**Universal Periodic Review of the United States of America, Third Cycle, 36th Session of the UPR, Human Rights Council, May 2020**

**Submission by** the National Lawyers Guild, https://www.nlg.org; International Association of Democratic Lawyers, https://www.iadllaw.org/; People's Action Institute, https://peoplesaction.org/institute/; and Rights and Democracy Institute, https://www.rights-democracy.org/
**Author contact**: Martha L. Schmidt, LL.M., J.D., for National Lawyers Guild International Committee, 1-206-306-6305, martha@marthalschmidt.net

## The Right to Health: How financing affects the right to health care in the U.S.

I.Financing systems used in the U.S. have a systemic impact on the right to health care. The US has a duty to support the right to health care by **adequate, equitable and sustainable** financing.

A.Despite the great outlay on health care overall ($3.6 trillion in 2018, 18% of GDP), particular funding is **inadequate**. This reinforces existing problems of inequality and discrimination in care. The system financing is the reverse of equity, with greater resources flowing to institutions and people with greater wealth rather than those with less wealth.
1.Inadequate and inequitable per capita funding for indigenous peoples (through Indian Health Service).
2.Denial of public financing for reproductive health care, including abortions.
3.Insufficient funding and targeting of resources to minority populations, e.g., Americans of African descent, who have grossly disparate mortality rates.
4.Unavailability of funding for health care of immigrants, with means and other testing related to citizenship statuses.
5.Stigmatization of mental health care, lack of funding and racial discrimination in allocation of resources for mental health correlate with high suicide, addiction and overdose mortality rates. The impact is most severe on Native Americans, Alaska Native peoples, veterans and senior citizens.

B.The use of general taxes, increasingly from individual income and social security taxes, while reducing corporation tax to fund health care, is **unsustainable and inequitable**. It burdens lower income individuals and increased implementation of user fees (premiums, co-pays, deductibles) burdens individuals in 1st-3rd income quintiles.

C.The financing of health care is a **non-sustainable system organized to provide profit** for private businesses as main object rather than health care. The search for profits and profit incentives in law, exemplified by massive denials of care by insurance companies, are antithetical to the human right to health.
1.The US has the most costly system in the world, and it produces inferior outcomes of well-being and life.

C.2.**Sustainability is being sacrificed through a process of privatizing our public, single payer systems** (Medicare by the Medicare Advantage program, Veterans Administration through 2018 Mission Act). Funding for the public systems is being diverted to guarantee profits for private companies, which raises the cost of the administration of the systems.

II.Violating the elements of **health care financing affects the right to an adequate standard of living. (Interdependency principle)**
A.Denial of the right to health care contributes to the increasing levels of economic inequality, with low income individuals more likely to go bankrupt and face economic ruin. Growing economic inequality has impacts on the rights to health and life, including decreased life expectancy.
B.Racial inequality has a negative synergistic effect on health. It affects sufficiency of income and resources available for individuals to pay for privatized health care.
C.The denial of health care affects and is affected by housing and sufficient (basic or adequate) income.

III.Violations of the right to health care-detail (partial)
A.**Universal access**
1. Everybody in-for 2018, 30 million+ estimated without health insurance
2.2018, underinsured- 71 million+
3.Not all residents are counted immigrants who are undocumented, children, seniors
B.**Affordability**
1.No cost controls, insurance premiums rising in 2018 as before PPACA (2010)
2.Medical costs are cause of more than 65% of bankruptcies
3. Continuing employer-based insurance- result is greater costs passed on to employees through high deductibles (e.g.. $5000), co-pays, etc.
4. Current single payer systems like Indian Health Service and Medicare don't cover 100% leaving low income individuals paying enormous portions of income for medical care and resulting in high medical debt
C.**Equality/non-discrimination**
Continuing gross discrepancies in outcomes, e.g., maternal mortality for Black women increased from 2017-2019.
D.**Quality (highest attainable standard of physical and mental health**)
1.PPACA based on inferior and better care depending on ability to pay
2.Rule-making to allow inferior quality of insurance under PPACA
E. **Quality and Availability**-no duty for physicians to accept Medicaid, Medicare patients

**IV.Recommendations requested: 1) Funding through public funds of a full, transparent national dialogue on health as a human right and single-payer financing 2) Support for national legislation to create a single-payer system that fully meets for all residents the principles of a human right to health care.**

**Universal Periodic Review of the United States of America, Third Cycle, 36th Session of the UPR, Human Rights Council, 9 November 2020 (rescheduled)**

March 2020 Addendum to Summary of report on **The Right to Health: How financing affects the right to health care in the U.S.: *The impact of the COVID-19 pandemic***

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The pandemic widely exposes inadequate, unsustainable and inequitable financing and lack of universal access to health facilities, goods and services.

**Facilities**

The pandemic is causing greater loss of health and life because facilities are private and organized for profit. Since 1975, less profitable hospitals have been closed and hospital bed count has been downsized. The U.S. now has 925,000 beds for 331 million people; it had 1.5 million in 1975 for a population of 216 million. Global Health Security ranks the U.S. 175th of 194 countries in access to health care. (Margaret Flowers, MD, Truthout, 3/31/20). The most adverse impact is on people in rural areas and poorer urban neighborhoods, causing disparate mortality in violation of common Article 2. Nursing homes and long-term care facilities are dominated by investor-owned chains, like the Life Care Center in Kirkland, WA, part of the largest chain in the U.S. and an epicenter for transmission of COVID-19. Patient care in nursing homes is delivered under private insurance subject to less regulation, and centers rely on low-waged workers denied sick leave (who also don't have unions to represent them).

**Goods**

Basic supplies for the general public for preventive measures, such as wipes and hand sanitizers are unavailable. Masks, gloves and other PPE for health care workers are unavailable and workers are being ordered to reuse equipment. Physicians have been fired for criticizing hospital violations, such as ER physician, Ming Lin, at St. Joseph's Medical Center in Bellingham, WA. (3/19 and 3/29/20, Seattle Times). Because of reliance on market demand and no regulations, hoarding, price-gouging and competition between states for supplies is common. New York and California are competing for masks.

**Services**

Politicians and the rich and famous have access to testing and to treatment if they test positive for COVID-19. During the week of March 23, 2020, a 17-year-old boy in Los Angeles County died of COVID-19 because he was denied treatment for lack of insurance.

Congress continues its failure to consider and act to make health care a human right. Two bills based on human rights principles are pending, one in the Senate and the other in the House of Representatives. These bills provide global budgeting for all hospitals, regardless of whether they serve poor people, and provide universal care to all residents, free at the point of access.