

## Abstract

*A right to health is not recognized in the United States Constitution. This article examines the right to health and to health care in the U.S. in terms of expert definitions of health, international human rights instruments, U.S. individualism, the U.S. Constitution, and the impact of stigmatization on health status as a violation of dignity. It argues that establishing a right to health care is a necessary but insufficient condition to protect health. A historically rooted ethos of individualism, in combination with a dominant biomedical paradigm of disease causation, underlies the resistance of the private and public sectors to the concept of health as a human right. Emerging public health knowledge about social causes of disease provides a valuable locus of intervention from which a coalition of public health and human rights advocates can advance the debate and build political will for government action.*

*Le droit à la santé n'est pas reconnu par la Constitution des Etats-Unis. Cet article examine le droit à la santé et aux soins médicaux aux Etats-Unis du point de vue des définitions de la santé proposées par les experts, des instruments internationaux applicables aux droits de la personne, de l'individualisme américain, de la Constitution des Etats-Unis, et de l'impact de la stigmatisation sur l'état santé comme une violation de la dignité humaine. Il avance que l'établissement du droit aux soins médicaux est une condition nécessaire mais non suffisante à la protection de la santé. Une éthique individualiste qui trouve ses racines dans l'histoire américaine, ajoutée à un paradigme dominant biomédical de la causalité de la maladie, sous-tend une résistance dans les secteurs privé et public au concept du droit à la santé en tant que droit de la personne. La prise de conscience actuelle des causes sociales de la maladie nous fournit une occasion précieuse d'intervention vers une coalition des défenseurs de la santé publique et des droits de la personne qui peut faire avancer le débat et renforcer la volonté politique d'action gouvernementale.*

*La Constitución de los Estados Unidos no reconoce el derecho a la salud. Este artículo examina el derecho a la salud y a la atención médica desde la óptica de cómo los expertos definen la salud, los instrumentos internacionales de derechos humanos, el individualismo reinante en los EEUU, la Constitución estadounidense, y el impacto de la estigmatización sobre la situación de salud como una violación a la dignidad. Se postula que el consagrar la atención en salud como un derecho constituye una condición necesaria pero insuficiente para proteger a la salud. La moral individualista históricamente arraigada en los EEUU, junto con un paradigma predominantemente biomédico sobre la causalidad de las enfermedades, explican la resistencia por parte del sector público y privados al enfoque de la salud como un derecho humano. Los recientes conocimientos en el campo de la salud pública que destacan las causas sociales de las enfermedades, proporcionan un valioso espacio de intervención a partir del cual una coalición de defensores de la salud pública y de los derechos humanos puede hacer avanzar el debate y construir voluntad política para la acción gubernamental.*

# THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH: Public Health's Opportunity to Reframe a Human Rights Debate in the United States

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*If we believe men have any personal rights at all as human beings, they have an absolute right to such measure of good health as society, and society alone, can give them.*

—Aristotle, 4th century B.C.

A right to health has long been recognized in most civilized societies and is set forth explicitly in globally accepted documents such as the Universal Declaration of Human Rights (UDHR) and the Constitution of the World Health Organization. A right to health is not recognized in the United States Constitution, and the topic has never been a prominent part of the U.S. political agenda.<sup>1</sup>

In contrast, the related but subordinate issue of a right to health *care*, especially as it relates to poverty, has for more than a century periodically generated vigorous public and legislative debate within the U.S. Although aggregate health outcome indicators in the U.S. show an overall status of good health, morbidity and mortality are inequitably distributed among the poor and among racial/ethnic minorities.<sup>2</sup> The U.S. is the only industrialized nation that provides no mechanism to guarantee universal access to health care, and in 1996, 42 million Americans, or 16% of the population, had no health insurance.<sup>3</sup> The problem of health care access in the U.S. remains unresolved and is a source of great ambivalence among the general populace and government representatives.

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Together, the private health care system and the federal and state health-protecting programs and services comprise a national health policy that Roemer has described as decentralized, incremental, and fragmented and that Iglehart has called a "paradox of excess and deprivation."<sup>4</sup>

Meanwhile, health as a human right in the U.S. enjoys no significant status as a topic of public discourse. Yet the right to health care and the right to health are intrinsically linked, and recognition of the underlying causes of resistance to the former are essential to overcoming indifference, ignorance, and political inertia about the latter.

A nation-state's view of the right to health and health care reflects its core values and beliefs. The individualistic, libertarian values that predominate in the U.S. are fundamental to a prevailing ethos of individual responsibility for many personal health outcomes and for the ability or inability to access health care.<sup>5</sup> From the beginning of the international human rights movement, the link between health and human rights has been understood largely in the context of direct state action that damages health, such as torture. More recently scholars have made a compelling case for recognition of a broader reciprocal relationship between health and human rights. For example, Mann et al. have asserted that all rights violations, especially when severe, widespread, and sustained, engender important health effects, and that the promotion and protection of human rights is fundamentally linked to the promotion and protection of health.<sup>6</sup>

This article argues that a broadly popular, historically rooted ethos of U.S. individualism, in combination with a dominant biomedical paradigm of disease causation, is at the root of insidious sustained resistance in the private and public sectors to respect for health as a human right in the United States. Stigmatization, which constitutes a widespread denial of individual dignity, is both a contributing cause and a consequence of this resistance.

The article examines the right to health and health care in the U.S. in terms of expert definitions of health, international human rights instruments, individualism as a U.S. value, and the constitutional framework. It argues that establishing a right to health care is a necessary but insufficient condition to protecting health, and the current narrow

focus by advocates in the U.S. on ensuring access to care needs to be broadened. Therefore this article also discusses social conditions as fundamental causes of disease and frames stigma within the denial of dignity, a fundamental human right essential to health. It suggests that the scientific community, particularly in the fields of epidemiology and public health, can play an important role in advancing this knowledge in the general populace.

Finally, the article proposes that recognition and acknowledgement by policy decision-makers (and those in the private and public sectors who influence them) of social determinants of health are prerequisites for progress toward U.S. nation-state protection and fulfillment of a fundamental human right to health. This effort would be advanced by a new level of collaboration among public health advocates and both traditional and nontraditional human rights advocates.

## **Health**

Health, according to the Constitution of the World Health Organization (WHO), is "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of human beings without distinction of race, religion, political belief, economic or social condition."<sup>7</sup> This definition, adopted in 1946, was reaffirmed at the 1978 International Conference on Primary Health Care at Alma-Ata, cosponsored by WHO and UNICEF.<sup>8</sup> The editors of a Pan American Health Organization (PAHO) constitutional study on the right to health care have stated: "Health provides both the foundation for a just and productive society and the cornerstone of an individual's chance to develop his or her full potential. A population that is not healthy cannot learn, cannot work, cannot develop."<sup>9</sup> WHO and other UN-sponsored agencies such as the United Nations Development Program (UNDP) and the World Bank have recognized that health is central to human development, not only at the individual level, but also in terms of global macrosystems and social stability.<sup>10</sup> Inequities that persist within countries and communities despite economic growth threaten social cohesion. According to Carlyle Guerra de Macedo, director of PAHO in 1989, the "so-

cial nature of health” encompasses four cultural dimensions:

1. Equity: a commitment to ensure that every individual is able to assert the right to health through equal and adequate access;
2. Integration of health measures across a continuum, including promotion, prevention, recovery, rehabilitation, and of intersectoral responsibility;
3. Participation: mutual responsibility between systems and society (individuals, communities, and organizations); and
4. Efficiency: appropriate use of available resources.<sup>11</sup>

Thus a broad definition of health includes not only individual, but also sociocultural dimensions. Finally, public health is defined by the Institute of Medicine as “what we as a society do collectively to assure the conditions in which people can be healthy.”<sup>12</sup>

### **The Right to Health in Human Rights Instruments**

A right to health is expressed in many international and regional treaties and declarations. As Buergenthal writes, “The fact that there exists an International Bill of Human Rights . . . gives those who seek to enforce the rights it proclaims a legal and political legitimacy that cannot but facilitate the achievement of this goal.”<sup>13</sup>

Article 25 of the UDHR states:

1. Everyone has the right to a standard of living adequate for the health and well-being of himself and 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, or other 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.<sup>14</sup>

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) addresses health:

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.<sup>15</sup>

This right has been reaffirmed, and elaborated upon in other treaties and declarations including:

- Convention on the Rights of the Child, Article 24: “States Parties recognize the right of the child to enjoyment of the highest attainable standard of health.”<sup>16</sup>
- Convention on the Elimination of All Forms of Racial Discrimination, Article 5: “States Parties undertake to prohibit and eliminate racial discrimination in the enjoyment of the right to public health, medical care, social security and social services.”<sup>17</sup>
- Convention on the Elimination of All Forms of Discrimination Against Women, Article 12: “States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure . . . access to health care services, including those related to family planning.”<sup>18</sup>

Additionally applicable to the U.S. is the American Declaration of the Rights and Duties of Man, Article 11:

Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.<sup>19</sup>

## **Debate and Dialogue about the “Right” to Health in the U.S.**

As Bell has written, “Health is a natural good which can be lost through natural processes for which no one can be held accountable.”<sup>20</sup> Many have argued that the phrase “right to health” is inaccurate and misleading, because everyone cannot be assured good or perfect health. Leary describes the language “right to health” as a shorthand expression emphasizing the link between health status and issues of dignity, nondiscrimination, justice, and participation.<sup>21</sup> The phrase is more commonly interpreted by legal scholars and ethicists to mean a right to health care and/or to health protection, including access to medical care and assurance of healthy

conditions.<sup>22</sup> It is not surprising then that dialogue and debate in the U.S. have focused on access to care, ignoring other important sociopolitical determinants of health. Nevertheless, even this limited perspective generates significant controversy and conflict.

Proposals for legislation creating universal access to health care have been debated in the U.S. since early in the 20th century. In 1912, the Association for Labor Legislation launched the first extensive movement promoting a comprehensive system of compulsory sickness insurance as a way to guarantee funds for worker access to health care. In 1916, the American Medical Association Committee on Social Insurance introduced model legislation to provide compulsory medical insurance in sixteen states.<sup>23</sup> Neither of these efforts was successful, and the debate has raged ever since.

Yet despite such early attempts, the general populace, the government, and the business sector remain deeply ambivalent about whether society has a moral obligation to assure a minimum level of health care.<sup>24</sup> The sources of this continued ambivalence toward the idea of a right to health care are (1) the inherent conflict between the right to health and powerful economic interests served by current distributions of health and social resources, (2) ideological tension between notions of liberty and equality, and (3) an implied conflict between human rights and free-market trade.<sup>25</sup> The U.S. concept of government-protected equal rights for all sometimes conflicts with the equally valued concept of individual liberty, especially in the domain of economic behavior. In a competitive free market, goods and services, or commodities, are distributed without government intervention, according to consumer "preferences" that shape supply and demand. Health care is a large industry in the U.S. and an important contributor to the gross national product; this fact influences the predominant U.S. view of health care as a commodity rather than an entitlement.

### **Ideas of Liberty and Equality**

Seymour Lipset has described what he calls an "American Creed" with five concepts: liberty, egalitarianism, individualism, populism, and laissez-faire.<sup>26</sup> He observes that U.S.

citizens are proud of their unique differences from the rest of the world, for better or worse. He offers this fact as an explanation of the perverse indifference among many in the U.S. to its “outlier” status when U.S. social programs and human rights protections are compared negatively to other nations. Lipset identifies Tocqueville as the initiator of writings on American exceptionalism.<sup>27</sup> In Tocqueville’s view, American egalitarianism involved equality of opportunity and respect, not of result or condition. Commenting on individualism in America, Tocqueville wrote:

As social conditions become more equal, the number of persons increases who have acquired or retained sufficient education and fortune to satisfy their wants. They owe nothing to any man, they expect nothing from any man; they acquire the habit of always considering themselves standing alone, and they are apt to imagine that their whole destiny is in their hands.<sup>28</sup>

These words imply that the notion of absolute individual agency is a fallacy and highlight the risk of what Lipset calls a “strong preference for public policy that promotes equality of opportunity over equality of outcome.”<sup>29</sup>

Some in the U.S. take a view of health care that is well in keeping with the creed Lipset describes. According to Roemer, this liberty-focused view sees medical care as a reward for personal achievement and control over compulsion to engage in behaviors risky to health, and as one of many needs like housing, education, or recreation, on which an individual has discretion to spend money.<sup>30</sup> This view supports a free-market view of health care. An egalitarian view, in contrast, is concerned with equalizing opportunities for choice. Health, say egalitarians, is a prerequisite for success and cannot rest only on individual achievement; we should not rely upon the free market because social intervention is necessary to ensure equity.<sup>31</sup> As an example, consider the plight of an individual in poverty whose child has lead poisoning from peeling paint and lead dust in substandard housing. In a liberty-focused view, housing supply and demand trends in an “efficient” free market economy dictate that a landlord has the right to find a buyer whose budget constraints will make that substandard apartment a consumption “pref-



erence." The family who chooses to rent there is exercising free choice. In an egalitarian view, protection of the health of the child requires that other social forces be made to counteract the health hazard, e.g., environmental regulations, access to medical screening and treatment, and nutritional support. Individual liberty related to commerce is addressed directly in the U.S. Constitution, whereas egalitarian rights to health protection have only been indirectly derived from cumulative constitutional interpretation, giving some advantage to the former.

### **The Impact of the U.S. Constitution on the Right to Health in the U.S.**

In 1983 a U.S. Presidential Commission on the Study of Ethical Problems in Biomedicine "rejected the concept of a right to health care as an ethical basis for reforms of the U.S. health care system."<sup>32</sup> The acceptance of a right to health care was not considered a necessary condition for appropriate government action to assure adequate care for all. This point of view, prevalent in the U.S., has its fundamental origins in the U.S. Constitution.

Health care is not a protected right under the U.S. Constitution; indeed the word health is not even contained in the document. Some have suggested that this is in part because 18th-century scientific knowledge was insufficient to protect health, which was therefore viewed as an individual or local responsibility.<sup>33</sup> The elaborate system of health-related laws, policies, and programs that has emerged in the U.S. derives its Constitutional authority from Article 1 of the Constitution, which gives Congress authority "to make all laws which shall be necessary and proper to . . . provide for the general Welfare."<sup>34</sup> This power, along with the Constitutional power to regulate interstate commerce, has provided the basis for the federal government's role in promoting health and safety. The U.S. Bill of Rights grants no such powers to the government; rather, it sets forth freedoms, or rights that do not directly require positive government action promoting social programs for their enforcement.<sup>35</sup>

In this century, U.S. legislators have periodically tried to enact universal health care in the belief that health care, like

schools, police protection, and courts, should be available to all regardless of socioeconomic status. Iglehart has attributed the failure of these efforts to “Americans’ distrust of government, the heterogeneity of their values, and the absence of a sense of noblesse oblige that reflects our society’s belief in individual freedom but compromises efforts to promote community.”<sup>36</sup> Less visible, but more insidiously influential, have been protectionist actions by labor management representatives, the health care industry, and the political allies of both to block, suppress, or sabotage these initiatives as threats to controlling and maximizing profits. For example, occupational safety regulations that require employers to provide protective equipment and medical surveillance for workers exposed to hazardous substances are often strenuously resisted by employers. They argue that the costs of such measures limit their profits, constrain free trade, and ultimately result in higher unemployment.

Nevertheless, due to advances in scientific knowledge and technology, the growth of public health as a discipline, the widespread economic burden of the Depression Era, and the persistent efforts of an activist minority concerned with social welfare and justice, a semblance of rights imposing positive state obligations has been progressively established through government policy and programs in this century. Social Security, Medicare and Medicaid, Workers’ Compensation, the Occupational Health and Safety Act, and the Environmental Protection Agency all represent gains.<sup>37</sup> Capron observes that the President’s Commission report said that health care is different from other goods and services and that society, through private bodies and the government, has at least a moral obligation to ensure equitable access to an adequate level of health care.<sup>38</sup>

The differing levels of perceived acceptability of Medicare and Medicaid are illustrative of a relevant and widely held view in the U.S. about the nature and meaning of poverty. Medicare, a health entitlement for the elderly who have worked, enjoys popular approval and the same dignity as the Social Security program. Medicaid, a health care program for the poor that is linked to welfare eligibility, has tenuous sup-

port and negative connotations.<sup>39</sup> As Priester has written:

The concept of the unworthy poor derives from the peculiarly American notion that for many poor people, poverty is somehow deserved. From this perspective, access to necessities such as health care, and clearly to all of life's luxuries, depends on personal effort, achievement or merit.<sup>40</sup>

Thus, in the U.S., poverty is perceived by some as diminishing dignity. Since the inherent dignity of all human beings is the core principle upon which human rights are based, the concept of conditional dignity must be recognized as unacceptable and to have serious implications for the protection of health within the U.S. Just as the expert definitions of health cited earlier include more than the absence of illness and disease, so too does health protection rely on more than access to health care. Social conditions, such as poverty, and social interactions that violate dignity, such as racial discrimination, are important determinants of health.

### **Dignity, Stigma, and Social Causes of Disease**

*All human beings are born free and equal in dignity and human rights.*

—Article 1, UDHR

The violation of dignity may be the least recognized social determinant of health. As Jonathan Mann has stated:

Future health professionals may look back at the current limited and narrow understanding of health and wonder how we could have missed seeing violations of dignity as sources of injury to well-being.<sup>41</sup>

Dignity is not explicitly defined in any human rights document. Over time human dignity has been alleged to rest variously on one's rationality, strength, political capacity, or moral integrity.<sup>42</sup> Interestingly, Webster's Dictionary defines dignity as "the quality or state of being worthy, *honored* or *esteemed* (emphasis added)". The passive tense of the terms "honored" and "esteemed" implies that dignity is an externally conferred status. Elizabeth Maclaren has argued that being valued as irreplaceable is what constitutes dignity—that dignity is essentially a matter of relationship—and that

the idea of intrinsic or "a priori" dignity is a fiction that prevents us from facing our power to make or unmake another as a person of dignity.<sup>43</sup>

If dignity as a concept implies a social relationship between individuals, then its antonym is surely stigma, with socioeconomic marginalization as a sequela. Webster's Dictionary defines stigma as a "scar," a "mark of shame or discredit." The dignity/stigma construct has profound implications for health and is relevant to redefining determinants of health as perceived by many in the U.S. As Alonzo and Reynolds put it:

The essence of the concept centers on deviance . . . people who are regarded negatively, some for having violated rules, others for being the sort of people they are, or having traits that are not highly valued. . . . The stigmatized are a category of people who are pejoratively regarded by the broader society and who are devalued, shunned or otherwise lessened in their life chances and in access to the humanizing benefit of free and unfettered social intercourse."<sup>44</sup>

Crawford has suggested that health has become a key part of the identity of the middle class and that this involves as its counterpart the construction of the "unhealthy other." Thus the pursuit of health becomes a pursuit of moral personhood, and health a metaphor for social control. By contrast, the presence of disease within an individual "can be seen as a metaphor for lack of control or an indication of immorality and irresponsibility."<sup>45</sup> If this metaphor is accepted, victim-blaming will likely be a logical consequence, and this in turn will subtly influence how social and health policy is shaped.

The powerlessness inflicted by stigmatization is a response to system-wide discrimination. As a chronic stressor, it has been associated with mental, physical and behavioral health problems.<sup>46</sup> As Mann has stated, "[I]t is increasingly evident that violations of dignity are pervasive events with potentially severe and sustained negative effects on physical, mental and social well-being."<sup>47</sup> The effects of economic and social marginalization are dramatically illustrated in health outcome data that show inequitable distribution of disease.<sup>48</sup> In a February 1998 public statement, U.S. President Bill

Clinton recognized this when he decried a “racial and ethnic gap” in infant mortality, diabetes, cancer, AIDS, and immunization rates.<sup>49</sup>

Link and Phelan identify social conditions as fundamental causes of disease linked to multiple disease outcomes through multiple risk-factor mechanisms involving access to resources that enable people to avoid risk for morbidity and mortality.<sup>50</sup> These resources include knowledge, money, power, social support, and prestige.<sup>51</sup> The association between a fundamental cause and a disease may be preserved despite changes in either mechanisms or outcomes; when the effect of one mechanism declines, the effect of another emerges or becomes more prominent. Link and Phelan promote consideration of a contextualized risk that causes the “risk of risks,” or what Mann and Tarantola call “vulnerability.”<sup>52</sup> It is in this sense that it seems appropriate to explicitly name stigmatization as a violation of the right to human dignity and as a social determinant of health outcomes.

Prominent epidemiologists have made important assertions that bring into focus the human rights content of social causes of disease and ill health. These may be summarized as follows:

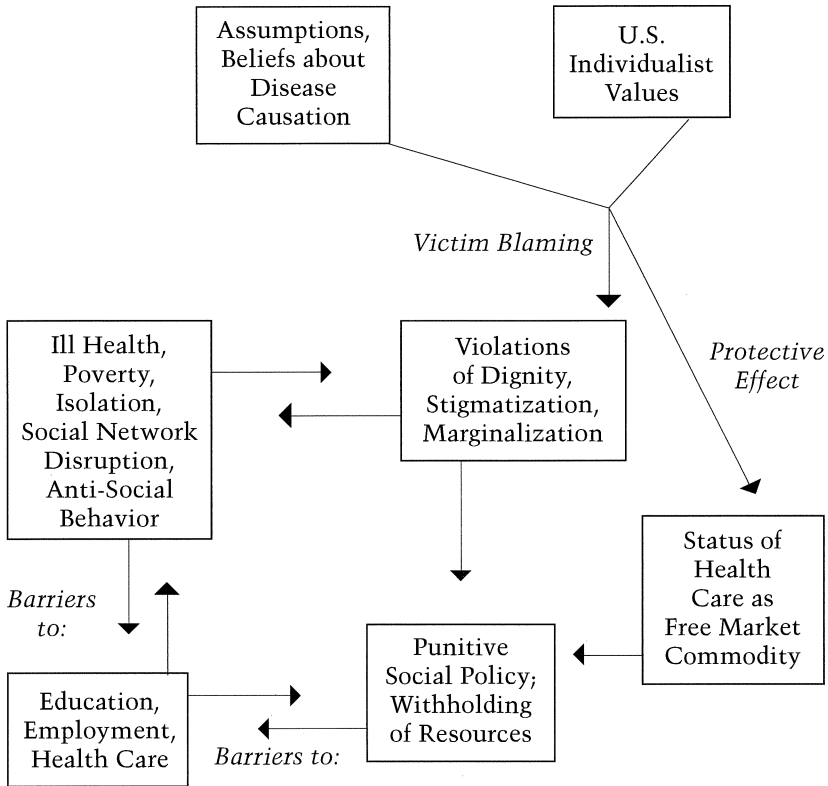
1. Exposure to conditions such as racism, gender discrimination, and poverty exert a physiological effect that explains excess rates of some kinds of cancer and cardiovascular disease among women, racial and ethnic minorities, and the poor.<sup>53</sup>

2. Risk factor analysis by the most advanced epidemiological methods does not fully account for disease occurrence in individuals or inequitable distribution of disease in populations. For example, risk factors for coronary heart disease (CHD) have been extensively documented through sound research, yet all the identified factors together explain only 50% of CHD that occurs.<sup>54</sup>

3. Mortality is related more closely to relative income within countries than to differences in absolute income between them.<sup>55</sup>

4. Equity of access to health care does not eradicate inequity of disease distribution caused by social variables.<sup>56</sup>

The relationship between individualism, the free-market health care system, theories of disease causation, stigmatization, and ill health are complex, multidirectional and self-perpetuating (see Figure 1). The relationship implicates the nation-state as



**Figure 1.** Relationship between U.S. Individualism, Free-Market Health Care System, Theories of Disease Causation, Violations of Dignity, and Health.

the sponsor of policies and programs that contribute directly and indirectly to stigmatization and therefore not only to lower access to health care but also to lower health status.

Compelling epidemiological evidence indicates that social determinants, such as stigma or racial and gender discrimination, require as much attention, if not more, than traditionally conceptualized causes of disease such as bacteria and viruses. Given the evidence, it is clear that the im-

portant struggle in the U.S. to improve access to health care must be expanded to address the broader human rights issues necessary to improve population health.

### **A Case for Action**

This article proposes that a broadly accepted reconceptualization of disease causation is necessary to create the political will in the U.S. to confront health as a right. A view of health and illness that focuses only on individual causes, to the exclusion of social causes, leads to inappropriate victim-blaming and helps maintain barriers to U.S. acceptance of a right to health. The ongoing debate about health care provides the fulcrum for enlarging the topic to protection of health as a right. Continued contemporary public tension and debate about access to health care and the history of American receptivity to scientific information indicate potentially optimal conditions for the activism necessary for the health of the population.

There are other facilitating forces. The various racial and ethnic groups in the U.S. differ substantially in their perceptions and assessment of the problems and situations faced by members of other groups and in their views of how much government should do to ease social and economic disparities. Yet health care is one of three areas in which, according to a recent study, large numbers from the major minority groups in the U.S. agree that the federal government has a responsibility to make sure that minorities have equality with others (the other two areas were public education and treatment by police and the courts).<sup>57</sup>

Development and implementation of a plan to advance the debate from its current status will require aggressive collaborative efforts between public health practitioners and human rights advocates, including such disparate actors as labor unions, social activists, and religious groups.<sup>58</sup>

To work toward improving health within the U.S., public health professionals should expand research about the causal relationships and biological pathways between social conditions and health outcomes. Research findings should be aggressively disseminated to the general populace and policy makers to change attitudes, perceptions, and awareness levels. Human rights advocates should monitor and

publicize in multiple forums the inequities in health status and access to medical care within the U.S. and advance the explicit connection between human rights and health. If such groups work together, an effective lobby for change in government policies is possible.

Since the right to health in the U.S. is currently framed by legislators and many advocates only as a right to access to health care, universal health insurance and defined levels of minimum adequate care constitute appropriate short-term goals. Long-term goals for a broader right to health should include (1) legalized, institutionalized mechanisms for explicit data collection identifying and linking health outcomes to discrimination by race, gender, and socioeconomic status and (2) intervention methods to control exposure to and treat the effects of social causes of disease.

## **Conclusion**

The idiosyncrasy of conflicting national ideals of individualism, liberty, as well as equality in the U.S., as well as the powerful influence of its free-market health care system, are critical factors contributing to its status as the only industrialized nation that does not guarantee universal access to health care, and fails to engage with health as a human right. This predominant view has also supported biomedical theories of disease causation that focus on individual risk factors, exposures, and behaviors. The conflation of these ideas has created powerful barriers to (1) recognition that disparities in population distribution of disease by gender, race/ethnicity, and socioeconomic position are inequitable and (2) the creation of health policy sufficiently grounded in the recent and growing scientific evidence of the role of social conditions such as racism, gender discrimination, and poverty as fundamental causes of disease.

Social causes require social interventions. The continued deep ambivalence within the U.S. about whether or not health care should be a protected right provides an encouraging opportunity. The endurance of the debate indicates that the nation's citizens and leaders are unwilling to abandon the consideration of a right to health care and may be receptive to new information that shifts the balance of arguments. In collaboration with human rights advocates, public health



practitioners must use all the weight the scientific community can bring to bear to make explicit the connection between disease and state-supported social conditions that violate human rights. Such activism is necessary to create sufficient political will within the U.S. to respect, protect, and fulfill the right to health and, from there, for the U.S. to apply its considerable resources to reduce inequity, thereby assuring, in the words of the UDHR, "freedom, justice and peace."

*It is part of the unceasing human endeavor to prove that the spirit of man can transcend the flaws of his own nature.*

—Aung San Suu Kyi, Nobel Peace Prize Winner

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15. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200 (XXI), UN GAOR, 21st Sess., Supp. No. 16, at 49, UN Doc. A/6316 (1966).

16. Convention on the Rights of the Child, G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 (1989).

17. Convention on the Elimination of All Forms of Racial Discrimination, UN G.A. Res. 2106A(XX) (1965).

18. Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180 UN GAOR, 34th Sess., Supp. No. 46, at 193, UN Doc. A/34/46 (1979).

19. American Declaration of the Rights and Duties of Man, approved by the Ninth International Conference of American States on 2 May 1948, Resolution XXX, Pan American Union. The Declaration is not a treaty, but an authoritative catalog of human rights that States parties to the OAS Charter are under legal obligation to promote.

The U.S. is not party to the ICESCR, the Convention on the Rights of the Child, or the Convention on the Elimination of All Forms of Discrimination Against Women.

20. N. K. Bell, "The Scarcity of Medical Resources: Are There Rights to Health Care?" *The Journal of Medicine and Philosophy* 1979, 4(2): 159.

21. V. Leary, "The Right to Health in International Health Rights Law," *Health and Human Rights* 1994, 1(1): 26–58.

22. Leary (see note 21); Bell (see note 20); Roemer (see note 4); M. Susser, "Health as a Human Right: An Epidemiologist's Perspective on the Public Health," *American Journal of Public Health* 1993, 83(3): 418–26.

23. G. Rosen, *A History of Public Health* (New York: MD Publishers Inc., 1958).

24. Iglehart (see note 3).

25. A. Eide, "Realization of Social and Economic Rights and the Minimum Threshold Approach," *Human Rights Law Journal* 1989, 10: 35–37; T. L. Beauchamp and R. R. Faden, "The Right to Health and the Right to Health Care," *The Journal of Medicine and Philosophy* 1979, 4(2): 118–31; Bell (see note 20); J. A. Childress, "A Right to Health Care?" *The Journal of Medicine and Philosophy* 1979, 4(2): 132–47; L. B. McCullough, "Rights, Health Care, and Public Policy," *The Journal of Medicine and Philosophy* 1979, 4(2): 204–15.

26. S. M. Lipset, *American Exceptionalism: A Double-Edged Sword* (New York: Norton, 1996). This "American Creed" summarizes a set of sometimes-conflicting U.S. values deeply embedded in the national psyche since its founding as a democracy: individual freedom and equality, absence of an aristocracy or monarchy, and freedom from government intervention, which also extends to capitalist free-market trade.

27. A. de Tocqueville (trans. H. Reeve), *Democracy in America* (New York: Vintage, 1990).

28. Tocqueville (see note 27), p. 99.

29. Lipset (see note 26), p. 72.

30. Roemer (see note 4), p. 19.

31. Roemer (see note 4), p. 19; Childress (see note 25).

32. Leary (see note 21).

33. A. M. Capron, "United States of America," in: H. Fuenzalida-Puelma and S. Connors (eds), *The Right to Health in the Americas* (Washington, DC: Pan American Health Organization, 1989); Curran (see note 1); Roemer (see note 4).
34. U.S. Constitution, art. 1. See Capron (note 33), p. 504.
35. Capron (see note 33). According to Capron, only the 1868 post-Civil War "equal protection" clause in Amendment XIV can be argued to "have broken the mold and created rights germane to a consideration of citizens health in relation to their government" (p. 500).
36. Iglehart (see note 3), p. 963.
37. These federal programs provide protection to U.S. citizens as follows: The Social Security Act of 1935 assures income assistance for those unable to work due to age or disability. Medicare provides financing of health care for those aged 65 or older. Medicaid finances health care for the poor, subject to income eligibility requirements. The Environmental Protection Agency (EPA) was established in 1970 to implement environmental legislation, all of which directly or indirectly impacts health (consider, for example, air and water pollution or pesticide use). The Occupational Safety and Health Administration was created in 1970 to ensure safe and healthy work conditions in the private sector. In addition to these federal programs, states administer workers' compensation plans for job-related injuries.
38. Capron (see note 33), p. 51.
39. R. A. Priester, "A Values Framework for Health System Reform," *Health Affairs* 1992, 11(2): 84.
40. Priester (see note 39).
41. J. Mann, "Dignity and Health: The UHDR's Revolutionary First Article," *Health and Human Rights* 1998, 3(2): 37.
42. E. Maclaren, "Dignity," *Journal of Medical Ethics* 1977, 3: 40-41.
43. Maclaren (see note 42), p. 41.
44. A. Alonzo and N. Reynolds, "Stigma, HIV and AIDS: An Explanation and Elaboration of a Stigma Trajectory," *Social Science and Medicine* 1995, 41(3): 304.
45. R. Crawford, "The Boundaries of the Self and the Unhealthy Other: Reflections on Health, Culture and AIDS," *Social Science and Medicine* 1994, 38(10): 1348.
46. S. Lawless, S. Kippax, and J. Crawford, "Dirty, Diseased and Underserving: The Positioning of HIV-Positive Women," *Social Science and Medicine* 1996, 43(9): 1377.
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48. E. Pamuk, D. Makuc, K. Heck, C. Reuben, and K. Lochner, *Status and Health Chart Book: Health, United States, 1998* (Hyattsville, Maryland: National Center for Health Statistics, 1998).
49. N. Wallerstein, "Powerlessness, Empowerment, and Health: Implications for Health Promotion Programs," *American Journal of Health Promotion* 1992, 6(3): 197-205.
50. B. G. Link and J. Phelan, "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behavior* 1995, 36(Extra Issue): 80-94.
51. E. O. Wright, "The Class Analysis of Poverty," *International Journal*

of *Health Services* 1995, 25(1): 91. Wright argues persuasively that poverty is not a byproduct of the American social system, but rather an inherent and crucial feature that benefits capitalists: "Economic oppression is thus a situation in which the material benefits of one group are acquired at the expense of another, and in which morally indictable coercive exclusion from resources is an essential part of the process by which this occurs" (p. 91).

52. J. Mann and D. Tarantola, *AIDS in the World II* (New York: Oxford University Press, 1996), p. 441.

53. N. Krieger, D. L. Rowley, et al. "Racism, Sexism, and Social Class: Implications for Studies of Health, Disease and Well-Being," *American Journal of Preventive Medicine* 1993, 9: 82-122; M. E. J. Wadsworth, "Health Inequalities in the Life Course Perspective," *Social Science and Medicine* 1997, 44: 859-69.

54. S. L. Syme, "Rethinking Disease: Where Do We Go from Here?" *Annals of Epidemiology* 1996, 6: 463.

55. R. G. Wilkinson, "Socioeconomic Determinants of Health: Health Inequalities: Relative or Absolute Deprivation?" *British Medicine Journal* 1997, 314: 591-95; N. E. Adler, T. Boyce, M. A. Chesney, et al., "Socioeconomic Status and Health: The Challenge of the Gradient," *American Psychologist* 1994, 49: 15-24.

56. Susser (see note 22); N. E. Adler, T. Boyce, M. A. Chesney, et al., "Socioeconomic Inequalities in Health: No Easy Solution," *Journal of the American Medical Association* 1993, 209(24): 3140-45.

57. M. Brodie, *The Four Americas: Government and Social Policy through the Eyes of America's Multi-Racial and Multi-Ethnic Society*, report of the Washington Post/Kaiser Family Foundation/Harvard Survey Project, December 1995.

58. Religious volunteerism movements, which are not always included when traditional human rights advocates are referenced, represent an untapped resource. Admittedly religious moral absolutism has often been a tool of oppression, but there is also a strong tradition of human rights advocacy in many religious sects.