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Promoting Health as a Human Right in the Post-ACA United States

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The World Health Organization (WHO) Constitution of 1946 declared that the “enjoyment of the highest attainable standard of health”—defined as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”—“is one of the fundamental rights of every human being” [1]. The constitution added that “governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures” [2]. With these statements the WHO achieved two important milestones: defining health in the context of social determinants and codifying the right to health as international law [3]. The international community furthered the right to health movement in the 1948 United Nations (UN) Declaration of Human Rights [4] and multiple subsequent international treaties [5–7]. In the upcoming UN summit on the new Sustainable Development Goals, the United States (US) is one of the member states expected to adopt the proposed goal to “ensure healthy lives and promote well-being for all at all ages,” which enshrines the universality of safeguarding health [8]. In the US, the right to health and health care movement is experiencing renewed relevance with the political debate surrounding the passage of the [Patient Protection and Affordable Care Act](#) (ACA) in 2010 [9] and the ensuing Supreme Court rulings of 2012 and [2015](#) [10, 11]. Although the ACA does much to expand access to health insurance coverage, it falls short of the goals espoused by the right to health movement. We will examine the limitations of the ACA and propose steps for furthering the goal of health as a human right.

Context of the Right to Health Movement in the US

We will begin by clarifying the major ethical, economic, and political arguments and forces that shape discussions about health care in the US. Internationally, the most often cited argument for pursuing universal health care is protection of human rights, a premise based in ethical theories about equity [12]. The major philosophical theories about justice, namely, libertarianism, utilitarianism, and liberal egalitarianism, generally accept that a society must in some way provide for its least advantaged members [13–16]. Yet there is not complete accord because health as a human right differs from most other human rights. Most widely recognized human rights are framed as “negative rights,” i.e., rights with which society cannot interfere; the right to health, on the other hand, is a “positive right,” i.e., something society has an obligation to provide [17]. The main challenges to the right to health movement thus stems from the difficulties in

defining health and its minimum entitlements as positive rights and determining who is responsible for ensuring their provision [18].

Although the ethical basis of the right to health has received acceptance internationally, it is often avoided in discussions about federal provision of health care in the US. Instead, the economic and political perspectives on health care as a human right predominate, and discussion centers on the tension between the financial burden of providing universal health care and the primacy of the free market in the US. Mainstream political ideologies agree that the disadvantaged in society require assistance to level the playing field. However, the political parties differ on how much social service to provide. Conservatives generally argue that medical care is a commodity and therefore “able-bodied individuals” should earn the ability to afford it [19]. In contrast, liberals frequently view health insurance and access to care as basic entitlements that should be available to all [20].

We should also consider the powerful influence of health care stakeholders in the national dialogue about a right to health. Health care lobbyists spent an estimated \$380 million dollars during the drafting of ACA legislation, with six registered health industry lobbyists for every member of Congress [21]. Despite a lack of transparency with regard to the specific legislation promoted by this health industry spending, we can infer that most lobbyists probably did not advocate for health care as a human right. Additionally, we must acknowledge the role that physician groups have historically played in petitioning against expanding coverage. For example, the American Medical Association sponsored “Operation Coffee Cup,” in which a recording of Ronald Reagan introduced the term “socialized medicine” into our public lexicon during congressional debate about expanding health insurance coverage for the elderly in 1961 [22, 23].

The Affordable Care Act: A Step toward Health Care as a Human Right

The ACA represents the biggest change to the US health care system since the creation of Medicaid and Medicare in 1965 [24]. Evaluations of the ACA five years after its enactment have focused on the increase in numbers of people with health insurance coverage, because it is still too soon to fully evaluate the law’s effects on costs of care or care quality [25]. Most notably, the number of uninsured Americans who have gained health insurance coverage under the ACA is estimated to be between 9.3 and 16.4 million [26–30], a sizeable reduction in the pre-ACA uninsured population of 57 million Americans [31]. The ACA was also intended to reduce the financial burden of health care through measures such as the Patient’s Bill of Rights, which includes coverage of preventive services [32]. With regard to gender parity, the ACA takes important steps with coverage of reproductive health and maternity services as well as banning of the practice of charging women higher premiums than men for health insurance [33].

But these valuable gains do not absolve the ACA of shortcomings regarding the goals of health as a human right. The focus in the US on health care financing and insurance is reflected in the ACA's silence on a human right to health and health care. Although the ACA makes strides in reducing the number of uninsured people, it was never designed to guarantee access to health care for everyone in the US—thus neglecting a basic premise of the right to health movement. Much of the political debate around health care reform during the greater part of the last century centered on the push for [universal health coverage by political liberals](#), but the ACA's individual mandate arose from the Heritage Foundation, a conservative think tank seeking to [preserve the free market](#) in health care [34]. Augmenting a complex private health insurance structure to increase coverage rather than approaching health care as a human right [18] preserves the notion of health care as a commodity in the US. Additionally, much of the research evaluating the impact of the ACA highlights a few percentage point improvements in preventive screening rates as evidence of the ACA's success [27, 35, 36]. These incremental increases, however, fall far short of meaningful improvements in population-level health outcomes. Thus, many opportunities remain for further reforms aimed at improving health and achieving the rights to health and health care.

Proposals for Enshrining the Right to Health Care in the US

We must acknowledge that the movement promoting the right to health in the United States is actually a movement for universal health care, which is not an unreasonable or even particularly remarkable goal. Nearly all other member nations of the Organization for Economic Cooperation and Development (OECD) provide for the health of all citizens as a fundamental responsibility, not as a condition of employment, income, disability status, or some other criterion [37]. The upcoming UN agreement represents both an opportunity and an imperative for the US to provide health care that is truly universally available to all Americans.

What would universal coverage and access to health care services look like in the US? In their seminal 2000 paper, Eisenberg and Power [38] laid out a framework for achieving quality health care, listing seven key tenets: (1) access to health insurance; (2) enrollment in an insurance plan; (3) coverage of services and clinicians; (4) choice of services and clinicians; (5) access to consistent primary care; (6) access to referral services; and (7) delivery of high-quality services. The first four items depend on the availability of comprehensive health insurance. In the US, a patient's access to any of these benefits is severely limited without such coverage.

Evidence from countries with universal health care systems suggests that a universal scheme may lead to enhanced access to care, improved efficiency and equity, and better health outcomes. A recent Commonwealth Fund study of health systems in 11 industrialized nations ranked the US, the only country without universal health care, at the bottom, noting particular deficiencies with regard to cost, efficiency, equity, and

healthy lives [39]. A 2013 report completed under the auspices of the National Research Council and the Institute of Medicine looked at mortality and health across the lifespan in 17 affluent nations, including the US. The report consistently found higher rates of mortality and worse health outcomes in the US than in the other 16 nations in the report, all of which have universal systems of health care [40]. Based on these observations, Americans could reasonably expect that adoption of a universal system of health care would be a significant step toward improving health care and health equity.

Beyond Health Care

In the US, we tend to conflate health with health care. As clinicians, we necessarily focus on the provision of health care and its role in providing for the health of populations. However, a right to health care is only one aspect of a larger right to health, particularly as described previously in the WHO definition of health [1] and as enshrined in the UN's Sustainable Development Goals [7]. A right to health encompasses a right to provision of social measures (in WHO terms) such as sufficient food and drinking water, adequate housing and working conditions, satisfactory education, racial and gender equality, and freedom from cruel or inhumane treatment [4]. Compared to other OECD members, the United States gives limited attention to social programs and continues to outspend its peers on medical care [41]. Social spending arguably has a greater aggregate impact on population health than medical care. A 2011 analysis of 30 OECD nations found an association between social service spending and better outcomes in three of five indicators of health [39]. Acknowledging a genuine right to health means addressing social determinants of health as well as working toward universal health care.

Conclusion

As current and future US clinicians, we share the professional responsibility to advocate for the health and well-being of our patients. Thus, we find the lack of universal health care in the world's wealthiest country to be both an embarrassment and a touchstone for action among medical and public health practitioners. While we acknowledge the achievements of the ACA in improving health insurance coverage, we advocate for universal health coverage as a necessary component in the drive toward broad recognition of the right to health. In addition, we have a responsibility to advocate for policies that improve population health regardless of whether they pertain to medical care. In advocating for the health of our patients, we must broaden our focus beyond the medical system and examine the social foundations that determine health on a population scale.

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