) (race was defined purely by the coloring of the skin, the texture of the hair, and the shape of the nose); see also *Hall*, supra at 401 (justifying that the Chinese were also inferior to whites based on their skull and pelvis size) (While neither of these cases are deferred to these days, and while *People v. Hall* has been called into doubt, they have never been overruled).

[38] *Buck v. Bell,* 143 Va. 310, 130 S.E. 516 (1925); *Buck v. Bell*, 274 U.S. 200, 47 S.Ct. 584 (1927).

[39] Leslie C. Griffin & Joan H. Krause, *Practicing Bioethics Law* 128 (2016).

[40] Katrin Weigmann, *In the name of science,* 2 EMBO Reports 871, 871 (2001).

[41] Joe Faegin, *Systemic racism and U.S. health care*, 103 Social Science & Med. 7, 9 (2014).

[42] H. Jack Geiger, *Racial stereotyping and medicine: the need for cultural competence*, 12 CMAJ 1699, 1699 (2001) (this report matches all patients for insurance, education, income, severity of disease, age, and other possible health and socioeconomic factors).

[43] Risa B. Burns et al., *Black women receive less mammography even with similar use of primary care*, 3 Annals of Internal Med. 173 (1996).

that blacks feel less pain than whites and would likely suggest inappropriate medical treatments to black patients.[44] To tackle today's racial disparity, the focus should be on the subtle acts of discrimination and racism disguised as legitimate medical procedure.

New and current medication is currently being analyzed and developed to see how they can impact diseases that work off of racial genetic differences. For example, a 1999 review of enalapril, isosorbide dinitrate, and hydralazine revealed that enalapril did not work as well for black patients as the combination of isosorbide dinitrate.[45] Yet, there is no specific reason as to why the medication works the way it does. The study merely links the success to black patients. However, the studies use race as a generalized term for skin color and other superficial features.[46] In truth, skin color and superficial features that may define "race" very poorly correlate to genetic variations that actually shape a susceptibility to diseases.[47] This kind of research does not look to the underlying genetic factors that affect a person or that social group. Instead, it merely places race as this crude marker that ill-defines the underlying root of the problem.

Certain critics would suggest that racism in healthcare is nothing more than statistics. For example, if individual x is a member of Group X, and Group X is commonly poverty-stricken and homeless, then it would be natural to assume that individual x would not be able to afford certain medical treatments.[48] Those same critics would say that group generalization, like race-based therapeutics, is a more financially sound strategy to providing healthcare as truly individualized healthcare would cost too much time and money.[49] However, these excuses overlook the need to further analyze the underlying causes; why is Group X prone to poverty and homelessness; and, as stated before, what are the genetic variances that make certain groups of people so susceptible to certain diseases? Of course these answers will not come immediately, but using these rudimentary placeholders like race and social groups merely perpetuates short-term results that never address underlying problems. The change that is needed, the analysis that is crucial, and the actions that are required will take time but will ultimately serve us better in the long-term. What needs to be addressed are the socioeconomic factors that affect racial disparity in healthcare.

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44 Kelly M. Hoffman et al., *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites*, 113 Proceedings of the Nat'l Acad. of Sci. 4296 (2016).

45 M. Gregg Bloche, *Race-Based Therapeutics*, 351 New Eng. J. Med. 2035, 2035 (2004).

46 *Id.*

47 *Id.*

48 Richard A. Epstein, *Disparities and Discrimination in Health Care Coverage: A Critique of the Institute of Medicine Study*, 48 Perspectives in Biology and Med. S26, S28 (2005).

49 *Id.*

C. Socioeconomic Factors of Healthcare Disparity

There is little disagreement that those in poverty are often those with the poorest health. As early as the 1920s, studies have shown that those who were poor and homeless were disproportionately afflicted with high rates of infant mortality, low birth weight, tuberculosis, physical abuse, and "other factors detrimental to health."[50] Further, children of impoverished families living in low-income communities will most likely attend under-funded schools, which means "reduced availability of textbooks and … other educational resources … and less-qualified teachers."[51] Indeed, the issues can be linked primarily to poverty, and those in poverty will suffer the most. No one thrusts themselves into poverty by choice; no one chooses decrepit shelter over adequate housing; and no one intentionally chooses ignorance. These situations occur due to improper support, government involvement, and poor funding allocation. Unfortunately, Hispanics and African-Americans are most often in those situations. Between the criminal justice system[52] and government action[53], minorities in the U.S., especially African Americans, have been systematically oppressed for several years. For them, the U.S. was not a land of opportunity but a land where they and their kin to come would be — and still are — disadvantaged.

1. Poverty

Poverty is one of the most, if not the most, prominent root cause to poor health. The most obvious link is that poverty often means the inability to access physicians due to financial restraints, either to directly access physicians or because of an inability to afford insurance. Yet, as stated earlier, poverty also means less access to more than just direct and indirect medical care. Between housing and education, poverty is the common link between the other two factors and itself.[54] Poverty leads to choices that mean compromise; it is not an easy decision to choose between food or a flu shot, paying for utility bills or prescription antibiotics, or choosing between your child's school supplies or new clothing.

For medical access, states offer medical assistance for the impoverished. All states provide some form of medical care for the impoverished.[55] Often called Medicaid, this state and

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[50] Robert J. Sampson, *The Neighborhood Context of Well-Being*, 46 Perspectives in Biology and Med. S53, S54 (2003).

[51] Jose J. Escarce, *Socioeconomic Status and the Fates of Adolescents*, 38 Health Serv. Research 1229, 1233 (2003).

[52] Referring to the plethora of court cases that furthered discriminatory policies against minorities and the numerous disproportionate incarcerations of African-Americans over Caucasians.

[53] Referring to the Jim Crow laws and "separate but equal" policies enacted by several states and the federal government.

[54] Travis P. Baggett, *The Unmet Health Care Needs of Homeless Adults: A National Study*, 100 Am. J. Pub. Health 1326, 1336 (2010).

[55] Medicare.gov, *Medicaid*, Center of Medicare and Medicaid Services, https://www.medicare.gov/your-medicare-costs/help-paying-costs/medicaid/medicaid.html.

federally funded program offers some respite to those who are poor. Historically, Medicaid was strictly for those who were poor and also met some other special criteria, such as single parents, disabled people, or pregnant women.[56] With the implementation of the ACA, some states have expanded the Medicaid coverage and made the only criteria for eligibility is to make at least 138% of the Federal Poverty Level.[57] This new criteria change alone already increases the number eligible for Medicaid. However, the greatest increase comes from media coverage and increased general knowledge of President Obama's ACA. Prior to the ACA, a large number of Americans were eligible for Medicaid but did not apply, most likely because not many people understood the criteria for applying for Medicaid.[58] So, on top of the newly eligible candidates, many previously eligible candidates were made aware they can now apply. So, thanks to President Obama's ACA, many impoverished people will have access to some form of medical care, and yet, a full year after implementing the ACA, racial disparity is still present.

However, not all states have expanded their Medicaid coverage. There are 19 states that have yet to act upon the ACA's Medicaid expansion, and therefore, they do not offer Medicaid to its citizens based on income alone.[59] So those in poverty in those states are still left without the medical access the ACA promises.

Again, racial disparity is more than just medical access. To reiterate, food and water have had the most impact on health than any medical intervention, but those in poverty are most likely to have an improper diet, namely the wrong kind of food and water. As an example, black youths are "2.3 … times more likely to have lower-quality diets" than their white counterparts.[60] In nearly every state[61], predominantly black neighborhoods are more amply supplied with fast food than supermarkets, vastly restricting the variety and quality of food present in those neighborhoods.[62] Fast food businesses also specifically target lower-income and minority neighborhoods. A study shows that low-income neighborhoods with a high concentration of minorities were "associated with significantly higher levels of exposure to

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[56] *Key Milestones in Medicare and Medicaid History, Selected Years: 1965-2003*, 27 Health Care Financing Rev. 1, 2 (2005).

[57] Medicare.gov, *Eligibility*, Center of Medicare and Medicaid Services, http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html (The poverty line is $11,880 for individuals, $16,020 for a family of 2, $20,160 for a family of 3, $24,300 for a family of 4, $28,440 for a family of 5, $32,580 for a family of 6, $36,730 for a family of 7, and $40,890 for a family of 8).

[58] Benjamin D. Sommers, *Why States Are So Miffed about Medicaid - Economics, Politics, and the "Woodwork Effect"*, 365 New Eng. J. Med.100, 101 (2011).

[59] The Henry J. Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision*, http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D (last visited Oct. 6, 2016).

[60] Archana P. Lamichhane, *Spatial patterning of supermarkets and fast food outlets with respect of neighborhood characteristics*, 23 Health & Place 157, 157 (2013).

[61] With the exception of Texas

[62] *Id.* at 158.

[unhealthy] food and beverage ads."[63] There is no surprise, then, that black youths have a 24.3% obesity prevalence rating as opposed to 14% for white youths.[64] A proper diet includes a variety of food that is not found at the local fast food supplier.[65] Yet, there are very few supermarkets or full-line grocery stores near impoverished neighborhoods.[66] The impoverished, especially black people, are in a situation where unhealthy fast foods are dominating the market for low income. Supermarkets have no desire to come to impoverished neighborhoods since those neighborhoods have citizens with low spending power and offer little financial return for supermarkets.[67] The impoverished, therefore, are stuck in a situation where they are in poverty and cannot claw out of poverty.

Poverty is more than just being low-income. Poverty robs people of honest choice, and not just for themselves. Low-income parents must gaze upon their children knowing that access to proper education, housing, and even basic necessities as food and water may be sub-standard, and this shall only continue for grandchildren. In order to properly address housing, education, and poverty, careful analysis is needed, but no one entity can do this — not even the federal government. Instead, cooperation between local, state, and the federal government will be necessary to work over generations of the impoverished to reach a long term goal of success.

2. Housing

Having a home, a place to rest and unwind after a long day's work, is often assumed or ignored in the face of greater issues of racial disparity in healthcare. However, housing is a factor that affects health just as much as poverty or education. Indeed, a home is one of the key factors in determining if someone has a good quality of life. However, note that the definition of homeless need not only mean the lack of a physical abode. Here, homelessness is synonymous with residential instability since its effects are at least as devastating as homelessness.[68]

There are indeed stories of successful homeless people: the homeless man with the golden voice,[69] homeless students working hard and getting accepted into Harvard,[70] and

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[63] Lisa M. Powell, *Racial/ethnic and income disparities in child and adolescent exposures to food and beverage television ads across the U.S. media markets*, 29 Health & Place 124, 128 (2014).

[64] *Id.* at 124.

[65] B. A. Laraia, *Proximity of supermarkets is positively associated with diet quality index for pregnancy*, 39 Preventative Med. 869, 874 (2004).

[66] Shannon N. Zenk, *Neighborhood Racial Composition, Neighborhood Poverty, and the Spatial Accessibility of Supermarkets in Metropolitan Detroit*, 95 Am. J. Pub. Health 660, 663 (2005).

[67] *Id.*

[68] G. Thomas Kingsley, *Addressing Residential Instability: Options for Cities and Community Initiatives*, 14 Cityscape 161, 162 (2012).

[69] Jennifer Calfas, *Former homeless man with 'golden voice' enters presidential race*, USA Today, June 30, 2015, http://www.usatoday.com/story/news/nation/2015/06/29/ted-williams-golden-voice-run-for-president/29470913/.

more. Yet, these stories are scarce, and the harsh norm of homelessness involves poor health and even poorer endings. There are very rarely singular reasons as to what causes homelessness. One study suggests that family origins has a huge impact on homelessness; the homeless that were interviewed have a common poor family structure during their childhood: alcoholism in the family, parental figures routinely being incarcerated, poorly educated parents, and more.[71] Another study suggests that problems that occur during, or around, the time of homelessness are more prevalent. This study found that the homeless interviewed were homeless because of severe emotional trauma, physical and mental health problems, or abusive and destructive behaviors.[72] Further still, a study in Hawaii believed that many were homeless because of social and cultural clashes between the many races of Hawaii and poverty.[73] There is no one reason for homelessness. Yet, just because there is no clear reasons does not make homelessness any less of a threat.

Homelessness is strongly linked to poor health.[74] Those without homes are much more likely to exhibit poor health choices.[75] The homeless often have to choose between obtaining good health and other factors like seeking shelter or determining where it is safe to sleep.[76] Compared to the general population of the U.S., who do not have to worry about making such terribly unfortunate choices, the homeless are six to ten times more likely to have unmet medical needs.[77] Regrettably, those very needs can also lead to further unmet medical needs, continuing an endless cycle of self-destruction all because of homelessness; the homeless are likely to forego consultation on proper nutrition in order to acquire food; the visually impaired might miss their optometrist appointment because they have no aid in seeing where to travel; and some may go to work because they cannot afford the doctor bill, which can only increase as medical conditions worsen.[78] The homeless are, therefore, in a situation wherein their housing status alone causes direct health problems.

To address homelessness, then, a bigger issue than housing needs to be studied. In the U.S., Hispanics and African-Americans make up 60% of all the homeless.[79] Research will

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[70] Esmeralda Bermudez, *She finally has a home: Harvard*, L.A. Times, June 20, 2009, http://articles.latimes.com/2009/jun/20/local/me-harvard20.

[71] W. A. Heffron, *Risk factors for homelessness: a study of families of origin*, 27 Fam. Med. 586, 590 (1995).

[72] Maureen Crane, *The Causes of Homelessness in Later Life: Findings From a 3-Nation Study*, 60 J. Gerontology S152, S155 (2004).

[73] J. S. Omori, *Reasons for homelessness among Micronesians at a transitional shelter in Hawai'i*, 14 Pac. Health Dialog 218, 220 (2007).

[74] Kelley M. Withy, *Health Care Needs of the Homeless of O'ahu*, 67 Hawaii Med. J. 213, 213 (2008).

[75] James D. Plumb, *Homelessness: reducing health disparities*, 163 Canadian Medical Ass'n J. 172, 172 (2000).

[76] *Id.*

[77] Bagget, *supra* note 54 at 1332.

[78] *Id.* at 1331.

[79] The U.S. Department of Housing and Urban Development, Office of Community Planning and Development, *The 2015 Annual Homeless Assessment Report (AHAR) to Congress* (last visited Oct. 5, 2016).

be needed, and this research will be a monumental task for local and state governments. There will need to be intense questioning as to what is the predominant issue among the homeless and how best to treat homelessness more as an illness rather than as a demographic.

3. Education

Having an education is critical to breaking an endless cycle of poverty and poor health generation after generation. Besides the countless studies (and arguably common knowledge) that show higher education leads to better jobs[80], having a better education can mean having better overall health. Countless studies have shown that those who have attended college have better overall chronic health[81], increased willingness and financial ability to utilize preventative health care[82], and are more likely to engage in physical activity in their older years.[83] Yet, for the minorities of America, it is not as simple as enrolling into college. First, there has been a long history of racial disparity in education: *Cumming v. Richmond County Board of Education,*[84] *Brown v. Board of Education,*[85] *Lum v. Rice,*[86] and *Berea College v. Kentucky*:[87] all show that education has a history of placing minorities is disfavored and lesser positions

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[80] Adam Looney et al., *Education Is the Key to Better Jobs*, Brookings (Sept. 17, 2012), https://www.brookings.edu/blog/up-front/2012/09/17/education-is-the-key-to-better-jobs/; Bernd Debusmann Jr., *Education pays off in better jobs, higher salaries*, Reuters (Aug. 5 2011), http://www.reuters.com/article/us-education-earnings-idUSTRE7746CW20110805; Eduardo Porter, *A Simple Equation: More Education = More Income*, The N.Y. Times (Sept. 10, 2014), http://www.nytimes.com/2014/09/11/business/economy/a-simple-equation-more-education-more-income.html; *See also* Philip Moeller, *Why Learning Leads to Happiness*, U.S. News (April 10, 2012), http://money.usnews.com/money/personal-finance/articles/2012/04/10/why-learning-leads-to-happiness.

[81] Gareth Leeves & Ireneous Soyiri, *Does More Education Always Lead to Better Health? Evidence from Rural Malaysia*, Biomed Research Int'l (2015).

[82] Jason M. Fletcher & David E. Frisvold, *Higher Education and Health Investments: Does More Schooling Affect Preventative Health Care Use?,* 3 J. Hum Cap 144 (2009).

[83] Benjamin A. Shaw & Linda S. Spokane, *Examining the Association Between Education Level and Physical Activity Changes During Early Old Age*, 20 J. Aging Health 767 (2008).

[84] *Cumming v. Richmond County Board of Education,* 175 U.S. 528 (1899); the county could legally fund only high schools with white students, leaving high schools with black students severely underfunded.

[85] *Brown v. Bd. of Ed. of Topeka, Shawnee Cty., Kan.*, 347 U.S. 483, 74 S. Ct. 686 (1954). *See also Brown v. Bd. of Educ. of Topeka, Kan.,* 349 U.S. 294, 75 S. Ct. 753 (1955); the Supreme Court admitted that segregation has a detrimental effect upon children, leaving black children to believe themselves to be inferior to white children. This belief lowered motivation in black children to learn. The second *Brown* case gave the responsibility of desegregation to the states with no specific directions other than to act with "all deliberate speed," ensuring that very little, if anything at all, was actually done to enforce what *Brown v. Bd. of Ed.* promised.

[86] *Lum v. Rice*, 275 U.S. 78, 48 S.Ct. 91 (1927); Segregation also affected other races, and the courts found numerous ways to justify that all races should be under some hierarchy with whites as the most superior.

[87] *Berea Coll. v. Commonwealth of Kentucky*, 211 U.S. 45, 29 S.Ct. 33 (1908); Even private institutions were not allowed to go against state segregation laws. Should the state decree it, no institution may be desegregated. This case is quite possibly the lowest point in American jurisprudence.

than their white counterparts. Today, minorities make up more than one-third of the U.S. population.[88] Yet, their education is most often overlooked. With a high population of African-Americans and Hispanics in low-income communities,[89] many of the schools for those communities are severely underfunded. In 2011, it was estimated that more than 40% of low-income schools are not receiving a fair share of state and local funds, leaving low-income/high-poverty students, who are already disadvantaged, even more disadvantaged than their wealthier peers.[90] However, this disparity extends even further. Elementary and secondary schools serve as educational foundations to encourage and motivate learning, and those who came from low-income areas where there are poorly funded schools are also those that either do not attend or have dropped out of college.[91] So, minority children in low-income/high-poverty communities lack the proper educational resources needed for developing children that affect their entire educational life going into college.

Insofar as food, schools do provide children with a meal plan. However, this is scarcely enough. There is certainly no doubt that hunger and food insecurity can affect a child's physical and mental health.[92] Something as simple as having breakfast can have a drastic positive impact on school grades, standardized test scores, and improve behavior in class.[93] Thankfully, both breakfast[94] and lunch[95] are provided to a vast majority of students in public schools. Yet this is nowhere near enough to discourage the racial disparity in education; what happens to students during the summer time? The aforementioned breakfasts and lunches are not served during summer. Further, serving school meals is irrelevant to the problem of poor funding or improper allocation of state funds. Further still, school meals have no impact on helping low-income students either attend or prevent students from dropping out of college. To that extent, what are those students — who

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[88] United States Census Bureau, https://www.census.gov/newsroom/press-releases/2015/cb15-tps16.html.

[89] Carmen DeNavas-Walt, *Income and Poverty in the United States: 2014*, United States Census Bureau (2015), https://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-252.pdf.

[90] *More Than 40% of Low-Income Schools Don't Get a Fair Share of State and Local Funds, Department of Education Research Finds*, U.S. Dep't of Educ. (Nov. 30, 2011), http://www.ed.gov/news/press-releases/more-40-low-income-schools-dont-get-fair-share-state-and-local-funds-department-education-research-finds.

[91] *Projected Postsecondary Outcomes of 1992 High School Graduates*, U.S. Dep't of Educ. (1999), https://www2.ed.gov/offices/OPE/AgenProj/report/theme1a.html.

[92] Linda Weinreb et al., *Hunger: its impact on children's health and mental health,* 110 Pediatrics e41 (2002); *See also* Janice Ke & Elizabeth Lee Ford-Jones, *Food insecurity and hunger: A review of the effects on children's health and behaviour*, 20 Paediatrics & Child Health 89 (2015).

[93] Katie Adolphus et al., *The effects of breakfast on behavior and academic performance in children and adolescents*, 7 Frontiers in Human Neuroscience 425 (2013).

[94] *School Breakfast Program Participation and Meals Served,* U.S. Dep't of Agric. (Sept. 9, 2016), http://www.fns.usda.gov/sites/default/files/pd/sbsummar.pdf.

[95] *National School Lunch Program: Participation and Lunches Served,* U.S. Dep't of Agric. (Sept. 9, 2016), http://www.fns.usda.gov/sites/default/files/pd/slsummar.pdf.

relied on public school meals to stave off hunger — to do during college where there are no free meals? School meals are certainly a necessary and welcomed feature towards improving the health of minorities. However, it is not a full solution and nor should it be used as an excuse to further delay the changes necessary to weed out disparity in education and, ultimately, health.

IV. Solutions

Unlike medical access, housing, poverty, and education disparities cannot be so easily solved by a singular federal solution. Due to the sensitive nature of these subjects, deference should be given to the states as they are now. Yet, an absent hand to guide the states will leave the U.S. no better off than it is now. Therefore, to truly combat this public health blight, a balance must be reached between the federal government and the states.

There is a need to have some level of quantitative regulations. A certain amount of funding must be allocated instead of allowing states to have discretion. In giving the states discretion, to cite *Brown* again, there is always the possibility that the states will do nothing at all or even undermine progress. Yet, this may prove difficult to achieve since Congress may not legislate powers normally delegated to the states,[96] nor can Congress employ overly-persuasive financial incentives to get states to surrender sovereignty.[97] The change, therefore, must come from the state level. However, in light of the recent ruling of the ACA, Congress may be able to implement a form of step-compliance under the authority of taxation and non-encumbering funding.[98]

1. Housing

At the moment, the District of Columbia (DC) has the highest rate of homelessness.[99] In an effort to assist the homeless, DC built around 4,000 beds in homeless shelters.[100] However, of those beds, only around 2,000 are available year-round, and even if all those beds were available, DC has nearly 7,000 homeless people.[101] It is not my intention to

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96 U.S. Const. amend. X, § 1. *See also U.S. v. Lopez*, 514 U.S. 549, 114 S.Ct. 1624 (1995).

97 *S. Dakota v. Dole*, 483 U.S. 203, 107 S.Ct. 2793 (1987).

98 *Halbig v. Burwell,* 758 F.3d 390, 394, 411 U.S.App.D.C. 199, 203 (2014). *See also King V. Burwell*, 135 S.Ct. 2480, 2488 (2015).

99 Metropolitan Washington Council of Governments' Homeless Services Planning and Coordinating Committee, *A Regional Portrait of Homelessness, 2011 Count of Homeless Persons in Metropolitan Washington*, May 2011, at 5.

100 Kids Count Data Center, *Number of Homeless – Persons, Children and Families*, http://www.datacenter.aecf.org/data/tables/4833-number-of-homeless—persons-children-and-families?loc=10&loct=3#detailed/3/any/false/36,868,867,133,38/988,1006,1007,1008/11208 (last visited Oct. 29, 2014).

101 *Id.*

chastise an act of good intent, but DC is a perfect example of what needs to start without stopping.

A possible solution, then, is to offer shelter to the homeless just like what DC started. The key, however, is to ensure that the homeless are offered shelter year-round. This means, therefore, that adequate funding is provided; that there must be the physical facilities that offer adequate shelter; that the shelter should provide reasonable privacy for the homeless; and that there must be adequate staff to maintain the facility and ensure it stays in appropriate living conditions, which can include janitors, nurses, security, and general management. Among the general management should be some form of social worker or other dedicated public staff to help the homeless get the resources and help they may need. These resources can be job networking, skills training, drug rehabilitation, and therapeutic counseling.

The end goal of assisting the homeless and preventing homelessness is to allow those who are homeless a chance at maintaining a stable and productive lifestyle on their own and to be self-sufficient. To accomplish this, an individual, case-by-case analysis is needed. This will not be a quick process. However, the short-term benefit of such a shelter program is seeing the homeless off the streets and into the care they so desperately need. The ultimate goal is not simply to house the homeless but to address the long list of problems that can pose as the root cause of homelessness: physical and emotional trauma, disability, drug use, and more. While poverty may be a common problem, other issues, namely physical and mental health, need to be addressed too. States will need to work with local governments to find the most prevailing problem. For example, if alcoholism is the predominant cause, the local government can start regulating alcohol purchases to limit the amount of alcohol readily available.[102] Regardless of the prevailing cause, careful attention will be needed. The goal of this proposed solution is compassion. In understanding the basic human need of shelter and help, homelessness can be addressed and treated steadily and for everyone.

2. Education

The disparity in education can first be addressed by ensuring funding is properly allocated. The municipalities that improperly allocated funds should be punished for furthering the disparities. However, simply placing money into the schools is only the first step. Qualified teachers will need to be hired.

High-quality teachers are certainly necessary in providing a high-quality education. If such

[102] MD CODE, Art. 2B, § 16-301 (West). Following suit of Montgomery County of Maryland, limiting alcohol does not inherently solve alcoholism, but by limiting the general availability to the public, there is less of an opportunity for abuse.

teachers are in short supply, an alternative could be to train current teachers by, for example, allowing elementary and secondary school teachers to attend college courses to hone their teaching craft. However, once this first step is done, there is a middle step between hiring and implementing a new curriculum: acclimating the new teachers and working with them and the school staff to see how students should best be taught.

Immediately jumping into writing and enforcing a new, higher-standard curriculum would be foolish. Instead, new teachers, either hired or further trained, need to work with students to figure out how best to teach them. For example, each year, teachers should implement an ever-higher standard of academic challenge until the students finally demonstrate a high level of education. However this is done, rushing to the end is not the best way to teach; similarly, a student should practice good study habits weekly instead of cramming an entire's semester of information all at once the night before. However, all of this is impossible if there is no proper funding.

Between hiring new teachers, re-training current ones, and implementing new curriculums, funding is needed. The federal government, as it did with the No Child Left Behind Act, needs to allocate funds. The same burden falls upon the states and local governments to allocate those very same funds. Again, funding low-income schools may not yield immediately apparent results. As an example, a school that is finally able to offer textbooks to all its students may not immediately yield a class of straight-A students, but in the long run, the practice of being properly supplied holds more promise than a school that is both under-funded and improperly supplied. Again, this is a goal that will reach its fullest fruition not immediately but over time. Patience will be needed, but eventually, provided efforts remain zealous, education will finally be equal for all, and with that, a chance to be in good health.

3. Poverty

Poverty is not so easily solved, and nor would it be correct to expect it gone within the near future. However, the efforts to eradicate poverty are not meant to achieve an immediate high of short-term satisfaction. However, there should be great caution to avoid lethargy while waiting for change, and nor should the slow results mean that efforts should be as slow. Indeed, the reward for hasty, powerful action should lead to a slow but satisfying end. The first step is to take the approaches above regarding education and housing. Further action is needed, but those act as a start and a theme for eradicating poverty: investing in low-income properties.

Addressing the homeless and education issue is setting forth a mindset. Instead of looking upon the homeless and poorly-educated as inferior or of a different class, homelessness and poor education need to be assessed and evaluated as concerns of the

public, so that the homeless and poorly-educated should be cared for just like the ill. Likewise, no immediate community benefit can be derived from improving education for low-income families. Yet, no amount of justification can be made to excuse continuing to underfund minority schools. By funding schools properly, instead of improperly allocating those funds elsewhere, generations will come where they can, after having a proper educational foundation and higher education accomplishments, earn more money to invest back into local communities. For in the end, investment is truly what will save low-income families.

In addition to aiding the homeless and low-income community schools, local and state governments should look into community infrastructure improvements, ensuring that: all homes have properly running utilities including water, electricity, and gas; roads are properly paved; buildings - commercial, residential, or otherwise - are both habitable and aesthetically pleasing; and other similar tasks. Granted, these renovations should not overburden any government, and need not be overly complex. Poverty is not purged within a short amount of time, but through diligence and helping people acquire their basic needs like shelter and intellectual acuity, a community can thrive, and when a collective of communities thrive, so, too, shall the whole state and its collective health.

V. Conclusion

Racial disparity in healthcare is not so easily solved by merely implementing universal healthcare. In truth, that which can be addressed, and maybe not even solved, by universal healthcare is only medical access. The scope of true healthcare extends beyond the doctor-patient relationship and into understanding all the factors that can affect health. Broadly, these categories — housing, education, and poverty — need to be addressed, and while general ideas are available, any of the ideas presented must be handled with careful scrutiny. For example, in handling education, the government needs to do more than simply telling state and local government to employ higher-quality teachers. There must be cooperation; the federal government needs to define quality; if need be, there needs to be an assessment as to the availability of quality teachers; the list of how to handle education continues on and on. Therefore, it is not enough to simply follow the protocols outlined herein.

Eradicating homelessness, unequal education, poverty, and implementing universal healthcare is no easy feat. Nor should anyone expect to reach any of these goals within what most consider a "short" time. Even a solution as seemingly simple as opening more facilities for the homeless will take time to coordinate building and zoning efforts, hiring

staff, training staff, and, quite possibly the most difficult, raising public awareness. However, a lack of a short-term benefit should be no reason to remain inactive. Legislative action must be done as soon as possible and with as much diligence on the 1,000th day as there was the first day. Yet if this can be done, if patience persists and efforts remain enthusiastic, racial disparity in healthcare, defined in its broadest scope, can be eliminated.

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