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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

The human right to health is a fundamental principle in contemporary society and governance. Based on the provisions in the Universal Declaration of Human Rights (1948) and the International Covenant on Economic, Social and Cultural Rights (1966), these right guarantees everyone a defined entitlement to good health. The development and normative architecture of the international right to health, with particular attention to its contents, duties, and mechanisms for realization can be seen as concerned to the global human rights law. Of special interest is the US, where an particular kind of healthcare system— with a privatised, insurance-based model vastly different from universal systems found in western European nations such as National Health Service and France— has developed. Using a comparative approach, the article illustrates that distance between international commitments and domestic implementation, focusing on consequences of non-ratification of ICESCR by the U.S. and on the weak constitutional recognition of health rights therein. 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 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

The right to health has become one of the most fundamental cornerstones for human rights and global justice today. It goes beyond the parochial domains of policy, economics and politics and represents mankind's common longing that each person be able to lead a life with dignity, in good health, free from want and fear. At the core of this right is the recognition that good health cannot be a privilege of the well-to-do, but an issue for all people which explicitly arises from humane existence itself. The notion of health as a right has not been universally assumed nor consistently realized, though. That evolution has been slow, born in moral philosophy, fostered by political will and finally reflected in international law. The late 19th century saw a transition from a worldview in which 'health' was the product of medical intervention to that in which a universal right to health had very broad dimensions including access to medical care, clean environments, nutrition and social determinants impacting on overall well-being.

The World Health Organization (WHO) Constitution of 1946 laid the first major foundation by declaring that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being." This was a radical claim for its time. It changed the concept of state responsibility from one of charity to one of duty. The WHO understood that public health was not just about individual well-being, but a tool of global stability, economic development and peace. Subsequently, the right to health found its way into the Universal Declaration of Human Rights (UDHR), which was adopted by the United Nations General Assembly in 1948 as part of Article 25 and set forth that everyone has a right to an adequate standard of living that includes food, clothing, housing, medical care and necessary social services. This was a historic occasion: health had officially come into the language of universal human rights.

This moral engagement then became concretized as a legally enforceable commitment in 1966 under the International Covenant on Economic, Social and Cultural Rights (ICESCR). The ICESCR, in article 12, requires State Parties to recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." It also outlines state obligations to protect maternal and child health, prevent disease and provide access to necessary medical care. In addition, the CRC and CEDAW did extended the right to health for certain vulnerable populations. Together these instruments developed a global setting which defines health as a right - and corresponding obligation upon states to respect, protect and fulfil this entitlement for all individuals. Yet, despite such a strong normative base, the global

achievement of the right to health is extremely uneven. Gaps between international pledge and domestic action illustrate ongoing problems of political volition, economic inequality and institutional capacity. Poverty, weak health systems and inability to access simple care in the Developing World are responsible for this right not being a reality. Yet ironically, even in many of the world's wealthiest countries, the right to health is still divisive and fragmented. The US is the most difficult and controversial case in point. It is a nation whose medical innovation, biotechnologies and research in health care are second to none globally— yet it is one of the only developed nations without universal health coverage or an explicit constitutional protection for such.

The American healthcare system is characterized by its market-driven model, where access to care is heavily dependent on private insurance and personal financial capacity. Unlike the U.K.'s National Health Service (NHS), or Canada's publicly funded system, the U.S. has long operated on a private–public hybrid model where government programs like Medicare and Medicaid coexist with private insurance companies. This model has led to some extraordinary medical advances but also profound inequities. Millions of Americans are uninsured or underinsured, and we continue to have one of the highest healthcare prices in the world. Non-universal access has underwritten continuing tension regarding whether the United States, despite its economic wealth, satisfies obligations established by international human rights standards that accord healthcare services with an inclusive non-discriminatory conception of right.

The philosophical foundation of the American model is based on concepts of individual liberty, minimal state interventions, and a free market system. This view has traditionally been invoked to argue against the notion of health care as a "right" in the sense of human rights. In the U.S., healthcare has been treated by policymakers and judges as a service or commodity, not an entitlement. This is an ideological rift with the international consensus established through UN conventions and WHO policy frameworks that argue for a rights-based understanding of health. 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. This legal posture highlights the intricate alignment and divergences between U.S. domestic law and international human rights norms.

In comparative terms this divergence is interesting. Can a country act like it truly respects human rights if healthcare is not accessible to all of its citizens? How does the lack of legal right to health care in U.S. law undermine its adherence to global principles of human rights? To what extent can transnational legal spheres affect or serve as a source of inspiration for reform in settings where health care is primarily provided through market-based and profits-driven institutions? These are critical questions animating current discussions of the relationship between health, law, and justice. They are not only conceptual but also have significant practical consequences, as we witnessed during various global crises such as the

COVID-19 pandemic which revealed weaknesses in health systems and the global resolve on health equity.

The pandemic of 2020 made the point that public health is not contained within national borders; it is a global public good. It also confirmed that the right to health was interrelated with other human rights, including the right to life, equality and social security. The international response emphasised the need for co-operation, transparency and solidarity in creating fair access to healthcare resources. But it also exposed deep inequalities, notably between rich and poor countries in access to vaccines and health care infrastructure. In the United States, the pandemic reignited national conversations about costs in health care, racial disparities in health outcomes and urgent demands for structural change. These developments have reignited the conversation about harmonizing U.S. health policy and transnational human rights duties. The right to health care, then, cannot be viewed in isolated terms, but must rather be conceived as an element of a web of human rights. It's part social and part legal construct, the product of political decisions, economic policies and cultural values. International law is the normative basis, but the key lies in national legislation, governance regimes and societal practices. The U.S. experience is a powerful teacher about the pathologic features of a country that can pioneer great health care changes while falling sick in access, cost and equity. It is a microcosm of the tug-of-war between individual freedom and communal obligation that underpins the world's argument over whether healthcare should be considered as a right or as a privilege. In the midst of this context, in this article I seek to take a more critical approach to existing international legal precedent relating to the right to healthcare and contrast it with the U.S. perspective. It aims to examine how the human right to health has developed under international law, consider the obligations this right places on states, and assess the degree to which recent U.S. policy aligns with – or deviates from -- these standards. The paper shall also explore the deeper philosophical, legal and institutional reasons behind American exceptionalism and analyze the domestic and international consequences of this approach in equity, justice and cooperation.

In addition, the goal is to add to wider deb ate on global health governance by showing how international actors such as both WHO and UN agencies regional integration entities promote convergence of health rights across countries. The article will compare the United States to other jurisdictions, such as the UK, Canada and certain European countries that have successfully implemented rights-based systems of health care. This comparative perspective can be used to recognize particular policies and legal innovations that may influence future shifts in U.S. health policy and law.

The right to health care is not an issue of public policy, alone; it's a moral and legal obligation that serves as a defining characteristic of a country. In a global world with pandemics, environmental crises and socio-economic inequalities that know no borders, the recognition and realization of this right testifies to our collective conviction for justice and solidarity. By comparing the U.S. position with worldwide standards, and by considering

international standards broadly, this article seeks to chart a course to a more just and humanized health paradigm for the twenty-first century.

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 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 Constitution1946. 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.

The 1989 Convention on the Rights of the Child (CRC) explicates in more detail this right to health for children. Article 24 confirms the child's right to the best possible health and requires that states take actions to diminish infant mortality, provide healthy nutrition for children and practice preventive medicine. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) also strengthens women's health rights by confronting gendered disparities in access to medical services, maternal healthcare and family planning. These instruments stress the right to health must be applied within an inclusive and equitable system that takes into account the specific needs of disadvantaged communities. Apart from treaty-based mechanisms, several declarations and world conferences have also influenced the emergence of the international right to health. The Alma-Ata Declaration of 1978, produced at the International Conference on Primary Health Care, articulated "Health for All" and identified primary healthcare as the path to universal health equity. Community involvement, intersectoral cooperation and accessibility were identified as the foundation stones of a health policy. This vision was restated in the Declaration of Astana (2018), which reiterated Primary Health Care as a fundamental approach toward achieving the Sustainable Development Goals (SDGs)—specifically SDG 3 to "ensure healthy lives and promote well-being for all at all ages". In addition, the SDGs have strengthened the international consensus that access to affordable, quality healthcare is a pre-requisite for human development and world peace.

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 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

The scope of right to healthcare at the international level sets universal standards with regard to access, equality, and non-discrimination. But the degree to which states realize these obligations varies widely as a function of countries' political ideologies, constitutional traditions and socioeconomic designs. The US leads the world in medical technology, biomedicine and innovation, yet it offers an exception model so starkly different from international consensus on healthcare as a human right. Compared with the healthcare systems in developed and other nations, the American system does not only have structural and ideological uniqueness but also profound contrast and consequences for social justice, human rights observance, and health equity.

i. Conceptual Framework: Healthcare as a Right vs. Healthcare as a Commodity

At its most basic level, an important difference between global human rights systems and the model pursued in the United States has to do with how health care is understood.

- As declared by WHO Constitution, UDHR and ICESCR according to international law healthcare is a basic human right. This right is the duty of States to respect, protect and fulfill by promoting equality in access to health services that are universally accessible, equitable and non-discriminatory.

- The USA also considers health care as a commodity built on market principles, not as something that is legally due to its citizens. 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. This commoditizing logic implies that health care is guided more by market forces and less by state-protected entitlements.

The ideological origins of the split are in the American focus on individual freedom, small government and free market economy. Although this competition has fostered innovation and efficiency in some respects, at the same time it has created social injustice whereby access to health care is established by wealth status rather than universal human dignity.

ii. Constitutional and Legal Context

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.

iii. 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.

Elsewhere, countries like the UK and Canada have pursued rights-based universal healthcare systems. The U.K.'s National Health Service (NHS) provides universal health care to all residents at no out-of-pocket cost to the patient through general taxation, having been established in 1948. Canada's Medicare system, run by the provinces but universally covering essential medical services. They are consistent with international human rights standards based on the principles of universality, equity, and solidarity.

iv. Comparative Outcomes and Equity

When evaluated through the lens of the international AAAQ framework (Availability, Accessibility, Acceptability, and Quality), the U.S. system reveals substantial gaps:

- **Availability**: While the U.S. is home to top-notch hospitals and medical technology, access isn't equal across the country. Too much need for rural care Rural areas often lacks enough doctors and hospitals, reflecting differences in access.
- **Accessibility**: Access is still primarily an eco-nomic issue. Millions of Americans continue to be uninsured or underinsured, despite the A.C.A.'s reforms. Healthcare is the most expensive in the world, and medical debt is among the leading causes of personal bankruptcy.
- **Acceptability**: Despite evidence of mixed cultural competence in healthcare, there are racial/ethnic and gender disparities in 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**: Good medical care can be found in certain areas, however not consistent throughout the system. There are systemic inequities: High quality care can depend on insurance status and geography.

Countries that follow international norms like Sweden, Germany or Japan fare more equitably. These countries realise their right to health mainly through universal coverage, strong state intervention and robust public health infrastructure, which are all associated with better population health outcomes – and cheaper costs per person.

v. Global obligations and international influence

Despite the fact that it has not ratified some critical health-related treaties, the U.S. has been a leader in global health policy formulation. 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. These actions indicate the

U.S.'s commitment to global health security, yet paradoxically the country refuses to write healthcare into law as a domestic human right.

International human rights observers have voiced a concern over this contradiction many times. The UN Special Rapporteur on the Right to Health and the Universal Periodic Review (UPR) have called on the US to better align its domestic policies with international standards, arguing that healthcare should not be treated as a privilege, but rather a right. But America is a federal culture, and fiercely protective of states' rights and very suspicious of people in Washington dictating their healthcare to them.

vi. Ideological and Political Barriers

The political economy of healthcare in the United States is shaped by powerful interest groups, ideological polarization, and the deep entrenchment of neoliberal economic values.

- Pharmaceutical and insurance companies wield significant power over law-making and policy making, typically opposing centered systems that would reduce profit.
- The debate on the government's role in health care has split Republicans and Democrats along party lines for decades. Democrats call it an expansion of public coverage and regulation; Republicans argue for market-based solutions and individual responsibility.
- 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

Global experiences offer valuable lessons in aligning U.S. healthcare policy with international human rights principles:

- **United Kingdom:** The NHS shows that taxpayer-funded, universal health care is compatible with quality and efficiency.
- **Canada**: It has a single-payer model to ensure equity and cost containment while also allowing the continued existence of private options for supplemental care.
- **Federal Republic of Germany:** Solidarity and competition in the social health insurance system via non-profit associations.
- **Brazil and South Africa:** Both enshrine the right to health in their constitutions, which enables courts to compel states into discharging their obligations and to check governments.

Such models demonstrate that acknowledging the right to health is compatible with efficiency and innovation, while securing laws and ethics guaranteeing inclusivity and justice.

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

Realizing the right to health in the US represents something of an irony in the human rights context more generally. And yet it remains one of the wealthiest nations on earth with state-of-the-art medical technology and world-class research facilities and top health care

infrastructure, but also plagued by inequities in access to care, costs that are higher than any other nation and profound health disparities. This American condition is frequently referred to as technology rich and socially poor, meaning that the focus on innovation, specialization has been at the expense of basic health services being universally available. 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.

Absence of a Constitutional Guarantee

Most countries recognize health as a fundamental right in their constitutions, but the U.S. Constitution does not specifically guarantee either healthcare or the right to health. Instead, healthcare is a policy issue to be solved by legislation and the market. The Supreme Court has repeatedly declined to interpret the right to health as encompassed by a broader implicit right to life or liberty under the Fifth and Fourteenth Amendments. This void in the Constitution has enabled policy makers to treat healthcare as a thing which can be bought and sold rather than something for which all citizens are entitled, and in doing so have created an incomplete patchwork that values personal responsibility over public good.

Market-Driven Healthcare Model

America's health system is largely a market one, with private insurance companies, corporate hospitals and pharmaceutical firms front and center. Opportunity for medical care tends to come with the ability to pay for insurance (which is connected with employment). That dependence on the market leaves millions of Americans without health insurance or too little health insurance—leading them to delay seeking care or do without. By contrast, most developed countries — the U.K. (through its National Health Service), Canada and Germany among them — have publicly funded or single-payer systems that ensure universal access. 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.

Inequality and Disparities in Access

Racial, income, geographic and gender based health disparities are deeply rooted in the United States. Racial and ethnic minorities have higher prevalence of chronic diseases, less use of preventive services, and worse health outcomes, according to the Centers for Disease Control and Prevention (CDC). The rifts are deepened when filtered through socioeconomic inequality — those who live in low-income households can be discouraged from even attempting to get affordable insurance, resulting in delayed diagnoses and untreated 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.

Balkanisation of Health Policy and Governance

The US health care system is a vast and fractured constellation of federal, state, and private actors. Unlike countries with one-stop health ministries, the US healthcare system is segmented across various agencies such as the Department of Health and Human Services

(HHS), the Centers for Medicare and Medicaid Services (CMS) and state-level entities. These decentralized conditions contribute to qualified standards that vary, access by plan and inefficiency in program administration. A lack of policy coherence weakens the work of service delivery in health; it frustrates efforts to achieve equity, and it reduces our ability to respond as a country effectively to national emergencies such as COVID-19.

High Cost of Healthcare

The United States has the highest per capita health expenditures of any country, but its health outcomes are sometimes much worse. High administration costs, drug pricing and plan premiums make it financially prohibitive for many. 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. Yet even though it advanced, the ACA reduced health to an entitlement, putting it within the market and firmly separating access from care. Outrages over cost remain one of the components keeping medical debt in place as a leading cause of personal bankruptcy in an America that likes to think that it does not consider such things, which is a pretty good sign from a human rights perspective of system breakdown.

Political Polarization and Ideological Resistance

Political polarization represents one of the greatest obstacles to the realization of a right to health in this country. The question of whether healthcare is a public right or a private responsibility has been deeply divisive in American politics. Conservative views emphasize minimal government involvement and individual freedom, where progressive beliefs support healthcare as a human right that should be available to everyone. On this basis, comprehensive reforms that conform to human rights obligations have been held back by ideological differences. Even modest measures such as Medicaid expansion have been fought at the state level, resulting in millions of people being left 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.

On International Human Rights Instruments Limited Interaction with them

There is also a major obstacle in the reluctance for the United States to ratify or domesticate international treaties which enshrine the right to health. While the U.S. has ratified its agreement to the ICESCR, it did not ratify the treaty itself, which means that the right to health is not directly legally actionable at the federal level in domestic courts. The U.S. government frequently asserts that social and economic rights require citizens to take positive action—something at odds with its constitutional regime. Thus, (international) human rights standards have limited impact on domestic health policy decision-making leading to a discrepancy between global norms and national practices.

Epidemics and System Vulnerability

The vulnerability of the US healthcare system and its ability to sustain equitable health protection was showcased by COVID-19. Testing, treatment and vaccination disparities unveiled systemic inequities deeply embedded in social and economic structures. Public health

infrastructure, chronically underfunded, strained to organize responses across states. The pandemic highlighted the need to view healthcare as a collective responsibility that is not an individual strain — a core concept in the global framework 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 insurers have immense lobbying influence when it comes to policy decisions that puts profit before public health. These monopolies mean that drug prices are often higher than the free market price, access to critical medicines is limited, and governments have little ability to regulate costs. These are circumstances in the breach of AAAQ (Availability, Accessibility, Acceptability and Quality) principles as envisaged by Committee on Economic Social and Cultural Rights in General Comment No. 14.

5. Case Studies and Comparative Insights

A comparison of health systems in multiple legal orders sheds light on how states implement the right to health using diverse regulatory and jurisdictional mechanisms. The experience of countries like the UK, Canada and some World Health Organization (WHO) models also shows us how it is possible to put into practice the principles of universality, equity and accessibility – which have been enshrined in international law. Such case studies also shed light on crucial lessons for the US as it contemplates how best to reconcile market-oriented healthcare/GHW with global human rights norms. The UK is one of the longest established rights-based health care systems in any market. Established in 1948, the National Health Service (NHS) was founded on a general consensus that medical care should be delivered free at point of delivery and made generally available across the board to everyone irrespective of income or social status. Predominantly paid for through taxation, the NHS represents health as a public good and social responsibility rather than a private commodity. This framework is coherent with the UDHR and the ICESCR, which prioritize the obligation of the state to secure equal access to healthcare. Though underfunded and overcrowded, the NHS strives to be guided by an ethic of equality, with social and financial inequalities not being permitted to present a barrier to access – something that is only partially true 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. These are the underlying principles that guarantee all Canadian residents access free of direct charges at point-of-care to medically necessary services. The Canadian analogue shows that national health services and a federal order of government are not mutually exclusive, with the national government setting policy guidelines and leaving to the provinces latitude in implementation. The Canadian case is a successful one because of its emphasis on local variation within a framework of national accountability and support, linked to the recognition that good health care serves as an expression of public generosity. On a global spectrum, the World Health Organization (WHO) sets a standard by which nation states work towards Universal Health Coverage (UHC)

as an integral part of Sustainable Development Goal 3, Good Health and Well-being. WHO recommends that everyone should be able to obtain the health services they need without suffering financial hardship. Some middle-income countries, like Thailand and Brazil, have embraced WHO's UHC model with great success. Thailand's "30 Baht Scheme" ensures the entire population has affordable access to essential services, for example, and Brazil's Unified Health System (SUS) offers free health care coverage to more than 75% of its people. These cases suggest that where there is political commitment, progressive financing and human rights-enhancing legislation, universal healthcare can be a viable reality even in resource-poor environments.

In contrast, the US is one of the few higher-income countries without universal healthcare. The experiences of U.K., Canada and WHO-led model make it clear that achievement of the right to health is based not only on a country's economic prosperity, but mainly on the policy emphases and political will blocks. It is completely feasible for a rights-based approach linked to equity and universality when their governments understand healthcare as one of the legal obligations, not as a policy target. 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 constitutionalize or otherwise expressly acknowledge healthcare as a right in order to establish basic health services as a legal entitlement rather than something that can be commodified. Constitutionally acknowledging the right would establish a federal-state responsibility to ensure all citizens receive access to care.

The ICESCR and Other Main Treaties that have been Ratified

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.

Adaptation of a UHC Framework

The U.S. needs to move incrementally toward Universal Health Coverage (UHC) which would provide care for all in a way that does not impose financial hardship of any kind. This approach should be underpinned by WHO's key principles of UHC such as equity, financial risk protection, and integrated service delivery.

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. Expanding these programs would go a long way toward addressing disparities and bringing coverage to those left behind.

Controlling Medical Expenses and Drug Prices

More rigorous pricing controls on drugs, insurance premiums and hospital fees are essential to achieving reduced costs. One possible solution is the establishment of a national health pricing commission to make prices transparent; that would be an important step in preventing price gouging and ensuring equitable access to life-saving drugs.

Reducing Health Disparities and Achieving Equity

It will require targeted policy to address racial, gender and socio-economic disparities in healthcare access. This entails enhancing health infrastructure in disadvantaged communities, increasing cultural competence in medical education and guaranteeing non-discriminatory treatment for all patients.

Integration of Preventive and Community-Based Healthcare

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.

Enhancement of Public Health Infrastructure

Investment in hospitals, emergency care systems, rural clinics and telemedicine must increase for both resilience and access. The COVID-19 pandemic underscores the importance of national strategies, and strong public health preparedness.

Strengthening Accountability and Data Transparency

Its terms of reference should include ensuring compliance with health standards, performance monitoring and the handling of grievances through a federal Health Rights Commission. Transparent collection of healthcare outcomes, costs and equity indicators would improve policy effectiveness and public confidence.

Public Awareness and Civic Participation

Long-term reform requires education, media and civic campaigns to educate the public about health as a human right. Supporting citizenry participation to demand accountability and engage in health policy processes can be useful in maintaining democratic legitimacy of health governance.

7. Conclusion

The health right also converges with human dignity, social justice and economic progress. 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). But the right is implemented very differently from one country to another. The USA, as one of the most technologically advanced countries in the world, paradoxically has a health care system that is at the forefront of innovation and investment while lagging behind in terms of universal access to healthcare 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 led to profound disparities, leaving millions of Americans uninsured or underinsured. The Affordable Care Act was a step in the right direction to inclusivity, but its patchy roll out and political attack undermined its transformative potential. On the other hand, countries that have adopted world-class universal healthcare systems — think the U.K., Canada and numerous developed nations in Europe — quantitatively illustrate how government intervention is compatible with both efficiency, equity and innovation.

For the US to come in line with international norms, it will take a change in thinking. It means seeing health as a legal right, expanding the reach of federal programs, regulating the costs of pharmaceuticals and insurance, challenging structural inequities that harm vulnerable populations. Furthermore, acceding to important international conventions such as the ICESCR would not only help generate global goodwill but also institutionalize accountability in domestic governance.

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