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TREATING HEALTH CARE UNDER THE RIGHT TO HEALTH: WHY THE PUBLIC OPTION IS THE ONLY WAY TO PREVENT INEQUITABLE ACCESS TO MEDICATIONS FROM BECOMING TERMINAL

Ashley Goren*

Introduction

In 2008, the late Senator Ted Kennedy (D-Mass) expressed an aspiration that the United States should recognize health care access as a right of all Americans.¹ He declared:

[t]his is a season of hope—new hope for a justice and fair prosperity for the many, and not just for the few . . . new hope that we will break the old gridlock and guarantee every American—north, south, east, west, young, old—will have decent, quality health care as a fundamental right and not a privilege.²

Access to health care is not just a dream, however, but a legal right protected by customary international law.³

The “right to health” is a prominent legal doctrine that pervades international law.⁴ President Franklin Roosevelt introduced a right to health care in his “four freedoms” speech, suggesting that Congress recognize “the right to adequate medical care and the opportunity to achieve and enjoy good health.”⁵ His speech influenced the content of the Universal Declaration of Human Rights (“UDHR”), one of the first international agreements to include the right to health.⁶

Despite ties between U.S. politicians and the growth of the right to health doctrine, however, the U.S. does not guarantee access to health care for many Americans.⁷ The picture of the American health care system is dire.⁸ Health problems create an immense economic burden on U.S. families, which can lead to the choice between health care and food.⁹ Many U.S. citizens are unable to afford medications, and therefore must go without them.¹⁰ Others go bankrupt as a result of the catastrophic financial strain imposed by illness.¹¹

Change is now a necessity. However, discussions of health reform create great friction in the U.S.¹² The

debate about whether to enact national health insurance began over seventy years ago.¹³ Although Congress recently took great strides towards accomplishing this elusive goal, a governmental guarantee of universal health care access remains a distant ideal.¹⁴

This article argues that the U.S. must eventually establish universal health insurance coverage in order to comply with international standards of health care access imposed by the right to health doctrine. In particular, contrasting the ability of U.S. citizens to access medicines against the internationally accepted standards will expose the disparities between the two.¹⁵ Part I surveys the evolution of the right to health and health care access within the U.S.¹⁶ Part I additionally looks at customary international law and its importance in the field of human rights.¹⁷ As the U.S. is not legally constrained by treaty law, it is only bound if the doctrine is a norm of customary international law. Part II concludes that the right to health is a part of customary international law and considers its definition and implications for the U.S.¹⁸ Part III suggests steps American leaders can take to conform to the international standards of health care access.¹⁹

I. Background

The concept of the “right to health” has evolved substantially during its long history.²⁰ International organizations have long grappled with its meaning, but it is now prominently understood as a right to enjoy access to necessary components of health care.²¹ The recent health reform debate provides a useful opportunity to evaluate the doctrine’s meaning and authority in relation to U.S. health care.

A. The Evolution of the “Right to Health”

The international community first announced a “right to health” as a component of human rights in the Constitution to the World Health Organization (“WHO”).²² The preamble of the Constitution recognizes that the enjoyment of the highest attainable standard of health is a fundamental right.²³ It goes on to establish WHO to help all individuals attain this right.²⁴

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Following WHO Constitution's initial proclamations, countries drafted myriad international treaties that recognize and formalize the right to health.²⁵ The Universal Declaration of Human Rights states in Article 25(1) that everyone has a right to health and security in the case of sickness or other "circumstances beyond [one's] control."²⁶ The International Covenant on Economic, Social, and Cultural Rights ("ICESCR") in Article 12(1) reaffirms this right²⁷ and further illustrates steps that state parties must take in Article 12(2).²⁸ International treaties with a more specific scope also reference the right to health, including the Convention on the Elimination of All Forms of Discrimination against Women, and the Convention of the Rights of the Child.²⁹ Increasingly, the international community espouses a common belief that access to the health system is an essential component of an equitable society.³⁰

B. Defining the "Right to Health"

Despite its widespread use, "right to health" is a broad and ambiguous phrase.³¹ It is difficult to conceptualize exactly what countries must do to comply with the requirements it establishes.³² For this reason, documents subsequent to the original treaties clarify the broad terminology and delineate the right's obligations.³³

WHO provided an initial interpretation of what "health" means and how it applies to the right to health.³⁴ The preamble to the WHO Constitution specifies that, "health is a state of complete physical, mental and social well-being and not the absence of disease or infirmity."³⁵ The Constitution asserts that "[g]overnments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures."³⁶

In 1978, WHO supplemented this vague standard with a document commonly called the "Alma-Ata Declaration."³⁷ The Alma-Ata Declaration presented necessary components for primary health care, including health education, promoting the availability of food and water, immunizations against prominent infections, appropriate treatment for common diseases and injuries, and the provision of essential drugs.³⁸ WHO reaffirmed these principles in 1998 with a resolution entitled "Health for All in the Twenty-First Century."³⁹

In defining the right to health, the U.N. did not adopt WHO's conception of health, but built upon the framework of the Alma-Ata Declaration.⁴⁰ The U.N. created the Committee on Economic, Social, and Cultural Rights ("CESCR") in 1985 to monitor and interpret the International Covenant on Economic, Social, and Cultural Rights.⁴¹ The Committee defines the right to health as "a right to the enjoyment of a variety of facilities, goods, services and conditions necessary" for the realization of health.⁴² General Comment No. 14 also establishes precise actions that states must take to ensure this enjoyment.⁴³

C. Customary International Law

The growth of the right to health leads to the question of whether it now constitutes customary international law.⁴⁴ Customary international law is a significant source of codifying human rights norms.⁴⁵ According to the International Court of Justice ("ICJ"), a rule becomes customary international law when two conditions are met: it must be carried out frequently enough to constitute "settled practice" and states must follow it pursuant to *opinio juris*, a belief that the practice is obligatory.⁴⁶ Once a law meets the test, it is binding upon all nations.⁴⁷

D. Health Care in the United States

Despite its widespread acceptance, the U.S. has a poor record of recognizing the right to health.⁴⁸ The U.S. largely declined to ratify the numerous treaties containing the right to health.⁴⁹ Additionally, unlike most developed nations, the U.S. does not provide universal access to health services, but relies heavily on private financing for health care.⁵⁰ Legal protections only ensure economic assistance to obtain health care for the poorest segments of the population and senior citizens.⁵¹

The cost of pharmaceuticals in the U.S. has dramatically increased since the 1990s.⁵² Insurance companies redistribute these added costs to consumers by restricting benefits and increasing the expenses of the insured.⁵³ Studies show that the high prices of medications, and the insurance companies' subsequent practices, restrict accessibility.⁵⁴ Some patients who cannot afford the cost of prescribed medication forego complying with their medication regimen.⁵⁵ Medical experts refer to this as "cost-related prescription nonadherence" ("CRNA").⁵⁶

In 2006, approximately twenty-three percent of patients in the U.S. did not comply with their prescriptions due to prohibitive medication costs.⁵⁷ Lack of health insurance coverage is closely linked to this phenomenon.⁵⁸ Additionally, CRNA is most common among marginalized populations, including individuals with lower incomes⁵⁹ and minorities.⁶⁰

Current trends accentuate the likelihood that members of the U.S. population will not be able to afford pharmaceuticals.⁶¹ The number of individuals without health care insurance is rapidly increasing.⁶² Furthermore, an increasing number of U.S. citizens are underinsured, meaning their health insurance does not adequately protect them from high health care costs.⁶³ These ominous figures indicate that the public could experience significant deleterious effects if the situation does not improve.⁶⁴

E. Health Care Legal Reforms in the United States

The government is taking action to change the dire health care situation in the U.S.⁶⁵ In 2009 the two houses of Congress each passed a bill to reform the health care system.⁶⁶ Both bills contained provisions to expand coverage to insure more individuals⁶⁷ and to lower costs.⁶⁸ They each additionally attempted to combat the problem of CRNA by requiring "essential



benefits” insurance companies must provide, including pharmaceutical coverage.⁶⁹

Although the late Senator Kennedy championed health care reform throughout his life,⁷⁰ his death ended a Democratic supermajority in the Senate, threatening to end the push towards reform.⁷¹ Therefore, on March 21, 2010, the House of Representatives abandoned the bill passed in the House, HR 3962, and instead adopted the bill approved by the Senate, HR 3590.⁷² On March 23, 2010, President Obama signed the Patient Protection and Affordable Healthcare Act into law, making health care reform a reality.⁷³ Soon after, both houses passed a “budget reconciliation bill” altering several provisions of the Senate bill.⁷⁴

The Patient Protection and Affordable Care Act requires most citizens and residents to obtain health insurance.⁷⁵ To ensure affordability, the law establishes state-based health care “exchanges” for consumers to purchase insurance coverage.⁷⁶ The “American Health Benefit Exchanges” will create forums that enable U.S. Citizens and legal immigrants to compare and select regulated health care plans.⁷⁷ It will have an online component to browse plans as well as a hotline for assistance.⁷⁸ The exchanges are intended to augment competition between plans and promote optimal coverage at minimal cost.⁷⁹ Although the plans within the exchanges will be regulated, existing health insurance plans will persist in the private market.⁸⁰

Insurance plans within the exchange will provide coverage based on a tiered structure.⁸¹ Through this system, insurance companies must cover at least 60% of total annual health care costs at the lowest tier and up to 90% at the highest tier of coverage.⁸² Additionally, each plan must ensure essential benefits including prescription medication.⁸³

The Act also enhances affordability through government assistance based on financial necessity. The Patient Protection an Affordable Care Act establishes government subsidies for families to reduce health care costs.⁸⁴ Families earning up to 400% of the federal poverty level will be eligible for assistance.⁸⁵

Although these benefits will improve health care access and affordability, the House of Representatives bill, HR 3962, was best suited to ameliorate the problems addressed in this article.⁸⁶ HR 3962 would have established a public option, thereby creating universal coverage.⁸⁷ The government would have run the public insurance option to compete with private insurance and guarantee coverage to the public.⁸⁸ Without a public option, the government cannot ensure all individuals can obtain health care insurance. The Congressional Budget Office estimates that over twenty million non-

elderly individuals will remain uninsured after the Act takes full effect.⁸⁹

II. Analysis

The health care system within the U.S. creates a jungle in which all citizens must fend for themselves. As a result, a disturbing percentage of citizens cannot afford the materials necessary to protect their health.⁹⁰ This begs the question: does the U.S. comply with the legal obligations of the right to health doctrine? In order to determine the answer, one must first discern the doctrine’s authority on the U.S., what it requires, and whether the U.S. meets these requirements.

A. The Right to Health Binds all Nations as Customary International Law

The right to health doctrine has ripened into a rule of customary international law.⁹¹ As established above, to form customary international law, a norm must constitute “settled practice” and states must follow it pursuant to a belief that the practice is obligatory.⁹² Evidence exists to meet both facets of this test.⁹³

1. Implementation of the Right to Health is Accepted Practice

A practice need not be universal, but should reflect a general acceptance by relevant states to amount to accepted practice.⁹⁴ Evidence of human rights as state practice includes domestic constitutional protection of the right, decisions upholding it in regional and national courts, U.N. resolutions, and regional organization resolutions.⁹⁵ The evolution and increasing acceptance of the right to health doctrine resulted in a proliferation of such evidence to demonstrate the doctrine’s status as customary international law.⁹⁶

The right to health enjoys widespread international acceptance.⁹⁷ Almost every country in the world is a party to at least one treaty that recognizes the right to health.⁹⁸ Copious regional agreements also recognize the right.⁹⁹ Over one hundred nations include health care access in their national constitutions.¹⁰⁰ Of these nations, at least six mandate specific steps the government must take towards achieving a successful health care system that all citizens can access.¹⁰¹ These countries thereby commit themselves to achieving quality health care that all citizens can afford.¹⁰²

The requirement to uphold the right to health is also enforced by courts.¹⁰³ An array of cases before domestic and regional courts condemned actions that violated the states’ duties to protect these rights.¹⁰⁴ Domestic courts have upheld obligations under the right to health doctrine in countries including South Africa, Canada, Argentina, Brazil, Colombia, Costa

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Rica, Ecuador, India, and Venezuela.¹⁰⁵ Additionally, the Inter-American Court protects the same rights inherent in the right to health doctrine, but more commonly under the “right to life.”¹⁰⁶ This shows that nations condemn violations of the right to health, accept the doctrine’s obligatory nature, and are actively enforcing its provisions.¹⁰⁷

Furthermore, state acceptance of the right to health doctrine goes beyond rhetoric.¹⁰⁸ All developed nations, except for the U.S., provide universal health care coverage.¹⁰⁹ Countries increasingly protect health care access as an integral right of citizenship.¹¹⁰ Even nations that do not confer health rights within their constitution spend exorbitantly to ensure health care accessibility.¹¹¹ Based on the near universal recognition and implementation, protection of the right to health now constitutes accepted practice.¹¹²

2. States Follow the Right to Health Doctrine Pursuant to a Perceived Obligation

States implement the right to health doctrine based on a perceived obligation.¹¹³ When states consent to international resolutions or enforce a legal doctrine in court, they accept the binding nature of the doctrine.¹¹⁴ The international community has validated the obligations imposed by the right to health doctrine through numerous international declarations.¹¹⁵ The members of the United Nations unanimously accepted the Universal Declaration of Human Rights, which heralded the right to health as a fundamental human right.¹¹⁶ Nations also accepted the right to health doctrine through World Health Organization resolutions, such as the Alma-Ata Declaration and “Health for All in the Twenty-First Century.”¹¹⁷

In addition to the international resolutions, widespread state participation in treaties recognizing the right to health supports the existence of *opinio juris* and establishes the right to health doctrine as customary law.¹¹⁸ Rights crystallized in multilateral treaties become customary international law when widespread practice conforms.¹¹⁹ Thus, the numerous international and regional treaties enforcing the doctrine lend additional credence to the doctrine’s status as customary international law.¹²⁰ The right to health is enshrined in as many treaties as the right to be free from torture, another human right now accepted as customary law.¹²¹ The myriad treaties protecting the right to health enjoy widespread ratification in addition to their prevalence.¹²²

Upholding the right to health doctrine is general practice followed pursuant to the belief that it imposes an obligation and is, therefore, customary international law.¹²³ As such, the right to health doctrine binds all

nations.¹²⁴ The doctrine thus holds authority over the U.S. under international law.¹²⁵

B. CESCR’s General Comment No. 14 Defines the Term “The Right to Health” and Provides Guidance on Compliance

The term “right to health” may invoke any number of different concepts.¹²⁶ Since the relevant treaties provide scant guidance on what steps countries must take to comply, states and scholars look to the U.N. Committee on Economic, Social and Cultural Rights’ General Comment No. 14 for guidance.¹²⁷ General Comment No. 14’s description of the obligations under the right to health doctrine is widely accepted and is considered the most comprehensive and respected delineation of the concept.¹²⁸

General Comment No. 14 contains the authoritative interpretation of the International Covenant on Economic, Social and Cultural Rights (“ICESCR”), the core treaty establishing the right to health.¹²⁹ When a treaty provision is also customary international law, it binds non-treaty parties only to the extent that it reflects state practice.¹³⁰ General Comment No. 14, however, not only establishes ICESCR’s scope, but also mirrors nations’ current practice.¹³¹ The obligations outlined by General Comment No. 14 frequently form the interpretation of the right, even outside of the U.N.¹³² Both regional and domestic bodies employ the analysis contained within the General Comment.¹³³ It is the most commanding and frequently invoked interpretation of the right to health doctrine.¹³⁴ It therefore provides the proper scope through which to interpret the right to health doctrine in customary international law.¹³⁵

C. The United States is in Breach of the Right to Health Doctrine as Defined in General Comment No. 14 because Medicine is Not Equitably Accessible Absent Discrimination

Pursuant to the requirements established by General Comment No. 14, the U.S. is in breach of the right to health doctrine under customary international law.¹³⁶ General Comment No. 14 reports that the right to health requires countries to ensure the availability, accessibility, acceptability, and quality of health care facilities, goods, and services.¹³⁷ However, prescription medications in the U.S. are not economically accessible to all citizens.¹³⁸

The term “goods” refers to products necessary to protect health.¹³⁹ The Committee on Economic, Social, and Cultural Rights specifies that treatment for diseases and “essential” medicines are core health care goods.¹⁴⁰ Prescription medication, an important health

“good,” can be crucial to the treatment, prevention, and control of diseases, and therefore is clearly protected by provisions guarding health goods.¹⁴¹

Although all aspects of the doctrine are crucial, the right to health predominantly focuses on individuals’ ability to access health care.¹⁴² Members of the population must be able to access health care equitably¹⁴³ and without discrimination.¹⁴⁴ States must ensure that socially disadvantaged groups can afford health care goods and services.¹⁴⁵

Prohibitive costs create subpar access to health goods.¹⁴⁶ Nations must ensure that essential medications are available equitably to all citizens, despite their economic status.¹⁴⁷ CESCR explains that states have an affirmative duty to ameliorate accessibility inequalities, even if they arise unintentionally.¹⁴⁸ A state may need to implement policies that favor the disadvantaged or impoverished portions of the population.¹⁴⁹ The requirements of nondiscrimination and equitable access exist throughout international law, nullifying any argument that an alternative definition of the right to health doctrine could exclude these provisions.¹⁵⁰ Therefore, if essential medications are not equitably and indiscriminately available to all, and the government does not act to change this situation, the state violates the right to health.¹⁵¹

Despite these obligations, medications are not equally accessible to all members of the population within the U.S.¹⁵² Medication accessibility is a significant problem.¹⁵³ In a study comparing the U.S. to four other developed nations, the country ranked last for patients’ ability to afford prescriptions.¹⁵⁴ As of 2006, 23% of U.S. citizens could not afford to comply with prescriptions and medication inaccessibility is increasing.¹⁵⁵ Poorer individuals are disproportionately affected.¹⁵⁶ However, it is a systemic problem reaching beyond indigent portions of the population.¹⁵⁷ Unfortunately, the government is not acting sufficiently to assist economically disadvantaged groups.¹⁵⁸

The situation is most dire for the marginalized populations the right to health doctrine expressly requires states to protect.¹⁵⁹ Troubling disparities currently exist in access based on income-level, gender, and ethnicity.¹⁶⁰ Low-income families are disproportionately unable to access medications, both due to lack of money and insufficient or nonexistent insurance coverage.¹⁶¹ Ethnic minorities and women are more susceptible to the effects of prohibitive cost barriers than the rest of the population.¹⁶² These facts reveal discriminatory medication accessibility.¹⁶³ This widespread inaccessibility of medications breaches the right to health doctrine under customary international law.¹⁶⁴

1. The United States is Not Respecting, Protecting, and Fulfilling Medication Accessibility Pursuant to the Right to Health Doctrine’s Obligations

Pursuant to General Comment No. 14, states must respect, protect, and fulfill the requirements of the right to health doctrine.¹⁶⁵ To respect the right to medicine accessibility as part of the right to health, countries must avoid any action or policy that hinders access.¹⁶⁶ To protect this right, governments must implement policies to safeguard access and prevent third parties from impeding accessibility.¹⁶⁷ To fulfill the requirements, states must establish all necessary policies to ensure medication accessibility.¹⁶⁸ Countries must ensure low pricing for medications, or insurance to compensate for high prices, such that all citizens can afford essential medications.¹⁶⁹

The U.S. is not upholding the obligations to respect, protect, and fulfill the right to health doctrine.¹⁷⁰ Most notably, the United States violates the duties to protect and to fulfill medication accessibility.¹⁷¹ To protect the entitlements under the doctrine, a state must prohibit third parties from preventing its fulfillment.¹⁷² However, the government has not implemented sufficient laws to protect individuals in the U.S. from excessive pharmaceutical prices or predatory insurance tactics.¹⁷³ The only national protections currently in place focus exclusively on the most impoverished individuals, the disabled, and the elderly.¹⁷⁴ Therefore, the U.S. does not currently uphold the duty to protect medication accessibility under the right to health doctrine.

Pursuant to the obligation to fulfill the right to health, the government must establish a national health plan to ensure medications are affordable and accessible to all, without discrimination.¹⁷⁵ Some argue that the U.S. meets the duty to fulfill through the creation of Medicare and Medicaid programs.¹⁷⁶ However, this position ignores the fact that many individuals do not benefit from these systems and still cannot access medications.¹⁷⁷ Additionally, private insurance plans are currently insufficient.¹⁷⁸ Through inaction, the U.S. thus violates the obligation to fulfill the right to health doctrine in addition to the obligation to protect it.¹⁷⁹

It is not yet clear how the Patient Protection and Affordable Care Act will affect pharmaceutical prices and affordability. However, pharmaceutical manufacturers preemptively increased prices to avoid decreased profits.¹⁸⁰ This signals that insurance and pharmaceutical companies may attempt to circumvent the efficacy of the reform act. Without a public insurance option, the government’s efforts will likely prove insufficient to correct the accessibility predicament. This is illustrated by the Congressional Budget Office’s expectation that twenty-three million nonelderly residents will be uninsured in 2019.¹⁸¹ Illegal residents only account for two-thirds of this figure.¹⁸² Thus, millions of legal residents will remain uninsured. Furthermore, the reform act may potentially exacerbate the problem of impoverished and unhealthy individuals shouldering a disproportionate burden of health care costs.¹⁸³ Only a public option could guarantee universal coverage and the lowest possible costs.¹⁸⁴

2. The United States is Unwilling, Not Unable to Uphold the Obligations Imposed by the Right to Health Doctrine

Economic considerations play a role in implementing the doctrine.¹⁸⁵ Therefore, a state only violates its obligations when it is unwilling, not unable, to comply.¹⁸⁶ This suggests a balancing test to determine a reasonable level of action: weighing a nation’s economic strength and ability against the measures it takes to ensure the public can access health care services.¹⁸⁷ If the state does not attempt to fulfill obligations to its full capacity, it violates the doctrine’s mandates.¹⁸⁸

In balancing the government’s ability to enable medication access under the right to health doctrine against its efforts, the scales are tipped heavily against the U.S.¹⁸⁹ The violations of the doctrine established above are based on a lack of will, not inability, to eradicate these problems.¹⁹⁰ Based on World Bank indicators on governance, the United States ranks highly in governmental capability.¹⁹¹ The nation’s 2009 gross domestic product (“GDP”) surpassed \$14 trillion, just behind the GDP of the entire European Union and more than any other country in the world.¹⁹² Additionally, the government currently spends more than any nation per capita on health

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care.¹⁹³ Yet, nations that spend substantially less are able to ensure universal health care access.¹⁹⁴ It is therefore clear that the U.S. has the capability and resources to implement the measures necessary to ensure access to essential medicines.

While General Comment No. 14 predominantly discusses “essential” medicines, the U.S. likely must ensure citizens can afford most, if not all, prescribed medications.¹⁹⁵ The General Comment requires states to uphold health accessibility to their maximum capability.¹⁹⁶ Based on the economic strength of the U.S., the government must take significant action to ensure medication accessibility for all.¹⁹⁷ Balancing the economic strength and significant capability of the U.S. to implement the obligations under the right to health doctrine against the meager protections afforded, the U.S. clearly breaches the obligations set forth in General Comment No. 14 and customary international law.¹⁹⁸

III. Recommendations

The most glaring problem in U.S. health care is that many individuals are uninsured and unable to afford medical necessities, such as prescription medication.¹⁹⁹ Thus, the first step to redeem the health care system is to create universal health care that incorporates prescription coverage. Additionally, the U.S. should ratify the International Covenant on Economic, Social, and Cultural Rights.

A. The United States Should Enact Reform Laws to Create A Public Health Care Option

In order for the U.S. to comply with the right to health doctrine, prescription medications must be equitably accessible without discrimination.²⁰⁰ Prohibitive pricing and manipulative health insurance tactics cannot be allowed. The government must take action to enable all citizens to enjoy the right to health and the right to access medicines.

Health care reform laws can ensure these rights.²⁰¹ As previously addressed, high prices create an insurmountable obstacle prohibiting uninsured or underinsured individuals from accessing medicine.²⁰² This tragedy is intensified in the recessed economy and by practices insurance companies employ to ensure high profits and to restrict an insured party's benefits.²⁰³

The Patient Protection and Affordable Care Act is a step in the right direction, but of the two bills before Congress in 2009, H.R. 3962 would have best ensured pharmaceutical access to the entire population without discrimination or prohibitive cost.²⁰⁴ A public insurance option is crucial to the eradication of access

disparities.²⁰⁵ It would address many of the underlying problems that create unequal access and ensure that all citizens could obtain coverage. Additionally, a public option would compete with private insurance to discourage unfavorable practices through market competition and could keep administrative costs to a minimum.²⁰⁶ Although the Patient Protection and Affordable Care Act will make great strides toward greater medication accessibility, it will likely fail to eradicate inaccessibility entirely and fulfill the requirements of the right to health doctrine. For this reason, Congress should establish a public option to bring the U.S. in line with its obligations under international law.

B. The United States Should Ratify the International Covenant on Economic, Social and Cultural Rights

The U.S. should formally ratify the International Covenant on Economic, Social, and Cultural Rights in Congress. Ratifying the Covenant would formally acknowledge the U.S.'s acceptance of the right to health doctrine's binding obligations. Such a public legal commitment can prove crucial for reform. Debates about access to health care currently center on moral imperatives, not legal rights. If the U.S. became a party to ICESCR, these problems would be discussed under the discourse of legal violations. This discourse is more likely to encourage change.²⁰⁷

Furthermore, if the U.S. ratifies the International Covenant on Economic, Social, and Cultural Rights, it would encompass the country under the purview of the Committee on Economic, Social and Cultural Rights. The Committee could then analyze the situation within the U.S. and provide guidance on measures for the U.S. to follow in order to improve access to health care and prescription medications.

Conclusion

It is time to fulfill the dreams of the millions of Americans who require health care and cannot afford prescription medications. This article demonstrates that access to health care is a fundamental human right ensured by customary international law, but unprotected in the U.S. The Founding Fathers of the U.S. declared, “all men are created equal” and “are endowed... with certain unalienable rights” including “Life, Liberty, and the Pursuit of Happiness.”²⁰⁸ An individual's health is integral to all three. A public option would neutralize systemic inequalities preventing their realization. As a nation that prides itself on being a beacon of hope and freedom, it is time to honor the memory of visionaries such as Theodore Roosevelt and Ted Kennedy. The United States should

join the advanced countries of the world in providing universal health care access. As Senator Kennedy urged:

It is the glory and the greatness of our tradition to speak for those who have no voice, to remember those who are forgotten, to respond to the frustrations and fulfill the aspirations of all Americans seeking a better life in a better land. We dare not forsake that tradition.²⁰⁹

¹ See Senator Edward Kennedy, Speech at the Democratic National Convention (Aug. 25, 2008) (transcript available at <http://www.americanrhetoric.com/speeches/convention2008/tedkenedy2008dnc.htm>) (praising Barack Obama's nomination as the presidential candidate for the Democratic party and highlighting the need to improve health care access in the U.S.).

² *Id.* (proclaiming that the introduction of health care reforms in the U.S. was the "cause of [his] life.").

³ See discussion *infra* Part II.A (evaluating the prominence of the right to health and concluding that it binds all nations because it is customary international law).

⁴ See discussion *infra* Part II.A.1 (establishing the prevalence of laws that mandate health care access internationally).

⁵ See, e.g., Jean Carmalt & Sarah Zaide, CENTER FOR ECON. AND SOC. RIGHTS, *The Right to Health in the U.S. of America What Does it Mean?*, at ii (Oct. 2004), <http://www.cesr.org/article.php?list=type&type=5> (advocating for the inclusion of the right to health within policy discussions about health care in the U.S., as President Roosevelt intended, to focus the debate on human rights and not economic costs) (internal quotations omitted); Michael Kirby, *The Right to Health Fifty Years On: Still Skeptical?* 4(1) HEALTH & HUM. RTS. 6, 8 (1999) (suggesting that the atrocities committed during World War II led President Roosevelt to fight for the protection of human rights).

⁶ See, e.g., THE UNIVERSAL DECLARATION OF HUMAN RIGHTS: A COMMON STANDARD OF ACHIEVEMENT xxvii (Gudmundar Alfredsson & Asbjorn Eide eds., Kluwer Law International 1999) (indicating that his influence may be due to the fact that his wife, Eleanor Roosevelt, chaired the Commission drafting the UDHR).

⁷ See Senator Edward M. Kennedy, *Health Care as a Basic Human Right: Moving from Lip Service to Reality* 22 HARV. HUM. RTS. J. 165, 165 (2009) (acknowledging the fact that the U.S. government does not ensure health care access for all citizens although the international community has recognized the right to health for more than sixty years).

⁸ See, e.g., Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the U.S.* 60 RUTGERS L. REV. 335, 368-70 (2008) (presenting indicators of the poor performance of U.S. health care including the fact that the U.S. population has a lower life expectancy than at least thirty other nations despite spending significantly more on health care than any other country).

⁹ See Kennedy, *supra* note 7, at 166 (linking a shorter life expectancy to individuals being underinsured because of their tendency to avoid necessary care as a result of costs).

¹⁰ See discussion *infra* Part I.D. (exploring the effects of prohibitive pricing and high rates of uninsured individuals on the population's ability to afford medications in the U.S.).

¹¹ See Kennedy, *supra* note 7, at 166 (relaying one study's findings that health care payments cause one-half of U.S. personal bankruptcies, and that every thirty seconds a family goes bankrupt for that reason).

¹² See Kinney, *supra* note 8, at 348-53 (tracing the history of the debate over national health care back to 1935, and noting that Presidents Truman, Nixon, Carter, and Clinton all advocated universal health care within the U.S. to no avail).

¹³ See Kinney, *supra* note 8, at 348 (pinpointing the debate over the Social Security Act in 1935 as the beginning of deliberations on whether to provide national health insurance coverage).

¹⁴ Cf. Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform* 36 AM. J.L. & MED. 7, 15 (2010) (concluding that the suggestion of a government-run health insurance plan is a "political lightning rod in the U.S." which provokes widespread backlash centering around allegations that such a plan would be tantamount to "socialized medicine.").

¹⁵ See discussion *infra* Part II.C (demonstrating that the U.S. does not currently meet the legal requirement of equitable access for all without discrimination).

¹⁶ See discussion *infra* Part I (laying out the high costs of medications within the U.S. and the subsequent effects on the population, as well as the reform bills proposed in 2009 to increase health care accessibility).

¹⁷ See discussion *infra* Part I.C (introducing the definition of customary international law and the International Court of Justice's inclination to recognize human rights as customary international law).

¹⁸ See discussion *infra* Part II (deducing that the right to health is binding on all nations as a part of customary international law and that it requires medication accessibility beyond the level obtained in the U.S.).

¹⁹ See discussion *infra* Part III (offering the possibility of universal health insurance as an answer to the hurdles preventing medication accessibility in compliance with the right to health).

²⁰ See discussion *infra* Part I.A (explaining the progression of human rights provisions establishing the right to health).

²¹ See discussion *infra* Part I.B (detailing the World Health Organization and United Nations attempts to narrow the definition of "health" and the "right to health").

²² See generally Constitution of the World Health Organization, July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185 [hereinafter WHO Constitution] (stating that the parties to the Constitution recognize that health is basic to international harmonious relations and establishing the World Health Organization to promote the protection of health).

²³ See WHO Constitution pmb. (specifying that countries should provide the right "without distinction of race, religion, political belief, economic or social condition").

²⁴ See *id.* pmb. (declaring that the promotion of health in any nation benefits the entire international community).

²⁵ See, e.g., International Covenant on Economic, Social, and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3, art. 12(1) [hereinafter ICESCR] (forming binding obligations for nations to recognize the right to health and adopt tools for its implementation); Universal Declaration of Human Rights, G.A. Res. 217A, U.N. Doc. A/810, art. 25(1) (Dec. 10, 1948) [hereinafter UDHR] (announcing a right to an adequate standard of living to support health and well-being as a human right).

²⁶ See UDHR, *supra* note 25, at art. 25(1). The UDHR's preamble proclaims a "recognition of the inherent dignity and . . . equal and inalienable rights of all members of the human family." *Id.* at preamble.

²⁷ See ICESCR, *supra* note 25, at art. 12(1). The ICESCR preamble asserts that U.N. members have "a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant." *Id.* at preamble.

²⁸ See ICESCR, *supra* note 25, at art. 12(2) (including requirements for the signatory countries to take steps to reduce stillbirth, decrease infant and child mortality rates, improve hygiene, and create conditions ensuring medical care to all).

²⁹ See World Health Organization, Fact Sheet: The Right to Health, http://www.who.int/mediacentre/factsheets/fs323_en.pdf [hereinafter WHO Fact Sheet] (displaying the extensive international acceptance of the right to health and noting that physical health and mental health are both protected).

³⁰ See Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights*, ¶ 12, delivered to the General Assembly, U.N. Doc. A/HRC/7/11 (Jan. 31, 2008) (by Paul Hunt) [hereinafter Promotion and Protection of All Human Rights] (elaborating that an effective health system is a "core institution" of government, just as a fair justice system is).

³¹ See DAVID P. FIDLER, INTERNATIONAL LAW AND PUBLIC HEALTH 302 (2000) (identifying difficulties in conceptualizing, implementing, and enforcing the right to health as main problems in the right's history).

³² Cf. Eleanor D. Kinney, Lecture, *The International Human Right to Health: What Does This Mean for Our Nation and World?* 34 IND. L. REV. 1457, 1457 (2001) (contending that the seemingly vague nature of the right to health doctrine should not deter nations from attempting to comply, as it is no more obscure than other social and cultural human rights incorporated into international law).

³³ Cf. Alicia Ely Yamin, *The Right to Health Under International Law and Its Relevance to the U.S.* 95(7) AM. J. PUB. HEALTH 1156, 1157-58 (July 2005)

(finding that a consensus has formed on what the right to health entails from international agreements).

³⁴ See WHO Constitution, *supra* note 22, pmb1. (providing an early attempt to define “health” which focused on the overall state of the body); see also FIDLER, *supra* note 31, at 278 (arguing that this definition was beneficial in advancing a concept of health looking at overall “well-being” instead of a narrow, medical focus).

³⁵ WHO Constitution, *supra* note 22, pmb1. (denouncing a simplistic view of health and linking the definition to governments’ obligations to protect the health of the members of society); see also FIDLER, *supra* note 31, at 279 (observing that the definition contained within the WHO Constitution may be the broadest vision of health within the discourse of modern health law).

³⁶ WHO Constitution, *supra* note 22, pmb1. (advancing the argument that the enjoyment of health is a fundamental right which is principal to individuals’ happiness and security).

³⁷ See Benjamin Mason Meier, J.D., LL.M., *Breathing Life into the Framework Convention on Tobacco Control: Smoking Cessation and the Right to Health*, 5 YALE J. HEALTH POL’Y L. & ETHICS 137, 157 (2005) (isolating the Alma-Ata Declaration as the beginning of a more encompassing view of the right to health).

³⁸ See International Conference on Primary Care, Alma-Ata, U.S.S.R., Sept. 6-12, 1978, *Declaration of Alma-Ata*, art. VII (calling the provision of primary health care “the key” for governments to protect the health of their populations).

³⁹ See Meier, *supra* note 37, at 157 (noting that both resolutions call for universal health care access).

⁴⁰ See U.N. Comm. on Econ., Soc., and Cultural Rights [CESCR], *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, ¶ 2, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment No. 14*] (rejecting the definitions suggested by WHO, reasoning that the history and wording of ICESCR Article 12(1) and 12(2) promote the inclusion of additional socio-economic factors as inherent in the right to health); *id.* ¶ 43 (naming the Alma-Ata Declaration as an instrument that helped to shape the specifications provided in the General Comment).

⁴¹ See High Commissioner for Human Rights, *Review of the composition, organization and administrative arrangements of the Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, E.S.C. Res. 1985/17, U.N. Doc. E/RES/1985/17 (May 28, 1985) (creating the Committee to be composed of eighteen human rights experts).

⁴² See *General Comment No. 14*, *supra* note 40, ¶ 9 (accepting that no state can guarantee that citizens will be healthy, and focusing instead on enabling citizens to access health services).

⁴³ See discussion *infra* Part II.B (relaying the actions necessary to comply with medication accessibility under the right to health).

⁴⁴ Cf. Kinney, *supra* note 32, at 1464 (finding customary law “promising” to establish the right to health as an internationally binding norm).

⁴⁵ See OSCAR SCHACHTER, *INTERNATIONAL LAW IN THEORY AND IN PRACTICE* 335 (1991) (recognizing customary international law’s influence on the field of human rights because it encompasses nations within the purview of human rights obligations that may not have signed the treaties that initially established the rights).

⁴⁶ See *North Sea Continental Shelf (F.R.G./Den. v. F.R.G./Neth.)*, 1969 I.C.J. 4, 45 (Feb. 20) (readministering the test originally set forth by the Permanent Court of International Justice and denying that continental shelf delimitation had reached the point of customary international law at that time); see also THEODOR MERON, *HUMAN RIGHTS AND HUMANITARIAN NORMS AS CUSTOMARY INTERNATIONAL LAW* 107 (1989) (commenting that the Continental Shelf Cases contains the classic definition of customary international law).

⁴⁷ See FIDLER, *supra* note 31, at 48 (clarifying that if a country is a “persistent objector” when the law is forming, it is not bound by the customary international law).

⁴⁸ Cf. Kinney, *supra* note 8, at 364 (contrasting the vast international recognition of the right to health with the U.S.’ “mixed” record of recognition by supporting the UDHR, ratifying CERD, but failing to ratify regional treaties).

⁴⁹ See Kinney, *supra* note 8, at 346-47 (suggesting the Cold War and racial tensions within the U.S. as reasons why the country did not join treaties during the height of the human rights movement).

⁵⁰ See Carmalt & Zaide, *supra* note 5, at 8-9 (arguing that the Medicare and Medicaid programs are the closest the American system comes to providing universal health care).

⁵¹ See Carmalt & Zaide, *supra* note 5, at 9 (lamenting that the current framework excludes millions of Americans who cannot receive aid based on the eligibility requirements).

⁵² See The Henry J. Kaiser Family Found., *Prescription Drug Trends* at 2 (Sept. 2008), www.kff.org/rxdrugs/upload/3057_07.pdf [hereinafter Kaiser] (illuminating that prices rose at an average rate of 6.9% per year between 1997 and 2007, over two and a half times the average annual inflation rate from this period and that the drug manufacturers ranked within the top five most profitable within the U.S. in that time).

⁵³ See *id.* at 4 (listing the techniques used by the insurance companies, such as excluding a greater number of medications from coverage, use of quality dispensing limit—such as only covering generic forms of a prescription—and increasing out-of-pocket copayments).

⁵⁴ See e.g., Jae Kennedy, Ph.D. et al., *Drug Affordability and Prescription Noncompliance in the U.S.: 1997-2002*, 26(4) CLIN. THER. 607, 607-14 (2004) (attributing these trends to, *inter alia*, increased third-party payment plans, changes in the population, new and more effective drugs, pharmaceutical companies’ direct marketing, and high pharmaceutical company profits).

⁵⁵ See e.g., Becky A. Briesacher, Ph.D. et al., *Patients at Risk for Cost-Related Medication Nonadherence: A Review of the Literature* 22(6) J. GEN. INTERN. MED. 864, 864 (June 2007) (reporting that as many as 32% of older adults decreased prescription drug use because of the cost).

⁵⁶ See e.g., *id.* at 864 (referring to the phenomenon as cost-related nonadherence); Kennedy et al., *supra* note 55, at 607-14 (utilizing the abbreviation CRNA).

⁵⁷ See Jae Kennedy, Ph.D. & Steve Morgan, Ph.D., *Cost-Related Prescription Nonadherence in the U.S. and Canada: A System-Level Comparison Using the 2007 International Health Policy Survey in Seven Countries* 31(1) CLIN. THER. 213, 215 (2009) (insisting that medication non-adherence is an important public health problem and suggesting that, based on their findings, mandated universal drug coverage is the most effective solution).

⁵⁸ Cf. Briesacher et al., *supra* note 55, at 866 (establishing lack of drug coverage as a leading cause of noncompliance through a comparison of seventeen separate studies); Kennedy & Morgan, *supra* note 57, at 217 tbl.II (quantifying the connection by showing that uninsured individuals amount to over 43% of those who could not afford to fill prescriptions).

⁵⁹ See Briesacher et al., *supra* note 55, at 866 tbl.2 (correlating a “significant” increase in noncompliance with low income and financial pressures); see also Kennedy & Morgan, *supra* note 57, at 266 tbl.I (specifying that 34.4% of individuals reporting CRNA received a below average income).

⁶⁰ Cf. Kennedy et al., *supra* note 54, at 609 (elucidating that women reported 7.1% noncompliance compared to 4.7% of men, and African Americans reported 8.4% and Hispanics 6.6%, whereas Caucasians reported 5.5% noncompliance).

⁶¹ Cf. Kennedy, *supra* note 7, at 165 (urging the population to support health care reform because the economic recession will exacerbate individuals’ struggles to afford health care).

⁶² See Sarah R. Collins, et al., *The Comprehensive Congressional Health Reform Bills of 2009: A Look at Health Insurance, Delivery System, and Financing Provisions*, at 3 (Dec. 18, 2009), <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2009/Oct/Congressional-Health-Reform-Bills.aspx> (referring to a Census Bureau report released in September of 2009 that determined 46.3 million individuals in the U.S. did not have insurance in 2008, and that this figure increased by eight million people since 2000); see also Carmalt & Zaide, *supra* note 5, at 15 (revealing the alarming fact that 78% of uninsured Americans between 2002 and 2003 were employed).

⁶³ See generally Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007* 27(4) HEALTH AFF. w298, w298 (June 10, 2008), <http://content.healthaffairs.org/cgi/content/abstract/27/4/w298> (showing that the population of underinsured individuals is encompassing a more affluent sector of U.S. citizens and thus more individuals are at risk of CRNA).

⁶⁴ See Robin A. Cohen, Ph.D. et al., *Health Insurance Coverage Trends*,

1959-2007: Estimates from the National Health Interview Survey, 17 NAT'L HEALTH STAT. REP., 1, 1 (July 1, 2009) (citing a recent report that found a "lack of health insurance coverage negatively affects both access to health care and health status"); see also Briesacher et al., *supra* note 55, at 869 (cautioning that such behavior prevents patients from receiving the full benefits of medications and creates health risks); Kennedy & Morgan, *supra* note 57, at 218 (decrying the fact that CRNA continues to pose an "important public health problem" despite the documented effectiveness of complying with prescriptions).

⁶⁵ Cf. Collins et al., *supra* note 62, at 1 (proclaiming that, "[t]his year, policymakers in Washington have risen to the challenge posed by the faltering U.S. health care system.").

⁶⁶ See generally Jennifer Haberkorn & S.A. Miller, *House OKs Health Reform Bill*, WASH. TIMES, NOV. 8, 2009 (announcing the ratification of H.R. 3962 in the House of Representative as a landmark in changing the U.S. health care system); Shailagh Murray and Lori Montgomery, *Senate Passes Health-Care Bill, Now Must Reconcile it With House*, WASH. POST, Dec. 25, 2009 (broadcasting the Senate's approval of its health care bill in the early morning of Dec. 24, 2009).

⁶⁷ See generally The Affordable Health Care for America Act, H.R. 3962, 111th Cong. (2009) (prohibiting the revocation of coverage unless the insured committed fraud on the company in § 103 and requiring plans to cover dependent children up to twenty-seven years of age in § 2703); The Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (2009) (extending required covering to dependent children up to twenty-six years old); see also Collins et al., *supra* note 62, at 8 (sharing projections from the Congressional Budget Office that the number of uninsured would decrease by thirty-six million people through the provisions of H.R. 3962, and thirty million people through H.R. 3590).

⁶⁸ See Collins et al., *supra* note 62, at 4 (pointing out that the bills would attempt to lower costs through enabling the population to better compare and choose between plans, by providing government subsidies based on income for those in need, and establishing maximum out-of-pocket expenses insurance companies can charge).

⁶⁹ See H.R. 3962 (including hospitalization, outpatient hospital and clinic services, medical and surgical care, immunizations, maternity care, and prescription medications among the minimum required benefits); H.R. 3590 (incorporating ambulatory services, emergency services, hospitalization, maternity care, rehabilitation, behavioral health treatment, preventative and wellness care, and pediatric services).

⁷⁰ See generally Kennedy, *supra* note 1 (emphasizing the importance of the goal to reform the healthcare system so that all Americans can access health care).

⁷¹ See e.g., Jim Acosta, et al., *Brown Wins Massachusetts Senate Race*, CNN, Jan. 19, 2010, <http://www.cnn.com/2010/POLITICS/01/19/massachusetts.senate/index.html> (announcing that Republican Scott Brown was elected to hold Senator Kennedy's seat resulting in only 59 Democrats in the Senate, one fewer than necessary to defeat a filibuster).

⁷² See e.g., Robert Pear and David M. Herszenhorn, *Obama Hails Vote on Health Care as Answering the 'Call of History'*, N.Y. TIMES, Mar. 21, 2010, <http://www.nytimes.com/2010/03/22/health/policy/22health.html> (noting the deep-seated ideological difference among U.S. citizens on the issue of healthcare reform and the "epic political battle" that was necessary to enact the reforms).

⁷³ See Henry J. Kaiser Family Found., *Summary of New Health Reform Law 1* (Apr. 21, 2010), <http://www.kff.org/healthreform/upload/8061.pdf> [hereinafter *New Health Reform Law*] (commenting that the law focuses on expanding coverage, restraining costs, and improving the efficiency of the health care system).

⁷⁴ See Jack Begg, *Budget Reconciliation*, N.Y. TIMES, Apr. 6, 2010, <http://www.nytimes.com/info/budget-reconciliation-us-congress/?inline=nyt-classifier> (explaining that the process of budget reconciliation allows Congress to alter fiscal provisions by a simple majority and without the possibility of filibuster in legislation where they are "merely incidental" to the true intent of the legislation").

⁷⁵ See *New Health Reform Law*, *supra* note 73, at 1 (clarifying that individuals without health insurance coverage would be subject to a tax penalty of at least \$695 per year up to a total of \$2,085 beginning in January of 2016).

⁷⁶ See Patient Protection and Affordable Care Act, Pub. L. No 111-148 § 1311 (2010) (requiring states to create an exchange no later than January 1, 2014).

⁷⁷ See e.g., Henry J. Kaiser Family Found., *Summary of Coverage Provisions in the Patient Protection and Affordable Care Act 2* (Apr. 28, 2010), <http://www.kff.org/healthreform/upload/8023-R.pdf> (elaborating that the exchanges will be specific to different states but that there will be at least two multistate exchange plans available in each American Health Benefit Exchange); Karen Davis, Ph.D., The Commonwealth Fund, *A New Era in American Health Care: Realizing the Potential of Reform 22-23* (June 2010), <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Jun/A-New-Era-in-American-Health-Care.aspx> (adding that experts expect the health insurance exchanges to lower consumer risk and reduce administrative costs and that at least one plan will be provided by a non-profit organization to further reduce prices).

⁷⁸ See Pub. L. No. 111-148 § 1311(c)(4) (laying out the minimum requirements for exchanges, including providing a rating for each insurance plan and using a standard format to display the plans to allow for easy comparison).

⁷⁹ Comm. on Educ. and Labor, 111st Cong., Press Release, *House Makes History on Health Reform*, Nov. 7, 2009, http://help.senate.gov/Press_releases.html (addressing the incentives for creating health insurance exchanges and claiming that health care reform will lead to affordable, quality health care coverage for eligible consumers).

⁸⁰ See e.g., *New Health Reform Law*, *supra* note 73, at 6 (pointing out that current plans will continue, but the plans must cover dependant children up until the age of twenty-six and, beginning in 2014, cannot impose a monetary limit on lifetime coverage, nor rescind coverage for reasons other than fraud).

⁸¹ See e.g., *New Health Reform Law*, *supra* note 73, at 5 (laying out the benefits of the four tiers, which includes the bronze plan that will cover 60% of total health care expenses, the silver plan that will cover 70%, the gold plan that will cover 80%, and the platinum plan that will cover 90% of total expenses).

⁸² See Davis, *supra* note 77, at 12 (noting that these plans will become available beginning in 2014 and that the tiered structure facilitates individuals' ability to understand the expenses each plan will cover).

⁸³ See Patient Protection and Affordable Care Act, Pub. L. No 111-148 § 1302(b) (2010) (consisting of ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use services, prescription medication, rehabilitative services, laboratory services, preventative and wellness services, and pediatric services).

⁸⁴ See *New Health Reform Law*, *supra* note 73, at 2 (observing that the cost-sharing limits will decrease for individuals receiving such subsidies).

⁸⁵ See Henry J. Kaiser Family Found., *supra* note 77, at 2 (denoting that the federal poverty level as of 2009 would allow for assistance for a family of four that earned \$88,200).

⁸⁶ See discussion *supra* Part I.D (confirming that lacking insurance coverage leads to CRNA and numerous individuals within the U.S. are uninsured); Kennedy & Morgan, *supra* note 57, at 218 (proving that the establishment of universal drug coverage lowers CRNA better than other insurance systems).

⁸⁷ See The Affordable Health Care for America Act, H.R. 3962 § 321(a) 111th Cong., (2009) (highlighting that the Secretary of Health and Human Services has a responsibility to structure the plan to ensure low costs but sustain quality).

⁸⁸ See H.R. 3962, § 322 (allowing for premiums to vary based on the location of the recipient).

⁸⁹ See Davis, *supra* note 77, at 8 exhibit 2 (predicting that twenty-six million non-elderly individuals will remain uninsured in 2015 and that the figure may decrease to twenty-one million individuals in 2016).

⁹⁰ See discussion *supra* Part I.D (containing statistical findings on the percentages of uninsured within the U.S. population and their subsequent inability to afford proper health care).

⁹¹ Cf. SCHACHTER, *supra* note 45, at 341 (suggesting that the right to "public assistance in matters of health" meets the two-part test of inclusion in national law and international recognition of its significance); see also FIDLER, *supra* note 31, at 155 (conceding the likelihood that the right to health is customary international law but finding that enforcement of customary law is elusive); Eibe Riedel *The Human Right to Health: Conceptual Foundations*

in REALIZING THE RIGHT TO HEALTH: SWISS HUMAN RIGHTS BOOK VOLUME 3 36-37 (Andrew Clapham et al., eds., Apr. 2009) (presuming that most states accept the right as a fundamental human right and thus enforce individuals' rights under the right to health doctrine in domestic law); Lisa Forman, "Rights" and Wrongs: What Utility for the Right to Health in Reforming Trade Rules on Medicines? 10(2) HEALTH & HUM. RTS. 37, 39 (2008) (insisting that the legal power of the right to health doctrine is escalating such that it is difficult to argue against its strength).

⁹² See *North Sea Continental Shelf (F.R.G./Den. v. F.R.G./Neth.)* 1969 I.C.J. 4, 45 (Feb. 20) (holding that the practice of defining continental shelf boundaries contained in Article 6 of the Geneva Conventions of 1958 did not yet amount to customary law because it failed this test).

⁹³ See discussion *infra* notes 96-125 and accompanying text (listing specific evidence corroborating the right to health's widespread acceptance and binding nature).

⁹⁴ See Peter Malanczuk, *Akehurst's Modern Introduction to International Law*, reprinted in HARRY J. STEINER & PHILIP ALSTON, INTERNATIONAL HUMAN RIGHTS IN CONTEXT 72, 74 (2d ed., 2000) (reasoning that no exact formula exists and state practice may vary as long as there are no major inconsistencies).

⁹⁵ See SCHACHTER, *supra* note 45, at 336 (rationalizing that because the protection of human rights is generally a domestic concern and human rights violations rarely affect nationals of other countries, states do not usually protest these violations, ergo national proclamations that the laws protecting human rights create binding obligations, or similar evidence that states follow the human rights norms based on perceived obligations, are rare); see also RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW § 103 (1987) (stating that substantial weight should be given to the opinions of international courts, domestic courts, scholarly writings, and state declarations as evidence of international law); see also Malanczuk, *supra* note 94, at 73 (speculating that most of the material that would verify state practice and intent, such as diplomatic correspondence and the opinions of legal advisors, are not published and therefore unavailable).

⁹⁶ See Kinney, *supra* note 32, at 1464-67 (contending that proper evidence supports considering the right to health doctrine as customary international law).

⁹⁷ See e.g., Promotion and Protection of All Human Rights, *supra* note 30, ¶ 12 (pointing out that the broad implementation of the right to health has demonstrated its importance as "a fundamental building block of sustainable development, poverty reduction and economic prosperity").

⁹⁸ Compare WHO Fact Sheet, *supra* note 29, at 1 (suggesting that the concept is internationally relevant because all countries have ratified at least one international treaty recognizing the right to health); and Gunilla Backman et al., *Health Systems and the Right to Health: An Assessment of 194 Countries*, 372 LANCET 2047, 2047 (Dec. 13, 2008), available at http://www.who.int/pmnch/topics/health_systems/en/ (agreeing that all states have ratified at least one binding treaty that includes the right to health and adding that one such treaty, the Convention on the Rights of the Child, is signed by all but two nations); with Kinney, *supra* note 8, at 364 (determining that a majority of nations recognize the right to health and showing the fact that the U.S. is not bound as a treaty party is unique).

⁹⁹ See WHO Fact Sheet, *supra* note 29, at 10 (naming The African Charter on Human and Peoples' Rights, the Additional Protocol of the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, the European Social Charter, the American Convention on Human Rights, and the European Convention for the Protection of Human Rights and Fundamental Freedoms as regional agreements that include the right to health).

¹⁰⁰ See Kinney, *supra* note 32, at 1461 (noting that the growth in accepting human rights was largely a result of nations reacting to the offences committed during World War II); see also Stephen P. Marks, *Access to Essential Medicines as a Component of the Right to Health*, in REALIZING THE RIGHT TO HEALTH, *supra* note 91, at 182 (quoting a United Nations task force finding that one hundred and thirty-five nations recognize health care as a fundamental right in their constitutions).

¹⁰¹ See WHO Fact Sheet, *supra* note 29, at 10 (including a state duty to develop health services or implement a budget for health care as examples of constitutional requirements); see also Puneet K. Sandhu, Comment, *A Legal Right to Health Care: What Can the U.S. Learn from Foreign Models of*

Health Rights Jurisprudence? 95 CAL. L. REV. 1151, 1175 (2007) (explaining that the South African Constitution in particular requires the government to provide health care access to all citizens and refrain from denying emergency medical care).

¹⁰² See Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health Care in Constitutions of the Countries of the World* 37 CORNELL INT'L L.J. 285, 286-87 (2004) (adding that these constitutions augment obligations imposed by legislation and administrative actions).

¹⁰³ See generally Hans v. Hogerzeil et al., *Is Access to Essential Medicines as Part of the Fulfillment of the Right to Health Enforceable Through Courts?* 368 LANCET 305 (July 22, 2006) (conducting a study to determine if the right to health is enforceable through domestic courts and finding fifty-nine cases of successful claims).

¹⁰⁴ See *supra* notes 107-08 (describing numerous cases before both domestic and regional courts enforcing health care access as a right); see also Forman, *supra* note 91, at 39 (discovering a trend among domestic courts upholding the rights contained within the right to health both directly, in countries such as South Africa and many Latin American nations, and under the purview of the right to life).

¹⁰⁵ See Horgezil et al., *supra* note 103, at 307-10 (finding success through the justice system is most likely where the country recognized the right to health in its constitution); Sandhu, *supra* note 101, at 1174-82 (detailing the cases of *Minister of Health v. Treatment Action Campaign* in South Africa in which the Court found that denying access to drugs to prevent mother-to-child HIV transmission violated the constitution, and the Canadian case of *Eldridge v. British Columbia* where the court held that the government violated the constitution by failing to provide equal access in health services).

¹⁰⁶ See generally Steven R. Keener & Javier Vasquez, *A Life Worth Living: Enforcement of the Right to Health Through the Right to Life in the Inter-American Court of Human Rights* 40 COLUM. HUM. RTS. L. REV. 595 (Spring 2009) (indicating that recent cases before the court recognized a right to medicine, food, clean water, sanitation, and access to medical care); see also FIDLER, *supra* note 31, at 308 (drawing on the 1977 *Ache Tribe Case* where the Court found that Paraguay's denial of medication during infectious disease epidemics violated the right to health and the 1985 *Yanomani Tribe Case*, where the court determined that Brazil infringed upon the right to health of the tribe by exposing them to diseases while building a road in the Amazon).

¹⁰⁷ See generally Forman, *supra* note 91 (stressing the importance of litigation to advance a public commitment to the right to health through the example of a South American dispute in which pharmaceutical companies brought a lawsuit to fight a bill to lower prices and inadvertently stirred public sentiment, resulting in international resolutions affirming the right to medicine accessibility).

¹⁰⁸ See e.g., Hans V. Hogerzeil, *Essential Medicine and Human Rights: What Can They Learn from Each Other?* 84(5) WHO BULL. 371, 371 (May 2006), available at <http://www.who.int/bulletin/volumes/en/> (observing that many nations are now taking actions to effectively implement the rights guaranteed under the right to health doctrine).

¹⁰⁹ See e.g., Michael de Looper & Gaetan Lafortune, *OECD Health Working Papers No. 43 Measuring Disparities in Health Status and in Access and Use of Health Care in OECD Countries* 32 fig.13 (2009), available at http://www.oecd.org/searchResult/0,3400,en_2649_37407_1_1_1_37407,00.html (charting the percentage of the public covered by health insurance for thirty countries in 2006 and finding that the U.S. is only one of three nations, along with Mexico and Turkey, that has not achieved universal coverage and the percentage of the U.S. under public coverage was by far the smallest of all nations).

¹¹⁰ See Promotion and Protection of All Human Rights, *supra* note 30, ¶ 12 (discerning a trend over the last six decades that the international community recognizes health as an integral component of prosperity and development).

¹¹¹ See Kinney & Clark, *supra* note 102, at 294 (ranking the commitment to health care in countries' constitutions on a scale of 0-3 and finding that, for example, Luxembourg spent the most to provide health care access, \$2518 U.S. per capita, even though the constitution only achieved a score of 1).

¹¹² See *supra* notes 99-113 and accompanying text.

¹¹³ Cf. Riedel, *supra* note 91, at 24 (commenting that states follow the instruments elaborating upon the right as if they are binding and the fact that they are not binding is therefore irrelevant).

¹¹⁴ See SCHACHTER, *supra* note 45, at 335 (explaining that a states' acceptance of resolutions signals both consent and practice); see also RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW §102 cmt. c (1987) (remarking that courts need not find evidence of *opinio juris* because they can infer it from state action).

¹¹⁵ See Riedel *supra* note 91, at 23 (raising U.N. declarations as evidence of the commitment to the right to health, including the Vienna Declaration and Program of Action of 1993 and the U.N. Millennium Declaration); see also SCHACHTER, *supra* note 45, at 89 (pondering that the votes on declarations and resolutions in the United Nations manifest the expression of the governments involved and thus provide evidence of *opinio juris*); WHO Fact Sheet, *supra* note 29, at 1 ("...States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences.").

¹¹⁶ See THE UNIVERSAL DECLARATION OF HUMAN RIGHTS: A COMMON STANDARD OF ACHIEVEMENT, *supra* note 6, at xxx (noticing that many scholars believe that the UDHR itself is customary international law and that it has weight beyond most General Assembly resolutions); see also RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW §102(2) (1965) (contending that international conferences may provide an occasion for states to express a consensus on a norm which supports its status as customary international law).

¹¹⁷ See *supra* notes 36-39 and accompanying text.

¹¹⁸ See Meier, *supra* note 37, at n.72 (arguing that the right to health is now customary international law because of the proliferation of treaties containing the obligation); see also BARRY E. CARTER, PHILLIP R. TRIMBLE & ALLEN S. WEINER, INTERNATIONAL LAW 135-36 (5th ed., 2007) (believing that multilateral treaties can hasten the establishment of a custom and that the process of treaties creating customary international law will likely increase due to the clarity of treaties and their convenience); Kinney, *supra* note 32, at 1464 (asserting that the International Covenant on Economic, Social, and Cultural Rights may be customary international law due to this principle).

¹¹⁹ See e.g., RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW §102 cmt. i (1987) (clarifying that even bilateral treaties can create customary law when states create many bilateral agreements containing comparable terms and these treaties are tantamount to state practice); FIDLER, *supra* note 31, at 48 (explaining that the practice is thus followed consistently based on a legal obligation, and even nations who did not join the treaty may begin to feel bound); Malanczuk, *supra* note 92, at 72 (noting that the existence of two bilateral treaties containing the same obligations is not enough to demonstrate the creation of customary law and that bilateral treaties are less likely to support custom than multilateral agreements).

¹²⁰ Cf. Riedel, *supra* note 91, at 25 ("The network of international treaty law instruments with significant for the right to health is very elaborate.")

¹²¹ See Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right Under International Law*, 21 B.U. INT'L L.J. 325, 336 (2003) (pointing out that the right is included in as many instruments as any classic civil right).

¹²² See Forman, *supra* note 91, at n.22 (enumerating that an "effective universality" of states, 193, are a party to the Children's Rights Convention, 185 to the Convention on the Elimination of Discrimination against Women, 173 to International Convention on the Elimination of Racial Discrimination, and 157 to the International Covenant on Economic, Social, and Cultural Rights).

¹²³ See *supra* notes 104-122 and accompanying text (showing that the right to health meets the standards of customary international law and satisfies the methods the ICJ uses to determine customary law in relation to human rights).

¹²⁴ See OPPENHEIM'S INTERNATIONAL LAW (Robert Jennings & Arthur Watts eds., 9th ed. 1992), reprinted in STEINER, *supra* note 94, at 224 (entitling such law "universal international law" for this reason, and treaty law "particular international law" because it does not apply universally).

¹²⁵ Cf. Kinney, *supra* note 32, at 1463 (neglecting to reach a conclusion on whether or not the right to health is customary international law, but affirming that if it were the case, the doctrine would impose legal obligations on all nations, including the U.S.).

¹²⁶ See Yamin, *supra* note 121, at 330 (lauding the General Comment for combating previous ambiguity and promoting a clear picture of the right to health that can be implemented).

¹²⁷ See *infra* note 132 and accompanying text; see also Keener & Vasquez,

supra note 106, at 603 (concluding that the General Comment has been integral in resolving the ambiguity of the definition of the right to health); Yamin, *supra* note 121, at 352 (explaining that the three-part requirement to respect, protect, and fulfill the obligations of the right to health, as asserted in General Comment No. 14, is "well-established" in international law and that a similar framework is now used in regional human rights bodies and domestic legal systems).

¹²⁸ See Keener & Vasquez, *supra* note 106, at 603 (referring to the document as the "most authoritative and comprehensive articulation of the right to health"); see also Kinney, *supra* note 8, at 364 (proposing that comparing national legislation to General Comment No. 14 is "an excellent approach to assessing [right to health] issues").

¹²⁹ Cf. SCHACHTER, *supra* note 45, at 87 (positing that the response of a treaty's parties is the main concern to determine the power of a treaty analysis, and if the parties agree in a resolution that an interpretation of the treaty is valid, then it is authoritative); see also Yamin, *supra* note 121, at 337 (referring to Article 12 of ICESCR as the "core provision" on the right to health).

¹³⁰ See *Continental Shelf (Tunis. v. Libya)* 1985 I.C.J. 3, 29-30 (Apr. 14) (proclaiming that courts look at state practice and *opinio juris* to determine the boundaries of customary international law, even where treaties "may have an important role to play in recording and defining rules deriving from custom, or indeed in developing them.").

¹³¹ Cf. Riedel, *supra* note 91, at 32 (speculating that the core obligations contained within the General Comment replicates the practice of "very many" states domestically and concluding it thus creates customary international law); see also Riedel, *supra* note 91, at 27 (acknowledging that U.N. Committees, such as CESCR, state their perceptions of international consensus on the law in General Comments, thus upholding their duty to interpret without legislating).

¹³² See e.g., Hans V. Hogerzeil, *The Concept of Essential Medicines: Lessons for Rich Countries* 329 BRIT. MED. J. 1169, 1170-71 (Nov. 13, 2004) (opining that many developing countries implemented national programs to promote the availability, accessibility, and affordability of medications, the four core duties under General Comment No. 14).

¹³³ See Riedel, *supra* note 91, at 32 (remarking that these requirements are sufficient to prove General Comment No. 14 establishes the right to health in customary international law).

¹³⁴ See *supra* notes 129-33 and accompanying text.

¹³⁵ See Riedel, *supra* note 91, at 32 (believing the fundamental concepts within General Comment No. 14 may additionally be "general principles of law," another classification of international law).

¹³⁶ Cf. Carmalt & Zaide, *supra* note 5, at 13 (surmising that the U.S. health care system "falls far short" of the standards imposed through international human rights law despite the government's extensive spending).

¹³⁷ See *General Comment No. 14*, *supra* note 40, ¶ 12 (clarifying that these requirements are all vital to executing the right to health doctrine and may overlap).

¹³⁸ See discussion *supra* Part I.D (outlining the growing problem of U.S. citizens neglecting their prescription regimen because of an inability to afford medications).

¹³⁹ See Marks, *supra* note 100, at 82-97 (likening that right to essential medicines to the right to water and concluding that they are both urgently needed and linked to all other legal rights as a precondition that must be fulfilled to benefit from any other entitlement).

¹⁴⁰ See *General Comment No. 14*, *supra* note 40, ¶ 17 (emphasizing that the right to health includes the necessity to protect both mental and physical health through proper goods and services); see also, Marks, *supra* note 100, at 83 (explaining WHO defined essential medicines as "those that satisfy the priority health care needs of the population and are intended to be available within the context of functioning health systems at all times...at a price the individual and community can afford").

¹⁴¹ Yamin, *supra* note 121, at 336 (arguing that access to medications is a vital component of the obligations inherent in the right to health and the right to access medicines may in itself be customary international law); see also Marks, *supra* note 100 at 94 (ascribing a new phenomenon of access to medications as a separate right stemming from the right to health doctrine, to the AIDS pandemic and the struggle to access antiretroviral treatments).

¹⁴² Cf. Benjamin Mason Meier and Larisa M. Mori, *The Highest Attainable*

Standard: Advancing a Collective Human Right to Public Health 37 COLUM. HUM. RTS. L. REV. 101, 117 (Fall 2005) (warning that the focus on individual accessibility may be detrimental to promoting health care collectively and that this concern is particularly pertinent in the human rights field when individuals do not have standing to challenge violations of the right).

¹⁴³ See Promotion and Protection of All Human Rights, *supra* note 30, ¶ 43 (imparting the fact that there is no set definition of equity, but offering “equal access to health care according to need” as a useful understanding).

¹⁴⁴ See *General Comment No. 14*, *supra* note 40, ¶ 12(b) (proscribing discrimination based on the basis of any prohibited grounds); WHO Fact Sheet, *supra* note 29, at 7 (defining discrimination as “any distinction, exclusion or restriction made on the basis of impairing or nullifying the recognition, enjoyment or exercise of human rights and fundamental freedoms” and noting that it is particularly relevant to vulnerable groups that are disproportionately burdened with health impairments); see also *General Comment No. 14*, *supra* note 40, ¶ 18 (listing reprehensible grounds of discrimination to include, *inter alia*, the basis of race, sex, language, religion, national origin, sexual orientation, and social status).

¹⁴⁵ Cf. *General Comment No. 14*, *supra* note 40, ¶ 12(b) (stipulating that poorer families should not be “disproportionately burdened” with expenses in comparison to others and mentioning in ¶ 19 a “special obligation” to supply for individuals who do not have the economic capability to access health care on their own); see also Riedel, *supra* note 91, at 29 (providing the example that if a health center charges fees that some cannot pay, it is not economically accessible and governments must assess strategies for change).

¹⁴⁶ See *General Comment No. 14*, *supra* note 40, ¶ 12(b) (elucidating that accessibility includes non-discrimination, economic accessibility/affordability, and information accessibility); see also Riedel, *supra* note 91 at 29 (pinpointing affordability as the most important component of accessibility).

¹⁴⁷ Cf. *General Comment No. 14*, *supra* note 40, ¶ 12(b) (including economic accessibility for goods and services as part of the minimum core standards of the right to health which all countries must provide).

¹⁴⁸ See *General Comment No. 14*, *supra* note 40, ¶ 18 (underscoring that states must protect vulnerable populations even when a country experiences “severe resource constraints”).

¹⁴⁹ See Backman et al., *supra* note 99, at 2049 (presuming that policymakers must create national policies that target traditionally vulnerable communities, such as women, people living with HIV, senior citizens, and people living with disabilities); see also WHO Fact Sheet, *supra* note 29, at 7 (ascertaining that states may need to compensate for a particular population’s health needs if that population disproportionately experiences a health problem, such as susceptibility to a particular ailment).

¹⁵⁰ See WHO Fact Sheet, *supra* note 29, at 7 (presenting Article 5 of the Convention on the Elimination of All Forms of Racial Discrimination, which requires the eradication of racial discrimination in access to health care, as an example of the international documents reinforcing these requirements).

¹⁵¹ See *supra* notes 138-50 and accompanying text (drawing out the obligations created by the accessibility facet of the right to health and demonstrating that they lead to the conclusion that a state must ensure essential medicines are equitably and indiscriminately accessible, or the state must act to ameliorate problems in access).

¹⁵² See Part I.D (presenting studies that show almost a quarter of U.S. patients cannot comply with prescription regimens).

¹⁵³ See *supra* Part I.D (outlining the problem that many Americans do not have health insurance, and even those who do may not have adequate coverage, and subsequently a considerable portion of the population cannot comply with their prescription regimen).

¹⁵⁴ See Kinney, *supra* note 8, at 374 fig.2 (proffering the results of a study which contrasted health care performance in the U.S. to Canada, Australia, New Zealand, and the United Kingdom, finding that in addition to the lowest medication accessibility, the U.S. health care system ranked highest in medication errors, such as receiving the wrong prescription or dose, and had the highest prevalence of patients who were unable to pay medical bills.).

¹⁵⁵ See Kennedy & Morgan, *supra* note 57, at 215 (displaying that this figure compares poorly to statistics from Canada); Cohen et al., *supra* note 64, at 1 (tracing trends in health care which show access is increasingly strained).

¹⁵⁶ See Kennedy & Morgan, *supra* note 57, at 216 tbl.I (separating the

individuals reporting CRNA by income level and finding that 13.8% receive a below-average income).

¹⁵⁷ See Kennedy & Morgan, *supra* note 57, at 216 tbl.I (reporting that 21% of individuals experiencing CRNA receive an average income and 15% receive an above average income)

¹⁵⁸ Cf. Davis, *supra* note 79, at 8 exhibit 2 (utilizing estimates from the Congressional Budget Office that find that even after the health care reform bill is in full effect, between twenty-one and twenty-six million nonelderly individuals will remain uninsured).

¹⁵⁹ See Kennedy & Morgan, *supra* note 57, at 214 (referencing variables that attribute to CRNA which include age, race, substandard health, and lower income).

¹⁶⁰ Cf. Kinney, *supra* note 8, at 368 (revealing that the United States ranked thirty-seventh for health care in a WHO Report principally because of race and income inequality); Yamin, *supra* note 33, at 1158 (invoking over one thousand studies that concluded that widespread disparities exist in the U.S. health care system).

¹⁶¹ See Carmalt & Zaide, *supra* note 5, at 15 (drawing the conclusion that health care costs amount to the highest percentage of income for families in the most economically vulnerable population and that this situation directly contradicts CESCR’s requirements); Briesacher et al., *supra* note 55, at 866 (demonstrating that lack of health insurance or prescription coverage strongly prohibits an individual’s ability to afford medications).

¹⁶² See Kennedy et al., *supra* note 54, at 609 (finding that African Americans were more likely than any other ethnic group, followed by Hispanic populations, to experience CRNA).

¹⁶³ Cf. Carmalt & Zaide, *supra* note 5, at 7 (pointing out that discrimination of any type violates human rights law, regardless of whether the discrimination is on an individual level or systemic).

¹⁶⁴ See *supra* Part II.B (determining that access to essential medications and the eradication of discrimination are both core obligations of the right to health).

¹⁶⁵ See *General Comment No. 14*, *supra* note 40, at ¶ 33 (expanding upon these obligations by adding that the responsibility to fulfill contains additional mandates to facilitate, provide, and promote aspects of the right to health); see also discussion *supra* note 127 (demonstrating that this three-level framework is accepted throughout international human rights law).

¹⁶⁶ See, Yamin, *supra* note 121, at 354 (furnishing the example that the Inter-American Court considers price increases on health care goods as a *prima facie* violation of the right to health).

¹⁶⁷ See *General Comment No. 14*, *supra* note 40, ¶ 35 (instructing states to enact legislation if necessary to guarantee that any privatization in the health care system does not prevent the realization of the right to health).

¹⁶⁸ See *General Comment No. 14*, *supra* note 40, ¶ 33 (encompassing legislative, administrative, budgetary, judicial, promotion, and “other measures” among the necessary actions to ensure the community enjoys the right to health).

¹⁶⁹ Cf. *General Comment No. 14*, *supra* note 40, ¶ 33 (permitting states to use a public or private system, or a mixture of the two, as long as a the nation has an insurance plan that is affordable for all); Marks, *supra* note 100, at 97 (surmising that General Comment No. 14 “strongly suggests” states should intervene where the actions of pharmaceutical companies detrimentally affect to the right to health).

¹⁷⁰ See *infra* notes 172-186 and accompanying text (comparing the requirements to respect, protect, and fulfill the right to health with the legal framework in place in the United States).

¹⁷¹ See discussion *infra* notes 172-186 and accompanying text.

¹⁷² See *General Comment No. 14*, *supra* note 40, ¶ 35 (mandating governments to ensure that allowing privatization or third parties marketing practices do not threaten accessibility).

¹⁷³ Cf. Kaiser, *supra* note 52, at 5 (listing techniques insurance companies use to redistribute higher pharmaceutical costs to customers such as excluding a greater number of medications from coverage, use of quality dispensing limits, such as only covering generic forms of a prescription, and increasing out-of-pocket copayments).

¹⁷⁴ See Carmalt & Zaide, *supra* note 5, at 9 (highlighting the fact that U.S. laws leave millions of Americans without the ability to afford health care); Kinney, *supra* note 8, at 357 (ascertaining that U.S. public insurance programs only provide for 27% of the population).

¹⁷⁵ See *General Comment No. 14*, *supra* note 40, ¶ 37 (affirming that nations must facilitate the population's attainment of the right to health, provide for those who cannot realize the benefits on their own, and promote the health of the population).

¹⁷⁶ See, e.g., Wendy Mariner, *Toward an Architecture of Health Law* 35 AM. J.L. & MED. 67, 76 (2009) (imagining how different American laws might fit within the framework established by General Comment No. 14 and placing programs to provide disaster relief and state programs to fund clinics within the duty to fulfill as well).

¹⁷⁷ See generally Ava Stanley et al., *Holes in the Safety Net: A Case Study of Access to Prescription Drugs and Specialty Care* 85(4) J. URB. HEALTH 555 (July 2008) (finding that the health care "safety net" within the U.S., which consists of a network of organizations such as clinics and hospitals that are meant to fill gaps in health care access, is highly inadequate as access to care and prescription drugs are still out of reach for many).

¹⁷⁸ See *id.*; see also Kennedy & Morgan, *supra* note 57, at 218 (noting that universal prescription coverage, as provided by the government in Quebec, best resolves the problem of cost-related nonadherence).

¹⁷⁹ Cf. *General Comment No. 14*, *supra* note 40, ¶ 49 (warning that a state can violate the obligations of the right to health through inaction or a failure to take proper action).

¹⁸⁰ See e.g., Duff Wilson, *Drug Makers Reform Prices in Face of Health Care Reform*, N.Y. TIMES, 15 Nov. 2009 (chronicling pharmaceutical companies' actions in raising prices at an accelerated rate when reforms appeared imminent despite decreasing expenses).

¹⁸¹ See Congressional Budget Office, *HR 4872, Reconciliation Act of 2010*, 9 (final Health Care Legislation), <http://www.cbo.gov/doc.cfm?index=11379> (deducing that 6% of nonelderly legal residents will remain uninsured in 2019).

¹⁸² See *id.* (predicting an 11% decrease in legal nonelderly uninsured).

¹⁸³ See Hoffman, *supra* note 14, at 49 (commenting that introducing an individual mandate to acquire health insurance coverage without restructuring the current health insurance market may force individuals with less money or more health costs to pay more than others because those individuals are likely to be grouped into the same plans and therefore will not have more wealthy, healthier individuals in the mix to pool expenses); see also Hoffman, *supra* note 14, at 60 (observing that individuals with health problems that are not currently covered by employer coverage will benefit the least from actuarial ratings for health insurance coverage).

¹⁸⁴ See generally John Holahan and Linda Blumberg, Urb. Inst., *Can a Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?* (2008), http://www.urban.org/UploadedPDF/411762_public_insurance.pdf (concluding that a public health insurance option is more likely to experience lower administrative costs and contain costs better than private health insurance plans and would be more likely to invest in researching and developing improved treatment for individuals with costly health conditions).

¹⁸⁵ See *General Comment No. 14*, *supra* note 40, ¶ 12 (outlining that the implementation of the right to health is colored by the specific conditions of a country and its developmental level). *But see General Comment No. 14*, *supra* note 40, ¶ 18 (asserting that adjusting policies and strategies can often be accomplished with minimal cost).

¹⁸⁶ See *General Comment No. 14*, *supra* note 40, ¶ 12 (outlining that the implementation of the right to health is colored by the specific conditions of a country and its developmental level).

¹⁸⁷ Cf. Yamin, *supra* note 121, at 327 (theorizing that in human rights, "cost-effectiveness concerns are balanced with other priorities and the state has a critical role to play both in ensuring basic health care goods and services" and the focus of the inquiry is whether the states "takes steps by all appropriate means to make medications accessible").

¹⁸⁸ See *General Comment No. 14*, *supra* note 40, ¶ 47 (laying out the standards to be considered to decide if a state violates the right to health and considering that the country must take all "necessary steps to the maximum of its available resources").

¹⁸⁹ See Carmalt & Zaide, *supra* note 5, at ii (condemning the current emphasis on profits in the U.S. health care system and attributing this driving

force with creating the problems in accessibility).

¹⁹⁰ See *infra* notes 191-94 and accompanying text.

¹⁹¹ See Kinney, *supra* note 8, at 375 (employing an analysis based on the World Bank indicators on governance which indicate that the government received a 91.9% ranking for government effectiveness, revealing that the United States government is powerful and able to implement change and, therefore, could likely create an effective health care system that embodies the standards from General Comment No. 14).

¹⁹² See Central Intelligence Agency, *The World Factbook: County Comparison-GDP* (2009), available at <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2001rank.html> (ranking the U.S.'s 2009 GDP above 226 other nations, with China coming in third at approximately \$9 trillion).

¹⁹³ See Kinney, *supra* note 8, at 368 (observing that the country spends "by far the highest amount per capita on health care of all the countries of the world.").

¹⁹⁴ Compare *supra* note 193 (noting that the U.S. spends more than any other country on the health care sector) with *OECD Working Papers*, *supra* note 109, at 32 fig.13 (demonstrating that seventeen countries are able to establish 100% insurance coverage for core services).

¹⁹⁵ Compare *General Comment No. 14*, *supra* note 40, ¶ 40 (reminding countries that they must uphold the obligations of the right to health to the maximum of their resources) with *supra* notes 190-94 (utilizing World Bank indicators on governance, national GDP, and spending on health care to illustrate the fact that the United States is highly capable).

¹⁹⁶ See *supra* Part II.C.2 (harmonizing the provisions of General Comment No. 14 to show that nations must enact the right to health to their full ability and therefore more capable nations must do more than others to implement the right to health).

¹⁹⁷ Cf. Kinney, *supra* note 32, at 1471 (avowing that states will differ in their implementation of health rights because it is reasonable to require the United States to ensure universal health care access, but extending the requirement to the Sudan would be absurd).

¹⁹⁸ See generally *supra* Part II.C.3

¹⁹⁹ See Carmalt & Zaide, *supra* note 5, at 3 ("The relentless grow in health costs, combined with the severe downturn in the economy, has deepened the health insurance crisis facing families across the country...").

²⁰⁰ See *supra* Part II.C.

²⁰¹ Cf. Cohen et al., *supra* note 66, at 1 (implying that providing statistics on health insurance trends can lead to the creation of better policies).

²⁰² See *supra* Part I.D.

²⁰³ See Carmalt & Zaide, *supra* note 5, at 3 ("The relentless grow in health costs, combined with the severe downturn in the economy, has deepened the health insurance crisis facing families across the country...").

²⁰⁴ See Collins, *supra* note 62, at 8 (projecting that the bill would cover covering 96% of uninsured legal working-age residents, whereas the Senate's version would only cover 94%).

²⁰⁵ See Kinney, *supra* note 8, at 356 (affirming that "[h]ealth insurance coverage is the most important means" for enabling health care accessibility).

²⁰⁶ See *supra* note 184.

²⁰⁷ See Forman, *supra* note 91, at 41 (embracing the idea that rights expressed as law may "ensure systemic trends towards justice"); MERON, *supra* note 46, at 9 (agreeing that the invocation of a norm as customary international law adds "rhetorical strength" to the necessity to comply); Yamin, *supra* note 33, at 1159 ("[F]raming an otherwise acknowledged problem such as disparities in treatment as a "rights violation" suggests that the situation could be different and that the government bears responsibility").

²⁰⁸ The Declaration of Independence (July 4, 1776), available at http://www.archives.gov/exhibits/charters/declaration_transcript.html.

²⁰⁹ Senator Edward Kennedy, Speech at the Democratic National Convention (Aug. 25, 2008) (transcript available at <http://www.americanrhetoric.com/speeches/convention2008/tedkennedy2008dnc.htm>).