



Healthcare, Opportunity and Human Rights at Home

BACKGROUND

The state of health care in the United States is in serious disrepair. Prosperous though it is, the United States is the only industrialized country with no universal access to health care, resulting in over 45 million uninsured Americans. People who lack health insurance are less likely to receive preventive health services, thereby increasing their risk for preventable chronic and infectious diseases. The 8 million uninsured who have chronic illnesses receive fewer health care services, and as a result, experience poorer health outcomes.ⁱ Nearly 80 million insured and uninsured Americans have experienced difficulty paying medical bills, and/or have accrued debt related to medical care costs. More importantly, two-thirds of people who experience problems with medical bills or debt go without needed care because of cost—a rate three times that for people without medical care-related financial problems.ⁱⁱ

Equally troubling are the disparities in health care access and quality between minorities and whites, and men and women—many of which occur among people who possess the same level of health insurance and are seen in the same types of hospitals and health systems. Some examples:

- Women with diabetes receive less treatment for many coronary heart disease risk factors than diabetic men.ⁱⁱⁱ
- Patients who don't speak English well, and who don't have access to appropriate interpretation and translation services or health care providers who speak their language are at greater risk for misdiagnosis, poor understanding of their diagnosis and treatment plan, and medical errors than

patients who experience no language barriers.^{iv}

- African-American heart patients are less likely than white patients to receive certain kinds of care, such as diagnostic procedures, revascularization procedures, and thrombolytic therapy, even if they have similar patient characteristics.^v
- African Americans are less likely to be put on waiting lists for kidney transplants or to receive dialysis.^{vi}
- Latinos with long-bone fractures are less likely to receive appropriate pain medication than whites with the same types of fractures seen in the same emergency department.^{vii}

Health care inequality is not only a violation of medicine's highest principles, but also runs

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counter to American ideals of opportunity by denying equal treatment and basic security. In doing so it violates the established human rights of millions of Americans.

A HUMAN RIGHT TO HEALTH

Enshrined in several human rights instruments, the principle of a right to health is the idea that all people have a right to health care and a right to healthy conditions. It does not equate to a right to be healthy, but rather, to the highest attainable standard of health.^{viii} At its core, the basic elements of the right to health are access to equitable, high-quality primary health care, basic immunization, adequate nutrition, sexual and reproductive health information and services, and information about health. More broadly, however, the right to health relies on a breadth of socioeconomic rights, which are integrally connected to individual health. For example, the right to health is related to and relies on the right to life, affordable housing, education, safe water, adequate sanitation, and a clean and safe environment, as well as freedom from discrimination and violence, as essential precursors to healthy conditions.

These guarantees are cornerstones of American conceptions of opportunity, and are important elements of the international human rights system that the United States helped to create.

A LEGAL RIGHT TO HEALTH

The following international human rights agreements recognize the right to health:

- [Universal Declaration of Human Rights \(UDHR\)](#). The UDHR, which the United

States and especially Eleanor Roosevelt played an essential role in drafting, states: “Everyone has a right to a standard of living adequate for the health and well-being of himself and of his family, including...medical care...and the right to security in the event of...sickness.”^{ix}

- [World Health Organization \(WHO\) Constitution](#). The WHO constitution states in its preamble that “the 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.”^x As a member of WHO, the United States accepts its constitution.
- [International Covenant on Economic, Social and Cultural Rights \(ICESCR\)](#). The ICESCR lays out the right to health even more clearly, recognizing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and going on to explain specific steps that party states must take.^{xi} The UN body responsible for interpreting the ICESCR, which itself is meant to compliment the UDHR, defined essential primary health care for everyone as a minimum guideline.^{xii} The United States has not ratified the ICESCR.

HEALTH CARE DISCRIMINATION: A HUMAN RIGHTS VIOLATION

At their core, human rights are about universality. They apply not only universally across countries but within countries, to all individuals without distinction for race,

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gender, and other social differences. In other words, human rights principles are first and foremost about non-discrimination. For example, the UN Charter sets out one of the UN's purposes as the promotion of freedoms and human rights for people regardless of race, sex, language, or religion.^{xiii} Also, the International Covenant on Civil and Political Rights, which the United States ratified in 1992, outlines the right to protection from discrimination, as does the ICESCR.

“The consequences of racism and racial discrimination in the field of health are reflected in the disparity in access to health care, the infant mortality rates and the life expectancy of Whites and Blacks or Latino Americans.”
- UN Special Rapporteur on Racism, 1994

Most important, the United States is a party to the Covenant on the Elimination of all Forms of Racial Discrimination (CERD), which it ratified in 1994. CERD has been interpreted to clearly bar discriminatory practices in health care delivery as a human rights violation.^{xiv} As a party to the covenant, the United States is bound to respond to instances of discrimination. Additionally, CERD requires remedies for collective or individual discrimination. And finally, the covenant requires party states to take action to *eliminate* all forms of discrimination. Although the United States is bound by CERD, it has not expressly incorporated the covenant into U.S. law and has articulated limitations on its domestic enforceability

Racial disparities and health conditions have been found to violate human rights equality principles. In 1994, the UN Special Rapporteur on Racism found that “the consequences of racism and racial discrimination in the field of health are reflected in the disparity in access to health care, the infant mortality rates and the life expectancy of Whites and Blacks or Latino Americans.”^{xv}

[The Convention on the Elimination of all Forms of Discrimination Against Women](#) (CEDAW) also sets out important obligations that relate to healthcare. For example, CEDAW affirmatively obligates nations to “take all appropriate measures to eliminate discrimination against women in the field of healthcare,” to provide women access to “information regarding the health and well being of families, including information and advice on family planning,” and ensure the right to “protection of health and to safety in working conditions.” The United States has not yet ratified CEDAW, although a vast majority of nations have.

Finally, two important world conferences in which the U.S. participated – the 1994 Conference on Population and Development and the 1995 Conference on Women – set out much more specific obligations and effective solutions with regard to equal healthcare access and treatment, as did the 2001 World Conference Against Racism, from which the U.S. withdrew before its conclusion.

RECOMMENDATIONS

Ensuring that all Americans have equal access to high quality healthcare and healthy conditions requires bold leadership and a

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strong commitment to government action. First, all people should have equitable access to health care. In terms of providing full access, programs such as Medicare are among the most cost-effective ways of providing health insurance, as Medicare's administrative costs are about one-fourth that of private health insurance plans. In addition, while health insurance costs have soared in the private sector in recent years, Medicare's costs have grown more modestly. Administrative expenses contribute significantly to rising health care costs, and are the fastest-rising component of national health expenditures.^{xvi} An expanded national program that serves all Americans is necessary to provide a basic level of access to health care.

Beyond insuring access to health care, the nation must also:

- **Make health care systems culturally and linguistically accessible.** The United States is becoming increasingly diverse with respect to race, ethnicity, primary language, and culture. In many instances, the nation's health care institutions have not kept pace with these demographic shifts. All health systems should assess the cultural and linguistic needs of the communities they serve, and provide professional interpretation and translation services where appropriate. In addition, health care professionals and administrators should receive training on cultural factors that influence health care, and should design care to accommodate these issues.
- **Monitor and publicly report health care quality measures for diverse groups, and establish mechanisms of accountability.** Many health care

organizations voluntarily participate in a public-private collaborative project to collect and report data on the quality of health care provided to patients with certain medical conditions. This effort – the Hospital Quality Alliance – is intended to make information about hospital performance accessible to the public, and to stimulate efforts to improve quality. Quality data can also be used to assess disparities in health care among racial, ethnic, gender, language, and socioeconomic groups. Federal leadership is needed to ensure that these data are collected and reported to the public, and that mechanisms for public accountability – such as timely investigation of patient complaints – are established.

- **Step up enforcement of existing civil rights laws.** In the late 1960s and early 1970s, the federal government actively enforced the nation's then-nascent civil rights laws and forced the desegregation of hospitals around the country. Today, the U.S. Department of Health and Human Services' Office of Civil Rights, which is the principal agency charged with enforcing civil rights laws in health care settings, faces great challenges – including budget limitations, a broad mandate that includes enforcement of the nation's health care privacy laws, and a large backlog of complaints about potential civil rights violations – to establishing a more active enforcement program. Giving this agency the mission and resources to focus on potential civil rights violations is an important step. In addition, the U.S.

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Department of Justice should also assume some of the responsibility for addressing potential civil rights violations in health care.

- **Adopting new, integrated opportunity and human rights protections.** New policies are needed that better address problems of implicit stereotypes and institutional bias in healthcare systems; prohibit discrimination based on income, immigrant status, sexual orientation and other social characteristics not fully covered by current law; and take a more proactive approach to building opportunity and human rights into policy decisions. For example, we recommend that federal, state, and local agencies use a new tool – an Opportunity Impact Statement – to ensure that health policy decisions like hospital closings or construction consider the implications for community health, equal access and treatment, as well as inviting the participation of community members in decisions that affect them.

CONCLUSION

Universal and equal access to high quality healthcare is essential to fulfilling the American ideal of opportunity for all. It is also the human right of all people, simply by virtue of their humanity. Bringing this human right home to the United States is therefore crucial to realizing the American Dream.

ⁱ Institute of Medicine, *Hidden Costs, Value Lost: Uninsurance in America*, Washington, DC: The National Academies Press, 2003.

ⁱⁱ Doty MM, Edwards JN, Holmgren AL. *Seeing Red: Americans Driven into Debt by Medical Bills*, New York: The Commonwealth Fund, August 2005.

ⁱⁱⁱ [Wexler DJ](#), [Grant RW](#), [Meigs JB](#), [Nathan DM](#), [Cagliero E](#), “Sex disparities in treatment of cardiac risk factors in patients with type 2 diabetes,” in *Diabetes Care*, 2005, 28(3):514-20.

^{iv} Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, Washington, DC: The National Academies Press, 2003.

^v Henry J. Kaiser Family Foundation and the American College of Cardiology, “Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence,” October 2002.

^{vi} Institute of Medicine, 2003

^{vii} [Todd KH](#), [Samaroo N](#), [Hoffman JR](#), “Ethnicity as a risk factor for inadequate emergency department analgesia,” *Journal of the American Medical Association*, 1993 269(12):1537-9.

^{viii} American Association for the Advancement of Science (AAAS), *The Right to Health: A Resource Manual for NGOs*, August 2004, www.aaas.org (September 23, 2004), Ch. 2, p. 17.

^{ix} Universal Declaration of Human Rights, U.N.G.A. res. 217A (III), U.N. Doc A/810 at 71 (1948).

^x Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946; entered into force on 7 April 1948.

^{xi} International Covenant on Economic, Social, and Cultural Rights, U.N.G.A. res. 2200A (XXI) of 16 December 1966 (entry into force 3 January 1976).

^{xii} Center for Economic and Social Rights, *The Right to Health in the United States*, October 2004, www.cser.org (October 31, 2004).

^{xiii} *Ibid.*

^{xiv} Center for Economic and Social Rights, 2004

^{xv} *Ibid.*

^{xvi} Davis K, “Making Health Care Affordable for All Americans, Testimony before Senate Committee on Health, Education, Labor, and Pensions,” The Commonwealth Fund, January, 2004, www.cmwf.org, (July 17, 2005).