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The International Framework on the Right to Healthcare: A Comparative Analysis with Special Reference to the United States

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Abstract

In today's society and government, the right to health is considered one of the basic human rights. These right guarantees everyone a clearly defined right to good health, based on the provisions in the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966). The international law of the right to health, including its substance, obligations and implementation, can be regarded as belonging to the field of international human rights law. Of particular interest is the USA where a particular type of healthcare system has emerged, a private and insurance-based system, far removed from the universal systems of western European countries like the National Health Service and France. The article takes a comparative perspective, and focuses on the consequences of the U.S. not ratifying ICESCR, as well as the fact that health rights are poorly recognized in the U.S. constitution. It also highlights that socioeconomic disparities, policy dysfunction and political division still stand in the way of fair access to health care. It, further, argues how the U.S. health care system could be brought into compliance with international human rights standards through such reforms as universal coverage, codification of the right to

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health and ratification of treaties on these issues.

Keywords: Right to health, International human rights, Healthcare law, ICESCR, United States healthcare system, Health equity, Social justice

1. Introduction: Understanding the Global Right to Healthcare

Today the right to health is one of the fundamental principles of human rights and global justice. It is more than confines of policy, economics and politics and is a human cry for all people to live a life of dignity, in good health, without want nor fear. The question of good health is one that affects everybody, and the right to it is an inalienable one, which is expressly based on the right to human life. But the idea of 'health as a right' is not an uncontested one and is not always fulfilled. It is a long progress which emerged from moral philosophy, was fostered by a political will and is proscribed in international law. The late 19th century witnessed a paradigm shift from a conception of 'health' as a result of medical treatment to one that encompassed a very expanded notion of access to medical care, clean environments, nutrition and social determinants affecting overall health.

The first milestone was set in the World Health Organization (WHO) Constitution of 1946 which defined the enjoyment of the highest attainable standard of health as one of the fundamental rights of every human being. It was an astounding statement at the time. It transformed the notion of the responsibility of the state from a charitable one to a duty. The WHO recognised that public health was more than about the health and well-being of an individual; it was about stability, economic development and peace, at the global level. The right to health was subsequently woven into the Universal Declaration of Human Rights (UDHR) that was adopted by the United Nations General Assembly in 1948, in Article 25 that states that everyone has the right to a standard of living adequate for the full enjoyment of life and its ways. This was a historical moment: for health was now a part of the language of universal human rights.

This moral involvement was then put on to a legal footing in 1966 in the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the ICESCR contains a clear commitment of the State Parties to the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health." It also outlines the states' obligations to maintain the health of mothers and children, to prevent disease and to make available the necessary medical treatment. In addition, CRC and CEDAW added the right to health to certain vulnerable groups. These instruments together created a world-wide setting, in which health is seen as a right – and a responsibility of governments to respect, protect and fulfil this right for all people. But, despite this good normative basis, the realization of the right to health has not been very uniform around the world. Lack of political will and institutional capacity and economic inequalities are ongoing challenges as illustrated by international pledges and domestic action gaps. This right is a reality because of poverty, inadequate health care systems and lack of access to basic health care in the Developing World. However,

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strangely, the right to health is still fractured and polarised even in many of the world's most prosperous countries. The most difficult and controversial case in point is the US. It is a country with second to none health care medical innovation, biotechnologies and research, but it is one of only developed countries with no constitutional protection of universal health coverage and no explicit health coverage.

The American health care system is very market oriented, with access to health care being largely dependent on private insurance and personal affluence. Unlike the National Health Service (NHS) in the U.K. and the publicly funded health care system in Canada, the health care system in the U.S. has been a mixture of private insurance companies and government programs, including Medicaid and Medicare, for some time. This concept has resulted in some extraordinary medical advances, and significant disparities. There are still millions of uninsured and underinsured Americans, and one of the highest costs of health care in the world. Non-universal access has been a source of continued debates on whether or not in this context the economy of the United States (U.S.) is complying with international human rights law's interpretation of the right to healthcare.

The American model is founded on individual liberty, limited government and a free market system. The argument to oppose the idea of health care as a “human right” has historically been based on this view. Healthcare has been a service or a commodity and not an entitlement in the U.S. This is a battle against international understanding, which is based on the UN conventions and WHO policy frameworks that put a health rights-based focus. The US played an important role in creating the post-war human rights regime, but significantly did not ratify the ICESCR such that it is not subject to international obligations directly under economic, social and cultural rights including health. From a legal perspective, this helps highlight the complicated relationship and tensions between domestic legal systems and international human rights.

It's interesting this divergence compared. If most of the population in a country does not have access to health services, how can they be said to have respect for human rights? How does U.S. law give no legal right to health care fit in with the principles of human rights in the world? What are the possibilities of transnational legal fields to shape or be shaped by the reform process, in a setting where health care services are mainly delivered through market oriented and profit-driven organisations? These are crucial questions which are being discussed in the current debate about health, law and justice. In addition to the conceptual, they are also very practical as they have highlighted gaps in health systems and how the world has reacted to health equity in many crises and international events, including the COVID-19 pandemic.

Because of the current pandemic in 2020, the idea of public health as a public good for the world is very clear. It also indicated that it had a link with the fundamental human rights of the right to life, equality and social security. The international reaction highlighted the importance of mutual collaboration, transparency and solidarity in establishing equitable access to health care resources. It also revealed the inequality within countries, especially between the rich and the poor country, in access to vaccines and health-care facilities. The pandemic has elevated the conversation about cost to a national level in the United States, as

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well as the issue of racial health inequities and the need for structural change. The developments have brought the United States' efforts to harmonize health policy and transnational human rights obligations to the fore of discussion once again. The right to health cannot be interpreted as a separate and distinct human right, but in connection with other human rights. It's part social and part legal construct, the product of political decisions, economic policies and cultural values. International law is the norm, national legislation and governance systems and civil practices are the essentials. The U.S. experience is so much a great educator on the pathologic characteristics of a country that can be a leader in major health access and equity health changes and still be sick in access, cost, and equity. It's a miniature version of the struggle between freedom and duty – this time between individuals and communities – that's become the debate in the world over what health care should be, a right and a privilege. In this context, in this article I aim to examine existing international legal precedents on the right to health in a more agnostic way and compare them with the

U.S. perspective. It aims to address: the development of the international law of the right to health; the duties of the state in relation to the right to health; and how this is or is not reflected in the recent U.S. policy. The paper will also examine the underlying philosophical, legal and institutional rationale of American exceptionalism and the impact of this outlook within the country and internationally in terms of equity, justice and cooperation.

Furthermore, the objective is to contribute to broader debate on global health governance in demonstrating how external actors, including WHO and the UN agencies, regional integration organisations facilitate country convergence of health rights. The article will then focus a comparison with other jurisdictions such as the UK, Canada and some European jurisdictions which have adopted rights-based health care systems which have worked and succeeded in the United States. This comparative perspective may also prove useful in the process of recognizing particular innovations in policy and law that might affect future policy and legal evolution in the U.S. health system.

Access to health care is not about public policy; it is about morality and justice and it is an integral part of a nation. This right, in a world of pandemics, environment and socio-economic inequalities without boundaries, points to our collective belief in justice and solidarity. This article aims to map a road to a more equitable and humane health paradigm in the twenty-first century by comparing the U.S. situation with international standards, and by reviewing international standards widely.

2. International Legal Framework on the Right to Healthcare

The international law on the right to health is considered one of the most impressive advancements in the development of international human rights law. It is a reflection of the international community's understanding that health plays a critical role in human dignity, social justice and sustainable development. In the 70 years since, a powerful system of treaties, conventions and declarations has enshrined the right to health as a universal and justiciable standard. This framework includes a state responsibility to take steps to achieve the full realization of the right of everyone to the highest attainable standard of physical and mental

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health. While country-level differences exist with respect to content, the international framework provides normative guidance for assessing and reforming national health policies (in countries like USA).

Origins of the international recognition of the right to health. The origins of international recognition of the right to health can be found at article 1 para 1, subpara f) WHO Constitution 1946. This document enshrined a revolutionary principle — that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.” The WHO Constitution not only reiterated the fact that health is a right, but also made it a mandatory duty of governments to achieve it through joint international efforts. In establishing health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” the preamble broadened what we mean by healthcare, moving it beyond medical care to address social determinants of health like living conditions, nutrition, and sanitation. Since then, WHO has been important in advancing a fair health distribution between countries by means of international health programs, technical assistance and policy advice.

The right to health was incorporated in the broader framework of human rights when the UN General Assembly adopted UDHR in 1948. “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care,” says Article 25 in the UDHR. This articulation’s emphasis on the universality of health and linkages with other social and economic rights as a dramatic shift in global governance. UDHR has turned right to health from a moral ideal into a legal obligation, by setting the moral and political tone during the drafting of legally binding human rights agreements.

The International Covenant on Economic Social and Cultural Rights (ICESCR) of 1966 provides the basis for international law on right to healthcare. Article 12 of the ICESCR affirms “the right of everyone to the enjoyment of...the highest attainable standard of physical and mental health.” It imposes on states some duties regarding reduction of infant mortality; improvement of environment in sanitation terms; the fight against diseases and illness, and securing health facilities for everyone. (3) The Committee on Economic, Social and Cultural Rights (CESCR), the body responsible for monitoring the implementation of the Covenant by its States-Parties, had issued a General Comment 14 (2000)— a landmark document that defines what’s included in the right to health: According to this comment, these four dimensions are availability: which means functioning public health and healthcare facilities, goods and services; accessibility: means participation in both medical treatment consumption and decision-making; acceptability said must be respectful of medical ethics; diversity and gender sensitivity); provides quality--as determined by an appropriate balanced services... with evidence based guidance). Those have as components that state shall ensure that there are sufficient health facilities and access to care; services must be culturally appropriate and scientifically proven. Importantly, in General Comment No.14 the CESCR determined that the right to health is one which demands progressive realisation; there are immediate obligations placed on states not to discriminate and to take steps with deliberate speed its implementation.

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The 1989 Convention on the Rights of the Child (CRC) explicates in more detail this right to health for children. Article 24 recognizes the child's right to health at the highest attainable standard and is to "take steps to reduce infant mortality and to ensure a balanced diet and to practice preventive medicine. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) also makes a powerful impact on women's health rights, addressing issues related to gender disparities in access to health services, maternal health and family planning. Addressing the right to health requires these instruments to be used in an inclusive and equitable development instrument which considers the needs of disadvantaged communities. In addition to treaty-based mechanisms, some declarations and world conferences have had an impact on the development of the international right to health. The Alma-Ata Declaration of 1978, which resulted from the International Conference on Primary Health Care, stated "Health for All" and drew the conclusion that primary healthcare is the road to health equity. The building blocks of a health policy were identified as community involvement, intersectoral cooperation and accessibility. This vision was reiterated in the Declaration of Astana (2018) which restated Primary Health Care as a basic approach to achieving Sustainable Development Goals (SDGs): SDG 3 "ensure healthy lives and promote well-being for all at all ages". Furthermore, the SDGs have reinforced the world's acceptance that health care is a prerequisite for human development and world peace, and that it is both affordable and of high quality.

In addition to the international human rights treaties, regional systems of human rights protection are another important avenue through which legal recognition is being reinforced. Explicit provisions on the right to health are included in the European Social Charter (1961), African Charter on Human and Peoples' Rights (1981) and Protocol of San Salvador (1988) under Inter-American system. These regional mechanisms have been successful in monitoring state compliance with judicial and quasi-judicial resolution, thereby increasing the enforceability of rights over health. For example, the European Committee of Social Rights has repeatedly construed Article 11 ESCR so as to oblige states to provide all inhabitants with access to healthcare on a non-discriminatory basis. Such regional jurisprudence provides an inspiration for operationalising principles in global treaties.

International law also recognizes that the right to health is an integral part of human rights and that they are inalienable and mutually dependent on one another. The right to the enjoyment of the highest attainable standard of physical and mental health was a dependent right, based on rights to food, housing, work, education and non-discrimination. The Human Rights Council and OHCHR have also reiterated this comprehensive interpretation, noting that states bear both negative obligations (not to deny or limit accesses to care) and positive obligations (to adopt measures to provide health care and address social determinants). The right to healthcare also generates interdependence duties between states, including financial, technical and policy support to each other (a standard which preferably would help marshalling states' efforts in response to global health crises or pandemics or vaccine distribution). The question, however, continues to be how these instruments can be transposed into domestic practice despite this sophisticated architecture. A wide-range of countries, including the United States, encounter

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legal and economic obstacles as well as ideological impediments to adopting a fundamental right to health care in domestic law. The U.S. has signed, but not ratified the ICESCR and therefore is not legally bound by Article 12. Within, the domestic law and constitutional structure do not explicitly acknowledge a fundamental right to healthcare, thus health care is considered accessible predominantly by market forces and legislative action. However, the majority of other developed countries, such as the UK, Canada and EU member states have already implemented legislation and established institutions consistent with their international responsibilities for universal health coverage. This split is indicative the concern that continues to characterize the exercise of global health norms and national sovereignty, a dynamic we analyse in greater detail later.

3. Comparative Analysis: Global Standards vs. the U.S. Healthcare System

Universal standards in the scope of right to healthcare at the international level define standards with regards to access, equality and non-discrimination. However, the extent to which these responsibilities are fulfilled is dependent on countries' political ideologies, constitutional traditions and socioeconomic designs. Despite being a leader in medicine, medical technology, biomedicine and innovation, the USA has an exception model very different from the one generally accepted internationally as a right to health. The American healthcare system is not just structurally and ideologically unique when compared to the healthcare systems of developed and other countries, but also has deep differences and implications for social justice, human rights enforcement and health equity.

i. Constitutional and Legal Context

- The conceptual framework examined the dichotomy of healthcare as a right and healthcare as a commodity. The conceptual framework explored was healthcare as a right versus healthcare as a commodity.
- A fundamental distinction between international human rights systems and the approach taken in the U.S. is the definition of health care.
- As declared by WHO Constitution, UDHR and ICESCR according to international law healthcare is a basic human right. This is the responsibility of States to respect, protect and fulfil through promoting equality of access to a health service, accessible, equitable and non-discriminatory.

The USA also views health care as a product of the market, and not something the citizens are entitled to in law. The government is only a payer of last resort in many cases (i.e. the ER) – access is primarily left to private insurance, employer coverage and personal means. The commoditizing logic suggests that the logic of the market should take over; that is, the logic of the state-protected entitlements should be reduced. The ideological origins of the split are in the American focus on individual freedom, small government and free market economy. This competition has brought about innovation and efficiency in some ways, but at the same time it has led to social injustice in that access to health care is based on wealth rather than universal human dignity.

ii. Constitutional and Legal Context

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The absence of a constitutional right to healthcare in the United States marks a significant point of departure from global human rights standards.

The “right to health” would require an even broader reading of the Constitution than a right to healthcare. Unlike most European and Latin American constitutions, the US Constitution does not contain provisions on social or economic rights (such as housing, jobs and education) besides those existing for civil and political rights (e.g. freedom of speech/religion), nor includes principles such as fundamental human dignity or social justice that are included in many other countries. The U.S. has signed, but not ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), and is thus free from legal requirements set forth in Article 12 on the right to health. This is illustrative of a broader suspicion of international human rights obligations that affirmations socio-economic responsibilities on the state. This limitation is also evident from the judicial precedents. U.S. courts have generally been reluctant to interpret the Constitution as protecting positive socioeconomic rights. In *Harris v. McRae* (1980), the Court found that there is no constitutional requirement to underwrite essential medical care for indigents, including abortions for poor women. Likewise, in *DeShaney v. Winnebago County* (1989), the Court stated that a State is not required to provide citizens with protections against private harms; further illustrating how there is no constitutional right to welfare.

- In contrast to this with countries like South Africa (Section 27), Brazil (Article 196) and India (as an interpretation of Article 21 by the judiciary) in which the right to health is provided formatively or interpretively as a justifiable constitutional right, giving impunity to individuals to hold their state responsible.
- Structure of the U.S. Healthcare System
- The American healthcare system is often described as a complex hybrid model that combines elements of public and private provision, but without universal coverage.
- The older you are, the richer or poorer you are and if you’re a child there’s Medicare, Medicaid and CHIP (Children’s Health Insurance Program).
- The 2010 Affordable Care Act (ACA) sought to provide coverage by requiring insurance and barring discrimination based on pre-existing conditions. Although it drastically reduced the number of uninsured, it failed to universalize health care.
- Corporate health insurers, corporations that sell private insurance policies to pay for American patient care, continue to be how the majority of Americans access healthcare. Premiums, deductibles and copays frequently keep care out of reach, especially for the middle and lower classes.

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iii. Structure of the U.S. Healthcare System

The American health-care system is often characterized as a hybrid, with both public and

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private elements, that lacks universal coverage.

- The older you are, the richer or poorer you are and if you're a child there's Medicare, Medicaid and CHIP (Children's Health Insurance Program).
- Under the 2010 Affordable Care Act (ACA), health insurance would be made available through the requirement for insurance, along with the prohibition on discrimination due to pre-existing conditions. It did lead to a dramatic decrease in the number of uninsured, but it did not universalize health care.
- Corporate health insurers, corporations that sell private insurance policies to pay for American patient care, continue to be how the majority of Americans access healthcare. Care is often unaffordable, particularly for the middle and lower classes, due to premiums, deductibles and copays.

In other countries such as the United Kingdom and Canada, a rights-based approach to universal health care has been adopted. The National Health Service (NHS) was created in 1948 to offer universal health care to all residents in the U.K. financed by general taxation without any out-of-pocket expense for the patient. A national health insurance program (Medicare), administered by the provinces and covering basic health care. They are grounded in the principle of human rights – universality, equity and solidarity – and are consistent with international human rights standards.

iv. Comparative Outcomes and Equity

When examined by the standards of the international AAAQ system (Availability, Accessibility, Acceptability and Quality), the U.S. system shows large gaps:

- Not all hospitals or medical technology in the U.S. is of the highest standard; availability is not equal around the country. Differences in access to doctors and hospitals, as too many in rural areas require care.
- Accessibility: Access is still primarily an economic issue. Millions of Americans continue to be uninsured or underinsured, despite the A.C.A.'s reforms. Medical debt is one of the biggest drivers of personal bankruptcy and the world's most expensive healthcare system.
- Although there is some mixed cultural competence in healthcare, there are disparities between racial/ethnic and gender health outcomes. These injustices were highlighted by the COVID-19 pandemic, particularly as it struck African-Americans, Hispanics and Native Americans at higher rates.
- Quality: Some areas have good medical care, but this is not necessarily true across the system. There are structural inequities: High quality care may be related to where you live as well as insurance status.

Those countries that adhere to international standards such as Sweden, Germany or Japan are more equitable. The right to health is achieved primarily through universal coverage, active state interventions and the provision of robust public health systems in these countries, with all of these being linked to improved population health outcomes – and lower cost per person.

v. Global obligations and international influence

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Though it has not yet ratified certain important health-related treaties, the U.S. has played a leading role in the formulation of global health policy. It is a founding member of the W.H.O., and one of the top contributors to international health programs, including PEPFAR (the President's Emergency Plan for AIDS Relief) and Gavi, the Vaccine Alliance. So these steps are a sign of the U.S. dedication to world health security, but it's paradoxical that America doesn't recognize healthcare as a human right at home.

International human rights observers have voiced a concern over this contradiction many times. UN Special Rapporteur on the Right to Health and the Universal Periodic Review (UPR) have urged the US to make its domestic policies more "conforming" with international standards; health care should be understood and enjoyed as a right and not a privilege. This is a federal culture, however, and America is extremely protective of states' rights, and quite suspicious of people in Washington telling them how they should cover their healthcare.

vi. Ideological and Political Barriers

Healthcare in the United States is influenced by entrenched interest groups, polarized ideology, and the influence of neoliberal economic values.

- Law making and policy making is very strongly influenced by pharmaceutical and insurance companies, who generally oppose systems without a profit focus.
- For decades, the issue of government's role in health care has divided Republicans and Democrats. The Democrats label it an extension of public coverage and public regulation whereas the Republicans say that it's a matter of responsibility and market solutions.
- Even public opinion itself is mixed: Although a majority of Americans say they are in favor in principle of universal coverage, worries about taxation and government domination, along with bureaucratic blundering, stand in the way.

These political and ideological obstacles set the U.S. apart from other countries in which cross-party agreement on health as a social right undergirds national health systems.

vii. Comparative Lessons from Global Models

International experiences provide lessons for the inclusion of U.S. healthcare policy in the principles of human rights:

- The UK's NHS demonstrates that high quality, efficient health care is possible in a universal, taxpayer-funded system.
- Canada: Single-payor design to achieve equity and cost containment and ensure the continued availability of private supplemental care.
- Federal Republic of Germany: Solidarity and competition in the social health insurance system via non-profit associations.
- The right to health is protected by the constitution in Brazil and South Africa, allowing courts to force states to fulfil their responsibilities and to hold governments to account.

These models show that if one recognizes the right to health, it is possible to be efficient and innovative, and that it's possible to have laws and ethics that ensure inclusivity and justice.

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4. Challenges in Implementing the Right to Health in the United States

It is a sort of irony in the human rights panorama, overall, that people in the US have the right to health. Still, it is one of the richest countries in the world, with cutting-edge medical technology, world class research institutions and the best health care system – yet it suffers from inequities in access to health care, prices that are much higher than in any other country, and massive health disparities. A condition frequently described as “technology rich and socially poor,” this American condition has resulted from the emphasis on innovation and specialization. To fully appreciate these challenges it is necessary to also understand the structural, legal, economic, and social impediments that prevent access to healthcare in the U.S.

A lack of a constitutional guarantee:

Most countries have a constitution which does recognize health as something that is a fundamental right, but there is no explicit constitutional guarantee in the U.S. Constitution of health care or the right to health. Rather, the healthcare issue is a policy one which can be addressed by legislation and the marketplace. The Supreme Court has consistently refused to read “right to health” into a more expansive “implied right to life”/“implied right to freedom of liberty” of the Fifth and Fourteenth Amendments. This gap in the Constitution has allowed policy makers to consider health care a commodity that can be purchased instead of a right that all citizens deserve and a void that has become an incomplete patchwork valuing personal responsibility over public good.

Market-Driven Healthcare Model

America's healthcare system is predominately a market-driven system, featuring private insurance companies, corporate hospitals and pharmaceutical companies at the forefront. Being able to afford insurance (and employment) is tied to the opportunity for medical care. That reliance on the market puts millions of Americans without any health insurance coverage or with insufficient coverage, so that they either don't seek medical care or delay their care. Most developed countries, such as the U.K. (via the National Health Service), Canada and Germany have publicly funded or single-payer health care systems that provide universal coverage, by contrast. The profit-driven U.S. model tends to put corporate interests ahead of patients, which makes this system contrary to the principle that health care should be available to everyone regardless of how much money they have.

Differential access to services and inequalities

Racial, income, geographic and gender based health disparities are deeply rooted in the United States. The Centers for Disease Control and Prevention (CDC) report that racial and ethnic minorities experience higher prevalence of chronic diseases, they are less likely to utilize preventive services, and they have worse health outcomes. Rifts are amplified when they are mediated by socioeconomic inequality – people in low-income households may not even be able to pursue low-cost insurance, leading to delayed diagnosis and missed treatment of diseases. The absence of a global system of health care fuels systemic injustices, contravening internationally protected principle of non-discrimination as set forth in Article 2 of the ICESCR as well as under Article 25 of the UDHR.

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Process of Balkanization of health policy and governance:

The US health care system is a sprawling and complex collection of actors, both federal, state, and private. The US healthcare system is split between multiple agencies including the Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS) and agencies at the state level. These are decentralized circumstances that result in qualified standards that are subject to variation, access via plan, and inefficiency in program administration. In the field of health, a lack of policy coherence undermines delivery of services and hampers our capacity to be equitable, and to address national emergencies, like COVID-19, effectively as a country.

Increasing Cost of Healthcare

The health spending of the United States is the highest per capita among all countries; yet, at the same time, the health outcomes are sometimes poor. Many cannot afford it due to high administration costs, drug pricing, and plan premiums. The ACA (2010) sought to alleviate some of these social challenges by expanding the availability of Medicaid, opening insurance exchanges and outlawing denial of insurance based on pre-existing conditions. Despite its progress, the ACA transformed health into an entitlement and made it a commodity on the market, with a clear distinction between access to health and access to care. Medical debt is one of the factors that continues to hold on as a major driver of personal bankruptcy in a country that imagines they don't have to worry about personal bankruptcy (which is a pretty good measure of the failure of the system from a human rights point of view).

Political polarization and Ideological resistance:

One of the biggest challenges to achieving the right to health in this country is political polarization. Whether health care should be a public or private matter has been hotly debated in American politics. While conservative beliefs put a focus on limited government and personal liberty, progressive beliefs focus on health care as a human right that should be provided for all. On this basis, comprehensive reforms that conform to human rights obligations have been held back by ideological differences. For example, even the relatively small step of expanding Medicaid has been resisted in the states, leading to millions of people without coverage. The more COVID partisans can do damage, the nature of healthcare gets damaged which means that drug policies and institutional arrangements for universal access all get reversed.

International Human Rights Instruments Limited Interaction:

The problem is also that there is a large scale reluctance to ratify or domesticate international treaties that recognise the right to health in the United States. The U.S. has ratified its commitment to the ICESCR, but it did not ratify the ICESCR, so the right to health is not directly legally enforceable in domestic courts at a federal level. But the U.S. government often claims that social and economic rights obligate citizens to act; this is not a constitutional standard. Therefore, the role of (international) human rights norms in decision-making processes on health policy at the domestic level is limited, resulting in a gap between international and domestic practice.

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Epidemics and System Vulnerability:

The vulnerability of the US healthcare system and its ability to sustain equitable health protection was showcased by COVID-19. The disparities in testing, treatment and vaccination revealed that social and economic systems have unequal inequities and barriers in place. Underfunded, Public Health had to be stretched thin to mobilize responses between states. The pandemic underscored the importance of recognizing that health care is a collective responsibility and not an individual effort, a fundamental tenet of the global norm of the right to health.

Pharmaceutical and Corporate Influence:

And corporate power in the U.S. health care system is a backward force as well. Pharmacy and private insurance carriers wield a tremendous amount of influence in policy making when the bottom line is more important than public health. As a result of these monopolies, the prices of certain important drugs are often higher than the free market price, access to these drugs is restricted and governments have limited capacity to control the cost. These are situations where the Committee on Economic Social and Cultural Rights in General Comment No. 14 have envisioned the violation of the principles of AAAQ (Availability, Accessibility, Acceptability and Quality).

5. Case Studies and Comparative Insights

An analysis of the health system in several legal orders provides an insight into the ways in which states ensure the right to health through a variety of regulatory and jurisdictional approaches. The experience of the countries that have applied the principles of universality, equity and accessibility (which have been included in international law) to their public health system also demonstrates this. Such case studies also offer insightful lessons for the US as it thinks through the best way to balance its market-based approach to healthcare/GHW with global human rights norms. The UK has one of the longest running rights based health care systems in any market. The National Health Service (NHS) was set up in 1948 and agreed that health care, particularly medical care, should be made generally available and provided free at point of delivery to all, regardless of income or social status. The NHS is paid for mainly by taxation, and is a public good and social responsibility, not a private commodity. This framework is harmonious with the ICESCR (establishing the positive duty of the State to ensure equal access to health) and the UDHR. Despite the lack of adequate funding and resources, the NHS remains committed to acting with an ethic of equality; that social and financial inequalities are not allowed to become a challenge to access – this is not the case in the U.S. model. Likewise, Canada's health care system (defined by the Canada Health Act 1984), is also dedicated to the right of access to necessary health care. Under a single payer system, the Canadian provinces deliver health care according to five core principles of public administration, comprehensiveness, universality, portability and accessibility. They are the principles that assure Canadians of access to medically necessary services at no cost, up front, to the individual. The Canadian analogue shows that national health services and a federal order of government are not mutually exclusive, with the national government setting policy

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guidelines and leaving to the provinces latitude in implementation. The Canadian case is a successful one not for the reasons of national certification of quality or for the idea of quality control, but because it places emphasis on local variation within a national framework for accountability and support, accompanied by an understanding that good health care is an expression of public generosity.

The World Health Organization (WHO) provides a benchmark on a global scale to help countries strive for Universal Health Coverage (UHC). as an integral part of Sustainable Development Goal 3, Good Health and Well-being. WHO calls for a basic level of health service availability to no one without financial hardship. Those middle-income countries that have adopted WHO's UHC model with success, such as Thailand and Brazil. The "30 Baht Scheme" in Thailand guarantees that everyone has access to basic services, such as health care, at a low cost, and Brazil's Unified Health System (SUS) provides health care coverage for over a quarter of the country's inhabitants. The cases illustrate that with political will, innovative financing and laws that promote human rights, a universal healthcare system can be a reality in resource-limited settings.

The United States is one of the few higher-income nations not to have universal health care. The experiences of U.K., Canada and WHO-led model make it clear that the achievement of the right to health relies not only on economic prosperity of the country, but primarily on the emphases of the policies, and political will blocks. It is entirely possible to have a rights based approach based on equity and universality as long as their governments see healthcare as one of their legal duties, not as one of their policy targets. For the United States, it would involve moving beyond our segmented insurance-based system to a universal one that assures every citizen's access to health care as its right, rather than a privilege.

6. Policy Recommendations

Constitutional Protection of the Right to Health

The US should make healthcare constitutional or at least make it explicit that healthcare is a right and not something that can be sold. If the right is acknowledged through the constitution, the government would have a constitutional obligation to provide the access to care.

International Covenant on Economic, Social and Cultural Rights:

The US has to ratify the International Covenant on Economic, Social and Cultural Rights (ICESCR) and other human rights conventions so that its domestic policies comply with international standards of law. It would be a small step toward having an increased international accountability, and a display of our nation's commitment to the universal right to health.

UHC Framework:

The U.S. should take small steps to achieve Universal Health Coverage (UHC) and provide access to care for everyone without imposing any financial hardship. This should be based on key principles of WHO's UHC approach, which include equity, financial risk protection, and integrated service delivery.

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Public Health Programs, Growth and Maturity:

Significant federal interventions like Medicare, Medicaid, and the ACA need to be made accessible to each resident regardless of income level, work status or immigration history. Growing these programs will help alleviate inequities and extend coverage to those uninsured.

Preventing high costs and low prices for drugs:

Costs must be brought down through more stringent pricing mechanisms on drugs, insurance premiums and hospital charges. A national health pricing commission to establish prices transparently is one solution that could help combat price gouging and help make essential medicines accessible to all.

Eliminating Health Disparities and Promoting Equity:

There will need to be specific policy to tackle racial, gender and socio-economic inequalities in health services. This includes strengthening health facilities in marginalized areas, improving cultural appropriateness in health education and ensuring that health care is not discriminatory in nature for anyone seeking treatment.

Implementation of a preventive/community-based healthcare approach:

The U.S. should also change its model from treatment-oriented to prevention-oriented and centered in the community.” Investing in primary health, strengthening the first tier of care and addressing social determinants (housing, nutrition and environmental health) will have greater holistic benefits.

Improvement of the Public Health Facilities

Resilience and access to care will require an increase in investments in hospitals, emergency care systems, rural clinics and telemedicine. The importance of national strategies and good public health preparedness has been emphasized during the COVID-19 pandemic.

Improve Accountability and Data Transparency

The terms of its reference should cover compliance with health standards, monitoring its performance and addressing grievances through a federal Health Rights Commission. Healthcare outcomes, costs and equity indicators should be collected transparently, enhancing the effectiveness of policies and trust in the public.

Public Awareness and Civic Participation

Education, media and civic campaigns to educate the public about health as a human right – a long-term reform. In this regard, it can be helpful to encourage citizenry participation to hold leaders to account and to be active in health policy processes to sustain democratic health governance.

7. Conclusion

The health right is also aligned with human dignity, social justice and economic development. The international community has recognized health as a fundamental right of every human being in instruments such as the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966). However, the

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right is realised in vastly different ways in different countries. As one of the world's most technologically advanced countries, the USA has a health care system that is both innovative and highly invested in, yet it is also behind the curve with regard to universal access to health care and equity.

Comparison of the global model with how the U.S. operates. Its comparison to international is illuminating in that while international law conceptualizes healthcare as a government duty with availability, accessibility and affordability, healthcare has topped reached market-based service for U.S. citizens. This has resulted in significant inequities and millions of Americans remain uninsured or underinsured. The Affordable Care Act was a positive step towards inclusiveness but has been insufficiently implemented and attacked by the politics. Countries with top-notch universal health care systems, on the other hand, such as the U.K., Canada, and many developed countries in Europe, show quantitatively how government intervention can be efficient, equitable and innovative.

For the US to come in line with international norms, it will take a change in thinking. It implies a legal right to health, greater scale of federal initiatives, control over drug and insurance prices, and a push against structural inequalities that affect vulnerable groups. In addition, accepting key international conventions like ICESCR would facilitate the creation of goodwill throughout the world and it would establish a system of accountability in the domestic governance.

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