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Organizations submitting this report

The **National Lawyers Guild (NLG)** is the oldest multiracial bar association in the US whose members are lawyers, law students, legal workers and jailhouse lawyers in most U.S. states and in the occupied Hawaiian Kingdom. The NLG is affiliated with the International Association of Democratic Lawyers. The NLG constitution directs members to work *in service to the people to the end that human rights and the rights of ecosystems are more important than property interests*. It has adopted resolutions supporting human rights to health, to a healthy environment and against discrimination. Martha L. Schmidt of NLG is author of this report.

Connecticut Citizen Action Group (CCAG) is a 501(c)(3) organization, based in Connecticut, which is engaged in research to improve public health and avoid public health disasters. It measures and studies toxicity in the environment, issues reports on its findings, and recommends remediation.

The **Hawai'i Institute of Human Rights** is a grassroots community organization which works to create a culture of peace by promoting human rights. It provides education on human rights principles and the structures and mechanisms of the UN and regional human rights systems and engages in advocacy.

The **National Center for Law and Economic Justice (NCLEJ)** is an organization which supports grassroots organizing and engages in policy advocacy and high impact litigation to advance the economic rights of low-income people. Among NCLEJ successes was the landmark Supreme Court decision in *Goldberg v Kelly* which established the right to due process for welfare benefits applicants.

National Conference of Black Lawyers (NCBL) is a 501(c)(3) organization of lawyers, judges, scholars, legal workers and legal activists. It serves as the legal arm of the movement for Black Liberation and its mission is to protect human rights, achieve self-determination of Africans and African Communities and work in coalition toward ending oppression. Besides its U.S. focus, it supports liberation movements outside the U.S., such as its work toward ending apartheid in South Africa.

National Single Payer (NSP) is a 501(c)(4) grassroots organization which organizes locally in the struggle for a national single payer system of health care for the U.S. Its participants share the common principles that health care is a human right, must be free from profit and will be achieved through national legislation.

People's Action Institute (PAI) is a 501(c)(3) organization with representatives nationwide which struggles for democratic rights and emphasizes health care. Its participants believe in 1) universal access, because health care is a human right and should be affordable and accessible to all, regardless of identity, residence, citizenship or work status; 2) public health, because a public health system would replace corporate power with democratic control; 3) an end to profiteering, because the health care system must serve people not profits; and 4) regulated, affordable drug prices.

The Poor Peoples Campaign (PPC), originally founded by the Rev. Dr. Martin Luther King, Jr. in 1968 as a moral initiative, is a 501(c)(3) organization with active groups in 40 states. Acting upon the federal Constitutional mandate to promote the general welfare, it proclaims that everybody has a right to live, that U.S. abundance should be used to protect the dignity of all. It demands universal single payer health care, among other human rights. The PPC calls for relief from wealth inequality and challenges the way the U.S. measures poverty as insufficient.

Rights and Democracy Institute (RDI) is a 501(c)(3) organization in Vermont and New Hampshire, with allies nationwide. It fights for human rights, democracy and against corporate greed, including of health insurance companies. RDI educates the public on human rights and helps people "name their rights to claim their rights." RDI sees health care as an intersectional human right and promotes health care as a public good, based on principles of participation, equity, transparency and universal access.

The Rights to Life and Health
How financing affects the right to health care in the U.S.

Introduction

1.This report focuses on health care and discusses obligations under UN Charter Articles 55 and 56; Arts. 2, 3, 25, and 28 of the UDHR; Arts. 2, 6, and 26 of the ICCPR; Art. 5 of the ICERD, as well as the duty of a signatory not to defeat the object and purpose of the ICESCR, including the right to health protected by Article 12.

2. Council recommendations related to health during the last review are taken into account in this report. These recommendations include ratification of treaties protecting the right to health (Recommendations 26.1-26.7, 26.9-26.32.); establishing a national human rights institution (Recommendations 26.91-26.100); combatting discrimination (Recommendations 26.114, 26.289-26.291, 26.294); providing a system of public health care with universal access, and guaranteeing rights to life and health (Recommendations 26.288, 26.290, 26.293, 26.295-26.298); guaranteeing comprehensive sexual and reproductive and full health care to women, girls and sexual minorities (Recommendations 26.300-26.310). Many recommendations addressed the need for equitable measures for vulnerable people, including immigrants.

3. General Comments No. 14 (2000) and No. 22 (2016) of the ESCR Committee on the right to health and reproductive health and the Interim Report of the Special Rapporteur on financing in the context of the right to health, have been consulted for legal authority and recommendations. ***/1/***

4. Personal testimonies, which are for public dissemination and not confidential, illustrate violations of the right to health care and are filed separately in an annexed document. See **Annex to The Rights to Life and Health: How financing affects the right to health care in the U.S.**

The U.S. and international human rights obligations

5. We are deeply worried that the U.S. manifests a continuing pattern of a state not committed to human rights including the right to health. No priority is given to ratification of human rights treaties by the major political parties and no action to ratify the applicable treaties has been taken by the Senate since the last review. Support for human rights law and rights as universal, interdependent and indivisible are lacking among politicians, although many civil society organizations view health, housing and an adequate standard of living as issues which intersect. Local governments have adopted many resolutions supporting the right to health care, including, for example, the Seattle, Washington City Council. Regular national surveys over the past decade indicate over a two thirds majority of the American people believe health care is a human right and that a national, single-payer system is needed, such as improved, expanded Medicare. ***/2/***

6. The murder of a CEO of one the largest health insurance corporations in the US on 4 December 2024 (United Health) inspired thousands to take action through street demonstrations, cartoons, art, commentary on social media and the internet, and writing about insurance company delays and denials of care causing harm and death to patients throughout the country. Respondents to a NORC/ University of Chicago poll in December 2024 held United Health and other insurance companies responsible for the violence because of their denials of treatment and profiteering. For 2024, United Health reported its highest revenue in history, over $400 billion. In February 2025, 67% of US adults said affordability of health care is a very important national issue we face. ***/3/***

7. We are concerned about U.S. policies that adopt hierarchies of rights, deny ESC rights and reject international human rights standard setting through the UN system. The current administration is repeating its prior record of retrogression on the right to health care: attempting to offer inferior quality insurance or no insurance; conditioning health insurance on working; reducing budget outlays to deprive everyone who is not wealthy, especially affecting lower income and minority people, of health insurance; reducing the capacity of the public health system through staffing cuts; openly discriminating and denying protection to individuals who face discrimination in delivery of care on the basis on sex, gender, immigrant status, race, and more.

8. Both the Trump and Biden administrations have continued the process of destroying the best of the U.S. public systems of health care, Medicare and the Veterans Administration (VA). An “innovation” center, authorized under the Patient Protection and Affordable Care Act (PPACA), in effect since 2014, has facilitated the privatizing of Medicare through administrative acts unaccountable to Congress, interposing third party decision makers into health care access, acts done in secret, without agreement of seniors enrolled in Medicare. Neither administration stopped the multiple abusive and fraudulent practices of insurance companies profiting from the private, parallel system known as Medicare Advantage. VA care has been defunded, staffing levels have not been maintained, and patients are encouraged to seek private care, which is less efficient and results in inferior outcomes.

9. For the second time, President Trump has withdrawn the U.S. from the World Health Organization, a serious retreat from advancing public health domestically and internationally. It appears that the U.S. has no plan to meet the 2030 Sustainable Development Goals (SDGs), specifically Goal 3, to provide universal access to primary health care. The U.S. ranking for adherence to the SDGs slipped from #39 in 2023 to #46 in 2024.

10. In 2014, the U.S. Supreme Court decided that non-humans, businesses, could have a “right of religion” which prevailed over a woman employee’s right to have health care, allowing employer health insurance to exclude coverage for contraceptives for women. ***/4/*** After the 45th President and his administration accelerated a campaign against abortion, the U.S. Supreme Court decided, in *Dobbs v Jackson* (2022), that there is no federal constitutional right to abortion. (The case was based on the implied right to privacy, not on a right to health). This decision led to laws in 12 states, as of March

2025, completely banning abortion, which were initiated by religious organizations opposed to women's equality. It has also led to threats of criminal prosecution by abortion-banning states against individuals in other states who provide contraception and termination of pregnancy to residents who reside in states where abortion is banned. In 2024, a Catholic-affiliated hospital which was required to provide emergency care under a statute designed to stabilize patients and save lives, denied emergency termination of pregnancy to a woman in Humboldt County, California. She had miscarried twins and almost died from bleeding to death. The state of California filed suit, obtained an injunction, and the woman has filed a private suit to stop other religiously-affiliated hospitals in the state from denying needed abortion care to others.

11. The administration denies its duty to address discrimination against minorities in many more areas than in healthcare, actively discriminating against individuals and groups on the basis of, *inter alia*, race, national origin, citizenship, birth, gender, sexual identity, and political opinions. Even speech about discrimination is being prohibited.

Response of the U.S. Government to the COVID-19 Pandemic

12. The U.S. suffered the most deaths from COVID of any country. This was the result of the lack of a national health care system. Deaths resulted from private, for profit, dysfunctional and inadequate health care and underfunding of public health. From 13 March 2020-13 March 2025, 1,222,603 people died from COVID in the U.S. In the government's report for the Third Cycle review, which was submitted late, the pandemic was not mentioned, although by 12 October 2020, more than 212,000 people had died. By then, tens of millions of people lost their jobs and 12 million lost health care access because health care access was (and is) linked to employment. At the start of the pandemic, 78 million people lacked access to health care. ***/5/*** In 2020 health insurance companies had their most profitable year in the history of the U.S., with a 52% increase in profits over 2019. This was possible because the insurers delivered less care and retained all the insurance premiums, paid directly pursuant to the PPACA. Investor-owned health insurance companies continue with record profits again in 2024.

13. In the addendum to our Third Cycle report, submitted in spring 2020, focusing on the pandemic, we expressed concern about the impact of the absence of a universally accessible, national health care system and reinforcement of systemic racism and inequality. We noted that nursing home workers (essential workers), often immigrants and mostly people of color, had no sick leave. Nursing homes were the first institutions where COVID spread quickly. It was predictable in a country with no national law requiring sick leave for workers and with low rates of unionized workers, that disproportionate illness and deaths of essential workers would result. Essential workers in retail and health services had worse outcomes not only because they had to go to work, work when sick, and use public transportation, but because they often lived in multi-generational households and other housing preventing individuals who were sick from isolating themselves. We also expressed concern that in the privatized system, there was competition rather than cooperation for scarce but necessary supplies such as masks. Competition for vaccines and complicated systems for scheduling

immunizations resulted in preference for those with the best phones and computer technology and more leisure time. In the year 2020 alone the deaths of 212,000 people could have been avoided if we had had a universal, national single-payer financed system. **/6/** Tragically, from March 2020-September 2023, 216,617 children had a parent or caregiver die from COVID. Among these children, American Indian and Alaska Native children were orphaned at 3 times the rate of white children and Black children at 2 times the rate of white children. **/7/**

14. The Biden administration and Congress expanded insurance coverage above the poverty level, by lifting the income ceiling on who could be covered under Medicaid, pursuant to PPACA. This allowed 94 million people to have insurance in 2021, a record.

15. When the pandemic was declared officially over in 2023, millions began to lose insurance and health care access. This is known as “the great unwinding.” In 2023 alone, 26 million people lost insurance coverage and health care access. In 2025 the number of people with access to health care through Medicaid and CHIP (the children’s program) insurance was reduced to about 72 million. It was expected to decline further during 2025 and in each subsequent year, despite “long COVID” and the many, ongoing health impacts from the pandemic on individuals of all ages.

Adequate Standard of Living, the Right to Health and Inequality

16. Health care and an adequate standard of living are not only interdependent but the violation of one often causes loss of the other. The Official Poverty Measurement (OPM) establishes a Federal Poverty Level (FPL), which is adjusted yearly and has different rates for elderly and non-elderly individuals and household sizes. PPACA has allowed subsidies for incomes above the FPL for health insurance, but this is likely to end in 2025 if not extended by Congress. The FPL, which is used for Medicaid and other programs, is woefully insufficient to measure “adequacy” or an adequate standard of living, if adequate means more than bare survival. Adequate requires sufficiency and preservation of the dignity of each person. The OPM doesn’t include the cost of housing, and the median annual cost of rent exceeds the annual income that qualifies a person as living at the FPL.

17. Inequality impairs rights to an adequate standard of living and to health. Income inequality and wealth inequality are not random acts but policy choices made by the Executive, Congress and the courts, which determine the lives and wellbeing of millions of people. An adequate standard of living for all presumes income and wealth transfers and a robust public system of health care. Since the 1970s, it has been well-established empirically that more equal societies have better health. **/8/**

18. The standard of living is declining in the U.S. for people who are at the median income quintile and below. Measurements of equality indicate this decline will have an impact on the rights to life and health, including health care, which is dependent on levels of income and wealth, rather than provided as a human right through a single payer system.

19. U.S. income inequality, as measured by the Gini Index, which was.482 in 2018, has continued at this level from the previous UPR. It was essentially the same from 2020-2023, ending at .483 in 2023, indicating U.S. inferiority to all comparator high income states and to some middle-income states, as well. **/9/**

20. The U.S. has a worse Gender Gap Index than its comparators**,** a measurement which factors in health, survival, and economic well-being. In 2024 it ranked #43, a slight improvement over the period before the last UPR, but much worse than similar HDCs and significantly inferior to Nicaragua, a low-income state which ranked #6. **/10/**

21. U.S. wealth inequality was the highest in the OECD before the last UPR. Wealth inequality continues to grow in the U.S. and is now the highest in history. Lack of wealth and redistribution through taxes affects longevity and health. Because the private insurance system fails to cover the costs of health care and the public systems are also not fully comprehensive, using their wealth is how individuals and families compensate for the state's failing its duty. It is estimated that 33% of people with income **above** the poverty level are "economically vulnerable." Economically vulnerable means lacking liquid assets to deal with illness or sudden loss of income by maintaining a poverty level standard of living for at least 3 months. **/11/**

22. The health care (medical care) and welfare systems (income support, long term care) in the U.S. have a negative, synergistic impact on vulnerable people, causing them to become impoverished in order to secure medical services and goods. For disabled individuals with chronic conditions, private insurers and insurance-like accountable care organizations (ACOs) and health maintenance organizations (HMOs) find ways to reduce or refuse care to them because they have greater needs. More care reduces profits for businesses; it's that simple. Requirements to exhaust assets, likely to be needed for support in the future, pegging support levels below the poverty line, and reducing financial support from one program because of a minor but inadequate increase in another program are common experiences. Meanwhile government demands copious documentation of all expenses and multiple forms, which discourage applications. Endless means testing deprives individuals of their dignity and actually are rarely worth the cost. As one person said: "It's not the disease that made me disabled; it's being forced into poverty to pay for medical care and the way the system works to keep me impoverished." **/12/**

23. Because of income and wealth inequality, African-Americans are a group especially affected by rising uncovered health costs. Since the last UPR, white households continue to have more than 6 times greater wealth than black households, and income inequality is still the main contributor to that wealth gap. **/13/**

24. Higher levels of income inequality coincide with increased mortality for lower income individuals, who are disproportionately female, people of color and minorities, as well as indigenous peoples. Inequality in life expectancy is growing. Men in the 1% highest income group live *14.6 years* longer than the men in lowest 1% income group. Similarly, women in the top 1% income group live *10.1 years* longer than their comparators in the

lowest 1%. **/14/** The common knowledge that higher mortality is predictable from particular policies and laws indicates that the U.S. is engaged in arbitrary deprivation of the right to life, in violation of Art. 6 of the ICCPR.

25. A reduction of 10% in inequality could cause mortality of those aged 25-59 to be reduced by 3-9%. **/15/** Reducing inequality by any mechanism of tax redistribution is unlikely, given the deliberate reduction of tax revenues flowing as a result of the Tax Cuts and Jobs Act of 2017, which cut corporate tax rates from 35% to 21%. **/16/** There are currently fresh proposals from the Executive Branch for more tax breaks for the highest income taxpayers along with cuts in programs serving middle and lower income people.

Duty of the U.S. to Support Health and Life by Adequate, Equitable and Sustainable Financing of the Healthcare System

Progressive realization and maximum available resources

26. A state must ensure that adequate funds are available for health and prioritize funding in the national budgets as well as ensure equitable allocation of health funds and resources. **/17/** Fulfillment of this duty enables a state to realize progressively the right to health. Progressive realization was designed to accommodate LDC countries, not to allow high GDP states such as the U.S. to avoid their human rights obligations to their people for decades. Progressive realization of the right to health care (and reduction of mortality rates) should have been achieved long ago, considering the size of U.S. GDP and the percentage devoted to health care. The U.S. spent $3.6 trillion on health care in 2018, of which 67% was derived from taxes, and health spending then was 18% of GDP. By 2024, health spending was over 18% and the Congressional Budget Office was predicting substantial increases for the future. **/18/** The U.S. percentage of national spending on health care is expected to climb to 20% by 2027. **/19/** The estimated cost over the next decade, 2019-2028, is *$50 trillion*. **/20/**

27. Budgeting choices require a state to ensure that maximum available resources (MAR) are committed to achieve the right to health. Funding human rights is, of course, not the same as paying for insurance. Wise targeting so that allocations are made according to need are required. However, the budgeting process in Congress fails to meet MAR. This is the result of *mis*allocation. For example, it has long been common knowledge that health care for prisoners is inadequate and deliberately substandard. This happens because of racial, wealth, and other discrimination and because funding for health is diverted into guaranteeing private profits.

28. Some health programs, departments, etc., clearly are not sufficiently funded, such as the Indian Health Service (IHS), which serves 2.2 million people in rural and urban locations and which is funded from discretionary funds. The budget of $8 billion is discriminatory. As contrasted with per person annual funding for Medicare ($11,000) and Medicaid ($5,700), the IHS has received a meager $3,700 per person. Funding for the IHS also fails to provide resources to upgrade aging facilities and to attract

physicians and practitioners to remote areas, other violations of equity and highest attainable quality. **/15/** In 2025, rather than fully fund and guarantee regular funding for the IHS according to treaties which are long-standing, Congress requires indigenous nations to seek and manage funds from Medicaid and other underfunded programs. This forces tribes to compete with states, adds more administrative complexity for tribal governments, and is inequitable, given the health issues which affect native communities, such as high rates of cancer, diabetes, and maternal mortality. The U.S. is in violation of its duty, under Articles 24, 21, and 7(1) of UNDRIP, which it has accepted, to support self-determination of indigenous peoples in health and health care. Use of MAR is necessary to correct this health injustice.

29. The MAR standard is also not applied to the financing of mental health care. Congress adopted a mental health parity law years ago to address the stigma of seeking care, but funding continues to be woefully insufficient. The U.S. is experiencing health crises of suicide (often poisonings from synthetic opioids) and mass killings, and the trauma from those affects communities all over the land. The Special Rapporteur has recommended addressing violence as a public health problem **/22/,** but that has only been accepted by the VA with respect to suicides. Another current, serious public health problem which affects 7% of the U.S. population- one in 15 adults- are mass shootings. This violence, which has a disparate impact on black people and on men, necessitates access to quality health care for trauma, depression, anxiety and fear. Those most at risk are young adults of Generation Z (born after 1996). **/23/** The data and research show the importance of a national, universally accessible health care system which treats health care as critically important for social and environmental health, for an adequate standard of living and life.

30. When we submitted our last report, suicide was the 10th cause of mortality overall. Those who suicided at the highest rates were people traumatized by cultural/national violence and war, Native Americans, Alaska Natives and veterans. In 2024, data became available for 2022. Suicide was at its 2nd highest rate in U.S. history with nearly 50,000 deaths, after a slight decline from 2018-2020. While the veterans' suicide rate has continued to climb overall, suicides of women veterans decreased in 2022, below the previous 5 years. **/24/**

31. The U.S. government knows public financing improves health outcomes. In an important study of structural determinants of U.S. mental health, which focused on suicides from 1990-2017, researchers observed that suicides escalated in 2007 with the Great Recession (housing and financial crash, with bailouts for banks and no meaningful public action for loss of housing). Suicides continued to climb post-recession in states with higher unemployment, stagnating wages and increased poverty. Addressing the rights to housing and employment with public programs, such as in 1933 through the New Deal, during the Great Depression, clearly resulted in improved health outcomes. The New Deal record serves as a warning about the importance of addressing housing and health care as interdependent. **/25/** In recognizing homelessness of veterans as a health problem, the VA collaborated with the Department of HUD (Housing and Urban Development) to reduce homelessness among

veterans by 50% over the last decade by providing coordinated social and economic support through vouchers. **/26/** This successful example is relevant to addressing the dual crisis of homelessness and healthcare which affects tens of thousands of non-veterans throughout the U.S.

Progressive taxation

32. The health care system of the U.S. is funded from general taxes, with a reliance on income and social security tax. Income tax is progressive, except that higher income individuals in the top quintiles can avoid taxes through the lower rate applied to capital gains, resulting in regressive tax collection. Social security tax is based on a percentage levied on each wage earner, commencing with the first dollar earned, more burdensome on lower paid workers, and this is matched by the employer. Self-employed individuals pay both their individual percentage and the employer percentage. This raises issues for workers wrongly classified as contractors by their employers, a common problem. A systemic financing problem is that individuals pay social security tax only up to a ceiling on income ($176,100 for 2025), so that the highest earning workers pay a smaller percentage, making the system more regressive. If this ceiling were lifted, the financing of the system would be more sustainable, as well as equitable. (There is some support for this in Congress.) This would also improve the funding of Medicare. About 10% of the funding of the health care system is paid for completely out-of-pocket, by the users of the system, the neoliberal response to financing collective needs. Those with wealth are less burdened, as are those who have less need for health care, which does not promote equity or social responsibility.

33. Less tax revenue is being collected from corporation tax because those taxes have been reduced. There is no tax from other capital sources. The tax system for health care fails to comply with the principle of equity. **/27/** Increasing funding from wage earners or from more progressive sources will be necessary to address the needs of an aging population. For some time, the U.S. has had lower effective corporate tax and higher reliance on individual income tax than its OECD comparators.

Profiteering, lack of accountability, destruction of public health care, privatization

34. The U.S. has a complicated private, multi-payer health care system with layers of intermediaries who remove profits and create waste and inefficiencies. It is designed to benefit private business rather than guarantee the human right to health. Insurance companies, as well as quasi-insurers like Accountable Care Organizations (ACOs) and Health Maintenance Organizations (HMOs), hospitals, and monopoly drug companies, among others, divert funding away from health care for individuals and exploit the system which has pitiful enforcement of regulatory law. The health sector of the economy is undergoing more consolidation and financialization since the last UPR, which facilitates profiteering and makes prosecution of fraud and abuse difficult, even if enforcement of statutes were funded by Congress, which they are not. Violation of the law generally leads to no consequences for corporations.

35. Some recurring problems noted by the Special Rapporteur apply more than ever to the U.S. These include insufficient regulation of private actors, such as insurers, hospitals, and drug companies, and failure to prosecute corrupt practices.

Profiteering

36. Since January 2014 when PPACA went into effect, commodification of health care has accelerated. Health care businesses have consolidated into a few large corporations. Financialized health care is exemplified by private equity ownership, a business model which has taken off in the last decade. Private equity is almost completely unregulated under corporate law and is attractive because it offers tax benefits and huge profits to investors without requiring transparency. The model, which is especially causing havoc in hospital ownership (22% of for-profit hospitals as of January 2024), uses debt to acquire property, rapidly squeezes whatever profits it can from the assets, fires employees, reduces quality, fails to pay bills, and turns over for sale whatever assets are marketable, all typically within 5-8 years. Private equity has invested in all areas of health care, including nursing homes, emergency medicine, medical debt collection, home health and hospice, dental care and physician practices, behavioral health and child care. Its extractive business model has already led to closure and unavailability of health facilities in rural areas, unemployment, worse outcomes in hospitals and nursing homes and increased mortality. One study found that private equity ownership of nursing homes increased the mortality rate of Medicare patients by 10%. **/28/** This phenomenon is accompanied by record high profits of health insurance companies, as previously noted, and the rest of the health industry. During the pandemic, the owners of Moderna, the company whose vaccine research was completely funded by the public, became billionaires.

Lack of accountability

37. PPACA established few rules for insurance provided by employers. Employers could ultimately decide not to offer insurance and force employees to purchase through the state health exchanges. If employers offered health insurance, they passed increased costs to employees, hence employees became stuck with insurance with high deductibles (what a few decades ago was sold as catastrophic insurance). People who have insurance from their employers are among those who are underinsured--exposed to high, out of pocket costs, risking financial ruin and bankruptcy.

38. PPACA, an act which amended laws covering the entire health care system, was advertised as a cost-control reform, but reducing costs through market competition has been demonstrated for decades as impossible. Subsidies for insurance purchased on the exchanges were channeled directly to private insurers, and the elaborate system was designed with tiers of coverage at different costs, based on ability to pay. The system also enabled, given its complexity, a lack of transparency about providers, networks, and costs. Nothing significant has been done to address these issues. People are charged excessive fees for going outside their networks, without awareness of their exposure, sometimes because of false information, and at times because they have no

choice. Older people are charged 3 times as much as younger people for insurance. A selling point of PPACA for middle class households with university students was that youths aged 19-26 could remain under their parents' health insurance, but that proved to be illusory because the premiums were so high most families could not afford them. Health and Human Services also waived the obligation of the insurance companies to cap out of pocket spending.

Destruction of public systems and privatization

39. Medicare and the Veterans Health Administration were set up as comprehensive public systems. But first Medicare and then the VA have had their funding siphoned off into for-profit parallel alternatives (Medicare Part C [dubbed Medicare Advantage or MA] and private care for veterans pursuant to the Mission Act).

40. Part B Medicare, which has administrative costs of 2%, has been set up to fail in the long run by Congressional guarantees of profit for private MA, which has large administrative costs, well over the legal ceiling of 15%. Medicare has no restrictions on who beneficiaries can consult for their care and offers universal access throughout the country. MA, which has restricted networks, and markets extras like gym memberships to healthier, wealthier potential beneficiaries, and offers a cap on costs, continues to extract ever more extra funding from Congress for using tax dollars inefficiently. The insurance companies who "manage" MA, as contrasted with public Medicare, require pre-authorization for care and delay and deny care as a way to reduce costs and make more profit. These adverse actions are difficult for patients to appeal and few do. Insurance companies offering MA engage in a fraudulent practice of "upcoding" (billing for higher priced care based on fabricated worse health conditions of patients) which results in billions of extra costs per year. Despite violations, they have not been stopped and they are rarely prosecuted. Because insurance companies selling MA are allowed to advertise to seniors using false and misleading promises and information about costs and real disinformation about "choices," this parallel system with inferior outcomes now covers 54% of those aged 65+.

41. Veterans' health care, which was ranked in 2018 as "equal to or better than private care" **/29/** was undermined by the Mission Act, which changed funding from mandatory to discretionary appropriations and set up a process for sending veterans outside the VA to private facilities. **/30/** In 2025 a number of bills are pending in Congress to reduce funding for the public functions of the VA (research and training) and to shift more veterans outside the VA, to private practitioners who are not salaried and who have less knowledge of the special problems of veterans.

42. Advertising to both seniors and veterans is highly manipulative. It frequently invokes individual choice, preying on groups who are most vulnerable to their fears of losing control.

Unsustainable for society

43. Health care spending has continued to rise as a percentage of GDP at the same rate since enactment of PPACA. Family coverage insurance premiums rose at the same rate after 2010 as they did before 2010. **/31/**

44. Given the lack of cost controls, the ever-increasing demands for profit, and the complexity of the private insurance system, the status quo is unsustainable for the society as a whole. The decline in indicators of wellbeing is country-wide. The inequity of life expectancy at birth, maternal mortality, infant mortality, and amenable mortality cannot be improved significantly without changing the health financing system. The U.S. has other priorities besides health spending and 1/5 of the budget presents an impossible dilemma. Not only is health spending in the U.S. highly inefficient, it produces worse outcomes than the spending for health care in other countries, especially those where single payer, national systems exist.

45. The choices being made in the financing of health care promote economic insecurity of individuals and families as a result of health-related costs. In our previous report we noted that medical costs were the main factor in 66.5% of personal bankruptcies from 2013-2016. In 2024, medical debt continued as the primary cause of 2/3 of personal bankruptcy cases. This problem has been known for a long time and was exposed in surveys done in 2001 and 2007. There is no evidence that PPACA reduced the proportion of bankruptcies, and expansion of Medicaid by a particular state had no impact on bankruptcies. **/32/** The persistence of personal bankruptcy is the proverbial canary in the coal mine for the U.S. health care system.

<u>The individual right to health care</u>
Discussion of violations of universality, affordability, equity, non-discrimination/equality, highest attainable quality, transparency

Universal Access

46. The U.S. has not attained a system of national, universal access. Because no social insurance system exists which provides individuals with health care starting at birth by merely proving residence, the best programs which exist are ones which offer health insurance to targeted populations at low or no cost. These restrict coverage even within the designated groups and do not provide comprehensive health care (dental care is left out, for example).

47. For access to all of Medicare (for people aged 65+), which covers 61.2 million (2025), an individual must meet a social security standard of 10 quarters worked. About 7.9 million disabled persons under age 65 are covered by Medicare (with different requirements).

48. Medicare is restricted to citizens and immigrants who are lawful permanent residents (LPRs). Medicare Part A, hospital care, is denied to LPRs, and immigrants may be subject to a waiting period of 5 years for Part B Medicare. From 1996-2020, nationals of the U.S. from the Marshall Islands, who were guaranteed the right to work,

qualify for Social Security and Medicare in the US through a treaty, the Compact of Free Association (COFA, *e.i.f.* 1986), were denied access to Medicare by a statute, the PWORA (the welfare reform regime passed under the Clinton administration in1996), in violation of international law.

49. Access to care through the Veterans Administration requires veterans to have at least a 30% level of injury resulting from their military service.

50. Access to Medicaid and CHIP (children's health program) is means-tested, using the Federal Poverty Level standard ($15,650 for an individual, aged 19-64, 2025), up to 138% of FPL. Access to subsidies to pay for care under PPACA is tied to a percentage of income above the FPL.

51. For workers who have health care through their employer insurance plans, even when their out-of-pocket premium costs don't exceed the 8% cap/individual, the high deductibles (e.g. $5000) and other out-of-pocket expenses, like copays and co-insurance, can be barriers to accessing care, especially for lower-paid workers. Employer insurance plans can require each individual on a family plan to pay costs equal to that individual's deductible before the insurance pays any family health costs. This underinsurance is by design.

52. For people without employer-sponsored health insurance who try to use the insurance exchanges, they may discover they cannot find an affordable health insurance plan in their state or locality, a problem in part related to the declining number of insurers. Insurers are not required to stay in business. Many states have only one or two insurance options on the exchanges.

53. Affordability is closely tied to equity, including for women, who are poorer than men throughout life. For example, even Medicare has an inequitable impact on women. This is because Medicare increases premium costs by 5% annually and imposes out of pocket costs on the individual, a barrier for many seniors who live on fixed retirement income. Another reason is because the senior poverty rate increased to 10.7% in 2021 and because the level at which Social Security income becomes liable for income tax ($25,000 for an individual) has not been adjusted for inflation since 1984. (If adjusted for inflation, the level for imposing income tax would start at $75,250.) In 2016, 50% of Medicare beneficiaries spent up to 33%, and another 23% spent 34-50%, of their Social Security income on health care. At that time, 50% of Medicare beneficiaries had incomes below $26,000/year, and for 25% of them, their income was below $15,250. **/33/** The Centers for Medicare and Medicaid Services have reported that Medicare covers only about 65% of costs and that health costs more than double between the ages of 70 and 90. **/34/**

54. In 2010 at the time of passage of PPACA, 50 million people had no health insurance and it was estimated 44,000 deaths per year resulted from that. In 2018, the estimated total number of individuals aged 19-64 without health insurance was 28.9 million.

55. In 2018 about 5.4 million individuals lacked health insurance because of immigration status, because they or family members were undocumented. **/35/** In February 2025, a labor economist estimated the current number of undocumented immigrants as 12 million people. **/36/** Since PPACA does not cover immigrants, it is left to particular states to fund health insurance for immigrants and make decisions about documentation status. Access to individually-purchased health insurance varies from one state to another, and fewer than half the states offer health care insurance to immigrants. (California covers immigrants regardless of status.)

56. The estimated number of deaths attributable to lack of insurance in 2018 was 28,000. **/37/** The estimated number of US deaths attributable to lack of insurance in 2024 was 68,000. In addition, in 2024, 44% of the population was socially and economically vulnerable to adverse health impacts because of lack of universal access: 9% had no health insurance, 12% were uninsured for part of the year, and 23% were underinsured. **/38/**

57. More people are covered by insurance presently, but are underinsured. With underinsurance comes financial distress. Media is replete with stories about charges for "out of network" care, information about which is not transparent, and hitherto unknown gaps in coverage. In both 2010 and 2018, 45% of people covered by employer insurance were underinsured. **/39/** The insurers and employers, whose actions are largely unregulated by PPACA, maintained their profits by increasing deductibles and pushing other costs onto employees. **/40/**

58. In October 2024 Medicaid and the Children's Health Insurance Program (CHIP) covered over 72 million individuals. **/41/** This was a large decline from the highest coverage in history, 94.1 million, during the COVID-19 pandemic. In 2023, governments started to disenroll individuals and 26 million lost Medicaid in 2023, with another decline of 7.5% in 2024. Medicaid coverage is predicted to decline 4.4% in 2025 and annually at 3.8% in each year from 2026-2034. The interruption of health care access through Medicaid insurance because of means tested disqualification necessarily leads to millions of people becoming, by design, completely uninsured. In 2023, at least 26 million people had no health insurance at all, and this was principally due to lack of affordability. **/42/** Currently about 1.4 million people are excluded from Medicaid in 10 states because their states did not expand coverage under PPACA. These are poor people by poverty standards (OPM and SPM), who do not qualify for subsidies because individuals and families must make 100% of FPL or above to qualify for subsidies in the exchanges. Almost 60% of the group are Latino and Black people. **/43/** The U.S. Supreme Court has decided that states were not required to expand Medicaid to individuals between 100-138% of the poverty level, as PPACA provided. **/44/**

59. The Medicaid program, because of its association with people who are poor and low income, has since its inception been subject to attack by politicians and others seeking to reduce spending for those considered unworthy of human rights. Although most adults on Medicaid work, the current administration is renewing attempts as it did in its previous administration, to impose work requirements as a way to reduce health care

spending for those it considers undeserving. Administrators know well that adding more criteria for qualification are not only barriers to access, but discriminate, and they discriminate against those who are most vulnerable and who need equitable treatment from society. **/45/** Qualifying often costs more to administer than the amount of savings gained and it reduces social cohesion. (See generally, Guy Standing, *Beyond the New Paternalism*, 2002, and Gwendolyn Mink, *Welfare's End*, 1998)

Highest Attainable Quality

60. By design, coverage for health insurance and access to health care under Medicaid offer individuals a lower quality of health care than people with private insurance. Only one state has a public Medicaid system (Connecticut rejected its previous privatized system when they realized they could save administrative costs); the other states administer Medicaid through their privatized systems of insurance gatekeepers which restrict which hospitals and physicians a Medicaid patient may choose. For example, it was reported that California restricts Medicaid patients from using its university health care clinics, considered higher quality care, and the reason given by UC administrators for this was that Medicaid paid them too little. **/46/** In nursing homes, the supplies for patients on Medicaid are inferior and segregated from supplies for other patients who have private insurance. **/47/** Nearly all prisoners are covered under Medicaid. People in prison, who are disproportionately black, Latino and indigenous, have had their health care needs neglected for years. In the state of Washington, a nun who was imprisoned for trespassing at a nuclear weapons base died because treatment for cancer was delayed until she had reached a late stage of the disease. **/48/** During the COVID-19 pandemic, a black prisoner over age 65, who is also a disabled veteran, nearly died because no one noticed he was sick with COVID, which he contracted from a guard, and then when it was noticed, emergency care was first denied and then delayed. (The Washington State Supreme Court eventually ruled his treatment constituted constitutionally-prohibited cruel and unusual punishment because he was also deprived of water and toilet facilities.) **/49/**

Non-Discrimination

61. One egregious example of health care discrimination and the need for equitable care measures is the barring of Marshallese immigrants in the U.S. from access to health care for 24 years from 1996-2020, except if they had insurance through their employer or were pregnant. **/50/** The Marshallese were forced to emigrate because their country was contaminated by U.S. nuclear weapons testing from 1946-1958, equivalent to a payload of 7,200 Hiroshima bombs **/51/**. Despite being administrator of the trust territory of the Marshall Islands and in violation of the decision of an international tribunal, the U.S. has failed to clean up most of the atolls and islands, as was mentioned as a recommendation by the Republic of the Marshall Islands diplomat during the last UPR. Radioactive fallout contaminated the people, their land, and the surrounding waters. The result has been a lack of safe, healthy traditional food, including fish, seafood, food from plant sources and potable water. The health problems which come from these acts are higher rates of cancer, diabetes, tuberculosis and reproductive

health anomalies, among others. Type 2 diabetes of Marshallese people is 400% that of the general U.S. population due to the dietary changes necessitated due to nuclear contamination. **/52/**

62. The U.S. record of failing to reduce extremely high maternal mortality of African-American and American Indian/Alaska Native women is discrimination of even longer duration. It is already a national scandal that in a country and under an administration that professes to be family-centered, the U.S. has the highest rate of maternal mortality of any wealthy country. Overall maternal mortality in the U.S. was 22.3:100,000 in 2022. **/53/** In 2022 the mortality rates for black and Native American/Alaska Native (AIAN) women were two-three times that for white women: for AIAN women it was 63.4:100,000 and for black women 55.9:100,000. **/54/** It is well-known that 80-91% of these deaths are preventable, making the outcomes not only a tragedy but arbitrary deprivation of life. The causes of high maternal mortality of black women have been studied along with the larger problem of discrimination against black women in healthcare. Black women receive less and disparate care throughout pregnancy and in labor and delivery. Racial disparities exist within and between hospitals. The treatment of black women during pregnancy and after childbirth follows their documented life history of less care when needed, inferior care 52% of the time (according to specific measures and compared with white women), clinician bias and discrimination. **/55/** A glaring truth about the exceptionally bad mortality rates of the U.S. is that all comparable countries with lower mortality rates and better outcomes have universal, single payer systems of healthcare.

<u>Conclusion</u>

63. By pooling funds at the national level, the U.S. could attain efficiencies needed to have high quality care while providing universal, affordable care and equity. It could reduce discrimination and inequality, ensure transparency and eliminate the waste and corruption of the current system. In a study done at the University of Massachusetts (2018), the feasibility of a national single payer system was shown to save between $5.5 and $11.8 trillion, with an estimated average of $6.1 trillion, over a 10-year period. **/56/** A 2020 study indicates that more than 68,000 lives per year could be saved by adopting a universal single payer system. **/57/** Considering that in the next decade, 55 million people in the US are expected to be displaced because of climate disasters, such as the January 2025 fires which displaced thousands of residents of Altadena and Pacific Palisades, California, a national system of social insurance which covers people wherever they live is more important than it has ever been.

<u>Recommendations requested</u>

-Adoption of national legislation for a universal single payer system which eliminates all for profit, investor-owned enterprises from health care

-If private delivery of health care is chosen rather than a national health service, strict regulation of non-profits, with a ceiling on incomes of highest paid personnel

-Strict regulation and affordable pricing of privately-produced pharmaceuticals (no or low cost); public ownership of production of some pharmaceuticals (most research is publicly financed and should continue)

-Establishment of democratically elected community and local oversight boards for accountability and community governance

-Protection of self-determination of indigenous peoples and respect for treaty rights

Endnotes

1/ E/C.12/2000/4 (2000); E/C.12/GC/22 (2016); A/67/302, 13 August 2012

2/ American Barometer Survey conducted by Hill TV and Harris X polling, 10/22/2018. https://thehill.com/hilltv/what-americas-thinking/412545-70-percent-of-americans-support-medicare-for-all-health-care (accessed 27 August 2019)

3/ Pew Research Poll, February 2025, https://pewresearch.org/politics/2025/02/20/americans-continue-to-view-several-issues-as-top-national-problems/

4/ *Burwell v Hobby Lobby Stores, Inc., 573 U.S. 682 (2014)*

5/ www.thelancet.com, vol.395, pp. 524-533

6/ Alison P. Galvani et al., Universal healthcare as pandemic preparedness: the lives and costs that could have been saved during the COVID-19 pandemic, June 13, 2022, pnas.org/doi/10.1073/pnas.2200536119

7/ Michele Cohn Marill, "COVID Stole a Parent from over 200,000 Children: Indian Country Lost the Most," 12 March 2025, Mind Site News, www.mindsitenews.org

8/ Wilkinson, Richard and Kate Pickett, **The Inner Level**, Penguin, New York, 2019, pp.2-3

9/ America's Health Rankings analysis of U.S. Census Bureau, American Community Survey, United Health Foundation, https://www.AmericasHealthRankings.org (accessed 2019); U.S. Census Bureau data for 2020-2023 Gini Index (accessed 2025)

10/ The Global Gender Gap Report 2024, https://www.wef ; The Global Gender Gap Report 2018, World Economic Forum, https://www.wef.ch/ggggr18;

11/ Carlotta Balestra and Richard Tonkin, OECD Statistics and Data Directorate, "Inequalities in household wealth across OECD countries: Evidence from the OECD Wealth Distribution Database," Working Paper No. 88, 20 June 2018, oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC(2018)1&docLanguage=En

12/ Personal interview with S.J. (name withheld), a resident of Santa Clara County, CA, an individual who suffers from myalgic encephalomyelitis (ME), 10 September 2019

13/ Dionissi Aliprantis et al., "The Dynamics of the Racial Wealth Gap," Working Paper No.19-18R, November 2022, Federal Reserve Bank of Cleveland; Dionissi Aliprantis and Daniel Carroll, "What is Behind the Persistence of the Racial Wealth Gap?" Economic Commentary No. 2019-03, 28 February 2019, Federal Reserve Bank of

Cleveland, clevelandfed.org/newsroom-and-events/publications/economic-commentary/2019-economic-commentaries/ec-201903-what-is-behind-the-persistance-of-the-racial-wealth-gap.aspx

14/ Raj Chetty and others, “The Association between Income and Life Expectancy in the United States, 2001-2014,” Journal of the American Medical Association, 315(16)(2016):1750-1766, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4866586/ (accessed 2019). See also GAO Report, Retirement Security-Income and Wealth Disparities Continue Through Old Age, GAO-19-587, study of individuals born between 1931-1941, released 8 September 2019 (commissioned by Senator Sanders), confirming mortality disparity between lowest and highest income quintiles.

15/ America’s Health Rankings analysis of U.S. Census Bureau, American Community Survey, United Health Foundation, https://www.AmericasHealthRankings.org (accessed 2019)

16/ Suresh Nallareddy, Ethan Rouen and Juan Carlos Suárez Serrato, “Corporate Tax Cuts Increase Income Inequality,” Working Paper 18-101, Harvard Business School, 2018, hbs.edu/faculty/Publication%20Files/18-101%20Rouen%20Corporate%20Tax%20Cuts_0a4626be-774c-4b9a-8f96-d27e5f317aad.pdf

17/ Interim report of the Special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 13 August 2012, A/67/302

18/ Andrea Witte, www.ConnectTheDotsUSA.com
Slide: “Despite ACA Improvements, U.S. Healthcare is Complex, Costly & Cruel,” updated 6/1/19 (sources omitted); www.ldi.upenn.edu/our-work/research-updates/unpacking-the-paradox-of-health-cares-gdp-percentage/

19/ Public Citizen, The Case for Medicare for All, 2019

20/ Andrea Witte, op. cit.

21/ Andrew Siddons, **Roll Call**, 5 March 2018 (accessed 2019), statement attributed to Ron Shaw, President, Association of American Indian Physicians

22/ Recommendations of the Special Rapporteur on the highest attainable standard of mental health. A/HRC/41/34 (June-July 2019)

23/ https://phys.org/news/2025-03-adults-scene-mass.html

24/ 2024 National Veteran Suicide Prevention Annual Report, December 2024, Office of Suicide Prevention, US Department of Veterans Affairs

25/ https://www.colorado.edu/today/2024/02/15/suicide-rates-us-are-rise-new-study-offers-surprising-reasons-why

26/ www.theguardian.com/us-news/2025/mar/13/homelessness-kevin-fagan

27/ Special Rapporteur's Report on financing, op. cit.

28/ https://nichcm.org/assets/articles/NIHCM-ExpertVoices-052023.pdf ; https://lowninstitute.org/the-rising-danger-of-private-equity-in-healthcare/

29/ Rebecca Anhang Price et al., "Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings," Journal of General Internal Medicine, E pub April 2018, and www.RAND.org

30/ Commission on Care Report to Congress, 2016, Veterans for Peace

31/ Kip Sullivan, JD and Stephen Soumerai, ScD, "No, Obamacare Did Not Lower U.S. Health Costs," July 29, 2019, https://www.medpagetoday.com/publichealthpolicy/healthpolicy/81275

32/ "Medical Bankruptcy: Still Common Despite the Affordable Care Act," by David U. Himmelstein, Robert M. Lawless, Deborah Thorne, Pamela Foohey, and Steffie Woolhandler, American Journal of Public Health, March 1, 2019 (online Feb. 6, 2019), DOI: 10.2105/AJPH.2018.304901
At least 530,000 people go bankrupt annually as a result of health care costs. See Andrea Witte, op. cit.

33/ Mary Johnson, "How Low Inflation and Rising Medicare Costs Threaten Social Security Benefit Growth," Senior Citizens League, Special Report, March 2018; https://thinkadvisor.com/2024/01/10/

34/ Marisa Iati, "Couple dead in apparent murder-suicide left notes saying they couldn't afford medical care, police say," Washington Post, 10 August 2019, https://www.washingtonpost.com/nation/2019/08/10/couple-dead-apparent-murder-suicide-left-notes-saying-they-couldnt-afford-medical-care-police-say/

35/ Congressional Budget Office, "Health Insurance Coverage for People Under Age 65: Definitions and Estimates for 2015 to 2018"

36/ Richard D. Wolff, PhD, 28 February 2025, www.counterpunch.org

37/ Andrea Witte, op. cit.

38/ https://pubmed.ncbi.nlm.nih.gov/32061298/

39/ Congressional Budget Office (CBO), op. cit.

40/ Sara R. Collins, Herman K. Bhupal, Michelle M. Doty, "Health Insurance Coverage Eight Years After the ACA: Fewer Uninsured Americans and Shorter Coverage Gaps but more Underinsured," 7 February 2019, Commonwealth Fund

41/ https://www.medicaid.gov

42/ https://kff.org/medicaid/issue-brief/medicaid-enrollment-spending-growth-fy-2024-2025/

43/ https://kff.org/status-of-state-medicaid-expansion-decisions

44/ *Nat'l Fed. of Ind. Bus. v. Sibelius, 576 U.S. 519 (2012)*

45/ Center on Budget and Policy Priorities reports, 2019

46/ Los Angeles Times, 4 April 2022.

47/ Personal communication of Martha L. Schmidt with Eliza Mary Crane, RN, 30 August, 2024.

48/ Personal knowledge of Martha L. Schmidt, n.d.

49/ *In re Pers. Restraint of Williams*, 198 Wn.2d 342, 496 P.3d 289 (2021)

50/ R.A. Narruhn and C.R. Espina, "I've Never Been to a Doctor: Healthcare Access for the Marshallese in Washington State" (2023), https://doi.org/10.1097/ANS.0000000000000456

51/ H. Barker, Bravo for the Marshallese: Regaining Control in a Post-Nuclear Post-Colonial World (Case Studies on Contemporary Social Issues), 2nd ed., Cengage Learning, 2012

52/ P.A. McElfish et al., "Health Beliefs of Marshallese Regarding Type 2 Diabetes" (2016), https://doi.org/10.5993/AJHB.40.2.10

53/ Munira Z. Gunja et al., "Insights into the U.S. Maternal Mortality Crisis: An International Comparison," 4 June 2024, Issue Brief, Commonwealth Fund, https://commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison

54/ Latoya Hill et al., "Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them," 25 October 2024, Issue Brief, Kaiser Family Foundation, https://kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/

55/ Munira Z. Gunja et al., op. cit.

56/ Gerald Friedman, Ph.D., “Yes, we can have improved Medicare for all,” 11 December 2018, www.pnhp.org

57/ Alison P. Galvani et al., op. cit.