# RECOGNITION OF THE INTERNATIONAL HUMAN RIGHT TO HEALTH AND HEALTH CARE IN THE UNITED STATES

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## I. INTRODUCTION

Nearly sixty years ago, the United Nations adopted the Universal Declaration of Human Rights (UDHR).[1] This charter document, adopted by the United Nations in the wake of World War II and its incredible atrocities,[2] is the foundational document of human rights for the world. This declaration is extraordinary. It recognizes an international consensus of one incredible idea—that all individuals on Earth have an array of inalienable rights for the protection and advancement of their lives by virtue of their status as human beings. As human beings, they are entitled to these rights irrespective of their specific status as to gender, religion, race, ethnicity, or national origin, which have justified disparate treatment of human beings in all societies since the inception of humankind.

This declaration states the promise of human rights in its first sentence: "Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world."[3] The UDHR then charges all people and organs of society to "strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance."[4] Next, the UDHR proceeds to outline specific human rights in thirty

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1. Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 10, 1948) [hereinafter UDHR].

2. *See generally* MARY ANN GLENDON, A WORLD MADE NEW: ELEANOR ROOSEVELT AND THE UNIVERSAL DECLARATION OF HUMAN RIGHTS (2001); JOHANNES MORSINK, THE UNIVERSAL DECLARATION OF HUMAN RIGHTS: ORIGINS, DRAFTING, AND INTENT (1999).

3. UDHR, *supra* note 1, pmbl.

4. *Id.*

articles.[5] These human rights range from civil and political rights, to economic, social, and cultural rights, to economic security, education, and health care.

This Article traces the recognition and implementation of the international human right to health in the United States.[6] First, it traces the record of the United States in the ratification of human rights treaties of the United Nations and the Organization of American States. Then, it describes the implementation of the human right to health at the federal, state, and local levels, as well as deficiencies in the U.S. health care sector that compromise implementation of the human right to health. The Article then compares the United States with other nations in the implementation of the human right to health.

The Article recognizes the extraordinarily difficult philosophical and economic issues associated with defining the international human right to health and the management of its implementation. Accordingly, the Article addresses these issues by pointing out the difficulties and referring to scholarship that analyzes these issues more comprehensively. Given the focus of the Article on practical implementation, the Article assumes that the international human right to health does exist as a coherent legal and moral principle and constitutes an appropriate contribution to the advancement of humankind. This Article also assumes that the human right to health means a right to the health care services and public health protections that facilitate the enjoyment of good health to the extent possible given specific and independent processes within human beings. This Article assumes that, while appreciating the analytic difficulties of economic human rights like the right to health, a world without international economic, social, and cultural rights would be a pessimistic world.

This Article closes with recommendations for how the United States might complete full realization of the international human right to health. With the end of the Cold War and the globalization of the planet, opportunities for realization of human rights have arguably increased. The United States should be a leader in the full realization of the international human right to health. United States leadership in this effort is sorely needed—not only for progress

5. UDHR, *supra* note 1.

6. In 2001, I published an article that was basically a summary of a lecture that I had given on the occasion of my becoming the Samuel R. Rosen Professor of Law. *See* Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457 (2001). This Article marks the beginning of my work on the international human right to health. In the present Article, I flesh out in much greater detail the ideas for implementing the international human right to health in the United States.

within the United States, but also for progress in countries throughout the world. Realization of the international human right to health can fundamentally change the dynamics and politics of health policymaking on a national and international level and ultimately promote the advancement of humankind.

## II. INTERNATIONAL TREATIES ON THE INTERNATIONAL HUMAN RIGHT TO HEALTH

The major sources of legal authority for the international human right to health are international and regional treaties. International and regional treaties define the content of the international human right to health and also impose on national governments—signatories of the international and regional treaties—the duties to assure health care services and promote and protect the health of its population. Figure 1 presents the important international and regional treaties to which the United States could become a party, which recognize the international human right to health and specify its content.[7]

Figure 1
SIGNATURE AND RATIFICATION OF MAJOR INTERNATIONAL HUMAN RIGHTS INSTRUMENTS BY THE UNITED STATES

| Instrument | Signature | Ratification |
|---|---|---|
| **United Nations** | | |
| U.N. Declaration of Human Rights (Not a Treaty) | Yes | N/A |
| Constitution of the World Health Organization | Yes | Yes |
| International Covenant for Civil and Political Rights (ICCPR) | Yes | Yes (June 8, 1992) |
| International Covenant for Economic, Social and Cultural Rights (ICESCR) | Yes (Oct. 5, 1977) | No |
| International Convention on the Elimination of All Forms of Racial Discrimination | Yes | Yes (Oct. 21, 1994) |
| Convention on the Elimination of All Forms of Discrimination Against Women | Yes (July 17, 1980) | No |
| Convention on the Rights of the Child | Yes (Feb. 16, 1995) | No |

7. Kinney, *supra* note 6, at 1463.

| **Organization of American States** | | |
|---|---|---|
| American Declaration of the Rights and Duties of Man (Not a Treaty) | Yes | N/A |
| American Convention on Human Rights ("Pact of San José, Costa Rica") (1969) | Yes<br>June 1, 1977 | No |
| Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador") (art. 10) (1988) | No | No |

### *A. International Treaties of the United Nations*

The United Nations has been the leader in the development of international human rights law.[8] The major U.N. treaties on the right to health are described below and presented in Figure 1.

#### 1. Constitution of the World Health Organization

The United Nations established the World Health Organization (WHO) in April 1948.[9] Defining "health" broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity,"[10] the WHO Constitution goes on to state that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[11]

#### 2. The Universal Declaration of Human Rights

In December 1948, the U.N. adopted the UDHR, which included a right to health and health care as a recognized international human right.[12] Article 25 of the UDHR articulated the human right to health differently than the WHO Constitution.[13] Specifically, Article 25 of the declaration states: "Everyone has the right to a standard of living adequate for the health and well-being of himself

8. *See generally* DAVID P. FORSYTHE, THE INTERNATIONALIZATION OF HUMAN RIGHTS 55-86 (1991).

9. *See* History of WHO, http://www.who.int/about/history/en/index.html (last visited Feb. 25, 2008).

10. Constitution of the World Health Organization, pmbl., July 22, 1946, 62 Stat. 6349, 14 U.N.T.S. 185, *reprinted in* 15 DEP'T ST. BULL. 211 (Aug. 4, 1946).

11. *Id.*

12. *See* UDHR, *supra* note 1, art. 25.

13. *See id.*

and of his family, including . . . medical care . . . and the right to security in the event of . . . sickness [and/or] disability . . . ."[14]

As a declaration, the UDHR does not impose specific obligations on state parties. Subsequently, the United Nations adopted two covenants to implement the UDHR: the International Covenant on Civil and Political Rights (ICCPR)[15] and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[16] Collectively, these instruments are known as the International Bill of Human Rights.[17]

### 3. The International Covenant on Economic, Social and Cultural Rights (ICESCR)

The ICESCR is the major U.N. treaty recognizing the international human right to health.[18] The U.N. General Assembly adopted the covenant on December 16, 1966.[19] The covenant entered into force on January 3, 1976 with the ratification or accession of thirty-five nations.[20] The United Nations proceeded with ICESCR as a separate covenant for economic, social, and cultural rights because of real concerns that little progress had been made to alleviate poverty in the world since the inception of the United Nations.[21]

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14. *Id.*

15. International Covenant on Civil and Political Rights, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976) [hereinafter ICCPR].

16. International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976) [hereinafter ICESCR].

17. MATTHEW C. R. CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS: A PERSPECTIVE ON ITS DEVELOPMENT 1 (1995). *See generally The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, U.N. Doc. E/CN.4/1987/17, *reprinted in* Symposium, *The Implementation of the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 122 (1987).

18. *See generally* CRAVEN, *supra* note 17; Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties' Obligations Under the International Covenant on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 156 (1987).

19. ICCPR, *supra* note 15.

20. ICESCR, *supra* note 16, art. 27.

21. The U.N. Web site states:

> Despite significant progress since the establishment of the United Nations in addressing problems of human deprivation, well over 1 billion people live in circumstances of extreme poverty, homelessness, hunger and malnutrition, unemployment, illiteracy and chronic ill health. More than 1.5 billion people lack access to clean drinking-water and sanitation: some 500 million children don't have access to even primary education; and more than one billion adults cannot read and write. This massive scale of marginalization, in spite of continued global economic growth and development, raises serious questions, not only in relation to development, but also in relation to basic human rights.

According to Article 12 of ICESCR, the right to health includes "the enjoyment of the highest attainable standard of physical and mental health."[22] Article 12 requires that all state parties "recognize [this] right of everyone."[23]

Since ICESCR went into effect in the 1970s, international policymakers and scholars have analyzed how ICESCR can be implemented effectively.[24] An important milestone in this evolution is the enunciation of the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights by the U.N. Economic, Social and Cultural Committee—the treaty body responsible for implementing and monitoring ICESCR—in 1987.[25] In addition to articulating the status of economic, social, and cultural rights as equal to political and civil rights and indispensable to the realization of these later rights,[26] the Limburg Principles also articulated the meaning of the statement in ICESCR, Article 2(1) on the obligation to take steps toward "full realization of the rights" contained in the Covenant.[27] Specifically, the Limburg Principles state that "[l]egislative measures alone are not sufficient to fulfill the obligations of the Covenant"[28] and that "[s]tates parties shall provide for effective remedies including, where appropriate, judicial remedies."[29]

The U.N. Economic, Social and Cultural Committee more recently published a General Comment 14 to ICESCR that outlines the content to the international right to health and its

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International Covenant on Economic, Social and Cultural Rights: Objectives, http://untreaty.un.org/English/millennium/law/iv-3.htm (last visited Feb. 28, 2008).

22. ICESCR, *supra* note 16, art. 12.

23. *Id.* Article 12 then enumerates several steps to be taken for "full realization" of this right. These steps include:

> (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.

*Id.*

24. *See, e.g.*, Aart Hendriks, *The Right to Health in National and International Jurisprudence*, 5 EUR. J. OF HEALTH L. 389 (1998); Phillip Alston, *Out of the Abyss: The Challenges Confronting the New U.N. Committee on Economic, Social and Cultural Rights*, 9 HUM. RTS. Q. 332 (1987); Alston & Quinn, *supra* note 18.

25. *The Limburg Principles*, *supra* note 17; *see* Hendriks, *supra* note 24, at 393.

26. *The Limburg Principles*, *supra* note 17, at 123-25.

27. ICESCR, *supra* note 16, art. 2(1).

28. *The Limburg Principles*, *supra* note 17, at 125.

29. *Id.*

implementation and enforcement.[30] Building on the typology of the content of social human rights developed by Asbjørn Eide in 1987,[31] General Comment 14 imposes three types or levels of obligations: the obligations to respect, protect, and fulfill. The obligation to respect requires states parties to refrain from interfering directly or indirectly with the enjoyment of the right to health.[32] The obligation to protect requires states parties to take measures that prevent third parties from interfering with Article 12 guarantees.[33] The obligation to fulfill requires states parties to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward the full realization of the right to health. [34]

General Comment 14 clearly addresses implementation. It imposes a duty on states parties "to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health."[35] Implementation also requires adoption of "a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks."[36] The national health strategy should also "identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources."[37] The national health strategy and plan of action should "be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health."[38]

There are also remedies if states parties do not fulfill the international human right to health. General Comment 14 explicitly provides that a state party "which is unwilling to use the maximum

30. U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights*, General Comment 14, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter ICESCR General Comment 14].

31. *See generally* Asbjørn Eide, *Economic, Social and Cultural Rights as Human Rights*, *in* ECONOMIC, SOCIAL AND CULTURAL RIGHTS 21 (Asbjørn Eide, Catarina Krause & Allan Rosas eds., 1995); Hendriks, *supra* note 24.

32. ICESCR General Comment 14, *supra* note 30, ¶ 33.

33. *Id.*

34. *Id.*

35. *Id.* ¶ 53.

36. *Id.*

37. *Id.*

38. *Id.* ¶ 55.

of its available resources for the realization of the right to health is in violation of its obligations under Article 12" and places the burden on the state party to justify that it has made use of "all available resources at its disposal" to satisfy its obligations regarding the right to health.[39] General Comment 14 also specifies violations of the Article 12, including "[s]tate actions, policies or laws that contravene the standards set out in [A]rticle 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality."[40] Violations of the obligation to protect include "the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties."[41] Violations of the obligation to fulfill include "failure of States parties to take all necessary steps to ensure the realization of the right to health."[42]

General Comment 14 accords remedies to individual parties. Specifically, any person or group that is the victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. "All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health."[43]

4. Other U.N. Treaties

A human right to health is also recognized in numerous other U.N. international human rights treaties that address the needs of historically vulnerable populations who have often been the subject of discrimination. Such treaties include the International Convention on the Elimination of All Forms of Racial Discrimination,[44] the Convention on the Elimination of All Forms of Discrimination against Women,[45] and the Convention on the Rights of the Child.[46]

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39. *Id.* ¶ 47.

40. *Id.* ¶ 50.

41. *Id.* ¶ 51.

42. *Id.* ¶ 52.

43. *Id.* ¶ 59.

44. International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195 (entered into force Jan. 4, 1969). *See generally* Egon Schwelb, *The International Convention on the Elimination of All Forms of Racial Discrimination,* 15 INT'L & COMP. L.Q. 996 (1966).

45. Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Mar. 1, 1980, 1249 U.N.T.S. 13 (entered into force Sept. 3, 1981).

All of these treaties specify rights to health for the respective groups in two respects. First, each prohibits discrimination in the provision of health care services. Second, they often state affirmative rights to particular types of health care services of special importance to the relevant population, such as the obstetrical and gynecological services for women.[47]

With respect to the Convention on the Elimination of All Forms of Discrimination against Women, the treaty language is quite specific about the guarantee of access to family planning and other reproductive health services for women.[48] In addition, the U.N. Committee on International Economic, Social and Cultural Rights has published a general comment specifying in great detail the nature of reproductive rights under this treaty.[49]

The Convention on the Rights of the Child is the most extensive in terms of provisions for child health care.[50] Specifically, states parties must recognize "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" and that states parties shall "strive to ensure that no child is deprived of his or her right of access to such health care services."[51] Care should include comprehensive preventive and health education services, "pre-natal and post-natal health care for mothers," and family planning education and services.[52] Further, states parties must take measures to abolish "traditional practices prejudicial to the health of children."[53] Finally, Article 23 establishes rights for the access to special care services for disabled children, including health care and

46. Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3(entered into force Sept. 2, 1990). *See generally* Susan Kilbourne, *U.S. Failure to Ratify the U.N. Convention on the Rights of the Child: Playing Politics with Children's Rights*, 6 TRANSNAT'L L. & CONTEMP. PROBS. 437 (1996); Alison Dundes Renteln, *Who's Afraid of the CRC: Objections to the Convention on the Rights of the Child*, 3 ILSA J. INT'L & COMP. L. 629 (1997).

47. Convention on the Elimination of all Forms of Discrimination Against Women, *supra* note 45, art. 12 ("States parties shall ensure to women appropriate services in connexion with pregnancy . . . and the post-natal period . . . as well as adequate nutrition during pregnancy and lactation.").

48. U.N. Econ. & Soc. Council, Comm. on the Elimination of Discrimination Against Women, *Report of the Committee on the Elimination of Discrimination Against Women*, General Recommendation 24, ¶ 1, U.N. Doc. A/54/38/Rev.1 (Feb. 5, 1999) ("reproductive health . . . is a basic right").

49. *Id.*

50. *See* Convention on the Rights of the Child, *supra* note 46.

51. *Id.* art. 24.1.

52. *Id.* art. 24.2.

53. *Id.* art. 24.3.

other services free of charge, to preclude financial barriers to these services.[54]

### *B. Regional Treaties of the Organization of American States*

In addition, the inter-American system for the protection of human rights of the Organization of American States (OAS) applies to the United States. This system is based primarily on the OAS American Declaration of the Rights and Duties of Man[55] and the OAS American Convention on Human Rights.[56] Specifically, Article 11 of the American Declaration of the Rights and Duties of Man states: "Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources."[57]

The more recent Protocol of San Salvador specifies a human right to health in its interpretation of the OAS Convention on Human Rights.[58] The Protocol of San Salvador contains a similar, but not identical, specification of the basic content of the right to health as Article 12 of ICESCR. Article 10 of the protocol states that: "Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being."[59] To "ensure the exercise of the right to health," the protocol states parties must adopt specific measures, such as primary health care, preventive measures, and health education.[60]

### *C. United States Action on International Human Rights Instruments*

Formal U.S. recognition of the international human right to health, particularly with respect to ratification of relevant international and regional treaties, has been limited. While a leader

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54. *Id.* art. 23.

55. American Declaration of the Rights and Duties of Man, O.A.S. res. XXX (1948), *reprinted in* ORGANIZATION OF AMERICAN STATES, BASIC DOCUMENTS PERTAINING TO HUMAN RIGHTS IN THE INTER-AMERICAN SYSTEM 17-24 (1988).

56. Organization of American States, American Convention on Human Rights, Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123, *reprinted in* ORGANIZATION OF AMERICAN STATES, *supra* note 55, at 25-54.

57. American Declaration of the Rights and Duties of Man, *supra* note 55, art. 11.

58. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, art. 10, Nov. 14, 1988, O.A.S. T.S. 69, *reprinted in* THE INTER-AMERICAN SYSTEM OF HUMAN RIGHTS 497-505 (David J. Harris & Stephen Livingstone eds., 1998) [hereinafter Protocol of San Salvador]; *see also* SCOTT DAVIDSON, THE INTER-AMERICAN HUMAN RIGHTS SYSTEM 33 (1997).

59. Protocol of San Salvador, *supra* note 58, art. 10.

60. *Id.*

of the development of the UDHR in the 1940s, the United States backed away from leadership in the realization of human rights generally.[61] Implementation of this remarkable declaration was quickly caught up in the ugly politics of the Cold War[62] and, in the United States, the even uglier racial politics that enabled egregious human rights violations against African Americans.[63] The United States could not realistically recognize international human rights until it aligned federal and state law with dismantling of racial segregation and discrimination.[64] Further, the United States was reluctant to embrace economic rights because of a perceived socialist connection that was not consistent with American foreign policy.[65] At the same time, the United States did not follow other western democracies that were establishing universal health coverage for their populations after World War II.[66]

1. The Great Depression and World War II

The origin of the idea of a right to health and health care took shape in the United States with the administration of President Franklin Delano Roosevelt.[67] Two events precipitated the development of this idea in the United States—the Great Depression of the 1930s and the battle against fascism in World War II.[68]

To address the consequences of the Great Depression, President Roosevelt and Congress enacted the Social Security Act of 1935 to provide social insurance and welfare benefits for vulnerable groups in the population.[69] In this legislation, the federal government took affirmative steps to guarantee the economic security of the U.S. population and effectively launched its modern welfare state. Although the Social Security Act of 1935 did not include health insurance, later congresses amended it to add limited medical

61. *See* FORSYTHE, *supra* note 8, at 121-27.

62. *Id.* at 122-27.

63. *See* Robert Traer, *U.S. Ratification of the International Covenant on Economic, Social and Cultural Rights*, *in* PROMISES TO KEEP: PROSPECTS FOR HUMAN RIGHTS 1, 3-5 (Charles S. McCoy ed., 2002).

64. *See id.*

65. *See id.* at 4.

66. *See* Daniel Callahan, *What is the Reasonable Demand on Health Care Resources? Designing a Basic Package of Benefits*, 8 J. CONTEMP. HEALTH L. & POL'Y 1, 3 (1992).

67. *See* 90 CONG. REC. 1, 55, 57 (1944) [hereinafter Roosevelt's Message].

68. *See id.* at 55-57.

69. Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620 (codified as amended at 42 U.S.C. §§ 301-302 (2006)).

assistance as a welfare benefit for the poor in 1960[70] and the Medicare and Medicaid programs in 1965.[71]

During his famous wartime state of the union address, President Roosevelt articulated four fundamental freedoms that all persons of the world deserved, including freedom from want and freedom from fear.[72] In his 1944 inaugural address, President Roosevelt called for recognition of a "second Bill of Rights" that espoused economic security and prosperity for all.[73] In his proposed second Bill of Rights, Roosevelt included the right to a decent job, home, education, and free market, as well as protection from the risks of age, sickness, accident, or unemployment.[74] Roosevelt's second Bill of Rights expressly included the "right to adequate medical care and the opportunity to achieve and enjoy good health."[75]

2. The Postwar Period

Later, the United States was at the forefront in the development and approval of the UDHR.[76] Eleanor Roosevelt, the widow of President Roosevelt, served on the newly formed U.N. Human Rights Commission and was elected its chair.[77] Despite the impending Cold War and the emerging tensions between East and West, Eleanor Roosevelt and the commission successfully drafted the extraordinary UDHR—a declaration of rights that drew upon global philosophical thought for content and authority.[78] With full support from the United States, the U.N. General Assembly adopted the document and thereby laid a firm foundation for international human rights law.[79]

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70. Social Security Amendments of 1960, Pub. L. No. 86-778, 74 Stat. 924, 987 (codified as amended at 42 U.S.C. § 301 (2006)).

71. Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 291 (codified as amended at 42 U.S.C. § 1395 (2006)) (Medicare); *id.* § 121(a), 79 Stat. 343 (codified as amended at 42 U.S.C. § 1396 (2006)) (Medicaid).

72. *See* Press Conference of Franklin D. Roosevelt (July 15, 1940), *in* THE PUBLIC PAPERS AND ADDRESSES OF FRANKLIN D. ROOSEVELT: WAR AND AID TO DEMOCRACIES, 1940-1941, at 284-85 (Samuel I. Rosenman ed., 1940); *see also* Roosevelt's Message, *supra* note 67, at 57 (referring to expanding set of basic rights for Americans, including the right to protection from economic fears associated with aging, health, and subsistence); CRAVEN, *supra* note 17, at 8 n.16.

73. Roosevelt's Message, *supra* note 67, at 57.

74. *Id.*

75. *Id.*

76. *See* GLENDON, *supra* note 2, at 4-5.

77. *See id.* at 33.

78. *See* UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO), HUMAN RIGHTS: COMMENTS AND INTERPRETATIONS (1973) (reporting the philosophical underpinnings for human rights in world thought). *See generally* GLENDON, *supra* note 2, at 73-78 (discussing how the UNESCO philosophers' committee analyzed human rights using diverse religious and political approaches).

79. *See* GLENDON, *supra* note 2, at 169-71.

However, even as the U.N. General Assembly was considering the UDHR, the Berlin airlift was underway and the Cold War had begun.[80]

But more disturbing than the spread of Communism as a barrier to the recognition of human rights was the United States' internal politics of race.[81] Mindful of the implications of the UDHR for domestic law, the United States Senate—in the early 1950s—considered a constitutional amendment that would have required a treaty to be implemented by separate federal legislation.[82] This campaign was an effort to ensure that international human rights treaties could not be used to promote civil rights for African Americans or otherwise supersede states' rights.[83] Also during the 1950s, the Eisenhower administration withdrew from leadership in U.N. human rights activities since the Senate was reluctant to ratify international human rights treaties.[84]

Regarding ratification of ICESCR, and even ICCPR, the United States was slow. In 1978, President Carter sent the two treaties to the Senate for ratification, stating that two covenants were "based upon the Universal Declaration of Human Rights, in whose conception, formulation and adoption the United States played a central role."[85] In 1992, at President George H.W. Bush's request, the Senate ratified ICCPR with extensive reservations, understandings, and declarations.[86] However, during the Bush and Reagan administrations, the official policy of the Department of State was that economic rights were not human rights, and no effort was made

80. *See id.* at 163.

81. *See* Traer, *supra* note 63, at 3.

82. Louis Henkin, *Editorial Comments—U.S. Ratification of Human Rights Conventions: The Ghost of Senator Bricker*, 89 AM. J. INT'L L. 341, 347 (1995); *see also* Traer, *supra* note 63, at 4.

83. *See* Traer, *supra* note 63, at 3-4.

84. *See* FORSYTHE, *supra* note 8, at 122-24.

85. President's Message to Congress Transmitting Four Treaties Pertaining to Human Rights, S. Exec. Docs. C, D, E and F, 95th Cong., 2d Sess., at III (1978); *see also* Jimmy Carter, *The American Road to a Human Rights Policy*, *in* REALIZING HUMAN RIGHTS: MOVING FROM INSPIRATION TO IMPACT 49, 53-56 (Samantha Power & Graham Allison eds., 2000).

86. 138 CONG. REC. S4781-84 (daily ed. Apr. 2, 1992); *White House Statement on Signing the International Covenant on Civil and Political Rights*, 29 WEEKLY COMP. PRES. DOC. 1008 (June 5, 1992)*; see* S. COMM. ON FOREIGN RELATIONS, INTERNATIONAL COVENANT ON CIVIL AND POLICY RIGHTS, S. EXEC. REP. NO. 102-23 (1992), *as reprinted in* 31 I.L.M. 645 (1992); *see also* David P. Stewart, *United States Ratification of the Covenant on Civil and Political Rights: The Significance of the Reservations, Understandings, and Declarations*, 42 DEPAUL L. REV. 1183, 1183-85 (1993).

to ratify ICESCR.[87] President Clinton took a different position and urged the Senate to ratify ICESCR.[88] However, to date, the United States has not ratified ICESCR.

## III. UNITED STATES CONSTITUTIONAL AND LEGISLATIVE RECOGNITION OF THE HUMAN RIGHT TO HEALTH

The United States has established a considerable legal infrastructure that effectively recognizes the human right to health for some groups under specified circumstances.[89] This section reviews this legal infrastructure. This section also reviews the actual progress in fulfilling the right to health in the United States even though it has not formally ratified international treaties recognizing the international human right to health and is not likely to do so in the foreseeable future.

### *A. The United States' Debate over the Human Right to Health*

Since the enactment of the Social Security Act of 1935,[90] there has been an ongoing debate over whether the federal government should sponsor national health insurance legislation. In 1935, Congress considered, but did not enact, national health insurance legislation.[91] President Harry S. Truman repeatedly called for national health insurance, and Congress considered several bills for national health insurance during his term.[92] In 1965, Congress enacted the Medicare and Medicaid programs for the aged, disabled, and some poor.[93] Subsequently, Presidents Nixon and Carter both proposed national health insurance plans.[94] Calls for national health insurance waned in the late 1970s, as a vigorous debate emerged

87. *See* PAULA DOBRIANSKY, U.S. DEP'T OF STATE, CURRENT POLICY NO. 1091, U.S. HUMAN RIGHTS POLICY: AN OVERVIEW 1 (1988); *see also* Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1, 8-10 (1994).

88. *See* Andrew Reding, *Counterpoint: Clinton is Right on International Human Rights,* WALL ST. J., July 15, 1993, at A13.

89. *See* Social Security Act of 1935, Pub. L. No. 74-271, 49 Stat. 620 (codified as amended at 42 U.S.C. §§ 301-302 (2006)).

90. *Id.*

91. *See* Edgar Sydenstricker, *Public Health Provisions of the Social Security Act*, 3 LAW & CONTEMP. PROBS. 263, 263-64 (1936).

92. *See* U.S. Dep't of Health & Human Servs., History of Medicare and Medicaid, http://www.cms.hhs.gov/history (last visited Jan. 12, 2008).

93. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 291 (codified as amended at 42 U.S.C. § 1395 (2006)); *id.* § 121(a), 79 Stat. 343 (codified as amended at 42 U.S.C. § 1396 (2006)).

94. *See* SUBCOMM. ON HEALTH OF THE H. COMM. ON WAYS AND MEANS, 94TH CONG., NATIONAL HEALTH INSURANCE RESOURCE BOOK 457 (Comm. Print 1976). *See generally* KAREN DAVIS, NATIONAL HEALTH INSURANCE: BENEFITS, COSTS, AND CONSEQUENCES (1975).

between the proponents of federally sponsored health insurance and those feeling that access to health coverage should be accomplished through the private market or a combination of public and private sources.[95]

Proposals for federally sponsored health coverage resurfaced in the early 1990s in the context of President Clinton's health reform initiative aimed at guaranteeing health coverage for all Americans.[96] The Clinton initiative sought to establish universal coverage with managed competition among integrated delivery networks under a regulatory framework that would assure quality and control costs.[97] The proposed legislation gave great attention to the procedural protections for health care consumers.[98]

Following congressional rejection of the Clinton health reform initiative in 1994, the American health care sector moved rapidly toward prepaid managed care independent of protective regulation.[99] Consequently, concerns about the protection of patients with regard to their rights vis-à-vis health plans took on greater urgency.[100] States enacted, and the federal government considered, legislation to protect the rights of patients in HMOs and managed care plans, and to address problems with access to private health insurance, which covered the greatest proportion of the insured United States population.[101] In the mid-1990s, Congress considered multiple patient protection bills, but none passed.[102]

Since the inauguration of Medicare and Medicaid, there has been a vigorous philosophical debate in the United States about whether there is a right to health and health care as a moral or philosophical

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95. *See* AM. ENTERPRISE INST. FOR PUB. POL'Y RES., NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER (Mark V. Pauly ed., 1980); *see also* ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 70 (1980).

96. *See President Clinton's Remarks on Presenting Proposed Health Care Reform Legislation to the Congress*, 2 PUB. PAPERS 1830, 1831 (Oct. 27, 1993) [hereinafter *Clinton's Remarks*].

97. *See* Eleanor D. Kinney, *Protecting Consumers and Providers Under Health Reform: An Overview of the Major Administrative Law Issues*, 5 HEALTH MATRIX 83, 83-86 (1995).

98. *See* Health Security Act, H.R. 3600, 103d Cong. §§ 5201-5243 (1st Sess. 1994).

99. *See* Mark A. Hall, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 247 (1997).

100. *See* ELEANOR D. KINNEY, PROTECTING AMERICAN HEALTH CARE CONSUMERS chs. 1-2 (2002).

101. *See* JILL A. MARSTELLER & RANDALL R. BOVBJERG, FEDERALISM AND PATIENT PROTECTION: CHANGING ROLES FOR STATE AND FEDERAL GOVERNMENT (1999); Frank A. Sloan & Mark A. Hall, *Market Failures and the Evolution of State Regulation of Managed Care*, LAW & CONTEMP. PROBS, Autumn 2002, at 169.

102. *See, e.g.,* DAVID G. SMITH, ENTITLEMENT POLITICS: MEDICARE AND MEDICAID 1995-2001, at 155-57 (2002).

matter.[103] The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, established by Congress in 1978,[104] provides a very important official statement of the philosophical debate over the right to health in the latter years of the twentieth century.[105] One important mandate for this prestigious commission was the study of the ethical and legal implications of differences in the availability of health services in American society.[106]

The commission, which published its report just after Republican Ronald Reagan took office as president, declined to declare that health care is either a legal or moral right.[107] Rather, the commission chose to frame its analysis of securing access to health "in terms of the special nature of health care and of society's moral obligation to achieve equity, without taking a position on whether the term 'obligation' should be read as entailing a moral right."[108] The commission defined "equitable access to health care" to require that "all citizens be able to secure an adequate level of care without excessive burdens."[109] The commission concluded that "society has an ethical obligation to ensure equitable access to health care for all" because of the "special importance of health care."[110] It determined that the societal obligation is balanced by individual obligations and described the content of an individual's obligations:

> Individuals ought to pay a fair share of the cost of their own health care and take reasonable steps to provide for such care when they can do so without excessive burdens. Nevertheless, the origins of health needs are too complex, and their

103. *See, e.g.,* TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (4th ed. 1994); NORMAN DANIELS ET AL., BENCHMARKS OF FAIRNESS FOR HEALTH CARE REFORM (1996); NORMAN DANIELS, JUST HEALTH CARE (1985); LARRY PALMER, LAW, MEDICINE AND SOCIAL JUSTICE (1989); JUSTICE AND HEALTH CARE (Earl E. Shelp ed., 1981); Tom L. Beauchamp & Ruth R. Faden, *The Right to Health and the Right to Health Care*, 4 J. MED. & PHIL. 118 (1979); Norman Daniels, *Health-Care Needs and Distributive Justice,* 10 PHIL. & PUB. AFF. 146 (1981); Norman Daniels, *Rights to Health Care and Distributive Justice: Programmatic Worries*, 4 J. MED. & PHIL. 174 (1979); Charles Fried, *Rights and Health Care—Beyond Equity and Efficiency*, NEW. ENG. J. MED., July 31, 1975, at 241.

104. Pub. L. 95-622, tit. III, § 301, 92 Stat. 3437 (1978) (codified as amended at 42 U.S.C. 300v (2006)).

105. *See* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBS. IN MED. & BIOMED. AND BEHAV. RES., SECURING ACCESS TO HEALTH CARE: A REPORT ON THE ETHICAL IMPLICATIONS OF DIFFERENCES IN THE AVAILABILITY OF HEALTH SERVICES (1983).

106. 42 U.S.C. § 300v-1(a)(1)(D) (2006).

107. PRESIDENT'S COMM'N, *supra* note 105, vol. I, at 32.

108. *Id.*

109. *Id.* vol. I, at 4.

110. *Id.*

> manifestations too acute and severe, to permit care to be regularly denied on the grounds that individuals are solely responsible for their own health.[111]

The next time the federal government visited the nature of governmental obligations to the population regarding health care was during President Clinton's health reform initiative.[112] In the 1990s, philosophical interest in the right to health, including health as an international human right,[113] receded with the demise of the Clinton health reform initiatives of that era. In the aftermath of President Clinton's initiative, the philosophical debate turned from a substantive right to health to procedural rights. In 1997, President Clinton's Commission on Health Care Quality and Consumer Protection proposed recommendations for reforms to federally sponsored and regulated health plans, which included a "Bill of Rights and Responsibilities" for health care consumers.[114] This procedural focus was consistent with the literature on the patient protection debate of the late-1990s, which focused primarily on procedural strategies for protecting patients enrolled in health plans.[115]

Also, in the late-1990s, a renewed interest in the international human right to health emerged with the fiftieth anniversary of the adoption of the Universal Declaration of Human Rights.[116] Several nongovernmental health care organizations formed a consortium for

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111. *Id.*

112. *See Clinton's Remarks, supra* note 96; *see also* Am. Med. Ass'n, Council on Ethical & Jud. Affs., *Ethical Issues in Health System Reform: The Provision of Adequate Health* Care, 272 J. AM. MED. ASS'N 1056 (1994) [hereinafter *Ethical Issues in Health System Reform*]; Ronald Dworkin, *Will Clinton's Plan be Fair?*, N.Y. REV. BOOKS, Jan. 13, 1994, at 20.

113. *See* HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH (Audrey R. Chapman ed., 1994).

114. *See* PRESIDENT'S ADVISORY COMM'N ON CONSUMER PROTECTION & QUALITY IN THE HEALTH CARE INDUSTRY, CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES (1997); *see also* PRESIDENT'S ADVISORY COMM'N ON CONSUMER PROTECTION & QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS (1998).

115. *See, e.g.,* KINNEY, *supra* note 100; MARC A. RODWIN, PROMOTING ACCOUNTABLE MANAGED HEALTH CARE: THE POTENTIAL ROLE FOR CONSUMER VOICE (2000); George J. Annas, *Patients' Rights in Managed Care—Exit, Voice, and Choice*, 337 NEW ENG. J. MED. 210 (1997); Eleanor D. Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335 (2000); Tracy E. Miller, *Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights*, 26 J.L. MED. & ETHICS 89 (1998); Marc A. Rodwin, *Consumer Protection and Managed Care: The Need for Organized Consumers*, 15 HEALTH AFF. 110, 110 (1996); Walter A. Zelman, *Consumer Protection in Managed Care: Finding the Balance,* 16 HEALTH AFF. 158, 158 (1997).

116. *See, e.g.,* George J. Annas, *Human Rights and Health: The Universal Declaration of Human Rights at 50*, 339 NEW. ENG. J. MED. 1778 (1998).

the promotion of the international human right to health.[117] Also, there was an important surge in scholarship on the issue.[118] Much of this scholarship and activity followed a major conference in Philadelphia in Fall 2001—sponsored by the American Society of Law, Medicine and Ethics and the Francois-Zavier Bagnoud Center for Health and Human Rights—entitled Health, Law and Human Rights: Exploring the Connections.[119]

Two important theoretical issues attend the philosophical debate over a right to health. The first issue is whether there is a minimum package of benefits that can provide a floor of adequate health care for all.[120] The second issue is whether it is necessary to ration health care services in some respect, because health care services are expensive and society is willing to publicly support only a finite amount. Since the 1960s, when government became more involved in the financing and delivery of health care services, scholars have addressed the question of whether and how to ration health care services in a just manner in the face of escalating health sector costs.[121]

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117. Consortium for Health & Hum. Rts., *Health and Human Rights: A Call to Action on the 50th Anniversary of the Universal Declaration of Human Rights*, 280 J. AM. MED. ASS'N 462, 464 (1998).

118. *See, e.g.,* HEALTH CARE REFORM, *supra* note 113; HEALTH AND HUMAN RIGHTS: A READER (Jonathan M. Mann et al. eds., 1999); BRIGIT TOEBES, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW (1999); Paul Farmer & Nicole Gastineau, *Rethinking Health and Human Rights: Time for a Paradigm Shift*, 30 J.L. MED. & ETHICS 655 (2002); Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1 (1994); Virginia A. Leary, *The Right to Health in International Human Rights Law*, 1 INT'L J. HEALTH & HUM. RTS. 25 (1994); Stephen P. Marks, *The Evolving Field of Health and Human Rights: Issues and Methods*, 30 J.L. MED. & ETHICS 739 (2002); Benjamin Mason Meier & Larisa M. Mori, *The Highest Attainable Standard: Advancing a Collective Human Right to Public Health*, 37 COLUM. HUM. RTS. L. REV. 101 (2005); George P. Smith, II, *Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection?* 38 VAND. J. TRANSNAT'L L. 1295 (2005); Brigit Toebes, *Towards an Improved Understanding of the International Human Right to Health*, 21 HUM. RTS. Q. 661 (1999).

119. *See generally* Symposium, *Health, Law and Human Rights: Exploring the Connections*, 30 J.L. MED. & ETHICS 490 (2002).

120. *See* Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55 (1984); Daniel Callahan, *What Is a Reasonable Demand on Health Care Resources? Designing a Basic Package of Benefits*, 8 J. CONTEMP. HEALTH L. & POL'Y 1 (1992); *Ethical Issues in Health Care System Reform*, *supra* note 112.

121. *See, e.g.,* DANIEL CALLAHAN, SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY (1987); LARRY R. CHURCHILL, RATIONING HEALTH CARE IN AMERICA: PERCEPTIONS AND PRINCIPLES OF JUSTICE (1987); VICTOR R. FUCHS, WHO SHALL LIVE?: HEALTH, ECONOMICS, AND SOCIAL CHOICE (1974); HALL, *supra* note 99; PAUL T. MENZEL, STRONG MEDICINE: THE ETHICAL RATIONING OF HEALTH CARE (1990); Henry Aaron & William B. Schwartz, *Rationing Health Care: The Choice Before Us,* 247 SCIENCE 418 (1990); Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV.

Addressing these questions about a minimum benefit package and rationing health care services is important, given the tremendous progress in highly effective and very expensive technology-heavy treatment modalities. For example, the fifteen most costly medical conditions accounted for half of the overall growth in health care spending between 1987 and 2000.[122] This phenomenon must be addressed in defining the content of the international human right to health. If these issues are not addressed, it will be difficult to assure full realization of the human right to health.[123]

### *B. Constitutional Recognition of the Human Right to Health*

In the federal system of the United States, the states, through the police power, have primary responsibility for the regulation and promotion of the public's health.[124] The Federal Constitution is silent on the matters of health and health care. However, the powers accorded Congress in the Constitution support establishment of federal health programs and also authorize regulation to improve health care delivery and promote public health.[125]

#### 1. State Constitutional Authority

The state police power is the foundational power of sovereign states irrespective of authorizing constitutional provisions.[126] The police power supports government authority to protect and promote public health in many dimensions. The police power includes protecting public safety and regulation of risks to health and safety in the environment, work place, and other public venues.[127] The

1449 (1994); Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693, 778 (1994); Richard D. Lamm, *Rationing of Health Care: Inevitable and Desirable,* 140 U. PA. L. REV. 1511 (1992).

122. *See* Kenneth E. Thorpe, Curtis S. Florence & Peter Joski, *Which Medical Conditions Account For The Rise In Health Care Spending?*, HEALTH AFF. (Web Exclusive), August 25, 2004, at W4-440, http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w4.437.

123. Frances H. Miller, *Patient Rights & Health Care Resources: Two Sides to An Irregular Coin*, *in* RIGHTS AND RESOURCES (Francis H. Miller ed., 2002).

124. *See* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 25-59 (2000); *see also* Elizabeth Fee, *Public Health and the State: The United States*, *in* THE HISTORY OF PUBLIC HEALTH AND THE MODERN STATE 224, 227-28 (Dorothy Porter ed., 1994); GEORGE ROSEN, A HISTORY OF PUBLIC HEALTH (1993).

125. *See infra* notes 135-42 and accompanying text.

126. *See* William J. Novak, *The Legal Origins of the Modern American State*, *in* LOOKING BACK AT LAW'S CENTURY 249 (Austin Sarat, Bryant Garth & Robert A. Kagan eds., 2002); *see also* Glenn H. Reynolds & David B. Kopel, *The Evolving Police Power: Some Observations for a New Century*, 27 HASTINGS CONST. L.Q. 511, 511 (2000).

127. *See supra* note 126.

United States Supreme Court has consistently recognized the breadth and depth of the state police power in the regulation of public health.[128] Early, in *Gibbons v. Ogden*, the Supreme Court recognized the broad state police power as:

> [The] immense mass of legislation, which embraces everything within the territory of a state, not surrendered to the general government; all which can be most advantageously exercised by the states themselves. Inspection laws, quarantine laws, health laws of every description, as well as laws for regulating the internal commerce of a state . . . .[129]

Further, the constitutions of a few states expressly recognize the importance of health in the exercise of state power.[130] For example, Alaska and Hawaii, the most recently admitted states, have provisions that either the legislature (Alaska) or the state (Hawaii) must provide for the promotion and protection of public health.[131] The Wyoming constitution contains a similar provision imposing the following duty on its legislature: "As the health and morality of the people are essential to their well-being, and to the peace and permanence of the state, it shall be the duty of the legislature to protect and promote these vital interests . . . ."[132] Similarly, South Carolina's constitution designates health a matter of public concern: "The health . . . of the people of this State and the conservation of its natural resources are matters of public concern."[133] Montana's constitution is perhaps the most emphatic in providing a right to health as an affirmative matter in its section on inalienable rights:

> All persons are born free and have certain inalienable rights. They include the right to a clean and healthful environment and the rights of pursuing life's basic necessities, enjoying and defending their lives and liberties, acquiring, possessing and protecting property, and *seeking their safety, health and*

128. *See* Price v. Illinois, 238 U.S. 446, 453-55 (1915) (upholding state prohibition on sale of certain food preservatives to protect the public health); New York *ex rel.* Lieberman v. Van de Carr, 199 U.S. 552, 563 (1905) (upholding the state prohibition on the sale of milk without a health board permit); Cal. Reduction Co. v. Sanitary Reduction Works, 199 U.S. 306, 324-25 (1905) (upholding an ordinance requiring refuse to be cremated or destroyed at owner's expense); Jacobson v. Massachusetts, 197 U.S. 11, 39 (1905) (upholding mandatory state vaccination statute).

129. 22 U.S. (9 Wheat.) 1, 203 (1824).

130. Kinney, *supra* note 6, at 1465-66.

131. *Id.* at 1465; *see also* ALASKA CONST. art. VII, § 5 ("The legislature shall provide for public welfare."); HAW. CONST. art. IX, § 1 ("The State shall provide for the protection and promotion of the public health.").

132. WYO. CONST. art. 7, § 20.

133. S.C. CONST. art. XII, § 1.

> *happiness in all lawful ways*. In enjoying these rights, all persons recognize corresponding responsibilities.[134]

2. Federal Constitutional Authority

Even though the police power resides with the states, constitutional authority for most federal health activities comes chiefly from the constitutional requirement that Congress provide for the general welfare.[135] Specifically, the Federal Constitution permits Congress to tax and spend to provide for the common defense and general welfare of the United States.[136] The power to tax and spend authorizes the federal government to commit financial resources to provide services and also to encourage states and the public to engage in activities that achieve laudable policy goals, including implementation of the international human right to health. As articulated in *McCulloch v. Maryland*,[137] this power is quite broad:

> Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are constitutional.[138]

It is the power to tax and spend that supports federal health insurance and public health promotion and protection programs.

The second important power of the federal government is the regulation of commerce among the several states.[139] Although there has not been a Supreme Court decision on point, Congress does have apparent authority under the Commerce Clause to enact health reform, including the creation of national health boards, payment systems, and other measures, demonstrating that the Federal Constitution clearly accorded such power.[140] However, while interpreting the commerce power broadly in the middle of the twentieth century,[141] the Supreme Court has cut back on this power in recent years.[142]

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134. MONT. CONST. art. II, § 3 (emphasis added).

135. *See* U.S. CONST. pmbl; *id.* art. I, § 8, cl. 1.

136. *Id.* art. 1, § 8, cl. 1.

137. 17 U.S. (4 Wheat.) 316 (1819).

138. *Id.* at 421.

139. U.S. CONST. art. 1, § 8, cl. 3.

140. *See* Memorandum from Walter Dellinger and H. Jefferson Powell, Department of Justice, to Attorney General Janet Reno and Associate Attorney General Webster L. Hubbell (Oct. 29, 1993), *available at* http://www.usdoj.gov/olc/1stlady.htm.

141. *See* Jesse H. Choper & John C. Yoo, *The Scope of the Commerce Clause after* Morrison, 25 OKLA. CITY U. L. REV. 843 (2000); Larry D. Kramer, *Putting the Politics Back into the Political Safeguards of Federalism*, 100 COLUM. L. REV. 215 (2000); Grant S. Nelson & Robert J. Pushaw, Jr., *Rethinking the Commerce Clause: Applying*

### *C. Legislative Recognition of the Human Right to Health*

In the United States, legislation has been the major vehicle establishing the legal infrastructure for the realization of the international human right to health. Legislation has addressed establishment of health insurance coverage for vulnerable groups and regulation of private health insurance coverage.[143] It has also addressed the protection and promotion of public health.[144]

Health insurance coverage is the most important means for assuring that individuals have access to expensive health care services. In the United States, health coverage is a mix of public and private programs. Table 1 presents the distribution of health insurance coverage in the United States in 2005.[145] Of note, in 2005 15.9% of the United States population had no health insurance coverage.[146]

Table 1
COVERAGE BY TYPE OF HEALTH INSURANCE:
2005[1] AND 2006

| **Source and Type of Health Plan** | **2005 (Percent)** | **2006 (Percent)** |
|---|---|---|
| **Private Insurance** | | |
| Any Private Plan | 68.5 | 67.9* |
| Employment-Based | 60.2 | 59.7* |
| Direct Purchase | 9.2 | 9.1* |
| **Government insurance** | | |
| Any Government Plan | 27.3 | 27.0* |
| Medicare | 13.7 | 13.6 |

*First Principles to Uphold Federal Commercial Regulations but Preserve State Control Over Social Issues*, 85 IOWA L. REV. 1 (1999); John C. Yoo, *The Judicial Safeguards of Federalism*, 70 S. CAL. L. REV. 1311 (1997).

142. *See* United States v. Morrison, 529 U.S. 598, 626-27 (2000) (striking down the private civil remedy provision of the Violence Against Women Act of 1994, 42 U.S.C. § 13981, as having no national effects); United States v. Lopez, 514 U.S. 549, 567 (1995) (holding that regulating the possession of guns in schools is outside the sphere of federal commerce power).

143. *See infra* notes 148-59, 176-85 and accompanying text.

144. *See infra* notes 187-89 and accompanying text.

145. CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 20 fig.7 (2007).

146. *Id*.

| | | |
|---|---|---|
| Medicaid | 13.0 | 12.9 |
| Military Health Care[2] | 3.8 | 3.6* |
| **No Insurance** | | |
| Not Covered | 15.3 | 15.8* |

Source: CARMEN DENAVAS-WALT, BERNADETTE D. PROCTOR & JESSICA SMITH, U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006 (2007).

Note: The estimates by type of coverage are not mutually exclusive; people can be covered by more than one type of health insurance during the year.

* Statistically different at the ninety percent confidence level.

1. The 2005 data have been revised since originally published. *See* U.S. Census Bureau, Revised CPS ASEC Health Insurance Data, www.census.gov/hhes/www/hlthins/usernote/schedule.html (last visited Feb. 27, 2008).

2. Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare and CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs and the military.

### 1. Government Sponsored Health Insurance

Public health insurance programs cover only twenty-seven percent of the U.S. population.[147] In 1965, Congress enacted the Medicare and Medicaid programs to provide health insurance coverage for the elderly and some poor.[148] Congress added the seriously disabled to the Medicare program in the Social Security Amendments of 1972.[149] The Medicare program is a social insurance program available to persons aged sixty-five and older, seriously disabled individuals, and people with end-stage renal disease.[150] Basic Medicare benefits include hospital and extended-care services, as well as physician and other outpatient services on a fee-for-service basis[151] or as part of a prepaid health plan.[152] In 2003, Congress

147. *Id.*

148. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 291 (codified as amended at 42 U.S.C. § 1395 (2006)); *id.* § 121(a), 79 Stat. 343 (codified as amended at 42 U.S.C. § 1396 (2006)).

149. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 301, 86 Stat. 1471 (codified as amended at 42 U.S.C. § 1382c (2006)).

150. 42 U.S.C. § 1395c (2006).

151. *See generally id.* §§ 1395c to 1395i; *id.* §§ 1395j to 1395w-4.

152. *Id.* § 1395w-21.

added a new, optional prescription-drug benefit to the Medicare program.[153]

Medicaid, jointly financed and administered by the federal government and the states, provides health insurance for some disabled and aged poor, as well as poor mothers, infants, and children.[154] The Federal Medicaid statute sets forth requirements for eligibility and benefits that states must adopt and also allows states to cover other groups of poor and provide other benefits at the state's option.[155] The Medicaid program provides basic hospital, physician, and long-term care services to eligible individuals.[156] In 1997, Congress enacted the State Children's Health Insurance Program, extending health coverage to all eligible children.[157] Now, all children in families with incomes up to 200% of the federal poverty level have health coverage through Medicaid or the Children's Health Insurance Program.[158]

In addition, the federal government provides a wide range of other programs providing health care, including massive health systems for the military and veterans.[159] The federal government also funds direct health care services through various block grants to states.[160] A crucial federal program provides direct services to the poor through community health centers in rural and medically underserved areas through community health services around the country.[161]

With regard to public health insurance programs, the Supreme Court has ruled that the government does not have to provide specific benefits in its public health insurance program, even though it has recognized that women may have the right to obtain these services as a matter of constitutional law. Specifically, in *Maher v. Roe*,[162] the Court stated that "[t]he Constitution imposes no obligation on the States to pay . . . any of the medical expenses of

153. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. No. 108-173, § 101(a)(1), 17 Stat. 2071 (codified at 42 U.S.C. § 1395w-101 (2006)).

154. *See* 42 U.S.C. § 1396.

155. *See id.* § 1396a.

156. *See id.*

157. State Children's Health Insurance Program, 42 U.S.C. § 1397aa.

158. *Id.*

159. 38 U.S.C. §§ 1701-1784.

160. 42 U.S.C. §§ 300w to 300y-11.

161. *Id.* §§ 254b to 254c-1.

162. 432 U.S. 464 (1977).

indigents."[163] In so doing, the Supreme Court rejected the idea that the Federal Constitution has recognized a right to health care that the state has a duty to fulfill as a matter of constitutional law.[164]

Indeed, the Supreme Court has historically been resistant to ruling that either the states or the federal government have an affirmative obligation to enhance the economic and social human rights of Americans as a matter of constitutional law. In *DeShaney v. Winnebago County Department of Social Services*,[165] which involved serious injury to a child by his father while under the supervision of social services for child abuse, the Supreme Court stated: "Consistent with these principles, our cases have recognized that the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual."[166]

Nevertheless, once the government decides to provide a health care benefit through a public program, it must comply with constitutional guarantees of procedural due process. In *Goldberg v. Kelly*,[167] the Supreme Court recognized that beneficiaries of government programs, which include health insurance programs, had an entitlement interest in benefits that was eligible for protection as property under the procedural Due Process Clauses of the Fifth and Fourteenth Amendments of the Federal Constitution.[168] As such, before benefits can be terminated, government agencies must provide notice and an opportunity to be heard in a meaningful time and manner.[169]

In recent years, both Congress and the courts have limited due process protections for beneficiaries of public entitlement

163. *Id.* at 469; *see also* Harris v. McRae, 448 U.S. 297, 309 (1980) (noting that Congress never intended "to require a participating state to assume the full costs of providing any health services in its Medicaid Plan").

164. BARRY R. FURROW ET AL., HEALTH LAW § 10-1 (1995).

165. 489 U.S. 189 (1989).

166. *Id.* at 196.

167. 397 U.S. 254 (1970).

168. *Id.* at 263-64.

169. *See id.* at 266; *see also* Henry J. Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267, 1268 (1975) (discussing the expanded use of hearings in various administrative areas after *Goldberg*); Laurence H. Tribe, *Structural Due Process*, 10 HARV. C.R.-C.L. L. REV. 269, 269 (1975) (discussing constitutional limitations, like hearing requirements, on administrative actions); JERRY L. MASHAW, DUE PROCESS IN THE ADMINISTRATIVE STATE 33 (1985) (discussing the impact of *Goldberg*'s hearing requirement); Charles H. Koch, ADMINISTRATIVE LAW AND PRACTICE §§ 2.23-.24 (2d ed. 1997); Kenneth C. Davis & Richard J. Pierce, Jr., ADMINISTRATIVE LAW TREATISE § 9.5 (3d ed. 1994).

programs.[170] One threat to procedural due process is the attack on the concept of entitlement programs and the judicial sanction of the diminished status of benefits in government entitlement programs due to their statutory definition.[171] Courts have upheld legislation specifically stating that a benefit is not an entitlement and is exhausted at the end of fiscal appropriations.[172] In legislation reforming welfare programs and establishing the children's health insurance program, Congress affirmatively stated that program benefits were not entitlements in order to eliminate open-ended obligations to actual and potential program clients.[173]

2. Regulation of Private Health Insurance

Most people in the United States (67.9%) have private health insurance—either through an employer or independently—or they are uninsured (15.8%).[174] Employers include private corporations with ERISA-regulated employee benefit plans as well as government employers that offer, in general, private health plans to public employees. Currently, no federal or state law requires employers directly to provide health coverage to employees.[175] They are motivated to do so because employee health insurance is a deductible business expense under federal and state income tax codes.[176]

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170. *See generally* Richard B. Stewart & Cass R. Sunstein, *Public Programs and Private Rights,* 95 HARV. L. REV. 1193 (1982); Stephen F. Williams, *Liberty and Property: The Problem of Government Benefits*, 12 J. LEGAL STUD. 3 (1983); Richard A. Epstein, *No New Property*, 56 BROOK. L. REV. 747 (1990).

171. *See generally* TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 24-51 (2003); SMITH, *supra* note 102; Timothy Stoltzfus Jost, *The Tenuous Nature of the Medicaid Entitlement,* 22 HEALTH AFF. 145 (2003).

172. *See, e.g.,* Colson v. Sillman, 35 F.3d 106 (2d Cir. 1994); Wash. Legal Clinic for the Homeless v. Barry, 107 F.3d 32, 38 (D.C. Cir. 1997); *see also* Sidney A. Shapiro & Richard E. Levy, *Government Benefits and the Rule of Law: Toward a Standards-Based Theory of Due Process,* 57 ADMIN. L. REV. 107 (2005); Richard J. Pierce, Jr., *The Due Process Counterrevolution of the 1990s?*, 96 COLUM. L. REV. 1973 (1996).

173. *See, e.g.,* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, § 103(a)(1), 110 Stat. 2113 (codified at 42 U.S.C. § 601(b) (2006)) (welfare program); Balanced Budget Act of 1997, Pub. L. No. 105-33, § 2102(b)(4), 111 Stat. 554 (codified at 42 U.S.C. § 1397bb(b)(4) (2006)) (State Children's Health Insurance Program).

174. CARMEN DENAVAS-WALT ET AL., *supra* note 145, at 20 fig.7.

175. Russell Korobkin, *The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another"*, 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 131 (2005) (noting that with the exception of Hawaii, no federal or state law requires employer-provided health coverage).

176. *See* I.R.C. § 162(a) (2006) (employer deduction); *id.* § 106 (employer contributions to employee health plans).

States regulate private health insurance that is not offered through employment.[177] In addition to solvency and market conduct with respect to consumers,[178] state health insurance regulation has focused on improving benefit packages of health insurance plans by mandating specific benefits for the plans[179] and regulating underwriting and pricing practices that discriminate against seriously ill people in individual and small-group health plans.[180]

The Federal Employee Retirement Income Security Act of 1974 (ERISA)[181] regulates employer-sponsored health insurance plans. Specifically, ERISA establishes requirements for employee benefit plans that are eligible for favorable federal tax treatment designed to protect plan participants and beneficiaries.[182] ERISA also has very specific enforcement provisions.[183] Lower courts, with the acquiescence of the Supreme Court, have accorded great latitude to sponsors of private health insurance in designing employee health plans, to the detriment of plan participants and beneficiaries.[184] Additionally, Congress has enacted health insurance reforms with amendments to ERISA and the federal tax laws, as well as through mandates for states.[185]

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177. *See* Paul v. Virginia, 75 U.S. 168, 184-85 (1868) (holding that the business of insurance was not in interstate commerce).

178. *See* KATHLEEN HEALD ETTLINGER ET AL., STATE INSURANCE REGULATION 129-63 (1995).

179. *See* NAT'L ASS'N INS. COMM'RS, COMPENDIUM OF STATE LAWS ON INSURANCE TOPICS: MANDATED BENEFITS (1995).

180. *See* Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J.L. REFORM 685, 691 (1999).

181. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 15 U.S.C., 26 U.S.C., 29 U.S.C., 42 U.S.C. & 42 U.S.C.).

182. *See* 29 U.S.C. § 1001(a)(2006).

183. *See id.* § 1132(a).

184. *See* McGann v. H. & H. Music Co., 946 F.2d 401, 408 (5th Cir. 1991) (upholding an employer's decisions to reduce lifetime benefits for employees after discovering they had an AIDS-related illness); Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 365 (4th Cir. 1997) (rejecting the effort of Maryland's insurance regulators due to ERISA preemption to require employee welfare benefit plans that purchased state-regulated stop-loss insurance to comply with state-mandated benefit provisions for the primary plan).

185. *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 10001, 100 Stat. 82, 222 (codified as amended at 26 U.S.C. § 162 (2006)); Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (2006) (codified in scattered sections of 29 U.S.C. & 42 U.S.C.); Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified in scattered sections of 26 U.S.C., 29 U.S.C. & 42 U.S.C.); Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, §§ 601-606, 110 Stat. 2874, 2935-44 (codified at 29 U.S.C. § 1185 (2006)).

3. State and Federal Public Health Legislation

All states have a public health agency that is responsible for the promotion and protection of the public health within state borders. Public health statutes grant governments certain powers within the state.[186]

The Public Health Service Act authorizes federal public health programs,[187] including public health protections through the Centers for Disease Control and Prevention, regulation of pharmaceuticals and medical devices through the Food and Drug Administration, and funding and promotion of biomedical research through the National Institutes of Health. In addition, since the 1960s and 1970s, the federal government has established multiple regulatory programs to reduce risks to safety and health in the environment, workplace, and other settings.[188]

4. Federal and State Civil Rights Authorities

Federal and state civil rights laws prohibit discrimination in public accommodations and access to government programs on the basis of race, religion, gender, and national origin.[189] Two federal laws specifically address discrimination on the basis of physical disability and thereby establish an important source of obligations and rights regarding access to health care. Specifically, section 504 of the Rehabilitation Act prohibits discrimination in employment against individuals with handicaps by entities that contract with or receive funds from the federal government.[190] The Americans with Disabilities Act (ADA), with a broader mandate, prohibits discrimination against the disabled in employment, public services, accommodations, and telecommunications.[191] Also, as a condition of receiving construction funds under the federal Hill-Burton program, health care institutions must be open to all people in the relevant

186. *See* Lawrence O. Gostin, *The Future of Public Health Law*, 12 AM. J.L. & MED. 461 (1986).

187. Public Health Service Act, Pub. L. No. 78-410, 58 Stat. 682 (1944) (codified as amended at 42 U.S.C. §§ 201-300hh (2006)).

188. Eleanor D. Kinney, *Administrative Law and the Public's Health,* 30 J.L. MED. & ETHICS 212, 214-15 (2002).

189. *See* 42 U.S.C. § 2000a(a) (2006) (federal civil rights authorities); 15 AM. JUR. 2D *Civil Rights* §§ 223-231 (2000) (state civil rights authorities).

190. Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified at 29 U.S.C. § 794 (2006)).

191. Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified at 42 U.S.C. § 12101 (2006))*; see also* David Orentlicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick,* 31 HARV. C.R.-C.L. L. REV. 49 (1996); Philip G. Peters, Jr., *Health Care Rationing and Disability Rights,* 70 IND. L.J. 491 (1995).

service area.[192] States also have civil rights laws that prohibit discrimination on the basis of disability, race, creed, gender, and national origin.[193]

## IV. COMPARATIVE UNITED STATES PERFORMANCE ON RECOGNITION AND IMPLEMENTATION

There are two key points of comparison of national performance with respect to recognition and implementation of the international human right to health. The first is formal recognition through official adoption of treaties and other legal authorities and establishing the programs mandated by the legal authorities. The second is to look at comparative statistical indicators that enable a comparison between the performances of national health sectors to assess real progress in implementation.

Statistical indicators are an essential tool in comparing the performance of national health care sectors to how national policymakers make policy and budgetary decisions to improve health sector performance.[194] They can be an important tool in advocacy as well. Indeed, the United Nations has emphasized the importance of statistical indicators in achieving the realization of international human rights in general:

> Statistical indicators are a powerful tool in the struggle for human rights. They make it possible for people and organizations—from grassroots activists and civil society to governments and the United Nations—to identify important actors and hold them accountable for their actions. This is why developing and using indicators for human rights has become a cutting-edge area of advocacy.[195]

### *A. Legal Recognition and Implementation*

The record of the United States on legal recognition of the international human right to health is mixed. As discussed above,[196] the United States has failed to ratify any of the U.N. treaties and instruments recognizing the international human right to health except for the Universal Declaration of Human Rights and the International Convention on the Elimination of all Forms of Racial Discrimination. Nor has the United States ratified regional treaties

192. 42 U.S.C. § 300o (repealed 1979); 42 C.F.R. § 124, subpt. G (2002).

193. AM. JUR. 2D *Civil Rights* §§ 223-231 (2000) (state civil rights authorities).

194. *See* Helen Watchirs, *Review of Methodologies Measuring Human Rights Implementation*, 30 J.L. MED. & ETHICS 716 (2002).

195. U.N. DEV. PROGRAMME (UNDP), HUMAN DEVELOPMENT REPORT 2000, at 89 (2000), http://hdr.undp.org/en/media/hdr_2000_en.pdf.

196. *See supra* note 7 and accompanying text.

recognizing the international human right to health.[197] Thus, as a practical matter, the United States is not obligated as a state party to implement the international human right to health.

Notably, however, the majority of the world's nation-states have recognized the international human right to health, as stated in U.N. and regional treaties. Specifically, just over half of the world's countries have ratified ICESCR.[198] About thirty percent of countries have ratified one or more regional treaties recognizing an international human right to health.[199] Of interest, nine countries have incorporated the ISESCR and/or regional human rights treaties pertaining to health into their national constitutions.[200]

The Federal Constitution, as interpreted by the United States Supreme Court, does not address the international human right to health and does not recognize a duty on the part of the federal government to provide or guarantee health care services to the United States' population.[201] The constitutions of a few states do, however, contain provisions regarding rights and/or duties with respect to health and health care.[202] Of the constitutions of the countries of the world, 67.5% have a provision addressing health or health care for their populations.[203]

However, express recognition of the international human right to health in a constitution is by no means essential to achieve national recognition. "Many countries that devote extensive resources to . . . health care [for] their populations have no relevant provisions in their constitutions regarding health or health care."[204] Of the twenty countries with the highest per capita government expenditures for health care in the world, thirteen have no provisions regarding health and health care in their constitutions.[205]

Regarding legislative infrastructure to implement the international human right to health, it is beyond the scope of this Article to compare state and federal legislation of the United States to that of other countries. Presumably, most countries, like the United States, have legislation pertaining to the financing, regulation, and provision of health care services to covered groups, as

197. *See supra* note 7 and accompanying text.

198. Eleanor D. Kinney & Brian A. Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285, 297-98, 298 tbl.2 (2004).

199. *Id.* at 298 tbl.2.

200. *Id.* at 297 fig.3.

201. *See supra* Part III.B.2.

202. *See supra* notes 130-34 and accompanying text.

203. Kinney & Clark, *supra* note 198, at 291.

204. *Id.* at 294.

205. *Id.* at 295 fig.2.

well as the protection and promotion of public health. And as discussed in Part III.B above, the United States and its states have legislation authorizing public health insurance coverage for vulnerable groups, regulating private health insurance to protect consumers, and prohibiting discrimination in access to health care services and instituting public health protections.

There are two important issues with respect to national legislation. The first is whether the legislation contains the requisite authority for full implementation of the international human right to health. The second is the degree to which the legislation, or other sources of domestic law, specifically protects the individual rights to access health care, either by obtaining promised services or preventing discrimination in the distribution of service. An excellent approach to assessing these issues is determining the degree to which the national legislation comports with the principles of General Comment 14 that the U.N. Economic, Social and Cultural Committee issued to guide implementation of ICESCR on a domestic basis.[206]

### *B. Comparative Recognition and Implementation*

In recent years, public international organizations, in conjunction with health services researchers, have developed an array of indicators and methodologies to assess national health sector performance, particularly on a comparative basis. Four public international organizations—the World Health Organization (WHO),[207] the United Nations Development Programme (UNDP),[208]

206. *See supra* notes 30-38 and accompanying text.

207. The WHO released its first-ever analysis of national health care systems in 2000. *See* WHO, THE WORLD HEALTH REPORT 2000, HEALTH SYSTEMS: IMPROVING PERFORMANCE (2000), http://www.who.int/entity/whr/2000/en/whr00_en.pdf. The WHO has devoted great attention to the standardization of measures of population health status to facilitate meaningful comparisons among countries. *See* WHO, *Measuring and Reporting on the Health of Populations: Report by the Secretariat*, U.N. Doc. EB107/8 (Dec. 15, 2000), http://ftp.who.int/gb/archive/pdf_files/ EB107/ee8.pdf; *see also* WHO, SUMMARY MEASURES OF POPULATION HEALTH: CONCEPTS, ETHICS, MEASUREMENT AND APPLICATIONS (Christopher J. L. Murray et al. eds., 2002).

More recently, the WHO has also stepped up its data collection on the health and health care of member states. Specifically, in its Global InfoBase, the WHO has assembled comprehensive, country-level data on the health sector of its member states. WHO, WHO Global Infobase Online, http://www.who.int/ncd_surveillance/infobase/web/surf2/online.html (last visited Feb. 27, 2008). From the data in the WHO Global InfoBase, including chronic disease data from member states, the WHO publishes the *Surveillance of Risk Factors Report* series (SuRF), which includes biennial, technical reports on country-level data for eight chronic disease risk factors. *See* WHO, THE SURF REPORT 2: SURVEILLANCE OF CHRONIC DISEASE RISK FACTORS: COUNTRY-LEVEL DATA AND COMPARABLE ESTIMATES (2005), http://www.who.int/ncd_surveillance/infobase/web/surf2/surf2.pdf. The WHO also maintains a Web

the Organization for Economic Co-operation and Development (OECD),[209] and the World Bank,[210] have been leaders in the

page with links to the major national databases with health sector data. *See* WHO, Links to National Health-Related Websites, http://www.who.int/whosis/database/national_sites/index.cfm (last visited Feb. 27, 2008).

208. The UNDP maintains relevant national data on health indicators, as well as other relevant indicators for tracking the progress of development. *See* UNDP, Human Development Reports, http://hdr.undp.org/en/reports/ (last visited Feb. 27, 2008).

209. OECD has been especially active in developing measures for comparing national health sectors of its members, which comprise the more developed nations of the world. In 2001, OECD launched a three-year health project that focused on measuring and analyzing the performance of health care systems in member countries and factors affecting performance. OECD, OECD Health Project, http://www.oecd.org/document/28/0,2340,en_2649_34631_2536540_1_1_1_1,00.html (last visited Feb. 27, 2008). Through this project, OECD publishes—in print and on the Web, and on an annual basis beginning in 2005—*OECD Health Data*, which provides the most comprehensive source of comparable statistics on health and health systems available among OECD countries. Also through this project, OECD has developed a system of health accounts that establishes a conceptual framework for comparing national health care sectors. *See* OECD, A SYSTEM OF HEALTH ACCOUNTS (2000), http://www.oecd/ org/health/sha.

In addition, OECD has analyzed disease-based methods and indicators for comparing health sector performance, as well as an analysis of how to achieve high-performing national health sectors. *See, e.g.,* OECD, A DISEASE-BASED COMPARISON OF HEALTH SYSTEMS: WHAT IS BEST AND AT WHAT COST? (2003); OECD, TOWARDS HIGH-PERFORMING HEALTH SYSTEMS: POLICY STUDIES (2004).

OECD has also launched its Health Care Quality Indicators Project (HCQI) to facilitate the comparison of the quality of care in OECD nations as a means of assessing the value for money spent for health care. *See* OECD, Health Care Quality Indicators Project, http://www.oecd.org/documentprint/0,3455,en_2649_34631_2484127_1_1_1_1,00.html (last visited Feb. 27, 2008). OECD data on "quality indicators" include measures of health outcome or health improvement attributable to medical care and depend heavily on the seminal work of the Institute of Medicine developing quality indicators through its Health Care Quality Initiative. *See* Institute of Medicine, Crossing the Quality Chasm: The IOM Health Care Quality Initiative, http://www.iom.edu/CMS/8089.aspx?printfriendly=true&redirect=0 (last visited Feb. 27, 2008). The Institute of Medicine report offers a framework for assessing health care quality, identifies the types of measures of health care quality that should be included in the report, and suggests the criteria for selecting measures. *See* INSTITUTE OF MEDICINE, ENVISIONING THE NATIONAL HEALTH CARE QUALITY REPORT (Margarita P. Hurtado, Elaine K. Swift & Janet M. Corrigan eds., 2001).

OECD has also developed measures for comparing national economic infrastructure. OECD, ECONOMIC SURVEY OF THE UNITED STATES (2005), http://www.oecd.org/dataoecd/4/11/35541272.pdf.

210. The World Bank is deeply involved in the generation of data and methodologies for comparing population health status and also assisting countries in improving health care and health status directly. The Health Systems Development (HSD) group of the Human Development Network's Health, Nutrition & Population Unit works on a variety of comparative health issues and provides technical assistance to developing nations on the improvement of their health care sectors. *See* The World Bank: Health Systems & Financing, http://www.worldbank.org/hsd (last visited Feb. 27, 2008). The World Bank also has a Web site containing technical notes on quantitative techniques

development of measures for comparing health systems and in providing technical assistance to nation-states to develop the infrastructure in terms of budgetary accounting and data management to develop and report the data on the comparative measures.

The importance of this data-collection effort cannot be overestimated, for it has enabled a new dimension of health services research that is proving essential to the realization of the international human right throughout the world. For example, The Commonwealth Fund has launched its International Program in Health Policy and Practices, which is building an international network of health care researchers and encouraging comparative research and collaboration.[211] Each year, The Commonwealth Fund conducts its International Health Policy Survey of whole populations and subpopulations (e.g., sicker adults, the elderly, hospital chief executives) in Australia, Canada, New Zealand, the United Kingdom, and the United States on such issues as views of the health care system, access to care, quality and safety of care, and costs.[212]

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for the analysis of health equity issues in a country. *See* OWEN O'DONNELL ET AL., THE WORLD BANK INSTITUTE, ANALYZING HEALTH EQUITY USING HOUSEHOLD SURVEY DATA: A GUIDE TO TECHNIQUES AND THEIR IMPLEMENTATION (2008), http://siteresources.worldbank.org/INTPAH/Resources/ Publications/459843-1195594469249/HealthEquityFinal.pdf.

Finally, the World Bank has developed a set of indicators for the quality of a state's governance that address six dimensions of governance: (1) voice and accountability, (2) political stability and absence of violence, (3) government effectiveness, (4) regulatory quality, (5) rule of law, and (6) control of corruption. *See* Daniel Kaufmann et al., World Bank, Governance Matters V: Aggregate and Individual Governance Indicators for 1996-2005 (2006) (unpublished manuscript), *available at* http://www .worldbank.org/wbi/governance/govmatters5.html; *see also* Daniel Kaufmann et al., World Bank, Governance Matters IV: Governance Indicators for 1996–2004 (2005) (unpublished manuscript), *available at* http://www.worldbank.org/wbi/governance/ pubs/govmatters4.html.

211. The Commonwealth Fund, International Health Program in Health Policy and Practice, http://www.cmwf.org/programs/programs_list.htm?attrib_id=9141 (last visited Feb. 27, 2008).

212. *See* KAREN DAVIS ET AL., THE COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: LOOKING AT THE QUALITY OF AMERICAN HEALTH CARE THROUGH THE PATIENT'S LENS (2004); *see also* Cathy Schoen et al., *Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries*, HEALTH AFF., http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.509/DC1; Karen Donelan et al., *The Cost of Health System Change: Public Discontent in Five Nations*, 18 HEALTH AFF. 206 (1999); Cathy Schoen et al., *Health Insurance Markets and Income Inequality: Findings from an International Health Policy Survey*, 51 HEALTH POL'Y 67 (2000) [hereinafter Schoen, *Health Insurance*]; Karen Donelan et al., *The Elderly in Five Nations: The Importance of Universal Coverage*, 19 HEALTH AFF. 226 (2000); Robert J. Blendon et al., *Physicians' Views on Quality of Care: A Five-Country Comparison*, 20 HEALTH AFF. 233 (2001); Robert J. Blendon et al., *Inequities in Health Care: A Five-Country Survey*, 21 HEALTH AFF. 182 (2002); Robert J. Blendon et al., *Common*

1. Recent Findings on the Comparative Performance of the U.S. Health Sector

More recent analyses comparing the U.S. health care sector with that of other countries suggest that the United States is behind its peer industrialized nations in terms of health sector performance.[213] In comparing the United States health care system with those of other countries, two remarkable realities emerge. The first is the tremendous cost of the health care sector compared to other countries. These comparisons are especially instructive because the United States spends by far the highest amount per capita on health care of all the countries of the world.[214] Annual per capita health spending for the United States in 2003 was $5711; Switzerland, the country with the next highest per capita health spending, was at $5035.[215] Such spending suggests that that the United States has progressed well in the recognition and implementation of the international human right to health. However, compared to other developed, democratic nations, the record of the United States with respect to the recognition and implementation of the international human right to health has been deficient.

The second reality is the high degree of inequity in American society leading to disparate health outcomes. The most recent U.N. development report[216] detailed shocking examples of inequality in the health outcomes in the U.S. population. Of note, the startlingly unfavorable ranking of the performance of the U.S. health sector in the 2000 WHO World Health Report—thirty-seventh among participants—was due primarily to disparities by race and income in American society.[217]

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*Concerns Amid Diverse Systems: Health Care Experiences in Five Countries*, 22 HEALTH AFF. 106 (2003).

213. TOM DASCHLE, CTR. FOR AM. PROGRESS, PAYING MORE BUT GETTING LESS: MYTHS AND THE GLOBAL CASE FOR U.S. HEALTH REFORM (2005), http://www.americanprogress.org/kf/paying_more_getting_less.pdf; OECD, HEALTH DATA 2005: HOW DOES THE UNITED STATES COMPARE (2005), *available at* http://www.oecd.org/dataoecd/15/23/34970246.pdf; Barbara Starfield, *Is U.S. Health Really the Best in the World?*, 284 J. AM. MED. ASS'N 483 (2000); Gerald F. Anderson et al., *Health Spending and Outcomes: Trends in OECD Countries, 1960-1998*, 19 HEALTH AFF. 150 (2000).

214. *See* WHO, WORLD HEALTH STATISTICS 2006, http://www.who.int/entity/whois/whostat2006_healthsystems.pdf (last visited Mar. 23, 2008); *see also* Gerald F. Anderson et al., *Health Spending in the United States and The Rest of the Industrialized World*, 24 HEALTH AFF. 904, 904-05 (2005).

215. WHO, WORLD HEALTH STATISTICS 2006, *supra* note 214.

216. UNDP, HUMAN DEVELOPMENT REPORT 2005 INTERNATIONAL COOPERATION AT A CROSSROADS: AID, TRADE AND SECURITY IN AN UNEQUAL WORLD (2005), http://hdr.undp.org/en/media/hdr05_complete.pdf.

217. *See* WHO, WORLD HEALTH REPORT 2000, *supra* note 207, at 155.

A significant body of scholarship has suggested that income inequality itself is an important determinant of health.[218] A recent review of this literature from an economics perspective argues that it is not clear that inequality of income operates so independently and that, after controlling for individuals' income, collective income inequality does not act independently on individual health.[219] It is noteworthy that the World Bank, in its 2005 development report, called for the reduction in inequities as an important force in economic growth.[220] Further, many scholars and policymakers see the realization of economic human rights, including the right of health, as a matter of global social justice in the face of great economic and social inequity throughout the world.[221]

### 2. Four Key Indicators for Comparing National Health Sector Performance

There are four important categories of indicators used to compare national health sector performance among nations: (1) population health status and outcomes, (2) population access to health care, (3) health sector performance on quality and efficiency, and (4) government competence and commitment to health care.

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218. *See, e.g.,* IS INEQUALITY BAD FOR OUR HEALTH (Norman Daniels, Bruce Kennedy & Ichiro Kawachi eds., 2000); Ichiro Kawachi et al., *Social Capital, Income Inequality, and Mortality,* 87 AM. J. PUB. HEALTH 1491, 1491-97 (1997); David Mechanic, *Rediscovering the Social Determinants of Health*, 19 HEALTH AFF. 269, 269-75 (2000); Michael Marmot*, Inequalities in Health*, 345 NEW ENG. J. MED. 134, 134-36 (2001); Judith A. Long et al., *Update on the Health Disparities Literature*, 141 ANN. INTERN. MED. 805, 805 (2004); Talmadge E. King Jr. & Margaret B. Wheeler, *Inequality in Health Care: Unjust, Inhumane, and Unattended!*, 141 ANN. INTERN. MED. 815, 815-17 (2004); *see also* SOCIAL DETERMINANTS OF HEALTH (Michael Marmot & Richard G. Wilkinson eds., 1999); James S. House & David R. Williams, *Understanding And Reducing Socioeconomic And Racial/Ethnic Disparities In Health*, *in* PROMOTING HEALTH: INTERVENTION STRATEGIES FROM SOCIAL AND BEHAVIORAL RESEARCH (B.D. Smedlers & S.L. Syme eds., 2000); RONALD LABONTE, TED SCHRECKER & AMIT SEN GUPTA, HEALTH FOR SOME: DEATH, DISEASE AND DISPARITY IN A GLOBALIZING ERA (2005).

219. *See* Angus Deaton, *Health, Inequality, and Economic Development,* 41 J. ECON. LIT. 113 (2003).

220. *See* WORLD BANK, WORLD DEVELOPMENT REPORT 2006: EQUITY AND DEVELOPMENT (2005), http://siteresources.worldbank.org/INTWDR2006/Resources/477383-1127230817535/WDR2006overview.pdf (last visited Mar. 23 2008).

221. *See* James Dwyer, *Global Health and Justice*, 19 BIOETHICS 460 (2005); Stephen P. Marks, *The Evolving Field of Health and Human Rights: Issues and Methods*, 30 J.L. MED. & ETHICS 739 (2002); Scott Burris, Ichiro Kawachi & Austin Sarat, *Integrating Law and Social Epidemiology*, 30 J.L. MED. & ETHICS 510 (2002).

a. Population Health Status

Population health status is crucial, since its improvement and maintenance is the primary goal of recognizing and implementing the international human right to health. The United States' performance on population health status is lower than many other countries. According to OECD data, the United States performs comparatively poorly in basic population health status indicators. With respect to life expectancy, at least thirty countries have a life expectancy greater than the United States.[222] Table 2 lists rates maternal and infant mortality, two United Nations Millennium Development Goals,[223] in which U.S. rankings are even more dismal. According to another OECD report, the infant mortality rate in the United States in 2002 was 7.0 per 1000 births, higher than all OECD countries except Turkey (26.7 per 1000), Mexico (21.4 per 1000), Slovak Republic (7.6 per 1000), Poland (7.5 per 1000), and Hungary (7.2 per 1000).[224] The 2002 infant mortality rate was up from 6.8 per 1000 births in 2001.[225]

Table 2
COMPARATIVE COUNTRY DATA ON
U.N. MILLENNIUM DEVELOPMENT INDICATORS

| Infant (0-1 year) mortality rate per 1000 live births (UNICEF 2004) | | Maternal mortality ratio per 100,000 live births (WHO, UNICEF, UNFPA 2000) | |
|---|---|---|---|
| Iceland | 2 | Iceland | 0 |
| Japan | 3 | Sweden | 2 |
| Singapore | 3 | Slovakia | 3 |
| Sweden | 3 | Austria | 4 |
| Spain | 3 | Martinique | 4 |
| Finland | 3 | Spain | 4 |
| San Marino | 3 | Denmark | 5 |
| France | 4 | Guadeloupe | 5 |
| Monaco | 4 | Ireland | 5 |
| Norway | 4 | Italy | 5 |

222. WHO, WORLD HEALTH STATISTICS 2006, *supra* note 214.

223. UNITED NATIONS, THE MILLENNIUM DEVELOPMENT GOALS REPORT (2005), http://unstats.un.org/unsd/mi/pdf/MDG%20Book.pdf.

224. OECD, Health Data 2006, http://www.oecd.org/dataoecd/7/41/35530083.xls (last visited Oct. 12, 2006).

225. *Id.*

| | | | |
|---|---|---|---|
| Denmark | 4 | Kuwait | 5 |
| Czech Republic | 4 | Portugal | 5 |
| Germany | 4 | Canada | 6 |
| Greece | 4 | Finland | 6 |
| Slovenia | 4 | New Zealand | 7 |
| Portugal | 4 | Qatar | 7 |
| Italy | 4 | Switzerland | 7 |
| Austria | 5 | Australia | 8 |
| Belgium | 5 | Croatia | 8 |
| Canada | 5 | Germany | 8 |
| Korea, Republic of | 5 | Czech Republic | 9 |
| Luxembourg | 5 | Greece | 9 |
| Netherlands | 5 | Belgium | 10 |
| Switzerland | 5 | Japan | 10 |
| United Kingdom | 5 | New Caledonia | 10 |
| Australia | 5 | Serbia and Montenegro | 11 |
| Cyprus | 5 | Guam | 12 |
| Ireland | 5 | Lithuania | 13 |
| Israel | 5 | Poland | 13 |
| Malta | 5 | United Kingdom | 13 |
| New Zealand | 5 | Hungary | 16 |
| Croatia | 6 | Netherlands | 16 |
| Cuba | 6 | Norway | 16 |
| Andorra | 6 | France | 17 |
| United States | 7 | Israel | 17 |
| | | Slovenia | 17 |
| | | United States | 17 |
| Source: United Nations, Statistics Division, The Millennium Development Goals Database, http://unstats.un.org/unsd/mi/mi-goals.asp (last visited Feb. 27, 2008). | | | |

### b. Population Access to Health Care Services

Health care access indicators are also critical. Access indicators reveal the distribution of health care services among the population and indicate whether groups in these populations are underserved or

not served.[226] The greatest deficiency in terms of access is the large proportion of the U.S. population, 15.8%, or 47 million people, who had no health insurance in 2006, up from 15.3%, or 44.8 million people, in 2005.[227] This deficiency comes at the same time the number of people living in poverty in the United States has been increasing from 2000 (the most recent low) to 2006. Specifically, both the number and rate of people living in poverty rose for four consecutive years, from 31.6 million and 11.3% in 2000 up to 37 million and 12.7% in 2004, respectively.[228]

Further, the United States does not compare well to other industrialized countries when it comes to per capita government expenditures on health care. According to the World Bank indicators, the United States—with 44.9% of recurrent and capital spending for health care from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds—is ranked last in the group of most industrialized states.[229] Table 3 presents the comparative public spending and public health expenditures of GDP in the world's most industrialized nations.

Table 3
COMPARATIVE HEALTH CARE EXPENDITURES &
PUBLIC HEALTH CARE EXPENDITURES OF GDP (2003)

| **Country** | **Percent Public Funding for Health Coverage** | **Percent Public Funding of GDP** |
|---|---|---|
| Sweden | 85 | 8 |
| Norway | 84 | 9 |
| United Kingdom | 86 | 7 |
| Germany | 78 | 9 |
| France | 76 | 8 |
| Italy | 75 | 6 |
| Canada | 70 | 7 |
| Switzerland | 59 | 7 |
| United States | 45 | 7 |

226. *See* WORLD BANK, WORLD DEVELOPMENT INDICATORS (2005), http://devdata.worldbank.org/wd:2005

227. DENAVAS-WALT ET AL., *supra* note 145, at 16 fig.5.

228. *Id.* at 11.

229. *See* The World Bank: Health Systems & Financing, *supra* note 210.

Source: International Bank for Reconstruction and Development/The World Bank, 2005 World Development Indicators, http://devdata.worldbank.org/hnpstats/query/default.html (last visited Feb. 27, 2006).

The United States, Mexico, and Greece are among the few OECD countries in which publicly sponsored coverage did not reach fifty percent of total coverage in 2003.[230] With 44.5% of public coverage in 2003,[231] the United States stands behind most other industrialized countries in the world. While clearly there may be differences in the quality of public coverage among OECD countries, nearly every OECD country has made a greater commitment to health coverage than the United States.[232]

In addition, the United States compares unfavorably in terms of available resources when compared to other OECD countries with comparable health care sectors—Australia, New Zealand, Canada, and the United Kingdom. Specifically, in 2004, the United States ranked below the median of these OECD countries in terms of beds per capita and physicians per capita.[233] Further, thirty-seven percent of lower-income people in the United States reported only seeing specialists, compared to fourteen to twenty-one percent in the other four countries.[234] Almost one-third of lower-income people reported going without medical tests and prescriptions due to concerns about costs.[235]

### c. Health Sector Performance on Quality and Efficiency

Quality indicators, besides their obvious importance as proxy indicators of the effectiveness of health care services, are important measures of the degree to which public and private purchasers of health care services are getting value for their health care expenditures. In comparisons of national health sectors, based on OECD indicators and methods,[236] the United States falls short. These comparisons indicate that serious inefficiencies and deficiencies exist even with the United States' high health care expenditures.

230. OECD, Health Data 2005, *supra* note 213.

231. *Id.*

232. *See* Gerard F. Anderson & Jean-Pierre Poullier, *Health Spending, Access, and Outcomes: Trends in Industrialized Countries*, 18 HEALTH AFF. 178 (1999).

233. OECD, HEALTH DATA 2006: HOW DOES THE UNITED STATES COMPARE (2006), http://www.oecd.org/dataoecd/29/52/36960035.pdf. In 2002, the number of nurses per capita in the United States fell below the OECD mean. Anderson et al., *supra* note 215, at 906.

234. Schoen, *Health Insurance*, *supra* note 212, at 77.

235. *Id.* at 78-79.

236. *See supra* note 213 and accompanying text.

Specifically, The Commonwealth Fund's study of comparative health sector quality and efficiency in the United States, Canada, Australia, New Zealand, and the United Kingdom, listed in Figure 2, demonstrates the inadequacies of the U.S. health care sector, particularly regarding patient safety and efficiency. Of note, the United States ranks last on medication errors among the other five countries studied and seemed only to exceed the other countries in reduced waiting times for services.

Figure 2
COMPARATIVE ANALYSIS OF PATIENT-CENTERED QUALITY MEASURES (THE COMMONWEALTH FUND 2001-2002)

| |
|---|
| **Patient Safety: United States Ranked Last** |
| Highest reports of medication errors (receiving the wrong medication or dose during the past two years). |
| Most likely to say a medical mistake was made in patients' treatments. |
| **Patient-Centered Care: United States Ranked Second to Last** |
| Ranked last (tied with the United Kingdom) on physicians spending enough time with patients. |
| Last on physicians listening carefully to patients' health concerns. |
| **Timeliness: United States Ranked Third** |
| Best on hospital admission waiting times. |
| Next to last on waiting five days or more for physician appointment when last needed medical attention. |
| **Efficiency: United States Ranked Last** |
| Last on being sent for duplicate tests by different health care professionals. |
| Worst on not having medical records or test results reach doctor's office in time for appointment. |
| **Effectiveness: United States Tied for Last** |
| Last in patients not getting a recommended test, treatment, or follow-up due to cost. |
| Last in patients not filling a prescription due to cost. |
| **Equity: United States Ranked Last for Lower-Income Patients** |
| Worst on patients having problems paying medical bills. |
| Worst on patients being unable to get care where they live. |
| Source: KAREN DAVIS ET AL., THE COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL: LOOKING AT THE QUALITY OF AMERICAN HEALTH CARE THROUGH THE PATIENT'S LENS (2004), http://www.commonwealthfund.org/usr_doc/davis_mirrormirror_683.pdf. |

These findings are consistent with other comparative studies of the world's most developed industrial countries.[237] Across multiple dimensions of care, the United States stands out for its relatively poor performance. With the exception of preventive measures, the U.S. primary care system ranked either last or significantly below

237. *See* Schoen, *Health Insurance*, *supra* note 212, at W5-510.

the leaders on almost all dimensions of patient-centered care: access, coordination, and physician-patient experiences.[238] These findings stand in stark contrast to U.S. spending rates that outstrip those of the rest of the world.

#### 4. Government Competence and Commitment to Health Care

Another type of relevant indicator measures government performance. These later indicators are essential for achieving progress toward implementation. Also important in comparing the performance of any country in its realization of economic human rights, such as the right to health, is the economic infrastructure. Finally, does the government deliver services and regulate in a transparent and efficient manner without corruption or ineptitude? This factor is critical if constitutional and legislative commitments regarding health and health care are to have meaning as a practical matter.

Regarding the World Bank indicators on governance, the United States ranks relatively high compared to other countries. Table 4 presents the relative ranking of the United States on the following six indicators: (1) voice and accountability, (2) political stability and absence of violence, (3) government effectiveness, (4) regulatory quality, (5) rule of law, and (6) control of corruption. These high ratings suggest that a U.S. commitment to realization of the international human right to health has a high likelihood of effective implementation.

Table 4
WORLD BANK GOVERNANCE INDICATORS FOR THE UNITED STATES (1998 & 2004)

| Governance Indicator | Year | Percentile Rank (0-100) |
|---|---|---|
| Voice and Accountability | 2005 | 88.9 |
| | 1998 | 94.2 |
| Political Stability | 2005 | 48.6 |
| | 1998 | 80.7 |
| Government Effectiveness | 2005 | 91.9 |
| | 1998 | 91.9 |
| Regulatory Quality | 2005 | 93.1 |
| | 1998 | 94.6 |

238. *Id.* at W5-517.

| | | |
|---|---|---|
| Rule of Law | 2005 | 91.8 |
| | 1998 | 92.3 |
| Control of Corruption | 2005 | 91.6 |
| | 1998 | 92.2 |

The governance indicators presented here reflect the statistical compilation of responses on the quality of governance given by a large number of enterprise, citizen, and expert survey respondents in industrial and developing countries, as reported by a number of survey institutes, think-tanks, nongovernmental organizations, and international organizations. The aggregate indicators in no way reflect the official position of the World Bank, its executive directors, or the countries they represent. As discussed in detail in the accompanying papers, countries' relative positions on these indicators are subject to margins of error that are clearly indicated. Consequently, precise country rankings should not be inferred from this data.

Source: DANIEL KAUFMANN ET AL., GOVERNANCE MATTERS V: GOVERNANCE INDICATORS FOR 1996–2005 (2006).

## V. RECOMMENDATIONS

In sum, the performance of the United States in the recognition and realization of the international human right to health falls short. The United States has done much to enhance access to health care services for its citizens through government programs and employer-sponsored health insurance, but has never made a commitment to the recognition and realization of the international human right to health. It is time for the United States to recognize this right legally and morally. The people of the United States should not accept the current reality—that their government's position on this most important human right is an option. To achieve full recognition of the international human right to health, the United States should take the following steps.

- Recognition through ratification of international human rights instruments.

An excellent first step would be the ratification of the relevant international and regional human rights instruments that establish the international human right to health as a matter of international law. These include primarily the instruments listed in Figure 1.

Ratification of these instruments would signal to the world, and also to the American public, that the government of the United States has recognized its obligations with respect to the health and health care of its population under international law. Once the federal government has taken this step, then regardless of the political party in power the government of the United States will have taken a public position in favor of assuring access to affordable, high quality health care services for all.

- Develop a national health plan to guide implementation of the international human right to health.

Ideally, it would be good for the federal government, in conjunction with states, to develop a national health plan. Such a step is recommended by General Comment 14 of the U.N. Committee on International Economic, Social and Cultural Rights.[239] However, this step, while ideal, should not stand in the way of proceeding to full realization and implementation of the international right to health in the United States. It is noteworthy that past efforts to develop a national health plan, as mandated under the National Health Planning and Resources Development Act of 1974,[240] proved to be almost impossible to accomplish because of the opposing political positions of various stakeholders.[241]

Regardless of whether there is a formal planning process that develops a document espousing goals and strategies for implementing the international human right to health, it is important that the goals of any health plan or steps toward implementation include universal coverage of some description that assures that individuals have access to affordable and high quality health care—virtually synonymous with the mandates of the international and regional human rights instruments.

- Enact or work with states to enact legislation to assure universal health coverage.

The crucial step for realization of the international human right to health in the United States is the enactment of legislation that assures universal health coverage and full public health protections for the people of the United States. The strategies that are employed are not important so long as these goals are achieved. Such flexibility is required to accommodate the profound ideological positions of different stakeholders about the public and/or private ownership and management of health care and federalism issues. It is beyond the scope and, indeed, purpose of this Article to specify the particular strategies for implementing universal coverage and public health protections. Once the political and ideological hurdle of full recognition of the international human right has been accomplished, the selection of strategies will be fairly easy.

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239. *See* ICESCR General Comment 14, *supra* note 30, at 15.

240. 42 U.S.C. §§ 300k-1 to 300k-3 (1982) (repealed by Pub. L. No. 99-660, tit. VII, § 701(a), 100 Stat. 3743).

241. *See generally* BONNIE LEFKOWITZ, HEALTH PLANNING: LESSONS FOR THE FUTURE (1983).

- Mandate and incorporate statistical indicators and data-collection methods in any legislation establishing universal health coverage and public health protections to monitor full implementation of the international human right to health.

It is imperative that legislation regarding universal health coverage and public health protections mandate effective performance indicators and data-collection methods to enable policymakers and the public to determine compliance with legislation and realizations of the international human right to health. The collection and reporting of data and comparison of data with other nations is the most effective way to assure compliance with international human rights instruments. Also, nongovernmental organizations and the public must have access to data on indicators in order to advocate effectively for the realization of human rights. Further, data on indicators must be fully discoverable in any litigation, to the extent that individuals seek legal recourse for discrimination or other denials of access to health care services and public health protections.

- Public and private health coverage programs and public health initiatives must be fully funded to assure complete implementation of the international human right to health.

Once legislation is enacted and programs are established, adequate funding in governmental budgets is essential. Similarly, to the extent that private actors are providing resources to implement the international human right to health, they must create a legal mandate to commit adequate resources to this end. Also, adequate funding includes resources to assure enforcement of antidiscrimination laws that protect access to health care and public health protections. Without adequate funding, the ratification of international human rights instruments, planning and enactment of legislation to assure health coverage, and public health protections are really meaningless. The difficult question is determining what is "adequate" funding—a question about which there is considerable debate even today.

## VI. CONCLUSION

Obviously, the devil is in the details in the implementation of these recommendations, and many options in the design and content of programs for implementation are possible. However, the United States has yet to take the first step—that is, the step of legal recognition. Taking this first step would establish a fundamental policy agenda that would change government budgetary priorities and programmatic directions.

Legal recognition of the international human right to health by the U.S. government would do much to spur action toward enhancing access to health coverage. It would create an imperative for public policymakers that would require action toward the achievement of health coverage and public health protections for the entire U.S. population.

The next step would be adoption of the goals listed above, as the steps toward full realization of the international human right to health. If these goals were to guide policy development and implementation, a national health plan—of whatever design and content—would likely achieve full recognition of the international human right to health in the United States. Full realization would then establish the United States as a world leader in one of the most laudable and beneficial goals of all time—enhanced health and well-being for all the people on Earth.