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The Human Right to Health Care in the United States

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Across the United States there is a growing demand for governments—national, state, and local—to recognize and implement health care as a human right. The health care crisis in the United States is well documented. Costs are rising significantly faster than inflation, millions of people are uninsured or underinsured, and employer-sponsored health insurance is becoming unsustainable.¹ As a result, many people do without the health care they need, fall into bankruptcy or homelessness if they do pay for care, or stay in abusive relationships to maintain health care insurance for themselves and their children.² An increasing number of people believe that the best way to respond to this crisis is to recognize that health care is a human right, not a market commodity to be bought and sold for profit. Together they are demanding the human right to health care in the United States.

The United States is well known to spend more money per capita than any other country in the world on health care and yet to achieve worse health outcomes than most, if not all, developed countries.³ The *Human Development Report 2010* indicates that the United States spends \$7,285 per person on health care each year.⁴ The next highest spender is Luxembourg at \$5,734 per person.⁵ Norway, Switzerland, and Malta spend somewhat over \$4,000 per person.⁶ Most of the Western European countries, as well as Canada and Australia, spend somewhat over \$3,000 per person—about half of what we spend in the United States per person for health care.⁷

On health outcomes, the *Human Development Report 2010* indicates that twenty-eight countries have longer life expectancies than the United States.⁸ Japan has the longest life expectancy, followed by Hong Kong, and then the Western European countries, as well as Australia and Canada.⁹ Among other countries with longer life expectancies

¹See, e.g., Elenora E. Connors & Lawrence O. Gostin, *Health Care Reform—A Historic Moment in U.S. Social Policy*, 303 *JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION* 2521 (2010); Edward M. Kennedy, *Health Care as a Basic Human Right: Moving from Lip Service to Reality*, 22 *HARVARD HUMAN RIGHTS JOURNAL* 165, 166–68 (2009).

²See Mariah McGill, *Using Human Rights to Move Beyond the Politically Possible*, 44 *CLEARINGHOUSE REVIEW* 459, 461 (Jan.–Feb. 2011).

³Connors & Gostin, *supra* note 1, at 2521.

⁴UNITED NATIONS DEVELOPMENT PROGRAM, *HUMAN DEVELOPMENT REPORT 2010, THE REAL WEALTH OF NATIONS: PATHWAYS TO HUMAN DEVELOPMENT* 197 (2010).

⁵*Id.*

⁶*Id.*

⁷*Id.*

⁸See *id.* at 143 (showing U.S. life expectancy at 79.6 years).

⁹*Id.* (all with 81-plus years).

than the United States are South Korea, Singapore, the Czech Republic, Cyprus, Andorra, and Kuwait.¹⁰

The data for child survival rates are similar. All of the countries with longer life expectancies also have higher rates of child survival than the United States.¹¹ Lithuania, Serbia, and Malaysia, which spend between \$600 and \$1,100 per person on health care, all have better outcomes than the United States on child survival.¹² In sum, health care spending and health outcomes are out of sync in the United States.

Typically this problem is examined from the standpoint of public health, ethics, or economics.¹³ Another way, however, is to look at the problem from a human rights perspective. International human rights law explicitly recognizes the human right to health, including the right to health care. How is our health system failing from a human rights perspective? How can the human rights legal framework in general, and the right to health in particular, help us improve health care and thereby health in the United States? Over the last several years in the United States there have been some inspiring successes, indicating that now is a promising time to move forward on realizing health care as a human right at home.

Here I explain the meaning of “the right to health,” or rather “the right to the highest attainable standard of health” as it is set out in international human rights law. I

examine the new U.S. federal health law, the Patient Protection and Affordable Care Act from a human rights perspective and consider whether the Act conforms to international human rights standards.¹⁴ I then look briefly at state and local initiatives that, in contrast to the Act, use a human rights framework as a basis for universal, equitable, and affordable health care, and I cite resources for advocates to learn more about human rights–based health care reform in the United States.

I. The Human Right to Health in International Law

The international right to health was first recognized in 1946 in the Constitution of the World Health Organization, which states that “[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”¹⁵ The Universal Declaration of Human Rights also includes the right to health as a component of the right to an adequate standard of living.¹⁶ Several international human rights treaties also recognize the right to health for specific groups, such as women, children, or people with disabilities.¹⁷

The most comprehensive provision, however, is Article 12 of the International Covenant on Economic, Social, and Cultural Rights, which applies to all people in the 160 countries that are party to this treaty.¹⁸

¹⁰*Id.*

¹¹*Id.* at 197. Child survival rates are reflected in the child mortality rates, which indicate the number of deaths per 1,000 live births for infants (under a year old) and for children under 5. (*id.*).

¹²*Id.* at 198.

¹³See Virginia Leary, *Defining the Right to Health Care*, in *HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH* 87 (Audrey Chapman ed., 1994).

¹⁴Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (2010).

¹⁵Constitution of the World Health Organization, July 22, 1946, 62 Stat. 6279, 14 U.N.T.S. 185 (1948), preamble.

¹⁶Universal Declaration of Human Rights, G.A. Res. 217(III)A, U.N. GAOR, 3d Sess., U.N. Doc. A/RES/217 (III) (Dec. 10, 1948), art. 25 (“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”).

¹⁷See, e.g., Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/34/36, art. 12 (Dec. 18, 1979); Convention of the Rights of the Child, G.A. Res. 44/25, U.N. GAOR, 44th Sess. Supp. No. 49, U.N. Doc. A/44/49, art. 24 (Nov. 20, 1989); International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities, G.A. Res. 61/106, Annex I, U.N. GAOR 61st Sess., Supp. No. 49, at 65, U.N. Doc. A/61/49 art. 25 (2006).

¹⁸United Nations Treaty Collection, Status of the International Covenant on Economic, Social, and Cultural Rights (2011), <http://bit.ly/64bPHA>.

The covenant states that the parties “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹⁹ It further specifies that parties must take steps to improve infant and child health, maintain a healthy environment, advance workplace safety, prevent and treat epidemics, and ensure health care for all.²⁰

In 2000 the Committee on Economic, Social and Cultural Rights—responsible for monitoring implementation of the Covenant at the domestic level—adopted General Comment 14 on the right to health, which explains the content of the right in more detail.²¹ First, it clarifies that the right to health includes both health care and the underlying determinants of health, such as nutritious food, secure housing, potable water, adequate sanitation, safe working conditions, and a healthy environment.²² The underlying determinants, sometimes called the “social determinants” of health, also include socioeconomic inequality, discrimination, and violence.²³ While the right to health care is my focus here, the international human right to health must include the underlying determinants of health as well.

The right to health is not a right to be healthy any more than the right to a fair trial confers the right to a favorable verdict. The government cannot guarantee anyone’s health. Rather, the Committee on Economic, Social and Cultural Rights de-

finer the right to health as the right to the enjoyment of a variety of facilities, goods, services, and conditions necessary for one to realize one’s highest attainable standard of health.²⁴ The committee also sets out four essential elements of the right to health: availability, accessibility, acceptability, and quality.²⁵

Availability means that health facilities, goods, and services must be available in sufficient quantity everywhere in the country.²⁶ This refers, for example, to hospitals, clinics, trained health professionals, and essential medicines.

Accessibility means that health facilities, goods, and services, first, must be accessible to everyone without discrimination.²⁷ Second, they must be physically accessible to everyone and within a safe and reasonable distance of the homes and workplaces of all sections of the population.²⁸ Third, they must be economically accessible and equitable, in other words, affordable for everyone.²⁹ Fourth, health information must be accessible, which means that individuals must have the right to seek and impart information and ideas.³⁰

Acceptability means that all health facilities, goods, and services must be respectful of medical ethics and therefore respect, for example, the confidentiality of medical information and comply with the requirement for full and informed consent to treatment.³¹ Acceptability also means that

¹⁹International Covenant on Economic, Social, and Cultural Rights, G.A. Res. 2200 (XXI), U.N. GAOR, 21st Sess. Supp. No. 16, at 49, U.N. Doc. A/6316 (Dec. 16, 1966) 993 U.N.T.S. 3, art. 12(1) (Jan. 3, 1976).

²⁰*Id.* art. 12(2).

²¹Committee on Economic, Social, and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4 (Aug. 11 2000) [hereinafter CESCR Gen. Cmt. 14].

²²*Id.* ¶ 4.

²³*Id.* ¶¶ 4, 10.

²⁴*Id.* ¶ 9.

²⁵*Id.* ¶ 12.

²⁶*Id.* ¶ 12(a).

²⁷*Id.* ¶ 12(b)(i).

²⁸*Id.* ¶ 12(b)(ii).

²⁹*Id.* ¶ 12(b)(iii).

³⁰*Id.* ¶ 12(b)(iv).

³¹*Id.* ¶ 12(c).

health care must be sensitive to cultures, communities, and gender.³²

Quality means that health facilities, goods, and services must be scientifically and medically appropriate and of good quality.³³ This requires skilled health professionals and scientifically tested and approved drugs and medical equipment.³⁴

To these four essential elements of the right to health care are added six concepts that apply to all economic and social rights, including the right to health: (1) universality, (2) progressive realization, (3) maximum available resources, (4) equality and nondiscrimination, (5) participation, and (6) accountability.

First, like all human rights, the right to health is universal. This means that all people everywhere in the world are entitled to the right to health at all times.³⁵ In terms of health care, universality means that all residents are entitled to the same health care benefits, rather than being separated into different programs or tiers.³⁶

Second, the right to health, like other economic and social rights, is subject to progressive realization, meaning that governments do not have to achieve fully all aspects immediately.³⁷ However, they must take deliberate, concrete, and targeted steps to achieve the right to health

care for all as quickly and effectively as possible.³⁸ In other words, the government must have a plan to universalize and equalize health care and must monitor progress toward achieving the right to health care for all. There is a strong presumption that retrogressive measures—steps backward—are impermissible, and the government has a high burden to justify them.³⁹

Third, governments must use maximum available resources to realize fully the right to health care for all.⁴⁰ This requirement raises questions such as: Has the government raised as much as it could in taxes? Has it allocated as much as it could to the health sector? Within the health sector, has it allocated enough to the priority areas of health care?⁴¹ This requirement also raises the question whether the government has selected the most efficient health care system or whether another scheme of financing or organization would be more efficient, providing more or better health care for the same resources.⁴² And this requirement raises the question whether the government is examining its budget from a human rights perspective so that it can answer these questions.

Fourth, the right to health requires equality and nondiscrimination in access to health facilities, goods, and services.⁴³

³²*Id.*

³³*Id.* ¶ 12(d).

³⁴*Id.*

³⁵[U.N. Development Group,] *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies* (n.d.), <http://bit.ly/5jnJMO>.

³⁶CESCR Gen. Cmt. 14, *supra* note 21, ¶¶ 17, 19; Anja Rudiger and Benjamin Mason Meier, *A Rights-Based Approach to Health Care Reform*, in *RIGHTS-BASED APPROACHES TO PUBLIC HEALTH* 67, 81 (Elvira Beracochea et al. eds., 2010).

³⁷CESCR Gen. Cmt. 14, *supra* note 21; see International Covenant on Economic, Social, and Cultural Rights, *supra* note 19, art. 2(1) (“Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.”).

³⁸CESCR Gen. Cmt. 14, *supra* note 21, ¶¶ 30–31.

³⁹*Id.* ¶ 32.

⁴⁰International Covenant on Economic, Social, and Cultural Rights, *supra* note 19, art. 2(1).

⁴¹See generally Radhika Balakrishnan et al., Center for Women’s Global Leadership, Rutgers University, *Maximum Available Resources and Human Rights: Analytical Report 3–4* (June 2011), <http://bit.ly/rhsgOa>.

⁴²See *my Healthcare Systems and Equality Rights*, 6 *EQUAL RIGHTS REVIEW* 61, 72 (2011).

⁴³CESCR Gen. Cmt. 14, *supra* note 21; International Covenant on Economic, Social, and Cultural Rights, *supra* note 19, art. 2(2) (states parties guarantee rights in covenant without discrimination on basis of “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”).

Under international human rights law, the government has the obligation to go beyond legislating nondiscrimination and must actively promote equality in health care for women and marginalized groups.⁴⁴

Fifth, the right to health requires participation by the population in all health-related policy-making at the community, state, national, and international levels.⁴⁵ This in turn requires universal health education, the right of access to health information, the right to express views freely, and transparent policy-making.

Sixth, and crucial to a human rights framework, the right to health demands access to effective mechanisms of accountability.⁴⁶ Judicial and administrative remedies at state, national, and international levels are among such mechanisms.⁴⁷ Accountability also entails proactive approaches to achieving the right to health care for all—for example, using indicators and benchmarks to monitor progressive realization of the right to health; other human rights tools, such as human rights impact assessment and budget analysis, to analyze whether proposed policies are likely to advance the right to health care or whether alternatives might be more effective in doing so.⁴⁸

In sum, the right to health care is a complex right with many component rights. Fundamentally, however, the right to health care demands that health care is a public good that is universal, equitable, and affordable for all.

II. The Patient Protection and Affordable Care Act Under the Human Rights Lens

Although the U.S. Senate has not ratified the International Covenant on Economic, Social, and Cultural Rights, economic and social rights are applicable and implemented here in many ways. As a signatory to the covenant, the United States must refrain from acts that would defeat the object and purpose of a treaty.⁴⁹ The United States also has obligations for human rights—including economic and social rights—that derive from the U.N. Charter, the Universal Declaration, and international customary law. These obligations are subject to review by the U.N. Charter-based mechanisms, among them the U.N. Special Rapporteurs and the U.N. Human Rights Council.⁵⁰

The U.S. government has acknowledged these obligations on several occasions. For example, it has invited several U.N. Special Rapporteurs to the United States to investigate the situation concerning the rights to education, housing, and water.⁵¹ Further, the U.S. government acknowledged its obligations with respect to health care—as well as other economic and social rights—in its August 2010 Universal Periodic Review report to the U.N. Human Rights Council.⁵² Devoting five paragraphs to the Patient Protection and Affordable Care Act in that report, the government claimed that the Act would expand health insurance coverage to thirty-two million people who lacked insurance.⁵³ In this way the U.S. govern-

⁴⁴See, e.g., CESCR Gen. Cmt. 14, *supra* note 21, ¶ 21 (“To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s health throughout their life span.”).

⁴⁵*Id.* ¶ 11.

⁴⁶*Id.* ¶ 59.

⁴⁷*Id.*

⁴⁸See Report of the High Commissioner for Human Rights on Implementation of Economic, Social, and Cultural Rights, U.N. Doc. E/2009/90, ¶¶ 34–54 (June 8, 2009).

⁴⁹Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, art. 18 (1969).

⁵⁰See generally Sarah H. Paoletti, *Using the Universal Periodic Review to Advance Human Rights: What Happens in Geneva Must Not Stay in Geneva*, in this issue.

⁵¹See my *Human Rights Frameworks, Strategies, and Tools for the Poverty Lawyer’s Toolbox*, 44 CLEARINGHOUSE REVIEW 437, 441–42 (Jan.–Feb. 2011).

⁵²United States of America, National Report Submitted in Accordance with paragraph 15(a) of the Annex to the Human Rights Council Resolution 5/1, U.N. Doc. A/HRC/WG.6/9/USA/1, ¶ 5 (Aug. 23, 2010).

⁵³*Id.* ¶¶ 69–73.

ment explicitly recognizes before the international community that health care is a human rights issue.

Accordingly how the new federal health care reform—the Patient Protection and Affordable Care Act—rates from a human rights perspective is appropriate to consider. The Act is a long and complex law totaling 2,562 pages; however, it has several key provisions that define the reform.

One of the main purposes of the Patient Protection and Affordable Care Act is to extend health insurance to people who have no insurance. In 2008 an estimated 46.3 million individuals were uninsured and 25 million underinsured.⁵⁴ Although the government maintains that the Act will expand coverage to about 32 million uninsured people, this would leave over 14 million uninsured. Moreover, whether the Act will deal with underinsurance is unclear.⁵⁵ In these respects the Act falls short of the human rights requirement that health care must be universal.

The Patient Protection and Affordable Care Act expands coverage in several ways. One is through extending Medicaid coverage in 2014 to individuals who have incomes up to 133 percent of the federal poverty level—including adults who have no dependent children and are not eligible.⁵⁶ This is predicted to increase Medicaid enrollment by sixteen to twenty million people.⁵⁷ The Act also allows young adults to stay on their parents' insurance until age 26.⁵⁸ These are both

very positive steps from a human rights perspective to make health care affordable; however, there are concerns that the lack of clinicians and low reimbursement rates will reduce the predicted expansion.⁵⁹

Another way of extending insurance coverage is the nondiscrimination provision, which prohibits insurers from excluding people with preexisting conditions or charging different rates to people based on health status.⁶⁰ The nondiscrimination provision applies to children starting in 2010 and to adults starting in 2014.⁶¹ From a human rights perspective, this is a great step forward because the right to health prohibits discrimination on the basis of health status.

On affordability the Patient Protection and Affordable Care Act has an individual mandate, requiring everyone to have qualifying health insurance or pay a tax penalty.⁶² This requirement ensures that healthy people purchase insurance and subsidize those who are sick—making insurance affordable for all.⁶³ The Act provides sliding-scale subsidies to individuals and families with income above the Medicaid level up to 400 percent of the poverty level.⁶⁴ At first glance the individual mandate appears to be a positive step that will extend coverage to many who otherwise might not purchase insurance, and the mandate makes it possible for insurers to cover unhealthy people protected by the nondiscrimination provision. The outcome is, however, rather uncertain.

⁵⁴Connors & Gostin, *supra* note 1, at 2521.

⁵⁵See Jean Connolly Carmalt et al., *Entrenched Inequity: Health Care in the United States*, in HUMAN RIGHTS IN THE UNITED STATES: BEYOND EXCEPTIONALISM 153, 154 (Shareen Hertel & Kathryn Libal eds., 2011).

⁵⁶Connors & Gostin, *supra* note 1, at 2521.

⁵⁷*Id.*

⁵⁸*Id.*

⁵⁹*Id.*

⁶⁰Michael Lee Jr., *Trends in the Law: The Patient Protection and Affordable Care Act*, 11 YALE JOURNAL OF HEALTH POLICY, LAW, AND ETHICS 1 (2011).

⁶¹Connors & Gostin, *supra* note 1, at 2521.

⁶²*Id.*

⁶³Lee, *supra* note 60, at 3.

⁶⁴Connors & Gostin, *supra* note 1, at 2521.

The Patient Protection and Affordable Care Act imposes a very low penalty for failing to purchase health insurance.⁶⁵ For a family, there is a maximum annual tax penalty of \$2,085.⁶⁶ Because health insurance costs several times this amount—the Congressional Budget Office estimates about \$12,000 per family for the Act’s low-benefit package—the penalty is not a great incentive to buy insurance.⁶⁷ For healthy people, to wait until they get sick to purchase insurance would make more sense, especially since insurers may no longer discriminate against individuals with preexisting conditions.⁶⁸ That the insurance system will not attract the healthy consumers necessary to make it work is quite possible as a result. If only unhealthy people purchased insurance, then insurance premiums would soar, and more people might drop their insurance and pay the penalty instead.⁶⁹ In this respect the Act does not adequately control costs or make health care insurance—much less health care—sustainable and affordable for all.⁷⁰

On equality the Patient Protection and Affordable Care Act does not score well because, rather than requiring equal benefits for all, it allows insurers to offer a variety of plans with different packages with different benefits, different deductibles, and so on. A dizzying array of choices no doubt also increases administrative costs, as does the maintenance of so many smaller pools.⁷¹ Due to these inefficiencies the Act also scores poorly on the use of maximum available resources to achieve the right to health care.

From a human rights perspective, does the Patient Protection and Affordable

Care Act take deliberate, concrete, and targeted steps to realize quickly and efficiently progressively the right to health care for all? The answer is not at all clear. On the one hand, the nondiscrimination provision for preexisting conditions will allow many people otherwise unable to purchase health insurance and increase their chances of accessing health care. On the other hand, the Act contains many provisions directly opposed to universality; the Act continues a fragmented, unequal, and administratively burdensome system that fails to use the maximum available resources to ensure the right to health.

The Patient Protection and Affordable Care Act prevents states (such as Vermont) that want to provide universal and equal access to health care from doing so. They must wait until 2017 to obtain a waiver from the Act’s system. Thus the Act deliberately interferes with the enjoyment of right to health care in these states and will undoubtedly result in hardship for many and even death for some. Any government action that deliberately interferes with the provision of health care violates the right to health, and may even conflict with the obligation of a signatory to the International Covenant on Economic, Social, and Cultural Rights not to take action to defeat the object and purpose of the treaty.

From a human rights perspective, therefore, the Patient Protection and Affordable Care Act receives mixed ratings. The main problem is that it reinforces and subsidizes a system that treats health care as a market commodity to be bought and sold for profit rather than as a human right.⁷²

⁶⁵*Id.*

⁶⁶*Id.* For individuals, the annual tax penalty will rise by 2016 to \$695 or 2.5 percent of household income.

⁶⁷Lee, *supra* note 60, at 5.

⁶⁸*Id.* at 5–6.

⁶⁹*Id.* at 6.

⁷⁰Indeed, the Patient Protection and Affordable Care Act anticipates that health care insurance will not be affordable for all and exempts people for whom the lowest-cost plan option exceeds 8 percent of their income.

⁷¹See Carmalt et al., *supra* note 55, at 166.

⁷²Anja Rudiger, *Why the Health Reform Law Fails to Meet Human Rights Standards*, HUFFINGTON POST, April 1, 2010, <http://huff.to/dIA4Ef>.

III. State and Local Initiatives on Health Care as a Human Right

At the state and local level there are some inspiring alternatives to the Patient Protection and Affordable Care Act's piecemeal approach. Advocates, grassroots organizations, local governments, and state legislatures are adopting human rights frameworks to guide health care reform.

The frontline story is the new health care reform in Vermont. In 2010 Vermont adopted a human rights framework to evaluate proposals for health care reform.⁷³ The 2010 legislation declared health care to be a public good and established a commission to propose three health care models to the legislature in the 2011 session. All three models had to comply with five human rights principles: universality, equity, accountability, transparency, and participation.⁷⁴ In May, after considering the three models, Vermont adopted legislation setting out the steps on the path to single-payer health care system to begin in 2017—as allowed under the Patient Protection and Affordable Care Act—that is again based upon human rights principles.⁷⁵ (See sidebar.) As the first state to do so, Vermont is an inspiration to other states seeking to guarantee universal, equal, and comprehensive health care for all.⁷⁶

At the local level, governments have also adopted a human rights framework for improving health care. King County in Washington State is one example. In

2008 the staff of the King County Board of Health adopted human rights principles—accessible, affordable, appropriate, and high-quality health care—to facilitate implementation of its Public Health Operational Master Plan, and in 2009 the board adopted an advocacy plan for human rights-based health care reform.⁷⁷ One of the goals of the advocacy plan “is to demonstrate that advocating for health and human rights, and specifically for health care reform that meets international human rights standards, fits within the public health mission of promoting community health.”⁷⁸ Human rights principles also form the basis for analyzing state and federal reform proposals, thereby informing the board's communications with state and federal legislators and the general public.⁷⁹

Notably, in both Vermont and King County, advocates and organizers use a “principles first” approach to health care reform, drawing on the human rights principles derived from international human rights instruments to analyze and inform decision making.⁸⁰ Both initiatives are new, and to see the differences they will make to people's health will take time. Yet they are both promising because they place people and their health at the center of reforms, rather than insurance companies and health care plans. These are the demands of the right to health.⁸¹



The right to health provides an authoritative and legitimate list of criteria for ana-

⁷³An Act Relating to Healthcare Financing and Universal Access to Healthcare in Vermont, 2010 Vt. Acts & Resolves §§ 2, 5, Act No. 128.

⁷⁴*Id.*

⁷⁵An Act Relating to a Universal and Unified Health System, 2011 Vt. Acts & Resolves, Act No. 48.

⁷⁶See, e.g., *The American Exception: Vermont May Become the First State to Have Government-Run Health Care*, ECONOMIST, May 12, 2011, <http://econ.st/mlMvuo>; David Goodman, *Vermont Passes Single-Payer Health Care, World Doesn't End*, MOTHER JONES, May 30, 2011, <http://bit.ly/jOLkbo>.

⁷⁷Roslyn Solomon, *Global Goes Local: Integrating Human Rights Principles into County Health Care Reform Projects*, 11(1) HEALTH AND HUMAN RIGHTS 105, 109 (2009).

⁷⁸*Id.*

⁷⁹*Id.*

⁸⁰*Id.* at 111.

⁸¹For further information on state and local initiatives on health and human rights, visit these websites: National Economic and Social Rights Initiative: <http://bit.ly/oRRdGq>; Vermont Workers' Center, Healthcare Is a Human Right Campaign: <http://bit.ly/CZobE>; Public Health—Seattle and King County, 2009 Health Reform Project: <http://1.usa.gov/nRvcY5>; South Los Angeles Health and Human Rights Conference: <http://bit.ly/oM9amF>; and Lewis and Clark County, Montana, Task Force on Universal Access to Health Care: <http://bit.ly/j94Ybh>. These are just a few of the resources available to advocates seeking to use a human rights framework to improve health, health care, and human rights in their communities.

lyzing health care reform that is enshrined in international law and widely accepted around the world and in many localities in the United States. It provides the legal and ethical framework under which the U.S. government is held to account at the international level before U.N. human rights bodies and by civil society organizations that submit shadow reports to these bodies and complaints to the U.N. Special Rapporteurs. On the ground here it provides

the framework for grassroots organizing by the Vermont Workers' Center and the South Los Angeles Coalition for Health and Human Rights and by other groups around the country. Between the grassroots organizers and the international authorities, the right to health provides the framework for innovative state and local health care reforms that aim to realize universal, equitable, and affordable health care, as well as human rights, for all.

“Everybody In, Nobody Out”: Vermont’s New Plan for Universal Health Care

On May 26, 2011, Vermont Gov. Peter Shumlin signed into law a sweeping health care bill that provides a framework for universal health care and incorporates human rights principles into Vermont state law (An Act Relating to a Universal and Unified Health System, 2011 Vt. Acts & Resolves, Act No. 48, <http://bit.ly/pVRLxV>).

The new law, Act 48, builds off the federal Patient Protection and Affordable Care Act and moves Vermont toward a universal health care system by 2017. Act 48, as required by the Patient Protection and Affordable Care Act, first establishes a health care exchange that will begin in 2014 and enable Vermonters to purchase private health insurance plans in a transparent market. The Patient Protection and Affordable Care Act allows states to obtain waivers to operate alternatives to the health care exchange beginning in 2017. Under Act 48 the health care exchange will be transformed in 2017 into Green Mountain Care, which will provide comprehensive, affordable, publicly financed health care coverage for all Vermont residents as a public good. It thereby will transform health care from a market commodity bought and sold on a health care exchange into a universal human right.

Human rights principles—universality, equity, accountability, transparency, and participation—are embedded into the new health care system. Act 48 requires the state to ensure that all residents of Vermont have access to and coverage for health care and that systemic barriers, such as cost, do not prevent people from obtaining health care. Under Act 48 the state is also required to ensure opportunities for public participation in the design and implementation of the health care plan. The Act states that the health care system must be transparent and accountable to the people it serves. And, the Act declares, government is responsible for ensuring that the health care system reflects these principles.

The passage of Act 48 would not have been possible without the concerted effort of the Vermont Workers' Center's "Healthcare Is a Human Right" campaign (see my *Using Human Rights to Move Beyond the Politically Possible*, 44 CLEARINGHOUSE REVIEW 459 (Jan.–Feb. 2011)). The center adopted a human rights framework for its three-year campaign for universal health care (Vermont Workers' Center, 2011 People's Toolkit (n.d.) <http://bit.ly/ok6YjG>). Using the human rights framework helped bring working Vermonters together to demand fundamental health care reform and diffused many potentially divisive wedge issues. When, for example, the Vermont Senate amended the bill to prevent undocumented immigrants from participating in the new health care system, the center reminded Vermonters of the universality of human rights and everyone's right to health care regardless of immigration status. The focus on human rights principles made clear that this amendment was unacceptable, and it was quickly stripped from the bill.

The universality of human rights was emphasized once again on May 26 at the signing of Act 48. Just before Governor Shumlin signed the bill into law, he shouted, "Everybody In." The crowd witnessing the signing responded, "Nobody Out" (David Goodman, *Vermont Passes Single-Payer Health Care, World Doesn't End*, MOTHER JONES, May 30, 2011 <http://bit.ly/pTwW2y>). Although there are still a number of obstacles to achieving the human right to health care in Vermont by 2017, the Vermont Workers' Center remains committed to ensuring that this campaign slogan becomes a reality in Vermont.

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