NESRI NATIONAL ECONOMIC & SOCIAL RIGHTS INITIATIVE

Women and the Human Right to Health Care: A Perspective on the Federal Health Reform Law

Despite a growing U.S. movement for realizing health care as a human right and a public good for all, recent efforts to reform the market-based health system continue to treat health care as a commodity. The new federal health law leaves many challenges in place for women who seek equal access to appropriate, comprehensive, and quality health care.

Women are more likely than men to forgo needed health care due to cost-related access barriers.[1] A quarter of women are not satisfied with their experiences in getting the care they need.[2] They have higher health care expenditures, particularly out-of-pocket costs, and are more likely to depend on their spouses for health insurance.[3] Women of color constitute over half of all women without health insurance, despite representing only a third of the female population.[4] Access difficulties are reflected in poor health outcomes: women, particularly those who are poor, report a lower health status than men.[5] The U.S. has a higher maternal mortality rate than most other high-income countries, with two to three women dying during pregnancy every day.[6]

What is the human right to health care?

All people have a right to the health care they need as recognized in the Universal Declaration of Human Rights. This right guarantees a system of health protection for all.

- **Universality:** Everyone must have access to equal high-quality and comprehensive health care.
- **Equity:** Costs and resources must be shared equitably, with everyone getting what they need and contributing what they can.
- **Accountability and Public Goods:** The people oversee the provision of health care as a public good, shared equitably by all.

Does the new law measure up for women's human rights?

We measure the new law against the human rights standards of **universality** and **equity**, and assess whether health care is treated as a **public good**, accessible and accountable to all.

Our assessment finds that the law fails to realize women's human right to health care.

While improving women's access to health insurance (especially through expanding Medicaid), requiring insurers to issue a policy to every applicant, and limiting gender rating, women's access to care will continue to depend on their ability to pay and be curtailed by restrictions to reproductive health care.

What is the Patient Protection and Affordable Care Act (P.L. 111-148)?

Signed into law by President Obama on March 23, 2010, this Act, together with the Health Care and Education Reconciliation Act (P.L. 111-152), expands Medicaid and tightens some insurance industry regulations, while leaving the current market-based system largely intact. Many provisions of the law will come into effect in 2014.

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Women and UNIVERSALITY

Human Rights Principle
Everyone must have guaranteed access to equal high-quality and comprehensive health care.

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Market-Based System
Different groups get different levels of coverage and coverage does not automatically give access to needed care.

What will health reform change?	What will stay the same?
↑ Insurance companies will be prohibited from discriminating based on health or pregnancy status. ↑ Insurance companies' practices of policy rescission (currently misused e.g. when women discover a breast tumor) will be more tightly regulated. ↑ Medicaid eligibility will be expanded to 133% of the poverty level, increasing the number of women covered. ↑ Minimum mandated health benefits package will include maternity benefits. ↑ New funds for pre- and postnatal home visits. ↑ Licensed practitioners in free-standing birthing centers will be eligible for Medicaid reimbursement.	→ No universal guarantee of access to health care. Twenty-three million people will remain uninsured.[7] A majority of the uninsured are likely to be lower-income, among which women are overrepresented. → Rescission regulations continue to offer loopholes, e.g. by not mandating third party review. Also, some regulations do not apply outside the exchanges. → No federal requirement for ensuring that poor women have temporary access to Medicaid while their application is pending (presumptive eligibility). → Women who are immigrants are barred from Medicaid for the first 5 years (or entirely excluded, if undocumented. Woman who are undocumented will also be prohibited from buying private coverage with their own money in the new insurance exchanges). → Ban on federal funding for abortion is consolidated and expanded. → Financial incentives for high-tech interventions remain in place, which have led to a medicalized model of birth that incentivizes c-sections and restricts use of midwives. In most U.S. states, midwives are not covered by private insurance despite proven health benefits.
↓ Access to abortion will be severely reduced for many women. Women—and everyone else using the new insurance exchanges to buy a plan that happens to cover abortion—must write two different checks, with one going toward the pool's abortion funds. Insurers must keep those funds separate. This added administrative burden may lead to insurers dropping abortion coverage entirely. ↓ States can ban any abortion coverage in their exchanges, and many are already passing legislation to do so.	

What reforms would ensure UNIVERSAL ACCESS for women?

Universality Standard: Women have a human right to get the comprehensive health services they need, including reproductive care. No one should be discriminated against on the basis of income, health status, gender, race, age, immigration status or other factors.

Example for advancing universal access for women:

- Canada's universal, publicly funded health insurance system guarantees all people access to comprehensive health care. This includes complete women's health services, including abortions, which are publicly funded and provided as needed at public and private clinics.

Women and EQUITY

Human Rights Principle
Health care costs and resources must be shared equitably, with everyone getting the care they need and contributing what they can.

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Market-Based System
Health care costs place a greater burden on lower-income people; more resources are available in wealthier, profitable areas.

What will health reform change?

- ↑ Most uses of gender rating by insurers will be prohibited, and pregnant women can no longer be charged higher premiums.
- ↑ Co-pays for certain preventive services, likely including pap smears and mammograms, will be eliminated.
- ↑ States will no longer require waivers for expanding Medicaid family planning services (excluding abortion) to low-income women otherwise ineligible for Medicaid.

- ↓ Insurers will be permitted to charge older people up to three times more than younger people. Older women may be particularly affected, as they tend to be poorer than men.
- ↓ Part-time employees (the majority of whom are women) will be excluded from employer coverage provisions.
- ↓ Insurers can give up to 30% premium rebates to those meeting certain health targets. Such 'wellness incentives' can exacerbate health inequities and penalize women, who are more likely than men to have chronic conditions and face income or time barriers to healthy foods and exercise.
- ↓ New restrictions on abortion coverage will add to the financial burden on women, thus increasing barriers for low-income women.
- ↓ A conscience clause will protect health professionals who refuse to provide certain services, yet not those who provide them.

What will stay the same?

- → Prohibition of gender rating will not apply to firms with over 100 employees, which may keep coverage more expensive in firms that employ a mostly female workforce.
- → Co-pays and deductibles for private insurance plans will continue to prevent many women, who tend to earn less than men while needing more services, from actually using their coverage.
- → Health insurance largely remains tied to employment, continuing many women's dependency on their spouses for coverage.
- → Access to emergency contraception will remain limited for poor women, as it is not covered by Medicaid in one third of all states, and requires a prescription in those states that do cover it.
- → The current ban on federal funding for abortion keeps cost and access barriers for poor women in place. 42% of abortion patients are poor, and more than half of all patients have had to pay for abortions out-of-pocket.[8]
- → Shortage of health professionals, including family doctors, midwives, and pharmacies, in many rural areas.
- → Hospitals with care restrictions or providers refusing services will still deliver substandard care for medical conditions that only affect women, compared to prevailing clinical standards of care for those conditions.[9]

What reforms would ensure EQUITY for women?

Equity Standard: Women have a human right to access health care on the basis of clinical need, not privilege, payment, employment, marriage, ideology, or other such factors.

Example for advancing equity for women:

- ► Many countries have decoupled access to health care from employment. This includes single-payer systems such as Canada and Australia, and publicly-run health services such as those in the United Kingdom, Sweden, and Spain. In these systems, health care access is continuous throughout life. Part-time and temporary workers, among whom women are overrepresented, are not disadvantaged. If employers are not in the role of gatekeepers, women's independence increases, and those without a spouse do not miss out on benefits conferred through marriage. In the U.S. employer-sponsored system, 24% of women are insured through their spouse's job, compared with only 11% of men.[10]

Women and Health Care as a PUBLIC GOOD

Human Rights Principle
Health care is a public good that belongs to all. Publicly financed and administered care is the strongest vehicle for making care accessible and accountable to all.

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Market-Based System
Health care is a commodity bought and sold in the marketplace. Private, for-profit entities are primarily accountable to shareholders.

What will health reform change?	What will stay the same?
↑ Expansion of the public Medicaid program will benefit poor women. ↑ Improved "consumer protections" through stricter regulation of insurance companies will benefit women who purchase private insurance plans.	→ Medicaid has been privatized in many states, reducing accountability to the women it is supposed to serve. There is an increasing pressure to privatize the soon-to-be expanded Medicaid programs. → Insurance regulation has loopholes (e.g. gender and age rating, rescissions), will not eliminate incentives for limiting and denying care, and will not control premium prices which may over time make coverage unaffordable for many women. → Health insurance remains a market commodity, excluding those who cannot pay and for whom limited public subsidies will be insufficient. As women tend to be poorer, they are particularly disadvantaged by the market model. → Public financing of some health services needed by women is explicitly banned by federal guidelines.
↓ New marketplaces (state-based insurance exchanges) with only private plans for purchase will be subsidized with public funds. These marketplaces won't be allowed to sell some of the health services only women need. ↓ An estimated $464 billion in public subsidies will be channeled to private insurers in the exchanges,[11] leading to further privatization and commercialization of the health system and expanding the transfer of taxpayer funds to private corporations, without guaranteeing health care access for women.	

Making health care a PUBLIC GOOD: what's in it for women?

- If the public sector, funded and overseen by the people, were to assume responsibility for the health and health care of the public as a whole, it would have to provide appropriate care for everyone—women and men. This would include those—primarily women—who are poorer, less likely to be in continuous, full-time employment, have particular health needs and use more health services.
- In an inclusive public system, women would no longer be alone in carrying the financial burden of their reproductive health needs, because everyone would be in a common pool, with their use of health care cross-subsidized rather than paid for individually.

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