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Rights-Based Approaches to Public Health

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CHAPTER 4

A Rights-Based Approach to Health Care Reform

Anja Rudiger and Benjamin Mason Meier

INTRODUCTION

Sixty-five years after the United States first gave serious consideration to universal health care, the political agenda has once again been dominated by health care reform. In considering the scope and content of a national health care system, international human rights law offers a normative framework for setting national health care policy. Human rights norms can guide policy decisions by delineating people's rights and associated duties of state and third party actors with regard to fulfilling the right to health care, thereby intervening in the debate on private and public responsibilities. This chapter seeks to describe the obligations imposed by the human right to health and how these have been applied to successive health care reform efforts in the United States. It argues that in the United States, these obligations require treating health care as a public good that is financed and administered publicly rather than left to the competing interests of the private market. The chapter concludes with a vision for shifting U.S. discourse and policy from the commodification of health care to the collective pursuit of a healthy society.

A RIGHTS-BASED APPROACH TO HEALTH CARE

Public health practitioners occasionally refer to health as a human right, but such rhetorical usage is not usually derived from the normative foundation presented in the international legal framework nor applied rigorously to health and health care policy decisions. As Jonathan Mann and Sophia Gruskin lamented more than a decade ago, the “lack of knowledge about human rights among health professionals . . . is the dominant problem” for the “nascent health and human rights movement.”¹ Despite a recent rise in rights-based discourse, normatively driven efforts to improve public health and to ensure universal access to care have been held back by a lack of awareness of how legal norms inform public policy obligations arising from the right to health. Given the prevailing American view of health care as a commodity (to be purchased in the market) rather than as a public good and a human right (to be grounded in social justice), U.S. health reform has repeatedly faltered and health inequities have increasingly widened. Without rights-based obligations, U.S. advocates have lacked a legal and analytical basis to advance legislation for the common good and have forfeited policy to those with financial interest in maintaining the status quo.

To bridge the conceptual divide between health care and human rights, it is necessary that health advocates deepen their understanding of the application of rights to policy. Grounded in the inherent dignity and equality of all human beings, human rights are considered to be those claims that are inalienable, universal, and indivisible, with each claim of a rights-holder implicating correlative duties on a governmental duty-bearer. As codified in international law, human rights impose binding obligations on governments. Working through formal human rights obligations, rather than the nonobligatory language of morality or charity, rights discourses have long provided a legal and analytical framework for evaluating state health policies under the purview of the human right to health.² By applying the language of international law and incorporating the obligations of the right to health in national policy debates, public health advocates can invoke governmental duties to realize rights-based health care reform.

EVOLUTION OF HEALTH RIGHTS IN THE UNITED STATES

The evolution of health rights discourse in the United States has long avoided international human rights obligations while exposing a perceived—if fallacious and uniquely American—tension between personal freedom and

health equity. With reflexive antipathy toward a human right to health care, the U.S. policy debate has largely excluded human rights obligations—to the detriment of universal health care reform. After 60 years in the evolution of health rights, are international legal obligations now ripe for application to U.S. health care reform?

Although the United States has faced political claims for universal health care for more than a century,³ the international codification of a human right to health began in the aftermath of the Second World War. Addressing human rights at the end of the Depression and in the midst of the War, U.S. President Franklin Delano Roosevelt announced to the world that the post-War era would be founded on four “essential human freedoms”: freedom of speech, freedom of religion, freedom from fear, and freedom from want.⁴ It is the final of these “four freedoms,” freedom from want, that heralded a state obligation to provide for the health of its people. With Roosevelt conceiving of these freedoms as the basis of a second American “Bill of Rights,” this freedom from want would be couched in the language of liberty, with the understanding that “a necessitous man is not a free man” and the guarantee of a “right to adequate medical care and the opportunity to achieve and enjoy good health.”⁵

Creating a formal international legal system of human rights, the United Nations proclaimed its Universal Declaration of Human Rights (UDHR) on December 10, 1948, establishing through it “a common standard of achievement for all peoples and all nations.”⁶ Defining a collective set of interrelated social welfare rights for all peoples, the nascent United Nations framed a right to health in the UDHR by which, “everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and *medical care* [italics added] and necessary social services.”⁷ In preparing this right to health, derived by Eleanor Roosevelt from drafts of the American Law Institute, there was widespread international agreement that this human right to health included both universal access to modern health care and the conditions conducive to health, as reflected in the contemporaneous thinking of social medicine scholars on “underlying determinants of health.”⁸ With the U.S. government providing unprecedented medical care for its military servicemen and veterans and facing mounting pressure for implementing a comprehensive social security system, America was poised to join European nations in the post-War enactment of universal health care reform.

However, with the U.S. Congress shifting to Republican control in the 1946 midterm election, breaking up the “New Deal coalition” in U.S. liberal politics, the United States abandoned previous efforts to

consider comprehensive health insurance and made its Cold War aversion to “socialized medicine” a hallmark of its policy in health. Aligning themselves with the political objections of the Republican Party, physician groups pressed fatal objections to the budding health and human rights movement, with the American Medical Association (AMA)—reminiscent of its opposition to the “public option” in the 2009 health care reform debate—objecting vigorously to what it characterized as governmental interference in private medical practice. In rejecting the human right to health as a basis for national health care reform,⁹ repelling both Roosevelt’s and Truman’s domestic efforts to create a universal health insurance program,¹⁰ the AMA would extend to international forums its well-funded advocacy of “personal freedom” against “socialized medicine.”¹¹ Despite governmental recognition that “access to the means for the attainment and preservation of health is a basic human right,”¹² this well-funded political and professional opposition would combine to create a 20-year impasse in health reform, without any advancement in international law for health or any assumption of responsibility by the U.S. government.

Under these U.S. constraints in the midst of the Cold War, it would not be until 1966 that the United Nations codified the obligations of the UDHR in the International Covenant on Economic, Social and Cultural Rights (ICESCR), defining in it a “right of everyone to the enjoyment of the highest attainable standard of physical and mental health” that included governmental obligations to progressively realize “conditions which would assure medical service and medical attention to all in the event of sickness.”¹³ In this same human rights spirit of the 1960s—galvanizing U.S. movements for civil rights, labor, and the elderly against the inequities of market-based health insurance—the demand for universal health care would arise anew in U.S. policy discourse. Viewing health as a first-order obligation of government, President Lyndon Johnson argued that “[i]t is imperative that we give first attention to our opportunities—and obligations [italics added]—for advancing the Nation’s health.”¹⁴ In accordance with this government responsibility, drawn from President John F. Kennedy’s “New Frontier,” the United States developed its Medicare and Medicaid systems under 1965 amendments to the Social Security Act. Promulgated over the strong objections of the Republican Party, AMA, and business interests,¹⁵ Medicare would meet the needs of the elderly through guaranteed payment of care for anyone above the statutory age whereas Medicaid would provide for the indigent through matching contributions to state health programs for designated groups among the economically disadvantaged.

Although U.S. scholars and advocates would turn explicitly to a human right to health in the wake of the Medicare and Medicaid debates¹⁶—making ideological demands for a minimum level of universal medical care and putting forward systems analogous to those in Europe as a means of assuring more equitable medical services¹⁷—those references to rights would come to be interpreted, specifically by the medical profession, as the right to individual choice rather than as a governmental duty to realize health on an equitable basis.¹⁸ As health care reform movements stagnated in the 1970s and 1980s—with the entrenched commercial interests of a consolidating health industry blunting any political efforts to consider public financing of universal care—health inequalities exploded under the market-based health care model.¹⁹

With the United States then widely perceived to be a system “in crisis,” proposed health insurance reforms of the early 1990s sought to avoid the political contentiousness of advocates’ efforts to advance a rights-based approach to health care. Given an understanding that the United States had fallen behind every other high-income country in providing for the health of its people (resulting in spiraling individual health care costs and diminishing public health outcomes), President Bill Clinton’s proposals for health care reform explicitly avoided human rights language, focusing on market-based rationales for insurance reform.²⁰ Without a normative rationale for care, these 1993 efforts fell prey to the same misleading demonization of “socialized medicine” and financial interests of a profitable health care industry.

Although some advocates for rights-based reform in the 1990s referred to international legal norms, they lacked the benefit of a recognized analytical framework to set out the parameters of the then amorphous right to health. This changed in 2000 with the publication of General Comment 14 by the UN Committee on Economic, Social and Cultural Rights (CESCR). Seeking to develop a right to health commensurate with an evolving understanding of health care, the CESCR interpreted the ICESCR to find that the right to health is an “inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health.” In providing for health care, General Comment 14 outlines that all health care services should be made available, accessible (physically and economically), acceptable, and of sufficient quality, including specifically,

the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care.²¹

Given these international efforts to clarify a human right to health care, U.S. scholars obtained a stronger platform to explore rights-based health care reform as part of a larger governmental mission of “leveling the social playing field with respect to health.”²² With the United States again pursuing health care reform under President Obama, advocates resumed the effort to create a stronger role for human rights in facilitating reform and in realizing health care, and ultimately health, for all.

HEALTH CARE REFORM DISCOURSE UNDER THE OBAMA ADMINISTRATION

Preceding the 2008 presidential campaign, several universal health care bills—including at least one of them granting an explicit right to health care²³—had languished in Congress, along with a proposed constitutional amendment for the equal right to health care.²⁴ However, in the absence of federal legislation, momentum for reform was driven by states and local districts, which carried out practical experiments with incremental measures to improve access to health care. An entire field of advocacy organizations mobilized in parallel with states’ actions to address the systemic failure to provide access to health care for all, which had led to an unconscionable exclusion from care on the one hand and unsustainable costs on the other. Several states (e.g., Massachusetts, Maine, and Vermont), many Democratic Party candidates in the 2008 elections, and most advocacy groups explicitly promoted “universal coverage” as a solution to the health care crisis.²⁵ However, they stopped short of recognizing the human right to health care or taking policy actions that would fulfill this right.

The political and social context of health care reform efforts under the Obama administration presented several new opportunities for advancing universal health care reform and the right to health care. The parameters of the debate briefly appeared to change when the right to health care was elevated to a prime-time topic in an October 2008 presidential debate, with then-Senator Obama confirming that health care should indeed be a right.²⁶ He was not the only leading politician to invoke a right to health care during this reform period, yet these assertions of such a right never advanced beyond rhetoric and did not indicate an understanding of human rights norms as codified in the international legal framework. Instead, as the debate progressed, policymakers agreed to pursue an “American solution,” based on an outright rejection of universal health care models from other countries, while failing to recognize the commodification of health care as the homegrown root of the crisis. In a system where health services are sold for profit on the market and financed

through private insurance and individual payments, access to and availability of health care inevitably remain restricted to those who can pay.

Despite the onset of an economic recession in late 2008, health care reform retained its prominent position on the policy agenda, as it was recast as integral to economic recovery. Access to health care was no longer a question of ensuring population health, let alone an issue of sharing costs and risks more equitably and thus fostering the redistributive processes on which functioning health systems rely. If reformers ever envisioned the universal and equitable protection of people’s health as a key goal for society, economic arguments and cost considerations all but eviscerated this normative perspective and turned health reform into an exercise of better market management in collaboration with the health care industries that stood to benefit.

For human right to health advocates, this signaled the continuing hegemony of a familiar position in the century-old debate on universal health care in the United States. Health care was treated as a market commodity, economic rights morphed into consumer choice and corporate claims to “fair” (yet subsidized) competition, and personal responsibility for healthy behaviors trumped the government’s obligation to secure equitable access to health care as a public good. Despite widespread popular agreement on the need for radical change of the U.S. health care system, reform efforts under the Obama administration were once again subjected to market imperatives combined with a uniquely American debate over the role of government and the allocation of public and private responsibilities.²⁷

As in earlier federal efforts, the contemporary policy impasse is best illustrated by the contested nature of the function of government; in this case, exemplified in the proposal for a so-called public option – a public health insurance plan offered alongside private and for-profit plans. From a human rights perspective, an expansion of public responsibility for securing access can be considered a step toward greater accountability and health protection. However, in this case, reformers’ proposals for a public “option” mirrored the operation of market-based, private coverage plans. In fact, proponents of a public plan, including President Obama, cast their support in the language of commodified health care, offering the government’s participation in the marketplace as an injection of much-needed competition that would not threaten the market but enable it to thrive. The hegemony of the market discourse thus prompted advocates to frame their case for the “change” promised during Obama’s presidential campaign as a fair and efficient market intervention rather than an effort to better protect the public’s health. This adoption of a market-based approach—be it strategic or ideological—led to the exclusion of proposals for a universal single payer health care system, depicted once again as a foreign introduction of “socialized medicine.”

Despite the single payer bills pending in Congress and state legislatures, and significant popular support for a national health care plan in the form of single payer, mainstream advocacy groups and the Democratic Party establishment dismissed single payer as facilitating “dislocation” and opted instead for protecting the interests of those enjoying relative stability and security under the existing system—primarily those with employer-based coverage and the health care industry itself.

This balancing act of protecting the status quo while advancing incremental reforms initially gave rise to the aspirational concept of shared responsibility, which could potentially be operationalized through collectively financed health care in the form of a social insurance system based on the solidarity needed to achieve universal access to care. However, subsequent plans to force individuals into the health insurance market in their role as consumers (not as equal members of society contributing to a shared public good) reduced shared responsibility to personal responsibility, effectively increasing the industry’s customer base rather than improving access to actual care. The “rights” of insurance companies to engage in relatively unencumbered “free enterprise” received priority over the rights of people to have their fundamental needs met through collectively financed public services. A reform model that treats health care as a product sold via the insurance market for individual consumption, not only glosses over obvious “market failures”—such as the exclusion of those who cannot pay—but also pretends that each person values health services differently, based on his or her own personal preferences that can be expressed in a market exchange. This neglects our common need for the best available care and renders cross-subsidizing of the costs of such care difficult. It also indicates that the ingrained hostility to public services, especially those with a redistributive component, is not only a prerogative of American conservatives but extends across the policy spectrum and reveals the deep-seated ideological rift between the United States and its European counterparts.²⁸

COMPONENTS OF A RIGHTS-BASED APPROACH TO HEALTH CARE REFORM

Advocates for rights-based reforms seek to confront the subjugation of human needs to market forces by building a sustainable movement for an ideological shift away from a commodification of needs and toward a collective fulfillment of rights. Right to health advocates seek to establish health care as a terrain contested by rights-based claims for universality and equity, not by economic interests framed as matters of individual responsibility and choice.

During the health reform period under the Obama administration, advocates using a right to health framework ranged from single payer networks, such as Healthcare-NOW!, to the Human Right to Health Caucus of the US Human Rights Network and the Human Right to Health Care Coalition formed by Amnesty International, the Opportunity Agenda, the National Health Law Program (NHeLP), and the National Economic and Social Rights Initiative (NESRI).²⁹ While some activists were content to adopt the rhetorical power of human rights, others sought to operationalize international norms by adapting the analytical framework set out by the CESCR in General Comment 14 to the U.S. health care context. These latter activists argued that rights-based claims without substantiation in legal and policy analysis risked remaining caught in an empty cycle of ideological exchange. In contrast, marshalling the analytical force of the human rights framework could help change the terms of the debate through policy guidance informed by normative principles, rights-based indicators, and empirical evidence.

To maximize the relevance of human rights norms to the U.S. health care reform debate, rights-based advocates developed workable standards for health care reform based on the international normative indicators of accessibility, availability, acceptability, and quality of health care. Using these standards as an assessment tool (see Figure 4.1), advocates completed detailed human rights analyses of reform plans, showing that market-based proposals, including the bills adopted by the U.S. Senate and the House of Representatives,³⁰ failed to meet key human rights standards.³¹ For example, insofar as *access* to care must be universal, equitable, affordable, and comprehensive, market-based proposals were unable to guarantee meaningful access in accordance with these international standards. None of the plans included everyone, nor did any propose to fund and distribute care equitably, or render it affordable by correlating contributions (or exemptions) with the ability to pay (or lack thereof). Moreover, in their focus on individual coverage “choices,” rather than a collective goal of health protection, they cast comprehensive coverage as a “Cadillac” option, available only to the few and subject to a proposed excise tax.

Beyond revealing the shortcomings of reform plans that purport to increase access, human rights norms offer guidance on how a health care system should be financed to meet rights-based standards. To translate this into practice, NESRI has developed 10 human rights principles for financing health care (see Figure 4.2), tailored to the U.S. context and derived from the standards outlined in General Comment 14.

Starting with the fundamental yet much neglected principle that the purpose of a health system is to secure comprehensive protection of people’s health—uncompromised by profit motives or other extraneous

FIGURE 4.1 Human Rights Assessment Tool for Health Care Reform

Summary Scorecard (Condensed Version)

Human Rights Principles		Proposal X	Proposal Y
Health care is a right			
Universal access to health, goods, facilities, and services	Universality		
	Affordability		
	Equity		
	Comprehensiveness		
Availability of health infrastructure and services everywhere			
Acceptability and dignity of care			
Quality of health care			
Accountability			

Assessment Standards (Condensed Version)

ACCESS		
Access to care must be universal and must protect everyone's health on an equitable basis. Facilities, goods, and services must be affordable , comprehensive , and physically accessible for all where and when needed.		
Universal		
Health care must be equally accessible to every person living in the United States, guaranteed and continuous throughout people's lives.		
Standards	Proposal X	Proposal Y
Everyone should have guaranteed access to health care. In an insurance system, this also implies that everyone receives comprehensive coverage.		
No one should be discriminated against on the basis of income, health status, gender, race, age, immigration status, or other factors.		
Access to care should be easy, continuous, and integrated for everyone.		
Affordable		
Health care must always be affordable for everyone, with financial contributions based on the ability to pay, not on the use of services.		
Standards	Proposal X	Proposal Y
Access to health services should be uncoupled from payment, with services funded through pooled contributions based on the ability to pay.		

(Continued)

FIGURE 4.1 Human Rights Assessment Tool for Health Care Reform Continued

Standard	Proposal X	Proposal Y
Prices charged by the private sector (e.g. insurers, providers, pharmacies) should be publicly regulated. There should be no financial barriers to care, including through deductibles or other out-of-pocket costs.		
Public subsidies should be designed to enable equitable access and incentivize comprehensive and quality services.		
In an insurance system, risk pools should be as broad as possible to share costs and risks equitably and increase affordability for all.		
Equitable		
Health care facilities, goods, and services must be distributed equitably, with resources allocated and accessed according to needs.		
Standards	Proposal X	Proposal Y
Disparities in access to care, and different tiers of access or coverage, should be eliminated.		
Access to care should be on the basis of clinical need, not privilege, payment, employment, immigration status, or any other factor.		
Health care should be recognized as a public good, which everyone can readily access based on their needs.		
The public financing and administration of the health care system should be expanded as the strongest vehicle for guaranteeing equal access.		
Comprehensive		
Everyone must get all screenings, treatments, therapies, drugs, and services needed to protect their health.		
Standards	Proposal X	Proposal Y
In an insurance system, coverage benefits for every person must be comprehensive and encompass all preventive, remedial, rehabilitative and palliative care, including mental health, dental and vision care, prescription drugs, and reproductive health.		
Health care services should not be restricted for certain groups, and no one should be penalized for his or her health status or behavior.		

(Continued)

FIGURE 4.1 Human Rights Assessment Tool for Health Care Reform Continued

AVAILABILITY		
Adequate health care infrastructure (e.g., hospitals, community health facilities, trained health care professionals), goods (e.g., drugs, equipment), and services (e.g., primary care, mental health care) must be available in all geographical areas and to all communities.		
Standards	Proposal X	Proposal Y
Health care infrastructure and resources should be distributed equitably to ensure that health care is available where it is needed.		
Health care professionals should be brought into underserved areas and fields.		
Hospitals and community health centers should be supported in underserved areas.		
Everyone should be able to have a regular primary care provider and to select providers of their choice.		
ACCEPTABILITY AND DIGNITY		
Health care institutions and providers must respect dignity, provide culturally appropriate care, and be responsive to needs based on gender, age, culture, language, and different ways of life and abilities. They must respect medical ethics and protect patient confidentiality and privacy rights.		
Standards	Proposal X	Proposal Y
Health services should be responsive to patients' needs and culturally appropriate.		
Language services should be routinely provided.		
Patient privacy rights and patient control over personal data should be strengthened.		
QUALITY		
All health care must be medically appropriate and of good quality, guided by quality standards and control mechanisms, and provided in a timely, continuous, safe, and patient-centered manner.		
Standards	Proposal X	Proposal Y
Uniform quality standards and independent quality control should be enforced for all insurers and providers.		
Disparities in quality of care received by different population groups should be eliminated.		
In an insurance system, payments to providers should not depend on a patient's insurance source, but instead be linked to appropriate, coordinated, and patient-oriented care and to health outcomes.		

(Continued)

FIGURE 4.1 Human Rights Assessment Tool for Health Care Reform Continued

ACCOUNTABILITY		
Private companies and public agencies must be held accountable for protecting the right to health care through enforceable standards, regulations, and independent compliance monitoring.		
Standards	Proposal X	Proposal Y
Insurers, providers, manufacturers, and public agencies should operate transparently, with democratic oversight and regulation.		
People should have adequate information to navigate the health system easily, and they should be able to participate in health system decision making.		
Private companies and public agencies should be held accountable for meeting the populations' health needs.		

interests—rights-based guidance then sets out the parameters for financing universal and equitable access. Universality requires that health care is financed in a way that includes every resident and avoids separating people into different tiers. The principle of equity requires that health care be treated as a public good and shared equitably by all, not as a market commodity sold only to those who can pay.³² As government is responsible for ensuring equal access to public goods for all, rights-based access to care is best achieved through public financing and administration. Although the international norms allow the possibility of a public, private, or mixed system (GC 14 at par. 36), there is overwhelming empirical evidence, both in the United States and abroad,³³ that governments have been unable to fulfill their obligation to protect against private actors, such as insurance companies, undermining the right to health care (GC 14 at par. 33). Instead, private or privately administered financing has consistently led to inequities and disincentives to providing appropriate coverage and care, because such market-based mechanisms must prioritize business imperatives over health concerns. As a result, evidence confirms that highly commodified systems are positively correlated with ill health.³⁴ The right to health requires the removal of all barriers interfering with access to health services (GC 14 at par. 21); therefore, access should be free at the point of use and financed in an equitable and collective way through progressive taxation or social insurance contributions. This also entails that insurance coverage may be a sufficient but not a necessary way to facilitate access to care. Coverage can fulfill this intermediary role only if it is based on the principle of income and

FIGURE 4.2 Human Rights Principles for Financing Health Care

A. Definition of Principles

1. **Focused on health:** Health care financing must be completely aligned with the central purpose of a health system: protecting people's health.
2. **Universal and unified:** Health care financing must secure automatic access to care for everyone and avoid separating people into different tiers.
3. **Public:** Health care is a public good that should be publicly financed and administered.
4. **Free:** At the point of access, health care services must be provided without charges or fees.
5. **Equitable:** Health care financing must be equitable and nondiscriminatory.
6. **Centered on care:** Care should be financed as directly as possible, without intermediaries. Insurance coverage, if used as a vehicle for financing care, works only if based on the principle of risk and income solidarity.
7. **Responsive to needs:** Resources must be allocated equitably, guided by health needs.
8. **Rewarding quality:** Financing mechanisms must reward the provision of quality, appropriate care, and the improvement of health outcomes.
9. **Cost-effective:** Resources must be used effectively and sustainably to protect the health of all.
10. **Accountable:** Financing mechanisms and procedures must be accountable to the people.

B. Scorecard for Health Care Financing Proposals

Human Rights Financing Principles	Proposal X	Proposal Y
Focused on health, with comprehensive services		
Universal and unified		
Public		
Free at the point of access		
Equitable		
Centered on care		
Responsive to needs		
Rewarding quality		
Cost-effective		
Accountable		

risk solidarity, with those who happen to enjoy better health or higher incomes contributing at a level that helps support the entire system.

Rights-based financing guidelines also address the indicators of availability, acceptability, and quality by requiring financing mechanisms to allocate resources based on needs, to reward the provision of quality and

appropriate care that improves health outcomes, and to use resources cost-effectively to benefit the whole of society while prioritizing investments for disadvantaged groups.³⁵ Finally, of particular significance to the U.S. health care financing debate are the procedural standards common to all human rights, requiring nondiscrimination, transparency, participation, and accountability. In a market-based system that commodifies needs, few procedural protections are available, whereas in a rights-based system, all financing mechanisms and procedures must be developed with and overseen by the people for whose benefit they exist.

These health care financing standards, derived from the international framework, are embedded in an overarching human rights narrative that is centered on the principles of universality, equity, and accountability. In a society that relegates the fulfillment of human needs to residual programs for the poor, universality is an important but often overlooked standard. The denial of economic and social rights affects everyone (albeit not equally), as does the call for solidarity to provide public goods collectively. The principle of equity is essential to challenging the health system's reliance on inherently unequal market distribution, driven by individual purchasing power rather than collective need.³⁶ Although this has not gone unnoticed by policymakers, evidenced by public funding for insurance programs such as Medicare and Medicaid as well as public health initiatives, these interventions effectively prop up a regressively financed system that continuously produces new inequities. As a result, health disparities in the United States remain far greater than in comparable high-income states, at the same time that any government involvement that could potentially rectify this is demonized. A rights-based emphasis on accountability can address the practical concerns that may contribute to these antigovernment sentiments. In a market-based system, accountability amounts to no more than buyer's choice, and government is seen as simultaneously remote and overbearing. In a rights-based system, however, institutions have a duty to enable people to participate in decision-making and exercise monitoring and oversight functions, which are crucial prerequisites for ensuring the system's legitimacy.

Outside the rights-based advocacy community, the principle of accountability remains largely limited to calls for basic transparency and information, and advocates' arguments for universality and equity tend to be muddled both along and across predictable fault lines. For example, moderate reformers seeking to supplement their market-based defense of a public insurance option with a normative argument have appealed to solidarity grounded in "the social contract that binds us to each other,"³⁷ whereas single payer advocates, whose proposals require social solidarity, have attempted to show that their plan would benefit self-interested individuals.³⁸

Using a human rights analysis, however, advocates can link rights with responsibilities, individual and community needs with collective contributions, and government involvement with people's participation in a way that builds support for the right to health care and fundamental U.S. health system reform.

CONCLUSION

Grounded in an analytical framework of human rights standards, advocates for rights-based health reform are able to address both the policy and practical implications of commodified health care and counter the ideological hegemony of individualism that resides within the "free market" paradigm. By envisioning health care as a public good, financed and administered collectively to realize the social goal of a healthy society, rights-based activists in the United States can create a powerful narrative to elevate the public sphere as an enabler of needs fulfillment, and a protector against inequitable market forces, thereby transcending the prevailing perception of human rights as protections only against the state. This may ultimately pave the way not only for the fulfillment of the right to health care but also for the recognition of the underlying social determinants of health and thus the realization of a synoptic right to health. If we are to progressively realize this right, we need to redouble our efforts to include health care reform advocates in a broader movement for social and economic rights in the United States.

NOTES

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CHAPTER 5

Rights-Based Approaches and Millennium Development Goals

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INTRODUCTION

Realizing human rights, particularly the right to health, requires States to develop policies, allocate resources, and create necessary infrastructure. In the case of health, this requires the delivery of promotive and preventive programs and quality and safe health services to all. At the global scale, this responsibility is usually shared between developing and developed countries (with developed countries typically serving as donors and trade partners).

With or without assistance from developed countries, some developing countries have created strategies more or less effective in ensuring the right to health of their citizens. Cuba¹ for example, has developed an army of more than 33,000 doctors that covers the entire population through a network of about 500 clinics with coverage of 30,000–60,000 citizens each. Bangladesh,² on the other hand, relies on a network of village health volunteers, government-run health centers, and nongovernmental organizations (NGOs) that provide services. However, like millions of people in developing countries, the lowest quintile in the socioeconomic scale in Bangladesh die at a much higher rate in spite of the existing affordable preventive and curative interventions.

Until the year 2000, there had not been a list of accepted measurable goals to gauge development progress toward ensuring access to health care for all. That year, the United Nations (UN) General Assembly, along with