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## Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards

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### Acknowledgements

I would like to thank the New York City Law Review for requesting my contribution to this issue. This piece draws on previous work with Sarah Zaidi and Alicia Ely Yamin. See Jean Connolly Carmalt, Sarah Zaidi, & Alicia Ely Yamin, *Entrenched Inequity: Health Care in the United States of America in The Right to Health in Comparative Perspective* (Stephen P. Marks, ed.) (forthcoming). Many thanks go to Alicia Ely Yamin for her comments regarding the ICESCR signature obligation. Special thanks are also due to Maxwell Carmalt for his patience, and to Daniel Connolly Carmalt, without whose support and substantive feedback this article could not have been completed.

# HOLDING THE U.S. ACCOUNTABLE: HOW AMERICAN HEALTH CARE FAILS TO MEET INTERNATIONAL HUMAN RIGHTS STANDARDS

*Jean Connolly Carmalt\**

## INTRODUCTION

The United States does not have a healthcare system. Rather, people in the U.S. live and die with a messy collection of ad hoc attempts to structure care according to particular financing schemes. The result has been disastrous: tens of millions of Americans cannot access health care because they do not have health insurance or the personal resources required for treatment without insurance.<sup>1</sup> Millions more hold insurance policies but are actually or effectively denied coverage because of complex or inadequate plans, steep co-pays, and refusals by their insurance companies to pay for prescribed treatments.<sup>2</sup> Overall, the poorest and sickest among us are denied care most frequently and carry the greatest financial burden, leading to the deep inequity that defines U.S. healthcare.<sup>3</sup>

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<sup>1</sup> In 2006, there were approximately forty-seven million Americans without health insurance. This figure does not include people covered by government health insurance programs such as Medicare, Medicaid, and the State Children's Health Insurance Program. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*, at 21 tbl.6 (2007), available at <http://www.census.gov/prod/2007pubs/p60-233.pdf> [hereinafter CENSUS BUREAU].

<sup>2</sup> Nearly 16 million people were estimated to be underinsured in 2003. Cathy Schoen et al., *Insured but Not Protected: How Many Adults are Underinsured?*, HEALTH AFFAIRS (WEB EXCLUSIVE) W5 289, W5 289 (2005) available at <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.289v1.pdf>.

<sup>3</sup> See WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000, at 148 (2000), available at [http://www.who.int/whr/2000/en/whr00\\_en.pdf](http://www.who.int/whr/2000/en/whr00_en.pdf) [hereinafter WORLD HEALTH REPORT 2000] ("Fairness of financial contribution starts with the concept of a household's contribution to the financing of the health system. The health financing

In 2005, the United States spent approximately \$2 trillion on health care, which amounted to 16% of the country's total economic activity (GDP).<sup>4</sup> Costs are projected to reach \$2.77 trillion by the year 2010.<sup>5</sup> The astronomical expenses associated with providing health care in this country are directly related to the fact that many people do not have available, accessible, acceptable, or quality care. In 2006, one in four Americans reported that their family had difficulty paying for care.<sup>6</sup> In that year too, more than a quarter of all Americans—twenty-eight percent—said that they or a family member delayed care because of costs.<sup>7</sup> The problem of high costs is more complex than who does or does not carry an insurance policy: nearly seventy percent of the people who have difficulty paying for care or receive delayed care due to cost hold insurance policies.<sup>8</sup> Nonetheless, those without health insurance are even more likely to face barriers to care because of cost, with nearly sixty percent struggling to pay for care and sixty-eight percent receiving delayed care.<sup>9</sup> In addition, most people who do not have health insurance—fifty-four percent—are uninsured because they cannot afford to purchase a policy.<sup>10</sup> This is not surprising given how expensive health insurance is in the United States; in 2007, the average annual premium for a health plan covering a family of four was over \$12,000, and the cost of insurance continues to rise.<sup>11</sup>

The costs associated with health care in the United States tell only part of the story. Focusing on the problem of high cost leaves out questions about why some racial groups are so disproportionately affected by the uneven access and quality of health care that is

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contribution of a household is defined as the ratio of total household spending on health to its permanent income above subsistence.”).

<sup>4</sup> THE HENRY J. KAISER FAMILY FOUND., HEALTH CARE COSTS: A PRIMER 2 (2007), available at <http://www.kff.org/insurance/upload/7670.pdf>.

<sup>5</sup> PLUNKETT RESEARCH, LTD., HEALTH CARE TRENDS (2006), <http://www.plunkettresearch.com/Industries/HealthCare/HealthCareTrends/tabid/294/Default.aspx> (last visited Apr. 23, 2008).

<sup>6</sup> ABC NEWS, KAISER FAMILY FOUND. & USA TODAY, HEALTH CARE IN AMERICA 2006 SURVEY, at chart 3 (2006), <http://www.kff.org/kaiserpolls/upload/7572.pdf> (last visited Apr. 23, 2008) [hereinafter ABC/KFF/USA Survey].

<sup>7</sup> *Id.* at chart 6.

<sup>8</sup> *Id.* at chart 3.

<sup>9</sup> ABC/KFF/USA Survey, *supra* note 6.

<sup>10</sup> *Id.* at chart 11.

<sup>11</sup> KAISER FAMILY FOUNDATION, HEALTH RESEARCH AND EDUCATIONAL TRUST & NATIONAL OPINION RESEARCH CENTER, EMPLOYEE HEALTH BENEFITS: 2007 ANNUAL SURVEY 18 (2007). The cost of insurance has risen 78% since 2001, with a 6.1% increase in 2007 alone. This increase cannot be explained by the rate of inflation (2.1% in 2007), nor can it be covered by the increase in workers earnings (3.7% in 2007). *Id.*

available in this country. It also sidelines discussions about what happens when the goal of making people healthy works at cross-purposes to the goal of maintaining profitability. These issues highlight the deeper structural flaws associated with contemporary U.S. health care. Despite a complex array of laws and regulations related to health and health care, the United States consistently fails to address these deeper problems, focusing on the outcomes of structural flaws rather than on the flaws themselves. As a result, the U.S. “system” fails to provide the best possible health care for all. It also violates international standards regarding the provision of health and health care.

This Article explores three long-standing issues facing U.S. health care and recasts these issues as violations of international human rights law: (1) the U.S. healthcare system operates under *de facto* discrimination based on race and income—discrimination which constitutes a violation of the obligation to respect the right to health, even when it does not violate domestic definitions of discrimination; (2) certain structural components of healthcare delivery, such as the way in which the health insurance industry operates in the U.S., constitute third-party infringements on the right to health; and (3) large numbers of Americans currently lack access to available, acceptable, and quality health care, which in and of itself represents a failure of the United States to fulfill the human right to health.

Each of these violations represents a level of governmental duty regarding the right to health. As with other human rights, the human right to health—as it is defined by the International Covenant on Economic, Social and Cultural Rights (“ICESCR”)—sets out three levels of responsibility: the duty to respect, the duty to protect, and the duty to fulfill.<sup>12</sup> These tripartite duties exist for all human rights under international law.<sup>13</sup> The duty to respect correlates to an obligation on behalf of the government not to violate the right through its own actions. The duty to protect requires a government to ensure that third parties, including private entities,

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<sup>12</sup> International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR]; U.N. Committee on Economic, Social and Cultural Rights [hereinafter CESCR], *General Comment 14: The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights)*, 22d Sess., para. 33, U.N. Doc. E/CN.12/2000/4 (2000) [hereinafter CESCR General Comment 14].

<sup>13</sup> Asbjørn Eide, *Economic, Social and Cultural Rights as Human Rights*, in *ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A TEXTBOOK* 9, 23 (Asbjørn Eide et al. eds., 2d rev. ed. 2001).

do not violate the right. The duty to fulfill requires governments to take the steps necessary to ensure that the right may be fully realized by all persons.

Part I(A) of this Article outlines the content of the right to health as it is defined by international human rights law. Although the focus of this piece is primarily on health *care*, human rights law recognizes the impossibility of separating the requirements for a successful healthcare system from the overall health needs of a population. The right to health therefore includes requirements regarding access to the underlying determinants of health, such as housing and education.

Part I(B) discusses the ways in which the United States may be legally obligated—under international law—to recognize and promote the right to health. Although the U.S. has not ratified the primary treaty that contains that right (the ICESCR), it is party to other treaties that are relevant to health, including the International Covenant on Civil and Political Rights (“ICCPR”)<sup>14</sup> and the International Convention on the Elimination of All Forms of Racial Discrimination (“ICERD”).<sup>15</sup> In addition, the U.S. has some limited legal obligations associated with its signature of the ICESCR. Beyond any legal obligation, the article also argues that moral, historical, and political interests support a rights-based approach to healthcare reform.

Part II, III, and IV evaluate whether the United States respects, protects, and fulfills the right to health, finding that it currently fails to meet international standards at each of these levels. This Article concludes that international human rights law provides an effective measuring tool for U.S. healthcare reform efforts because it ensures that the primary focus of any proposal will be to promote the highest attainable standard of health for everyone.<sup>16</sup>

#### I. APPLICABLE LAW PERTAINING TO THE HUMAN RIGHT TO HEALTH

International law related to the human right to health appears in numerous treaties and declarations, beginning with the Universal Declaration of Human Rights of 1948 (“UDHR”) and including a variety of international and regional instruments.<sup>17</sup> Overall, the

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<sup>14</sup> International Covenant on Civil and Political Rights, *opened for signature* Dec. 16, 1966, S. Exec. E, 95-2 (1978), 999 U.N.T.S. 171 [hereinafter ICCPR].

<sup>15</sup> International Convention on the Elimination of All Forms of Racial Discrimination, Dec. 21, 1965, S. Exec. Doc. C, 95-2 (1978), 660 U.N.T.S. 195 [hereinafter ICERD].

<sup>16</sup> ICESCR, *supra* note 12, art. 12(1).

<sup>17</sup> Universal Declaration of Human Rights, G.A. Res. 217A, at 76, U.N. GAOR, 3d

goal of the international right to health is to promote the highest attainable standard of health for everyone.<sup>18</sup> The United States has some legal obligations to respect, protect, and fulfill the right to health despite the fact it has only signed—not ratified—the ICESCR. These include an obligation under the ICCPR to respect, protect, and fulfill the right to health insofar as doing so is necessary to prevent the arbitrary deprivation of life.<sup>19</sup> The U.S. also has an obligation under the ICERD to respect the right to health in terms of prohibiting all forms of discrimination.<sup>20</sup> Finally, the U.S. has limited legal obligations associated with its signature of the ICESCR.<sup>21</sup> Regardless of any international legal obligations to uphold the right to health, it is also in the best political interest of the United States to evaluate its policies from a rights-based perspective. Since viewing health as a human right carries both moral and historical resonance, using a rights-based approach avoids deeply entrenched and politicized arguments regarding healthcare reform.

A. *The right to health under international law*

The legal basis for the international human right to health appears in both the Universal Declaration of Human Rights, which includes health as part of the broader right to an adequate standard of living,<sup>22</sup> and in the ICESCR, which elaborates on the right under article 12.<sup>23</sup> Article 12 provides:

1. The States Parties to the present Covenant recognize the right

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Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948) [hereinafter UDHR]. *Accord* ICESCR, *supra* note 12; ICERD, *supra* note 15, art. 5(e)(iv). *See also* Convention on the Elimination of All Forms of Discrimination Against Women art. 11(1)(f), 12, Dec. 18, 1979, 1249 U.N.T.S. 513; Convention on the Rights of the Child art. 24, Nov. 20, 1989, 1577 U.N.T.S. 3; European Social Charter art. 11, Oct. 18, 1961, Europ. T.S. No. 35; African Charter on Human and Peoples' Rights art. 16, June 27, 1981, 21 I.L.M. 58; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights art. 10, Nov. 17, 1988, O.A.S.T.S. 69.

<sup>18</sup> ICESCR, *supra* note 12, art. 12(1).

<sup>19</sup> ICCPR, *supra* note 14, art. 6(1).

<sup>20</sup> ICERD, *supra* note 15, art. 5(e)(iv).

<sup>21</sup> Vienna Convention on the Law of Treaties art. 18, *opened for signature* May 23, 1969, S. Exec. Doc. L, 92-1 (1971), 1155 U.N.T.S. 331.

<sup>22</sup> UDHR, *supra* note 17, art. 25(1).

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

*Id.*

<sup>23</sup> ICESCR, *supra* note 12, art. 12.

of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) The improvement of all aspects of environmental and industrial hygiene;
- (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.<sup>24</sup>

The Committee on Economic, Social and Cultural Rights (“CESCR”) has provided additional interpretation of article 12 in its General Comment 14, which is explored in more detail below.<sup>25</sup> Under international law, the human right to health is not the right to be healthy. Rather, it is the right to the enjoyment of the *highest attainable* standard of health.<sup>26</sup> The focus on attainable health instead of actual health highlights the impossibility of guaranteeing good health in the face of genetic, habitual, and circumstantial variation. The difference is significant, since it allows for contextual variation depending on the characteristics of individuals and the resources of particular locations.<sup>27</sup>

The right to health includes two tiers. The core minimum content is non-derogable and considered attainable in all instances. The core content is part of the more comprehensive right to health as it is defined under international law.

### 1. Core requirements

Like all human rights, the human right to health is rooted in the promotion of human dignity, and therefore should be interpreted in such a way as to best promote dignity.<sup>28</sup> To that end, there are minimum core obligations for the right to health that are

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<sup>24</sup> *Id.*

<sup>25</sup> CESCR General Comment 14, *supra* note 12, para. 4.

<sup>26</sup> ICESCR, *supra* note 12, art. 12(1).

<sup>27</sup> Under Article 2(1) of the ICESCR, State Parties are permitted to achieve the full realization of the rights “progressively” and to the “maximum of its available resources.” *Id.* at art. 2(1). This provision is limited in two ways: by the core requirements (see *infra* note 29) and by the principle of non-retrogression, under which State Parties may not undo achievements made towards realizing the right in question. CESCR General Comment 14, *supra* note 12, paras. 47–48.

<sup>28</sup> Chris Jochnick, *Confronting the Impunity of Non-State Actors: New Fields for the Promotion of Human Rights*, 21 HUM. RTS. Q. 56, 60–61 (1999).



considered attainable in all circumstances, and therefore not subject to the doctrine of progressive realization.<sup>29</sup> According to the CESCR, these core obligations include “at least” the following:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.<sup>30</sup>

Further, the Committee laid out “obligations of comparable priority” to the core obligations:

- (a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- (b) To provide immunization against the major infectious diseases occurring in the community;
- (c) To take measures to prevent, treat and control epidemic and endemic diseases;
- (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- (e) To provide appropriate training for health personnel, in-

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<sup>29</sup> CESCR, *General Comment 3: The Nature of States Parties Obligations (Art. 2, Para. 1 of the Covenant)*, 5th Sess., para. 10, U.N. Doc. E/1991/23 (1990) [hereinafter CESCR General Comment 3] (“[A] minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party.”); CESCR General Comment 14, *supra* note 12, para. 47 (“It should be stressed . . . that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.”).

<sup>30</sup> CESCR General Comment 14, *supra* note 12, para. 43.

cluding education on health and human rights.<sup>31</sup>

As with the right to health overall, these minimum obligations include both procedural components (e.g. providing access to information) and substantive components (e.g. providing access to health facilities). The core content of the right to health is non-derogable, even when a State has such limited resources that it must implement other portions of the right to health progressively.<sup>32</sup>

The United States already meets the core content of the right to health in many ways. For example, the Centers for Disease Control and Prevention (“CDC”) is a federally-funded agency that promotes “health and quality of life by preventing and controlling disease, injury, and disability.”<sup>33</sup> Among other activities, CDC programs provide immunizations and take measures to prevent, treat and control diseases.<sup>34</sup> However, other minimum obligations remain unmet, such as the obligation to provide “access to health facilities, goods and services on a non-discriminatory basis.”<sup>35</sup>

## 2. Substantive and procedural elements of the right to health

The core requirements associated with the right to health constitute only a fraction of the overall duties associated with that right. The CESCR has elaborated on these obligations in the form of four substantive elements which require the provision of health care that is (1) available, (2) accessible (including physical and economic accessibility in addition to procedural requirements relevant to access), (3) ethically and culturally acceptable, and (4) of good quality.<sup>36</sup> These four elements work together to create a comprehensive approach to health: they are interdependent and frequently overlap in the context of particular places and communities. Each of the elements is explained in greater detail below.

*Availability* focuses on the number and type of services that exist in specific communities. Availability requires sufficient numbers

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<sup>31</sup> *Id.* at para. 44.

<sup>32</sup> ICESCR, *supra* note 12, art. 12.

<sup>33</sup> Centers for Disease Control and Prevention, Vision, Mission, Core Values, and Pledge, <http://www.cdc.gov/about/organization/mission.htm> (last visited Mar. 25, 2008).

<sup>34</sup> *Id.*

<sup>35</sup> CESCR General Comment 14, *supra* note 12, para. 43(a). Discrimination in this case includes intentional and non-intentional discrimination. *See infra* Part II(A).

<sup>36</sup> CESCR General Comment 14, *supra* note 12, para. 12.

of personnel and facilities.<sup>37</sup> It also requires that the personnel and facilities are capable of addressing the health concerns of the community.<sup>38</sup> For example, if a city with high rates of heart disease has only one cardiologist, that city has a shortage of available medical personnel. Providing the city with additional anesthesiologists or podiatrists will not meet the problem of availability, since those additional anesthesiologists or podiatrists will not provide additional cardiac services.

In the United States, availability is a particular problem in rural areas, which frequently face shortages of medical services and of physicians.<sup>39</sup> However, from a rights-based perspective, it would not be enough simply to increase the number of available services and physicians. Instead, a rights-based approach would ask (1) whether the geographic distribution of additional services and physicians addresses the shortages of rural areas, and (2) whether the additional services and physicians meet the needs of those populations. For example, a rights-based policy might consult local communities in defining their health needs and then provide the appropriate incentives and services to ensure that those needs are met.

Availability overlaps to some extent with the requirement for *accessibility*, since physical distance may be one of the reasons that medical personnel and services are unavailable, particularly for rural populations. Physical accessibility requires that medical goods and services be literally accessible to the people they are meant to serve. However, physical accessibility includes multiple geographic

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<sup>37</sup> *Id.* at para. 12(a) (“Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party.”).

<sup>38</sup> *Id.* at para. 12. The CESCR stresses that the elements of the right to health are interrelated. Therefore, availability also includes ensuring that provided services are culturally and ethically acceptable to the community and that individuals and groups have the opportunity to participate in decision-making processes that may affect their development. *Id.* at para. 12(c), 54.

<sup>39</sup> Thomas C. Ricketts, *The Changing Nature of Rural Health Care*, 21 ANN. REV. PUB. HEALTH 639, 640 (2000) (“[R]ural America has 20% of the nation’s population but less than 11% of its physicians”); W Nelson, et al., *A Proposed Rural Health Care Ethics Agenda*, 33 J. MED ETHICS 136, 137 (2007).

Fewer health care providers are available per capita for rural versus urban populations. . . . In particular, the availability of mental health services is limited for people living in rural communities. Most areas that are short of health professionals are in the rural counties. Rural health-care facilities generally are small and often provide a limited range of services.

*Id.* (citations omitted).

scales, from the miles between hospitals to the architecture of individual health facilities.

In the United States, the smaller scales of physical accessibility are addressed by the Americans with Disabilities Act (“ADA”), which requires that medical facilities meet certain building standards to ensure that all persons are able to physically access those facilities.<sup>40</sup> The ADA also ensures physical access not only through the requirements for the buildings themselves, which are extensive, but also by providing that transportation services be “readily accessible to and usable by” persons with disabilities.<sup>41</sup> In this way, the United States meets some of the physical accessibility requirements associated with the human right to health.

The requirement for accessibility has multiple dimensions. In addition to physical accessibility, the human right to health requires health services to be *economically* accessible, or affordable.<sup>42</sup> Affordability means more than simply ensuring that the cost of services is as low as possible. It also includes the principle of proportionality, so that poorer households should not be “disproportionately burdened with health expenses as compared to richer households.”<sup>43</sup> This means that the absolute cost of medical services is less important than the percentage cost for households. For example, if a household earning \$500,000 per year pays \$5,000 in medical expenses, then a household earning \$50,000 per year should only pay \$500 in medical expenses. It is *unequal* to require wealthy and poor households to pay the same dollar amount for healthcare services.

In addition to physical and economic access, accessibility requires non-discrimination and access to information.<sup>44</sup> These two procedural components of access underscore the overlapping nature of procedural and substantive elements within the right to health. Under international law, non-discrimination includes both *de facto* and *de jure* discrimination on the basis of any of the prohibited grounds: race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual ori-

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<sup>40</sup> ADA Standards for Accessible Design, 28 C.F.R. pt. 36, App. A, § 6 (1994).

<sup>41</sup> Intercity and Commuter Rail Actions Considered Discriminatory, 42 U.S.C. § 12162 (2003); Prohibition of Discrimination in Specified Public Transportation Provided by Private Entities, 42 U.S.C. § 12184 (2003).

<sup>42</sup> CESCR General Comment 14, *supra* note 12, para. 12(b).

<sup>43</sup> *Id.*

<sup>44</sup> *Id.*

entation and civil, political, social or other status.<sup>45</sup> The prohibition of discrimination under international law is discussed in more detail below.<sup>46</sup> Accessibility also includes equal access to information about health services. The CESCR has defined the right to information as “the right to seek, receive and impart information and ideas concerning health issues.”<sup>47</sup> This includes information about reproductive health and health services, and it includes a duty on behalf of the government to provide information in a language that can be understood by its recipients. The right to information can be particularly important for communities that are traditionally underserved and for those who suffer from disparate impacts, and it therefore overlaps with the requirement for non-discrimination.

In addition to availability and accessibility, under international law, health care must also be *acceptable* and of high *quality*. The requirement for acceptability includes ethical standards, cultural sensitivity, and a gender perspective.<sup>48</sup> Often, acceptability can be improved by including affected populations in the formulation and implementation of health strategies.<sup>49</sup> Quality requires that medical goods and services are “scientifically and medically appropriate,” which means that there must be “skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”<sup>50</sup> In many respects, the United States meets and surpasses these quality requirements. For example, medical facilities are typically sanitary,

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<sup>45</sup> *Id.* at para. 18.

<sup>46</sup> *See infra* Part I(B)(ii).

<sup>47</sup> CESCR General Comment 14, *supra* note 12, para. 12.

<sup>48</sup> *Id.* (“All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”).

<sup>49</sup> *Id.* at para. 54.

The formulation and implementation of national health strategies and plans of action should respect, inter alia, the principles of non-discrimination and people’s participation. In particular, the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people’s participation is secured by States.

*Id.*

<sup>50</sup> *Id.* at para. 12.

and equipped with scientifically approved, unexpired drugs, and safe water. In addition, advances in medical knowledge and technologies have resulted in increased quality for many.<sup>51</sup> Nonetheless, the U.S. system continues to be plagued by its inability to provide quality care consistently, leading to widespread concern regarding quality shortcomings.<sup>52</sup>

Quality and acceptability are deeply intertwined. For example, there is a direct relationship between culturally acceptable care and quality of care, particularly for minority populations who are less likely to have medical providers from their own culture.<sup>53</sup> The relationship between acceptability and quality emerges in part because of the importance of effective communication between patients and their care providers: since effective provider-patient communication is a necessary precursor to patient satisfaction and adherence to prescribed treatment, failure to communicate effectively across cultural differences will result in poorer health outcomes.<sup>54</sup> In the United States, there is a significant gap between the percentage of minorities in the population as a whole and the percentage of minorities who are physicians,<sup>55</sup> which results in a problem of both acceptability and quality.

The four substantive elements discussed above are complemented by five procedural elements:

- (1) Non-discrimination. Non-discrimination includes both intentional and non-intentional discrimination, and is discussed in more detail below.<sup>56</sup>

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<sup>51</sup> INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 2 (2001).

<sup>52</sup> *Id.* at 2–3.

<sup>53</sup> INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 200 (Brian D. Smedley, et. al. eds., 2003) [hereinafter *UNEQUAL TREATMENT*]. (“Thus, when sociocultural differences between patient and provider aren’t appreciated, explored, understood, or communicated in the medical encounter, the result is patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care.”) (citation omitted).

<sup>54</sup> *Id.* at 200 fig.6-1.

<sup>55</sup> THE SULLIVAN COMM’N, *MISSING PERSONS: MINORITIES IN THE HEALTH PROFESSIONS* 2.

Together, African Americans, Hispanic Americans, and American Indians make up more than 25 percent of the U.S. population but only 9 percent of the nation’s nurses, 6 percent of its physicians, and 5 percent of dentists. Similar disparities show up in the faculties of health professional schools. For example, minorities make up less than 10 percent of baccalaureate nursing faculties, 8.6 percent of dental school faculties, and only 4.2 percent of medical school faculties.

*Id.*

<sup>56</sup> See *infra* Part I(B)(ii).

- (2) Participation. The right to participation is particularly important in terms of the decision-making process for health policy and health care reform, in part because consulting affected populations makes it significantly more likely that the outcomes of policy discussions will address their needs and thus meet the standards set out by the right to health.<sup>57</sup>
- (3) Access to remedies. The right to health requires that states provide access to effective legal remedies for violations of the right to health.<sup>58</sup>
- (4) Provision of information. The right to information “includes the right to seek, receive and impart information and ideas concerning health issues.”<sup>59</sup>
- (5) Non-retrogression. Once a government recognizes the right to health, regression is generally impermissible.<sup>60</sup>

The procedural elements of the right to health are deeply intertwined and interdependent with the substantive elements. For example, effective access to health services requires that potential patients understand which services are available to them and how to reach those services. They are more likely to have that information if they participate in the decision-making process regarding those services, and the services themselves will more likely meet their medical and cultural needs if their participation is sought. Similarly, if a state provides universal access to services but does not monitor the quality and ethical standards provided by those services, it will still fail to meet its obligations under the right to health.

In the United States, the current healthcare system meets many of the requirements set out by human rights law. For example, practicing physicians in the U.S. have long followed a code of ethics maintained by the American Medical Association, which is one of the requirements of acceptability.<sup>61</sup> Medical facilities are

<sup>57</sup> CESCR General Comment 14, *supra* note 12, para. 54.

<sup>58</sup> CTR. FOR ECON. AND SOC. RIGHTS, ECONOMIC, SOCIAL AND CULTURAL RIGHTS: A GUIDE TO THE LEGAL FRAMEWORK, <http://cesr.org/node/162> (last visited Apr. 23, 2008).

<sup>59</sup> CESCR General Comment 14, *supra* note 12, para. 12(b).

<sup>60</sup> CESCR General Comment 3, *supra* note 29, para. 9. Retrogression is always impermissible in the case of the core obligations. CESCR General Comment 14, *supra* note 12, para. 48 (“The adoption of any retrogressive measures incompatible with the core obligations under the right to health . . . constitutes a violation of the right to health.”); *see also* Jean Connolly Carmalt, Sarah Zaidi, & Alicia Ely Yamin, *Entrenched Inequity: Health Care in the United States of America*, in *THE RIGHT TO HEALTH IN COMPARATIVE PERSPECTIVE* (Stephen P. Marks, ed.) (forthcoming) [hereinafter Carmalt et al.].

<sup>61</sup> AM. MED. ASS’N, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MEDICAL

typically sanitary, with potable water and scientifically approved drugs. There are remedies available for some violations of the right to health (such as tortious misconduct by physicians) and there is some legal recognition for portions of the right to health, such as federal and state laws that provide for a right to emergency care in hospitals participating in the Medicare program.<sup>62</sup> Nonetheless, taken as a whole, U.S. health care reflects significant racial and income-based health disparities, widespread barriers to economic accessibility, and uneven quality of care. Worse, these problems are deepening with each passing year.

*B. U.S. legal obligations to uphold the human right to health*

The United States has signed, but not ratified, the primary treaty that explicitly includes the right to health, the International Covenant on Economic, Social, and Cultural Rights.<sup>63</sup> Nevertheless, the U.S. is legally bound to uphold key portions of the right to health. It should be noted that the discussion below focuses on U.S. obligations *according to international law*. In other words, it is not a discussion about the extent to which the U.S. recognizes and enforces the right to health under domestic law, nor is it a discussion of the degree to which international obligations may be binding in federal or state courts.<sup>64</sup> Rather, the focus here is on how legal obligations stemming from public international law require the U.S. to promote the right to health. First, as a State party to the ICCPR, the United States is obligated to uphold the right to health insofar as doing so is necessary for preventing the arbitrary deprivation of life. Second, as a party to the ICERD, the U.S. must undertake to eliminate discrimination—including *de facto* discrimination—in the right to public health and medical care. Third, as a signatory to the ICESCR, the U.S. is obligated not to take actions that defeat the object and purpose of that treaty.

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<sup>62</sup> Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the United States*, 95 AM. J. PUBLIC HEALTH 1156, 1157 (2005).

<sup>63</sup> Office of the U.N. High Commissioner for Human Rights [hereinafter OHCHR], Status of Ratification, International Covenant on Economic, Social and Cultural Rights New York 16 December 1966, <http://www2.ohchr.org/english/bodies/ratification/3.htm> (last visited Apr. 23, 2008) [hereinafter Status of Ratification, ICESCR]. The United States signed the ICESCR on October 5, 1977. *Id.*

<sup>64</sup> For a discussion of the latter, see JEFFREY L. DUNOFF ET AL., INTERNATIONAL LAW: NORMS, ACTORS, PROCESS: A PROBLEM-ORIENTED APPROACH 253–328 (2002).



1. The obligation to respect, protect, and fulfill the right to health as part of the right to life under the ICCPR

The United States signed both the ICCPR and the ICESCR in 1977.<sup>65</sup> Congress went on to ratify the ICCPR in 1992, making the U.S. a State party legally bound by the Covenant's terms.<sup>66</sup> Included in those terms is the right to life under article 6, which reads: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."<sup>67</sup> Like the right to health, the right to life is not the right to *be alive*, but rather a set of governmental obligations to take the steps necessary to prevent the arbitrary loss of life within its jurisdiction. The obligations associated with the right to life are some of the strongest under international law: they are non-derogable even in times of public emergency, and according to the Human Rights Committee, they should be interpreted broadly at all times.<sup>68</sup>

States must ensure that their residents are not arbitrarily deprived of life for *any* reason. The causal factors behind deprivation of life are widely varied: they may be attributable to individual action (as in criminal activity), to State action (as in actions by security forces), or to natural disasters, just to name a few examples.

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<sup>65</sup> Status of Ratification, ICESCR, *supra* note 63; OHCHR, Status of Ratification, International Covenant on Civil and Political Rights New York 16 December 1966, <http://www2.ohchr.org/english/bodies/ratification/4.htm> (last visited Apr. 23, 2008) [hereinafter Status of Ratification, ICCPR].

<sup>66</sup> Status of Ratification, ICCPR, *supra* note 65. Various arguments exist for the extent of domestic legal obligations associated with the ratification of an international treaty—particularly a human rights treaty—with the advice and consent of the Senate. The discussion here is limited to the legal obligations under international law. *See* U.S. CONST. art. VI, § 2 ("This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land . . . ."); DUNOFF ET AL., *supra* note 64, at 428–441 (discussing the legal impact of U.S. Reservations, Understandings, and Declarations entered in conjunction with ICCPR ratification).

<sup>67</sup> ICCPR, *supra* note 14, art. 6.

<sup>68</sup> *Id.* at art. 4(2). Human Rights Committee [hereinafter HRC], *General Comment No. 6: Article 6 (Right to Life)*, paras. 1–7, U.N. Doc. HRI/GEN/1/Rev. 7 (2004) [hereinafter HRC General Comment 6].

The right to life enunciated in article 6 of the Covenant has been dealt with in all State reports. It is the supreme right from which no derogation is permitted even in time of public emergency which threatens the life of the nation (art. 4). However, the Committee has noted that quite often the information given concerning article 6 was limited to only one or other aspect of this right. It is a right which should not be interpreted narrowly.

*Id.*

When a State has control over causal factors—such as when the deprivation of life comes from the State’s own security forces—that State has an obligation to respect the right to life by preventing actions that would result in arbitrary deprivation of life.<sup>69</sup> Although a State may deprive persons of life through exercise of the death penalty, such deprivation must be for non-arbitrary reasons and according to guidelines established under international and domestic law.<sup>70</sup> Even when a State is not directly responsible for the factors threatening a life, it still must take all possible measures to protect against loss of that life. For example, in the case of epidemics and infant mortality, a State must take all possible measures to protect against the arbitrary deprivation of life.<sup>71</sup> Similarly, if a natural disaster threatens the lives of residents in a particular area, the State has an obligation to do everything possible to protect the lives of residents living in that region.<sup>72</sup>

The United States has interpreted the requirement to protect the right to life broadly in accordance with its obligations under the ICCPR, both in terms of the breadth of protection and in terms of state obligations in response to threats. This broad reading is illustrated in its 2005 report to the Human Rights Committee.<sup>73</sup> In that report, the U.S. cited widely varying causal factors that triggered the State’s obligation to protect life, including protection of life for the terminally ill<sup>74</sup> and victims of crime.<sup>75</sup> In addition, the U.S. included the Unborn Victims of Violence Act of 2004 as evidence that it was fulfilling its obligations under article 6.<sup>76</sup> By citing a law that protects the right to life of unborn fetuses, the U.S. has made it clear that it interprets its obligations under article 6

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<sup>69</sup> HRC General Comment 6, *supra* note 68, para. 3.

<sup>70</sup> ICCPR, *supra* note 14, arts. 4, 6 & 14.

<sup>71</sup> HRC General Comment 6, *supra* note 68, para 5; *see also* U.S. HUMAN RIGHTS NETWORK, HURRICANE KATRINA AND VIOLATIONS OF ICCPR ARTICLES 6 AND 26: A RESPONSE TO THE THIRD PERIODIC REPORT OF THE UNITED STATES OF AMERICA 3 (2005), available at <http://www2.ohchr.org/english/bodies/hrc/docs/ngos/USHRN.pdf>.

<sup>72</sup> HRC, *Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: Concluding Observations of the Human Rights Committee, United States of America*, para. 26, U.N. Doc. CCPR/C/USA/CO/3/Rev.1 (2006) [hereinafter HRC Concluding Observations].

<sup>73</sup> United States of America, *Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant: Third Periodic Reports of States Parties Due in 2003, delivered to the HRC*, U.N. Doc. CCPR/C/USA/3 (2005) [hereinafter US HRC Report].

<sup>74</sup> *Id.* at paras. 96–101.

<sup>75</sup> *Id.* at paras. 115–119.

<sup>76</sup> *Id.* at para. 98. The Unborn Victims of Violence Act of 2004 criminalizes the act of intentionally killing a fetus when such killing takes place in the course of committing certain federal crimes. 18 U.S.C. § 1841 (2004).

broadly.<sup>77</sup> In addition, the United States has interpreted the corresponding duties of the right to life broadly, citing both negative measures (such as prohibiting application of the death penalty to persons who were under the age of 18 at the time their crime was committed) and positive measures (such as compensation and other measures of assistance to victims) in its description of how it fulfills its obligations under article 6.<sup>78</sup>

Now that we have established that the U.S. obligations to respect, protect, and fulfill the right to life under ICCPR article 6 entail certain obligations with respect to the right to health, we must determine the extent of those obligations. The right to life requires a country to protect against the arbitrary deprivation of life from both direct and indirect threats. Some violations of the right to health—such as tortious misconduct or denial of benefits for cancer patients—constitute direct threats to life. Other violations—such as not having access to health insurance—may constitute indirect threats.<sup>79</sup> Whether threats are direct or indirect, they fall under the obligation to respect the right to life when they are a product of state policies and laws. This includes, for example, a state's failure to prohibit *de facto* discrimination. As the Human Rights Committee has noted, it is an article 6 problem when ethnic minorities are disproportionately affected by threats to life.<sup>80</sup> Since minorities are more likely to die because of threats to their right to health, the failure of the U.S. to prohibit *de facto* discrimination in terms of access to the underlying determinants of health and health care violates its ICCPR obligation to respect the right to life.<sup>81</sup>

The obligations to protect and fulfill the right to life are similarly applicable to the right to health. For the right to life, there is an obligation to protect even from indirect threats. For example, the Human Rights Committee has commented that states should “take all possible measures to reduce infant mortality and to increase life expectancy.”<sup>82</sup> These indicators are closely tied to the overall ability of a healthcare system to promote the highest attain-

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<sup>77</sup> The U.S. position on this issue raises the possibility of an estoppel argument for any who would seek to apply a narrower interpretation of ICCPR article 6.

<sup>78</sup> US HRC Report, *supra* note 73, paras. 96–125.

<sup>79</sup> See INST. OF MED., *INSURING AMERICA'S HEALTH: PRINCIPLES AND RECOMMENDATIONS* (2004).

<sup>80</sup> HRC Concluding Observations, *supra* note 72, para. 29 (expressing concern about studies showing that the death penalty may be imposed disproportionately on ethnic minorities as well as on low-income groups).

<sup>81</sup> See *infra* Part II(B).

<sup>82</sup> HRC General Comment 6, *supra* note 68, para. 5.

able standard of health for everyone. Therefore, taking “all possible measures” to address these threats should include ensuring that the state’s approach to healthcare delivery does not create barriers to accessing care or threaten the availability, acceptability, or quality of health goods and services.

The United States interprets its ICCPR article 6 obligations broadly in accordance with the recommendations of the Human Rights Committee. Therefore, to prevent the arbitrary deprivation of life due to inadequate availability, accessibility, acceptability, and quality of health goods and services, the United States should respect, protect, and fulfill the human right to health. By including the right to health in its right to life obligations, the U.S. would be taking measures to prevent the arbitrary deprivation of life by promoting the highest attainable standard of health for everyone.

2. The obligation to respect the right to health as part of the prohibition against discrimination under the ICERD

In addition to its obligations under the ICCPR, the U.S. is also bound by the terms of the International Convention on the Elimination of All Forms of Racial Discrimination (“ICERD”), which it ratified on October 21, 1994.<sup>83</sup> ICERD prohibits racial discrimination in all its forms, which it defines as:

any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.<sup>84</sup>

Discrimination under the ICERD includes both *de facto* and *de jure* discrimination.<sup>85</sup> Article 1(c) of the Convention requires State

<sup>83</sup> OHCHR, Status of Ratification, International Covenant on the Elimination of All Forms of Racial Discrimination New York, 7 March 1966, <http://www2.ohchr.org/english/bodies/ratification/2.htm> (last visited Apr. 23, 2008).

<sup>84</sup> ICERD, *supra* note 15, art. 1(1).

<sup>85</sup> *Id.* at art. 2(1)(c); U.N. Committee on the Elimination of Racial Discrimination [hereinafter CERD], *General Recommendation XIV on Article 1, Paragraph 1, of the Convention*, CERD, 42nd Sess., U.N. Doc. HRI/GEN/1/Rev.7 206 (2004) [hereinafter CERD General Recommendation XIV]. The Human Rights Committee has also interpreted the ICCPR to include both *de jure* and *de facto* discrimination. See HRC, *General Comment 18: Non-Discrimination*, 37th Sess., para. 7, U.N. Doc. HRI/GEN/1/Rev.7, 147 (2004).

[T]he term “discrimination” as used in the Covenant should be understood to imply any distinction, exclusion, restriction or preference which is based on any ground such as race, colour, sex, language, relig-

Parties to “take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations *which have the effect of creating or perpetuating racial discrimination wherever it exists.*”<sup>86</sup> The Committee on the Elimination of Racial Discrimination (“CERD”) emphasized the fact that the Convention prohibits *de facto* discrimination in its General Recommendation XIV.<sup>87</sup> In 2001, CERD explicitly called on the United States to “undertake to prohibit and to eliminate racial discrimination in all its forms, including practices and legislation that may not be discriminatory in purpose, but in effect.”<sup>88</sup>

The prohibition against *de jure* and *de facto* discrimination under ICERD applies specifically to the right to health. Article 5(e)(iv) of the Convention calls on State Parties to prohibit discrimination in all its forms for the right to “public health” and “medical care.”<sup>89</sup> Therefore, the United States is legally obligated under that treaty to address *de jure* and *de facto* discrimination that affects access to healthcare services. CERD noted this obligation when it reviewed U.S. practice in 2001, stating, “[T]he Committee is concerned about persistent disparities in the enjoyment of, in particular, the right to adequate housing, equal opportunities for education and employment, and access to public and private health care.”<sup>90</sup>

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ion, political or other opinion, national or social origin, property, birth or other status, and which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons, on an equal footing, of all rights and freedoms.

*Id.*

<sup>86</sup> ICERD, *supra* note 15, art. 2, para. 1(c) (emphasis added).

<sup>87</sup> CERD General Recommendation XIV, *supra* note 85, para. 1.

Non-discrimination, together with equality before the law and equal protection of the law without any discrimination, constitutes a basic principle in the protection of human rights. The Committee wishes to draw the attention of States parties to certain features of the definition of racial discrimination in article 1, paragraph 1, of the ICERD. It is of the opinion that the words “based on” do not bear any meaning different from “on the grounds of” [race] in preambular paragraph 7. A distinction is contrary to the Convention if it has either the purpose or the effect of impairing particular rights and freedoms[.] This is confirmed by the obligation placed upon States parties by article 2, paragraph 1 (c), to nullify any law or practice which has the effect of creating or perpetuating racial discrimination.

*Id.*

<sup>88</sup> *Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America*, U.N. CERD, 59th Sess., para. 393, U.N. Doc. A/56/18 (2001) [hereinafter CERD Concluding Observations].

<sup>89</sup> ICERD, *supra* note 15, art. 5(e)(iv).

<sup>90</sup> CERD Concluding Observations, *supra* note 88, para. 398.

The United States is legally obligated to prohibit and address *de facto* discrimination in terms of public health and medical care. However, this obligation may also be characterized as the duty to *respect* the right to health, since a state violates the duty to respect the right to health when access to health goods, services, or facilities is denied due to *de jure* or *de facto* discrimination.<sup>91</sup> Under international law, therefore, the U.S. is legally obligated to respect the right to health in terms of the prohibition against discrimination.

3. The obligation to refrain from violating the right to health insofar as doing so would defeat the object and purpose of the ICESCR

The third international legal obligation to uphold the right to health comes from the U.S. signing of the ICESCR. Contemporary law on treaty interpretation holds that signing a treaty is insufficient to show the necessary consent to be bound by that treaty.<sup>92</sup> Instead, ratification or accession is the typical way in which states demonstrate their consent to be bound, while a signature merely indicates the intention of the state to subsequently ratify. Thus, the U.S. signature on the ICESCR does not legally bind the U.S. to that treaty's terms. Nonetheless, unless and until the U.S. makes it clear that it has no intention of ratifying the ICESCR, its signature entails a lesser obligation to refrain from actions that defeat the object and purpose of the treaty.<sup>93</sup> This lesser obligation associated with signing a treaty is contained in the Vienna Convention on the Law of Treaties, which the United States has long recog-

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<sup>91</sup> See CESCR General Comment 14, *supra* note 12, para. 50.

<sup>92</sup> Curtis A. Bradley, *Unratified Treaties, Domestic Politics, and the U.S. Constitution*, 48 HARV. INT'L L. J. 307, 313 (2007).

<sup>93</sup> Vienna Convention on the Law of Treaties, *supra* note 21, art. 18.

A State is obliged to refrain from acts which would defeat the object and purpose of a treaty when: (a) it has signed the treaty or has exchanged instruments constituting the treaty subject to ratification, acceptance or approval, until it shall have made its intention clear not to become a party to the treaty.

*Id.* One could argue that because the U.S. signature on the ICESCR was several decades ago, the mere passage of time is enough to demonstrate that there is no intention of ratifying the treaty. However, that argument does not account for the fact that the U.S. has previously taken several decades to ratify treaties such as the Genocide Convention, which it signed in 1948 but did not ratify until 1988. This argument is further undermined by the fact that the U.S. recently *unsigned* a treaty—the Rome Statute of the International Criminal Court—on the grounds that it did not want to be bound by the obligations associated with signature. See Felicity Barringer, *U.N. Renews U.S. Peacekeepers' Exemption from Prosecution*, N.Y. TIMES, June 13, 2003, at A18.

nized as binding customary international law.<sup>94</sup> Therefore, the fact the U.S. has signed the ICESCR means there is a minimum requirement to respect the right to health insofar as failing to do so would defeat the object and purpose of the ICESCR.<sup>95</sup>

The meaning of “object and purpose” is not defined under the Vienna Convention, which has led to differing interpretations regarding the breadth of the article 18 obligation. Some scholars interpret the provision broadly to mean it applies to the core content of human rights such as those found in the Convention on the Rights of the Child.<sup>96</sup> However, it is unlikely that such a broad interpretation applies to the ICESCR; although the CESCR has stated that the Covenant would be largely deprived of its reason for being if it did not include a core content for each of the rights contained within it, the reasoning behind this claim is that the Covenant must provide clear guidelines for State Parties, not that the core content is itself the object and purpose of the treaty.<sup>97</sup> Furthermore, given the drafting history of article 18, it is likely the signature obligation is somewhat narrower than a prohibition on any violation of a general treaty objective.<sup>98</sup> In his article on the signature obligation

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<sup>94</sup> The United States has signed, but not ratified, the Vienna Convention on the Law of Treaties. However, the U.S. recognizes that the Convention is “generally recognized as the authoritative guide to current treaty law and practice.” Message from the President of the United States Transmitting the Vienna Convention on the Law of Treaties Signed for the United States on April 24, 1970, at 1, S. Exec. Doc. L., 92-1 (1971). See also RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW § 101 (1987); IAN BROWNLIE, PRINCIPLES OF PUBLIC INTERNATIONAL LAW 582 (Oxford U. Press 6th ed. 2003) (1966).

<sup>95</sup> This obligation may be relevant in “assessing US trade and aid policies to the extent that these have health impacts.” Yamin, *supra* note 62, at 1158.

<sup>96</sup> Bradley, *supra* note 92, at 308. See, e.g., William A. Schabas, Professor of Law, University of Quebec, Opening Remarks at the 1998 ABA Annual Meeting of the Section of Individual Rights and Responsibilities (Aug. 3, 1998), in 67 FORDHAM L. REV. 2793, 2812 (1999); Letter from Lois Whitman, Executive Director, Human Rights Watch Children’s Rights Division, to The Honorable Seth Waxman, Solicitor General, U.S. Department of Justice (Sept. 24, 1999), available at <http://hrw.org/about/projects/crd/domingues.htm>.

<sup>97</sup> CESCR General Comment 3, *supra* note 29, para. 10. Although one could argue that when States do not respect the core content, they cannot be moving towards the overarching goal of promoting the rights contained in the treaty, this interpretation has not been supported by Committee commentary or jurisprudence. See also *Minister of Health v. Treatment Action Campaign*, 2002 (5) SA 721 (CC) at 27 (S.Afr.) (discussing the issue of whether minimum core content is equivalent to a self-standing right under the South African Constitution). “[T]he socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them. Minimum core was thus treated as possibly being relevant to reasonableness under section 26(2), and not as a self-standing right conferred on everyone under section 26(1).” *Id.*

<sup>98</sup> Bradley, *supra* note 92, at 308.

and U.S. domestic policies, Curtis Bradley argues that the obligation “is best construed as precluding only actions that would substantially undermine the ability of the parties to comply with, or benefit from, the treaty after ratification.”<sup>99</sup> This narrower interpretation of the article 18 signature obligation is more likely to apply to the ICESCR given the CESCR’s comments regarding the object of the treaty.<sup>100</sup>

In some respects, a narrow interpretation of article 18 obligations means that the United States would not have obligations to uphold the right to health because of its ICESCR signature. Indeed, Bradley concludes that the narrower interpretation of the article 18 obligation means that the obligation is not relevant to human rights treaties at all, since “pre-ratification conduct inconsistent with the treaty is not likely to undo the bargain reflected in the treaty.”<sup>101</sup> However, that claim fails to take into account different *types* of human rights violations. Although it may be true that some human rights violations—such as torture, or arbitrary application of the death penalty, for example—may cease immediately upon ratification, others involve long-term structural violations that can prove extremely difficult—if not impossible—to undo upon ratification. In the United States, for example, extensive reliance on private sector pharmaceutical companies for research and development of new drugs may substantially undermine the *future* ability of the U.S. to meet obligations associated with the human right to health.<sup>102</sup>

Although it is unclear exactly what the Vienna Convention article 18 obligation includes, even a narrow interpretation of that obligation means the U.S. should not introduce long-term, structural reforms that violate the right to health.<sup>103</sup> Indeed, the U.S. should instead uphold one of the core content requirements of the right to health, which is to develop its system from a rights-based perspective.<sup>104</sup> To do otherwise would make it extremely difficult, if not impossible, for the United States to comply with the ICESCR after ratification.

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<sup>99</sup> *Id.*

<sup>100</sup> CESCR General Comment 3, *supra* note 29, para. 10.

<sup>101</sup> Bradley, *supra* note 92, at 308.

<sup>102</sup> *See infra* Part IV.

<sup>103</sup> This does not mean that structural violations are the *only* violations that may arise because of article 18 obligations in relation to the ICESCR. For example, the obligation may also be relevant in terms of U.S. policies relating to trade or aid, when those policies impact health. Yamin, *supra* note 62, at 1158.

<sup>104</sup> CESCR General Comment 14, *supra* note 12, para. 43(f). *See supra* Part I(A)(i).



C. *Political benefits to using the international right to health to reform the U.S. healthcare system*

Beyond any legal obligations of the United States to uphold the human right to health, there are political benefits to using international law to shape the healthcare reform process in this country. Given the history of failed healthcare reform in the U.S. and the ongoing debates focused on the same failed structure already in place, it is strategically beneficial to approach health and health care with a new perspective, and specifically one that refocuses the discussion on *health* above all else.

Viewing health as an inalienable right is not new in the United States. In 1944, President Roosevelt argued that every American has the right to “adequate medical care and the opportunity to achieve and enjoy good health.”<sup>105</sup> The right to health was subsequently included in the Universal Declaration of Human Rights,<sup>106</sup> which was drafted under Eleanor Roosevelt’s guidance.<sup>107</sup> More recently, some cities and states have started recognizing the right to health, at least in terms of health *care*. In 2005, citizens in the City of Seattle passed an advisory ballot measure stating, “Every person in the United States should have the right to health care of equal high quality. The Congress should immediately enact legislation to implement this right.”<sup>108</sup> Two years later, the neighboring city of Tacoma passed a similar measure expressing citizen and city council support for “state and federal legislation that would recognize the right of access and availability to high-quality, appropriate health care for all.”<sup>109</sup> North Carolina and Minnesota have introduced constitutional amendments regarding the right to health, and Wisconsin has a new public insurance plan that will cover children in the state by 2008, which recognizes that “every Wisconsin resident has the right to health care.”<sup>110</sup> Therefore, viewing health—and particularly health *care*—as a fundamental right in the United States is neither new nor revolutionary. Rather, it has a

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<sup>105</sup> Yamin, *supra* note 62, at 1157.

<sup>106</sup> UDHR, *supra* note 17, art. 25(1).

<sup>107</sup> PAUL GORDON LAUREN, *THE EVOLUTION OF INTERNATIONAL HUMAN RIGHTS: VISIONS SEEN* 210 (2d ed. 1998).

<sup>108</sup> CITY OF SEATTLE HEALTH CARE ADVISORY BALLOT MEASURE (2005), *available at* <http://www2.seattle.gov/ethics/vg/20051108/healthct.htm>.

<sup>109</sup> City of Tacoma, W.A., Res. 37226 (2007).

<sup>110</sup> NAT’L ECON. AND SOC. RIGHTS INITIATIVE, *PURSUING A NEW VISION FOR HEALTH CARE: A HUMAN RIGHTS ASSESSMENT OF THE PRESIDENTIAL CANDIDATES’ PROPOSALS* 4 (2007), *available at* [http://www.nesri.org/Human\\_Rights\\_Assessment.pdf?sku=C8821](http://www.nesri.org/Human_Rights_Assessment.pdf?sku=C8821).

long history that continues to reemerge throughout the country as a morally appropriate way to frame healthcare discussions.

In addition to carrying moral and historical resonance, viewing health as a right also circumvents deeply entrenched positions regarding the organization and financing of healthcare delivery. For example, one of the enduring legacies of the Cold War is a widespread suspicion of anything labeled—reasonably or not—as “socialized,” including “socialized medicine.”<sup>111</sup> The fear that the United States might descend into totalitarianism if the government guaranteed access to health care for even part of its population has incongruently outlasted implementation of programs designed to do just that.<sup>112</sup> Current debates over healthcare reform continue to fall into the same deeply grooved contours surrounding the role of government versus market.<sup>113</sup> However, a rights-based approach does an end-run around debates over the appropriate scope of government in provision of health services. Instead of dictating a particular relationship between the government and market, a rights-based perspective instead focuses on the level of health available to the population. In other words, the degree of public or private involvement in healthcare delivery, goods, and services is *only* relevant to the extent that it undermines or promotes the overall health of the population. Taking a rights-based approach therefore forces healthcare debates to focus on the health of a population, rather than allowing the discussion to stagnate over philosophical and political differences on the role of government.

The political benefits to approaching healthcare reform from a rights-based perspective underscore the need to find a new way to evaluate reform proposals. The next sections evaluate the current U.S. healthcare system (or non-system) according to the three levels of responsibility set out in international law: respect, protect, and fulfill. At each level of responsibility, the U.S. should approach health in terms of *all* of its substantive and procedural elements, keeping in mind the interdependency of those elements. Although the discussion primarily focuses on the provision of health *care*, it is equally important to address the underlying determinants of health—such as education, food, and housing—that are inseparable ingredients to a person’s overall health.

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<sup>111</sup> Carmalt et al., *supra* note 60, at 3.

<sup>112</sup> Paul Krugman, Op-Ed., *Health Care Terror*, N.Y. TIMES, July 9, 2007, at A17 (referencing words by former U.S. President Ronald Reagan to the American Medical Association warning that the program now known as Medicare would lead to totalitarianism).

<sup>113</sup> Yamin, *supra* note 62, at 1157–58.

## II. FAILING TO RESPECT THE RIGHT TO HEALTH: DISCRIMINATION IN U.S. HEALTHCARE DELIVERY

The first level of governmental obligation regarding any human right is the obligation to *respect*, meaning the United States may not interfere—directly or indirectly—with the right to health.<sup>114</sup> The United States is obligated to respect the human right to health insofar as failing to do so may result in arbitrary deprivation of life because of its obligations under article 6 of the ICCPR.<sup>115</sup> The U.S. is also obligated by its ratification of the ICERD to respect the right to health specifically in terms of ensuring that it prohibits all forms of discrimination that affect access to public health and medical care.<sup>116</sup> The CESCR has specifically noted the relationship between the prohibition against discrimination and the obligation to respect the right to health in its General Comment 14:

Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality. Examples include the denial of access to health facilities, goods and services to particular individuals or groups as a result of *de jure* or *de facto* discrimination . . . .<sup>117</sup>

The United States violates the obligation to respect the right to health because (a) its laws and policies do not prohibit *de facto* discrimination in the access to health facilities, goods and services and (b) such discrimination exists and can result in the arbitrary deprivation of life.<sup>118</sup>

### A. *Failing to prohibit de facto discrimination*

Domestic law in the United States prohibits only intentional,

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<sup>114</sup> CESCR General Comment 14, *supra* note 12, para. 33. For a discussion of the three levels of obligation—respect, protect, fulfill—as they relate specifically to the right to health, see Brigit Toebes, *The Right to Health*, in Eide et al., *supra* note 13, at 169.

<sup>115</sup> ICCPR, *supra* note 14, art. 6. See discussion *supra* Part I(B)(i).

<sup>116</sup> ICERD, *supra* note 15, art. 5(e)(iv). See discussion *supra* Part I(B)(ii).

<sup>117</sup> CESCR General Comment 14, *supra* note 12, para. 50.

<sup>118</sup> Arguably, existing *de facto* discrimination could also be considered a violation of the obligation to protect, since it threatens the right to health but is not part of state activities. However, the fact that the United States does not prohibit *de facto* discrimination means that its laws are likely to result in violations of the right to health. See CESCR General Comment 14, *supra* note 12, para. 50. Therefore, the problem of *de facto* discrimination is analyzed here in terms of the obligation to respect rather than the obligation to protect.

*de jure* discrimination.<sup>119</sup> The provisions under U.S. law that prohibit discrimination<sup>120</sup> could include *de facto* discrimination, but they have not been interpreted that way. Instead, since 1976 the Supreme Court has interpreted the prohibition against discrimination under U.S. law to include an intent requirement; the so-called “intent doctrine” was articulated in *Washington v. Davis*, which held that “a law or other official act, without regard to whether it reflects a racial discriminatory purpose, is [not] unconstitutional *solely* because it has a racially disproportionate impact.”<sup>121</sup> The intent doctrine has been extended to apply to actions under Title VI of the Civil Rights Act of 1964,<sup>122</sup> and most recently, to actions challenging government policy.<sup>123</sup> Taken together, these holdings mean that the United States does not interpret the domestic prohibition against discrimination to include *de facto* discrimination. This interpretation directly conflicts with U.S. obligations under the ICCPR and ICERD, both of which specifically include *de facto* discrimination as part of the overall prohibition against discrimination.<sup>124</sup> Insofar as the U.S. legal stance allows *de facto* discrimination to continue in access to health facilities, goods and services, it also constitutes a violation of the obligation to respect the right to health.

*B. Existing de facto discrimination and health disparities*

In addition to failing to prohibit *de facto* discrimination, the United States also has significant *de facto* discrimination in terms of access to health care and to the underlying determinants of health. The effects of this discrimination are dramatic. For example, whites are expected to live 5.2 years longer on average than African

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<sup>119</sup> *Washington v. Davis*, 426 U.S. 229, 239 (1976); *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 287 (1978); *Guardians Assn. v. Civil Serv. Comm’n of N.Y.*, 463 U.S. 582, 610 (1982) (Powell J., concurring); *Alexander v. Sandoval*, 532 U.S. 275, 281 (2001).

<sup>120</sup> 42 U.S.C. § 2000d et seq.; U.S. CONST. amend. XIV, § 1.

<sup>121</sup> *Washington*, 426 U.S. at 239.

<sup>122</sup> *Bakke*, 438 U.S. at 287; *Guardians Assn.*, 463 U.S. at 610.

<sup>123</sup> *Alexander*, 532 U.S. at 281.

<sup>124</sup> In 2000, the United States submitted that “existing U.S. law provides protections and remedies sufficient to satisfy the requirements of the [ICERD]. Moreover, federal, state and local laws already provide a comprehensive basis for challenging discriminatory statutes, regulations and other governmental actions in court, as well as certain forms of discriminatory conduct by private actors.” *Third Periodic Reports of States Parties Due in 1999: Addendum: United States of America*, U.N. CERD, 59th Sess., para. 171, U.N. Doc. CERD/C/351/Add.1 (2000). However, at the time of this statement, it was still possible for U.S. citizens to challenge *de facto* discrimination of government policy. *Alexander*, 532 U.S. at 293.

Americans,<sup>125</sup> infant mortality rates for African Americans are more than double that for whites,<sup>126</sup> and significant disparities exist in a wide variety of other health indicators, including cardiac disease and HIV/AIDS.<sup>127</sup> Disparate health impacts are not limited to African Americans; American Indians and Pacific Islanders also have consistently poorer health than whites, as do other subpopulations such as those of differing nationality or immigration status.<sup>128</sup> Racial disparities in health indicators are particularly dramatic when they are compounded by gender. For example, maternal mortality rates for African American women are nearly four times what they are for white women.<sup>129</sup>

These disparities are no accident; they are rooted in structural inequities that have existed in this country since its inception.<sup>130</sup> Although they have many direct and indirect causes, disparate health outcomes continue to exist (and in some cases, worsen) because there is unequal access to both health *care* and to the underlying *determinants* of health.<sup>131</sup> Underlying determinants of health include a wide variety of factors, but some of the most important are the conditions of housing and education and the physical and social environments in which people live.<sup>132</sup> The United States has high levels of racial residential segregation, with racial groups living in different, isolated geographic areas.<sup>133</sup> Where people live is a fundamental causal factor in terms of health outcomes, especially when it is combined with poverty.<sup>134</sup> For example, poor African

<sup>125</sup> See NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL AND PREVENTION, HEALTH, UNITED STATES, 2006, at 176 tbl.27 (2006), available at <http://www.cdc.gov/nchs/data/hus/06.pdf#027>.

<sup>126</sup> See NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL AND PREVENTION, NATIONAL VITAL STATISTICS REPORT, VOL. 50, NO. 12, INFANT MORTALITY STATISTICS FROM THE 2000 PERIOD LINKED BIRTH/INFANT DEATH DATA SET, 10 tbl.1 (2002), available at [http://www.cdc.gov/nchs/data/nvsr/nvsr50/50\\_12t1.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr50/50_12t1.pdf).

<sup>127</sup> CERD WORKING GROUP ON HEALTH AND ENVIRONMENTAL HEALTH, UNEQUAL HEALTH OUTCOMES IN THE UNITED STATES 9 (2008), available at <http://www.pirac.org/pdf/CERDhealthEnvironmentReport.pdf> [hereinafter CERD Shadow Report].

<sup>128</sup> *Id.* at 10.

<sup>129</sup> CERD Shadow Report, *supra* note 127, at 11; NAT'L CTR. FOR HEALTH STATISTICS, CTRS. FOR DISEASE CONTROL, Maternal Mortality and Related Concepts, Vital Health Statistics, Series 3, No. 33, at 13-14 (Feb. 2007), available at [www.cdc.gov/nchs/data/series/sr\\_03/sr03\\_033.pdf](http://www.cdc.gov/nchs/data/series/sr_03/sr03_033.pdf).

<sup>130</sup> See UNEQUAL TREATMENT, *supra* note 53, at 1; CERD Shadow Report, *supra* note 127, at 3.

<sup>131</sup> Benn Greenspan, *Health Disparities and the US Health Care System*, 116 PUB. HEALTH REP. 417, 417 (2001).

<sup>132</sup> CERD Shadow Report, *supra* note 127, at 18-20.

<sup>133</sup> David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, 116 PUB. HEALTH REP. 404, 404 (2001).

<sup>134</sup> Greenspan, *supra* note 131, at 417-18.

Americans are more likely than poor whites to live in areas of concentrated poverty.<sup>135</sup> These areas receive fewer public investments, which leads to deteriorating infrastructure, housing, education, and a lower overall standard of living that is directly related to a variety of lower health outcomes.<sup>136</sup> In addition, racial residential segregation results in problems of health care availability: approximately 50 million people—a disproportionate percentage of whom are minorities—live in areas that are underserved by physicians.<sup>137</sup>

The racial divide in access to the underlying determinants of health is exacerbated by the lack of available, accessible, acceptable, and quality health *care* for minorities in the United States. The high cost of health goods and services means that people without health insurance are less likely to have economic access to services. In the United States, there are significant racial disparities in terms of who does or does not have insurance. For example, the 2006 National Healthcare Disparities Report (“NHDR”) found that decreased access to health care for Hispanics is directly related to the fact that “Hispanics of every income and education level were significantly less likely than respective non-Hispanic Whites to have health insurance.”<sup>138</sup>

However, economic barriers to accessing health care in the U.S. are more complex than who does or does not have insurance. Although the vast majority of uninsured people do *not* have access to health care, it does not follow that the people *with* insurance *do* have access to care. In other words, just because people have health insurance does not mean they can afford health care. Indeed, African Americans in the United States have about the same access as whites to health insurance, but they still face worsening economic access to care.<sup>139</sup> This finding reflects the problem of *underinsurance* in the United States, which occurs when individuals hold health insurance policies that provide inadequate coverage.<sup>140</sup> Although there is some debate over what constitutes adequate or inadequate coverage, it is at least clear that when a group of in-

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<sup>135</sup> Williams and Collins, *supra* note 124, at 416.

<sup>136</sup> *Id.* at 404–16.

<sup>137</sup> Carmalt et al, *supra* note 60; see GRANT MAKERS IN HEALTH, TRAINING THE HEALTH WORKFORCE OF TOMORROW, ISSUE BRIEF NO. 12, at 2 (2002).

<sup>138</sup> See AGENCY FOR HEALTHCARE RES. & QUALITY, U.S. DEP’T OF HEALTH & HUMAN SERVICES, PUBLICATION NO. 07-0012, 2006 NATIONAL HEALTHCARE DISPARITIES REPORT 102–105 (2006), available at <http://www.ahrq.gov/qual/nhdr06/nhdr06.htm> [hereinafter 2006 NHDR].

<sup>139</sup> See *id.* at 119.

<sup>140</sup> See Andrew Ward, *The Concept of Underinsurance: A General Typology*, 31 J. MED. & PHIL. 499, 500 (2006).

sured individuals continues to face significant financial barriers to accessing health care, that insurance is not sufficient to provide adequate coverage.

Problems of availability and accessibility are compounded for minorities by issues of quality and acceptability. In the United States, racial disparities exist across multiple dimensions of quality of health care.<sup>141</sup> For example, the NHDR found that during the years studied, there were significantly higher rates of postoperative complications for blacks than for whites<sup>142</sup> and significantly higher rates of death following complications in care for Asians or Pacific Islanders than for whites.<sup>143</sup> The acceptability of care—for example, in terms of patient-provider communications and the timeliness in responding to patient needs—also reflects significant and worsening differences between minorities and whites.<sup>144</sup> In addition to conclusions made by the latest NHDR, the Institute of Medicine's extensive review of inequality in health care found that minorities experience a wide range of barriers to quality care, including "barriers of language, geography, and cultural familiarity."<sup>145</sup>

The lack of available, accessible, acceptable, quality health care for minorities is compounded by the lack of access to the underlying determinants of health. It therefore violates the human right to health as it is defined under international law. In addition, it violates the U.S. obligation to respect the right to life under article 6 of the ICCPR.<sup>146</sup> Since the U.S. does not recognize *de facto* discrimination as a prohibited form of discrimination (in violation of its obligations under the ICERD), these disparities do not trigger a domestic legal response. Instead, the bifurcated system has continued to produce health inequity, violating the obligation to respect the human right to health, and violating U.S. obligations under the ICCPR and ICERD.

### III. FAILING TO PROTECT THE RIGHT TO HEALTH: STRUCTURAL FLAWS IN U.S. HEALTH CARE

The obligation to protect requires a state to prevent third parties from interfering with guarantees associated with the human

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<sup>141</sup> See 2006 NHDR, *supra* note 138, at 2; UNEQUAL TREATMENT, *supra* note 53, at 1.

<sup>142</sup> See 2006 NHDR, *supra* note 138, at 70.

<sup>143</sup> See *id.* at 73.

<sup>144</sup> See *id.* at 3.

<sup>145</sup> UNEQUAL TREATMENT, *supra* note 53, at 1.

<sup>146</sup> See ICCPR, *supra* note 14, art. 6. See *supra* Part I(B)(i).

right to health.<sup>147</sup> The United States has an obligation to protect the right to health as part of its obligation to prevent the arbitrary deprivation of life under article 6 of the ICCPR.<sup>148</sup> To the extent that failing to protect against these actions may allow structural flaws to deepen, the U.S. also violates the obligations associated with its signing of the ICESCR.<sup>149</sup>

Third parties may include other states, individual actors, or privately held entities, such as for-profit companies or transnational corporations.<sup>150</sup> The nature of prohibited third-party interference is varied and may include individual or systemic threats. For example, under the Sixth Amendment, criminal defendants have a right to a speedy and public trial.<sup>151</sup> An individual threat to a defendant's trial may occur if a person disrupts the court's proceedings. The state protects against that threat in the form of a judge who maintains order in the courtroom. However, the duty to protect may also be triggered by structural flaws that result in systemic violations. A systemic threat to the indigent criminal defendant's rights, for example, would arise if the only available defense attorneys were those that required payment for their services. The state protects against this systemic threat to the right to a fair trial by providing public defenders that represent indigent criminal defendants at no cost.<sup>152</sup>

Like the right to a fair trial, the right to health also requires protection against both individual and systemic threats. To that end, the CESCR states that the right to health includes a duty "to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services."<sup>153</sup> Privatizing the healthcare sector is not in and of itself a human rights issue; from a rights-based perspective, what matters is not how a system is financed but whether the system promotes the highest attainable standard of

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<sup>147</sup> See General Comment 14, *supra* note 12, para. 33.

<sup>148</sup> ICCPR, *supra* note 14, art. 6. See *supra* Part I(B)(i).

<sup>149</sup> See Vienna Convention on the Law of Treaties, *supra* note 21, art. 18.

<sup>150</sup> See Jochnick, *supra* note 28, at 66. The standard for holding a state liable for a private actor's actions is due diligence: a state must have taken reasonable or serious steps to prevent or respond to an abuse by a private actor, including investigating and providing a remedy such as compensation. See, e.g., Case of Velásquez-Rodríguez v. Honduras, 1989 Inter-Am. Ct. H.R. (ser. C) No. 4, at 35 (July 29, 1988) available at [http://www.corteidh.or.cr/docs/casos/articulos/seriec\\_04\\_ing.pdf](http://www.corteidh.or.cr/docs/casos/articulos/seriec_04_ing.pdf).

<sup>151</sup> U.S. CONST. amend. VI.

<sup>152</sup> See *Gideon v. Wainwright*, 372 U.S. 335 (1963).

<sup>153</sup> CESCR General Comment 14 *supra* note 12, para. 35; see also Toebes, *supra* note 114, at 181.



mental and physical health.<sup>154</sup> However, if a state chooses to privatize its healthcare sector, it must ensure that its reliance on the private sector does not threaten the right to health.<sup>155</sup>

Like most countries, the United States uses a mixture of private and public insurers to provide access to health goods and services. However, unlike other countries, the U.S. relies primarily on for-profit entities to provide access to health services and goods. In 2006, approximately two-thirds of the non-elderly American population (about 158 million people) had private health insurance, while the remaining third held publicly provided insurance or were uninsured.<sup>156</sup> Most of those with private health insurance—sixty-one percent<sup>157</sup>—are covered by their employers or as an employee-dependant.<sup>158</sup> Public insurance is available for the very poor and for the elderly through Medicaid and Medicare, respectively.<sup>159</sup> It is also available for children in families within a certain percentage of the poverty line through the State Children's Health Insurance Program (SCHIP).<sup>160</sup> These programs provide an important safety net, but their exclusivity contravenes the fundamental principle of a human right to health, which calls for *universal* access to health facilities, goods, and services.<sup>161</sup> Moreover, the high costs of medical treatment in the United States coupled with low-income eligibility requirements means that many millions of people who cannot afford private insurance remain ineligible for

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<sup>154</sup> See ICESCR, *supra* note 12, art. 12.

<sup>155</sup> Discussions of how to protect a right may overlap with a state's obligation to fulfill a right. For example, the judge who holds a disruptive party in contempt of court *protects* the rights of the individual on trial, but the state that pays that judge to do his or her job is *fulfilling* the right to a fair trial by taking positive measures to ensure that right can be realized. This section focuses on structural flaws associated with U.S. health care—and specifically the way in which the current system provides incentives to deny access to care—that violate the duty to *protect*. The next section turns to the failure to take positive measures to *fulfill* the right to health.

<sup>156</sup> See KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER 2 (2007), *available at* <http://www.kff.org/uninsured/upload/7451-03.pdf> [hereinafter THE UNINSURED: A PRIMER]; THE KAISER FAMILY FOUND. AND THE HEALTH RES. AND EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2007 ANNUAL SURVEY 1 (2007), *available at* <http://www.kff.org/insurance/7672/upload/76723.pdf> [hereinafter EMPLOYER HEALTH BENEFITS 2007].

<sup>157</sup> See THE UNINSURED: A PRIMER, *supra* note 156, at 2.

<sup>158</sup> See *id.* See generally EMPLOYER HEALTH BENEFITS 2007, *supra* note 156.

<sup>159</sup> See U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services, <http://www.cms.hhs.gov/medicareGenInfo> (last visited Apr. 23, 2008).

<sup>160</sup> See State Children's Health Insurance Programs (SCHIPs), 42 C.F.R. § 457.310 (2006).

<sup>161</sup> Carmalt et al., *supra* note 60, at 9.

the public safety net.<sup>162</sup>

The dominance of the private sector in the United States violates the right to health for two reasons: (1) because insurance companies consistently deny *coverage* to unhealthy or poor individuals, which results in problems of availability and accessibility, and (2) because companies consistently deny *benefits* to insured individuals, which results in problems of accessibility and quality. In both cases, the violations arise not because of reliance on private companies *per se*, but rather because of the failure to ensure that the organizations providing access to health care have the ultimate goal of promoting *health* for the population as a whole.

A. *Denial of coverage to the poor and unhealthy*

Nearly seventy percent of the people without health insurance coverage are unable to afford it or were denied coverage due to poor health, illness, or age.<sup>163</sup> This means that the poorest and sickest Americans are unable to obtain private health insurance. Although some of those without insurance are eligible for public insurance, millions are not: in 2005, three-quarters of the 44.6 million people without insurance were ineligible for Medicaid on the basis of income.<sup>164</sup> Being ineligible for Medicaid does not mean that they can afford health insurance: of the approximately 33.5 million uninsured people ineligible for Medicaid, only about 8 million had annual incomes more than 300% of the federal poverty line.<sup>165</sup>

The incentives of the U.S. market-based healthcare system lead to denial of coverage to the poor and to the unhealthy.<sup>166</sup> More than any others, these two groups lack access to health care due almost entirely to an unregulated market-based system. Peo-

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<sup>162</sup> See JOHN HOLAHAN ET AL., KAISER COMM'N ON MEDICAID AND THE UNINSURED, CHARACTERISTICS OF THE UNINSURED: WHO IS ELIGIBLE FOR PUBLIC COVERAGE AND WHO NEEDS HELP AFFORDING COVERAGE? 1 (2007), available at <http://www.kff.org/uninsured/upload/7613.pdf>.

<sup>163</sup> Among those who say they are uninsured, 54% said they did not have insurance because it is too expensive. An additional 15% said they did not have insurance because they could not get coverage/were refused coverage due to poor health, illness, or age. ABC/KFF/USA Survey, *supra* note 6, at chart 11.

<sup>164</sup> HOLAHAN ET AL., *supra* note 162, at 1.

<sup>165</sup> See *id.*

<sup>166</sup> The very poorest Americans can obtain public insurance in the form of Medicaid. However, most of those who are currently uninsured are not poor enough to qualify for Medicaid but still cannot afford private insurance. See generally U.S. Dep't of Health & Human Services, Centers for Medicare & Medicaid Services, [www.cms.hhs.gov/MedicaidEligibility](http://www.cms.hhs.gov/MedicaidEligibility) (providing general Medicaid eligibility guidelines) (last visited Apr. 23, 2008).

ple living in poverty typically have lesser access to the underlying determinants of health, so that poverty and health are deeply intertwined.<sup>167</sup>

### 1. Incentives to deny coverage

Instead of providing a financial incentive to *promote* health, private health insurance companies have an incentive to *deny* access to health care, goods, and services. In particular, there is a financial incentive to provide coverage to the healthy and wealthy and to deny it to individuals who are unhealthy and/or poor (two qualities that frequently go together, since poverty typically results in restricted access to the underlying determinants of health).<sup>168</sup>

The incentive to deny coverage to people who are poor arises from the inability of poor people to pay insurance premiums. Most people in the U.S. who have private health insurance are covered by their employers or as an employee dependent.<sup>169</sup> However, the vast majority (over eight in ten) of the people who are uninsured come from working families.<sup>170</sup> In other words, even with Medicaid in place to cover the very poorest portion of the population, working families cannot afford to purchase health insurance. From the insurance company's perspective, there is no incentive to provide insurance to people who cannot afford it, since those people will be unable to pay the premiums. Since the insurance company's goal is to maintain profitability rather than to increase accessibility to health care, there is no incentive to extend coverage to those who cannot afford to purchase a policy.

Market-based incentives similarly work against the interests of those who are unhealthy. The nature of health expenses is such that most of the population will require few payments most of the time. For example, in 2003, "health spending roughly followed the '80-20 rule': 20 percent of the population accounted for 80 percent of expenses."<sup>171</sup> From an insurance company's perspective, therefore, there is a financial incentive to cover the eighty percent of people who will not need services (except those who cannot pay for the policy) and there is an incentive *not to* insure the twenty percent who do need services (i.e. the sick, who are, typically, also poor). Thus, those who are in the greatest need of healthcare cov-

<sup>167</sup> See CERD Shadow Report, *supra* note 127, at 16.

<sup>168</sup> See PAUL FARMER, INFECTIONS AND INEQUALITIES: THE MODERN PLAGUES (1999).

<sup>169</sup> See HOLAHAN ET AL., *supra* note 162.

<sup>170</sup> THE UNINSURED: A PRIMER, *supra* note 156, at 4.

<sup>171</sup> Paul Krugman and Robin Wells, *The Health Care Crisis and What to Do About It*, 53(5) N.Y. REV. BOOKS, Mar. 23, 2006, at 38.

erage are the most likely to have difficulty obtaining it.<sup>172</sup>

## 2. Social costs

The high cost of medical goods and services in the United States means that having health insurance directly corresponds to economic access for most health facilities, goods, and services.<sup>173</sup> People without health insurance are significantly more likely to go without needed medical care, and are less likely to receive preventive care when healthy or regular care for chronic conditions.<sup>174</sup> According to the Institute of Medicine, the lack of health insurance causes approximately 18,000 deaths in the United States each year.<sup>175</sup> For many people without insurance (one in six), emergency rooms are the regular source of care because those departments are the only ones required to treat all patients, regardless of ability to pay.<sup>176</sup> Given the high costs of emergency care and the forty-seven million people without insurance,<sup>177</sup> this reliance on emergency departments drives costs up across the board, negatively affecting access to medical goods and services for both the uninsured *and* the insured.

### B. Denial of benefits

In addition to the incentives to deny coverage, there is a financial incentive for companies to deny coverage for health *benefits* for people who already hold policies. Indeed, patients with poor physical functioning are more likely to report denial of coverage from

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<sup>172</sup> Although the U.S. has addressed this problem in a limited way by providing publicly available health insurance for the very poor and for the elderly (through Medicaid and Medicare), those programs are not extensive enough to reach huge portions of the population given the extent of U.S. reliance on private insurance to provide access to health care for its population. See OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, POLICY INFO. CTR.—DEP'T OF HEALTH AND HUMAN SERVS., ASPE ISSUE BRIEF: LONG-TERM GROWTH OF MEDICAL EXPENDITURES—PUBLIC AND PRIVATE (2005), <http://aspe.hhs.gov/health/medicalexpenditures> (last visited Apr. 23, 2008).

<sup>173</sup> INST. OF MED., COVERAGE MATTERS: INSURANCE AND HEALTH CARE 18 (2001), available at <http://www.nap.edu/openbook/0309076099/html/R1.html> [hereinafter COVERAGE MATTERS].

<sup>174</sup> *Id.* at 22.

<sup>175</sup> Press Release, Institute of Medicine Board on Health Care Services, IOM Report Calls for Universal Health Coverage by 2010; Offers Principles to Judge, Compare Proposed Solutions (Jan. 14, 2004), available at <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID=10874>.

<sup>176</sup> COVERAGE MATTERS, *supra* note 173, at 32.

<sup>177</sup> *Id.*; see also CENSUS BUREAU, *supra* note 2, at 21 tbl.6.

insurance companies.<sup>178</sup> The practice of denying benefits jeopardizes economic access to care and the quality of care received. However, the problem is more complex than simply a matter of admonishing companies for isolated instances of denial of benefits. The system as it is currently set up means that it is *more profitable* for companies to deny health benefits, which results in systemic violations of the right to health.

This is particularly true as the medical profession becomes increasingly advanced in ways that involve expensive equipment and training. Many of the technological advances in care provision—such as magnetic resonance imaging (MRI) scans—have high up-front costs for purchase and installation.<sup>179</sup> Although it is medical providers rather than insurance companies who are responsible for the up-front costs, those costs translate into high per-use costs that *are* submitted to insurance companies. Moreover, using expensive equipment requires additional training, adding to the cost of providing good medicine. Overall, training the medical profession has become increasingly expensive as education has improved and expanded over time. In other words, providing good medicine—particularly in an industrialized society with highly trained practitioners—is an expensive endeavor. Although it may sometimes be true that the cheapest treatment is also the best way to promote health in the population, the opposite is often the case. Therefore, the goal of an insurance company (i.e. to make profit) works at cross-purposes to the goal of providing good medicine.

Although there have been isolated efforts to force insurance companies to change their policies regarding coverage of expensive services, those efforts fail to address the underlying structural flaw of relying on profit-based organizations to deliver access to unprofitable services.<sup>180</sup> Denying coverage for health benefits results in economic barriers to access by making needed services too expensive for patients to afford. It also creates problems in quality,

<sup>178</sup> Steven D. Pearson, *Patient Reports of Coverage Denial: Association With Ratings of Health Plan Quality and Trust in Physician*, 9 AM. J. MANAGED CARE 238, 238 (2003).

<sup>179</sup> These costs are estimated to be approximately \$2 million. Leigh Page, *Should You Add an MRI?*, *Outpatient Surgery Mag.*, Mar. 2005, <http://www.outpatientsurgery.net/2005/03/print&id=4506> (last visited Apr. 23, 2008).

<sup>180</sup> One example of an effort to change insurance company policies comes from a recent arbitration in California that awarded the claimant \$9 million in damages when her insurance company dropped her in the midst of chemotherapy treatments for breast cancer. The company's policy (which it has announced it will change) rewarded employees for denying insurance coverage to their insured or for meeting cancellation quotas. Lisa Girion, *Insurer loses, alters course, A woman with cancer whose policy was canceled is awarded millions*, L.A. TIMES, Feb. 23, 2008 at 1.

since medical decisions are being made on the basis of cost instead of on the basis of what is medically appropriate in a given situation.

Relying extensively on the private sector to provide access to health care does not have to threaten the right to health; it just happens to do so in the United States. Other countries use private health insurance as part of their healthcare delivery and do not have the widespread systemic violations to the right to health that exist in the United States. For example, the United Kingdom and the Netherlands utilize both public and private health insurance. In the U.K., private insurance provides a niche-oriented supplement to publicly provided coverage.<sup>181</sup> In the Netherlands, the wealthiest third or so of society is responsible for paying for most of its own health care, with public funds covering the rest.<sup>182</sup> Yet according to the World Health Organization, both the U.K. and the Netherlands have significantly more equitable health systems than the United States<sup>183</sup> and both meet the majority their obligations associated with the human right to health.<sup>184</sup> From a rights-based perspective, what matters is the structure of the relationship between public and private provision of health care, not simply the existence of one or the other.<sup>185</sup>

The private health industry in the United States currently operates in such a manner as to constitute a threat to the right to health. The widespread and systematic threat continues to cause the arbitrary deprivation of life, and the United States is legally

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<sup>181</sup> Carolyn Hughes Tuohy et al., *How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Nations*, 29 J. HEALTH POL. POL'Y & L., 359, 362 (2004).

<sup>182</sup> *Id.* at 364; Carmalt et al., *supra* note 1, at 10.

<sup>183</sup> The U.K. and the Netherlands ranked 8-11 and 20-22, respectively, in terms of fairness of financial contribution to health systems, as compared to a ranking of 54-55 for the United States. WORLD HEALTH REPORT 2000, *supra* note 3, at 148-49, 188-89.

<sup>184</sup> In reviewing the practices of the U.K. and the Netherlands in terms of their obligations under the ICESCR, the CESCR has made recommendations for improving the right to health, such as shortening waiting times for receipt of health services. However, the Committee has also noted positive aspects, such as the adoption of national standards of care. Moreover, it has refrained from additional recommendations needed to bring the states in line with their ICESCR obligations under article 12, which implies that the states are mostly meeting their obligations under the Covenant. CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: United Kingdom of Great Britain and Northern Ireland*, 17th Sess., para. 15, U.N. Doc. E/C.12/1/Add.19 (1997); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: United Kingdom of Great Britain and Northern Ireland, The Crown Dependencies and the Overseas Dependent Territories*, 28th Sess., para. 7, U.N. Doc. E/C.12/1/Add.79 (2002); CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: The Netherlands*, 37th Sess., para. 30, U.N. Doc. E/C.12/NLD/CO/3 (2006).

<sup>185</sup> Tuohy et al., *supra* note 181, at 360.

obligated to protect that right by its ratification of the ICCPR.<sup>186</sup> Even where individual violations of the right to health fall short of threatening life, however, it is in the best interests of the United States to address the structural reasons behind systemic violations. To do otherwise risks continuing the status quo, which sees increasing numbers of Americans unable to access quality health care, goods, and services.

#### IV. FAILING TO FULFILL THE RIGHT TO HEALTH: REFORM MEASURES THAT MAKE THINGS WORSE

The obligations to respect and protect are complimented by a third level of governmental responsibility under human rights law: the obligation to fulfill. The United States has an obligation to fulfill the right to health because doing so contributes to the prevention of arbitrary deprivation of life, in accordance with its obligations under the ICCPR.<sup>187</sup> Moreover, because the U.S. signed the ICESCR, it is prohibited from taking actions that would defeat the object and purpose of that treaty, such as introducing structural changes that make it unlikely or impossible for the state to meet its article 12 obligations in the future.<sup>188</sup> Therefore, the United States should take a rights-based approach to healthcare reform and regulation so that it does not deepen structural flaws that jeopardize future adherence to the right to health.

According to the CESCRC, the obligation to fulfill the right to health “requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.”<sup>189</sup> Those measures should be designed to implement the right to health, and they should not only include the provision of health care, but should also include “equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions.”<sup>190</sup> Violations of the obligation to fulfill the right to health include, *inter alia*, the failure to “adopt or implement a national health policy designed to ensure the right to health for everyone.”<sup>191</sup>

Although the U.S. relies extensively on the private sector to

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<sup>186</sup> ICCPR, *supra* note 14, art. 6(1). *See supra* Part I(B)(i).

<sup>187</sup> *Id.*

<sup>188</sup> ICESCR, *supra* note 12, art.12. *See supra* Part I(B)(iii).

<sup>189</sup> CESCRC General Comment 14, *supra* note 12, para. 33.

<sup>190</sup> *Id.* at para. 36.

<sup>191</sup> *Id.* at para. 52.

provide access to health goods and services in this country, it does not rely exclusively on market mechanisms to govern private sector activities.<sup>192</sup> Instead, the U.S. has an extensive set of laws and regulations that apply to private delivery of health care, goods, and services. Some of these laws relate to the way the health industry operates. For example, the Employment Retirement Income Security Act (“ERISA”) preemption provision is a federal statute that basically prohibits individuals from suing their managed care organizations.<sup>193</sup> Other laws address specific bits and pieces of health-care delivery, such as the requirement that managed care organizations approve hospital stays for mothers who have just given birth.<sup>194</sup> Despite these federal attempts to regulate the health system, the United States fails to recognize the right to health at the national level. It is the only industrialized country to do so, and the Supreme Court has declared it unnecessary for Congress to fund even constitutionally protected health services.<sup>195</sup> The failure to use a rights-based approach means that federal efforts remain fragmented or superficial at best, and harmful to health at worst.

This lack of recognition of the right to health has meant that the U.S. does not take a rights-based approach to reforms. For example, the 2003 Medicare Prescription Drug, Improvement, and

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<sup>192</sup> Some commentators suggest that the market flaws that currently exist in health care access and delivery result from too much government intervention (i.e. tax code provisions that result in employer-based care), which prevents a system where consumers could make the lowest cost choice. See, e.g., CATO HANDBOOK ON POLICY 74 (6th ed. 2005). However, that argument only addresses the problem of an *expensive* system, not the problem of a system that fails to promote the health of the population as a whole. Since good care is often *expensive* care, promoting the lowest-cost choice does not necessarily correlate to promoting the best choice for health. Moreover, it would still be the case that some people are simply not profitable to insure. In addition, the market model does not account for the fact that individuals have no choice about whether or not they need health care; unlike other types of insurance (e.g. property insurance), the “consumer” has no option of simply forgoing the benefits offered by the insurance. The result is (a) an inequitable bargaining position for individuals needing access to health care, and (b) increased reliance on emergency services for non-emergency treatment. Therefore, even with a direct relationship between individuals and private health insurers, there would still be little or no market incentive for health insurance providers to compete in terms of providing better services.

<sup>193</sup> 29 U.S.C. § 1144(a). ERISA preempts state-based causes of action against applicable employee benefit plans. The purpose of ERISA is to allow broad removal to federal court to ensure a uniform regulatory regime over employee benefit plans. *AETNA Health Inc. v. Davila*, 542 U.S. 200, 208 (2004).

<sup>194</sup> Newborns’ and Mothers’ Health Protection Act Of 1996, 42 U.S.C. § 300gg-4 (1996).

<sup>195</sup> *Maher v. Roe*, 432 U.S. 464, 469 (1977); Carmalt et al., *supra* note 60, at 9.



Modernization Act (“MMA”) introduced a complex set of structural changes to the Medicare and Medicaid programs.<sup>196</sup> These include an increased role for private pharmaceutical companies in the provision of prescription drugs to Medicare and Medicaid recipients, thus expanding the reliance on private industry to develop and provide needed drugs. However, the market incentives of the pharmaceutical industry do not promote the highest attainable standard for health for all. Since these companies must make a profit, they have an incentive to research and develop new drugs that will be profitable. Drugs are designed and targeted not at the populations that most need relief, but at the populations with the most capital, which results in the majority of research investment going to “me-too drugs” instead of research for new therapies.<sup>197</sup> Therefore, the most vulnerable populations are least likely to receive the treatment they need.

This is not only a violation of the right to health *right now*; it also sets in place a system that will *continue* to violate the right to health into the future. This system discourages research and development in areas of medicine needed by the most vulnerable populations. In this way, the structural flaws of U.S. health care that violate the right to health undermines the *future* ability of the United States to promote the right to health.<sup>198</sup> Although the U.S. has not ratified the ICESCR, its signature alone obligates it to refrain from activities that would defeat the object and purpose of the treaty. Structural change to health care in the United States is needed so that it will be possible for the U.S. to fulfill its obligations under the Covenant if and when it chooses to ratify it.

By framing issues in terms of how to expand the existing system instead of reframing them according to the goal of promoting an overall right to health, discussions about health care reform gloss over important underlying issues that result in barriers to

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<sup>196</sup> Pub. L. No. 108-173, § 641, 117 Stat. 2066. The MMA introduced two large changes: first, it created a separate set of plans that only cover prescription drugs; and second, it provided for a substantial increase for the participation of private health care providers to participate in the Medicare system. See Carmalt et al., *supra* note 60, at 11.

<sup>197</sup> Michael S. Wilkes and Jerome R. Hoffman, *The Truth About the Drug Companies: How they Deceive Us, and What to Do About It; On the Take: How Medicine's Complicity With Big Business Can Endanger Your Health* 293(24) JAMA 3107, 3107 (2005) (book review); see also Marcia Angell, *The Truth About the Drug Companies*, 45 JURIMETRICS J. 465, 467 (2005).

<sup>198</sup> The same analysis applies to *proposed* reforms, meaning that proposals involving structural reform should not maintain or introduce structural flaws that undermine the future ability of the United States to promote the right to health.

health care. For example, the debate over whether individuals should be required to purchase health insurance policies makes the crucial assumption that having an insurance policy will result in having access to health services. However, as discussed above, holding a health insurance policy is not enough to guarantee access to health services.<sup>199</sup> Moreover, expanding the pool of people who hold insurance policies does little to address issues like racial disparities, uneven quality of care, or the incentives to companies to deny coverage and benefits. In other words, since reform proposals do not begin with the goal of promoting an overall right to health, they do not end up promoting the highest attainable standard of health for everyone. Instead, the entrenched politics of health care reform continue to govern national debates. By failing to reshape its discussions from a rights-based perspective, the United States fails to fulfill the international human right to health.

#### CONCLUSION

The United States has large numbers of residents who currently lack access to available, acceptable, and quality health care.<sup>200</sup> The problems plaguing U.S. health care do not result from a failure to spend money on the problem. Indeed, the United States spends more per capita on health care than any other country on earth.<sup>201</sup> Despite all this spending, however, the U.S. has millions of people without access to health care and growing numbers without access to health goods and services, in large part because of structural flaws with the current way in which health care is or-

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<sup>199</sup> See *supra* Part II(B); see also ABC/KFF/USA Survey, *supra* note 6 ch.3; Schoen et al., *supra* note 2.

<sup>200</sup> See Carmalt et al., *supra* note 60.

<sup>201</sup> Gerard F. Anderson et. al., *It's the Prices, Stupid: Why the United States is so Different from Other Countries*, 22 HEALTH AFFAIRS 89, 90-91 (2003) ("The U.S. level [of per capita health spending] was 44 percent higher than Switzerland's, the country with the next-highest expenditure per capita . . .").

Switzerland also relies extensively on private health insurance. The CESCR has criticized Switzerland for the high costs of its health services, which are detrimental to the standards of living for both workers and pensioners. CESCR, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Switzerland*, CESCR, 19th Sess., para. 24, U.N. Doc. E/C.12/1/Add.30 (1998). Switzerland's health system also has relatively high levels of inequity, ranking 38-40 on the World Health Organization's evaluation of fairness of financial contribution to health systems, as compared to neighboring France (ranking 26-29) and Germany (ranking 6-7). The World Health Organization measures the equity of health systems in terms of the health financing contribution of a household, which is defined as "as the ratio of total household spending on health to its permanent income above subsistence." WORLD HEALTH REPORT 2000, *supra* note 3, at 148-88 (2000).

ganized. Compounding the lack of economic access are the lack of available services for minorities and rural populations, disproportionately low minority representation in the health workforce that results in culturally unacceptable care, and uneven quality of care across the population.<sup>202</sup>

International human rights law begins with the premise that healthcare systems should be structured to promote the highest attainable standard of health for everyone. This presents a different approach to thinking about the U.S. approach to health care: instead of asking how low-income families can best afford health insurance, human rights law asks how insurance can best provide health coverage to low-income families. By reversing the question, a rights-based approach avoids common assumptions like the idea that providing insurance results in access to health goods and services. It also reshapes deeply politicized discussions about the role of government in providing health care.<sup>203</sup> Under a human rights approach, the role of the government is to protect and ensure the availability, accessibility, acceptability, and quality of health facilities, goods, and services. Whether government provides health services directly, relies on the market for such services, or uses a combination of both is only relevant insofar as it affects the ability of people to have the highest attainable standard of health.

Although the United States is not a party to the ICESCR, it is nonetheless legally required to uphold the right to health insofar as that right is part of its ICCPR article 6 obligations. In addition, as a party to the ICERD, the U.S. is legally required by international law to recognize and address the existing *de facto* segregation of its healthcare system. Finally, the fact the U.S. has signed the ICESCR means that it is legally required to refrain from defeating that treaty's object and purpose. Taken together, these obligations mean that the United States has some legal duty to respect, protect, and fulfill the right to health. However, even beyond any legal obligation, it is in the country's best interest to reform health care from a rights-based perspective. To do otherwise risks continuing the downward spiral of inequitable coverage and prohibitive costs by reinforcing existing structural flaws. The United States should use the human right to health to rethink its approach to health care and to reform its system to promote the highest attainable standard of health for everyone.

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<sup>202</sup> Carmalt et al., *supra* note 60.

<sup>203</sup> Yamin, *supra* note 62, at 1158 (2005) (discussing the ways in which framing health as a right can shift the contours of debates about the role of state and market).

