

**A Human Rights Analysis Of
The 2007 Bush Healthcare Proposal**

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Introduction

In his 2007 State of the Union Address, President George W. Bush proposed a new healthcare initiative (“Bush Proposal” or “Proposal”). This paper evaluates the Bush Proposal according to international human rights law, and specifically, in terms of the human right to health. A human rights approach focuses on *health* before all else, particularly for the most vulnerable populations. In terms of the 2007 Bush Healthcare Proposal, a human rights approach asks whether the proposed reforms will work towards the goal of making as many people as possible as healthy as possible.

International human rights law offers explicit criteria for evaluating proposed healthcare reforms, whether they are broad policy agendas set out at the federal level or specific measures to be implemented on the local level. The key criteria are:

- *Availability*: Are there sufficient medical personnel and facilities to treat prevailing health problems for all segments of the population?
- *Accessibility*: Do all persons have physical, geographical, and economic access to healthcare? Access also requires the ability to seek, receive, and impart information and ideas concerning health issues.
- *Quality*: Does healthcare meet state and federal regulations and other quantifiable measurements of quality care? Quality also examines intangible components of care, such as whether healthcare providers have the time and resources to relate to and communicate with their patients.
- *Appropriateness*: Does healthcare meet physical, educational, mental, ethical, and cultural standards? Is the healthcare system sufficiently simple and straightforward?

Human rights law also requires that individuals affected by healthcare reform have an opportunity to *participate* in its design and implementation. In addition to participation, other procedural requirements include ensuring that individuals affected by a healthcare system:

- Do not experience discriminatory impacts (or intentional discrimination) on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status
- Have sufficient information and education so that they can take advantage of its benefits; and
- Have a means of seeking remedies for violations of the availability, accessibility, quality or appropriateness requirements listed above.

The report uses these internationally recognized criteria to briefly explain the current crisis in the American healthcare system. The report describes the basic components of the Bush Proposal and evaluates the Proposal in accordance with these same internationally recognized criteria, focusing throughout on whether the Bush Proposal ultimately represents a step in the right direction for our healthcare system. The conclusion is that it does not.

Overview of the Current Healthcare Crisis

Although the United States offers some of the highest quality medical services available for those who can afford them, the current American healthcare system faces multiple challenges. Approximately 16% of the population has no health insurance, which in the privatized American system means they have little or no access to medical services.¹ Rural and poor regions of the country suffer from sparse facilities that are insufficient to serve the population. Quality of medical services has deteriorated in many hospitals because medical decisions are being made for non-medical reasons. And administrative complexities erect barriers to health care delivery throughout the system.²

The crisis in American healthcare rests on three inherent weaknesses of the current system. First, healthcare is viewed as a commodity instead of as a fundamental right. Second, administrative complexity and expense make insurance difficult to obtain for both individuals and employers. And third, the current insurance model does not adequately share the risk of accident or disease across the population. Each of these three elements is discussed in turn below.

Healthcare as a commodity

The structure of the current insurance system is defined by market terms. Under this model, patients are considered “consumers” and healthcare is considered a consumable good. Such a “market” view of healthcare assumes that patients always have the choice to walk away, that economic efficiency and cost-savings are always beneficial, and that increased profit is equivalent to better healthcare. Although this logic may apply to purchases of cars, computers or cameras, it does not apply to medical services. Most patients – and particularly patients facing emergency situations – do not make a “choice” to “consume” health services. Efficiency and cost-savings frequently lead to cutting important corners or to placing

¹ Approximately 47 million Americans have no health insurance according to the U.S. Census Bureau. The current population of the United States is approximately 300 million.

² For an overview of how the U.S. healthcare system lives up to the standards articulated by the international human right to health, see J. Carmalt and S. Zaidi. *The Right to Health in the United States of America: What Does it Mean?* Center for Economic and Social Rights (October 2004) (hereinafter “CESR Report”).

dangerous emphasis on cheaper procedures. And large profit margins have little or nothing to do with good healthcare.

Healthcare is an essential part of life. For a healthcare system to promote *health*, patients and doctors – not third-party insurers – must be the ones to make decisions about the proper treatments for the care of specific medical conditions.

Administrative Complexity and Expense

Health care costs are rising at a rate that ranges from 4.35 to 8.87 times the consumer price index, yet billions of dollars spent annually on health *insurance* do not pay for the costs of health *care*³. In 2006, profit alone amounted to over \$9 billion dollars for the top five insurance companies.⁴ Health insurance costs in the United States are driven by significant administrative, marketing, and salary-related expenses as much as they are driven by the healthcare needs of the insured.⁵ The expense of health insurance is related to its complexity: every hour spent by employers, patients, and healthcare providers on efforts to access the system represents time and money not spent on healthcare.

Because healthcare insurance is so expensive, more and more employers are choosing not to provide health benefits at all. Many of the employees not receiving benefits are seasonal workers or low-wage workers who cannot afford to purchase private insurance.

Separately, the array of insurance companies and plans (each with different levels of care, restrictions, and exclusions) poses an administrative burden on providers, patients, and employers alike. Patients and doctors are faced with restrictions, myriad claim forms, and coverage limitations. In addition, patients sometimes must fight for payment of covered

³ Cooper, Scott, “Health-insurance inflation is still well above overall consumer index.” Business First of Columbus, April 28, 2006.

⁴ Fortune 500 2006 Industry: Health Care: Insurance and Managed Care. *Available at:* http://money.cnn.com/magazines/fortune/fortune500/industries/Health_Care_Insurance_Managed_Care/1.html.

⁵ For example, the head of United Health Care recently retired with a pension plan valued at \$1.8 billion. The CEO of PacifiCare earns 3.38 million; The CEO of Wellpoint earns \$25 million. The CEOs of the managed care divisions of Cigna and Aetna earn \$13.3 million and \$22.2 million, respectively. See, “Special Report CEO Compensation.” Forbes.com, Scott DeCarlo, Editor.

services. Insured individuals also pay annual deductibles and co-pays. As currently structured, private health insurance limits the availability of care for those who have it.

Insurance that does not share the risk

In theory, insurance is a means of spreading the risk of disease, accidents, and chronic illness across the population so that no one individual carries too great of a personal burden. However, the current system has turned the concept of insurance on its head. Private insurance companies typically refuse to provide insurance to the chronically ill, those with pre-existing conditions, or those at a higher risk of becoming ill. These are the very individuals insurance was designed to protect, and by doing so, the insurance industry has created a class of people who are uninsurable by virtue of their medical history.

This result is not surprising because the insurance industry must provide profits to shareholders as well as healthcare to the American population: by definition, a profit-based healthcare system will provide healthcare to those who are profitable, but not to those who are deemed unprofitable. Since medical services are expensive, a profit-based system concerned with cutting costs is fundamentally focused on how to *avoid* providing healthcare, instead of the other way around.

These three problems inherent to the current healthcare system have contributed to the lack of adequate care for millions of Americans. The Bush Proposal does not address these structural elements and so it will do little to improve current health outcomes.

Summary of the Bush Healthcare proposal

The Proposal has two components:

First, it provides for a standard federal tax deduction for those individuals who purchase health insurance or receive it from their employers. The deduction is \$7,500 for individuals and \$15,000 for families. The goal of this provision is to make the purchase of private insurance more affordable for those individuals and families who do not receive employer-provided health benefits.

In the case of individuals currently receiving employer-provided health insurance, this previously untaxed benefit will be taxed under the Proposal, subject to the proposed deduction. The goal of this provision is to “level the playing field.” The Administration views those who receive these more expensive, “gold plated” plans as receiving additional income, a portion of which should be subject to tax.

In the case of individuals who pay for their own health insurance, the Proposal’s deduction will theoretically decrease the amount of federal taxes such people owe, by decreasing the adjusted gross income of such individuals by the deduction amount. Just as the mortgage tax deduction encourages people to purchase homes, which, in turn, supports the real estate and construction industries, the tax deduction is designed to encourage individuals to purchase insurance, which will, in turn, support the private health insurance industry. The Administration projects that this tax reform will decrease the number of uninsured by 3 million by 2010.

The Proposal also provides funds to States to pay for part of the cost of local programs that help uninsured individuals and families purchase private health insurance. In a separate report, we analyze the ability of state-based plans like those found in Massachusetts and Illinois to meet rights-based criteria. This report focuses on the tax component of the Bush Proposal only.

**Lack of available healthcare:
Exacerbating the problem by relying on faulty assumptions**

For healthcare to be available, a country must have sufficient quantities of functioning facilities, services, and programs.⁶ In the United States, there are two health care systems: the first has high-quality, functioning facilities with sufficient personnel; the second experiences chronic shortages of personnel, facilities, equipment, and treatments. The division between these two systems is partly geographic (rural areas suffer from chronic shortages) and partly economic (the second system is built for the poor). These two systems exist because Americans have assumed that a market-based system can deliver health care to people who are poor and/or sick. This assumption has proved faulty because it is not profitable for the private insurance industry to provide services to these populations.

The Bush Proposal does not address the need for increased services for rural, poor, and chronically sick populations. The Proposal instead relies on market mechanisms to address the problem of unavailable healthcare for vulnerable populations by suggesting that open competition will create cost-appropriate individually tailored plans in the private insurance market. However, since the current shortages in available services arose precisely because vulnerable populations are not profitable to insure, and since the Bush Proposal does not provide any means by which the most vulnerable Americans would be more profitable to insure, there is no reason to believe profit-based insurance companies would be willing or capable of addressing the current insufficiencies. By expanding the healthcare sector's reliance on market-based mechanisms, the Bush Plan will instead exacerbate current divisions between healthy (insurable) and unhealthy (uninsurable) populations.

⁶ Committee on Economic Social and Cultural Rights. General Comment Number 14 (2000): The right to the highest attainable standard of health. 11/08/2000 (UN Doc. E/C.12/2000/4) (hereinafter "General Comment 14").

Lack of accessible healthcare: How tax cuts fail to provide health insurance

International human rights law requires that a health care system be physically and economically accessible. Like all human rights, the right to health and health care prohibits discrimination on any basis, and requires full accessibility to health services as an integral part of meeting that requirement. However, the U.S. healthcare system actively discriminates on the basis of income: wealthy people have access to a high-quality system with sufficient doctors and hospitals, while poor people do not.

The Bush Proposal claims that a standard tax deduction for health insurance costs will eliminate this disparity because it “lowers taxes for all currently uninsured Americans who decide to purchase health insurance.”⁷ The logic of the Proposal is that poor and lower-income families will make enough extra money from the new deduction to be able to afford adequate health insurance. However, the tax deduction will fail to measurably increase the number of Americans who can afford insurance for three reasons:

- First, although the tax deduction acts as a subsidy to those who purchase private insurance, the subsidy provides greater economic advantage to the wealthy. This is due to the fact that the value of the deduction is greater to those in a higher tax bracket. A high-income taxpayer in a 30% tax bracket can save a maximum of 30% of \$7,500, or \$2,250. However, a low-income taxpayer in a 10% tax bracket will save only \$750 for the same insurance plan. Thus, the Proposal provides greater subsidies to those less in need of them.
- Second, the poorest and most vulnerable Americans, who do not have health insurance, do not pay federal income tax at all, which means that a tax deduction is meaningless in terms of their ability to purchase health insurance. According to the U.S. Census Bureau, approximately 31% of uninsured Americans make less than \$25,000 per year.⁸ Of this group of uninsured Americans, there are many whose

⁷ The White House: Strengthening Healthcare (<http://www.whitehouse.gov/infocus/healthcare/>).

⁸ U.S. Census Table 8: People With or Without Health Insurance Coverage by Selected Characteristics: 2004 and 2005. *Available at:* <http://www.census.gov/hhes/www/hlthins/hlthin05/hlthtables05.html>.

annual income is so low that they have no annual federal tax liability, yet may not qualify for Medicaid. Therefore, a tax deduction does nothing for the ability of these Americans to afford private health insurance.

- Third, the tax deduction also fails to help lower-income Americans purchase a private insurance plan. For example, a single mother with one child who makes \$30,000 per year will be liable for approximately \$1,300 in federal taxes. After the new deduction, that same parent would pay approximately \$300 in taxes, meaning she would save an extra \$1,000. However, by the most conservative estimates, the average family health insurance plan costs at least four times that much, meaning the mother would need to spend an additional 10% of her annual salary to purchase private health insurance, even with the new tax deduction. Families that are already struggling to make ends meet cannot afford the costs of health insurance, even when they come with the Proposal's subsidy for low-income families.

These examples illustrate the degree to which a federal tax subsidy will not result in greater affordability of health insurance. Approximately two-thirds of the people in this country without health insurance earn less than \$50,000 per year.⁹ A tax deduction would do little to defray the costs of insurance for these working poor who already have a minimal tax burden and who have little extra income to spare for costly insurance plans. As such, the Bush Proposal will not measurably increase access to healthcare for Americans.

⁹ *Id.*

Lack of quality healthcare: Discouraging preventive care by encouraging low-coverage policies

International human rights law requires that a health care system be of high quality. This means that services are scientifically and medically sound.¹⁰ In the United States, challenges to the quality of care arise from two sources: first, from trends to overuse or under-use medical services because of insurance or financial concerns,¹¹ and second, from restrictions on open communications between patients and their health providers.¹² Both of these issues of quality are direct results of restrictions on the types of services that can be used and the lack of available or accessible preventive healthcare.

The Bush Proposal risks exacerbating both of these problems by encouraging insurance companies to compete in order to provide the cheapest plans possible.¹³ The Proposal fails to address what *kind* of health insurance would result from this race to the bottom. Experiences at the state level show that competition in this context results in stripped down plans that have lower monthly bills but limit what types of services are covered and often exclude preventive healthcare.¹⁴

¹⁰ General Comment 14, *supra* note 6.

¹¹ CESR Report at 18, *supra* note 2.

¹² For example, lack of quality communication has been cited as a possible contributing factor to African American health disparities. *See* John Hopkins Bloomberg School of Public Health Press Release, "Lack of Quality Communication During Medical Visits May Contribute to African-American Health Disparities" 21 December 2004. *Available at*:

http://www.jhsph.edu/publichealthnews/press_releases/PR_2004/Cooper_communication.html

¹³ E.g., "Once we stop subsidizing health insurance relative to anything else . . . [insurance companies] would put together plans that were cheaper and cheaper and cheaper until people found a plan that they really liked." Comment by Katherine Baicker at the Press briefing on: The President's State of the Union Health Care Initiative, January 22, 2007.

¹⁴ In their article, "The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back," Steffie Woolhandler and David Himmelstein describe the Rand Corporation research on the impact of high deductible plans:

[H]igh deductibles caused a 17 percent fall in toddler immunizations and swelled the number of children failing to see a doctor in the course of a year from 15 percent to 32 percent among school-aged children and from 5 percent to 18 percent among infants and toddlers. While high deductibles reduced children's use of "rarely effective care" by 33 percent, they also reduced "highly effective care" by 28 percent. Adults . . . also used less preventive and primary care, and had higher blood pressure and higher risks of dying, when high deductibles were placed on their insurance coverage. In our own work on medical bankruptcy, 76 percent of those bankrupted by medical problems had insurance at the onset of the illness that bankrupted them; many were ruined by co-payments, deductibles, and uncovered expenses such as physical therapy.

Woolhandler, Steffie and David U. Himmelstein. "The New Massachusetts Health Reform: Half a Step Forward and Three Steps Back," The Hastings Center Report. Vol. 36, No.5., pp. 19-21, Sept.-Oct., 2006.

The underlying assumption is that market mechanisms will solve the problem because people have a choice when it comes to picking insurance plans. However, people cannot pick health care services the way they would pick options for a new car. There is no way to predict in advance which services might be needed, and there is frequently no choice at all about what kinds of services are, in fact, required in a given instance. The “choice” is really a gamble: people are required to gamble away future services in exchange for lower upfront costs. Under the Proposal, people will be more likely to seek cheaper plans, take the tax deduction, and forego the higher costs of preventive healthcare plans. Individuals with lower cost plans will seek treatment only after their more minor problems have become serious (and more expensive) medical conditions covered by their limited plans.

The stripped-down, competition-driven plans encouraged by the Proposal could result in the under-use of important preventive healthcare, and the over use of other more drastic procedures that could have been prevented at an earlier stage. Decisions about health care will be driven not by a consultation process between doctor and patient, but by the exigencies of a particular insurance plan, designed not to maximize health but to maximize profit. These features of the Proposal undermine rather than improve the quality of American health care.

**Lack of appropriate healthcare:
Making things more complicated by using the tax code to deliver healthcare**

Under international human rights law, appropriate care is that which respects medical ethics, is culturally appropriate, and is designed to improve health status. As noted above, the current system does not improve health status because it does not provide true insurance; it creates a class of uninsurable individuals. However, even for those who do enjoy health insurance, the system is so complex that even highly educated wealthy patients face inappropriate barriers to obtaining care.

Although bureaucratic complexity is not in and of itself a human rights problem, bureaucratic complexity that results in problems of availability, accessibility, and quality amounts to a problem of cultural appropriateness. In the United States, obtaining healthcare can be so complicated that many people have trouble negotiating their way through the system, let alone choosing the most beneficial services from an array of “choices”. The bureaucratic requirements for obtaining care are not just burdensome and difficult: they create a system that is inappropriate for the American population.

The Bush Proposal fails to address this central failure of the U.S. health care system, and it exacerbates existing complexities by using the federal tax code as a vehicle for healthcare reform. Using the tax code in this way adds yet another layer of complexity on top of the already complicated healthcare system.

This increased complexity was illustrated by the challenge the Administration faced when it tried to explain exactly what the Proposal meant at a recent press conference. An Administration official used the following example:

Take a family earning \$60,000 in the 15-percent income tax bracket, 15-percent payroll tax bracket, if they are currently uninsured and they go buy insurance, under the current system it costs them \$5,200 today. Under this system in 2009, once it phases in, they get \$15,000 of compensation tax-free. They're paying 30 percent marginal tax rate on that, so that's \$4,500. That's a huge chunk of the cost of an insurance policy out there.¹⁵

¹⁵ Katherine Baicker. “Press briefing on: The President’s State of the Union Health Care Initiative,” by Julie Goon, Special Assistant to the President for Economic Policy, Katherine Baicker, Council of Economic Advisors. January 22, 2007.

This explanation is confusing because the official neglected to explain several of her underlying assumptions: that the family's income was from self-employment; that a family of four could obtain insurance for an annual payment of \$5,200; and that the family had no other adjustments to its income. The actual circumstances affecting individual tax payers and the impact of the deduction is thus impossible to predict under the Proposal because of the complexity of the tax code, the unique set of circumstances facing each taxpayer, and the complexity of the health insurance system.

Adding complexity to a system where bureaucratic burdens already create barriers to access, exacerbate problems of availability, and interfere with quality services, is a violation of international human rights standards. A human rights approach to healthcare requires that a healthcare system meet cultural, ethical, and educational standards appropriate for that society. Only a small minority of Americans is familiar with the detailed intricacies of the federal tax code and many millions have difficulty navigating our current health insurance system. Putting the two together creates an inappropriate system that causes more problems than it solves.

Conclusion

In the United States, the high cost of healthcare is cited as the primary reason many people in this wealthy country lack the most basic medical services. However, this reasoning overlooks the ways in which a profit-based industry may not be able to provide unprofitable services. Private health insurance may well have an important role to play in a new American healthcare system, but the primary goal of any healthcare reform should be about improving health, not about preserving a particular method of supplying insurance. Using international human rights to evaluate healthcare reform changes the terms of debate. Instead of being bogged down in philosophical and financial rhetoric about public versus private or single-payer versus multiple payer, human rights law focuses the discussion on one key question: Whether a proposed plan will increase the ability of more Americans to live healthier lives.

In the case of the Bush Proposal, this standard has not been met. The Proposal relies on unproven assumptions and complex approaches. Because of its explicit adoption of market mechanisms and its reliance on the tax code to curb costs, the Proposal does nothing to cover people who are currently uninsurable; nothing to bring the costs of insurance within the reach of the working poor; nothing to ensure that health care decisions are driven by a patient's best interests rather than by business exigencies; and nothing to minimize the complexity and proliferation of insurance plans. Because it does not address these problems, the Proposal fails to increase the availability, accessibility, quality or appropriateness of healthcare in the United States. Further, the Proposal fails to meet the procedural goals of international human rights law because it does not provide an opportunity for those affected by the plan to comment on its design and implementation. A human rights approach to health puts the focus back where it should be – on how to ensure the best possible health outcomes for the greatest number of people. The Bush Proposal's approach to healthcare reform does not use this standard as its measuring stick, and it therefore fails to meet the standards set out by the right to health.

Appendix: Healthcare in International Human Rights Law

Substance of the right

Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. Healthcare is a necessary component of the right to health.

Availability. Healthcare facilities must be sufficient to meet the needs of the population in urban and rural areas. They must also be able to function, meaning they need to have clean water, appropriate sanitation, and sufficient numbers of medical service providers.

Accessibility. Healthcare must be geographically, physically, and economically accessible for all persons. Accessibility requires non-discrimination, and it requires that people know *how* to access healthcare (i.e. have the information necessary to access healthcare).

Acceptability. All health facilities, goods and services must be respectful of medical ethics and be culturally appropriate.

Quality. As well as being culturally acceptable, healthcare must be scientifically and medically appropriate, according to both quantifiable and intangible measures.

Each of the above elements must be carried out in accordance with the following procedural requirements:

Participation. Any healthcare plan or service must be developed with the participation of the affected community.

Non-discrimination: any sort of discrimination is considered a human rights violation. Discrimination is explicitly prohibited on the basis of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status.

Information: patients and potential patients must have adequate information and education about potential health services

Access to remedy: when violations to the right to healthcare occur, a government must provide redress through civil or criminal penalties, or by seeking system-wide changes where appropriate.

International instruments pertaining to the right to health and healthcare

- Universal Declaration of Human Rights, Article 25
- International Covenant on Economic, Social & Cultural Rights, Article 12
- Convention on the Elimination of All Forms of Discrimination against Women, Article 12

- International Convention on the Elimination of All Forms of Racial Discrimination Article 5
- African [Banjul] Charter on Human and Peoples' Rights Article 16
- Constitution of the World Health Organization
- Agenda 21, Paragraph 6.12
- Copenhagen Declaration, Commitment 6
- Beijing Platform for Action, Paragraph 106
- The Cairo Declaration on Human Rights in Islam, Article 17
- Declaration of Alma-Ata, Article 1
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, 'Protocol of San Salvador', Article 10

About Uplift International



Uplift International's mission is to improve the well being of the world's most vulnerable populations by promoting the universal human right to health through education, advocacy, and humanitarian efforts. Uplift International views health through a human rights lens and human rights through a health lens.

Our Core Principles

- All people, regardless of economic or social status, have the right to access health information and services to improve their individual, family, and community health
- All people have the right to be free from the inequality, discrimination, or inadvertent neglect that adversely impacts health
- Local implementation of international human rights norms promotes social justice

Uplift International improves health and health equity through rights-based advocacy. We build relationships with professional associations, universities, and with health, law, local governments and business professionals. Our work is carried out through collaborative partnerships that build bridges among diverse groups to respect, protect, and fulfill the right to health for vulnerable populations.

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