

## **U.S. Health Reform and the Elusive Target of Human Rights**

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### **Introduction:**

I would like to thank all of you for inviting me to deliver this year's John F. Roatch Lecture. It is a great honor to be here and to have the opportunity to speak with all of you about the United States health care reform debate and human rights.

In my preparations for this lecture, I was interested to come across the comments of Professor Gregory Marchildon, who delivered the Roatch Lecture in 2006. Professor Marchildon, in comparing the health care systems in the United States and Canada, suggested three modes for framing health care: as an economic commodity, as a social service, or as a right of citizenship. He presented a nuanced discussion of the political and social forces in the two countries and the prevailing perceptions of how each country understood the place of health care in society, concluding that the United States system adopts the first model (economic commodity) and Canada the second model (social service). He held out hope that either country could adopt the third model (right of citizenship) in the future. (Marchildon Remarks, 2006). While I agree with Professor Marchildon's analysis in large part, especially his models, it seems to me that the prospects of the United States embracing a right to health care (much less a broader right to health) remain elusive. This conclusion is borne out by the contours and tenor of the current health reform debate in the United States, the content of the legislative proposals being considered by Congress, and the fluctuating likelihood of legislation passing at the end of this process.

If health reform legislation is enacted in the United States, it will be an important national milestone that will affect the lives of millions of Americans for years to come. The United States has by far the most expensive health care system in the world. In 2007, the United States spent \$7,290 per capita on health care, which amounted to \$2.241 trillion in national health expenditures and 17.3% of GDP. (Anderson & Frogner, 2008; Centers for Medicare and Medicaid Services, 2007; OECD Health Data, 2009). This amount greatly exceeds health care spending—both per capita and by percentage of GDP—in all other OECD countries. For example, Canada spends \$4,403 per capita and the United Kingdom \$3,867 per capita (10.1% and 8.4% of GDP respectively). Yet, by many important measures of health quality, the United States gets inferior health outcomes. According to the World Health Organization, the United States ranks a paltry 34<sup>th</sup> worldwide in maternal mortality rates and 40<sup>th</sup> in the probability that a child dies before age 5. By comparison, Canada ranks 21<sup>st</sup> and 28<sup>th</sup>, while the United Kingdom ranks 25<sup>th</sup> and 28<sup>th</sup>. Although we spend nearly twice as much per person, the average American lives two years less than his or her counterpart in the United Kingdom. On

average, we live three years less than our Canadian neighbors (WHO, 2009). Recent data suggest that approximately 46.3 million people in the United States lack health insurance (US Census Bureau, 2009). Millions more have health insurance that provides inadequate coverage should they become seriously ill (Cohn, 2007). Expert analysis predicts that without changes to the current health care system in the United States, 54 million nonelderly persons will lack insurance by 2019, a number that would be reduced to 23 million if the Senate health reform legislation were enacted. (Commonwealth Fund, 2009).

The prevailing discrepancy between our high health care expenditures and our less than impressive health outcomes stems from a number of sources, including inefficient and anticompetitive health insurance markets and a preference for costly high-technology health care over more affordable preventive approaches. Gross disparities exist between wealthy and poor Americans in access to health care and health outcomes. A sad reality of health in the United States is that we have two very different standards of care within our health system: a very high standard with excellent health outcomes for the wealthy and privileged with good health insurance, and an inadequate standard with poor health outcomes for those with less resources, many of whom are also members of minority groups.

These facts present a health care system that, while strong in some ways, remains fundamentally unjust. Moreover, it is a system that fails to comport with principles of human rights, which require governments to ensure that fundamental rights and freedoms are upheld for all people. International law, scholarly commentary, and many national governments around the world have explicitly recognized health as a human right (Yamin, 2005; Kinney, 2008; Mann et al., 1994). The United States, by contrast, has resisted acknowledging health as a human right, thus precluding opportunities to adopt rights-based health policies and strategies that could resolve some of our systemic deficiencies.

I would like to address three overarching themes in my comments today. First, I will discuss the evolution of the right to health and rights-based approaches to health. The conceptualization of the right to health has undergone substantial development in recent years, resulting in a much more detailed understanding of the underlying determinants that comprise health. Similarly, there has been a widespread recognition not only that health and human rights are closely connected, but that rights-based approaches to health hold significant promise for improving health outcomes.

Second, I will try to draw some insights from the current health care reform debate in the United States. The United States has never recognized the right to health as a legally enforceable right. Our constitutional jurisprudence and political culture traditionally have been wary of government involvement in social and economic issues and dismissive of social and economic rights. Yet, ironically, when social benefits have become established within our national systems through programs such as Medicare, Medicaid, and Social Security, the public strongly supports these programs and the services they provide.

The current health reform debate continues this tradition. Despite comments from the 2008 presidential debates from President Obama that health care should be a “right for every American” (Second Presidential Debate, 2008) and later remarks that health care is a “core ethical and moral obligation” (Zeleny & Hulse, 2009), none of the health reform proposals have sought to recognize health as a human right or even to use human rights language in support of health reform. The proposals have not pursued rights-based approaches for expanding health insurance coverage, increasing access to health services, or achieving quality improvements or cost containment within the health care system. Likewise, the substantive normative values underlying human rights discourse— notions of universality, dignity, justice, and respect for persons—have been lacking in the debate, which instead has focused largely on process and political gamesmanship.

Third, I will highlight some of the main proposals offered by the pending health reform legislation and the human rights implications of these proposals. While rights-based strategies have not been explicitly pursued in these bills, many of the provisions proposed could impact human rights in both positive and negative ways. If health reform does not succeed, preservation of the status quo in the United States health care system would also produce consequences for health and human rights.

Finally, I will conclude by offering some thoughts about the future of the right to health in the United States.

Participants in the health reform debate should consider and utilize human rights principles and approaches for two reasons. First, human rights provide a powerful set of tools to advance health systemically across a range of intersecting areas that go far beyond the health insurance system or the health care delivery system. Second, framing health as a human rights issue provides additional moral and legal support to efforts to improve health. Human rights standards set a floor of acceptable behavior and are therefore flexible enough to allow for local efforts to thrive as long as these basic standards required have been adequately met.

### **Part I. Health as a human right: an evolution of substance and process**

Health affects all facets of life and cuts across a wide-range of human activities. Yet defining health or developing policies and systems to address health risks and needs presents challenges. Health can be defined as one’s physical and mental state of being or as an aspirational goal to improve or perfect that state of being. The Constitution of the World Health Organization famously defines health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.” (WHO, 1948). A minimum level of health is a precondition for full participation in society. Thus, health is simultaneously integral to the human condition and a complex, relativistic concept. The fact that health is recognized as a fundamental human right, guaranteed by international law, does not resolve this complexity. Conceiving health as a human right does, however, connect health to a powerful legal and conceptual framework supported by moral and ethical imperatives.

Human rights law, as developed through international treaties and explanatory documents and implemented through various legal regimes around the world, relies on two foundational concepts. First, human rights are universal and immutable. They cannot be relinquished or abolished through political machinations (Henkin, 1990). Second, human rights transcend state sovereignty and obligate governments to protect, respect, and fulfill the human rights of all people within their jurisdictions (Henkin, 1979).

The universal character of human rights rests on the premise that all humans possess a core set of fundamental rights arising from their humanity and that these rights cannot be rejected or taken away. Human rights do not depend on a person's citizenship, physical or mental characteristics, or ability to conform to socially-accepted behaviors. Application of human rights does not rely on government benevolence. Rather, human rights provisions, as developed under international law, require governments to ensure that fundamental rights and freedoms are upheld and provide individuals with a legal claim enforceable against the state for rights violations (Gostin & Gable, 2004).

In a seminal 1994 article, Jonathan Mann and colleagues posited three important relationships between health and human rights (Mann et al., 1994). First, health programs, policies, and practices may violate human rights. A health care system, for example, that impedes access to health services due to a substantial number of people not being able to afford the cost of health services or health insurance to cover those services would violate the right to health, and possibly others human rights. Second, contravention of human rights can have harmful affects on health. In addition to violations of the right to health itself, failure to uphold other human rights can impose a substantial impact on health. Failure to protect women against violence or to prevent discrimination against poor and minority groups can directly cause negative health consequences. Third, the inextricable linkage between health and human rights suggests that policies that promote both health and human rights will have aggregative benefits. To return to my earlier example, people excluded from access to health insurance not only suffer negative health effects of not being able to pay for needed care; they also often face downstream ramifications with severe financial and personal consequences, including loss of ability to work and to care for family members. A policy that facilitates access to health care for all who need it would improve individual health as well as the other aspects of life undermined by poor health, and would allow people greater opportunities to exercise their human rights.

The right to health itself has undergone a gradual transformation since it's formal inception in Article 25 of the 1948 Universal Declaration of Human Rights (UDHR). Article 25 recognized everyone's "right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control." (UDHR, 1948). The UDHR, although not a binding legal standard, defines health broadly to include a range of social and economic determinants that form the foundation of achieving good health.

In 1966, the International Covenant of Economic, Social, and Cultural Rights (ICESCR) codified a right to health into a binding international treaty, although framed somewhat ambiguously in Article 12 as “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” This Covenant, which incidentally has not been ratified by the United States, goes on to require states to take steps to create “conditions which would assure to all medical service and medical attention in the event of sickness.” (ICESCR, 1966).

The international community would eventually return to a broader conception of health by reintroducing the concept of underlying determinants of health into the right to health discourse and further developing the content of the right. Three distinct developments have buttressed this movement. First, the Declaration of Alma-Ata in 1978 reaffirmed the importance of underlying determinants of health as essential aspects of primary health care (WHO, 1978). Second, the UN Committee on Economic, Social, and Cultural Rights drafted General Comment 14, a guidance document that interpreted the scope of the right to health in Article 12 of the ICESCR (UN, 2000). Third, the establishment of a Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health has helped to interpret further the content of the right to health.

I would like to highlight the contributions of General Comment 14 and the Special Rapporteur in particular, since they have greatly affected international understandings of the right to health. General Comment 14 defines the right to health inclusively. Health rights are not restricted to providing access to medical care and treatment, but rather encompass an array of underlying determinants of health, including access to safe and potable water, adequate sanitation, adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information (including on sexual and reproductive health), and participation in health-related decision making at community, national, and international levels (UN, 2000, para. 11). In respecting, protecting, and fulfilling these aspects of the right to health, a state must contemplate the availability, accessibility, acceptability, and quality of facilities, goods, services, and programs within its health system (UN, 2000, para. 12). Interestingly, this guidance requires states to adopt a national strategy to realize the right to health and implement sufficient legal infrastructure to support this strategy (UN, 2000, para. 53-56).

The Special Rapporteur on the Right to Health has issued several useful reports that provide explanatory context to General Comment 14. Notably, one report examined the relationship of health systems and the right to health, recognizing that “a strong health system is an essential element of a healthy and equitable society” (UN, 2008, p. 12). Drawing on WHO’s identification of six building blocks for a health system (health services; health workforce; health information systems; medical products, vaccines, and technology; health financing; and leadership, governance, and stewardship (WHO, 2007)), the Special Rapporteur has analyzed the interface between these building blocks and the right to health, concluding with a series of legal obligations to strengthen public health systems through national health reform (UN, 2008; Backman et al., 2008).

Neither General Comment 14 nor the work of the Special Rapporteur have legally binding effect, even on states that have ratified the ICESCR, but their conceptualization of the right to health is useful nonetheless as a means to evaluate health policies and programs according to international human rights standards.

## **Part II. Health reform in the United States: a perennial struggle for common ground**

As discussed above, the human rights paradigm provides a powerful framework for advancing health. Yet efforts to reform the health care system in the United States have largely avoided the language of human rights and have not attempted to grasp the moral mantle or prodigious infrastructure of established human rights norms and systems.

The history of health reform in the United States is marked by numerous failed attempts to create national health insurance programs dating back at least to Theodore Roosevelt's presidency. Significant efforts were mounted during the New Deal Era by Franklin Delano Roosevelt and again during the Truman administration. Lyndon Johnson succeeded in passing legislation establishing Medicare and Medicaid, but was unable to secure a broader comprehensive government health insurance program. National health insurance proposals were offered, without success, by Nixon, Carter, and Clinton.

The failure of most of these efforts to enact broad systemic changes to the health care system can be attributed to a number of factors. Strong political opposition from politicians and the health care industry doomed many of these provisions. Political resistance of this sort was often coupled with populist opposition arising from the historical American aversion to strong national government and concerns about upsetting the status quo to uncut health reform initiatives.

In the absence of comprehensive national health insurance reform, the federal government instead engaged more politically-viable efforts in the form of piecemeal expansions of government regulation of or participation in the health care system. Major legislation over the last 20 years, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Children's Health Insurance Program, and Medicare Part D, has reshaped the federal role in financing and regulating health care. (P.L. 104-191, 1996; P.L. 105-33, 1997; P.L. 108-173, 2003). But in spite of these legislative and regulatory efforts, the problems extant in the American health care system—inadequate access to health care services and insurance coverage to pay for care; rampant health care cost increases that outpace inflation; and pervasive disparities in access and quality of care—persist and have worsened over time.

President Obama arrived in office with a strong electoral showing and riding a wave of optimism that the major policy changes proposed during his presidential campaign would be advanced and enacted. The financial crisis of Fall 2008 dominated the first few months of his presidency, but he quickly turned to health reform as his second major legislative initiative.

The ensuing debate over health reform in the United States that has dominated the political and policy discourse for the past year has been protracted, contentious, and at times frustrating. Health reform legislation moved through multiple Congressional committees in both the House of Representatives and the Senate, overcoming staunch opposition from Republican legislators. H.R. 3962, also known as the “Affordable Health Care for America Act,” passed the House on November 7, 2009. The Senate bill, entitled the “Patient Protection and Affordable Care Act,” was passed on December 24, 2009 after days of procedural maneuvering. The White House released a compromise plan, based largely on the Senate bill, in February 2010. At the time of this writing, it remains uncertain whether Congress will succeed in reconciling the two bills and sending a final bill to the President for his signature. [Note: Health reform legislation and reconciliation fixes to the legislation passed in March 2010 and have been signed by President Obama.]

Neither of the bills currently passed by Congress nor the statements emanating from the White House in support of health reform has embraced human rights discourse or employed rights-based approaches to reforming the health system in the United States. In his September 9, 2009 address to Congress, for instance, President Obama did not invoke health care as a right. Instead, his three themes focused on straightforward policy goals: increasing stability and security for those who have insurance, providing insurance for those who don’t have it, and reducing cost in the system. The only statement linking health reform to a larger ethical concern was a reference from a letter written to the President by the late Senator Edward Kennedy, extolling the “fundamental principles of social justice and the character of our country” underlying health reform proposals (Obama, 2009). This inattention to human rights represents a missed opportunity to strengthen the arguments for reforming the United States health system as well as a repudiation of the interrelationship between health and human rights in the context of contemporary American political and legal discourse.

The unwillingness of lawmakers to recognize a right to health in this current legislative debate generates no surprise given the long tradition of disdain in the United States against international law generally and international human rights standards in particular (Yamin, 2005). Historically, while the United States has been a fierce advocate for human rights and the primary international actor in shaping the content of human rights treaties, domestic political and philosophical opposition to international human rights obligations have limited their acceptance (Alston, 2008). American exceptionalism in this regard applies to both the ratification of human rights treaties and the domestic incorporation of human rights into political and legal discourse (we prefer to speak instead of “civil rights” which entail mostly civil and political rights). American jurisprudence and politics has consistently rejected economic, social, and cultural rights in particular. Opponents of social and economic rights have raised reasonable objections on issues such as cost and difficulty of implementation. However, issues of cost and complexity should not render human rights any less fundamental and the process of “progressive realization” permits gradual improvement to meet the standards required by social and economic rights.

Given these realities, the Obama Administration and its Congressional allies may have chosen not to pursue legislation that acknowledged a right to health for strategic political reasons. The legislation as proposed spurred vociferous protests and a strong political backlash. Adopting a right to health as a cornerstone of the legislation could have complicated the health care debate since recognition of this right likely would have required more extensive systemic changes and therefore a greater deviation from the status quo. Antipathy for international human rights obligations, coupled with existing political wariness of the federal government and the prospect of the expansion of its role in the health care system may have strengthened the opposition to the legislation.

On the other hand, the omission of human rights perspectives from this debate may have deprived proponents of health reform of powerful arguments to support changes to the existing system. Characterizing health as a human right grants it significant moral weight even in the absence of legal obligations to enforce the right. Focusing on the process of health reform rather than the values being protected may have been a strategic blunder. Similarly, the preoccupation with health insurance schemes rather than how best to design a health system that progressively realizes health and ensures accessibility, acceptability, availability, and quality of health services may have been misplaced.

### **Part III: Health reform proposals and human rights**

Despite the inapplicability of international human rights legal standards for the right to health in the United States, the right to health as described in these international instruments provides a useful yardstick to measure current health reform proposals with respect to human rights.

The House and Senate health reform bills have much overlap conceptually, substantively, and structurally, but they also contain key differences. In addition, these legislative proposals are detailed and voluminous, precluding any sort of comprehensive assessment in my remarks today. The White House proposal is much shorter and predicated on the Senate, but nevertheless contains some unique provisions. For purposes of this lecture, I will briefly outline some of the major substantive provisions of these three proposals and discuss a few of the most significant ideas and their implications for human rights.

The health reform proposals essentially raise three types of issues: 1) how to provide expanded access to health insurance coverage; 2) how to contain costs in the health care system; and 3) how to improve quality and health outcomes. Each of these issues is discussed below. (Reconciliation Act of 2010, 2010).

1) *Expanding access to health insurance for the uninsured or underinsured.* The proposals attempt to expand access to affordable health insurance by establishing three interlinked policies: limits on pre-existing condition exclusions and expenditure caps, mandates for individuals and employers to purchase coverage, and financial assistance for qualifying persons and entities.



*Limiting pre-existing condition exclusions and expenditures caps.* All three proposals target a major impediment for accessing health insurance by limiting the ability of insurers to exclude people based on pre-existing conditions, to place lifetime and yearly aggregate limits on health expenditures, and from rescinding coverage except in cases of fraud. These provisions if enacted would herald a significant change in current insurance practices, which often exclude people from coverage or charge them exorbitant premium rates on the basis of their past medical history or current medical condition. (Title I. Standards Guaranteeing Access to Affordable Coverage, Subtitle B)

*Individual mandate and employer mandate.* All three proposals also require individuals to have insurance coverage, whether purchased through employer-sponsored plans or the individual market via a health insurance exchange, or provided by a government health insurance program. Individuals who do not have qualifying/adequate health coverage can be penalized.

Employers with more than 50 employees also are required to provide health insurance coverage to their employees and to pay a designated percentage of that coverage. Employers will face penalties for failure to meet this requirement. (Title III. Shared Responsibility)

*Subsidies for qualifying individuals and small businesses.* The mandate requirements have presented one of the more politically contentious aspects of the reform proposals due to the cost they impose on individuals and employers. Consequently, the reform proposals provide qualifying individuals and employers with premium subsidies to assist with the cost of health insurance.

These three policies work together to expand access; prevent persistent insurance problems like cherry picking and adverse selection; and avoid imposing substantial financial burdens on any individual purchaser. All three are necessary to avoid negative policy implications. The limits on eligibility criteria and caps are only workable if the insurance pool is sufficiently large to adequately spread risk. The mandates assure that this is possible, and the subsidies ensure that the mandates are affordable for all. From a human rights perspective, to the extent this triumverate of policies succeeds in expanding access to insurance and by extension to health services it will help to protect and fulfill the right to health.

*Health insurance exchanges.* The reform proposals create health insurance exchanges as a mechanism to facilitate purchasing of health insurance. The exchanges would aggregate insurance options in one place to allow purchasers to easily compare and thus to spur competition among insurance providers. The House bill would create one national exchange, while the Senate and Presidential proposals would permit the establishment of multiple exchanges.

The House bill authorizes the creation of a public health insurance option that would compete with private insurance plans. The Senate and Presidential

proposals do not include a public option plan. The public option received significant attention in the debates surrounding this legislation. Proponents argued that it was vital to have a public option to ensure adequate competition for private insurers. Opponents argued that it would undermine the private insurance market and lay the groundwork for a single payer system. It is not easy to evaluate this policy decision from a human rights perspective. Assuming that the public option would have succeeded in increasing competition and expanding access to affordable health insurance, then it would support the realization of the right to health. (Title II. Health Insurance Exchange and Related Provisions)

*Essential health benefit packages.* All of the health reform proposals establish requirements for a minimum level of benefits covered by a health insurance plan. The inclusion of a base-level health insurance benefit comports with notions of accessibility and acceptability under the right to health. (Title I, Subtitle C. Standards Guaranteeing Access to Essential Benefits).

*Abortion.* The Senate bill and Presidential proposal require that at least one plan per exchange must not provide abortion coverage. States will also have the option to exclude abortion coverage in their exchanges. The House bill includes a much more restrictive abortion provision that prohibits coverage of abortions by the public option plan and limits coverage in private plans in the exchange. Restrictions on abortion coverage can infringe on human rights if they result in the inability of a women to protect her health because she cannot afford needed services. It can also limit the ability of a woman to exercise her rights to privacy and liberty in making a decision about whether or not to terminate a pregnancy.

*Other access expansions.* A number of additional provisions seek to expand eligibility for health insurance or the scope of coverage provided by health insurance plans. The proposals include expansions of Medicaid eligibility to cover people making a higher income, the elimination of the Medicare Part D prescription drug coverage gap—the so-called “donut hole”, and authorization for states to form interstate purchasing compact to allow insurers to sell policies across state lines.

2) *Cost containment across the health system.* Several provisions in the three proposals seek to contain costs related to health care expenditures. Reductions in payments to certain health plans and providers in Medicare and Medicaid account for some proposed savings, as do programs to implement administrative streamlining and to reduce waste, fraud, and abuse. The Senate bill and Presidential proposal impose an excise tax on expensive health plans. The human rights implications of these cost containment proposals are in tension. Cost containment across the health care system can support the right to health by preserving resources for essential services that would otherwise be expended on less vital needs. By contrast, some of the proposals, namely the reductions in insurance payments and excise tax on generous plans could have the effect of reducing coverage of certain services and a concomitant reduction in access to those services. While expanded coverage and access do not automatically lead to better health outcomes,

this disincentive would seem to directly undermine aspects of accessibility or quality of health services available to many people.

3) *Quality improvement.* A number of provisions in the three proposals attempt to improve the quality of care and services provided in the health care system. Proposals include promising ideas such as comparative effectiveness research, payment experiments in Medicare and Medicaid to encourage coordinated care, promotion and funding for preventive care and wellness programs, funding for community health centers and school based health centers, and nutrition label provisions. The focus on quality of care, prevention, and wellness is consistent with improving quality under the right to health. Furthermore, efforts to provide incentives for health care workforce expansion and improvement meet the criteria for enhancing availability of health care services. (Title IV. Quality).

*Single payer systems and human rights.* With so much of the health reform debate centered on the question of who pays for health services, it is important to note that human rights principles do not require a particular system or model of health care financing. While many human rights advocates support more government control over health care financing (whether in the form of a single-payer social insurance system or otherwise), the right to health does not necessarily require government to be the primary payor for health services. Rather, human rights demand that government ensure that all people can access the necessary health services, whether the services are paid for by public or private sources, or a combination of the two.

#### **Part IV: Recommendations**

The President and Congress should move forward and pass health reform legislation. Despite its many flaws, the bills before Congress would certainly have a beneficial impact on the ability of many people to afford health insurance and access health care services. Moreover, this legislation would strengthen the overall health system in the United States and reduce the federal budget deficit over the long term. While the bill does not take a rights-based approach to health reform, it does nevertheless augur improvements to the health system that are consistent with human rights principles, as discussed above.

Health reform advocates should, however, advance right-based perspectives in future efforts to reform and improve the United States health care and public health systems. This course of action is advisable for several reasons.

As stated above, the Obama Administration has taken a well-worn path in avoiding a rights-based model for health reform. Nevertheless, the case for health reform could have been bolstered by invoking rights-based approaches and human rights discourse. Rights-based arguments provide a solid moral justification for expanding access and quality within the health care system. Indeed, President Obama's difficulty in generating sufficient public and Congressional support for health reform arguably stems in part from his failure to link health and human rights in the debate over reform. His retreat from framing the debate as one grounded in values to a discussion of process and

stability diluted the moral imperative of expanding access to health care service through universal health insurance. When health ceases to be perceived as a right and instead becomes an option or a privilege, it loses much of its moral gravity and becomes harder to persuasively justify.

Rights-based approaches to health reform also would expand the context of health reform beyond its current form to incorporate the larger systemic factors that impact health, including a greater effort to address the underlying determinants of health. Contrast this model with the current efforts to reform the health care system in which the legislative and policy debates have revolved largely around the creation of complex mechanisms to expand access to health insurance. The myopic focus on health care financing and insurance reform in the legislation minimizes the role that underlying determinants of health play in assuring the conditions for a healthy population. While universal access to health insurance is certainly relevant as a determinant of health, insurance concerns disproportionately dominate the legislative proposals and the overall reform debate. Having adequate insurance does not guarantee quality care or adequate access to appropriate health services, nor does it necessarily support other underlying determinants of health. (For example, strengthening the public health framework, encouraging scientific research and education, and maintaining robust economic growth all contribute to efforts to protect health.)

Beyond the moral suasion and practical norm-creation generated by the right to health, the groundwork should be laid for the eventual recognition of a legally-enforceable right to health in the United States. This will require a willingness within the government to accept the legitimacy of economic and social rights within the United States constitutional framework. Frankly, such a development is not likely to occur anytime soon. However, recognition of the right to health through ratification of the ICESCR and other international instruments would send a strong message internationally and domestically that we care about upholding the health of our population (Kinney, 2008).

In the meantime, theories linking health and human rights will have to arise from arguments appealing to civil and political rights. Several scholars have noted that the right to health, while grouped with other social and economic rights, contains aspects of civil and political rights as well. Since civil and political rights (such as the right to fair process or to be free of discrimination) are more widely-accepted in the United States, these rights may provide a promising approach to protecting some aspect of the right to health. (Hill, 2009).

## **Conclusion**

In conclusion, even though the three health care reform proposals largely disregard human rights and do not acknowledge a right to health, multiple aspects of these proposals are consistent with the right to health. In increasing access to health services and greater protections for individuals against systemic impediments to health, the legislation advances right to health goals without embracing the right to health itself.

Other provisions of the legislation, however, may contravene components of the right to health.

If health reform legislation is enacted, it will only be the first step in a long-term effort to improve our health system in the United States. The recognition of the right to health and the adoption of rights-based approach to health reform in these future reform efforts could help to solidify the ability of every person in the United States to have access to adequate health services.

Postscript: Health reform legislation and the reconciliation fixes to the legislation were passed by both house of Congress in March 2010 and have been signed by President Obama. The final legislation has many of the provisions described above and continues to omit the right to health. Alas, the right to health remains an elusive presence in health care law in the United States.

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