Entrenched Inequity: Health Care in the United States of America

Jean Connolly Carmalt, University of Washington - Seattle Campus
Sarah Zaidi, Lahore University of Management Sciences
Alicia Ely Yamin
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HEALTH CARE IN THE UNITED STATES OF AMERICA

Jean Connolly Carmalt, Sarah Zaidi, Alicia Ely Yamin

1 This article is substantially adapted from a report published by the Center for Economic and Social Rights: The Right to Health in The United States of America: What Does it Mean? (2004), www.cesr.org.
2 Jean Connolly Carmalt is the former Legal Coordinator for the Center for Economic and Social Rights. She is currently a PhD. candidate in Geography at the University of Washington.
3 Sarah Zaidi is the former Research Director and Co-founder of the Center for Economic and Social Rights. She is currently an Associate Professor in the Department of Social Sciences at the Lahore University of Management Sciences.
4 Alicia Ely Yamin is the 2007-09 Joseph H. Flom Fellow on Global Health and Human Rights at Harvard Law School and an Instructor at the Harvard School of Public Health. Her contribution to this article was made possible by the Joseph H. Flom Global Health and Human Rights Initiative. Yamin is also on the Board of the Center for Economic and Social Rights.
Abstract

This article analyzes the U.S. system for delivering health services in terms of the international human rights standards that apply to the human right to health. To that end, the article evaluates whether the health care system provides available, accessible, acceptable, and quality health goods and services. It finds that the United States fails to provide available care because services are insufficient in quantity and not located in reasonable proximity to all communities; that it fails to provide accessible care because of financial barriers to access and overly complicated requirements for access; that it fails to provide acceptable care because of the failure to maintain cultural sensitivity; and that it fails to provide quality care because of uneven delivery and systemic safety concerns. The article concludes that in order to meet international standards, the U.S. health care system must provide available and accessible care, and that it must meet standards of cultural sensitivity and quality. Finally, the article argues that health care policy should be focused on the right to health.
INTRODUCTION

In 1941, President Franklin D. Roosevelt proclaimed “freedom from want” to be one of the four essential liberties necessary to achieve human security. The polio-stricken President included in his definition of freedom “the right to adequate medical care and the opportunity to achieve and enjoy good health.” This expansive vision of a right to health, which included both medical care and the preconditions to health, was subsequently incorporated into the Universal Declaration of Human Rights, and has since been enshrined in many international and regional human rights treaties.

Roosevelt’s vision was unfortunately never fulfilled as the United States turned its back on economic and social rights. Health care was commoditized, and for years now, the American health care system has been in a state of ever-deepening crisis. Despite spending far more per capita on health care than any other country, the US continues to have some of the poorest health indicators in the industrialized world. It is the only industrialized nation to deny its citizens universal access to medical services. Fully one third of the population lacks health insurance for at least part of the year. Of the 47 million who are completely uninsured, 73.1% work full- or part-time. Furthermore, the quality of health care for all but the wealthiest patients has declined dramatically, with more people dying each year from avoidable medical mistakes than from car accidents. Add to these problems the lack of services for Americans in rural areas, discrimination in health care provision and outcomes between white people and non-white minorities, and pharmaceutical and insurance costs that are spiraling out of control, and it is clear the US health care system is in a profound predicament.

Current discussions regarding health care reform in the United States tend to focus on how to contain cost growth and excessive expenditures while improving quality of care. There is no shortage of ideas on how to fix the US health care system, with proposals ranging from single payer national health insurance to increased reliance on health savings accounts and other market-based solutions. Many of the proposals for reform

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5 For more on the evolution of economic and social rights in the United States from Franklin D. Roosevelt’s time to the present, see Cass R. Sunstein, The Second Bill of Rights: FDR’s Unfinished Revolution and Why We Need It More Than Ever (2004).
6 The four freedoms include freedom of speech, freedom of religion, freedom from want, and freedom from fear. 87 Cong. Rec. 45 (1941). Roosevelt’s “Second Bill of Rights” also included the right to work, the right to earn enough for adequate food, clothing, and recreation, the right of farmers and businessmen to fair business practices, markets, and trade, the right to housing, the right to economic security, and the right to education. From the January 11, 1944, message to Congress on the State of the Union, The Public Papers and Addresses of Franklin D. Roosevelt v. 13: 1944-45, 41 (1938-50).
9 Institute of Medicine, To Err is Human: Building a Safer Health System (2000) [hereinafter To Err is Human].
claim to be “consumer-driven” models, allowing health care consumers to extract greater value from the system, and much research has been devoted to applying cost effectiveness analysis to a broad spectrum of health care services. Much of health law scholarship has been devoted to addressing how to reconcile the information, agency and incentive problems in the health care domain with a regime that still principally allocates health care through market mechanisms.

By contrast, an approach to health care reform rooted in human rights begins with different foundational premises. In a human rights framework, health claims—claims of entitlement to health care and enabling conditions—are reconceptualized as “assets of citizenship.” The health care system, in this view, is construed as far more than just a delivery mechanism for services and products to consumers. Rather, under human rights law, the health care system is viewed as a site through which to exercise citizenship. It is a core social system, more akin to the justice system than, for example, to the post office which provides a service and competes with any number of private providers. As such, the health system both reflects and contributes to the quality of democracy in a country. In the United States, the fragmented, disparate, market-driven, commoditized pieces of health care reflect and contribute to entrenched inequities in American society.

This chapter gives substance to President Roosevelt’s vision by using international human rights principles as a framework for health care reform in the US. Posing the familiar problems with the US health care system as matters of fundamental rights opens a space for new solutions to problems that currently result in certain people and social groups being systematically harmed by the government’s inaction, as well as by its failure to regulate others’ actions. International human rights norms provide standards by which to evaluate a government’s conduct and can be used to articulate demands for accountability. Acknowledging a right to health can shift policy debates from a narrow focus on “efficiency” (which itself can be a spurious notion when many costs—e.g. the loss of productivity due to employee health problems—are externalized) to questions of how to guarantee people an effective voice in policy and programming decisions that affect their well-being.

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Traditional approaches to human rights violations have often focused on legislative reform. Yet social movements, such as the civil rights movement in the United States in the 1960s and human rights movements in numerous countries, have also been effective at mobilizing grassroots political support for substantial policy as well as legislative changes. The US health care system has reached a point where critical and dramatic action is needed, which in turn requires the kind of popular support created by a rights-based campaign. Even in a culture profoundly unused to invoking rights claims relating to social programs, during the debates over Congressional reauthorization of the State Children’s Health Insurance Program (SCHIP) in the fall of 2007, public rhetoric turned to claims of children’s fundamental rights. International law offers a framework to promote transformational changes to the system, which would restore a right to health to its proper place at the center of health care legislation, policies, and practice.

Such a campaign will undoubtedly be an uphill battle. Not only do special interests, ranging from insurance companies to the organized medical profession to “Big Pharma,” exercise inordinate influence over political debates relating to health care reform, but the United States government has historically resisted guarantees of social and economic rights. For example, the US government has refused to ratify international and regional legal instruments containing social rights guarantees. Despite President Roosevelt’s articulation of a Second Bill of Rights and his leadership in establishing an international system with the United Nations at its center, the US has a poor record of implementing international human rights standards on the domestic level. Moreover, the legacy of Cold War propaganda persists as an obstacle to health care reform, as corporations and conservative pundits continue to suggest that greater government involvement in the financing and oversight of health care would constitute “socialized medicine,” – a term which apparently continues to have talismanic powers in US social discourse to conjure deep-seated fear and aversion.

The chapter is divided into four parts. Part One examines the legal framework governing the right to health, with a focus on health care, in the United States. Part Two discusses the structure of the current US health care system and its impact on health care delivery. Part Three examines how the US system measures up to international human rights standards. Finally, Part Four presents the chapter’s conclusions with respect to what needs to be done to align the US health care system with international standards.


I. THE LEGAL FRAMEWORK FOR THE RIGHT TO HEALTH

The right to health is enshrined in international legal instruments, many of which were
drafted with US leadership. Among the most important are the Universal Declaration of
Human Rights (UDHR)\(^\text{15}\) and the International Covenant on Economic, Social, and
Cultural Rights (ICESCR).\(^\text{16}\) As is the case with civil and political rights (the right to a
fair trial, for example), a government’s responsibilities to ensure that its population enjoy
the right to health is equally about process and outcome. These responsibilities include
access to trained medical personnel, the availability of affordable and acceptable drugs
and health services, and the assurance that care is of adequate quality. While the
government must work to promote health within the limits of its resources, it cannot be
held responsible for ensuring any particular individual’s health \textit{per se}, unless their health
problems stem directly from discrimination or other human rights violations. \textit{The right to
health is not equivalent to a guarantee that one will actually be healthy.}

A focus on health \textit{care} leaves aside many of the salient issues concerning the right to
health and its implementation at the national level.\(^\text{17}\) For example, the right to health
requires not only that certain minimum standards of care be met or exceeded, but basic
preconditions to health also be met, including adequate shelter, food, and sanitation.\(^\text{18}\)
Also, a right to health requires that people be safeguarded from health threats such as
water and air pollution, as well as workplace hazards.\(^\text{19}\) It is worth noting that United
States law does contain substantial legislation relating to the regulation of environmental
exposures, as well as occupational and safety risks, and—although enforcement has
become increasingly deficient in recent years—institutions do exist to monitor
compliance with environmental and labor standards.\(^\text{20}\)

\(^{15}\) Universal Declaration of Human Rights, G.A. res. 217A (III), UN Doc A/810 (1948) [hereinafter
“UDHR”]. Although the UDHR is a General Assembly declaration instead of a treaty, it may be legally
binding on the US as either customary international law or as authoritative interpretation of the UN Charter.
See \textsc{Henry J. Steiner \\& Philip Alston, International Human Rights in Context: Law, Politics,
Morals} 143 (2000).

\(^{16}\) ICESCR, supra note 12. The US signed the ICESCR on October 5, 1977, but it has not yet been ratified,
which is required to make it legally binding. However, the US signature indicates its support of the
ICESCR provisions, and makes its terms politically binding. In addition, the US is part of an international
system that views right to health as an essential human right, including the World Health Organization
Charter, the Conventions Nos. 102 and 103 of the International Labor Organization, and Rules 22 to 26 of
the Standard Minimum Rules for the Treatment of Prisoners.

\(^{17}\) For a discussion of how and why the right to health should be framed in terms of power alignments and
the ability to control one’s own health, see Alicia Ely Yamin, \textit{Defining Questions: Situating Issues of
Power in the Formulation of a Right to Health under International Law}, 18 \textsc{Human Rights Quarterly}

\(^{18}\) UN Committee on Economic, Social and Cultural Rights [hereinafter “CESCR”], \textit{General Comment 14,
The Right to the Highest Attainable Standard of Health}, CESC, 22nd Sess., para. 4, UN Doc.

\(^{19}\) ICESCR, supra note 12, at art. 12. \textit{Also see Bright Toebes, The Right to Health as a Human Right
in International Law} (1998) [hereinafter Toebes].

\(^{20}\) The Environmental Protection Agency, the Occupational Safety and Health Administration, and the Food
and Drug Administration are three central institutions engaged in monitoring environmental, occupational,
and food safety standards, respectively.
A. THE RIGHT TO HEALTH IN THE UDHR AND ICESCR

The Universal Declaration of Human Rights (UDHR) was one of the first great achievements of the United Nations (UN). Its preamble includes the “four freedoms” enumerated in Franklin D. Roosevelt’s famous speech to the US Congress, and its adoption marked the first time that international law protected the individual rights of citizens within their own countries. Eleanor Roosevelt, elected to serve as head of the UN Human Rights Commission, led the drafting discussions of the UDHR. Her influence is clear throughout the text of both the UDHR and its two implementing Covenants. The UDHR’s provision on the right to health is complemented by the provision in the ICESCR, which is meant to elaborate on the term’s meaning.

Under international law, the fallacious distinction between positive and negative rights has been discarded for a focus on the three dimensions of state obligations flowing from all rights, whether civil and political or economic and social. Governments are obliged to respect, protect and fulfill the rights in treaties they ratify. In relation to health, these obligations imply the following:

Respect. A government must refrain from directly infringing upon the right to health, as it would by cutting funding for doctors working in underserved areas or systematically discriminating against certain populations in its health care system, for example.

Protect. A government is responsible for preventing third parties from violating the right to health. Eviscerating environmental regulations arguably violates the right to health, as does allowing price gouging by oligopolistic pharmaceutical companies.

Fulfill. A government must take steps to ensure all citizens have access to basic health services as well as preconditions for health, such as sanitation and clean water.

21 UDHR, supra note 15, at preamble, ¶ 2 (“the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people”).
23 Together, the Covenants and the UDHR constitute the International Bill of Human Rights.
24 UDHR, supra note 15, article 25(1) reads: “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.” For a discussion on how article 25 was formulated, see Toebes, supra note 19, at 36-40. Initially the right was proposed as “access to medical care,” but that was considered insufficient since it left out public health measures. It is clear from the drafting discussion that a right to medical care is essential to the provision.
25 ICESCR, supra note 12, article 12 reads: “1. The States Parties to the present Covenant recognize the right 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.”
The ICESCR sets out the core provision relating to the right to health under international law. However, the provisions of the treaty are quite broad. While they recognize the right of everyone to enjoy “the highest attainable standard” of physical and mental health, they do not offer a recipe for implementation, nor do they take a position on the respective desirability of public or private financing for health care.

The UN Committee on Economic, Social, and Cultural Rights (CESCR), the primary body responsible for interpreting the ICESCR, has however developed guidelines on how the right to health should be interpreted at the national level. The first fundamental component of those guidelines is a minimum floor below which no country may fall; in the case of health, this means ensuring essential primary health care for the entire population. In its General Comment No. 3, the CESCR clarified steps that should be taken by governments regardless of their “economic and political systems.” In General Comment No. 14, the Committee enumerated four substantive interrelated elements which are essential to the right to health: availability, accessibility, acceptability, and quality.

B. Substantive Elements Required to Fulfill the Right to Health

Availability. Governments must ensure that health care is available to all sectors of the population. This requires that “functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity.” It also means that the facilities that exist have to be capable of actually providing care. Basic determinants of health must be present, such as potable water, adequate sanitation, trained medical personnel who receive domestically competitive salaries, and essential medicines. According to the World Health Organization, basic health care also requires universally available immunizations and education about how to prevent and control

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26 This phrasing, similar to the constitution of the World Health Organization, was based on a suggestion from the United States delegation. The right to health is also recognized in regional instruments including the American Declaration on the Rights and Duties of Man (article 33), the European Social Charter (article 11), and the African Charter on Human and Peoples’ Rights (article 16), and in other international treaties such as the Convention on the Rights of the Child (articles 23 and 24), Convention on the Elimination of Discrimination Against Women (articles 10(a), 11(f), 12, and 14(b)), and International Convention on the Elimination of All Forms of Racial Discrimination, U.N.G.A. res. 2106 (XX) art. 5(e)(iv) (1965) [hereinafter ICERD].

27 The guidelines appear in the CESCR’s General Comment 14, supra note 18. General Comments originated in the third session of the Committee and are prepared to assist the State Parties in interpreting and fulfilling their obligations.

28 CESCR General Comment No. 3, The Nature of State Parties’ Obligations, 5th Sess., ¶ 8, UN Doc. E/1991/93 (1990). (“…in terms of political and economic systems the Covenant is neutral and its principals cannot accurately be described as being predicated exclusively upon the need for, or the desirability of, a socialist or a capitalist system, or a mixed, centrally planned, or laissez-faire economy, or upon any other particular approach.”)

29 CESCR General Comment 14, supra note 18, at ¶¶ 9, 12. There is overlap between these categories, but we have chosen to use a narrow definition of each. For example, we restrict “availability” to geographical availability and focus “accessibility” on economic accessibility.

30 Id.
prevailing health problems in the community. In the United States, although there are a substantial number of medical facilities and personnel, these are concentrated in urban and white areas, while rural and minority areas often have insufficient services.

**Accessibility.** Health facilities, goods, and services must not only be available, but must also be accessible. Accessibility requires that basic health care services must be affordable for every person in society, and “poorer households should not be disproportionately burdened with health expenses as compared to richer households.” Access to information about health—including access to information about sexual health—is required. In the US, the approximately 47 million people without health insurance, together with substantial bureaucratic, financial and sometimes cultural and linguistic barriers to obtaining care, reflect failures of accessibility.

**Acceptability.** Under international law, acceptable health care is that which both meets ethical standards and is culturally appropriate. This requires binding ethical guidelines for doctors and other medical practitioners. If medical personnel do not speak the same language as their patients, an interpreter should be available. In addition, acceptable health care requires that ethical and cultural training be part of a medical education. In the US, disadvantaged minorities typically receive poorer health care than white people, at least in part because there are disproportionately low numbers of minority caregivers, as well as because of unequal treatment of patients based on their race.

**Quality.** The state must ensure that health facilities, goods, and services are scientifically and medically sound. Quality requires skilled medical personnel that prescribe medicines and medical procedures appropriately. Health facilities must be adequately supplied with, among other things, scientifically approved and unexpired medicines and hospital equipment, adequate sanitation, and skilled medical personnel. Although some very high-quality health care is available in the US for the wealthy, studies indicate inconsistent levels of quality throughout the overall health care system, and alarming numbers of avoidable errors.

**C. PROCEDURAL PROTECTIONS RELATING TO THE RIGHT TO HEALTH**

A number of procedural protections complement the four substantive requirements listed above. The primary procedural protections include non-retrogression, non-discrimination, participation, access to remedies, and information.

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32 GRANT MAKERS IN HEALTH, TRAINING THE HEALTH WORKFORCE OF TOMORROW, ISSUE BRIEF NO. 12 2 (2002) [hereinafter Training the Health Workforce of Tomorrow].
33 CESCR General Comment 14, supra note 18, at ¶ 12.
34 BRIAN D. SMEDLEY ET. AL. (EDS.), UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE (2003) [hereinafter Unequal Treatment].
35 CESCR General Comment 14, supra note 18, at ¶ 12.
36 INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 13 (2001) [hereinafter Crossing the Quality Chasm].
Non-retrogression. Once a right to health is recognized, retrogression—or backsliding—is generally considered inconsistent with a country’s obligations and a government bears the burden of demonstrating that such retrogression was unavoidable and was as narrowly tailored in its effects and duration as possible.

Non-discrimination. Any sort of discrimination—whether on an individual level or system-wide—is a human rights violation. CESCR General Comment No. 14 explicitly prohibits discrimination on the basis of 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 orientation and civil, political, social or other status.\(^{37}\)

Remedy. When violations of the right to health occur, states must provide remedies. Remedies may redress individual abuses by providing civil or criminal penalties, or they may seek to correct system-wide violations by introducing changes in policy or governing legislation.

Participation. States must ensure that patients are fully able to participate in decisions regarding their own health on both an individual and a collective level. For example, patients should not be excluded from treatment decisions due to insurance company policies. Further, decisions regarding health policy and coverage should be made on the basis of a participatory, public, and transparent process.

Information. States are required to ensure that their population receives adequate information and education about medical practices and services (including those related to sexual and reproductive health).\(^{38}\) The procedural requirement for information overlaps with the substantive requirement of accessibility because information is a prerequisite to accessing care. It is also a prerequisite to effective participation.

The emphasis on process in a human rights framework shows that the right to health goes beyond the latest drugs, sterile needles, or any particular service. Rather than implementing piecemeal fixes to discrete problems in the delivery of health care apparatus, the government’s obligation to respect, protect, and fulfill the right to health demands that policymakers approach health care reform with a view towards promoting improved health care as a dimension of social justice in the United States.

**THE CURRENT US SYSTEM**

The United States is the only industrialized country that does not recognize a government’s obligations to provide health care. In 1977, the Supreme Court went so far as to declare it unnecessary for Congress to require government funds for abortion

\(^{37}\) CESCR General Comment 14, *supra* note 18, at ¶ 18.

\(^{38}\) *Id.*, at ¶ 11 (“The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending… [to] access to health-related education and information, including on sexual and reproductive health.”)
services, even when the right to such services was constitutionally protected. At the federal level, the closest Americans have come to securing their right to health are programs like Medicare and Medicaid, which are rooted in the idea that the elderly and poor should be guaranteed a minimum level of health services. The State Children’s Health Insurance Program (SCHIP), which like Medicaid provides federal funds to states to administer, was enacted in 1997 to expand insurance coverage to families with incomes within a certain percentage above the poverty line. Important as these programs are, the exclusivity of their premise contradicts the notion of a universal right to health elaborated under international law.

There is also a very limited right to emergency care in the United States at the federal level. In 1986, Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to supersede disparate and sometimes conflicting common law precedents regarding rights of access to emergency services. Section 1867 of the Social Security Act establishes that all Medicare-participating hospitals that offer emergency services—i.e., virtually all hospitals in the United States—must provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of the person’s ability to pay. If an emergency medical condition is detected, the hospitals are further required to provide stabilizing treatment for the patient but are not required to do any more.

In the US federalist system, much of the operationalization of the few health care entitlements that exist occurs at the state level. There is considerable variation among states both in law and practice, which is another factor that breeds inequity from the standpoint of international human rights law. Furthermore, even the strongest legal provisions, such as Article 17 in the New York State Constitution, regard provisions of services as attending to the concerns of the “needy,” rather than fully recognizing access to health services as a basic right and a prerequisite to human dignity. In many cases, therefore, as currently framed, even essential services and limited benefits can be taken away when the legislature so determines, which is inconsistent with a rights-based view of durable entitlements that are not subject to retrogression.

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40 Under international human rights law, even in a federalist system, the federal government is ultimately responsible for ensuring respect, protection, and fulfillment of certain minimum guarantees within its territory.
41 N.Y. CONST., art. XVII (“The aid, care and support of the needy are public concerns and shall be provided by the state…”). New York’s provision is one of the strongest because it specifies within article 17 that the “protection and promotion of the health of the inhabitants of the state are matters of public concern” Art. XVII §3. Some state provisions—including those from Alaska and Hawaii—do actually require the legislature (in Alaska) or the state (in Hawaii) to provide for “public health.” However, their breadth is limited by federal restrictions like ERISA preemption. See the ALASKA CONST. art. VII, § 4 and the HAWAII CONST. art. IX, § 1.
Even though there are recognitions of the special relationship between physician and patient and the failures of the market model with respect to health care, these are treated as exceptions to the default paradigm. American law and policy still generally approach health care as a commodity—either to be doled out to the needy as a matter of charity, or to be regulated through the market. Nonetheless, there have been repeated attempts to establish national health insurance in the United States. In 1915, the American Association for Labor Legislation campaigned for sickness insurance. The campaign lost ground when the American Medical Association (AMA) reversed its position on compulsory health insurance provided through the state. President Truman officially endorsed a national health insurance scheme as proposed by the Wagner-Murray-Dingell bill, but the bill never came to a vote in Congress since it was vigorously opposed by representatives of organized physicians and pharmaceuticals, who classified it as “socialized medicine.” Associations such as the AMA spent more than a quarter of a million dollars in giving out misinformation about the bill and equating it with communism at a time when intense anti-communist suspicion—McCarthyism—was on the rise in the United States.42

Some public funding does exist for certain groups (e.g. those over the age of 65, those poor enough to meet Medicaid criteria or children poor enough to meet SCHIP criteria, and the military), but private financing is meant to cover everyone else.43 Although some other industrialized countries also incorporate private financing, there is typically a governmental safety net that ensures equity and access. In the Netherlands, for example, the wealthiest 36% of the population is responsible for paying for most of its own care, while public funds cover the rest of the population.44 France also has a thriving supplemental insurance market, even though the national health insurance covers the population. The problem with US health care is not the mixture of public and private funding per se, but rather the failure of the government to step in and level the playing field in the face of obvious inequities in the system.

Many current proposals related to health care reform fail to address this underlying problem with the US system. For example, proposals that call for “individual mandates” would require individuals to purchase health insurance in the same way they do auto insurance. From a human rights perspective, health is a right because it is a fundamental, non-optional requirement for human dignity. Driving a car is not. Shifting our society’s responsibility regarding health onto the individual means that existing inequities in our society will likely be once again exaggerated in health provision. Critics of individual mandates, which have been enacted in Massachusetts, have pointed out that the poor will likely have minimum packages of coverage or plans with exceptionally high premiums, while the drivers of inequity in the way medicine is practiced and delivered in this country will be unaffected. Setting aside questions regarding the sustainability of the

43 Private financing can be through employment or personal purchase of health care plans.
financing of these plans, from a rights perspective that emphasizes the importance of health claims as assets of citizenship, this approach is untenable and unjust.

D. THE LEGAL STRUCTURE

Health care in the United States is financed and delivered according to terms set out in a complex array of federal and state laws and regulations, administered through a complex array of federal and state institutions. Laws range from the specific, such as the requirement that managed care organizations approve hospital stays for mothers who have just given birth, to the general, such as the Employment Retirement Income Security Act (ERISA) preemption provision, a federal statute which essentially prohibits individuals from suing their managed care organizations. The legal structure regulating health care is bifurcated into two main branches: laws that regulate government-run programs, such as Medicare, and laws that regulate private sector health care groups, such as managed care organizations (MCOs).

The funding framework for government-administered programs stems from a 1965 amendment to the Social Security Act signed into law by President Lyndon B. Johnson. The amendment was designed to create safety nets for two groups of vulnerable Americans: the elderly and the poor. The elderly (defined as those over the age of 65) are eligible for Medicare, which is financed by federal funds. The poor (defined individually by each state) are eligible for Medicaid, which is financed by a combination of federal and state funds. Federal funds also provide health insurance coverage for the military and for federal employees.

In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) introduced the most sweeping modifications to the Medicare and Medicaid programs since their creation. The MMA includes two significant changes: first, it splits coverage for prescription drugs off from the rest of health care coverage, creating a new group of prescription drug plans to fund those drugs. Second, it provides substantial incentives for private health care providers to enter the Medicare system. Previous attempts by private health plans to enter Medicare had not been profitable, but the MMA

45 42 USCS Sec. 300gg-4 (1996).
46 29 USC. § 1144(a). ERISA is a federal statute that 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 US 200 (2004).
47 There are several kinds of MCOs. Health Maintenance Organizations (HMOs) are probably most the most talked about MCO, but MCOs also include Preferred Provider Organizations and Point of Service Plans. The payment structures and treatment options for these plans vary widely. For more information, see Stacey Duncan-Jackson et al., Institute for Health Care Studies, Michigan State University Understanding Managed Care, (no date), http://www.healthteam.msu.edu/imc/modules/UMC2003/UMC2003.pdf.
48 The current version of Medicare is at 42 USC. 1395 et seq.
49 42 USC. 1396 et seq.
has proven extremely profitable for pharmaceutical companies.\footnote{\citet{Waxman2006}} At the same time, the immense complexity that results from what Paul Krugman terms the plan’s “gratuitous privatization” has resulted in delayed implementation, tremendous overhead costs, and the continuation of a system in which elderly and vulnerable Americans have the poorest health care coverage.\footnote{\citet{Krugman2007}}

Given the MMA’s efforts to involve the private sector in Medicare, the laws governing private sector health care funding are more important than ever. Under President Nixon, the HMO Act (1973) kick-started the managed care industry by requiring all health care providers to accept patients from at least two managed care organizations.\footnote{\citet{Yehezkelevich1975}} The Act was fueled by the concern that physicians had a financial incentive to provide more health services than necessary.\footnote{\citet{Duncan-Jackson2000}} HMOs were seen as a way to curb waste by penalizing doctors for providing unnecessary services. However, despite some success in eliminating waste, and despite the capacity of HMOs to negotiate drug discounts and ensure quality control, in the 1990s the organizations began to come under increasingly heavy criticism for depriving their members of needed treatments in order to save costs, for ignoring unprofitable problems of quality, and for creating burdensome administrative barriers to care.\footnote{\citet{Many2003}}

Some measures have been taken to curb the worst effects of managed care’s cost-cutting in relation to patient care. However, one reason it is difficult to assess the scope of these concerns—or to address them systematically—is that health care is largely regulated through the courts, one case at a time. Litigation-based regulation is not particularly effective for improving HMOs’ responsiveness because the ERISA preemption provision exempts most managed care providers from state-based civil liability, including claims of wrongful death and other traditionally state-regulated torts.\footnote{\citet{DiFelice2003}} Thus, most of the time, individuals cannot sue their HMOs.

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E. THE FINANCIAL STRUCTURE: WHO PAYS? WHO PROFITS?

The United States spends more on health care per person than any other industrialized country. The latest OECD comparison calculated US costs at $6,401 per person, per year. Total health costs continue to increase at approximately 7% per year, with costs projected to increase from $2.17 trillion to $2.88 trillion in 2010. Yet the US has a lower-than-average physician to patient ratio, has one of the lowest rates of acute care beds per capita among industrialized countries, and is the only one that does not provide universal access to medical services. The lack of available care is even more acute for minority patients, and in particular for patients who are black or Hispanic. Where does all that money go, if it is not going to increase access and availability? This is a central question for any rights-based reform to consider and address.

There are many reasons why health care in the US is so expensive, ranging from high administrative costs to exorbitant drug costs, as well as inflated salaries paid to physicians who are far more likely to be specialists—and therefore earning more—than are their counterparts in other industrialized countries. As health care becomes increasingly reliant on high-tech interventions, the Baby Boomer generation grows older, and as the American population grows in size, costs will continue to rise. Health economists have been keen to explore how to contain the growth of these costs through outcomes assessments and examinations of whether certain interventions are medically appropriate.

Less scholarly attention has been devoted to the other manifestations of the failures of a market model: the profits made by health maintenance organizations and pharmaceutical companies, which dwarf those of other industries and suggest significant deadweight loss. For example, in 2001, as the overall profits of Fortune 500 companies declined by 53%, the top 10 US drug makers increased their profits by 33%, from $28 billion to $37 billion. In the first half of 2006, pharmaceutical company profits increased by over $8 billion dollars, due to the introduction of the new Medicare drug program discussed...

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57 Gerard F. Anderson et. al., It’s the Prices, Stupid: Why the United States is so Different from Other Countries, 22 HEALTH AFFAIRS 89 (2003). (“[In 2000] the US level [of per capita health spending] was 44% higher than Switzerland’s, the country with the next highest expenditure per capita.”)
62 For example, the increasing use of MRIs as a diagnostic tool is expensive. We are not suggesting MRIs should not be used, but only that their increased use is part of the reason health care costs continue to rise. Other uses of technology—such as using more email for communication—may help decrease costs, though it is unclear by how much.
63 See e.g. K. Balcker et al., Geographic Variation in the Appropriate Use of Cesarean Delivery: Do Higher Rates Reflect Medically Inappropriate Use of this Procedure? 25 HEALTH AFFAIRS 355 (2006).
above. Managed care organizations have also reported high profit growth, by as much as 73% in the second quarter of 2003 (a $1.8 billion increase over 2002). Lavish salaries accompany these profits. In 2002, William W. McGuire, the Chairman and CEO of UnitedHealth Group, had a reported net worth of nearly $530 million. Meanwhile, HMO premiums for 2004 increased at an average rate of almost 18%, prompting more companies to require their employees to contribute to their health insurance plans.

Wide profit margins for shareholders in managed care organizations, multi-million dollar salaries for pharmaceutical executives, and vast sums spent on industry lobbying represent hundreds of millions of dollars that are leaving the system without advancing research, delivering care, or paying medical providers. Among health care organizations, pharmaceuticals spend the most on lobbying ($96 million in 2000) followed by physicians, and health care organizations. Of the 1,192 organizations involved in health care lobbying, the AMA spent $17 million and the American Hospital Association $10 million. Couple this waste with rising insurance premiums, a growing population, and the growing costs of providing quality care, and one begins to get a sense of why an increasing number of Americans cannot afford access to even basic care.

**INTERNATIONAL STANDARDS IN THE US CONTEXT**

Although the US health care system provides some of the best care in the world for those who can afford to pay, overall the health care system falls far short of international human rights standards. Many of the existing problems in the system will only continue to deteriorate as long as health care is considered primarily a commodity, rather than a basic right. Although the US government is not a party to the ICESCR, this section will examine how the US health care system fares with respect to the four interrelated

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65 Waxman, supra note 51.
67 *Id.*
70 For example, in a study comparing care in Australia, Canada, New Zealand, the United Kingdom, and the United States, the US had the highest survival rates for breast cancer, the lowest waiting times for elective surgery, and the highest likelihood of doctors who would ask for the patient’s opinion and discuss the emotional burden of illness. THE COMMONWEALTH FUND, FIRST REPORT AND RECOMMENDATIONS OF THE COMMONWEALTH FUND’S INTERNATIONAL WORKING GROUP ON QUALITY INDICATORS, vii (2004).
71 The United States government has signed and ratified the following three international human rights treaties: ICERD, *supra* note 26, the International Covenant on Civil and Political Rights, and the Convention Against Torture and Other Cruel and Inhuman or Degrading Treatment or Punishment. In addition, it has signed the following treaties: the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child. *See* http://www.unhchr.ch/.
substantive elements identified by the CESCR as essential to the right to health: availability, accessibility, acceptability, and quality.

F. AVAILABILITY

For health care to be considered “available,” facilities and personnel must exist in sufficient quantity and be located within reasonable proximity to all communities, regardless of their geographic location or racial, ethnic, or cultural makeup. In the United States, health care cannot be considered truly available, given the drastic shortages of care for people living in rural areas and for minorities.

As of 2002, there were approximately 50 million people living in underserved areas in the United States.72 Such shortages persist despite the large numbers of doctors who graduate every year from medical school. Federal policy initiatives have successfully doubled the total number of doctors since 1970, but efforts have been based on the faulty assumption that market demand will even out geographical disparities.73 Instead, the result has been over-saturation of urban markets, and concomitant under-supply in rural and minority-dominated areas. There is a sharp divide between rural and urban areas in their doctor-patient ratios. Cities such as Washington, D.C., Boston, and San Francisco benefit from a ratio as high as one physician per 167 persons,74 while rural areas suffer severe medical service shortages.75 Appalachia, for example, has less than one physician per 1,000 persons.76 The coverage that does exist in rural areas is largely due to training subsidized at the state and federal levels—a fact that underscores the importance of nonprofit (whether governmental or non-governmental) participation in health care delivery.77

Compounding the rural-urban divide is a significant racial gap in the availability of medical services. According to a study published in the New England Journal of Medicine, “communities with high proportions of black and Hispanic residents were four times as likely as others to have a shortage of physicians, regardless of community income.”78 In July 2000, the federal government designated 2,706 geographic areas, population groups, and facilities as “primary medical care health professional shortage” areas. These areas encompass 50 million people, a disproportionate number of whom are minorities.79 Since then, dozens of reports have continued to document the “raw,

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72 Training the Health Workforce of Tomorrow, supra note 32.
73 Id. at 2.
75 Training the Health Workforce of Tomorrow, supra note 32 at 2.
76 Id.
77 See e.g., MONTANA BOARD OF REGENTS OF HIGHER EDUCATION, POLICY AND PROCEDURES MANUAL, POLICY 940.25 RURAL PHYSICIAN INCENTIVE PROGRAM (providing payment of educational debts for physicians practicing in underserved rural areas).
79 Training the Health Workforce of Tomorrow, supra note 32 at 2.
fester wound on America’s social conscience” that is the crisis of minority health care.  

The lack of health care facilities, goods, and services in rural and minority areas in the United States violates the requirement that health care be available. A human rights-based health care policy would entail maintaining training programs and incentives for those seeking to practice in underserved areas, and would focus on ensuring availability for all populations in the United States. This does not mean putting a hospital on every corner, but it does require narrowing the gap in service availability between rural or minority areas and urban or white areas.

G. ACCESSIBILITY

Even when health care is available, it may not be accessible. For example, health care in America is closely linked with holding a full-time job. While those that are unemployed can purchase health insurance, it is often expensive. Even those with health insurance are frequently subject to large co-payments or pharmaceutical bills that preclude true economic access to health care. They also face growing fears of losing their benefits as employer insurance premiums rise. This lack of economic accessibility (affordability) is compounded by a lack of access to information concerning health services and issues and by an increasingly complex series of bureaucratic hurdles to accessing payment exemptions.

From 2002 to 2003, approximately one third of the population lacked health insurance for at least part of the year, and in 2006, 15.8% of the population lacked health insurance for the full year. Health insurance is so prohibitively expensive that going without is not confined to the indigent or to those who are unemployed. Indeed, 73% of the uninsured between 18 and 65 worked for part of the year. In short, for those Americans who cannot afford medical insurance, there is very limited meaningful access to health care.

80 Dorschner, supra note 61; Unequal Treatment, supra note 34.
82 To Err is Human, supra note 9, at 24.
83 FAMILIES USA, ONE IN THREE: NON-ELDERLY AMERICANS WITHOUT HEALTH INSURANCE, 2002-2003 (2004) [hereinafter One in Three]. This includes only those under the age of 65, since that is the population ineligible for Medicare. The numbers vary from state to state; 14 states had more than one out of three uninsured people (Texas was highest, with 43.4% of the population uninsured).
84 Genaro C. Armas, Ranks of Poverty, Uninsured Rose in 2003, ASSOCIATED PRESS, August 26, 2004. (The US Census Bureau reported that nearly 45 million people were uninsured in 2003. This includes only those who were uninsured for the entire year.)
85 Id.
86 Children are particularly vulnerable when they lack health insurance. About 37% of all children under the age of 18 in the United States did not have health insurance for some period during 2002-2003. This number is likely to go up as children are increasingly cut from state-run insurance programs in response to state budget deficits. One in Three, supra note 83, at 7; LEIGHTON KU & SASHI NIMALENDRAN, CENTER ON
The uninsured receive less preventive care, less appropriate care for chronic illnesses, and fewer hospital services when admitted. They are also more likely to die prematurely. Because they do not enjoy the benefit of negotiated discounts or set fee schedules, they also tend to pay more for health services than those with insurance. Ironically, people without insurance pick up a large portion of the nation’s health care tab. In 2001, the uninsured spent $80.1 billion on health care.

Overall, the lowest-income patients and those with chronic health conditions end up carrying the greatest health care burden as a percentage of their family income. The inequity of the US system is reflected in the World Health Organization’s statistical analysis comparing health systems around the world: the US ranks 54th and 55th (tying with Fiji) in terms of the fairness of financial contribution. This situation contravenes human rights principles as set forth in the CESCR’s guideline that “poorer households should not be disproportionately burdened with health expenses as compared to richer households.” Although coverage for the very poorest Americans is offered through Medicaid, this fails to reach millions of Americans who do not qualify as the “poorest” but still have far too little money to afford purchasing their own health insurance and do not have access to it through employment. In addition, many who are eligible for Medicaid do not join because of the program’s administrative burdens and web of complexities.

In addition to issues of financial accessibility and inequity, the US system includes barriers to access because of the way in which it is structured. With federal, state, and private funding sources, hundreds of individual insurance plans to choose from, and different referral procedures for different types of delivery systems, obtaining basic care can become a bureaucratic nightmare for patients. Although a complicated system may deliver adequate health care, the fact is that the current system does not, and part of the reason is its complexity.

BUDGET AND POLICY PRIORITIES, LOSING OUT: STATES ARE CUTTING 1.2 TO 1.6 MILLION LOW-INCOME PEOPLE FROM MEDICAID, SCHIP AND OTHER STATE HEALTH INSURANCE PROGRAMS (2003).
88 Id.
89 Medical Fees are Often Higher for Patients without Insurance, N.Y. TIMES, April 2, 2001. See also Irene Wielawski, Gouging the Medically Uninsured: A Tale of Two Bills, 19 HEALTH AFFAIRS 180 (2000).
91 Id.
92 Fairness of financial contribution is defined by the World Health Organization as starting “with the concept of a household’s contribution to the financing of the health system. The health financing contribution of a household is defined as the ratio of total household spending on health to its permanent income above subsistence.” WORLD HEALTH ORGANIZATION, THE WORLD HEALTH REPORT 2000 - HEALTH SYSTEMS: IMPROVING PERFORMANCE 148 (2000).
93 Hadley & Holahan, supra note 90.
94 INSTITUTE OF MEDICINE, UNINSURANCE FACTS & FIGURES: INCREMENTAL APPROACHES TO EXTEND COVERAGE ARE INSUFFICIENT (no date), http://www.iom.edu/Object.File/Master/17/740/0.pdf ("Complex enrollment and re-enrollment procedures create barriers to participating in public insurance programs.")
The complicated system of billing and payment has become a significant barrier to accessibility. Individuals trying to select an insurance plan face a bewildering array of premiums, co-payments, and services. Wading through all of these “choices”—ostensibly created to increase accessibility—is an overwhelming task. When administrative complexities create barriers to accessibility, inhibit the ability to monitor delivery of health services, and deprive people of having a voice in their own treatment, those complexities become human rights concerns.

H. ACCEPTABILITY

The United States has a strong history of requiring its physicians and other medical personnel to adhere to minimum ethical guidelines. Although there are certainly examples of individual practitioners who may violate these ethical requirements, the vast majority of workers in the health profession uphold high ethical standards.

In addition to being ethically guided, acceptable health care must be culturally sensitive under international law. Unfortunately, the US health care system has not found culturally appropriate care to be as important as ethical care and, as a result, there is a significant gap in the quality of care received by minorities. In 1994, the United Nations Special Rapporteur on Racism found that in the United States “the consequences of racism and racial discrimination in the field of health are reflected in the disparity in access to health care, the infant mortality rates, and the life expectancy of Whites and Blacks or Latino Americans.” More than ten years after his visit, the situation has not improved. It is perhaps not a coincidence that minorities are also more likely to die of cancer and heart disease, less likely to get preventive care and screening, and less likely to receive analgesia in emergency rooms for bone fractures. This is not typically a result of deliberate discrimination on part of medical workers, but instead reflects system-wide inequalities.

In a country where minorities constitute more than one quarter of the population (and are projected to constitute one third by 2010), they still represent less than 10% of the health care workforce. The meager representation of minorities among medical professionals

95 Id. (“Strict eligibility requirements often make public coverage and some private insurance difficult to obtain, including different eligibility rules for members of the same family…complex enrollment and re-enrollment procedures create barriers to participating in public insurance programs.”)
99 Nancy R. Kressin & Laura A. Peterson, Racial Differences in the Use of Invasive Cardiovascular Procedures: Review of the Literature and Prescription for Future Research, 135 ANNALS OF INTERNAL MEDICINE 352 (2001). (Article indicates minority groups in various health care settings are less likely to receive invasive cardiovascular procedures that improve diagnostic precision, delay death, and relieve symptoms for many patients with coronary heart disease.)
100 Unequal Treatment, supra note 34, at 30.
101 Training the Health Workforce of Tomorrow, supra note 32 at 8.
must be addressed by any rights-based evaluation of health care reform. Although the minority health care problem affects each legal requirement for the right to health, it is particularly relevant to the requirement for culturally acceptable care.

The patient-doctor relationship is critical to effective health care delivery, which requires trust between a physician and patient, a certain level of comfort, and uncompromised communication. Research indicates that minority patients have a higher level of comfort when treated by physicians of their own race, and that they are more likely to follow through with necessary treatments and seek preventive care when they are satisfied with their physicians. The reasons vary, and include language barriers and the patient's level of education. For African-Americans, a physician's recommended treatment can be compromised by a “mistrust of health professionals that stems from racial discrimination and the history of segregated and inferior care for minorities.”

According to a 1995 study by the Pew Health Professions Commission, “a substantial body of literature concludes that culturally sensitive care is good care.” To achieve this, the Commission recommended that medical schools both increase the number of minority students and integrate cultural sensitivity training into the basic medical curriculum. Increasing the number of minority students is also shown to increase access to medical services in under-served communities.

Language is another significant barrier to acceptable—and high-quality—care. Among the most important laws currently not being enforced is the Department of Health and Human Services’ regulation requiring all medical facilities that accept federal money to provide adequate translation services for non-English-speaking patients. The law is particularly important for victims of sexual and intimate partner violence, whose medical needs cannot be met without translation that is provided by a non-family member.

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102 Unequal Treatment, supra note 34, at 131.
103 Id., at 131-2.
104 Brief of the Association of American Medical Colleges et al as Amici Curiae in support of the Respondents at 12, Grutter v. Bollinger, No. 02-241 (U.S. Supreme Court 2003).
105 Lisa Cooper-Patrick et al., Race, Gender, and Partnership in the Patient-Physician Relationship, 282 J. OF THE AMERICAN MEDICAL ASSOCIATION 583 (1999).
106 Unequal Treatment. supra note 34, at 131.
108 Id.
109 A number of studies have shown that students from rural or minority communities are significantly more likely to return to those communities to practice medicine. See, e.g. ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC), DIVISION OF COMMUNITY AND MINORITY PROGRAMS, MINORITY STUDENTS IN MEDICAL EDUCATION: FACTS AND FIGURES XII (2002), www.aamc.org/publications.
110 45 CFR 80.3(b)(2) requires all recipients of federal financial assistance to provide meaningful access to persons with limited English language skills.
111 LATINA ALLIANCE AGAINST SEXUAL AGGRESSION, LATINA ALLIANCE AGAINST SEXUAL AGGRESSION, ELIMINATING BARRIERS TO SERVICES FOR LATINA/O SURVIVORS OF SEXUAL AND INTIMATE PARTNER VIOLENCE (2004).
A human rights-based reform to the health care system would require all medical institutions to introduce training in cultural competency for all medical personnel. It would also go further, requiring institutional changes to ensure that minorities have equal access to primary providers who come to know them and can speak their language or have constant access to interpreters, encouraging the training of minority health professionals, and ensuring institutional monitoring and enforcement of racial equality in treatment.

I. QUALITY

The United States boasts some of the best physicians and most state-of-the-art medical technologies and techniques anywhere. Top medical programs with stellar reputations for

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113 The AAMC, which has as members every accredited medical school in the United States, has a program designed to “increase diversity in medical education and advance health care equity in the US.” See www.aamc.org/diversity/initiatives.htm.
114 The project increased minority enrollment to 12.4% of the total between 1990 and 1994—a 34.5% increase. Unequal Treatment, supra note 34, at 121.
115 Id.
116 Grutter v. Bollinger, 529 US 306 (2003) held that affirmative action at Michigan Law School could continue since it was necessary for substantive educational reasons. The AAMC submitted an amicus curiae brief (supra note 86) in the case in favor of keeping member affirmative action plans, and after the case was published, the AAMC put out a statement specifically defining the affirmative action practiced by its member schools as in accordance with the Court’s decision. See http://www.aamc.org/meded/urm/statusofnewdefinition.pdf.
training and research attract students from around the world. However, despite these achievements, the quality of care delivered to patients varies widely, and good quality care is unavailable to vast numbers of Americans.

The Institute of Medicine (IOM) has called attention to the growing safety flaws and quality problems in the US health care system. The IOM has divided these quality problems into three categories: overuse, under-use, and misuse. Overuse occurs when health services are provided even though the potential risks outweigh any potential benefits. For example, one study found that 60% of patients reporting symptoms associated with the common cold filled prescriptions for antibiotics. Under-use stems from lack of insurance and lack of preventive care, including when those who are insured fail to seek treatment for which the potential benefits outweigh potential risks. One example of under-use is that approximately one-quarter of American children have not received appropriate immunizations. Finally, misuse includes errors by medical personnel, which can be difficult to document because instances often go unreported. According to the IOM, “at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors.” This is more than the number of people who die in car accidents every year, and more than those that die from HIV-AIDS.

Poor-quality health care is expensive; unnecessary treatments cost money, correcting mistreatment costs money, and treatments that could have been avoided by earlier care cost money. However, waste and mistreatment are difficult to fix under the current system, in part because payment arrangements are developed by private companies (such as HMOs) whose decisions are based on cost containment or issues of financial access for their members, but necessarily not on larger questions about quality of care. Although health care costs could be reduced by eliminating waste, this process can be expensive in the short term. The problems in quality are largely because of the current system design, and not because individual providers or products are deficient. To improve the quality

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118 For example, for nine of the past ten years there has been at least one American laureate for the Nobel Prize in Physiology or Medicine. See http://nobelprize.org/medicine/.
119 Crossing the Quality Chasm, supra note 36, at 13.
120 The Institute of Medicine was chartered in 1970 as a component of the National Academy of Sciences. See www.iom.edu.
121 Crossing the Quality Chasm, supra note 36.
122 Id., at 23.
123 Id., at 226, 292. The report also lists coronary artery bypass grafts as an example of common overuse of health care that demonstrates poor quality. Id., at 226.
124 Id., at 227.
125 Id., at 250.
126 Id.
127 To Err is Human, supra note 9, at 26.
128 Id.
129 Crossing the Quality Chasm, supra note 36, at 182.
130 INSTITUTE OF MEDICINE, PRIORITY AREAS FOR NATIONAL ACTION: TRANSFORMING HEALTH CARE QUALITY 2 (2003). (“[Poor quality care] is due not to lack of effective treatments, but to inadequate health care delivery systems that fail to implement these treatments.”); World Health Organization, Quality of Care: Patient Safety (March 23, 2002), p. 3. (“Current conceptual thinking on the safety of patients places
of care and meet international standards requires more than technology assessment or outcomes assessment performed by experts; it requires shifting public debates about health care reform in this country.

IV. CONCLUSIONS
The neglect of basic medical services for much of its population and the commoditization of health care belies the United States’ reputation as a leader in the field of health. As the number of uninsured continues to rise, and the cost of health care spirals out of control, it is increasingly urgent to rethink the way the US finances health care and the delivery of services, including essential drugs.

Notwithstanding the fact that the United States is one of the few countries in the world not to have ratified the ICESCR, shifts in Americans’ understanding of constituent rights may usefully be informed not merely by the health care systems of other industrialized countries but also by the principles enunciated in international human rights law. Reforms rooted in these human rights principles can contribute to lasting improvement in the health care situation for the majority of Americans.

A. HEALTH CARE MUST BE UNIVERSALLY AVAILABLE AND ACCESSIBLE
Americans living in rural and predominantly minority-inhabited areas must have access to health care services. Ensuring access means more than simply extending health insurance to the uninsured, however. It also means addressing the growing problem of those with health insurance who still cannot afford adequate medical services. The type of health coverage provided is as important as the number of people enrolled in a program.

Universal access to health services requires a fundamental change in the way the US approaches health care. That is, the default for policymaking about health care allocation cannot be guided by the “invisible hand” of the marketplace. Millions of uninsured and underinsured Americans, minority Americans without access to appropriate services, and rural patients unable to access health care facilities all indicate that market forces simply will not fill the gaps in health care coverage. In all other industrialized nations, there is a starting assumption that the state has a role to play in leveling the playing field and providing a safety net in terms of health care.

\footnote{131 Paul Krugman, America’s Failing Health, N. Y. TIMES, Aug. 27, 2004. (“[R]ising health care costs aren’t just causing a rapid rise in the ranks of the uninsured… they’re also, because of their link to employment, a major reason why this economic recovery has generated fewer jobs than any previous economic expansion.”)}

\footnote{132 Some other countries that have not ratified include: Cuba, Indonesia, Malaysia, Myanmar, Pakistan, Saudia Arabia, and several smaller states of the Pacific. All other industrialized countries have ratified the ICESCR.
The way in which universal coverage is implemented tends to be deeply culturally contingent. For example, Britain has a national health service where the government is responsible for financing and delivery of services while Canada has a single-payer system where the government is only responsible for financing services. Other models use private-public mixtures that still incorporate rights-based principles. In France, for example, national health insurance acts as a branch of Social Security, and all residents have equal access to private or public facilities.\textsuperscript{133} No matter what the financing structure, countries that have successfully implemented universal access to health coverage have in common their refusal to rely solely on market forces to deliver care, and their political commitment to providing universal access as a matter of right.

\textbf{B. \textit{Increase Quality and Diversity, Including Cultural Sensitivity}}

To meet international standards, the federal government must take responsibility for ensuring that health care is of good quality and culturally appropriate. This means enforcing existing regulations, as well as expanding cultural competency training and protections for cultural differences. As much as the US government has historically tended to scoff at international treaty obligations, the fact remains that as a state, party to the International Covenant on the Elimination of all Forms of Racial Discrimination (ICERD),\textsuperscript{134} the United States is legally bound to address the systematic racial discrimination within the US health care system. In fact, the US government has admitted that minorities receive “less adequate access to health insurance and health care,”\textsuperscript{135} and the governing Committee for ICERD has recommended that the United States ensure the right of everyone to access public and private health care.\textsuperscript{136}

Beyond enforcing the laws that already exist, there must also be a commitment to addressing underlying structural factors that increase racial disparities in care, including increasing minority representation within the medical profession and providing funding for medical personnel who are minorities or who wish to practice in underserved minority areas. Cultural competency training should be made an integrated part of training for all physicians and other health professionals. Further, such programs need to be accompanied by institutional change that facilitates greater access to care for minorities.

The parallel and inferior health care system encountered by many minorities is inconsistent with a universal right to available, accessible, appropriate, and quality care. It is also inconsistent with US commitments to prevent contemporary forms of racial discrimination. The piecemeal laws created to provide greater access for minority patients are an important step in the process of recognizing the depth of these issues. A more integral, human rights-based perspective would require placing race disparities in health

\textsuperscript{133} For more information on the French health care system, see \texttt{http://www.info-france-usa.org/atoz/health.asp.}

\textsuperscript{134} ICERD, supra note 26.


care in their larger social context and using internationally agreed-upon criteria to evaluate proposed policy solutions.

C. HEALTH CARE POLICY NEEDS TO BE ABOUT THE RIGHT TO HEALTH

Americans pay more per capita for health care than the population of any other country in the world, and receive far less for the money. Under the current system, a tremendous amount of that money goes towards private-sector profits rather than building new rural care facilities, providing wider coverage, or implementing new quality control measures. Rights-based reform does not dictate financing mechanisms—any mixture of private and public funding may fail or meet human rights standards—but it does require that all Americans enjoy the minimum standards of availability, accessibility, acceptability, and quality when it comes to their health care.

All Americans should have access to basic health care as a matter of right. Although many initiatives have been proposed for health care reform, including universal health insurance, a campaign based on the right to health steps back from questions about how to most efficiently reorganize the financing of the health care system to the underlying purpose of the health care system. The international norms are then able to provide standards by which to evaluate competing proposals. Framing debates about health care reform as a matter of fundamental rights underscores that people must have a voice in the decisions that affect their well-being, and thus demands a participatory process for reform where those who are affected have the opportunity for genuine consultation.

Embracing Roosevelt’s dictum that “freedom is no half-and-half affair” would return the human being to the center of health care legislation, policies, and practices. It was the active support of the civil rights community that enabled one of the most important strides towards improving the national health care system—the enactment of Medicare as part of Lyndon Johnson’s “war on poverty.” The widespread grassroots outreach of civil rights activists of the 1960s, with the support of large unions like the AFL-CIO, lent credibility to the reform and gave it more emotional and social relevance. Like the civil rights movement, the human rights movement can provide a universal and populist language to the cause of health care reform. The time has come for the US to fully recognize the universality of all human rights, and to join others in implementing a health care system that fulfils Franklin D. Roosevelt’s vision.