Live and Let Live:
Healthcare is a Fundamental Human Right

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I. INTRODUCTION

Healthcare is a fundamental human right. The right to health is as important as the right to food and shelter. Although the United States leads the world in advancing medical technology and science, it significantly lags behind other industrialized nations in regard to the basic human right to health. Healthcare has become a commodity in the United States. The affluent have absolute access to health; the disadvantaged and marginalized are denied this necessary access.

A story told by Laurel Baldwin-Ragaven MD, the Henry R. Luce Professor of Health and Human Rights at Trinity College, exemplifies the healthcare disparity in this country. A child, born to an upper-middle class family, was born without a brain. The doctors and the family knew the child couldn't live without life-sustaining machines. Even if the family spent millions under their healthcare insurance, it would not be possible for the child to survive more than one month. The parents insisted on keeping the child alive, despite the poor quality of life. The doctors agreed because they had the opportunity to try various scientific experiments. As expected, the child died within a month, costing the healthcare industry tens of millions of dollars.

In the United States, healthcare is for those who can afford it. In the United States, healthcare is a commodity. In the United States, those marginalized in society suffer and die needlessly from common medical ailments such as tuberculosis and sexually transmitted diseases. In the United States, the consensus is to spend money on the dying rather than the living.

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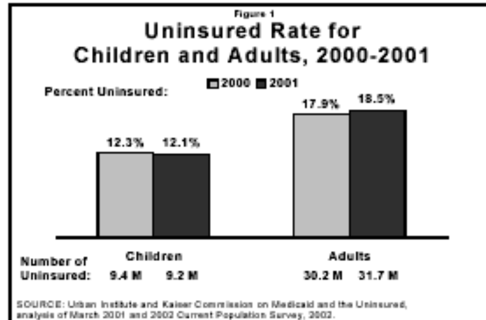
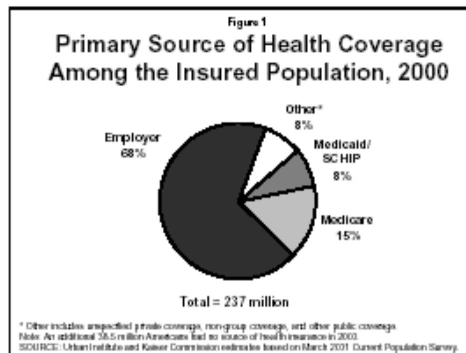
II. THE IMPORTANCE OF HEALTHCARE

Many American citizens are without healthcare. Forty-one million Americans have no form of health insurance and 16% of the non-elderly are uninsured.[1]





While nearly two-thirds of non-elderly Americans receive health insurance coverage through their employers and almost all the elderly are covered through Medicare, millions of Americans lack health insurance, either because their employer does not offer it or they cannot afford to pay for it. Medicaid and the State Children's Health Insurance Program (SCHIP) play an important role by covering over 40 million non-elderly low-income people, especially children. However, limits to these public

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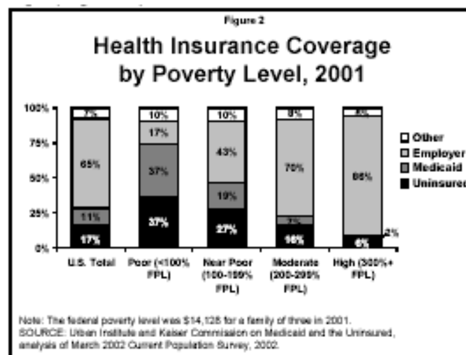
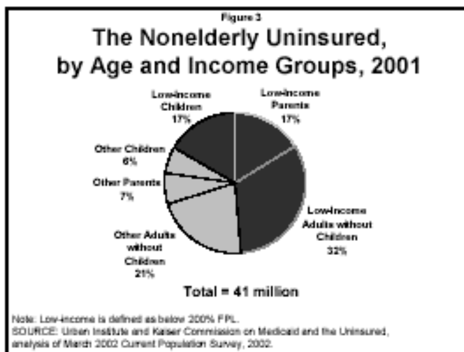
[1] The Henry J. Kaiser Family Foundation, *The Kaiser Commission on Medicaid and the Uninsured: The Uninsured and Their Access to Healthcare* (Dec. 2003), available *at* http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=29284.

programs and gaps in employer coverage leave 41 million Americans uninsured — creating substantial barriers to healthcare.[2]

In the 1990s, the number of uninsured Americans increased by approximately one million every year.[3] In 1999, there was a slight decrease in the number of individuals who were uninsured due to the economic boom.[4] However, in 2000 the number of uninsured Americans increased due to the economic downturn.[5]

Statistics show that there is a significant relationship between poverty level and lack of health insurance. One-fourth to one-third of the poor lack health insurance coverage.[6]





Recent findings indicate the following:

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[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*

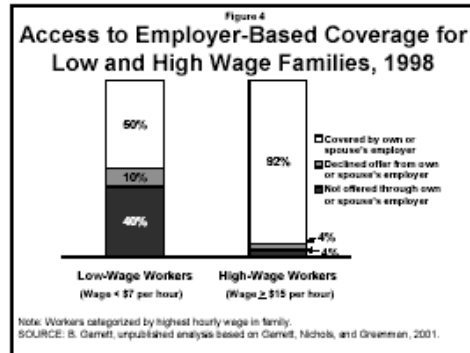
> The poor and the near-poor comprise two-thirds (66%) of the uninsured population. Four out of five (82%) of the uninsured are in working families: 70% live in households with a full-time worker and 12% live with a part-time worker. Low-wage workers are at greater risk of being uninsured, as are laborers, service workers, and those employed in small businesses. Over 60% of uninsured adults have incomes less than 200% of the poverty level.[7]

Many Americans are without any form of health insurance because of the exurbanite price of health insurance.[8] Insurance is expensive and many Americans simply cannot afford it.[9] Health insurance is not an option for lower-class citizens.[10]

Although "Medicaid fills in gaps in coverage for over forty million low-income Americans…coverage for adults is very limited," recent data indicates that even the poorest individuals are ineligible for health insurance if they do not have children.[11]

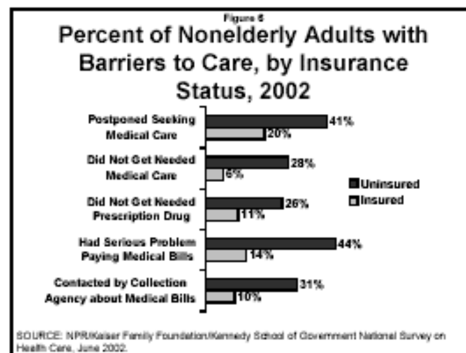
> Parents may qualify for Medicaid, but their income eligibility levels are set much lower than children's. In addition, neither Medicaid nor SCHIP has reached its full enrollment potential, leaving many eligible children still uninsured. There is no "standard" health insurance plan, and coverage—particularly for services such as vision and dental care, prescription drugs, and mental health—varies. In 2001, 10% of insured non-elderly adults reported that they lacked drug coverage, and about a third reported that they had no dental or vision coverage (29% and 37%, respectively). Plans vary; some people have a co-pay of $10, while others pay 20% or more of the bill.[12]

[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*



Sadly enough, medical bills are one of the top reasons Americans are forced to file bankruptcy.[13] "Nearly a quarter (24%) of insured families spent $2,000 or more out-of-pocket on their healthcare in a year (including their share of health plan premiums). Individuals with chronic conditions spend significantly more, largely due to their higher expenses for necessary prescription drugs."[14]

Due to the price of health insurance, uninsured Americans are not seeking medical attention when it is needed. "In 2002, over 40% of uninsured adults postponed seeking medical care, and 28% say they needed but did not get medical care in the past year."[15]



Most uninsured children do not receive routine medical attention. "70% of uninsured kids won't get medical care for routine problems."[16]

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[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*

The ramifications of not receiving routine medical attention and waiting until a condition is at its worst are extremely expensive medical bills that drive thousands of Americans to bankruptcy.

III. INTERNATIONAL

Generally, Americans have the freedom to worship, criticize the government and trade, etc.[17] "Because of these freedoms we tend to associate human right violations with political prisoners who live outside U.S. borders. Our privilege and misconception often prevent us from seeing the injustice of everyday human rights violations in the United States."[18] Statistics demonstrate that human rights violations occur in the United States everyday: "thirty million Americans don't have enough food to eat, five to seven million Americans are homeless, forty million Americans have no health insurance, two million Americans are in prison and [t]he United States has the highest child poverty rate in the industrialized world."[19]

"The most comprehensive document articulating human rights written in the last hundred years is the 1948 Universal Declaration of Human Rights (UDHR)."[20] A country that signs the UHDR is not legally bound to the document; it is a document that aspires to establish the standards for human rights.[21] The United Nations created treaties that "develop[ed] the principles of the Declaration [UDHR] into laws."[22] In 1966, the UN created treaties such as the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant of Economic, Social and Cultural Rights (ICESCR).[23]

> ICESCR recognizes healthcare as a fundamental right.
> 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.

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[17] National Center for Human Rights Education, *1999 Statistics from the Food First Information and Action Network* (2001) *available at* http://www.nchre.org/readingroom/perspectivepapers/humanrightsintheus.shtml.
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] *Id.*

> 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:
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> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
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> (b) The improvement of all aspects of environmental and industrial hygiene;
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> (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.[24]

The treaty was vague as to what a country should do in order to attain the highest standard of physical and mental health. On May 12, 2000, the UN created General Comment 14 of the ICESR in order to clarify the ambiguity regarding healthcare.[25]

General Comment 14 of the ICESCR points specifically to the fundamental rights to primary healthcare as one of the "most basic obligations assumed by a state that becomes a party to the Covenant."[26]

Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

> **Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party**. Accessibility has four overlapping dimensions:
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> **Non-discrimination**: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.

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[24] *Available at* http://www.unhchr.ch/html/menu3/b/a_cescr.htm.

[25] *Available at* http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4en?OpenDocument.

[26] Cassandra LaRae-Perez , *Economic Sanction As a Use of Force: Re-evaluating the Legality of Sanctions from a Effects-based Perspective*, 20 B.U. INT'L L.J. 161, 176 (2002).

> **Physical accessibility**: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.
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> **Economic accessibility** (affordability): health facilities, goods and services must be affordable for all. Payment for healthcare services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
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> **Information accessibility**: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.[27]

The United States has been resistant to join the international human rights community.[28] "The United States government has had difficulty accepting the legitimacy of the UDHR and has blocked its implementation. It is the responsibility of the U.S. Senate to ratify human rights treaties and make them application to the people of this country."[29] According to the U.S. Constitution, treaty law is equivalent to federal law; "therefore, human rights treaty law would challenge federal law and

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[27] *Supra* note 25.
[28] *Supra* note 17.
[29] *Id.*

would force all fifty states to adopt universal standards for the treatment of people."[30]

The U.S. waited to ratify the ICCPR until 1992. Even when a country ratifies a treaty, it may do so by exempting themselves from following the treaty. The United States did just that; "[u]pon ratification, the government made several 'reservations' to the treat and refused to enforce the treat when it appeared to contain more protections that those provided the by the United States Constitution."[31] The United States has yet to ratify the ICESR.[32] "[T]he United States has ratified only three of the twenty-six available human rights treaties, the lowest number for any industrialized nation."[33]

American culture and society is obsessed with the capitalistic, "pull-yourself-up-by-your-own-boot-straps mentality."[34] The government denies individuals basic access to healthcare due to economic reasons.[35] American society believes individuals "whose rights are violated are…a burden to society (i.e. immigrants, people with disabilities, low-income families) and are accused of wanting 'special rights.'"[36] Capitalism is based on the fact that there are those who have and those who have not; Americans who have wealth can buy the right to healthcare and Americans who do not have wealth are deprived of the fundamental right to healthcare.

Furthermore, the American government has created a warped definition of human rights. "When the United States government uses the term human rights they limit its focus to political and civil rights."[37] The American public has been misled to believe that human rights do not include the right to housing, healthcare, food and education.[38]

The United States government has an obligation to follow international law and set an example for other nations in the world to do the same.

> Governments are responsible not only for not directly violating rights but also for ensuring the conditions which enable individuals to realize their rights as fully as possible.

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[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] *Id.*

> This is understood as an obligation to respect, protect, and fulfill rights, and governments are legally responsible for complying with this range of obligations for every right in every human rights document they have ratified.[39]

The United States is a super-power in the world. Most countries in the world take example from the United States. If the richest country in the world does not recognize healthcare as a fundamental right and does not take any action to provide basic healthcare to its citizens, it sets the example that basic healthcare to individuals is an unnecessary expense of the state.

The various treaties recognizing healthcare as a fundamental right were ratified because so many individuals throughout the world are without any medical care. The result of zero preventative care and zero medical attention is that the poor and desolate are put to the wayside and killed or maimed by diseases which can be cured by inexpensive medical treatment. It is a social injustice for thousands to lose their lives to outdated diseases in this modern world of technology.

The United Nations' treaties were passed in the hopes that the countries signing them would recognize healthcare as a fundamental right, and also to serve as a catalyst to change the legal structure of states in order to include healthcare as a fundamental right. Moreover, the poorer nations of the world have no impetus to change their healthcare system when the richest country in the world decides that healthcare is not an important issue. The United States must ratify treaties that recognizes healthcare as a fundamental right, and it has a responsibility to adhere to this principal in order for Americans to have healthcare and to inspire other nations to do the same.

IV. FEDERAL GOVERNMENT

A. *Prisoners Have a Right to Healthcare Because Otherwise it would be Wanton and Willful Infliction of Pain*

Unfortunately, even today the United States Constitution does not ensure healthcare as a fundamental right.

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[39] *See generally* Sofia Gruskin & Daniel Tarantola, *Health and Human Rights, in* OXFORD TEXTBOOK OF PUBLIC HEALTH 314 (Detels, Beaglehole & Tanaka eds., 4th ed.).

> [I]n the United States, only the incarcerated have a legal right to healthcare. This right stems from early recognition by the courts that, "the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself." However, the Supreme Court did not formally recognize an inmate's constitutional right to healthcare until 1976, when the court established that deliberate indifference to serious medical needs of prisoners is a violation of the Eighth Amendment. [40]

A prisoner's right to healthcare stems from the Eighth Amendment. The Eighth Amendment prohibits cruel and unusual punishment to prisoners. "Although originally intended to prevent 'tortures and other barbarous forms of punishment,' the clause has been interpreted by the Supreme Court to include a right to medical treatment for convicted inmates that does not allow wanton and willful infliction of pain."[41]

Furthermore, according to the Fourteenth Amendment:

> Pre-trial detainees also have a right to healthcare, under the Fourteenth Amendment, which prohibits the government's denial of "life, liberty or property without due process of law." Although the pre and post-conviction rights come from separate constitutional provisions, the Supreme Court has never articulated the due process medical care standard, and the rights have been interpreted by the courts to require the same level of treatment.[42]

In 1976, the Supreme Court of the United States faced the issue of the healthcare to prisoners in *Estelle v. Gamble*:

> The court held that deliberate indifference to serious medical needs is prohibited whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally

[40] Mary Sylla & David Thomas, *The Rules: Law and AIDS in Corrections*, HIV EDUCATION PRISON PROJECT NEWS, Nov. 2000, *available at* http://www.aegis.com/pubs/hepp/2000/HEPP2000-1101.html (construing Spicer v. Williams, 191 N.C. 487 (1926)).
[41] *Id.*
[42] *Id.* (construing Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983)).

> denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a [claim under the Constitution].[43]

In *Farmer v. Brennan*, the Supreme Court narrowed the deliberate indifference standard. "In 1994 the Court said that deliberate indifference . . . [lies] somewhere between the poles of negligence at one end and purpose or knowledge at the other."[44] However, although the Court held that "prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care,"[45] the Court "went on to emphasize that deliberate indifference requires a culpable state of mind."[46] This area of law is not settled yet. The result has been variations in the law regarding the meaning of adequate medical care.[47]

The Eighth Amendment has been interpreted to mean that a prisoner has a fundamental right to healthcare. The reasoning for this right is that without healthcare, the penal system would be inflicting wanton and willful infliction of pain. An analogy could be drawn between prisoners and the indigent of society. Essentially, both are without the means to afford medical attention on their own. One can argue that the prisoner does not have the choice to find gainful employment and the indigent individual does have that choice. However, statistics show that 82% of uninsured Americans are in working families. These individuals have gainful employment, but still cannot afford health insurance. These startling statistics demonstrate that a distinction should not be drawn between prisoners and uninsured Americans simply on the basis that non-prisoners have the opportunity to obtain health insurance through gainful employment. Gainful employment is no guarantee of the affordability of health insurance.

B. ADA

The *McNeil v. Time Insurance Co.*[48] case exemplifies the discriminatory power insurance companies have over individuals who

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[43] *Id.* (construing Estelle v. Gamble 429 U.S. 96, 104-05 (1976)).
[44] *Id.* (construing Farmer v. Brennan, 511 U.S. 825 (1994)).
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] McNeil v. Time Ins. Co., 205 F.3d 179 (5th Cir. 2000).

have a disability under the American Disability Act (ADA). In the spring of 1994, Michael McNeil purchased a self-funded life and health insurance policy for his small business from Time Insurance Company (Time). The policy contained a $10,000 cap on treatment of illnesses related to Acquired Immune Deficiency Syndrome (AIDS). Time had no actuarial basis or past experience to justify this cap; the company could not establish that its cap was not arbitrary or discriminatory.

In September of 1994, McNeil was diagnosed with AIDS. Time paid only the first $10,000 of McNeil's AIDS-related bills that eventually exceeded $400,000 before McNeil died on March 1, 1995. Prior to his death, McNeil sued Time in Texas state court. After McNeil's death his father took over the suit, asserting "numerous common law causes of action: breach of contract, breach of duty of good faith and fair dealing, negligent misrepresentation, common law discrimination, waiver, estoppel, and ratification." He also charged that Time violated numerous state and federal statutes, including the Americans with Disabilities Act (ADA). Time removed the case to federal district court in Texas based on diversity and preemption under the Employee Retirement Income Security Act (ERISA).

The district court dismissed all of the claims. The court found that the ADA claim failed because Time's provision of insurance was not a "public accommodation." The court also found that ERISA preempted the state law claims. The Fifth Circuit affirmed, agreeing that Title III of the ADA did not apply to the policy. It relied on the ADA's plain language, reasoning that Title III does not regulate the content of goods and services offered by a public accommodation. The court also affirmed the lower court's ERISA finding.[49]

Catherine Olender argues there is a circuit split regarding whether insurance companies have the right to discriminately cap benefits to individuals for the treatment of certain diseases.[50] Furthermore, she states that since "state law does not regulate the content of self-funded health insurance plans, in which an employer pays participants' claims directly out of its own funds," there is an ERISA loophole regarding coverage of certain ADA covered diseases, like AIDS.[51]

Title III of the ADA states:

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[49] Catherine Olender, *Capping AIDS Benefits: Does Title III of the ADA Regulate the Content of Insurance Policies?,* 28 AM. J. L. & MED. 107, 107-08 (2002).
[50] *Id.* at 109.
[51] *Id.* at 110.

> No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.[52]

Olender argues that both the Department of Justice (DOJ) and the legislative history demonstrate that Title III of the ADA applies to insurance companies.

Olender believes that universal healthcare may be the solution to the AIDS capping problem. Universal healthcare may be a legislative solution to the AIDS capping problem. Mary Crossley suggests "it is not fair to judge the ADA," a civil rights statute, "as a failure in the realm of healthcare." Although persons with disabilities may face barriers posed by lack of insurance, Crossley notes that "underinsurance and administrative constraints on accessing care are not unique to persons with disabilities." Therefore, she concludes, healthcare reform that addresses these concerns may ultimately improve healthcare for disabled individuals more than the ADA ever will. Though she expresses doubt that universal coverage in the United States will occur in the near future, she cites "incremental measures*such as the recent Ticket to Work and Work Incentives Improvement Act of 1999*[which] can expand the numbers of persons with disabilities with effective coverage." Consequently, she urges those working to improve healthcare services for disabled persons to continue using the ADA to challenge disadvantageous healthcare policies and to advocate for reforms that provide increased coverage for the growing number of uninsured.[53]

It is unfortunate to see ambitious small business owners such as Michael McNeil suffer from the discriminatory practices of health insurance providers. Mr. McNeil was gainfully employed and even purchased self-funded health insurance; yet, the insurance companies were blocked his access to treatment for a debilitating disease. This again shows how the healthcare access is denied due to purely economic reasons. Insurance companies place caps on debilitating diseases, such as AIDS, because the medical treatments of such diseases are expensive. Federal laws need to be enacted to prevent insurance companies from discriminating against individuals with disabilities, and thereby reflect

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[52] 42 U.S.C. § 12182 (a) (2004).

[53] *Id.* at 122; Mary Crossley, *Becoming Visible: The ADA's Impact on Healthcare For Persons With Disabilities*, 52 ALA. L. REV. 51, 88-89 (2000).

the non-discriminatory nature of Title III of the ADA.

V. HEALTHCARE DISPARITY

> If I define my neighbor as the one I must go out to look for, on the highways and byways, in the factories and slums, on the farms and in the mines – then my world changes. This is what is happening with the "option for the poor," for in the gospel it is the poor person who is the neighbor par excellence.
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> But the poor person does not exist as an inescapable fact of destiny. His or her existence is not politically neutral, and it is not ethically innocent. The poor are a by-product of the system in which we live and for which are responsible. They are marginalized by our social and cultural world. They are oppressed, exploited proletariat, robbed of the fruit of their labor and despoiled of their humanity. Hence the poverty of the poor is not a call to generous relief action, but a demand that we go and build a different social order.[54]

Americans do not have equal access to healthcare. The underprivileged of society are discriminated against by the current healthcare system. The 2002 Institute of Medicine report found startling statistics concerning the inequalities of healthcare between minorities and whites. "Undeserved population undergo bypass operations at a rate less than one quarter that of whites, receive angioplasties at one-third the rate, and have higher rates of leg amputation and lower rates of leg-saving operations if they have diabetes or circulatory problems."[55]

One of the major mediums for determining healthcare disparity is evaluating infant mortality rates.[56] The infant mortality rate of black

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[54] PAUL FARMER, PATHOLOGIES OF POWER: HEALTH, HUMAN RIGHTS, AND THE NEW WAR OF THE POOR 139 (2003).

[55] Inst. of Med., *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (2002), *available at* http://www.nap.edu/books/030908265X/html/.

[56] Thomas A. Laveist, *Segregation, Poverty and Empowerment: Health Consequences for African Americans*, 71 MILBANK Q. 83 (1993) ("Infant mortality rate is a long-standing general indicator of overall social and economic development, availability, and use of health services, health status of women of childbearing age, and quality of social and physical environment.").

infants is double that of white infants.[57] In some extreme cases, the black infant mortality rate is five times greater than the white infant mortality rate.[58]

Furthermore, statistics show that there is an enormous income gap in the United States.[59]

> In 1997, the top 1/5 of families received 47% of nation's total income and the bottom 1/5 of the families received 4% of the nation's total income. In 1995, 39 percent of total household wealth was controlled by the top 1 percent of wealth holders, while the bottom 80 percent controlled just 16 percent of the nation's wealth. This is the highest concentration of wealth amassed in the United States since the Great Depression.[60]

The National Center for Health Statistics confirms that Americans earning $9000 or less have a 3% to 7% higher death rate than Americans who earn $25,000 or more.[61]

Sociologists believe the reason for the healthcare disparities is primarily due to discrimination based on race and economic status. African-Americans face the most amount of healthcare disparity. This is most likely due to the fact that African-Americans encounter the most segregation.[62] Residential segregation has a domino effect leading up to the healthcare disparity.[63] Due to residential segregation, minorities, especially African-Americans, receive poor primary and secondary education. Statistics prove that in 96% of white schools, the children were from middle-income families.[64] Furthermore, schools that contain the majority of African-American and Hispanic students are vastly poor.

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[57] *Id.* at 77.
[58] *Id.* at 78.
[59] Peter S. Arno & Janis Barry Figueroa, *The Social and Economic Determinants of Health, in* UNCONVENTIONAL WISDOM: ALTERNATIVE PERSPECTIVES ON THE NEW ECONOMY 100 (Jeff Madrick ed., 2000).
[60] *Id.*
[61] *A New Mechanism of Disease,* RACHEL'S ENV'T & HEALTH WKLY., Feb. 5, 1998, at 584.
[62] David R. Williams & Chiquita Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health,* 116 PUB. HEALTH REP. 405 (Sept. 2001) ("Williams and Collins believe that racial segregation is the cornerstone of health disparity in the United States. Furthermore, African-Americans live in the highest level of segregation, more so than any other immigrant group.").
[63] *Id.* at 406.
[64] *Id.*

The poor educational opportunities affect high school drop out rates and basic high school competence. They also have an affect on employment opportunities. In today's economy, it is difficult to obtain employment solely based on a GED or high school diploma.[65] "National data … indicates that in 1996, black households in which the survey respondent was a college-educated male earned 80 cents for every dollar earned by a comparable white household."[66]

African-Americans generally reside in large cities. Cities are generally more expensive to live in. Grocery stores are more expensive in cities than suburban areas.[67] Therefore, African-Americans buy less nutritious food due to its high cost. The cities have many more billboards that advertise cigarettes and alcohol, which are targeted toward inner-city youth.[68] Furthermore, in conjunction with poor nutrition, statistics demonstrate that African-Americans receive less quality healthcare even when they do have access to it.[69]

Universal healthcare is not the only answer to solving the problem of healthcare disparities. According to studies done by Peter Arno and Janis Figueroa, healthcare disparities still exist in countries regardless of the improved access to healthcare.[70] "Access involves more than the simple ability to afford care. It also requires that adequately funded health services be available in a non-threatening environment."[71] Barriers such as cultural and racial discrimination will not be eliminated by increased access to healthcare.

Thus, the answer to healthcare disparity is not merely increased access to healthcare or technological advances. The first problem that needs to be addressed is the condition of the poor and underprivileged of society. The underprivileged have poor sanitation, nutrition, and live in environmentally hazardous conditions. Solving the problem of poverty is the necessary first step to extinguishing healthcare disparities.

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[65] *Id.*
[66] *Id.*
[67] *Id.* at 410.
[68] *Id.*
[69] *Id.* at 411 (Research indicates that the quality of medical care is less in segregated areas. "One recent study of New York City neighborhoods revealed that pharmacies in minority neighborhoods were less likely than pharmacies in other areas to have adequate medication in stock to treat people with severe pain. Moreover, other recent research documents that, irrespective of residence, African-Americans and members of other minority groups are less likely than whites to receive appropriate medical treatment after they gain access to medical care.").
[70] Arno, *supra* note 59, at 99.
[71] *Id.* at 9.

VI. HEALTHCARE IS A FUNDAMENTAL HUMAN RIGHT

From the perspective of preferential options for the poor, the right to healthcare, housing, decent work, protection against hunger, and other economic, social, and cultural necessities are as important as civil and political rights or more so.[72] The United States has one of the worst healthcare systems of any industrialized nation. Ironically, the United States spends more money than any other nation on healthcare.[73]

> It is one of the great and sobering truths of our profession that modern healthcare probably has less impact on the population than economic status, education, housing, nutrition and sanitation. Yet . . . we have fostered the idea that abundant, readily available high quality healthcare would be some kind of panacea for the ills of society and the individual. This is a fiction, a hoax.[74]

A human right transcends legal rights in the sense that each individual is owed this right regardless of their nation of origin. This right is special because each person is owed a specific duty simply because they are a human being. Although the United States does not currently recognize the fundamental right to health, the international community has affirmed this right. The affirmation began with the UHDR and then the ICESR. The United States continues to believe that human rights are limited to civil and political rights and nothing more.

Paul Farmer, a leading scholar in the human rights arena, believes that social and economic rights go hand in hand with health and human rights.[75] Dr. Farmer believes that without social and economic rights to healthcare, individuals that can afford access essentially hoard the scientific advances in medicine.[76] Human rights have moved away from

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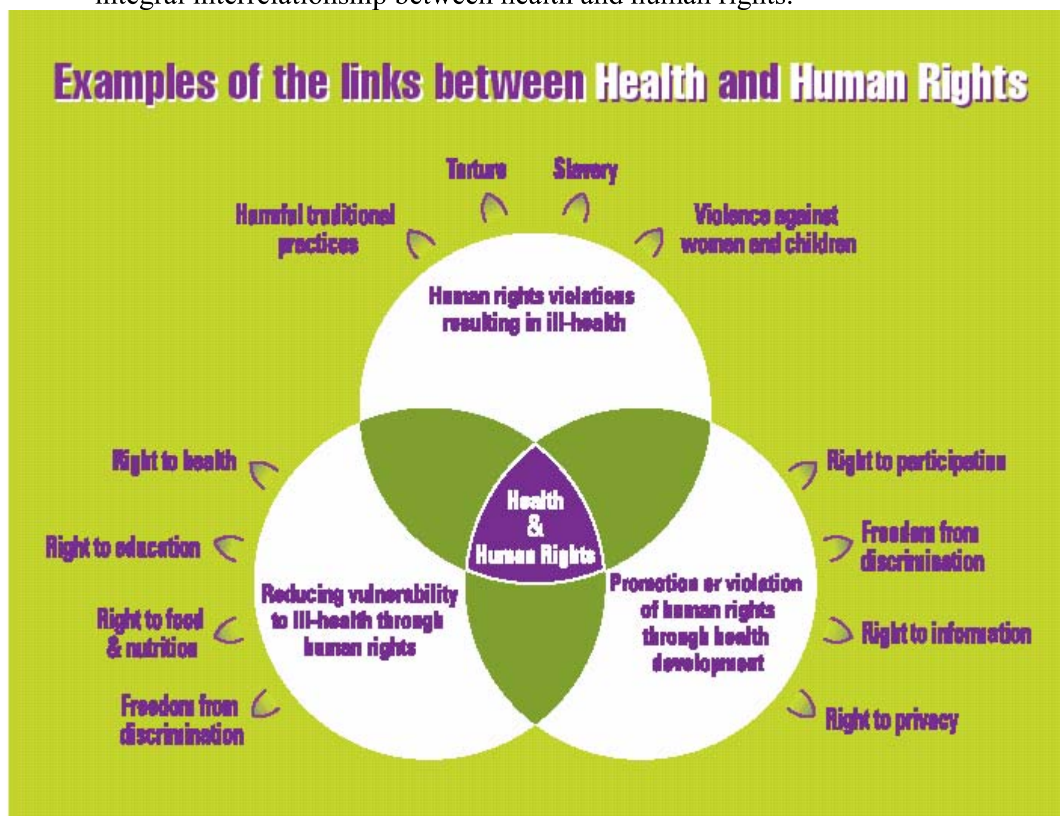
[72] FARMER, *supra* note 54, at 213.
[73] JAMES A. AUERBACH, BARBARA KIVIMAE KRIMGOLD, & BONNIE LEFKOWITZ, IMPROVING HEALTH: IT DOESN'T TAKE A REVOLUTION 1 (2000) ("[I]nformation compiled by Gerald Anderson and Jean-Pierre Poulier, shows that the United States spends roughly $4,000 per person on medical care annually --far more than any other nation -- but that three-fourths of developed countries outrank American on common health status measures such as life expectancy and infant mortality.").
[74] *Id.* at 3 (as stated by Theodore Cooper, U.S. Assistant Secretary for Health approximately 25 years ago).
[75] FARMER, *supra* note 54, at 219.
[76] *Id.* at 221.

coercive public health standards such as mandatory testing and quarantine towards the notion that health issues can only be addressed by evaluating the underlying societal conditions that marginalize people.[77] Essentially, without the right to healthcare, civil, political and economic rights become meaningless. A person who is physically or mentally ill cannot take advantage of his/her political and economic rights. All human rights are intertwined and interrelated. Every person's human rights are composed of civil rights, health rights, political rights, cultural rights and economic rights. The following figure exemplifies the integral interrelationship between health and human rights.[78]



[77] Jonathan Mann, *Health and Human Rights*, UNESCO COURIER, June 1995, at 29-30.

[78] *25 Questions on Health and Human Rights*, Health and Human Rights Series (July 2002), *available at* http://www.soziologie.ch/users/markus/health/docs/0.02_25_Questions_on_Helth_and%20Human_Rights.pdf.

Research regarding HIV infection demonstrates that discrimination and marginalization of gay men led to the spread of the virus.[79] This marginalization and discrimination led to interference with HIV education and prevention.[80] According to Jonathan Mann, gay men did not have adequate access to information because the climate of fear and violence prohibits such communities from organizing.[81] Furthermore, research indicates that individuals who have been discriminated against are less likely to act in a sexually responsible, such as the use of a condom.[82] This is explained by comparing a young heterosexual male who has a bright future to a young, gay heterosexual male who has faced discrimination, fear and violence.[83] The young, gay male has been ostracized and abused his entire life; thus, his attitude is not to be careful about disease and infection because he does not feel he has control over his environment.[84] When an individual has been discriminated and marginalized they feel powerless, and this directly affects their health. Research on third world countries indicates that women who know their husbands are HIV-infected continue to have sexual relations without a condom because they have no legitimate power as a woman in a patriarchal society.[85]

VII. CONCLUSION

Healthcare is a fundamental human right. Unfortunately, this country lags behind the rest of the world because it does not recognize the fundamental nature of this right. The United States is one of the biggest human rights violators in the world. This is due to the historic American belief that human rights issues (like health) are solely domestic issues. Furthermore, the United Nations created many health-rights treaties during the Cold War. Many communist and socialist Eastern European countries ratified these treaties; the United States, in order to avoid being associated with communism and/or socialism, did not ratify them.

The necessary first step for this country is to disseminate information to the American public that health is a fundamental right,

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[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] Mann, *supra* note 77, at 31.
[83] *Id.*
[84] *Id.*
[85] *Id.* Generally, women in third world countries are unequal to men in the eyes of the law and in societal status.

according to the United Nations and virtually every other country in the world. Once this is accomplished, the United States needs to respect, protect, and fulfill its duty to healthcare.[86]

> The obligation of *respect* requires state parties to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires states parties to take measures that prevent third parties from interfering with article 12 guarantees. The obligation to *fulfill* requires states parties to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.[87]

The General Comment also identifies fundamental obligations that must be met in order to ensure that nations provide a minimum of health services.[88]

> The minimal level of services consists of (1) access to health services on a nondiscriminatory basis, especially when they belong to vulnerable or marginalized groups; (2) sufficient food that is nutritionally adequate and safe; (3) basic shelter, sanitation, and safe and potable water; and (4) essential drugs. To fully realize the right to health, states must adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, that will address the health concerns of the whole population. The CESCR also gives priority to the following services: reproductive and maternal, immunization, infectious disease control, and health information.[89]

The United States must invest money to fulfill its duties to its citizens.

The United States government's view of healthcare must change. The healthcare system in the United States, where healthcare is a commodity, hurts the marginalized, discriminated, and vulnerable in

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[86] U.N. GAOR, 21st Sess. Supp. No. 16, at 51, U.N. Doc. A/6316 (1966).
[87] Eleanor D. Kinney*, The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457, 1470 (2001).
[88] Lawrence O. Gostin, *The Right to Health: A Right to the A Highest Attainable Standard of Health*, HASTINGS CENTER REP.,Vol. 31, Issue 2, at 29 (Mar. 2001)
[89] *Id.*

society. Change cannot occur until the United States acknowledges that health is a fundamental human right.[90] "In contrast, commodified medicine invariably begins with the notion that health is a desirable outcome to be attained through the purchase of the right goods and services."[91] The American mindset of healthcare as a commodity needs to be altered. A great percentage of the health budget is spent on the last ten days of an individual's life. This exemplifies how the United States needs to evaluate what its goals are with respect to healthcare. Paul Farmer argues there are three approaches to the problem of healthcare: charity, development, and social justice.[92] Farmer believes that the correct answer to the inadequacy of healthcare is social justice.[93] According to Robert McAfee Brown, "unless we agree that the world should not be the way it is…there is no point of contact, because the world that is satisfying to us is the same world that is utterly devastating to them."[94]

The primary reason the United States violates the right to health is the inequitable distribution of access to health in this country. American society should not ask whether there is a fundamental right to healthcare, but rather how we should achieve that right. The question of "how" is answered by tackling the bigger problem of social injustice and economic disparity in the United States.

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[90] FARMER, *supra* note 54, at 152.
[91] *Id.*
[92] *Id.*
[93] *Id.*
[94] FARMER, *supra* note 54, at 157.