

Pursuing A New Vision For Health Care: A Human Rights Assessment of the Presidential Candidates' Proposals

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..."
Preamble to the Constitution of the World Health Organization

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
Martin Luther King Jr.

Why Apply Human Rights Principles to Health Care in the United States?

The purpose of a health care system is to preserve and improve health. While most people would agree with this simple premise, health care in the United States does not adequately achieve this purpose. Although many doctors, community clinics and public hospitals serve our health, a significant segment of the health care industry is designed to maximize profit rather than care.

Indeed, private insurers and providers have a legal obligation to their shareholders and investors to make a profit. In this model, health care is a commodity. This has grave consequences for our health: studies have shown that maximizing profit generally correlates with minimizing care, higher rates of death, unnecessary suffering, and loss of health (see box).

Profits Getting Bigger People Getting Sicker

► For-profit hospitals maximize profits and minimize care:

Payments for care at investor-owned, for-profit hospitals are 19% higher than at not-for-profit hospitals; death rates at for-profit hospitals are 7% higher than at not-for-profit hospitals, and 25% higher than at teaching hospitals (New England Journal of Medicine, 1999).

► Public and not-for-profit hospitals provide better care:

Public and not-for-profit hospitals consistently perform better than for-profit hospitals, with federal and military hospitals performing best. Quality of care was measured for three common medical conditions: congestive heart failure, heart attack, and pneumonia (Archives of Internal Medicine, 2006).

The commodity-based approach to health care is fundamentally flawed. It restricts access to health care to those who can afford to buy it and assumes that prices will be reasonable because supply and demand are linked. With most products, consumers limit their demand based on price. But in the case of health care, demand is not price sensitive – *when you are sick you don't have a choice*. Supply, on the other hand, is most profitable if care is either charged at expensive rates, in the case of providers, or avoided altogether, in the case of private insurers. Insurance companies operate under incentives to reduce care and do not need to deliver a quality product or service in order to make money.

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Market Forces Pay Death Dividends

Giuliani (R) is one of several candidates who intend to let market forces determine the demand for and supply of health care. He seeks to deregulate the private health insurance industry, so that insurers everywhere can sell policies with no set minimum benefits, refuse applicants with health risks, and charge different premium rates based on applicant profiles or status.

Projected Impact: Currently, many people with health issues have difficulties obtaining insurance. In 2006 almost one in five patients with cancer could not buy health insurance or lost their coverage. Nearly one in three uninsured cancer patients delayed or did not get treatment because of costs (*National Survey of Households Affected by Cancer*, 2006). Over 22,000 people die unnecessarily each year because they are uninsured (Urban Institute, 2007). Further deregulation, such as the removal of “consumer protections”, would mean that even more people would be denied coverage and lack access to adequate care.

Human Rights Implication: This would constitute a violation of the human right of all persons to have equal access to appropriate health care.

Health care is not just another consumer product that we can choose to buy or forgo. When it comes to our health, we are not consumers but human beings. Using human rights to inform policy ensures that we will develop a health care system that enables any person in the United States to get the care they need.

What Is the Human Right to Health?

A human right is one that each person possesses by virtue of being human. The United States recognized human rights as early as the Declaration of Independence:

“[T]hat all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness. — That to secure these rights, Governments are instituted among Men [...].”

Indeed, the early founders saw protection of human rights as one of government’s primary functions. The human right to health is an indispensable component of the right to life, liberty and the pursuit of happiness. Health is fundamental to the well-being of human beings and to our pursuit of fulfilling lives.

While we cannot claim a right to be healthy, we do have the right to be as healthy as possible, within the limits posed by our bodies and behaviors. Many external factors influence our health, such as the environment, housing and workplace conditions, and medical care. In so far as these are shaped by society, government has an obligation to protect our health and to help us be as healthy as possible.

Where Is the Human Right to Health and Health Care Recognized?

- Universal Declaration of Human Rights (Article 25)*
- American Declaration on the Rights and Duties of Man (Article 11) *
- International Covenant on Economic, Social and Cultural Rights (Article 12)
- Convention on the Elimination of All Forms of Racial Discrimination (Article 5) *
- Convention on the Elimination of All Forms of Discrimination Against Women (Articles 12 & 14)
- Convention on the Rights of the Child (Article 24)

* The United States has committed to these Declarations and Conventions.

- ▶ The human right to health guarantees a system of health protection.
- ▶ Everyone has the right to enjoy, on an equal basis, a variety of facilities, goods, services, and conditions necessary for the realization of the highest attainable standard of health.
- ▶ This right includes access to appropriate health care, and to the underlying social determinants of health, such as adequate food, housing, and a healthy environment.

Many countries around the world have long recognized the human right to health, in particular through ensuring universal access to health care for their people. The United States stands alone among industrialized countries in failing to ensure that all of its people have access to care.

Adoption of Universal Health Care Around the World

Germany	1883	Canada	1966
Switzerland	1911	Denmark	1973
New Zealand	1938	Australia	1974
Belgium	1945	France	1978
United Kingdom	1946	Italy	1978
Sweden	1947	Portugal	1979
Greece	1961	Spain	1986
Japan	1961	South Africa	1996

How Can Human Rights Principles Guide Health Care Reform?

In a health care system based on human rights the financing and delivery of care prioritizes the protection of health over any other factors. Such a system may not restrict care to save costs at the expense of good health, either to gain profit or reduce public expenditure. It cuts costs by preventing disease and ill health, not by denying care to those who need it.

According to human rights principles, which include universality and equity, the development (or reform) of a health care system must focus on the most vulnerable people while aiming to address the needs of all. Reforms can be incremental, progressing toward

universal availability of and access to care, but they must not regress and endanger existing access to services. There is no specific human rights model for health care financing and delivery, but the principles of the right to health care form a holistic framework against which any development or proposal can be assessed.

A core aspect of these principles is the government's obligation to respect, protect, and fulfill the right to health. This includes addressing human rights violations, such as health inequalities, ensuring access to appropriate care, and holding private health insurers and providers accountable for meeting human rights standards.

Preserving Health: It's Happening Now, Somewhere in America

The national tuberculosis program, run by a division of the Centers for Disease Control and Prevention, seeks to promote health and quality of life through preventing, controlling, and eliminating tuberculosis (TB). Successful screening for and treatment of tuberculosis is seen as beneficial both for the patient and the community. Therefore, the treatment of TB, whether carried out by a public or private provider, is considered a public health function delivered at no cost to the patient. The provider is obliged to prescribe and adhere to an appropriate regimen until treatment is completed. This includes addressing both clinical and social issues that are relevant to the patient, and tailoring the treatment accordingly, based on the principles of patient-centered care. In 2005 the TB rate (4.8 cases per 100,000 people) was the lowest since national reporting began in 1953 (Centers for Disease Control, 2006).

Human Rights Implication: The government's TB program is addressing its obligation to ensure everyone has equal access to widely available, quality care.

Guiding Questions for Health Care Reform

The following questions can guide health care reform efforts in shifting from a market framework to one based on human rights.

- ?** Does the reform effort treat health care as a consumer product, a privilege, or charity? Or does it recognize that we all have the right to health care?
- ?** Does the reform effort include financial incentives to limit delivery of health care? Or does it base its financing model on the public obligation to preserve health?
- ?** Does the reform effort set a goal of universal access to care, with attention to those who are most vulnerable due to age, income or similar factors? Or does it limit access to those who can afford it?
- ?** Does the reform effort reverse any gains made in increasing the availability of, and access to, health care? Or does it offer steps toward more widely available and accessible quality care?
- ?** Does the reform effort seek to achieve affordable coverage by limiting the care available to patients? Or does it set minimum standards of comprehensive, quality care for all?

Answers from State-Based Reform Efforts

States across the country have taken a lead in health care reforms. While most of these reforms are incremental in nature, rather than fully shifting to a human rights framework, they do offer valuable examples for comprehensive reforms at a federal level.

Recognizing the Right to Health	Expanding Access	Increasing Availability of Care
<ul style="list-style-type: none"> ▶ Constitutional amendments to recognize the right to health have been introduced in North Carolina and Minnesota. ▶ The constitutions of Alaska, Hawaii, Louisiana, Michigan and New York declare that the state should provide for the promotion and protection of public health. ▶ In Wisconsin, as of 2008 all children will be covered by a new public insurance plan, which is based on recognizing that “every Wisconsin resident has the right to health care.” ▶ Seattle voters approved a local ballot measure in 2005 stating that “everyone in America has the right to health care of equal high quality”. A similar resolution was approved by Tacoma voters in 2007. 	<ul style="list-style-type: none"> ▶ Several states have enacted, or are planning to enact, universal or near-universal health insurance coverage, including Maine, Massachusetts, Vermont and, with a bill pending, California. In eleven other states, comprehensive reform plans are under consideration. ▶ New Jersey has expanded insurance coverage to children from families with incomes up to 350% of the federal poverty level (FPL). Additionally, all families with uninsured children are afforded the opportunity to buy into state-sponsored health care. ▶ States such as Maine, Minnesota, Pennsylvania and the District of Columbia have expanded Medicaid eligibility to parents with incomes between 200% and 300% FPL. 	<ul style="list-style-type: none"> ▶ Over 3,800 nonprofit community health facilities provide care to 15 million people, regardless of ability to pay, in underserved rural and inner city areas. 36 states support their community health centers with state funds. ▶ Pennsylvania’s health care reform efforts include funds for 2008 to increase access to primary health care in underserved rural areas, starting with a new community health center and two mobile health clinics. ▶ Montana’s legislature enacted a law in 2007 allocating annual funds to develop new community health centers and provide new primary care services to approximately 16,000 Montanans.

Key Principles of the Right to Health Care

The right to health care means that hospitals, clinics, medicines and doctor's services must be **accessible**, **available**, **acceptable**, and of good **quality** for everyone, on an equitable basis, where and when needed.

Health care must be financed and delivered in a **non-discriminatory** way that enables the **participation** of individuals and communities, provides access to **information**, ensures **transparency** of institutions and processes, and has effective mechanisms to hold both private sector and government agencies **accountable**.

The following tables introduce these substantive and procedural principles, and present highlights from the presidential candidates' proposals to illustrate how a human rights framework can be applied.

ACCESS		
Access to health care must be universal, guaranteed for all on an equitable basis. Health care must be affordable and comprehensive for everyone, and physically accessible where and when needed.		
AFFORDABILITY	EQUITY	COMPREHENSIVENESS
Health care is affordable for everyone, with charges based on the ability to pay, regardless of how health care delivery is financed.	Health care is distributed equitably, with resources allocated and used according to needs and health risks.	Health care includes all screening, treatments, therapies and drugs needed to preserve and restore health.
<ul style="list-style-type: none"> • Universal coverage should be guaranteed, not just mandated, e.g. through automatic enrollment. • Making private insurance policies more affordable may require regulating the price of premiums and out-of-pocket costs. • Costs of private coverage should be linked to ability to pay, which may require public subsidies to buy private insurance. Subsidies should be designed to have the same value for everyone. They should also create incentives to select coverage and care according to the quality. • Insurers, pharmaceutical companies and providers should be regulated to limit profits and overhead. • Reforms should not push people into smaller risk pools, e.g. moving from employer coverage to individual policies, as that would reduce affordability. 	<ul style="list-style-type: none"> • Disparities in access to care should be eliminated, e.g. the government should regulate the private sector to reduce disparities and, where it has contracts with private insurers and providers, it should include goals and targets for reducing disparities. • Access to health care should be on the basis of need, not privilege, and should not be refused or limited because of health status, income, age, sex, sexuality, disability, race, ethnicity, language, or national origin. • Access to care should be the same for everyone, regardless of financing source. • Health care should be delivered in a way that allows full and adequate access regardless of physical distance, business hours, disabilities, primary language, etc. 	<ul style="list-style-type: none"> • Incentives for comprehensive care that improves health outcomes should replace market-based incentives for limiting care. • All insurance plans should be subject to minimum standards for coverage benefits, that include comprehensive benefits covering preventive, diagnostic, curative, chronic, palliative, mental, reproductive, dental and eye care. • Patients who avoid getting preventive care should not be penalized by restricting (or increasing charges for) access to curative care. Instead, positive incentives should be put in place.

These principles are derived from the international human rights framework, including General Comment 14 on *The right to the highest attainable standard of health*, issued by the UN Committee on Economic, Social and Cultural Rights in 2000.

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) must be available in all geographical areas and to all communities.

- Health care should be available where it is needed.
- Health needs assessments should identify underserved geographical areas and social groups, including shortages in infrastructure, workforce, goods and services, and provide a basis for equitable distribution according to needs.
- Sufficient health care professionals should be recruited and retained, and, if necessary, receive incentives for working in underserved areas.
- Hospitals should be built and supported in underserved areas, such as poor rural and inner city communities.
- All insurers, including public programs, should pay appropriate reimbursement rates to providers to ensure that providers accept all patients.

ACCEPTABILITY and DIGNITY

Health care institutions and providers must respect dignity, provide culturally appropriate care, be responsive to needs based on gender, age, culture, language, and different ways of life and abilities. They must respect medical ethics and protect confidentiality.

- All aspects of health services (clinicians, hospitals, insurers, public agencies) should be responsive and sensitive to patients' diverse needs, including those based on gender and age. This is an obligation on institutions as well as on health care professionals.
- Health services need to be culturally appropriate, delivered by personnel trained in cultural competence.
- Insurers and providers should make translation/interpretation available as a standard service for limited English proficiency speakers and other groups, such as the Deaf community.
- Diversity of the health care workforce should be facilitated through concrete measures, in order to achieve a better representation of marginalized communities at all levels, including among physicians and specialists.
- Health services should foster a culture of dignity that helps to prevent neglect and degrading treatment.
- Patient confidentiality should be guaranteed through privacy protections for, and patient control of, personal data.

QUALITY

All health care must be medically appropriate and of good quality, guided by quality standards and control mechanisms, and provided in a timely, safe, and patient-centered manner.

- Private insurers and providers should be required to focus on improving the quality of care. Incentives should be realigned to ensure quality, safe, patient-oriented and timely care.
- Uniform quality standards and independent quality control processes should be adopted and enforced for all public and private insurers and providers.
- Paying providers based on performance should not encourage them to cherry pick among patients, e.g. by trying to exclude sicker people.
- Quality should be measured by how well a program meets health needs, not by assessing the healthy behaviors of people being served.

ACCESS

Insured People Are Healthier

Clinton, Edwards and Obama (D) all propose to expand eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP), e.g. through including childless adults at 100% of the federal poverty level and children up to 250% FPL. No proposals have been made for expanding eligibility for Medicare (currently from age 65).

Projected Impact: Uninsured people - most of whom are working adults with lower incomes - tend to develop more serious health conditions and die prematurely (Institute of Medicine, 2004). Older adults are a key group that could benefit from expanding insurance. Previously uninsured older people with cardiovascular disease or diabetes have shown significant improvements in health after acquiring Medicare coverage at age 65 (Journal of the American Medical Association, 2007). Any increase in access to insurance, through expanding Medicaid and SCHIP, and possibly through including people from age 50 or 55 in Medicare, is likely to improve health outcomes.

Human Rights Implication: Lack of health insurance is linked to lower access to care and poorer health outcomes, which undermines the human right to health. Expanding public insurance can help improve both access and health.

AVAILABILITY

Wanted: Doctors and Hospitals in Our Communities

Clinton (D) proposes a loan forgiveness program to address the shortage of physicians providing primary care. However, her plan does not address the broader problem that entire communities in inner cities and poor rural areas lack doctors, hospitals and clinics.

Projected Impact: Six of the eight hospitals that closed in New York City between 1995 and 2005 were located in or near communities of color (Opportunity Agenda, 2006). Across the country there are today 300 fewer public hospitals, which provide a crucial safety net function, than 15 years ago, with recent closures in L.A., D.C., St. Louis and Milwaukee, and the threatened closure of Atlanta's largest hospital (New York Times, January 2008). If this trend is not addressed, increasing numbers of people will have no adequate health care available in their communities.

Human Rights Implication: A lack of attention to the availability of sufficient health care services everywhere could result in a human rights violation as care becomes less available to people who need it, threatening the health of whole communities.

ACCEPTABILITY

Care That Speaks Our Language

Candidates: Most Democratic candidates recognize the health inequalities based on ethnicity and language, and some call for more translation services or for enhancing the cultural and language competence of health services.

Projected Impact: Cultural and language barriers affect both access to and quality of care. For example, among low-income citizens, only 48% of Spanish-speaking Latinos visited a doctor in a year, compared to 67% of White English speakers and 56% of English-speaking Latinos (Kaiser Commission, 2003). Translation and interpretation services, coupled with cultural competency programs, can help overcome those barriers to quality health care. Training in the provision of culturally appropriate care may have to be mandated to ensure widespread uptake. Some good practice exists, such as laws in New Jersey and Washington that require health care professionals to receive cultural competency training. In New Jersey, this is a mandatory condition for physicians renewing their licenses.

Human Rights Implications: If health reform plans mandated training, this would help achieve better cultural and language competence. Such training could contribute to the protection of the rights to health and to equality.

QUALITY

Making Standards Count

McCain (R) suggests developing national standards for treatments and outcomes, as do many Democratic candidates. Standards can measure clinical effectiveness for research and development purposes, which seems to be McCain's focus, or the performance of providers and insurers to improve quality. However, McCain states that the quality of American health care is already the best in the world, despite evidence to the contrary.

Projected Impact: There are up to 101,000 unnecessary deaths a year because of the way health care is organized. The United States ranks at the bottom of 19 industrialized countries regarding preventable mortality (Health Affairs, 2008). Standards coordinated at the national level could be an incentive to improve performance, if they are used not only for collecting and reporting data but also for implementing practical changes and enforcing compliance.

Human Rights Implications: Preventable deaths violate the human right to life. Uniform standards, control and compliance mechanisms can help counteract pressures for cutting corners and increase accountability for the human right to health and life.

What Do Procedural Human Rights Principles Mean for Health Care Reform?

<p>Non-Discrimination</p> <p>Health care is provided and accessible without discrimination (in intent or effect) based on health status, race, ethnicity, age, sex, sexuality, disability, language, religion, national origin, income, or social status.</p>	<p>Information & Transparency</p> <p>Health information is easily accessible for everyone, enabling people to protect their health and claim quality health services. Institutions that organize, finance or deliver health care operate in a transparent way.</p>
<ul style="list-style-type: none"> • Direct and indirect discrimination by insurers and providers should be eliminated, using monitoring, reporting and compliance procedures. • Data should be collected throughout the health system to detect discrimination and disparities (regarding patients, communities, and workers), and used to meet targets for improving performance. All prohibited grounds of discrimination should be addressed. • Health care provision should not be restricted for certain groups, e.g. women should be able to access comprehensive health care, including reproductive care. 	<ul style="list-style-type: none"> • Comprehensive public information on treatments, services, facilities, costs and entitlements should be made available in user-friendly formats. • Patient education programs should be offered. • Communication between patients and providers should be facilitated. • Processes and systems of insurers, providers and public agencies should be fully transparent.
<p>Participation</p> <p>Individuals and communities can take an active role in decisions that affect their health, including in the organization and implementation of health care services.</p>	<p>Accountability</p> <p>Private companies and public agencies are held accountable for protecting the right to health care through enforceable standards, regulations, and independent compliance monitoring.</p>
<ul style="list-style-type: none"> • Patients and communities should be able to participate in health system decision-making, beyond decisions relating directly to their own health. • Patients should be part of insurer and provider governance and oversight structures. • Communities should be enabled to take part in local decisions about health care. • Community health workers should be supported to facilitate patients' interaction with institutions. • Robust complaint procedures should exist in all institutions. • Reforms should not reduce participation (e.g. medical liability reform) 	<ul style="list-style-type: none"> • Employers: mechanisms for ensuring a set minimum contribution to employees' coverage or to public health care costs. • Insurers: mechanisms for ensuring that provision of care is prioritized over profit (e.g. regulation of policy issuing, pricing, profit, marketing, benefits) • Providers: enforceable mechanisms for quality and cost control; accountable to patients directly • Public agencies/ government: enforcement of private sector accountability; health impact assessments; right to seek redress in court to enforce obligations; public insurers to prioritize appropriate reimbursement rates over cost cutting.

PARTICIPATION

The Health Care We Need: Having Our Say

Edwards (D) proposes to “empower patients” through report cards on hospitals’ effectiveness in treating injuries and diseases. He also suggests email and group consultations to promote communication between patients and doctors.

Projected Impact: These measures can inform patients about their choices of treatments, but fall short of enabling people to take an active role in decisions that shape these choices, such as the placement of hospitals and the way services are provided to their community, to ensure that these meet their needs. Good practice exists at the level of community health centers, which are the only health care providers required to have a majority of active patients on their governing boards. Research has shown that this participation makes providers more responsive to community needs and improves access and quality (National Association of Community Health Centers, 2007).

Human Rights Implication: Participation in decision-making is a key principle applicable to all human rights. Any health care reform that does not involve individuals and communities in the reform effort and in health care decisions would violate this principle, as well as reduce the effectiveness of health care services provided.

How Are the 2008 Presidential Candidates Measuring Up?

Most presidential candidates have proposed some kind of health care reform. An assessment of these proposals, using human rights principles, shows their strengths and shortcomings. While most of them do not refer to the right to health care, some of their ideas contain crucial elements of this right, such as requiring insurers to issue policies to any applicant, regardless of health status. To build on these elements and enable everyone to obtain the health care they need, reform proposals would need to shift their perspective from health care as a product and privilege to health care as a right.

Principles	Clinton	Edwards	Obama	Kucinich	Giuliani	Huckabee	McCain
Recognition of right to health care	-	-	-	-/+	-	-	-
Elements of guaranteeing the human right to health and health care:							
Availability of health infrastructure and services everywhere	-	-/+	-/+	+	-	-	-
Universal access to health goods, facilities and services	Affordability	-/+	-/+	-/+	+	-/+	-/+
	Equity	-	-	-	+	-	-
	Comprehensiveness	-/+	-/+	-/+	-/+	-	-
Acceptability and dignity of care	-/+	-/+	-/+	+	-	-	-
Quality of health care	-/+	-/+	-/+	+	-	-	-/+
Non-discrimination	-/+	-/+	-/+	+	-	-	-
Participation	-	-	-	+	-	-	-
Information and transparency	-/+	-/+	-/+	-/+	-/+	-	-/+
Accountability	-	-/+	-/+	-/+	-	-	-

KEY: + fully meets human rights standards; -/+ partially meets human rights standards; - fails to meet human rights standards
The complete analysis of the candidates' proposals, on which this table is based, can be obtained from NESRI and NHeLP.

This brief assessment shows that none of the reform proposals fully meet human rights standards. Democrats, on the whole, score better than Republicans, although only one candidate's proposal, consisting of a Congressional bill (HR 676) co-sponsored by Representative Kucinich, fulfils most human rights principles. Viewed from a human rights perspective, the proposals of the leading Democratic candidates are almost indistinguishable from each other, as are those of leading Republicans. Most Democrats favor a multi-payer, mixed public-private system with mandates for employers and individuals. Most Republicans rely on appeals to personal responsibility for preserving health, and give private insurers and public programs the power to reward healthy behaviors. Both Democrats and Republicans offer tax subsidies for the purchase of insurance. For Republicans, this subsidy is linked to market deregulation and a shift from employer-based coverage to the individual insurance market, whereas Democrats call for regulation - through more or less specific measures - of the health insurance market.

Almost all candidates score lowest on the principles of equity and participation. Democrats note the existence of health disparities but fail to recognize that such inequities are fueled by a segregated system in which the care people receive is dictated by their status, their coverage source, and the neighborhood they live in, but not by their needs. No candidates address how people can take part in shaping health care planning and implementation. Both participation and equity form blind spots in a perspective that regards health care as a product to be bought rather than a right to be exercised.

Comparing the potential human rights impact of the different proposals, plans based on deregulation are likely to benefit the healthy and wealthy, whereas plans including mandates to provide or purchase insurance could increase access to some level of health insurance. Deregulation proposals could in fact lead to a reduction in insurance coverage and health care benefits, and thus constitute a human rights violation (for a related analysis, see also Commonwealth Fund, 2008). While proposals favoring individual mandates might encourage incremental steps toward access to health care for all, they also move new resources into the private insurance industry and risk that these will not primarily be spent on health protection.

This human rights assessment shows that the approach to health care reform adopted by candidates does not differ fundamentally between parties with regard to their reliance on market-based initiatives. Their failure to meet the key principles of the human right to health care can largely be attributed to this approach.

Failure to Shift from a Profit to a People-Centered Understanding of Health Care

Most presidential candidates, Democrats and Republicans, focus their health care proposals on reorganizing the financing of care. Their intention is to reduce costs (to the public and to individuals) and to increase access to insurance coverage, with Republicans stressing the former and Democrats the latter. To achieve these goals, candidates from both parties want to create more consumers to purchase health care as a product. They seek to do this through offering tax subsidies for buying insurance, with most Democrats mandating individuals to undertake such a purchase.

Democrats and Republicans alike regard health care as a commodity, not as a right. They neglect the challenges a market-based health care system poses for equitable access to appropriate quality care. In doing so they fail to ensure that the health system fulfills its true purpose, the preservation of health.

Only one proposal offered by candidates is not based on market principles: Representative Kucinich's plan for a public single payer system. While such a system appears to be largely compatible with human rights principles, it is not the only system that can meet those standards. Human rights principles do not prescribe the type of health care system a society should have, nor how it should be financed. They provide a set of criteria to assess what works best to realize the human right to health care. Applying those criteria, for example, a multi-payer, public insurance model, as operated in Germany, also performs well, as it provides care to everyone on an equitable basis. In this system, insurers are accountable to the people through public oversight mechanisms.

Public Insurance System: The Example of Germany

The German health care system prioritizes universal and equitable access to care. It is an employer-based social insurance system with a few hundred public insurance companies that are federally regulated and tasked by law to preserve, restore or improve the health of the insured. All insured people have the same benefits, which are set by law, and share the same care delivery system. Premiums are based on the ability to pay, regardless of health status, age or gender, and prices are regulated by the government, which also pays the premiums of those who are unable to pay, such as the unemployed. Insurance companies operate under a cost recovery principle, whereby premiums must be returned to patients in the form of care services.

About 90% of Germans are insured by their employers (or as family members) in this public insurance scheme, based on a mandate that applies to everyone but the highest earners. High-income or self-employed people can opt into the public insurance scheme or take out private insurance from for-profit companies (which cover about 9.8% of the population). Only 0.1% to 0.3% of the population is uninsured.

Popular Health Care Reform Ideas: What Works, What Doesn't

Individual Mandates

To achieve universal insurance coverage, many candidates have stated that they would seek to mandate that individuals buy insurance, and impose penalties if they fail to do so. This "car insurance" model of health care fails to meet several fundamental human rights concerns.

What Doesn't Work

No Universal Access
No Affordability
No Equity
No Comprehensiveness
No Dignity
No Accountability

- Mandates do not provide or guarantee insurance coverage. They merely avoid government obligation by shifting the burden to individuals, thus undermining our shared responsibility to protect health. Mandates leave individuals to fend for themselves, as owners of an insurance product - if they can afford coverage - facing the threat of punishment for non-compliance. This punitive approach is not compatible with human dignity.
- Mandating coverage does not ensure that it will be affordable (particularly considering that 65% of the uninsured earn less than 200% of the federal poverty level; Kaiser Commission, 2007), or that the coverage benefits are adequate. Proposed hardship exemptions are an acknowledgment that mandates will not create affordable and adequate coverage for all.
- Individual mandates force people into the private marketplace to buy a product. This creates guaranteed customers for the private insurance industry, which increases the potential for profits, if not profiteering, and therefore decreases the likelihood that the coverage will be affordable and high quality. It also shifts resources needed for health care to a punitive bureaucracy enforcing the purchase of insurance.
- Punitive measures are likely to have a disproportionate effect on working people who may have difficulties paying for insurance coverage. This could lead to a criminalization of working families. For example, in Massachusetts, mandates appear to penalize those who are ineligible for both tax subsidies and public programs, such as families earning just above 300% of the federal poverty level.

What Can Work: Securing Access and Accountability

Mandates can be conceived as a universal obligation to contribute to a shared risk or good that yields assured benefits for everyone in the form of guaranteed public or publicly regulated services. For example, mandatory individual contributions to social insurance programs, such as Medicare, differ from mandates that require the purchase of insurance from private vendors. These are joint contributions, usually through taxation, to a wider public good. Costs, risks and benefits are shared by all members of society. Social health insurance schemes automatically enroll people, charge according to the ability to pay, and provide the same benefits for everyone.

Employer Mandates

With rising health insurances costs over recent years, many employers have dropped health insurance coverage for their employees. Between 2000 and 2007, the total number of firms offering coverage declined by 9%, from 69% of employers to 60% (Families USA, 2007). Most Democratic candidates seek to halt this decline and propose shared responsibility for health insurance costs by mandating employers to provide coverage or pay into a public fund. From a human rights perspective, there are number of challenges this approach must address.

What Doesn't Work

No Universal Access
? Affordability
No Equity
? Comprehensiveness
? Accountability

- From a perspective of affordability, current reform plans do not address whether and how employers would be prevented from shifting health insurance costs back onto workers in the form of decreased or less-frequently increased wages.
- Employer-based coverage that requires employees to pay a portion of the premium is inequitable if charges are flat rather than linked to their income.

- Employer mandates do not address people who are unemployed, temporary employees, day laborers, consultants or in similar transient jobs. Minorities tend to be overrepresented in many of these groups.
- Employer mandates in some proposals include exemptions for small businesses, which could either disadvantage employees in these firms or require a public subsidy.
- Employer-based insurance tends to tie individuals and their families to a particular job in a particular place. Unless such insurance was made fully portable, this would restrict access to continuous and comprehensive coverage.

What Can Work: Increasing Access, Equity and Accountability

- Current reform proposals by Democratic candidates call for employer mandates but do not specify whether these will be subject to specific cost and benefits regulations. Such regulations would have to set the minimum share of premiums employers must pay, minimum health benefits they must cover, and maximum cost-sharing by employees. It has not yet been possible to fully test such regulations at the state level, as a federal law (ERISA) currently prohibits regulation of employer benefits.
- Proposals by Democratic candidates state that employers who do not provide insurance must contribute to a public health fund. Proposals have yet to specify the level of this contribution, which should be set at an appropriate payroll percentage and include compliance mechanisms.
- Mandates may help address existing disparities in access to employer-based insurance, particularly if they require employers to offer coverage to part-time and low-income workers. Minorities and women are overrepresented in these jobs and therefore disadvantaged in the current system.

Regulation or Deregulation of the Private Insurance Market

All but one of the presidential candidates see a continued role for private, profit-driven insurers and providers in the financing and delivery of health care. While Democrats seek to regulate this industry to varying degrees, most Republican candidates propose deregulating the insurance market. From a human rights perspective, market-based incentives for putting profits over people are problematic, for they exert a constant pressure to cut costs, which can result in serious harm to health.

What Doesn't Work

No Universal Access
No Affordability
No Equity
No Comprehensiveness
No Accountability

- Proposals that promote deregulation would allow insurance companies to trade across state lines and thus evade current state level protections against discrimination, such as cherry picking by refusing coverage to those with health risks, and restricting benefits so that some common, or expensive, illnesses or treatments are not covered.
- Allowing cheap insurance policies with no minimum benefit levels would endanger access to comprehensive care.
- Current proposals do not include price controls for premiums or cost-sharing (although under Obama's plan insurers would have to justify "above-average" premium increases), so that affordability can only be achieved through subsidies rather than through reining in excess profits and administrative waste.
- Current proposals do not include uniform, enforceable quality standards and quality control mechanisms (for safety, success of treatment, patient-centered care, etc.). Instead, insurers and providers can continue to cut corners in order to increase profits.

What Can Work: Increasing Equity, Comprehensiveness and Quality

Health care reform can help shift incentives toward quality care through comprehensively regulating insurers and providers on issues of price, profit, and service, using effective compliance mechanisms.

- Guaranteed issue and community ratings: Most Democratic candidates state that insurance companies would be required to issue policies to all applicants, without discriminating on the basis of health, age, gender, or occupation. Seventeen states have adopted some form of community ratings that restrict

cherry picking, to varying degree, by requiring insurance companies to issue and renew policies and limit the extent by which premiums can vary due to health status, age or gender.

- Minimum benefit standards: Some candidates indicate that they will require insurers to offer only policies that cover a certain minimum of benefits. Depending on the level of minimum benefits, this could ensure access to comprehensive care for all policyholders.
- Medical loss ratios: Insurers can be required to spend a certain percentage of premium prices on actual medical care, as opposed to overheads and profits. In the current market, individual policies often have a medical loss ratio of 45%, i.e. less than half the premium cost is spent on care. Typical insurance plans have a medical loss ratio of around 72%, whereas Medicare has a medical loss ratio of over 95%, i.e. most of the money goes to health care. To make private insurers as competitive as public programs, regulation could set the medical loss ratio floor at levels similar to that of Medicare (Edwards' plan proposes an 85% floor).

Public Program Expansion

Some progress in increasing access to health care has been made at the state level through the expansion of public health insurance programs. States co-fund and implement Medicaid and SCHIP, and until recently have had considerable flexibility in doing so. A number of states have expanded these programs to cover groups beyond the constituency required by federal law, and some have done so explicitly with the objective of moving toward universal health care. However, the Bush administration has imposed new restrictions on states' ability to decide eligibility criteria for Medicaid and SCHIP. For example, federal matching funds have been denied to states seeking to expand programs to a wider pool of uninsured children, either under SCHIP (e.g. in NY and Louisiana) or Medicaid (e.g. Ohio, Montana, Oklahoma). On the other hand, Democratic candidates generally favor expanding eligibility for public programs in some form. From a human rights perspective, expanding coverage to a broader range of disadvantaged groups may be a useful strategy to gradually achieve universal health care.

What Doesn't Work

No Universal Access

- Eligibility criteria, even if expanded, maintain a divided system of care: one for those who are eligible and one for those who are not. Population groups are given differential access to care, based on factors such as income or age. Eligibility thresholds mean there is no universal access, unless programs raise the thresholds to the point of elimination, with universal access as the ultimate goal.
- Barriers to enrollment can stifle expansion based on increased eligibility. Not everyone who is currently eligible for public programs is enrolled. Enrollment requirements such as strict citizenship documentation rules exclude many eligible people.
- Public program expansion should not be financed by reducing benefits or increasing costs to patients, as that would undermine access to comprehensive care.
- Public reimbursement rates to providers have to be set at an appropriate level to ensure an adequate number of providers to serve patients.

What Can Work: Expanding From Entitlements to a Universal Right

Yes	Right to Health Care
Yes	Affordability
?	Equity
Yes	Comprehensiveness
?	Accountability

- Public programs are entitlements, i.e. those who meet the eligibility criteria have a right to the public health care on offer. While not universal in scope, this can serve as a starting point for extending legal recognition of the right to health care. Therefore, public programs should be expanded with a view toward universal and equitable coverage.
- Public program expansion should target vulnerable groups that have fallen through the cracks, e.g. those ineligible for Medicaid or SCHIP but with incomes too low to buy private insurance, and those just under the 65 year age threshold set for acquiring Medicare coverage.
- Public programs have comparatively comprehensive benefits which can be extended to more people.

Making Change Real: We Need Human Rights to Transform Health Care

Health care reform is one of the most important challenges facing the United States. In the past, policymakers have failed to address the unnecessary structural barriers our current system poses to providing care for everyone. As the health care debate grows among politicians and the public alike, we have an opportunity to make a break from those approaches. Rather than merely shifting costs between patients, insurers and providers, we can shift our fundamental perspective to make health care work for all people.

The presidential candidates emphasize that real change is needed, but they must develop plans that both recognize and protect our human right to lead lives that are as healthy as possible. Several states have already taken a lead in developing and implementing concrete reforms that tackle some of the pernicious problems posed by the lack of health insurance coverage, unnecessarily high morbidity and mortality rates, health inequalities between social groups, and bankruptcies and public budget deficits due to unfairly distributed health care. In pursuing such efforts, a human rights approach can help us create a health care system that prioritizes people's health, not profits. To do so, politicians must take up their obligation to transform health care into a public good, with costs and benefits shared by all of us, in order to maintain and achieve positive health outcomes for individuals, communities, and society as a whole. This level of commitment is required to protect dignity and ensure equity in American society.

A human rights approach to health care reform provides a grounded and comprehensive framework for change in this election year and beyond, at both the federal and state levels. It enables us to place our health at the heart of our health care system.

REFERENCES

- Centers for Disease Control, *Morbidity and Mortality Weekly Report*, March 24, 2006 / 55(11), 305-308.
- Collins/ Kriss, *Envisioning the Future: The 2008 Presidential Candidates' Health Reform Proposals*, Commonwealth Fund, January 2008.
- Dorn, S., *Uninsured and Dying Because of It*, Urban Institute 2008.
- Families USA, *Too Great A Burden: America's Families at Risk*, December 2007.
- Institute of Medicine, "The Uninsured Are Sicker and Die Sooner," *Uninsurance Facts & Figures*, 2004.
- Kaiser Commission on Medicaid and the Uninsured, *Disparities in Health Coverage, Access, and Quality: The Impact of Citizenship Status and Language on Low-Income Immigrants*, 2003.
- Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*, 2007.
- Landon/ Normand/ Lessler/ O'Malley/ Schmaltz/ Loeb/ McNeil, "Quality of Care for the Treatment of Acute Medical Conditions in US Hospitals", *Archives of Internal Medicine*, Vol. 166, 11/25, 2006.
- McWilliams/ Meara/ Zaslavsky/ Ayanian, "Health of Previously Uninsured Adults After Acquiring Medicare Coverage," *Journal of the American Medical Association*, December 2007, 298(24), 2886-94.
- National Association of Community Health Centers, *The Importance of Community Governance*, December 2007.
- *The New York Times*, "A Safety-Net Hospital Falls Into Financial Crisis," January 8, 2008.
- Nolte/ McKee, "Measuring The Health Of Nations: Updating An Earlier Analysis," *Health Affairs*, 27, No. 1 (2008), 58-71.
- Opportunity Agenda, *Dangerous and Unlawful: Why Our Health Care System Is Failing New York Communities and How to Fix It*, 2006.
- Woolhandler/ Himmelstein, "When Money is the Mission - The High Costs of Investor-Owned Care," *NEJM*, August 5, 1999.
- USA Today/Kaiser Family Foundation/Harvard School of Public Health, *National Survey of Households Affected by Cancer*, 2006.

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