

**The Healthcare System in the United States Runs Afoul of International Law**

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I. Introduction:

On March 28, 2013, Forbes released an article titled, “Yes, Health Care is a Right – An Individual Right.”<sup>1</sup> This article discusses the life of Deamonte Driver and Brian Hall. Deamonte Driver is an African American welfare kid from Prince George’s County, MD. In 2007, Deamonte went to his mother complaining of a headache. Naturally, his mother took him to the hospital where he was diagnosed with severe dental abscess. At the hospital, he was given medication, sent home but still his condition worsened. The infection in his tooth spread to his brain. Deamonte underwent two emergency surgeries before he felt better again. Regardless, unexpectedly, a few weeks later he died. Deamonte was 12 years old and he died of a toothache.

Note Deamonte did not die because he was uninsured. Deamonte died while insured, insured by the government. He was on Medicaid. While on Medicaid, Deamonte never received routine dental care. In fact, only 16 percent of Maryland dentists accept Medicaid patients. *Id.* Nationally, the Medicaid acceptance rate is not any better: acceptance rates vary dramatically from state to state creating even greater access disparities to healthcare nationwide. <sup>2</sup>A reason why so few doctors accept Medicaid insurance is because Medicaid pays doctors far less than the actual

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<sup>1</sup> Roy, Avik. *Yes, Health Care is a Right—An Individual Right*. (Mar. 2013) available at <http://www.forbes.com/sites/theapothecary/2013/03/28/yes-health-care-is-a-right-an-individual-right/> (last visited Mar. 10, 2014).

<sup>2</sup> Dominic Aratari, *How Easy is it to Find A Medicaid Doctor?* CNN Money Interactive, available at <http://www.money.cnn.com/interactive/economy/2013-medicaid-acceptance/> (last visited Mar. 10, 2014).

cost of care. *Id.* Additionally, the percentage of payment for healthcare by Medicaid also varies from state to state: in Connecticut Medicaid pays 63 cents of every dollar of the cost of care while in New York and Rhode Island, it is 26 cents for every dollar. For instance, if a particular health service costs the physician \$10, in Connecticut, the state will only cover \$6.30 of the \$10 cost of treatment and the rest is left to the individual receiving the service.

Now consider the life of Brian Hall, a 69 year old retiree from Catlett, Virginia. Brian's office job allowed him to purchase private insurance. After retirement Brian was also able to maintain his insurance policy. His policy also, included a health savings account to which he annually deposited \$4,000 a year.<sup>3</sup> *Id.* Unlike Deamonte, Brian could use his insurance policy to gain access to any doctor he wanted so long as he did not enroll in Medicare. Medicare is a federal health insurance program for people who are 65 years or older, certain younger people with disabilities and people with End-Stage Renal Disease.<sup>4</sup> It has been a largely successful program for the individuals who qualify.<sup>5</sup> However, Brian preferred not to receive Medicare benefits because he had saved enough over the years, so his healthcare policy was more beneficial. In comparison to Deamonte, Brian Hall is very fortunate but is it

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<sup>3</sup> Roy, Avik. *Yes, Health Care is a Right—An Individual Right*. (Mar. 2013) available at <http://www.forbes.com/sites/theapothecary/2013/03/28/yes-health-care-is-a-right-an-individual-right/> (last visited Mar. 10, 2014).

<sup>4</sup> Medicare Website. *What is Medicare?* <http://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> (last visited Mar. 15, 2014).

<sup>5</sup> Faiz Shakir et al., 44 Years of Medicare Success. Huffington Post, Jul. 30 2009, available at [http://www.huffingtonpost.com/the-progress-report/44-years-of-medicare-succ\\_b\\_247834.html](http://www.huffingtonpost.com/the-progress-report/44-years-of-medicare-succ_b_247834.html) (last visited Mar. 15, 2014).

fair? Is it fair to people like Deamonte who cannot gain access to basic healthcare? Is there some standard of health that should be provided to all Americans? And, does this standard include equal access to basic healthcare? If it does, exactly access to what type of basic healthcare? Is access to the emergency room basic healthcare? Or is it emergency care?

This paper does not aim to answer these broad theoretical questions. Instead, this paper analyzes the international right to health and questions whether the current state of the American healthcare system runs afoul of international law. If so, does the U.S. have a legal obligation to under international law to respect this human right to health? It is does shouldn't the U.S reform it's polices to acknowledge the human right to health?

## II. U.S. Obligation to Respect, Protect and Fulfill the Human Right to Health Under International Treaty Law:

For an international treaty to become binding on the United States, the US must sign and ratify the treaty. According to Article II, Section 2 of the United States Constitution, ratification means that the President “shall have the Power, by and with the advice and consent of the Senate to make Treaties, provided by two-thirds of the Senators present concur.”<sup>6</sup> Therefore, for an international treaty to be binding on the United States, the treaty must be approved by the Senate with a 2/3 majority; the Senate may make amendments to the treaty and then send it back to the

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<sup>6</sup> See U.S. Const. art. VI, § 2

President for ratification.<sup>7</sup> A treaty that undergoes this ratification process is a non-self-executing treaty. A non-self-executing treaty by definition is a treaty ratified with the understanding that it is not to have a domestic effect of its own force.<sup>8</sup> An act of the legislature must be executed for the treaty to be binding on domestic courts.<sup>9</sup> Hence, once a treaty is ratified, the Senate and House must promulgate a national law in accordance with the international treaty.<sup>10</sup> However, a nation can also be bound to the obligations of a treaty if the treaty is self-executing. A self-executing treaty is effective immediately without the need of any type of implementing action from the legislature.<sup>11</sup> Therefore, the treaty is equivalent to an act of the legislature if it conveys an intention to be self-executing and is ratified with that intention.<sup>12</sup>

It is important to note that once a state becomes a party to an international human rights treaty, it assumes obligations and duties under international law to respect, to protect and to fulfill the treaty.<sup>13</sup> The obligation to respect means that States must refrain from interfering or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against

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<sup>7</sup> United States Senate, Treaties, available at <http://www.senate.gov/artandhistory/history/common/briefing/Treaties.htm#3> (last visited Mar. 11, 2014).

<sup>8</sup> *Medellin v. Texas*, 552 U.S. 491, 495, 128 S.Ct. 1346, 1351 (2008).

<sup>9</sup> *Id.* at 552 U.S. 491, 514, 128 S.Ct. 1346, 1362 (2008).

<sup>10</sup> *Id.*

<sup>11</sup> Black's Law Dictionary (9<sup>th</sup> ed. 2009), self-executing.

<sup>12</sup> *Medellin v. Texas*, 552 U.S. 491, 505, 128 S.Ct. 1346, 1357 (2008).

<sup>13</sup> OHCHR Website, *International Human Rights Law*, available at <http://www.ohchr.org/en/professionalinterest/pages/internationallaw.aspx> (last visited Mar. 30, 2014).

human rights abuses. The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights.<sup>14</sup>

Furthermore, if the US is reluctant about adopting a particular treaty, it may choose not to be a signatory to the treaty or may make a reservation to a particular section(s) of a treaty. A reservation is a statement made when ratifying a treaty whereby a nation purports to exclude or to modify certain portions of a treaty from being binding on that nation.<sup>15</sup> This is a protective measure that nations frequently adopt in order to avoid the obligations of a treaty.

With respect to the international human right to health, numerous international treaties and declarations contribute to the development of this right. These treaties and declarations are: the Universal Declaration of Human Rights of 1948 (UDHR), the International Covenant of Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). In addition to the text of the treaties, an evaluation of the comments provided by various treaty committees will help define more clearly this human right to health. By definition, these committees are legal, human rights treaty bodies of independent experts that monitor and examine the implementation of the core

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<sup>14</sup> *Id.*

<sup>15</sup> Vienna Convention on the Law of Treaties, art. 19., May 23, 1969, available at <https://treaties.un.org/doc/Publication/UNTS/Volume%201155/volume-1155-I-18232-English.pdf> (last visited 3/11/2014).

international human rights treaties.<sup>16</sup> Committees to this treaties are very influential because “as the treaty bodies’ output is non binding, its de facto legal force and impact depends on how convincing and persuasively it is argues, which in turn is significantly shaped by the consistent use of an accepted... legal method of interpretation... and rule of law.”<sup>17</sup>

The Universal Declaration of Human Rights (UDHR) is the most comprehensive document articulating human rights. It is a nonbinding document that aspires to establish the standard for human rights.<sup>18</sup> Over time, UDHR in conjunction with the ICESCR and the ICCPR, informally termed the International Bill of Rights,<sup>19</sup> has brought force to the development of the international human rights. Particularly, relevant to this paper is the international human right to health.

The treaty that explicitly contains the international human right to health is the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Although, the US has not ratified the ICESCR, it did sign the treaty on October 5,

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<sup>16</sup>Monitoring the Core International Human Rights Treaties, OHCHR <http://www.ohchr.org/EN/HRBodies/Pages/TreatyBodies.aspx> (last visited Mar. 25 2014)

<sup>17</sup> Kerstin Mechlem, *Treaty Bodies and the Interpretation of Human Rights*, Vand. J. Transnat'l L. Vol. 42, 905, 905-906

<sup>18</sup> Anita Pereira, *Live and Let Live: Healthcare is a fundamental Human Right*, 3 Conn. Pub. Int. L.J. 481, 486 (Spring 2008).

<sup>19</sup>International Bill of Human Rights, United Nations Human Rights, Office of the High Commissioner for Human Rights, <http://www.ohchr.org/Documents/Publications/Compilation1.1en.pdf> (last visited Mar. 13, 2014)

1977.<sup>20</sup> Signing a treaty according to international law is not sufficient enough to show consent to be bound. Instead, it is the ratification process that clearly establishes the consent to be bound. However, a mere signature to a treaty does attach a lesser obligation. It attaches the obligation for a signatory, a state party, to refrain from actions that would defeat the object and purpose of the treaty.<sup>21</sup> This obligation is also known as the Vienna Convention Article 18 obligation and has long been recognized by the United States.<sup>22</sup> Although this obligation is well recognized in customary international law, the meaning of the phrase “object and purpose” has yet to be settled but has come to mean the core content of the rights contained in the treaty, the essence and goal of a treaty.<sup>23</sup>

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<sup>20</sup>United Nations Treaty Collection, available at [https://treaties.un.org/pages/viewdetails.aspx?chapter=4&lang=en&mtdsg\\_no=iv-3&src=treaty](https://treaties.un.org/pages/viewdetails.aspx?chapter=4&lang=en&mtdsg_no=iv-3&src=treaty) (last visited 3/14/2014).

<sup>21</sup> Vienna Convention on the Law of Treaties, May 23, 1969, available at <https://treaties.un.org/doc/Publication/UNTS/Volume%201155/volume-1155-I-18232-English.pdf> (last visited 3/19/2014).

<sup>22</sup> The United States has signed, but not ratified, the Vienna Convention on the Law of Treaties. However, the U.S. recognizes that the Convention is “generally recognized as the authoritative guide to current treaty law and practice.” Message from the President of the United States Transmitting the Vienna Convention on the Law of Treaties Signed for the United States on April 24, 1970, at 1, S. Exec. Doc. L., 92-1 (1971).

<sup>23</sup> David S. Jonas, Thomas N. Saunders. The Object and Purpose of a Treaty: Three Interpretive Methods. *Vanderbilt Transnational Law Journal*, Volume 43, Number 3, May 2010, 565, 567, available at [http://www.vanderbilt.edu/jotl/manage/wp-content/uploads/JonasSaunders-cr\\_v2.pdf](http://www.vanderbilt.edu/jotl/manage/wp-content/uploads/JonasSaunders-cr_v2.pdf) (last visited 3/19/2014).



With respect to the object and purpose of the ICESCR, along with the many human rights it establishes, it emphasizes the right to health is a human right.<sup>24</sup>

According to Article 12, ICESCR:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
  - b. The improvement of all aspects of environmental and industrial hygiene;
  - c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
  - d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.<sup>25</sup>

As indicate, the human right to health is not the right to be healthy. Instead, the Committee on Economic, Social and Cultural Rights (CESCR) explained, the right to health is a fundamental human right to the enjoyment of the highest attainable

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<sup>24</sup> ICESCR, International Covenant on Economic, Social and Cultural Rights, opened for signature Dec. 16, 1966, 993 U.N.T.S. 3; [hereinafter ICESCR]; U.N. Committee on Economic, Social and Cultural Rights [hereinafter CESCR], General Comment 14: The Right to the Highest Attainable Standard of Health (Article 12(1) of the International Covenant on Economic, Social and Cultural Rights), 22d Sess., para. 33, U.N. Doc. E/CN.12/2000/4 (2000) [hereinafter CESCR General Comment 14], available at [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11) (last visited 3/11/2014).

<sup>25</sup> International Covenant on Economic, Social and Cultural Rights, Art. 12, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) on 16 December 1966, entry into force 3 January 1976, <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx> (last visited Mar. 13, 2014).

standard of health.<sup>26</sup> Furthermore, the CESCR also identified core requirements associated with the right to health; these obligations are in the form of four substantive elements necessary to achieving the right to health: availability, accessibility, acceptability and quality.<sup>27</sup> According to the CESCR,

Governments must make health facilities, goods, and services *available* to all in their territory. They must also make health care *accessible* by eliminating physical and economic barriers and preventing discrimination in the provision of health care services. *Acceptability* is the principle that health care should respect medical ethics and be culturally appropriate. *Quality* is the principle that governments have a duty to ensure that health care services are scientifically and medically appropriate.<sup>28</sup>

Therefore, the US, as a signatory should uphold the aforementioned elements; otherwise, it will defeat the object of purpose of the ICESCR and will be in violation of international human rights law.<sup>29</sup>

The United States has also signed the International Covenant on Civil and Political Rights (ICCPR) in 1977 and Congress ratified the ICCPR in 1992, binding the US to the terms of the treaty.<sup>30</sup> Drawing attention to Article 6 of the ICCPR, it states: “Every human being has the inherent right to life. This right shall be

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<sup>26</sup> *Id.*

<sup>27</sup> *Id.* at CESCR General Comment 14, *supra* note 12, paragra. 12(a-d).

<sup>28</sup> Mariah McGill, Esq., The Human Right to Health Care in the State of Vermont, 37 Vt. B.J. 28, 28 (Summer 2011).

<sup>29</sup> *Id.*

<sup>30</sup> OHCHR, Status of Ratification, International Covenant on Civil and Political Rights New York 16 December 1966, available at <http://www2.ohchr.org/english/bodies/ratification/4.htm> [hereinafter Status of Ratification, ICCPR] (last visited 3/10/2014).

protected by the law. No one shall be arbitrarily deprived of his [her] life.”<sup>31</sup>The U.S has not issued a reservation with respect to Art. 6 of the ICCPR; therefore, the article is fully applicable to the United States after its ratification of the ICCPR.<sup>32</sup> Like the right to health, the right to life is not the right to be alive but rather a set of governmental obligations to take steps necessary to prevent the arbitrary loss of life within its jurisdiction.<sup>33</sup>

Further, the Human Right Committee (HRC), the Committee responsible for the implementation of the ICCPR, illustrates that the right to life is a strong right and cannot be derogated even in times of emergency.<sup>34</sup> The HRC explains that the deprivation of life can happen by individual action (criminal acts), state action (actions by state authorities) and natural disaster (epidemics).<sup>35</sup> Regardless, whether a state is directly or indirectly responsible for the loss of life, it still must

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<sup>31</sup> ICCPR, supra note 14, art. 6.

<sup>32</sup> Reservations to the ICCPR, Status, Mar. 29, 2014, available at [https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg\\_no=IV-4&chapter=4&lang=en](https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en) (last visited 3/20/2014).

<sup>33</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 373 (Summer 2008).

<sup>34</sup> *Id.* The right to life enunciated in article 6 of the ICCPR has been dealt with in all State reports. It is the supreme right from which no derogation is permitted even in time of public emergency which threatens the life of the nation (art. 4). However, the Committee has noted that quite often the information given concerning article 6 was limited to only one or other aspect of this right. It is a right which should not be interpreted narrowly.

<sup>35</sup> Human Rights Committee [hereinafter HRC], General Comment No. 6: Article 6 (Right to Life), paras. 1-7, U.N. Doc. HRI/GEN/1/Rev. 7 (2004) [hereinafter HRC General Comment 6]. available at [http://tbinternet.ohchr.org/\\_layouts/treatybodyexternal/Download.aspx?symbolno=HRI%2fGEN%2f1%2fRev.9%20\(Vol.%20I\)&Lang=en](http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=HRI%2fGEN%2f1%2fRev.9%20(Vol.%20I)&Lang=en) (last visited 3/20/2014).

take all possible measures to protect against such a loss.<sup>36</sup> For example, “taking all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measure to eliminate malnutrition and epidemics.”<sup>37</sup> While the interpretation of the right to life may broad, it is an interpretation the U.S accepts.

In a HRC report, the US itself, listed varying factors that triggered the US’s obligation to protect the right to life, for instance, protection of life for the terminally ill and victims of crimes, protecting the right to life of unborn fetuses and prohibiting application of the death penalty to persons under the age of 18 during the commission of the crime.<sup>38</sup> These broad interpretations indicate that the U.S recognizes that the right to life implicates obligations that are connected to protecting the right to health. Further, to prevent an arbitrary deprivation to the right to life that may result from “inadequate availability, accessibility, acceptability and quality of health goods and services, the U.S should respect, protect and fulfill the human right to health.”<sup>39</sup>

The United States is also obligated to comply with the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD). The

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<sup>36</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 375 (Summer 2008).

<sup>37</sup> *Id.* General Comment No. 6: Article 6 (Right to Life), paras. 5, U.N. Doc. HRI/GEN/1/Rev. 7 (2004) [hereinafter HRC General Comment 6].

<sup>38</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 375 (Summer 2008).

<sup>39</sup> *Id.* at 9.

U.S ratified the treaty on October 21, 1994.<sup>40</sup> ICERD mandates that all state parties make an effort to prevent all forms of racial discrimination.<sup>41</sup> ICERD defines discrimination as:

Any distinction, exclusion, restriction or preference based on race, color, descent or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.<sup>42</sup>

Article 1(c) of ICERD, emphasizes in order for a state party to guard against such discrimination “it must take positive measures to review governmental, national and local policies and to amend, rescind or nullify any regulation which have the effect of creating or perpetuation of de facto or de jure racial discrimination wherever it exists.”<sup>43</sup> This prohibition of de jure and de facto discrimination is also applicable to the right of health via article 5(e)(iv) of ICERD, which requires state parties to eliminate discrimination and guarantee, without distinction, the right to public health and medical care.<sup>44</sup> Further, “public health was interpreted by the Special Rapporteur on the Right to Health to include not only health care systems but also the underlying determinant of health such as access to safe and potable

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<sup>40</sup> OHCHR, Status of Ratification, International Covenant on the Elimination of All Forms of Racial Discrimination New York, 7 March 1966, available at <http://www2.ohchr.org/english/bodies/ratification/2.htm> (last visited Apr. 23, 2008).

<sup>41</sup> *Id.*

<sup>42</sup> ICERD, supra note 15, art. 1(1).

<sup>43</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 379 (Summer 2008).

<sup>44</sup> ICERD, supra note 15, art. 5(e)(iv).

water and adequate sanitation, healthy occupational and environmental conditions and access to health-related education information..."<sup>45</sup> Therefore, as a state party to ICERD, the United States is legally obliged to ensure no form of discrimination creates disparities in healthcare services and environmental conditions that ultimately have an effect on health. In fact 2001, the Committee on the Elimination of Racial Discrimination (CERD), specifically demanded the US to prohibit and to eliminate racial discrimination in all its forms against the right to health.<sup>46</sup> Therefore, according to ICERD, the US has a legal duty to respect the right to health and take affirmative steps to prevent de facto and de jure discrimination from stripping the right to health.

### III. Current Unequal Health Outcomes in the United States Violates

#### International Law:

According to the World Health Organization, as of 2012, the United States, spends approximately 17.9 % of its GDP on health expenditures, which is significantly more in comparison to other industrialized nations.<sup>47</sup> Even though a large percentage of the U.S' GDP is allocated to health expenditures, many

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<sup>45</sup> ECOSOC, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur, Paul Hunt*, 59th Sess., ¶ 25, UN Doc. E/CN.4/2003/58 (2003) (emphasis added).

<sup>46</sup> Concluding Observations of the Committee on the Elimination of Racial Discrimination: United States of America, U.N. CERD, 59th Sess., para. 393-398, U.N. Doc. A/56/18 (2001) [hereinafter CERD Concluding Observations].

<sup>47</sup> World Health Organization, Country Profiles, available at <http://www.who.int/countries/usa/en> (last visited 3/19/2014).

Americans are still without health insurance. Currently, 48 million<sup>48</sup> Americans have no form of health insurance and another 38 million have inadequate health insurance.<sup>49</sup> Millions of Americans lack health insurance because their employer does not provide it or they cannot afford to pay for it. A study by the American Journal of Public Health released that nearly 45,000 annual deaths are associated with the lack of health insurance; this number was calculated after accounting for factors such as education, income, smoking and obesity.<sup>50</sup> More importantly, statistics have also shown a significant relationship between poverty level and the lack of health insurance.<sup>51</sup>

The poor and the near-poor comprise two-thirds (66%) of the uninsured population. Four out of five (82%) of the uninsured are in working families: 70% live in households with a full-time worker and 12% live with a part-time worker. Low-wage workers are at greater risk of being uninsured, as are laborers, service workers, and those employed in small businesses. Over 60% of uninsured adults have incomes less than 200% of the poverty level.<sup>52</sup>

Analyzing the above statistics, reveals that among the uninsured individuals in the

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<sup>48</sup> Kaiser Health News, *48 Million Americans Remain Uninsured*, *Census Bureau Reports*, available at <http://www.kaiserhealthnews.org/stories/2013/september/17/census-numbers-uninsured-numbers-remain-nearly-unchanged.aspx> (last visited 3/19/2014).

<sup>49</sup> Sherry Glied, *Healthcare Crisis, The Uninsured*, available at <http://www.pbs.org/healthcarecrisis/uninsured.html> (last visited 3/19/2014).

<sup>50</sup> David Cecere, *New Study Finds 45,000 Death Annually Linked to Lack of Health Coverage*, *Harvard Gazette*, available at <http://news.harvard.edu/gazette/story/2009/09/new-study-finds-45000-deaths-annually-linked-to-lack-of-health-coverage/> (last visited 3/19/2014).

<sup>51</sup> The Henry J. Kaiser Family Foundation, *The Kaiser Commission on Medicaid and the Uninsured: The Uninsured and Their Access to Healthcare* (Dec. 2003), available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29284> (last visited 3/19/2014).

<sup>52</sup> *Id.*

United States, the poor is the group most negatively affected by the uninsured crisis. Worse, in 2002, 40% of uninsured adults postponed seeking medical care and most uninsured children did not receive routine medical attention.<sup>53</sup> The consequence of not receiving medical attention or waiting until conditions worsen can be life threatening and extremely expensive. Medical bills are one of the top reasons Americans are forced to file bankruptcy.<sup>54</sup> In the U.S such economic barriers persistently interfere with the availability, accessibility, acceptability and quality of health services and goods. and this is a violation of the right to health.

Viewing health as a fundamental human right is an ideal that is neither new nor revolutionary to the United States. It is an issue that carries a long historic and moral resonance that continues to reemerge throughout the United States as a morally appropriate way of structuring healthcare discussions but, it has never been implemented.<sup>55</sup> Much of this reluctance can be attributed to the American capitalistic ethos and the fact that the right to healthcare is not recognized under U.S. federal law.<sup>56</sup> Consequentially, the current US healthcare system falls short from meeting the standard to respect, protect and fulfill the human right to health under

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<sup>53</sup> *Id.*

<sup>54</sup> Anita Pereira, *Live and Let Live: Healthcare is a fundamental Human Right*, 3 Conn. Pub. Int. L.J. 481, 485 (Spring 2008).

<sup>55</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 381 (Summer 2008).

<sup>56</sup> CERD, *Sixth Periodic Reports of States Parties Due in 2005: Addendum: United States of America*, U.N. CERD, 72nd Sess., ¶331 (Advance Edited Version), U.N. Doc. CERD/C/USA/6 (2007), available at [http://www.ohchr.org/english/bodies/cerd/docs/AdvanceVersion/cerd\\_c\\_usa6.doc](http://www.ohchr.org/english/bodies/cerd/docs/AdvanceVersion/cerd_c_usa6.doc) [hereinafter 2007 U.S. Report].



ICESCR, the right to life under ICCPR, and the obligation under ICERD to prevent racial disparities in healthcare treatment and access.

In January of 2008, an ICERD working group, U.N. Committee on the Elimination of Racial Discrimination, was formed to conduct a report on the disparities of healthcare within the United States and the U.S. failure to enforce its obligation under ICERD.<sup>57</sup> This working group encompassed professors, experts and organizations that specialize in the health industry.<sup>58</sup> The working group reported,

Health care disparities in the U.S. are not new –they are a relic of segregation and inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention (and in some cases government imposed inequality) for over 100 years after the end of the Civil War. Less than 40 years ago, minorities received inequitable care in segregate settings, if care was received at all. Today communities of color

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<sup>57</sup> CERD Working Group on Health and Environmental Health, *Unequal Health Outcomes in the United States* 9 (2008), available at <http://www.prrac.org/pdf/CERDhealthEnvironmentReport.pdf>

<sup>58</sup> *Id.* **Submitted by: Organizations** The Opportunity Agenda—Poverty & Race Research Action Council—National Health Law Program—Center for American Progress—Center for Reproductive Rights—New York Lawyers for the Public Interest—Families USA—Physicians for Human Rights—Alliance for Healthy Homes— Center for Social Inclusion—Out of Many, One—Summit Health Institute for Research and Education, Inc. (SHIRE)—Community Catalyst—Lawyers Committee for Civil Rights Under Law—Ipas— National Economic & Social Rights Initiative—Uplift International—Generations Ahead—Natural Resources Defense Council—PolicyLink—The Praxis Project—Kirwan Institute for the Study of Race and Ethnicity—Medical-Legal Partnership for Children at Boston Medical Center—Kellogg Health Scholars Program—Environmental Justice Resource Center at Clark Atlanta University; **Individuals:** Dolores Acevedo-Garcia, Harvard School of Public Health—Ana V. Diez-Roux, University of Michigan—Jack Geiger, City University of New York Medical School—Rachel D.Godsil, Seton Hall University School of Law—Professor Sherman James, Duke University—Nancy Krieger, Harvard School of Public Health—Vernellia R. Randall, University of Dayton Law School—David Barton Smith, Temple University—David R.Williams, Harvard School of Public Health

continue to experience significant disparities relative to whites in both access to care and in quality of care received.<sup>59</sup>

Currently, in the United States the notion of de facto discrimination is not recognized only de jure discrimination is prohibited.<sup>60</sup> This precedence was established by a case called *Washington v. Davis*, where the Supreme Court held that a law with a racially neutral purpose but disparate impacts is not unconstitutional because there needs to be a showing of discriminatory intent.<sup>61</sup> After this decision, in order to effectively make a claim of discrimination under the 14<sup>th</sup> Amendment Equal Protection Clause a showing of discriminatory intent was and still is needed. Now, healthcare disparities aside, the US's prohibition on de facto discrimination places the U.S in violation of ICERD because a perpetuation of de facto discrimination that denies equal access to public health and medical care is violation of ICERC that state parties must affirmatively prevent within their jurisdictions.

The United States, in so far as the ICERD working group reported, is plagued with de facto discrimination in terms of access to healthcare and the underlying determinants of health.<sup>62</sup> The U.S. Agency for Healthcare Research and Quality conducted a National Healthcare Disparities Report in 2006 and found that access to healthcare for African American and American Indians were either the same or

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<sup>59</sup> *Id.* at 9.

<sup>60</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 384 (Summer 2008).

<sup>61</sup> *Washington v. Davis*, 426 U.S. 229, 229 (1976).

<sup>62</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 384 (Summer 2008).

worse than for whites,<sup>63</sup> whereas Latinos, experienced the greatest difficulty accessing healthcare in comparison to other ethnic groups.<sup>64</sup> Additionally, “with respect healthcare quality, minority groups also “faired poorly relative to whites: African American and Latinos received poorer quality care than whites on 73% and 77% of the measures; respectively, Asian Americans and American Indians received poorer care on 32% and 41% of measures.”<sup>65</sup>

While disparities in access and quality of healthcare exist, there are also disparities among the underlying determinants of health that exacerbate inequities in health among racial groups in the United States. Particularly, in the neighborhood and social context, residential segregation feeds disparities in access to health and health determinant. Residential segregation deteriorates the health of people of color because it channels non-white communities with inadequate healthcare, poor public education, toxic living conditions, higher rates of disorder, crime and incarceration.<sup>66</sup>

Consequently, people of color tend to live in communities isolated and neglected from resources needed to promote health. In the United States, over 56% of residents living in neighborhoods with commercial hazardous waste facilities are people of color; as a result, people of color are more like

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<sup>63</sup> CERD Working Group on Health and Environmental Health, *Unequal Health Outcomes in the United States* 9 (2008), available at

<http://www.prrac.org/pdf/CERDhealthEnvironmentReport.pdf>

<sup>64</sup> *Id.* at 9.

<sup>65</sup> *Id.*

<sup>66</sup> *Id.* at 19.

to be exposed to pollution and other toxic waste.<sup>67</sup> Additionally, low-income neighborhoods of color also lack health-enhancing resources such as supermarkets and farmer's markets.<sup>68</sup> The lack nutritious food in these communities is closely linked to dietary habits that negatively affect people of color and in turn affect the health of these individuals.

Considering the underlying determinants of health is critical in promotion of the right to health because according to the CESCR, "the obligation to fulfill the right to health... should not only include the provision of healthcare but should include equal access for all to the underlying determinates of health such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions."<sup>69</sup> Therefore, for the U.S to respect, protect and fulfill the right to health it must provide healthcare that is available, accessible, acceptable and of quality. but also ensure equal access to the underlying determinants to health.<sup>70</sup>

Currently, in the United States access to health services and goods is primarily controlled by the private sector. The dominance of the private sector is problematic because it violates the right to health when insurance companies consistently deny coverage to unhealthy or poor individuals.

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<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 395 (Summer 2008).

<sup>70</sup> *Id.*

Denial of coverage is a violation of the right to health because it prevents individuals from receiving access to healthcare services and goods that are available, accessible, acceptable and of quality.<sup>71</sup> Among the 48 million Americans that reported to be uninsured,<sup>72</sup> 54% said they did not have insurance because it was too expensive and 15% said they could not get coverage or were refused coverage due to poor health, illness or age.<sup>73</sup> To make matters worse, there are “33.5 million uninsured Americans who are ineligible for Medicaid and only about 8 million had annual incomes that were 300% above the federal poverty line.”<sup>74</sup> As a result of this privately run health market, the poor and the unhealthy have emerged as a class of individuals that are marginalized from access to healthcare. This threatens the right to health because statistically it shows 40% of uninsured adults postponed seeking medical care and most uninsured children do not receive routine medical attention.<sup>75</sup> The consequence of not receiving medical

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<sup>71</sup> *Id.* at 390.

<sup>72</sup> Kaiser Health News, *48 Million Americans Remain Uninsured, Census Bureau Reports*, available at

<http://www.kaiserhealthnews.org/stories/2013/september/17/census-numbers-uninsured-numbers-remain-nearly-unchanged.aspx> (last visited 3/19/2014).

<sup>73</sup> John Holahan et al., Kaiser Comm'n on Medicaid and the Uninsured, *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?* 6 (2007), available at <http://www.kff.org/uninsured/upload/7613.pdf>.

<sup>74</sup> Jean Conolly Carnalt, *Holding the U.S. Accountable: How American Health Care Fails to Meet International Human Rights Standards*, 11 N.Y. City L. Rev. 359, 395 (Summer 2008).

<sup>75</sup> *Id.*

attention and waiting until a condition worsens can be detrimental which constitute an arbitrary deprivation of life under the ICCPR.

#### IV. Conclusion

The United States is one of the world's wealthiest nations.<sup>76</sup> It is a country that is well respected. While the U.S may be held in such high regard, its' reputation with respect to healthcare is not admirable. A report by the Commonwealth Fund, found that "by virtually all measures of cost, access to care and ease of dealing with insurance problems, Americans faired poorly compared to people in other advance countries."<sup>77</sup> Although the United States is a world leader in many facets, it lags behind in implementing a comprehensive healthcare system. Many industrialized nations like "Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland and Britain all have put in place universal or near universal health coverage decades ago."<sup>78</sup> The United States trails behind these nations because in the U.S the right to health is not recognized by federal law; ergo, the U.S has not ratified ICECSR, which is an international treaty that explicitly enumerates the right to health as a fundamental human right.

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<sup>76</sup> Forbes, *The World's Richest Countries*, available at <http://www.forbes.com/pictures/egim45egde/7-united-states/> (last visited 4/10/14).

<sup>77</sup> Editorial Board, *The Shame of American Health Care*, New York Times, Nov. 17, 2013, available at <http://www.nytimes.com/2013/11/18/opinion/the-shame-of-american-health-care.html? r=0> (last visited 4/14/2013).

<sup>78</sup> *Id.*

The U.S however, has signed ICESCR therefore, as a signatory it must not defeat the object and purpose of the treaty by assuring healthcare and health facilities are accessible, available, acceptable and of quality. The U.S. also has a duty under international law to respect, protect and fulfill the human right to health under ICCPR and ICERD because it has ratified these treaties. Both treaties requires states parties to take affirmative steps to ensure equal access to healthcare and health determinants so, it does not infringe on the right to life or perpetuate de facto discrimination and disparities in healthcare.

In the lens of international human rights law, the current healthcare status in the United States is in violation of ICESCR, ICCPR and ICERD. Under these treaties that U.S. has failed to provide its citizens with equitable healthcare, facilities, services and goods that are accessible, acceptable, available and of quality because it does not recognize the human right to health. As a result, 48 million Americans are currently without health insurance and another 38 million are with inadequate health insurance.

Now recall the story of Deamonte Driver the welfare kid from Prince George's County who died at the age of 12 from an infection that began as a simple toothache. The healthcare Demonte received was not accessible, available, acceptable or quality. Deamonte suffered an arbitrary deprivation of his life because he was not provided adequate healthcare. Deamonte's deprivation is quite evident when his circumstance is compared against

Brian Hall. Brian is 69 years old retiree from Virginia, who's job allowed him to purchase private insurance, save for retirement, and have access to any doctor he needed or wanted. Referring back to Deamonte's story helps bring to life the reality of the healthcare crisis in the U.S. Stories like Deamonte's unfortunately are common in the U.S and this reinforces the de facto inequities embedded within the American health care system.

The United States should rethink its approach to healthcare because so many Americans are hurting. The United States should use the international human rights approach to healthcare as a blueprint to promote the highest attainable standard of health for everyone.<sup>79</sup> The global community created the international human right to health and it has been ratified by a majority of the world. It is only a matter of time before the U.S does the same. The passage of the Affordable Care Act in 2010 is evidence of the soon to come change. It is a change that is needed because the current healthcare system in the United States of America is dejecting. In the words of Sam Cooke, "a change is going to come."

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