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Assessing Universal Access to Health Care: An Analysis of Legal Principle and Economic Feasibility

I. Introduction

The United States has the disturbing distinction that it, alone among Western democracies, permits a sizeable percentage of its population to go entirely without health insurance coverage.¹ It has left the world wondering why and how a civilized nation develops a health care system that embodies no social definition of equity, makes feeble attempts to contain costs, leaves thirty-seven million citizens with no health insurance at all and millions more with inadequate coverage.² The dilemma is further complicated by the irony that the health care system in America today assures that those who need coverage the most have the hardest time getting it.

Criticism of our health care system has become so widespread that even traditionally apologetic organizations, such as the American Medical Association (AMA), are joining the outcry for reform.³ The inadequacy of the nation's health care delivery system continues to be one of the most important unresolved social problems in the United States.⁴ The phrase "right to health" is being used increasingly in legal, philosophical and medical circles.⁵ Some call only for reform of the system. Others maintain that the current framework is so bad that significant reform is impossible.⁶ They claim that only a total revolution in the organization and distribution of health ser-

1. John Holahan, *An American Approach to Health System Reform*, 265 J.A.M.A. 2537-44 (1991). There are over 36 million Americans that are uninsured and 63 million Americans that are under insured. *Id.* at 2537.

2. Lawrence D. Brown, *The Merits of Mandates*, 15 J. HEALTH POL. POL'Y. AND L. 793(1990) [hereinafter Brown].

3. Nancy E. Cropely, *The American "Right to Health Care — An Idea Whose Time Has Come?*, 20 GOLDEN GATE U.L. REV. 681, 682 (1990) [hereinafter Cropely]. The president of the American Hospital Association began a speech to that body's annual convention with the words: "Let me start with a blunt summation:" Something is wrong in American health care. . . . Our national health care expenditures total more than 11% of the Gross National Product. Yet there are gaps. No, there are gaping holes in health care coverage." *Id.* at 683.

4. Leary, *Health, Human Rights and International Law* 82 AM. SOC'Y INT'L PROC. 122-41 (1988) [hereinafter Leary].

5. *Id.* at 123.

6. William T. Blackstone, *On Health Care As A Legal Right: An Exploration of Legal and Moral Grounds*, 10 GA. L. REV. 391 (1976) [herinafter Blackstone].

vices will cure the problem.⁷

The severity of the insurance ailment raises three issues which must be addressed promptly if such abuses are to be remedied. These issues are: 1) whether international law secures a fundamental human right to basic health care which the United States is obligated to recognize and enforce;⁸ 2) whether a democracy that considers itself the moral hope of the world can justify grave inequities in access to health care, which in most modern countries is considered an essential human need;⁹ and 3) whether, in reforming America's health care system, we should build on the existing employer-based and private insurance system or abandon it and replace it with a taxpayer financed system.¹⁰

Presently, there are three general views concerning the disposition of health care services.¹¹ The first approach views medical care as something that should be dispensed through the free enterprise system. In this first model, health care is seen as a commodity to be purchased by those who can afford it. Those who cannot afford it must either do without or receive care from a charity.¹² The second view is a "halfway house." This approach envisions privately owned and operated health care facilities which are heavily subsidized by public monies, Medicare and Medicaid being examples.¹³ Finally, there is the view that medical care should be reconstituted as a public system, in which health care is seen as a right, not simply a privilege.¹⁴

If health care is properly viewed as a right, which by definition carries with it a correlative obligation to assure equal access to the available public resources required to fulfill that right, then there are strong grounds for the creation of a socialized health delivery system.¹⁵ There is also the argument that, while not being a legal right, universal access to basic health care should be viewed as a moral right.¹⁶ This comment will therefore examine the issue of principle in moral theory and analyze how that principle has affected the realization of universal access to health care in other developed nations.

A state's obligation to ensure universal access to health care can

7. Gimler, *supra* note 3, at 602.

8. CONG. REC Leary, *supra* note 4, at 122.

9. Emily Friedman, *The Uninsured*, 265 J.A.M.A. 2491, 2494 (1991) [hereinafter Friedman].

10. Ronald S. Bronow, *The Physicians Who Care Plan*, 265 J.A.M.A. 2511, 2511 (1991) [hereinafter Bronow]. It is the belief of "Physicians Who Care" that a tax-payer financed system will not work in the United States. *Id.*

11. Blackstone, *supra* note 6, at 392.

12. *Id.*

13. *Id.* at 392, 393.

14. *Id.* at 393.

15. *Id.*

16. Blackstone, *supra* note 6, at 410.

take many forms. A "right" based approach tends to support a nationalized system of health care. In such a system, the state assumes full responsibility to insure that all of its citizens may obtain basic medical care. The premise is ideal but the reality of asking government to manage a national health care system is replete with such problems as: stifled development, lower quality of care, and reduced incentive for providers to efficiently maximize the delivery of health care services.

On the other hand, the principal of moral obligation allows a state more leeway in determining how universal access will be achieved. Germany, for example, has adopted the principle of "obligations" to secure universal access.¹⁷ Under such a system, providers and insurers are required to negotiate efficient and reasonable agreements for the provision and reimbursement of health care services. The Government steps in only where private institutions fail to maintain universal access. Because of America's unique *laissez faire* political tradition, discussion of health care reform should focus on efforts to create and maintain a health care system with shared responsibility between the public and private sector.

II. International Law

A. *The Universal Declaration of Human Rights*

Pursuant to Article 68¹⁸ of the Charter of the United Nations, the Economic and Social Council (ECOSOC) established the United Nations' Commission On Human Rights (Commission). The Commission was assigned the task of submitting proposals and recommendations for, inter alia, an International Bill of Human Rights. At its third session (May 24 to June 16, 1948), the Commission completed its work on the Declaration.¹⁹ The United Nations General Assembly (Assembly) unanimously adopted the "Universal Declaration of Human Rights"²⁰ on December 10, 1948, and proclaimed the Declaration "a common standard of achievement for all people and all Nations."²¹ Article 25²² of the Declaration provides that, "Every-

17. See generally Bradford L. Kirkman-Liff, *Physician Payment and Cost-Containment Strategies in West Germany: Suggestions for Medical Reform*, 15 J. HEALTH POL. POL'Y. AND L. 69-99 (1990) [hereinafter *Physician Payment*].

18. Article 68 provides that: The Economic and Social Council shall set up commissions in economic and social fields and for the promotion of human rights, and such other commissions as may be required for the performance of its functions. U.N. Charter art 68.

19. ROSCAM ABBING, *INTERNATIONAL ORGANIZATIONS IN EUROPE AND THE RIGHT TO HEALTH CARE* 14 (1979) [hereinafter *ABBING*]. For a detailed description of the elaboration of the Universal Declaration of Human Rights, see *Id.* at 34-47.

20. *Id.* at 14. Universal Declaration of Human Rights, G.A. Res. 217A(III), U.N. Doc. A/810 at 71 (1948). [hereinafter *Declaration*].

21. *Id.*

22. Article 25 of the Universal Declaration of Human Rights reads as follows:

1. Everyone has the right to a standard of living adequate for the health and

one has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing housing and medical care."²³ The drafting committee believed that the Article should closely follow the Constitution of the World Health Organization by expressly addressing the role of the community in fulfilling the right to health care.²⁴ Additionally, the committee specifically inserted the words "medical care" into the text so as to clearly indicate what an individual's right would be in the case of loss of health or endangered health.²⁵

While Article 25 of the Declaration recognizes that everyone should have a fundamental right to health care, mere recognition of this right is not sufficient. In order to be claimable, a right must also be qualified as to its content. An attempt to qualify the right to health care was made during the various drafting stages of the Article. For example, drafters made reference to "the highest obtainable standard of health" and delegated responsibility for securing the right to the state and the community.²⁶ However, the present wording of Article 25 leaves the interpretation of the word "health" open. It also fails to define in detail the responsibility of those member states who are willing to recognize the right to health care and to act accordingly.²⁷ These interpretation issues arise because the Declaration serves only as an enumeration of universal human rights without any concomitant legal obligations.²⁸ The compromising nature of the document is, in part, a direct result of the great diversity of existing values and standards²⁹ among the member states. Because of this diversity, the Declaration can be no more than a mere statement of principles; not giving any precise definitions or rules, and providing for no authority beyond general guidance. In effect, the document

well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

ABBING, *supra* note 19, at 64.

23. *Id.*

24. The Constitution of the World Health Organization reads: "Everyone, without distinction as to economic or social conditions, has a right to the highest attainable standard of health. The responsibility of the State and Community for the health and safety of its people can be fulfilled only by provision of adequate health and social measures." E/CN.4/21, Annex F, Article 33. ABBING, *supra* note 19, at 65.

25. *Id.* at 69.

26. *Id.* at 70. Some attention is given to this in the "umbrella" covering Article 22 of the Universal Declaration, which refers to "national efforts" and "international co-operation." *Id.*

27. *Id.*

28. *Id.* at 15.

29. ABBING, *supra* note 19, at 15.

does little more than outline a political model for member states. If states choose to embrace the model, international legal processes provide support for the progressive implementation of the Declaration principle. Standing alone, however, the Declaration has no legally binding effect.

B. Covenant on Economic, Social and Cultural Rights

In an effort to make the rights enunciated in the Declaration more claimable, the Assembly asked the Commission to prepare a "Convention" on human rights for the purpose of implementing, under international control, the general principles proclaimed by the Universal Declaration.³⁰ At its sixth session,³¹ the Assembly decided on the preparation of two distinct Covenants: The Covenant on Civil and Political Rights³² and the Covenant on Economic, Social and Cultural Rights.³³ Article 12³⁴ of the Covenant on Economic, Social and Cultural Rights provides for the right of everyone to "the highest attainable standard of physical and mental health."³⁵

1. Legislative History of Article 12—Initially, discussion of Article 12 centered upon the extent to which the right to health care should be qualified.³⁶ Surprisingly, the amendments proposed by the

30. *Id.* at 16. The commission's first draft of the "Convention" contained only civil and political rights. The Assembly decided in 1950 (fifth session, 19 September to 15 December 1950), that the "Convention" on human rights should also contain provisions on economic, social and cultural rights. (Assembly Resolution 421 E(V) of 4 December 1950 and Council Resolution 349 (XII) of 23 February 1951). *Id.*

31. *Id.* Assembly Resolution 543 (VI); *see also* Council Resolution 415 (S-I).

32. ABBING, *supra* note 19, at 16; International Covenant on Civil and Political Rights, 21 U.N. GAOR, Supp. No. 16 at 52, U.N. Doc. A/6316 (1966) [hereinafter Political Covenant].

33. ABBING, *supra* note 19, at 70; International Covenant on Economic, Social and Cultural Rights, 21 U.N. GAOR, Supp. No. 16, at 49, U.N. Doc. A/6316 (1966) [hereinafter Economic Covenant].

34. Article 12 of the Economic Covenant provides:

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

Economic Covenant, *supra* note 33, art 12.

35. This language is the same as that in the Constitution of the World Health Organization, *supra* note 24.

36. ABBING, *supra* note 19, at 70-72.

United States³⁷ sought to clearly define the right. For example, the U.S. suggested that health was not merely the absence of disease or infirmity, but "a state of complete physical, mental and social well-being."³⁸

A proposal to define the obligation of a state to assure the right to health care was also strongly supported by other delegates. In particular, emphasis was placed on the need for clear obligations on the part of the state to assure the right of all persons to "medical service and medical attention in the event of sickness."³⁹ This effort to qualify the right and to specify the states obligations was challenged by other member states.⁴⁰ The opposing states believed that the general provisions of Article 2, which required "progressive" implementation of all the rights secured by the Covenant, sufficiently defined the obligations of the member states with regards to the right to health care.⁴¹ These states believed that repetition of the obligation within a particular article would weaken the meaning of the general Article.⁴²

2. *Article 12: Weaknesses*—In the end, the Assembly opted to rely on the Covenant's general Article 2 provision to prescribe the states' obligations.⁴³ This compromise resulted in the removal of provisions requiring specific legislative measures by member states. Consequently, the Article on the right to health care has become equivocal. Now, it is only a "statement" of those conditions which are considered essential for the protection and promotion of an individual's health. Thus, individuals cannot bring claims against the state based solely on the wording of Article 12.⁴⁴

The very nature of the Economic Covenant poses another weakness. The rights contained in the Covenant are to be achieved progressively and are formulated in general terms, with an overall

37. *Id.* at 72; E/CN.4SR.296 and E/2256, para. 132. This proposal was opposed on the grounds that it was unnecessary to define the right to health any more specifically than other rights. *Id.*

38. *Id.* at 74.

39. *Id.* The Russian representative felt that the argument put forward by others, that it was unnecessary to formulate obligations on the part of the States Parties since relevant provisions had been laid down in the general Article 2 governing all the subsequent Articles, did not suffice to ensure enactment. The general Article 2 only laid down the obligation for the states to undertake certain measures for the progressive realization of the rights recognized in the Covenant, which did not necessarily lead to legislation securing the right to health care. *Id.*

40. ABBING, *supra* note 19 at 74-76. While recommending a clear and qualified definition of health care, the United States supported the view that the general Article 2 sufficiently covered the States obligations. *Id.*

41. *Id.*

42. *Id.*

43. *Id.* at 77.

44. ABBING, *supra* note 19 at 77. It should further be noted that, unlike the Universal Declaration where an "adequate standard of living" is closely linked to the level of "health" which should be attained, the Economic Covenant has separated the "standard of living" from the Article on the right to health care. *Id.*

clause concerning permissible limitations.⁴⁵ This can be contrasted with the Covenant on Civil and Political Rights wherein it is provided that the rights are to be recognized and implemented immediately.⁴⁶

However, the largest obstacle to realizing a "right" under the Economic Covenant remains the United States refusal to ratify the Covenant.⁴⁷ In 1978, President Carter transmitted the Economic Convention to the Senate for its advice and consent to ratification. The consent of the Senate was not obtained during that session and it has not been obtained subsequently.

The reasons for Senate refusal are primarily two-fold. First, there is concern that some of the substantive provisions are inconsistent with the letter and spirit of the United States Constitution and laws.⁴⁸ However, this problem can be avoided by making reservations to the Covenant before ratification.⁴⁹ Second, and more fundamental, is the United State's unwillingness to compromise its sovereignty, or to challenge its political tradition.⁵⁰ This attitude was expressed in arguments made to the Committee during ratification proceedings: "The Economic Covenant is largely the historical product of the Marxist ideology espoused by the Soviet bloc, coupled with the non-communist world's postwar infatuation with various forms of democratic socialism."⁵¹ It is "a document of collectivist inspiration alien in spirit and philosophy to the principles of a free economy."⁵² The traditional concern has been that the Covenant would commit the United States to ever-increasing levels of welfare, governmental control of the economy, and restrictions on individual initiative and freedom.⁵³

III. Lessons from Abroad

In contrast with the United States unwillingness to ratify

45. *Id.* at 19. The Economic Covenant contains a "general, overall" clause of permissible limitations in Article 4, which provides that States Parties may subject the rights contained in the Covenant only to such limitations as are determined by law, but only insofar as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare of a democratic society. The Covenant on Civil and Political Rights, on the other hand, defines precisely the permissible limitations for each formulated right, and regulations are clearly outlined for their direct application. *Id.*

46. *Id.*

47. HENRY J. STEINER & DETLEV F. VAGTS, *TRANSNATIONAL LEGAL PROBLEMS* 680-87 (3d ed. 1987) [hereinafter STEINER]. While the United States is a signatory, it has also failed to ratify both the Convention on the Elimination of all forms of Racial Discrimination and the American Convention on Human Rights adopted by the Organization of American States. *Id.* at 686.

48. *Id.*

49. *Id.*

50. *Id.*

51. STEINER, *supra* note 47, at 693.

52. *Id.*

53. *Id.*

Human Rights treaties, European states have taken a more active role in the realization and promotion of international human rights. The United Nation's International Covenant on Economic, Social and Cultural Rights served as the model for The Council of Europe's European Social Charter.⁵⁴ Article 11⁵⁵ of that Charter recognizes the right to health care.⁵⁶ In accordance with Article 11, all Western European democracies have implemented legislation that seeks to secure the provision of basic medical service for all citizens. Standing alone, this fact is a strong indication that universal access to health care is a fundamental principle that can be effectively accomplished. For the purposes of this comment, the German health care system will be analyzed. It provides one model whereby universal access to health care can be effectively accomplished.

A. *The German Health Care System*

The health care system in Germany⁵⁷ is not government owned or operated, as is the case in the former U.S.S.R., Great Britain, and Canada.⁵⁸ Germany has preserved a decentralized system with private practice physicians and independent hospitals.⁵⁹ The system is financed through insurance, which is provided by private insurers and autonomous sickness funds.⁶⁰ These funds are similar to

54. ABBING, *supra* note 19, at 27. The purpose of the Charter was to define the social objectives aimed at by members (a guide in particular for a common European social policy), to establish social principles that correspond to individual rights and to lay down the aims of a European social policy as well as to establish binding provisions which would guarantee certain minimum standards in vital social fields (document 312 of the Consultative Assembly, September 1954). *Id.*

55. *Id.* at 77. Article 11 of the European Social Charter provides that:

With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organizations, to take appropriate measures designed inter-alia:

1. to remove as far as possible the cause of ill-health
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health
3. to prevent as far as possible epidemic, endemic and other diseases.

Id.

56. *Id.*

57. *Physician Payment*, *supra* note 17, at 69-99. The West German health care system pays ambulatory care physicians on a fee-for-basis structure, but employs a national relative value scale and regional capitation-based revenue pools to achieve expenditure controls on total physician reimbursement. Physician controlled organizations manage these pools and conduct utilization review of their own members. The capitation rates are determined between the physician associations and health insurers. The West German government exerts its influence on the outcome of these negotiations through a quasi-governmental advisory body. *Id.*

58. *Id.* at 73.

59. *Id.* Physicians in Germany can be divided into two major groups: ambulatory care physicians and hospital based physicians. The ambulatory care physicians are paid on a fee-for-service basis. Hospital based physicians are paid a salary by their hospital. The majority of hospitals in West Germany are non-profit institutions. German hospitals are much larger than American hospitals and serve larger geographical areas. This is the result of more than 40 years of hospital planning, which has focused on developing efficient regional resource allocations. *Id.*

60. *Physician Payment*, *supra* note 17, at 73. "Sickness funds" receive their revenues

America's Blue Cross/Blue Shield programs. Approximately ninety-two percent⁶¹ of the German public obtains health insurance through sickness funds. These individuals and their families are obligated to become members because they fall below certain income levels or are in certain occupational classifications.⁶²

Unlike "public" health care systems which tend to limit choice and restrict physician autonomy, German citizens are generally free to choose their primary care physicians.⁶³ More importantly, statistical data reveals that the quality of patient care is as good in Germany as it is in the United States.⁶⁴ This fact obviates the argument made by many critics that universal access can only be achieved at a cost to quality care. The German health care system appears well on its way to securing universal access to basic medical care while maintaining physician autonomy, assuring quality patient care and preserving a private sector model of health care delivery.

There seems to be a resonance between the values in the health care system of Germany and traditional American values. Since any recommendations for reform must take into account the interests of hospitals and physicians, it is essential to implement a system which preserves the autonomy of health care providers, while at the same time expanding individual access to medical care.⁶⁵

Compared with the Canadian, British, and Swedish systems,⁶⁶ the health care system in Germany provides American policymakers with models that are closer to our own current structure. The following analysis reveals the similarities between the two systems. Such comparative analysis is critical to any proposal recommending adoption of another system's structure and guidelines.

Under the German system, it is the private sector, not the government, that is responsible for universal insurance.⁶⁷ Universal coverage is not achieved through a single governmental agency, but

from their members. The members pay half of this premium, and the rest is paid by their employer. To some extent there are government subsidies and cross-fund transfers to reduce the magnitude of premium rate variations. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Physician Payment*, *supra* note 17, at 73.

65. Bradford L. Kirkman-Liff, *Health Insurance Values and Implementation in the Netherlands and the Federal Republic of Germany*, 265 J.A.M.A. 2496, 2501 (1991) [hereinafter *Health Insurance*]. In the United States, physicians and hospital administrations have traditionally been opposed to the notion of nationalized medicine, as exists in the United Kingdom for example. The West German health care system provides an alternative to achieving universal access that allows the medical profession to retain its autonomy. *Id.*

66. For a detailed description of the British and Canadian systems see Carol Sakala, *The Development of National Medical Care Programs in the United Kingdom and Canada: Applicability to Current Conditions in the United States*, 15 J. HEALTH POL. POL'Y AND L. 709-753 (1990).

67. *Health Insurance*, *supra* note 65, at 2501.

through a variety of for-profit and non-profit insurers. The system is generally supported by income-based premiums, not by progressive income taxes.⁶⁸ Fees and budgets are not dictated to providers, but are arrived at through negotiation between private parties.⁶⁹ Determination of health care policy is shared by the federal government, the regional authorities, and autonomous interest group associations. Overall, such a system is more closely aligned with American political traditions than one involving government-provided insurance.

B. *The American Health Care System*

The similarities of public and private coverage within both the German and American systems, raise the question of why the American system has failed so miserably, while the German system has effectively obtained results. Theoretically, coverage of health care costs is available to virtually all Americans through one of four routes⁷⁰: Medicare for the elderly and disabled; Medicaid for low-income men, women, children and those with certain disabilities; employer-subsidized coverage for those in the work force; or self-purchased coverage for those ineligible for the previous three.⁷¹ In reality, however, all four forms of coverage have been riddled with problems.

Among these programs, Medicare has fared the best. It is neither means tested nor related to the workplace.⁷² Each year Medicare covers more Americans for acute care.⁷³ However, beneficiaries' out-of-pocket costs remain high, and coverage for long-term care remains a problem, which has been aggravated by the repeal of Medicare catastrophic care coverage.⁷⁴

The second form of coverage, Medicaid, is primarily a state-level program. Each state defines its own eligibility scales and, depending on the state's resources, the federal government subsidizes a portion of these expenses.⁷⁵ As a result, coverage has always varied from state to state. Throughout the 1980's, both the federal government and state governments sought to control or reduce medicaid expenditures in the face of tax cuts, growing costs and reduced federal funding for the program.⁷⁶ Because of these reductions and Medicaid's categorical approach to eligibility, certain groups, mostly

68. *Id.*

69. *Id.*

70. Friedman, *supra* note 9, at 2491-92.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.*

75. Friedman, *supra* note 9, at 2491-92. Northern states and some western states offer more generous coverage than southern and other states. *Id.*

76. *Id.* This led to reductions in both eligibility and provider payments. *Id.*

low-income men and childless couples, were no longer eligible for coverage.⁷⁷ As a result, by 1989 only forty percent of America's poor were covered by the Medicaid program.⁷⁸ The unfortunate reality today is that a high percentage of the poor population remains unprotected by the program that was designed to address their medical needs.

The third route to coverage, employer-subsidized insurance, has also seen serious erosion in recent years.⁷⁹ Traditionally, such coverage provided health care security to the majority of Americans. While not being an explicit policy, there was an unspoken understanding that employers would provide their employees with some form of health care insurance. Today, however, the majority of the uninsured are tied, either directly or through family relationships, to a workplace that is no longer an automatic source of coverage.⁸⁰ The primary problem is that small businesses are seen by insurers as a high risk. Consequently, small businesses are subject to more exclusions and denials of coverage.⁸¹ In addition, insurance is becoming less affordable simply because the cost of the services it covers is doubling every few years.

This analysis indicates that while America's health care system was designed to provide virtually universal access, the traditional structure can no longer support the population it was intended to protect. The crisis has developed primarily because America has allowed itself to get too tangled up in the "business" of health care. The American system has lost track of the "obligations" that each participant in the system has to all other participants. This notion of "obligations" is the very gravamen of the German system and has been the key to its success in achieving universal access.

C. *Health Care Lessons for the United States*

Health Care analysts who specialize in reform maintain that the German system has four lessons that can guide future health policy in the United States with respect to securing a legal right to health care:⁸²

1. If a consensus is to be reached on the strategy to achieve universal coverage and cost containment, the general public must acknowledge the present crisis and begin explicit discussion about the

77. *Id.*

78. Friedman, *supra* note 9, at 2491-92.

79. *Id.*

80. *Id.* at 2493. The Employee Benefits Research Institute found that, in 1988, 85% of the uninsured were either workers or family members of workers. *Id.*

81. *Id.*

82. See *Health Insurance*, *supra* note 65, at 2501. The author based these conclusions on extensive studies, reports and statistical data concerning general health care policy. *Id.*

underlying values.⁸³ The German health care system focuses on "obligations" and the ways in which participants in the health care sector are bound together by these mutual, interlocking obligations.⁸⁴ A discussion of obligations in health care can focus on the responsibilities of individuals and groups to their society. American health care has lost sight of this. Each interest group concentrates only on how it can best protect its own interests. For example, physicians and hospitals need to affirm their obligation to provide medically necessary care to all patients. This obligation is central to the concept of professional ethics.⁸⁵

2. If the system is to achieve employee cost awareness and a sense of shared ownership in the financing structure, employees must assume responsibility for a percentage of their premium coverage.⁸⁶ While the American system emphasizes the need for employer coverage, it rarely addresses the employee's obligation to secure coverage. In Germany, employees are obligated to pay for half of their coverage.⁸⁷ In this way, they become actively involved in the system of universal coverage.

3. If employers and insurers wish to preserve a private sector approach, it is essential that employers realize an obligation to provide coverage to their employees and insurance companies be required to offer reasonable policies.⁸⁸ No workers, be they part-time, seasonal, or temporary, should be excluded from insurance coverage. The biggest problem in the United States is that the cost of insurance coverage has become too high. In Germany, the requirement that all persons must purchase insurance results in the obligation that the insurers must operate at the lowest possible costs. Working through regional and national councils, providers and insurers participate in regulatory efforts, thereby working to eliminate the problem of high risk pools that exists in the United States.⁸⁹

4. Under government "guidelines," national and regional negotiations between insurers and providers will establish fees and budgets that adequately compensate all providers while ensuring that costs are controlled.⁹⁰ A primary concern of American health care providers is that too often they are uncompensated for their services. The German system obviates this concern by requiring providers and in-

83. *Id.*

84. *Id.* at 2496-97.

85. *Id.* at 2497. See also Anrys, *Medical Ethics and Human Rights*, 38 *World Med. J.* 42-47 (1991). The Council of Europe has initiated a program dedicated to education in medical schools concerning human rights. *Id.* at 42.

86. *Health Insurance*, *supra* note 65, at 2501.

87. *Id.* at 2500-01.

88. *Id.*

89. *Id.* at 2500.

90. *Id.* at 2501.

surers to enter into negotiations. The outcome of the negotiation process is a set of fees, rates, and budgets for all providers, which the insurers are obligated to observe.

This acknowledgement of the German system is not to suggest that the United States should adopt all aspects of that system. There are some aspects of the German system that may not be compatible with American values. For example, the notion that insurers be required to contract with all providers is somewhat repugnant to the idea of free enterprise. However, such obligations can be substituted by having the government contract with certain parties through a system of subsidies. The benefit of analyzing the German system is that it provides an alternative to a completely public health care system. It illustrates that universal access to health care can be achieved without sacrificing the values that make up the American political tradition.

IV. America's Unique Political Tradition

America was founded on the notion that certain individual rights are "natural" and inherent.⁹¹ In the Lockean spirit, they are not a gift from society or from any government.⁹² They do not derive from the Constitution, they antecede it.⁹³ When the American people adopted the Constitution, they retained for themselves certain autonomy and freedoms as individual rights against that government.⁹⁴ Notably, government was not to provide the people with a "welfare-state", but rather to leave the individual free to pursue such welfare himself.⁹⁵

One school of thought contends that the nation's inability to solve the problem of the uninsured is a natural expression of the U.S. value system.⁹⁶ It is suggested that, "The American allegiance to economic individualism and our moralistic, punitive stance towards the poor set us apart from Europe, Canada, and other nations where the principal of solidarity is stronger and the 'right' to health care is accepted as a kind of civic axiom."⁹⁷

The current state of our health care system leads one to wonder if Americans are really as callous as we seem. However, polls indicate that Americans generally do not think that fellow citizens

91. Henry J. Steiner & Detlev F. Vagts, *Transnational Legal Problems* 680-695 (3d ed. 1986) [hereinafter *Steiner*].

92. *Id.* at 687.

93. *Id.*

94. *Id.* at 690.

95. *Id.*

96. Lawrence D. Brown, *The Medically Uninsured: Problems, Policies, and Politics*, 15 *J. HEALTH POL. POL'Y AND L.* 413, 422 (1990) [hereinafter *Brown*].

97. *Id.*

should lack basic medical care simply because they do not have the means to purchase it.⁹⁸ Although the public cares, very little is being done to remedy the situation. The complacency from the general public is most likely due to the following sources: 1) the public wrongly believes that existing programs, such as Medicare and Medicaid, do or could cover most of the uninsured; 2) the public fails to recognize the imperfect correlation between work and insurance; or 3) the public assumes that anyone that falls seriously ill can go to the emergency room of the local hospital and get reasonable care in a timely fashion.⁹⁹ It's not that Americans don't care about the health and welfare of others, but rather they're not informed as to the nature of the crisis.

In fact, there is no doubt that the United States is now, to a significant degree, a welfare state.¹⁰⁰ But it is not a welfare state by constitutional compulsion. Notions of economic liberty, individual rights and freedom of contract were strong forces in stifling the development of the welfare state.¹⁰¹ It has only been through Congressional mandate that the United States has moved away from "negative" government. Consequently, Americans have begun to think and to speak of certain benefits, such as social security, as matters of entitlement and right.¹⁰² The challenge is to see if this rising sentiment can be harnessed and channeled towards ensuring a "right" to health care.

V. Moral Right Argument

European democracies have long had universal access to health care due to the stronger sense of solidarity that exemplifies their form of democratic socialism. The European Social Charter, itself provides for a "right" to health care.¹⁰³ The various state legislatures of western Europe have effected that right through legislative enactment. The citizens of European democracies have secured a right to basic medical care. This can largely be attributed to the sense of moral duty that forms the bedrock of the modern European political tradition. With American politics becoming increasingly influenced by a sense of social obligation, the moral argument for creating a right to health care must be examined.

In several moral theories or codes, minimum welfare would seem to have the status of a right, as long as other conditions, like

98. *Id.* An SRI Gallup survey conducted in 1987. *Id.*

99. *Id.*

100. Steiner, *supra* note 91, at 691.

101. *Id.*

102. *Id.*

103. *Abbing, supra* note 19, at 27.

resource availability, are satisfied.¹⁰⁴ This theory requires that equal consideration be given to every individual's interest in the calculation of consequences.¹⁰⁵ While equal consideration does not mean that goods and services must be distributed in identical amounts or with absolute equality, it does mean that distribution of resources should be such that the "basic" needs of each person are met.¹⁰⁶ Premised on a commitment to the principle of equal opportunity, "minimum welfare" is presumably a notion embraced by even the American moral perspective.

The American political tradition is one based upon competition. In this spirit, the principle of minimum welfare simply provides that each person should have a fair chance to play the game and to compete with others on the basis of his or her talents and abilities.¹⁰⁷ But in order to have an equal opportunity to compete, a person must at least have an opportunity to develop his or her capabilities.¹⁰⁸ Without the fulfillment of certain basic needs, such as food, education, and health care, people are prevented from developing their capabilities and are thus excluded from the game of competition. Therefore, justice requires that "basic" needs be provided to all so that there is equal opportunity to develop within the system. Clearly, the security of basic medical care, like public education and social security, must be accessible to each individual if the competition, inherent in our society, is to be fair and just.

The premise that a minimum level of health care is a fundamental right, inevitably raises the issue of justiciability and enforcement. By relying on a judicial remedy, we are assuming that judges alone are competent to determine from the bench the minimum level of health care required and the techniques and procedures necessary to satisfy this minimum standard. We can not expect such omniscience from individual judges.¹⁰⁹ The attempt to make a right to health care manageable, obviously requires something more. The best approach would be to ensure a legal right to health care through legislative initiative. This view is in accord with: 1) the mechanisms provided for in international human rights instruments, 2) the tradi-

104. Blackstone, *supra* note 6, at 410. See also J. Rawls, *A Theory of Justice* 101 (1971).

105. Blackstone, *supra* note 6, at 410.

106. *Id.*

107. See generally Amartya Sen, *On Ethics and Economics* 29-56 (1987) [hereinafter Sen].

108. *Id.*

109. *Burnham v. Department of Public Health*, 349 F.Supp. 1335, 1342(N.D. Ga. 1972), *rev'd*, 503 F.2d 1319 (5th Cir. 1974), *cert. denied*, 422 U.S. 1057. In *Burnham*, the court was asked to order constitutionally "adequate" treatment for mental health patients. While acknowledging that the provision of adequate medical treatment is an issue of urgent social concern, the court had the wisdom to recognize that the judiciary lacks the expertise and resources to solve the problem of medical adequacy. *Id.*

tional method of complimenting our constitution through legislation, and 3) the fundamental purpose of a government which is to protect and to promote the welfare of its citizens.

VI. Legislative Proposals

While the need for substantial changes in the American health care system is widely acknowledged, there is little agreement on how these changes should be effectuated.¹¹⁰ A viable plan, that provides access to health care for all Americans, must address the concerns of those groups capable of affecting such change. Maintaining the realization of a right to health care as the paramount concern is essential. If the United State's health care system is to ensure universal access, the proposal must acknowledge and effectively address the necessary reforms.

A. *The Pepper Commission's Blueprint for Health Care*

In September 1990, the U.S. Bipartisan Commission on Comprehensive Health Care issued a call to action to address the health care crisis.¹¹¹ Their purpose was to examine the implementation of a system wide health care reform that would "guarantee all Americans health care coverage in an efficient, effective health care system."¹¹² The Commission aimed to develop recommendations for enactable legislation that could resolve the access problem and provide for a right to health care. Towards this end, the Commission heard testimony from numerous witnesses in public hearings, received a series of expert briefings and engaged in extensive deliberations.¹¹³

The Commission's blueprint for reform rests on four fundamental principles necessary for realizing universal access to health care:¹¹⁴ First, health insurance coverage must be universal. Only if everyone is adequately covered can we assure all Americans access to care when they need it and bring an end to "cost shifting" and underservice to the uninsured.¹¹⁵ Second, incremental patchwork on the current system, as exemplified by Medicaid expansion, cannot achieve universal coverage.¹¹⁶ Such an attempt would not meet the universality requirement and moreover would have insured taxpayers

110. See generally 265 J.A.M.A. 2449-2624 (1991). Therein alone, seven proposals are suggested varying in theory from complete government control to a free market health care system. *Id.*

111. Sen. John D. Rockefeller IV, *A Call For Action: Final Report of the Pepper Commission*, 265 J.A.M.A. 2507 (1991).

112. *Id.*

113. *Id.* at 2508. The bipartisan commission, created by the Medicare Catastrophic Coverage Act of 1988, included 12 members of Congress and three presidential appointees. *Id.*

114. *Id.*

115. Rockefeller, *supra* note 111, at 2508.

116. *Id.*

bear the cost of the patchwork.

Third, a completely government operated health care system would not be practical.¹¹⁷ Shifting so many people and so many dollars from the private sector to the public sector is too disruptive to be politically or economically feasible in the near future. Fourth, expanding access to health care and controlling the cost of services must proceed simultaneously.¹¹⁸ To pursue one goal without the other would be to further undermine a system already suffering serious stress. Only by securing and extending the combination of job-based and public coverage, can the new system guarantee adequate coverage for all Americans and ensure effective and efficient operation.¹¹⁹ The following proposal summarizes the Pepper Commission Plan for structuring an effective system of universal coverage.

1. Employer Responsibilities—To make job-based coverage universal, all workers must be entitled to health care coverage in their jobs, just as they are legally entitled to a minimum wage and participation in social security.¹²⁰ Three fourths of the uninsured are workers or are in worker's families.¹²¹ If all employers covered their workers, as the majority do now, a substantial gain in coverage would result.¹²²

The problem lies with small businesses.¹²³ The Commission recommends special measures to alleviate the barriers to the voluntary purchase of insurance which these smaller firms now face. This would be achieved by making reforms in the private insurance market that would guarantee the availability of a specified minimum benefit package.¹²⁴ In essence, the restructuring would eliminate the discrimination that small businesses now face based on insurer's perception of industry risks.

To ease the burden of health insurance costs, the Commission also recommends two kinds of tax credits for small employers.¹²⁵ One allows small businesses to deduct from their taxable income the entire cost of their health insurance premiums. The second tax credit

117. *Id.*

118. *Id.*

119. *Id.*

120. Rockefeller, *supra* note 111, at 2508.

121. *Id.*

122. *Id.* Almost all businesses with more than 100 employees now provide adequate coverage for most of their employees. Consequently, with a brief period for adjustment, the commission would require all such businesses to provide coverage to all their workers and non-working dependents. *Id.*

123. *Id.* Although the majority of even the smallest businesses provide coverage, employers with fewer than 25 workers employ about half of the working uninsured; employers with fewer than 100 workers employ about two thirds. Rockefeller, *supra* note 111 at 2508.

124. *Id.*

125. *Id.*

provides a forty percent subsidy against premium costs for employers with fewer than twenty-five workers and an average pay-roll of less than \$18,000 per worker. These credits would be extended over a five year period. The combination of insurance reform and subsidies should provide small employers with the opportunity many now lack to purchase insurance for their workers.¹²⁶ More importantly, such reforms would provide insurance for those who presently make up seventy-five percent of the uninsured populace.

2. *Affordable Coverage*—If the health care system is going to require small businesses to provide coverage, the government must guarantee that affordable coverage plans are available. This can be accomplished by offering employers a choice: purchase private coverage or purchase coverage from a newly established federal program.¹²⁷ Such a program could be administered in conjunction with or as part of the Medicare program.¹²⁸ Like Medicare, it could be administered through private insurers or by states, subject to federal regulations. The price for public coverage would be set as a specified percentage of the payroll. This would place a cap on employers' obligations and avoid excessive costs for covering part-time workers.¹²⁹ The percentages would be set to encourage employers who now purchase private insurance to retain that coverage and to establish a fair balance of additional coverage responsibilities between private insurers and the public program.¹³⁰

3. *Federal Coverage*—The Commission recognizes that even if job-based coverage reaches all workers, it cannot achieve "universal" access since twenty-five percent of the uninsured are not employed or are self-employed.¹³¹ To cover this group of individuals, the commission would require that the government establish a program that pays appropriately for services, and guarantees access to basic medical care.¹³² Medicaid, with its current eligibility, payment, and benefit limitations, falls far short of this objective.

The federal program would provide the same minimum benefits that employers would be required to provide for their employees.¹³³

126. *Id.* However, if after 4 to 5 years small businesses have not availed themselves of the opportunity by covering at least 80% of workers and dependents who now lack coverage from their employers, the commission recommends that small businesses, like larger ones, be required to purchase coverage. *Id.*

127. Rockefeller, *supra* note 111 at 2508.

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.*

132. Rockefeller, *supra* note 111 at 2508-09.

133. *Id.* Because Medicaid now covers services not included in the minimum benefits described in the report, that program would not be completely eliminated. It would continue in

These requirements would ensure national standards for eligibility, benefits, and payment. In contrast to the present Medicaid program, this would guarantee all Americans, irrespective of their income, employment status, or place of residence, access to affordable insurance protection.¹³⁴

4. *Qualifying A Minimum Benefits Package*—Universal access to health care can only be effective if it, in no uncertain terms, establishes an adequate minimum standard of coverage.¹³⁵ The commission recommends an adequate minimum standard that guarantees the uninsured, most of whom have low incomes, access to “primary,” as well as “catastrophic,” care.¹³⁶ Such coverage includes: hospital care, surgical and other inpatient services, physician office visits, diagnostic tests, and limited mental health benefits. In addition, benefits would include preventive services.¹³⁷ By placing emphasis on preventive services, the Commission embraces the view that early diagnosis and treatment may result in reduced mortality rates, increased quality of life, and increased savings. Thus, the need for expensive future treatment may be avoided.

Like the system of “obligations” in Germany, American citizens would contribute to the cost of coverage, subject to limits on out-of-pocket spending and ability to pay.¹³⁸ So that cost sharing does not become a barrier to insurance coverage or service use, premiums and cost sharing would be subsidized for low-income people.¹³⁹ Subsidies would apply to both private and public coverage.¹⁴⁰

5. *Quality Assurance*—Just as coverage responsibility would be shared between employers and government, public and private in-

its present form for benefits not included in the new federal program. *Id.* at 2509.

134. *Id.* The federal program would pay providers rates determined according to Medicaid rules, replacing the sometimes arbitrary Medicaid payment limitations with rates more likely to ensure access to care. *Id.*

135. Rockefeller, *supra* note 111, at 2509. The commission recommends an adequate minimum standard that is similar to but less generous than coverage that most employers now offer. *Id.*

136. *Id.* Relating to the first stages of disease or illness.

137. *Id.* Preventive services would include; pre-natal care, well-child care including immunization, mammograms, Papanicolaou smears, corectal and prostrate screening procedures, and other preventive services that evidence are effective relative to cost. *Id.*

138. Rockefeller, *supra* note 111, at 2509. Specifically, individuals covered through employment would pay a maximum of 20% of premium costs for private coverage or a contribution to the public plan equivalent to 20% of the combined employer-employee contribution, paid as a percentage of wages. Individuals not covered through employment would pay the full cost of public coverage, subject to ability to pay. *Id.*

139. *Id.*

140. *Id.* People with incomes below 100% of the federal poverty standard would pay no premiums or coinsurance, and subsidies would be available on a sliding scale for people with incomes up to at least twice the poverty standard. For this population, contribution to premiums could not exceed 3% of income. *Id.*

initiatives are necessary to promote health care delivery.¹⁴¹ In the private sector, the Commission recommends insurance reform that would prohibit competition based on a quest for good risks and promote competition among insurers to manage health care efficiently.¹⁴² Furthermore, insurers who offer managed care to large businesses would be required to extend it to the small businesses that they cover as well.¹⁴³

On the public side, the mechanisms of prospective payments for hospitals and the resource based relative value scale for physicians would ensure efficiency and cost control in the public program. This would also serve as a model for payment in the private sector.¹⁴⁴ The Commission would require federal action in assisting consumers and insurers to become prudent purchasers of medical care. The federal government would be responsible for undertaking the data collection, outcomes research, and development of practice guidelines, as well as the quality assurance mechanisms that are critical to helping public and private purchasers use their money wisely.¹⁴⁵ Initiatives already underway, in the recently created Agency for Health Care Policy and Research, provide the foundation for these efforts.

Finally, medical malpractice litigation as currently handled, fails to protect patients and burdens the health care system with high premiums and the cost of defensive medicine. Some states have responded to this problem by requiring all medical malpractice claims to be subject to arbitration.¹⁴⁶ Because there is no consensus on the best way to remedy these problems, the Commission recommends assessing cost experience and initiatives to contain costs in both the public and private sectors, while making periodic recommendations to the Congress on the need for federal initiatives.¹⁴⁷

6. Implementation—The commission recommends that implementation of these reforms occur gradually over a five year period.¹⁴⁸ The first step would be to expand coverage to ensure protection for

141. Rockefeller, *supra* note 111, at 2509.

142. *Id.*

143. *Id.*

144. *Id.* The minimum benefit standard establishes cost-sharing requirements so that individuals, subject to ability to pay, would take costs as well as benefits into account as they use medical care. *Id.*

145. Rockefeller, *supra* note 111 at 2509.

146. *Vermont Takes Stride Toward Universal Health Care*, 20,6 HEALTH LAW. NEWS REPORT, 3(1992) [hereinafter *Vermont*].

147. *Id.* The commission calls on both the physician Payment Review Commission and the Prospective Payment Assessment Commission, responsible for oversight of Medicare physicians and hospital payments respectively, to assess cost experience and initiatives to contain costs in the public and private sectors, and to make periodic recommendations to the Congress on the need for federal initiatives. *Id.*

148. Rockefeller, *supra* note 111, at 2510.

pregnant women and young children who are currently uninsured.¹⁴⁹ This would be accomplished by granting these groups immediate access to the new federal public program. At the same time, insurance reforms would be initiated to reverse the disintegration of the private insurance market for small employers.¹⁵⁰ These actions would address the most urgent gaps in coverage and would create an environment in which employers would have an opportunity to provide the coverage called for under the proposal.¹⁵¹

The second step, to take place in years two through five, would put in place the incentives and requirements for job-based coverage, thus giving employers time to adjust to their new obligations.¹⁵² The final step to occur in year five is to extend the federal program to all non-workers.¹⁵³ By year five, all Americans would have access to health care.

The Pepper Commission's proposal is designed to share costs fairly among individuals, employers, and government. Therefore, the burdens many now face, because of cost shifting, uncompensated care, and excessive out-of-pocket payments, would be dramatically reduced.¹⁵⁴ No longer would those who have insurance have to pay higher premiums to provide health care for those that do not. The proper parties would assume the obligations of providing access to medical care.

Finally, any discussion concerning reform of America's health care system must address the cost of such a project. The Pepper Commission's proposal aims to extend coverage to America's thirty-six million uninsured at a modest two percent increase in health care costs.¹⁵⁵ If implemented in 1991, that would mean an increase in the nation's health care bill, from \$647 billion to \$659 billion.¹⁵⁶ The Commission's blueprint for health care reform could serve as a strong rallying point for the political consensus needed to make universal coverage within an efficient health care system a reality.

B. *Benefits of the Proposal*

The Pepper Commission has developed the most reasonable pol-

149. *Id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. Rockefeller, *supra* note 111, at 2510.

154. *Id.* Employers who now offer health insurance to workers and dependents would save an estimated 13 billion per year because they would no longer pay the cost of covering individuals who work for other firms. State and local government would save an estimated 7 billion in payment they now make, beyond Medicaid, to finance care to the uninsured. *Id.*

155. *Id.*

156. *Id.* Of this overall increase, just over half would go to hospitals and about one fourth to physicians. The remainder would go to other professionals and services. Rockefeller, *supra* note 111, at 2510.

icy proposal that builds upon American institutions. It goes a long way toward providing a structure that could effectively reform the United States health care system and ensure universal access. Like the German system, the Commission's proposal directly addresses the "high-risk" problems that small businesses now face. By recognizing that government has an obligation to ensure affordable coverage, the proposal achieves the German system's dynamic of interlocking obligations.

Second, by establishing a federal program for the unemployed and self-employed, the proposal provides for a minimum benefits package that would ensure national standards of eligibility for those groups. Like the German system, this program would guarantee access to affordable coverage regardless of income, employment status or place of residence.

Furthermore, the proposal mirrors the German system's efforts to control costs by establishing a scale of fees, rates and budgets for hospitals and physicians. In fact, the proposal goes further than the German system by requiring that the federal government undertake data collection in this area so that providers and insurers can negotiate more effectively within the systems guidelines.

While it is argued that the proposal provides for only limited cost containment efforts,¹⁵⁷ there are mechanisms within the proposal that provide for subsequent changes. Overall, the proposal provides for a system that would build on a private/public partnership to assure universal access. Based on America's political tradition and the pressing need to solve the problem of the uninsured, the proposal is the most reasonable means of reforming America's health care system.

VII. Conclusion

Human rights are born of the conviction that we all share an underlying common humanity. It is in this sense that we discuss the right to health care. It is meant to signify that health care is an important social value, so fundamental to the realization of other rights, that it should be given particular legal protection and promotion within our society. This principle was the premise for establishing a "right" to health care in both the Covenant on Economic, Social and Cultural Rights and The European Social Charter.

While the enforceability of these legal instruments remains ambiguous, it is clear that all western democracies, except the United States, have embraced the principles therein and have taken affirmative action to ensure universal access to basic health care. While

157. Holohan, *supra* note 1.

America has thus far hesitated to embrace the concept of a "right" to health care, it is evident that the failure of the present system to adequately provide health care must give way to reform. As the United States affirms its social commitment to equality, the necessary resolve to structure and to implement universal access to health care becomes stronger.

Legislative proposals have been submitted to assure the right to health care in the United States. In accordance with the underlying principles of the Economic, Social and Cultural Covenant on Human Rights, these proposals provide for progressive and flexible implementation. The only remaining issue is whether the United States will seize the importance of the crisis and, through effective legislation, ensure the long overdue "right" to health care for all her citizens.

Carlo V. DiFlorio

