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Introduction: Health and Human Rights

George J. Annas

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Civil Rights and Social Justice Section

Section Office:
1050 Connecticut Ave., N.W., Suite 400
Washington, D.C. 20036
tel: 202-662-1030, fax: 202-662-1031
email: crsj@americanbar.org
americanbar.org/groups/crsj.html

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Health and Human Rights

By George J. Annas

The American health care industry is killing us, and the casualties are mounting daily. Instead of saving lives, it is more often taking them, and not only by failing to seriously confront the coronavirus pandemic and racism in the industry, but also by the way health care is financed.

"BEST IN THE WORLD"

We have the most expensive health care system in the world, and until the ravages of the pandemic became undeniable, we could take some comfort in believing it was, at least for those with access, the "best in the world." This characterization is no longer tenable. In the summer of 2020, with 5 percent of the world's population, we had 25 percent of the world's COVID-19 infections and 25 percent of the world's deaths (more than 175,000 by August 25). And this is just the most dramatic deadly trend.

For more than 100 years, since the great flu pandemic of 1918, life expectancy in the United States increased by four months every year (30 additional years of life expectancy in a century)—even though it stubbornly remained below that in our peer countries. But even this sturdy trend, fueled mostly by public health measures, has reversed. In three of the last four years, life expectancy in the United States has actually decreased. Many of the deaths that have brought about this decrease are in the horrible category, labeled "deaths of despair," caused by suicide, drugs, and alcohol.

Combined with the failure to effectively respond to the pandemic, the urgency of the Black Lives Matter movement, and unprecedented unemployment levels, we may be at an inflexion point where radical change is possible. That means voting for change in November really does matter. Changing our perspective and our language to insist that health (including decent health care) is a human right, not a commodity, could also help change reality. The rhetoric of health and human rights is powerful. Born in the depths of the HIV/AIDS epidemic, it grew from the perception that, as Jonathan Mann put it, health and human rights are "inextricably linked." We failed at the time to generalize from HIV to all other medical conditions. COVID-19 gives us a second opportunity. It has revealed gaping flaws in our health care industry, especially as related to race, sex, and poverty, but also as related to both government-financed (Medicare and Medicaid) and private, employer-sponsored health insurance.

CAPITALISM AND PUBLIC GOODS

We cannot blame everything on our capitalist system. Capitalism itself is simply unable to fairly allocate public goods, like health care. Capitalism that was not slated to self-destruct always required a safety net that included the provision to all of what has become known as "the right to health." Lawyers should have worked harder to make this right, which includes the basics necessary to live a dignified, healthy life, such as nutritious food, clean water, decent housing, excellent education, quality health care, and a safe and healthy environment,

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a reality. Presidents Franklin Roosevelt and Harry Truman both tried and failed to enshrine the right to health into U.S. domestic law.

Since World War II, the primary way most Americans continue to have access to health care insurance (and to health care) is through employer-provided health insurance in which premiums are effectively deducted from wages. We have, however, supplemented employer-provided and employee-financed health insurance with government-financed health insurance for the elderly (the federal Medicare program) and the poor (the state-federal Medicaid program), both signed into law in 1965 by President Lyndon Johnson. President Barack Obama's Affordable Care Act (ACA) sought to provide health insurance to the 40 million Americans who still had none. The ACA survived the first of what has been a series of court challenges, but only by giving state governments the option of declining Medicaid expansion, thus limiting "Obamacare" coverage to about half of the uninsured. Medicare and Medicaid remain such central parts of health care financing in the United States that four of the articles in this issue on health and human rights are devoted to aspects of these programs. It is also worth noting that the House of Representatives approved ACA legislation only when President Obama promised not to use any ACA funds to pay for abortion. Reproductive rights continue to be treated separately from all other health care issues. We still insist on radical discrimination against women in health care by trying to deny them access to medical care that only women need.

Economists Anne Case and Angus Deaton, who coined the term "deaths of despair," have argued persuasively that our health care industry itself causes deaths by the way it is financed and organized to maximize profits (*Deaths of Despair and the Future of Capitalism,* Princeton, 2020). Tens of millions of people not only can't get access to care but are actively preyed on by an industry that promotes dangerous products, including addictive drugs, like opioids. Employer-sponsored health insurance also negatively affects Americans by depressing their wages as the price of health insurance continues to rise faster than the cost of living. When health insurance becomes too expensive, employers can simply stop providing jobs with health insurance benefits, creating new segments of the working poor. When jobs are no longer available (because of the high price of health insurance to employers), unemployed, low-skilled workers can easily fall into depression and sometimes death. On a macro scale, with almost 20 percent of the gross domestic product going to the health care industry, any additional money that goes into the health care industry is taken directly from areas that would improve the quality of our lives, including education, public infrastructure, housing, pollution abatement, parks and recreation, and even food and water.

PATIENT RIGHTS

Our health care industry is not only a financial disaster; it is more and more unaccountable to the sick and their families, as illustrated at the beginning of the pandemic. Hospitals and nursing homes, for example, curtailed or eliminated visiting hours to sick and dying patients, treating them like prisoners who could be cut off from the world and put in virtual solitary confinement. Prisoners check many of their human rights at the door of the prison—patients do not (or at least have not until the pandemic).

The most important of all patient rights is the right to informed choice, usually denoted as informed consent. Individual choice, including the right to refuse treatment (arguably, and ironically, the most honored patient right) is accepted and insisted on by individuals on both the right and the left of the political spectrum. That is one reason why it was so easy for the president to turn wearing a face mask in public into a political statement.

Another powerful patient right, this one inconsistent with treating health care as a market good, is the right to emergency care. By both common law and statute, people who arrive at a hospital emergency department suffering from a medical emergency have a legal right to be seen and treated. Virtually everyone in the health care debate is against watching people die on the streets (a small consolation). To the extent that this aversion is based on empathy, it is worth continuing to try to extend the right to emergency care to encompass the right to treatment of all conditions that cause serious suffering.

CONFRONTING AMERICAN MEDICINE

What makes our health care industry simultaneously crushingly expensive and sickeningly inept are four characteristics of American society that our health care industry mirrors: We are death denying, individualistic, technologically driven, and wasteful. Does this mean the pandemic has a silver lining? Perhaps we can now at least talk about death, put public health on par with individual medical care, recognize that we cannot rely on technology to save us (although our child-like faith that the pharmaceutical industry will find an effective vaccine soon suggests this faith will not easily be challenged), and stop wasting money on medicine that does not improve the quality of our lives. Perhaps. These are all conversations that are worth having.

The Universal Declaration of Human Rights, which includes the right to health, imposes on governments the obligation to make the right to health a reality. In the United States, the language of the market has historically overwhelmed the language of human rights, especially the right to health—which has been deformed into the right to accumulate and retain wealth in an increasingly unequal, unfair, and lethal society.

Reforming a corrupt health care system and redistributing income to provide quality care to all, regardless of ability to pay, race, gender, or religion, or any other characteristic used to discriminate, will be no easy task. In the midst of the worst global pandemic in a century, and a continuing epidemic of racism, there is at least some reason to believe that the duality of human rights and health may emerge as a more powerful pair than rights and money. The challenge, as Bob Dylan put it to describe his Frankenstein-like project to build a new version of his former girlfriend from dead body parts: Our new health care industry must be constructed "with decency and common sense" (from "My Own Version of You," 2020).

George J. Annas is director of the Center for Health Law, Ethics & Human Rights at Boston University School of Public Health.