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Health Care Refugees

Patricia C. Gunn
Ohio University

HEALTH CARE REFUGEES

Patricia C. Gunn†

Introduction

Developed nations[1] of the world have long helped refugees who have been forced to flee their homes because of natural disasters, wars, genocides, and other catastrophes. Developed nations should now consider giving special humanitarian protection to a new class of refugees: the "health care refugee". Life-threatening illnesses or injuries are no less pernicious than the aforementioned disasters to their victims, whose lives may be lost or irreparably damaged unless they receive help from those in a position to do so. When the victims of life-threatening illnesses or injuries live in a country that has the ability to give them life-saving medical care, and the government of that country refuses to provide the necessary health care, then the global community must address this deliberate threat to human life.

> [T]he state is obliged to provide a considerable array of protections for the life and personal security of all persons who fall under its jurisdiction .... [A] state that fails to provide basic law and order usually is respon-

† The author is a graduate of Boston College Law School. She practiced law at the United States Department of Justice in Washington, D.C. for eleven years; nine of those as a Senior Trial Attorney in the Office of International Affairs. She is currently an Associate Professor of Law in the Department of African American Studies at Ohio University.

[1] In theory, any country in the world could grant health care refugee status to any person who might seek such assistance. In practicality, however, only developed countries with strong economies and health care systems should be asked to accommodate health care refugees. For example, U.N. member states such as those comprising the G-8 might be called upon to grant "health care refugee" status to persons in need of such humanitarian protection. Canada, France, Germany, Italy, Japan, and the United Kingdom, all members of the G-8, have universal health care for their citizens. Furthermore, the G-8, of which the United States is a member, has taken a strong position on the importance of the universal access to health services. In the July 8, 2008 Toyako Framework for Action on Global Health, the G-8 Health Experts Group recommended to the leaders of the G-8, the following:

> 8. In addressing global health challenges, the human security perspective focusing on protection and empowerment of individuals and communities is critical, given that the health challenges directly affect human dignity and, in the words of the preamble to the World Health Organization Constitution, the right to the highest attainable standard of health, which is one of the fundamental human rights of every human being.
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> 11. Health systems are multi-dimensional. The international community should tackle various aspects of health systems such as the health workforce and human resources for health; health information; good governance; essential infrastructure; quality assurance; management of medical products and essential drug supply systems; and sustainable and equitable health financing of the health systems. **Aiming to work towards universal access to health services, the G8 emphasizes the importance of comprehensive approaches to address the strengthening of health systems including social health protection, and will work with partner countries to promote adequate coverage of recurrent costs in health systems.** (Emphasis added).

G8 Summit, Hokkaido Toyako Summit, Toyako, Japan, July 8, 2008, *Toyako Framework for Action on Global Health: Report of the G8 Health Experts Group*, ¶¶ 8, 11 [hereinafter Toyako Report].

> sible for violations of rights that they "merely" allow, through inaction, to occur.
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> The state, of course, is not obliged to protect every person against all possible threats to life or security. Denial of guaranteed access to health care, however, is neither an obscure nor an uncharted threat.[2]

In this article, "health care refugee" is defined as a person who lacks the means to pay for needed life-saving medical care and whose government refuses to provide the means for such care, despite having the financial, medical, and technical wherewithal to do so, and where said government's refusal is based on the person's race, ethnicity, religion, nationality, political opinion, or membership of a particular social or economic group. This definition both captures and expands the definition of refugee set forth in Article 1(A)(2) of the 1951 United Nations Convention relating to the Status of Refugees,[3] which applies to any person who:

> As a result of events occurring before 1 January 1951 owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it.

In later years it became clear to the international community that the term "refugee" as defined by the 1951 Convention relating to the Status of Refugees was too narrow, because there were many people inside and outside of war-torn Europe who had, become *de facto* refugees *after* January 1, 1951. In 1967, the world community acknowledged this in the preamble to the Protocol to the Convention relating to the Status of Refugees[4] and in Article 1 thereof.[5]

In this century, the world community has again recognized that the term "refugee" does not fully capture the status of persons who are displaced as a result of natural disasters, wars, genocides and other catastrophes that may cause persons to leave their country for equally forceful reasons. The community of nations, acting through the Office of the United Nations High Commissioner for Refu-

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[2] JACK DONNELLY, *International Human Rights and Health Care Reform*, *in* HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH, 134-35 (Audrey R. Chapman ed., Georgetown University Press 1994).

[3] Convention Relating to the Status of Refugees art. 1(A)(2), July 28, 1951, 189 U.N.T.S. 150.

[4] Protocol Relating to the Status of Refugees, Jan. 31, 1967, 606 U.N.T.S. 267.

[5] *Id.* art. I (expanding the definition of refugee to include persons who fall within the definition of Article 1 of the Convention but became refugees after January 1951).

gees[6] ("UNHCR"), has determined that "persons of concern" to the UNHCR include seven groups:[7]

> (a) refugees; (b) asylum-seekers; (c) internally displaced persons (IDPs); (d) refugees who have returned home (returnees); (e) IDPs who have returned home; (f) stateless persons; and (g) other people who do not fall under any of the above categories but to whom the Office extends its protection and/or assistance activities.[8] Two additional sub-categories have been added: (i) people in refugee-like situations (included under refugees); and (ii) people in IDP-like situations (included under IDPs).[9]

The UNHCHR has interpreted "refugees" to "include individuals recognized under the 1951 Convention Relating to the Status of Refugees; its 1967 Protocol; the 1969 OAU Convention Governing the Specific Aspects of Refugee Problems in Africa; those recognized in accordance with the UNHCR Statute; individuals granted complementary forms of protection;[10] or, those enjoying 'temporary protection.'"[11]

To grant a "health care refugee" some type of subsidiary protection[12] for medical treatment within a given developed country, would fall well within the meaning of "complementary protection". In this sense, complementary protection "refers to formal permission, under national law, provided on humanitarian grounds to persons who are in need of international protection to reside in a country, even though they might not qualify for refugee status under conven-

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[6] UNHCR – Basic Facts, http://www.unhcr.org/basics.html (last visited Nov. 10, 2008).

> The Office of the United Nations High Commissioner for Refugees was established on December 14, 1950 by the United Nations General Assembly. The agency is mandated to lead and coordinate international action to protect refugees and resolve refugee problems worldwide. Its primary purpose is to safeguard the rights and well-being of refugees. It strives to ensure that everyone can exercise the right to seek asylum and find safe refuge in another State, with the option to return home voluntarily, integrate locally or to resettle in a third country.

Id.

[7] Field Info. and Coordination Support Section (FICSS), Division of Operational Services at UNHCR, 2007 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons 4 (June 2008), http://www.reliefweb.int/rw/lib.nsf/db900sid/PANA-7FPK47/$file/UNHCR_jun2008.pdf?openelement [hereinafter Global Trends].

[8] *Id.* In addition to those who fall within the enumerated categories, UNHCR extends its protection or assistance activities to individuals whom it considers "of concern." *Id.* at 20. "These activities are based on humanitarian or other special grounds and might, for instance, include asylum-seekers who have been rejected, but who are deemed by UNHCR to be in need of international protection." *Id.* at 20.

[9] *Id.* at 4.

[10] "Complementary protection refers to formal permission, under national law, provided on humanitarian ground[s] to persons who are in need of international protection to reside in a country, even though they might not qualify for refugee status under conventional refugee criteria." *Id.* at 4 n.8.

[11] "Temporary protection refers to arrangements developed by States to offer protection of a temporary nature to persons arriving en masse from situations of conflict or generalized violence without the necessity for formal or individual status determination." *Id.* at 4 n.9.

[12] For example, in Council Directive 2004/83/EC of 29 April 2004, Council Directive, 2004/83, 2004 O.J. (L 304) 12, 13 (EC) [hereinafter Council Directive 2004/83/EC], the European Union had already begun to address "the situation of persons whose need of international protection can only be met by the attribution of subsidiary protection." Freedom Security and Justice–Asylum–Refugee Subsidiary Protection, The European Union Clarifies What it Means by Refugee and Subsidiary Protection, http://ec.europa.eu/justice_home/fsj/asylum/subsidiary/fsj_asylum_subsidiary_en.htm (last visited May 1, 2009).

tional refugee criteria."[13] For example, the European Union has adopted a directive[14] that allows its member states to grant subsidiary protection status to persons on three grounds:

1. Where there is a well-founded fear of torture, inhuman or degrading treatment or punishment;[15]
2. **Where there is a well-founded fear of violation of other human rights;**[16] and
3. In situations involving the mass influx of displaced persons, where a person establishes a well-founded fear for his or her life on an individual basis.[17]

Allowing a developed country the decision to grant "health care refugees" the opportunity to receive medical care on a case-by-case basis in that country should also come within the purview of conventional refugee criteria: A health care refugee is a person who lacks the means to pay for life-saving medical care and whose government has the means to provide medical care but refuses, for reasons of race, ethnicity, religion, nationality, political opinion, or membership of a particular social or economic group.

Methodology

Though a health care refugee could be of any nationality, for purposes of this paper, the concept will be examined through the lens of the American health care system[18] and focus on American citizens.[19] Because the United States government has willfully failed to provide adequate health care for its citizens for so long, many Americans who lack financial security have a well-founded fear of being left to suffer and die from serious illnesses or injuries, for the sole reason

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[13] GLOBAL TRENDS, *supra* note 7, at 4 n.8.

[14] Council Directive 2004/83/EC, *supra* note 12. The Directive's subsidiary protection provisions are consistent with the proposed provisions of the Commission from 2001. *Commission Proposal for a Council Directive on Minimum Standards for the Qualification and Status of Third Country Nationals or Stateless Persons as Refugees or as Persons Who Otherwise Need International Protection*, at 26-27, COM (2001) 510 final (Sept. 12, 2001).

[15] Council Directive 2004/83/EC, *supra* note 12, art. 15(a).

[16] *Id.* art. 15(b).

[17] *Id.* art. 15(c).

[18] The author is familiar with the health care system in the United States and can, therefore, best test her proposed theory by using this country as an example of one whose citizens might choose to seek health care refugee status.

[19] Citizens of the United States have given billions of dollars in foreign aid and charity to benefit people around the world since World War II. For example, American tax dollars have been used to fund: the U.N. Relief and Rehabilitation Administration, the Marshall Plan (a.k.a. the European Recovery Program), the North Atlantic Treaty Organization, President Truman's "Point 4" Technological Assistance Program, the U.S. Agency for International Development, many U.N. programs, and countless other programs. *See* Columbia Electronic Encyclopedia– Foreign Aid, http://www.infoplease.com/ce6/history/A0858180.html (last visited Aug. 18, 2009). Citizens of the United States have, for decades, given generously of their treasure, time, and lives to needy people around the world. In their season of need Americans too poor to buy life-saving medical treatment will, hopefully, receive help from their fellow human beings living in developed countries.

that they cannot afford to purchase needed medical care. While the United States Government provides health insurance for some Americans,[20] nearly forty-six million Americans have no health insurance.[21] Of those, approximately twenty-two thousand are too poor to buy health insurance, but too *rich* to qualify for a government sponsored insurance program, and will die for lack of adequate health care.[22]

The abandonment by the United States government of its citizens who are too poor to purchase medical care, who receive no health insurance coverage or too little coverage through their employers, or who earn too much to qualify for any of the government-sponsored health insurance programs is tantamount to persecution of a particular socio-economic group: low and middle-income Americans. Undoubtedly such hard working Americans would seek health care treatment in the United States were the government willing to provide them with such health care.[23] However, this group has no real expectation that such protection will become available to them in the foreseeable future, especially given the current financial crisis facing the United States.[24]

This paper proposes that health care refugees should be permitted to apply for health care refugee status to United Nations member states with developed economies. Because this concept is being examined through the lens of the American health care system, this paper examines a number of human rights treaties, the international law principle of *jus cogens,* and United States law to determine whether they provide a legal basis to support this proposal.

I. Health Care Background

People who can afford to buy medical services find some of the best physicians, medical facilities, and medical technology in the world in the United States. Unfortunately, American citizens who lack the financial resources to buy themselves quality health care discover that the United States health care system is ailing almost as much as they are.[25] The United States spends more on health

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[20] *See infra*, note 44 and accompanying text.

[21] *See infra*, note 47.

[22] *See infra*, note 86 and accompanying text.

[23] *See e.g.*, Puneet K. Sandhu, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151, 1154 (2007).

> Americans believe that access to health care should not be limited to those who can afford it, yet the federal government has not managed to ensure universal access to health care. Creating a judicially cognizable right to health care may effectively break the political stalemate and achieve universal access by requiring the government to take action. An affirmative legal obligation, either statutory or constitutional, to ensure access to health care (combined with judicial enforcement) would create the positive pressure needed to force the political branches to make the difficult decisions and compromises necessary to create a comprehensive health care system that they heretofore have proven reluctant to make.

[24] *See infra* note 58 and accompanying text.

[25] *See* Karen Davis et al., *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*, THE COMMONWEALTH FUND, May 2007, http://www.commonwealthfund.org/usr_doc/1027_Davis_mirror_mirror_international_update_final.pdf?section=4039. "The U.S. health system is the most expensive in the world, but comparative analyses consistently show the United States underperforms relative to other countries on most dimensions of performance." *Id.* at vii.

care than any other industrialized nation,[26] yet the United States ranks last among six OECD countries in a recent survey[27] comparing overall health outcomes[28] of patients.[29] Unless America's elected officials summon the political will and courage[30] to help all Americans who are uninsured,[3132] underinsured,[33] chroni-

[26] *See CR Investigates Health Care: Are You Really Covered?*, CONSUMER REP., Sept. 2007 [hereinafter CONSUMER REP.]. "The U.S. spends an average of $7,000.00 per capita on health care. According to a 2007 analysis by McKinsey Global Institute, that's 28 percent more than any other industrialized country, even after adjusting for its relative wealth." *Id.* at 19.

[27] Davis et al., *supra* note 25, at vii, 5. In a study of six Organization for Economic Cooperation and Development (OECD) nations—Australia, Canada, Germany, New Zealand, the United Kingdom, and the United States—the authors determined that in 2004 the United States spent $6,102 per capita on health expenditures, almost twice as much as Canada ($3,165), Germany ($3,005 - 2003), and Australia ($2,876 - 2003); almost 2.4 times as much as the U.K. ($2,546) and almost three times as much as New Zealand ($2,083). *Id.*

[28] *Id.* at viii, 4. "The U.S. ranks last overall across the five dimensions (Quality Care, Access, Efficiency, Equity, Healthy Lives) of a high performance health system." The overall rankings were: first, U.K.; second, Germany; Australia and New Zealand tied at 3.5; fifth, Canada; and sixth, United States. *Id.* at 4.

[29] Recipients of health care in the other five countries studied were all beneficiaries of universal health care systems. The United States is the only one of the six countries that does not provide universal health insurance coverage to its citizens. *Id.* at vii. "It is difficult to disentangle the effects of health insurance coverage from the quality of care experiences reported by U.S. patients." *Id.* at 22.

[30] *See* David Mechanic, The Truth About Health Care, Why Reform Is Not Working in America (Rutgers University Press 2006).

> At some point, we as a nation will have to decide whether we wish to design our health care system primarily to satisfy those who profit from it or to protect the health and welfare of all Americans. No one promises that achieving universal or higher quality health care will be easy or even that they are inevitable. But anything is possible if the public begins to appreciate how little it gets for what it really pays and [then] organizes politically to promote a health care system that is fairer, more inclusive, and offers more value for money.

Id. at 188.

[31] *Compare* Center for Disease Control and Prevention, Health Insurance Coverage, http://www.cdc.gov/nchs/fastats/hinsure.htm (last visited Nov. 11, 2008) (In 2007, the CDC estimated that 43 million (16.4%) of the population under age 65 were uninsured.), *with* U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2007, 27 (Aug. 2008), http://www.census.gov/prod/2008pubs/p60-235.pdf (The U.S. Census Bureau reported that in 2007 approximately 45.7 million (15.3%) of the population were without health insurance.) [hereinafter U.S. CENSUS BUREAU 2007]. This comparison is hereafter referred to as CDC v. Census Comparison.

[32] *See* J. Michael McWilliams, M.D. et al., *Use of Health Services by Previously Uninsured Medicare Beneficiaries,* 357 NEW ENG. J. MED. 143 (2007). The study found that:

> In this nationally representative longitudinal study, obtaining Medicare coverage at 65 years of age was associated with greater increases in doctor visits, hospital stays, and total medical expenditures for previously uninsured beneficiaries than for previously insured beneficiaries. Previously uninsured adults reported consistently greater use of health services and total medical expenditures after age 65 than previously insured adults with similar characteristics at ages 59 to 60 and comparable coverage after age 65. Self-reported use of health services for previously uninsured adults with cardiovascular disease or diabetes remained elevated through 72 years of age, indicating that the earlier lack of insurance was associated with persistent increases in health care needs rather than with transient spikes. These findings support the hypothesis that previously uninsured adults used health services more intensively and required costlier care as Medicare beneficiaries than they would have if previously insured.
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> . . . Our findings have important policy implications. Near-elderly adults who were uninsured required more intensive and costlier care in the Medicare program after the age of 65 years than previously insured adults who were otherwise similar at ages 59 to 60. Therefore, providing health insurance coverage for uninsured near-elderly adults may improve their health outcomes and reduce their health care use and spending after age 65. Particularly for those with cardiovas-

cally ill,[34] mentally ill,[35] aged,[36] or receiving disparate care[37] because of race,[38][39]

cular disease or diabetes, these benefits may be substantial and may partially offset the costs of expanding coverage. *Id.* at 149-51.

[33] *See* Cathy Shoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, HEALTH AFFAIRS WEB EXCLUSIVE, June 10, 2008, http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=688615.

> The number of underinsured U.S. adults [ages of 19-64] – that is people who have health coverage that does not adequately protect them from high medical expenses - has risen dramatically, a Commonwealth Fund study finds. As of 2007, there were an estimated 25 million underinsured adults in the United States, up 60 percent from 2003. Much of this growth comes from the ranks of the middle class. While low-income people remain vulnerable, middle-income families have been hit hardest. For adults with incomes above 200 percent of the federal poverty level (about $40,000 per year for a family), the underinsured rates nearly tripled since 2003.

Id.

[34] *See*, James S. Marks, "A chronic illness is a disease that has a prolonged course, does not resolve spontaneously, and rarely is completely cured. Typical examples include cancer, heart disease, diabetes, and arthritis. These illnesses are usually more common as a population ages. In the United States, as in most developed countries, chronic diseases account for approximately 70 percent of all deaths, and a similar proportion of all health care costs." Healthline, Chronic Illness, http://www.healthline.com/galecontent/chronic-illness (last visited Aug. 18, 2009).

[35] *See* National Alliance on Mental Illness, Grading the States 2006: A Report on America's Health Care System for Serious Mental Illness, http://www.nami.org/gtsTemplate.cfm?Section=project_Overview&Template=/ContentManagement/ContentDisplay.cfm&ContentID=30919 (last visited Aug. 18, 2009).

> This report is the first comprehensive survey and grading of state adult public mental healthcare systems conducted in more than 15 years. . . . The report confirms in state-by-state detail what President Bush's New Freedom Commission on Mental Health called a fragmented "system in shambles." Nationally, the system is in trouble. Its grade is no better than a D. *Id.*

[36] "The first U.S. Baby Boomers [people born between 1946 and 1964] will turn 65 in 2011, inaugurating a rapid increase in the older population during the 2010 to 2030 period. The older population in 2030 is projected to be double that of 2000, growing from 35 million to 72 million." *See* WAN HE ET AL., U.S. CENSUS BUREAU, 65+ IN THE UNITED STATES: 2005, 12 (U.S. Gov't Printing Office 2005), http://www.census.gov/prod/2006pubs/p23-209.pdf.

[37] *See* Joan Redmond Leonard et al., *Health Disparities: A Selected Bibliography from the National Center for Chronic Disease Prevention and Health Promotion, January 2000-January 2005* (March 2005), http://www.cdc.gov/nccdphp/publications/healthdisparities/pdf/biblography.pdf. There is reason to hope that disparities in health care might someday be eliminated, since that "is an overarching goal of the *Healthy People 2010* national public health agenda and . . . a top priority for the Centers for Disease Control and Prevention (CDC)." *Id.* at vi.

[38] *See* Vickie L. Shavers & Brenda S. Shavers, *Racism and Health Inequity Among Americans*, 98 J. NAT'L MED. ASS'N 386, 386 (2006). "Racial/ethnic minorities suffer disproportionate morbidity and mortality from chronic diseases, such as cancer, heart disease, diabetes, and stroke." *See also* Junling Wang et.al., *Disparities in Access to Essential New Prescription Drugs between Non—Hispanic Whites, Non-Hispanic Blacks, and Hispanic Whites*, 63 MED. CARE RES. & REV. 742, 758 (2006). "[The] findings concur with previous work by Mayberry, Mili, and Ofili (2000), which found that while racial and ethnic groups frequently do not have the same access to services, access appears to be particularly problematic for blacks." *Id.* at 758. *See also* DAVID M. SATCHER, *Securing The Right To Healthcare and Well-being, Introduction* to THE COVENANT WITH BLACK AMERICA 3 (Third World Press 2006).

> [I]f we had eliminated disparities in health in the last century, there would have been 85,000 fewer black deaths overall in 2000. Among others, these include: 24,000 fewer deaths from cardiovascular disease; 4,700 fewer black infant deaths in the first year of life; 22,000 fewer deaths from diabetes; and almost 2,000 fewer black women would have died from breast cancer. *Id.*

See generally, David Barton Smith, *Eliminating Disparities in Treatment and the Struggle to End Segregation*, THE COMMONWEALTH FUND, Aug. 2005, http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2005/Aug/Eliminating-Disparities-in-Treatment-and-the-Struggle-to-End-Segregation.aspx (concluding that segregation in the health care system increases the cost and reduces the quality of care for everyone and suggesting four strategies for reducing racial, ethnic, and economic disparities in treatment).

or ethnicity, then increasing numbers of Americans will suffer health care persecution primarily because of their socio—economic status.[40]

The United States is a great country and we are a good people.[41] Yet, our elected representatives allow millions of low and middle-income Americans to live on the brink of medical and financial disaster[42] by failing to provide all Americans with an adequate level of health care. While most Americans[43] do have some type of health insurance,[44] either private[45] or public,[46] a survey by the U.S. Census Bureau reported that in 2007 approximately 45.7 million people,

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[39] For an excellent on-line tutorial on this topic see Cara James, *Race, Ethnicity and Health Care*, http://www.kaiseredu.org/tutorials/REHealthcare/player.html (last visited Aug. 18, 2009).

[40] *See* Davis et al., *supra* note 25, at 18. "The Institute of Medicine defines equity as 'providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and *socioeconomic* status.'" *Id.* (emphasis added).

> The U.S. ranks last on all the access to care measures and, as a result, ranks a clear sixth [when compared with Australia, Canada, Germany, New Zealand, and the United Kingdom] on all measures of equity. Americans with below-average incomes were much more likely than their counterparts in other countries to report not visiting a physician when sick and not getting a recommended test, treatment, or follow-up care, not filling a prescription, or not seeing a dentist when needed because of costs. On each of these indicators, more than two-fifths of lower-income adults in the U.S. said they went without needed care because of costs in the past year.

Id. at 20.

[41] French lawyer, historian, and politician Alexis de Tocqueville is credited with having said, "America is great because she is good. If America ceases to be good, America will cease to be great." One wonders how much longer we can consider ourselves to be good if we stand by and watch millions of our fellow Americans suffer physically, mentally, emotionally and financially, and in some instances, die, because they have no health insurance or because they are underinsured.

[42] *See* David U. Himmelstein et al., *MarketWatch: Illness and Injury As Contributors To Bankruptcy*, HEALTHAFFAIRS.ORG, Feb. 2, 2005, *available at* http://www.silverbankruptcy.com/images/Harvard.pdf (last visited Aug. 18, 2009). Some of the study's findings are included in the article's abstract:

> In 2001, 1.458 million American families filed for bankruptcy. To investigate medical contributors to bankruptcy, we surveyed 1,771 personal bankruptcy filers in five federal courts and subsequently completed in-depth interviews with 931 of them. About half cited medical causes, which indicates that 1.9–2.2 million Americans (filers plus dependents) experienced medical bankruptcy. Among those whose illnesses led to bankruptcy, out-of-pocket costs averaged $11,854 since the start of illness; 75.7 percent had insurance at the onset of illness. Medical debtors were 42 percent more likely than other debtors to experience lapses in coverage. Even middle-class insured families often fall prey to financial catastrophe when sick. *Id.* at 1.

[43] "The number of people with health insurance increased to 253.4 million in 2007 (up from 249.8 million in 2006)." *See* U.S. CENSUS BUREAU 2007, *supra* note 31, at 19.

[44] Most people have private health insurance, "provided through an employer or union or purchased by an individual from a private health insurance company," or Government-sponsored insurance. *See* U.S. Census Bureau, Health Insurance, http://www.census.gov/hhes/www/hlthins/hlthinstypes.html (last visited Nov. 9, 2009). The U.S. Census Bureau's Current Population Survey (CPS), defines the following eight types of Government-sponsored health insurance programs:

which represents 15.3 percent of the population, were without health insurance.[47] Of that number, approximately 20.5 million non-Hispanic Whites and 14.8 million Hispanics were uninsured,[48] while approximately 7.4 million Blacks were without insurance.[49] It is alarming to note that of the nearly 46 million Americans who were without health insurance in 2007, approximately 8.1 million were

Government Insurance Program	Type of Coverage
Medicare	Federal program - helps pay health care costs for people 65 and older and for certain people under 65 with long-term disabilities.
Medicaid	Program administered at the state level - provides medical assistance to the needy. Families with dependent children, the aged, blind, and disabled who are in financial need are eligible for Medicaid. It may be known by different names in different states.
State Children's Health Insurance Program (SCHIP)	Program administered at the state level - provides health care to low-income children whose parents do not qualify for Medicaid. SCHIP may be known by different names in different states.
Civilian Health and Medical Program of the Uniformed Services (TRICARE/CHAMPUS)	Military health care program for active duty and retired members of the uniformed services, their families, and survivors.
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)	Medical program through which the Department of Veterans Affairs helps pay the cost of medical services for eligible veterans, veteran's dependents, and survivors of veterans.
Department of Veterans Affairs (VA)	Provides medical assistance to eligible veterans of the Armed Forces.
State-specific plans	Some states have their own health insurance programs for low-income uninsured individuals. These health plans may be known by different names in different states.
Indian Health Service (IHS)	Health care program through which the Department of Health and Human Services provides medical assistance to eligible American Indians at IHS facilities. In addition, the IHS helps pay the cost of selected health care services provided at non-IHS facilities.

[45] *See* Jonathan Cylus & Gerard F. Anderson, *Multinational Comparisons of Health Systems Data, 2006*, THE COMMONWEALTH FUND, May 2007, http://www.commonwealthfund.org/Content/Publications/Chartbooks/2007/May/Multinational-Comparisons-of-Health-Systems-Data—2006.aspx.

> The United States spent over 17 times more than the median OECD [Organization for Economic Cooperation and Development] country on PRIVATE HEALTH CARE SPENDING (excluding out-of-pocket spending). While private health insurance coverage is the most common source of health insurance coverage in the United States, in other countries private insurance is usually supplementary to public insurance coverage. Out-of-pocket spending per capita in the United States was more than twice as high as in the median OECD country.

Id. at 8 (emphasis added).

[46] "Among all OECD countries, the United States had the highest level of spending from PUBLIC SOURCES in 2004. This is somewhat surprising because only one quarter of all Americans have publicly financed health insurance." *Id.* (emphasis added).

[47] *See* U.S. CENSUS BUREAU 2007, *supra* note 31, at 20.

[48] *Id.*

[49] *See* U.S. Census Bureau, Health Insurance Coverage: 2007, http://www.census.gov/hhes/www/hlthins/hlthin07/hlth07asc.html (last visited Aug. 18, 2009).

children.[50] In other words, one of every five uninsured Americans is a child,[51] and that is even with the State Children's Health Insurance Program.[52] Sadly, even amongst Americans who are fortunate enough to have health insurance, many are underinsured.[53] Being without insurance[54] or being underinsured can have seriously adverse financial[55] and medical consequences.[56]

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[50] *See* U.S. CENSUS BUREAU 2007, *supra* note 31, at 28. The CDC reports that 8.9 million children under age 18 were uninsured in 2007. *See also* CDC v. Census Comparison, *supra* note 31.

[51] For an excellent discussion of the "often-overlooked fact that [o]ne out of every five uninsured Americans is a child," *see* FAMILIES USA, NO SHELTER FROM THE STORM: AMERICA'S UNINSURED CHILDREN, CAMPAIGN FOR CHILDREN'S HEALTH CARE (Sept. 2006), http://www.familiesusa.org/assets/pdfs/campaign-for-childrens-health-care/no-shelter-from-the-storm.pdf.

[52] The Balanced Budget Act of 1997, Title XXI State Children's Health Insurance Program (SCHIP), PL 105-33, H.R. 2015, 105th Congress (1997). SCHIP is "jointly financed by the Federal and State governments and administered by the States." Centers for Medicare & Medicaid Services, Low Cost Health Insurance For Families and Children, http://www.cms.hhs.gov/LowCostHealthInsFamChild/ (last visited Feb. 25, 2009). In 2008, SCHIP provided health insurance coverage to approximately 7.4 million low-income children whose families earned too much to be eligible for Medicaid and were unable to afford private insurance. Centers for Medicare & Medicaid Services, CHIP Ever Enrolled Graph, http://www.cms.hhs.gov/NationalCHIPPolicy/downloads/CHIPEverEnrolledYearGraph.pdf (last visited May 1, 2009). In February 2009, President Barack Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (previously known as SCHIP). The Act will finance the Children's Health Insurance Program (CHIP) through FY 2013.

[53] A survey conducted by Consumer Reports National Research Center in May 2007, sampled 2,905 Americans between ages 18 and 64. The survey found evidence that middle-income Americans are increasingly underinsured. The survey showed that, "the median household income of respondents who were underinsured was $58,950, well above the U.S. median; 22 percent lived in households making more than $100,000 per year." CONSUMER REP., *supra* note 26, at 17-18.

[54] *See* SHARON K. LONG & JOHN A. GRAVES, URBAN INST., WHAT HAPPENS WHEN PUBLIC COVERAGE IS NO LONGER AVAILABLE?, 6 (Jan. 2006), http://www.kff.org/medicaid/upload/7449.pdf. The uninsured have higher rates of morbidity and mortality, are less likely to have prevention service, and generally receive less care. *Id.* at 6. These results yield negative economic impacts on their communities: higher job absenteeism rates; lost productivity; and strain on local heath care systems. *Id.* at 6.

[55] Himmelstein et al., *supra* note 42, at 9-10. Four policy implications result from their findings:

> 1) [E]ven brief lapses in insurance coverage may be ruinous and should not be viewed as benign. While 45 million Americans are uninsured at any point in time, many more experience spells without coverage. We find little evidence that such gaps were voluntary. Only a handful of medical debtors with a gap in coverage had chosen to forego insurance because they had not perceived a need for it; the overwhelming majority had found coverage unaffordable or effectively unavailable.
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> . . ..
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> 2) [M]any health insurance policies prove to be too skimpy in the face of serious illness. We doubt that such underinsurance reflects families' preference for risk; few Americans have more than one or two health insurance options. Many insured families are bankrupted by medical expenses well below the "catastrophic" thresholds of high-deductible plans that are increasingly popular with employers.
>
> . . ..
>
> 3) [E]ven good employment-based coverage sometimes fails to protect families, because illness may lead to job loss and the consequent loss of coverage. Lost jobs. . .also leave families without health coverage when they are at their financially most vulnerable.
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> . . ..
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> 4) [I]llness often leads to financial catastrophe through loss of income, as well as high medical bills. Hence disability insurance and paid sick leave are also critical to financial survival of a serious illness.

[56] "A new study commissioned by the Kaiser Family Foundation and . . . featured in the March 14, 2007, *Journal of the American Medical Association* . . . documents that people who are uninsured receive

With more low and middle-income Americans suffering financial hardship[57] it will be increasingly difficult for them to purchase health insurance and medical care. With our country facing trillions of dollars in debt,[58] and with an ailing health care system[59] that will only increase the debt, it is time for the United States Congress, the medical community, the legal profession, and the American public to begin working together to overhaul the existing health care system[60] and start afresh.[61] Until that happens, however, low and middle-income Americans who cannot afford to buy life-saving medical care in the United States and who do not qualify for help pursuant to any governmental program, should be

less care and have worse outcomes following an accident or the onset of a new chronic condition than those with insurance." Kaiser Commission on Medicaid & the Uninsured, Lesson Shows Uninsured Receive Less Care and Experience Worse Outcomes, Mar. 14, 2007, http://www.kff.org/uninsured/kcmu031407oth.cfm.

57 *See* DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS, GROWING UNEQUAL? INCOME DISTRIBUTION AND POVERTY IN OECD COUNTRIES (OECD Oct. 2008), *available at* http://www.oecd.org/dataoecd/47/2/41528678.pdf (last visited Aug. 18, 2009).

> The United States is the country with the highest inequality level and poverty rate across the OECD, Mexico and Turkey excepted. Since 2000, income inequality has increased rapidly, continuing a long-term trend that goes back to the 1970s. . . . Rich households in America have been leaving both middle and poorer income groups behind. This has happened in many countries, but nowhere has the trend been so stark as in the United States. . . . The distribution of earnings widened by 20% since the mid-1980s, which is more than in most other OECD countries. This is the main reason for widening inequality in America.

Id. at Country Note: United States.

58 The General Accountability Office (GAO) calculates that the United States has "major fiscal exposures" totaling approximately $52.7 trillion dollars. *See* Major Fiscal Exposure, http://www.gao.gov/special.pubs/longterm/1207fiscal_exposures.pdf (last visited Feb. 25, 2009). Furthermore, the GAO has concluded that:

> [C]urrent fiscal policy is unsustainable over the long term. Absent reform of federal retirement and health care programs for the elderly - - including Social Security, Medicare, and Medicaid - - federal budgetary flexibility will become increasingly constrained. Assuming no changes to projected benefits or revenues, spending on these entitlements will drive increasingly large, persistent, and ultimately unsustainable federal deficits and debts as the baby boom generation retires.

See The Nation's Long-Term Fiscal Challenge, http://www.gao.gov/special.pubs/longterm/challenge.html (last visited Feb. 25, 2009).

59 *See generally*, DONALD L. BARLETT & JAMES B. STEELE, CRITICAL CONDITION: HOW HEALTH CARE IN AMERICA BECAME BIG BUSINESS AND BAD MEDICINE (Doubleday, New York, 2004). After detailing myriad causes that have resulted in the critical condition of the U.S. health care system, the authors explain that, "[i]t is really no system at all. Rather it's a stunningly fragmented collection of businesses, government agencies, health care facilities, educational institutions, and other special interests wasting tens of billions of dollars and turning the treatment of disease and sickness into a lottery where some losers pay with their lives." *Id.* at 235-36.

60 *Id.* at 237. Barlett & Steele propose the following:

> The simplest and most cost-effective remedy would be to provide universal coverage and to create one agency to collect medical fees and pay claims. This would eliminate the staggering overlap, duplication, bureaucracy, and waste created by thousands of individual plans, the hidden costs [of which] continue to drive health care out of reach for a steadily growing number of Americans. Under a single-payer system, all health care providers – doctors, hospitals, clinics – would bill one agency for their services and would be reimbursed by the same agency. Every American would receive basic comprehensive health care, including essential prescription drugs and rehabilitative care. Any one who needed to be treated or hospitalized could receive medical care without having to wrestle with referrals and without fear of financial ruin. Complex billing procedures and ambiguities over what is covered by insurance would be eliminated.

61 "Consumers Union, the nonprofit publisher of Consumer Reports, believes that any reform should ensure that financial barriers don't stop people from getting the care they need and that the U.S. should move rapidly toward a system that makes clinical decisions based on scientific evidence instead of profit and [that] moderates health-care cost inflation." *See* CONSUMER REP., *supra* note 26, at 20.

permitted to seek "health care refugee" status from developed countries that are willing to provide them with needed health care treatment they cannot afford to buy in the United States.

II. Legal Issues

This section will examine certain U.N. treaties[62] to determine whether they create a legal right to health care and, if so, whether the U.N. treaties[63] are binding on the United States. This section will also examine United States law to determine whether United States citizens may use an international treaty as a basis for requiring the United States Government to provide an adequate level of health care to all its citizens.

A. Human Rights Treaties Encompassing the Right to Health Care[64]

There are a number of U.N. human rights treaties encompassing the right to health care,[65] some of which the United States has signed and ratified, others of which we have signed, but not ratified. There are also some treaties the United States has neither signed nor ratified.[66] Additionally, even though they are not treaties, there are many international declarations and standards relevant to health and human rights to which the United States may in theory be bound, because

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[62] *See* Vienna Convention on the Law of Treaties art.2-1(a), May 23, 1969, 1155 U.N.T.S. 331, *available at* http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf [hereinafter Vienna Convention] (defining a "treaty" as "an international agreement concluded between States in written form and governed by international law, whether embodied in a single instrument or in two or more related instruments and whatever its particular designation.").

[63] In addition to U.N. treaties addressing the right to health care, there are declarations, regional agreements, and national constitutions that recognize health care as a fundamental human right. *See, e.g.*, European Social Charter arts. 11,13, Feb. 26, 1965, 529 U.N.T.S. 89; African Charter on Human and Peoples' Rights art. 16, June 27, 1981, 21 I.L.M. 58; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights art. 10, Nov. 17, 1988, 28 I.L.M. 156.

[64] *See* Stephen D. Jamar, *The International Human Right to Health,* 22 S.U. L. REV. 1 (1994) (discussion of health care as a human right).

[65] Numerous U.N. human rights treaties and conventions subsume health care rights: U.N. Charter art. 55; International Convention on the Elimination of All Forms of Racial Discrimination art. 5, para. (e)(iv), Dec. 21,1965, 660 U.N.T.S. 195; International Covenant on Civil and Political Rights art. 22, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR]; International Covenant on Economic, Social & Cultural Rights art.12, Dec, 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR]; Convention on the Elimination of all Forms of Discrimination Against Women, G.A. Res. 34/180, ¶ 12, U.N. Doc. A/34/46 (Dec. 18, 1979); Convention on the Rights of the Child, G.A. Res. 44/25, ¶ 24, U.N. Doc. A/44/49 (Nov. 20, 1989); Convention on the Rights of Persons with Disabilities, G.A. Res. 56/168, ¶ 25, U.N. Doc. A/RES/61/106, Annex I (Dec. 13, 2006).

[66] *See, e.g.*, International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, G.A. Res. 45/158, ¶ 28, U.N. Doc. A/45/49 (July 1, 2003).

> Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

Id. ¶ 28.

such declarations and standards might express peremptory norms[67]of conduct widely accepted by the world community as *jus cogens*.[68]

The principle that every human being is entitled to health care or medical care has been enshrined in international law since the first half of the Twentieth Century,[69] as illustrated by an examination of certain provisions in the following international agreements.

1. The Charter of the United Nations

When the Charter of the United Nations came into force on October 24, 1945, the United States became one of its charter members.[70] Article 55 of the U.N. Charter provides:

> With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on the principle of equal rights . . . the United Nations shall promote:
>
> **a. higher standards of living**, full employment, and conditions of economic and social progress and development.
>
> b. solutions of international economic, social, **health,** and related **problems**; and international cultural and educational co-operation; and
>
> c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.[71]

The right to health care is a fundamental human right that requires that citizens receive the help they need from their governments to achieve the highest attainable standard of health. Health is one of several measures that may be used to determine a country's standard of living.[72] By improving the health of its citi-

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[67] Vienna Convention, *supra* note 62, art. 53. The Vienna Convention states that, "a peremptory norm of general international law is a norm accepted and recognized by the international community of States as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character." *Id.* For a discussion of the Vienna Convention's binding nature on the United States, *See* Jamar, *supra* note 64, 17-18, n.37.

[68] The Oxford Dictionary of Law defines "jus cogens" as "a rule or principle in international law that is so fundamental that it binds all states and does not allow any exceptions. Such rules . . . will only amount to *jus cogens* rules if they are recognized as such by the international community as a whole." OXFORD DICTIONARY of LAW (Elizabeth A. Martin & Jonathan Law eds., 2006). Under this definition, a conflicting treating is void, and states cannot create regional customary law contrary to *jus cogens* rules. *Id.* "Most authorities agree that the laws prohibiting slavery, genocide, piracy, and acts of aggression or illegal use of force are *jus cogens* laws. Some suggest that certain human rights provisions (*e.g.* those prohibiting racial discrimination) also come under the category of *jus cogens*." *Id.*

[69] *See e.g.*, Universal Declaration of Human Rights, G.A. Res. 217 A(III), ¶ 25, U.N. Doc A/810 (Dec. 10, 1948) [hereinafter UDHR].

[70] List of United Nations Member States, http://www.un.org/members/list.shtml (last visited Nov. 10, 2008).

[71] U.N. Charter, art. 55 (emphasis added).

[72] *See* Richard H. Steckel, *A History of the Standard of Living in the United States*, ECON. HIST. SERVICES, July 22, 2002, http://eh.net/encyclopedia/article/steckel.standard.living.us.

zens, a government is likely to improve the standard of living in its country. The countries of Europe,[73] as well as many of the world's other countries, have enacted legislation to address a wide-range of human rights issues, including their health care obligations, which likely improves the standard of living and the potential for human development[74] in those countries. At present the United States has a high potential for human development.[75] But this could change drastically if the Government continues to abdicate to "market forces" the Government's obligation to provide adequate health care to all of its citizens.

2. *International Convention on the Elimination of All Forms of Racial Discrimination*

The United States became a party to the Convention on the Elimination of All Forms of Racial Discrimination on November 20, 1994. Article 1 defines racial discrimination as:

> [A]ny distinction, exclusion, restriction or preference based on race, color, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.[76]

Notably, Article 5 specifically provides for State Parties to guarantee the right to "public health, medical care, social security and social services."[77]

Racial minorities in the United States are disproportionately more likely to suffer serious heath problems.[78] While poverty is a major contributing factor to

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[73] *See* The European Social Charter, *supra* note 63, arts. 11, 13 (discussing the rights to protection of health and the rights to social and medical assistance, respectively).

[74] *See* UN Development Programme [UNDP], Human Development Concept, http://hdr.undp.org/en/humandev/ (last visited Aug.18, 2009).

> Human Development is a development paradigm that is about much more than the rise or fall of national incomes. It is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. People are the real wealth of nations. Development is thus about expanding the choices people have to lead lives that they value. And it is thus about much more than economic growth, which is only a means—if a very important one—of enlarging people's choices.
>
> Fundamental to enlarging these choices is building human capabilities —the range of things that people can do or be in life. The most basic capabilities for human development are to lead long and healthy lives, to be knowledgeable, to have access to the resources needed for a decent standard of living and to be able to participate in the life of the community. Without these, many choices are simply not available, and many opportunities in life remain inaccessible.

Id.

[75] Among the 179 countries listed on the UN Human Development Index for 2008, the United States is ranked as number fifteen. United Nations Human Development Index, http://hdr.undp.org/en/statistics/ (last visited Aug. 18, 2009).

[76] International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 65, art. 1.

[77] *Id.* art. 5(e)(iv).

[78] *See* Shavers & Shavers, *supra* note 38, and James, *supra* note 39, for a discussion on disparities in health care in the United States and the deleterious effect on racial minorities.

poor health[79] among such groups,[80] the disparities in health care they experience, both qualitatively and quantitatively, raise the specter that racial discrimination[81] might also be responsible for the differences in rates of disease, access to medical care and course of treatment, and medical outcomes.[82] Providing adequate levels of health care to all its citizens may be the only way the United States can realistically eliminate the health care gap experienced by many of its minority citizens.[83] Unless the United States Government does this, minorities who cannot afford to buy life-saving medical care in America, may be able to obtain such care only if they are granted health care refugee status by countries with well-developed health care systems and economies.

3. The International Covenant on Civil and Political Rights (ICCPR)[84]

The United States became a party to the ICCPR on September 8, 1992. Article 6(1) of the ICCPR provides that "[e]very human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."[85]

A person who has a serious illness or medical condition, which if left untreated will result in death, in essence has been sentenced to die if she is refused medical treatment because she has neither money nor insurance.[86] If said person

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[79] *See generally*, GAO, Poverty In America: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions As Well As The Economic Growth Rate 9 (GAO Report 07-344, Jan. 24, 2007), http://www.gao.gov/new.items/d07344.pdf at p. 13 0f 35 (last visited Aug. 18, 2009) (discussing health outcomes for individuals with low incomes and their limited access to health insurance and health care).

[80] "As defined by the Office of Management and Budget and updated for inflation using the Consumer Price Index, the weighted average poverty threshold for a family of four in 2007 was $21,203; for a family of three: $16,530; for a family of two: $13,540; and for unrelated individuals: $10,590." Press Release, U.S. Census Bureau, Household Income Rises, Poverty Rate Unchanged, Number of Uninsured Down (Aug. 26, 2008), http://www.census.gov/Press-Release/www/releases/archives/income_wealth/012528.html (last visited Aug. 18, 2009).
In 2007, 24.5 percent of Blacks, 21.5 percent of Hispanics, 10.2 percent of Asians, and 8.2 percent of non-Hispanic Whites lived in poverty. *Id.*

[81] *See generally*, WORLD HEALTH ORGANIZATION, HEALTH & HUMAN RIGHTS PUBLICATION SERIES, ISSUE NO. 2, HEALTH AND FREEDOM FROM DISCRIMINATION 8 (2001) (discussing health disparities, and the underlying social inequalities that produce them).

[82] *See generally*, Susan D. Cochran & Namdi W. Barnes, *Discrimination Contributes To African-Americans Health Disparities*, MEDICAL NEWS TODAY, Nov. 1, 2006, http://www.medicalnewstoday.com/articles/55345.php (discussing race-based discrimination as an underlying source for increased health issues in African Americans).

[83] *See Addressing Disparities in Health and Health Care: Issues for Reform: Hearing Before the United States H.R. Comm. on Ways and Means Health Subcomm.*, 113th Cong. (2008), *available at* http://www.kff.org/minorityhealth/upload/7780.pdf (testimony of Marsha Lillie-Blanton, Dr. P.H., Senior Advisor on Race, Ethnicity, and Health Care, Henry J. Kaiser Family Foundation discussing the role of influence of health insurance on racial disparities in health care).

[84] ICCPR, *supra* note 65.

[85] *Id.* art. 6(1).

[86] *See* STAN DORN, UNINSURED AND DYING BECAUSE OF IT: UPDATING THE INSTITUTE OF MEDICINE ANALYSIS ON THE IMPACT OF UNINSURANCE ON MORTALITY 6 (The Urban Institute January 2008), http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf (estimating that 137,000 uninsured Americans from age 25-64 died from 2000-2006, because they lacked health insurance).

resides in the United States, it is arguable that she has been arbitrarily deprived of her life because she is poor. A wealthier American with the same medical condition and sufficient financial means and insurance would be able to receive the necessary medical treatment and have a much better chance of living. The willful failure of the United States government to provide adequate health care for all its citizens is, in effect, an arbitrary death sentence to many of its poor, low-income, and uninsured citizens, as well as for many of its underinsured middle-class citizens.[87]

4. International Covenant on Economic, Social and Cultural Rights (ICESCR)

The United States signed the ICESR on October 5, 1977, but has yet to ratify it.[88] Article 12 of ICESCR provides as follows:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the **highest attainable standard of physical and mental health.**
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> . . . .
>
> (d) The **creation of conditions which would assure to all medical service and medical attention in the event of sickness.**[89]

Though the United States signed the ICESCR in 1977, the U.S. Government has still not chosen to provide an adequate level of health care to all its citizens. As a result, many poor and middle-class Americans, who do not have and cannot afford to buy health insurance, suffer "a range of [adverse] consequences, including lower quality of life, increased morbidity and mortality, and higher financial burdens."[90]

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[87] JACK DONNELLY, *International Human Rights and Health Care Reform, in* HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH 134 (Georgetown University Press 1994):

> [I]t is still of great moral significance to let people die (or suffer)–at least when one is aware of their impending death (or injury), possesses the resources needed to prevent death, and is not severely constrained from acting. The offense is especially great if the resulting deaths (or injuries) are systematic. This is precisely the case with access to health care. Despite our immense wealth and considerable spending on health care, the performance of the United States as measured by such standard statistical measures as life expectancy and infant mortality is dismal.

[88] *See* U.N. Treaty Collection, Status of International Covenant on Economic, Social and Cultural Rights, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited Aug. 19, 2009).

[89] ICESCR, *supra* note 65, art.12 (emphasis added).

[90] DORN, *supra* note 86, at 2.

5. Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)

The United States signed the CEDAW on July 17, 1980, but has not yet ratified it.[91] Article 12 of the CEDAW provides as follows: "States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning."[92]

"Approximately 16.7 women [in the United States] are uninsured. This number has grown by 1.2 million since 2004, with half of the growth among low-income women. These individuals lack adequate access to care, get a lower standard of care when they are in the health system, and have poorer health outcomes."[93] Low-income women, young women, and minority women are particularly at risk of being uninsured.[94] To the extent that the overall well-being of women in the United States ranks 106 out of 156 countries,[95] it is important that the United States work to improve the health care status of American women. Because women in America generally earn only seventy-six cents for every dollar earned by men,[96] women have less money with which to purchase health care. Allowing women's access to health care to be determined by market forces is not acceptable. Until the United States Government acts to ensure adequate levels of health care for all its citizens, some American women may have to seek health care refugee status in order to receive life-saving medical care.

6. Convention on the Rights of the Child (CRC)[97]

The United States signed the CRC on February 16, 1995, but has not yet ratified it.[98] Article 24 of the CRC provides as follows:[99]

> 1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of

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[91] *See* UN CEDAW: States Parties, http://www.un.org/womenwatch/daw/cedaw/states.htm (last visited Aug. 18, 2009).

[92] Convention on the Elimination of all Forms of Discrimination Against Women, *supra* note 65, art. 12.

[93] *See* THE HENRY J. KAISER FAMILY FOUNDATION, WOMEN'S HEALTH INSURANCE COVERAGE FACT SHEET 2 (Oct. 2008), http://www.kff.org/womenshealth/upload/6000_07.pdf.

[94] *Id.*

[95] UNDP, 2007/2008 HUMAN DEVELOPMENT REPORT: UNITED STATES, http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_USA.html. "The greater the gender disparity in basic human development, the lower is a country's gender-related development index (GDI) relative to its [human development index] HDI. . . . Out of the 156 countries with both HDI and GDI values, 106 countries have a better ratio than the United States's." *Id.*

[96] Amy Caiazza et al., Women's Economic Status in the States: Wide Disparities by Race, Ethnicity and Region 13 (Inst. for Women's Policy Res. 2004), http://www.iwpr.org/pdf/R260.pdf.

[97] Convention on the Rights of the Child, *supra* note 65.

[98] *See* U.N. Treaty Collection, Status of Convention on the Rights of the Child, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en (last visited Aug. 19, 2009).

[99] Convention on the Rights of the Child, *supra* note 65, art. 24.

> illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
>
> 2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
>
> (a) To diminish infant and child mortality;
>
> (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
>
> (c) To combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
>
> (d) To ensure appropriate pre-natal and post-natal health care for mothers;
>
> (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
>
> (f) To develop preventive health care, guidance for parents and family planning education and services.
>
> 3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
>
> 4. States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Children are the most vulnerable group in any society. They generally have no voice in the halls of power and are entirely dependent on adults for their well-being, including their health care. Thus it is only fitting that their special status be recognized and protected by a legally binding international agreement. Sadly, the United States of America is one of only two countries[100] that has not ratified the Convention on the Rights of the Child. Equally sad, is the fact that over eight million children in the United States are uninsured.[101] In a wealthy nation where politicians repeatedly claim to value life and to care about children, it is incomprehensible that even one child lives without the necessary health care.

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[100] Status of Convention on the Rights of the Child, *supra* note 98. Besides the United States, Somalia is the only other member country of the United Nations that has not ratified the Convention on the Rights of the Child.

[101] *See* CDC v. Census Comparison *supra* note 31; *and* U.S. CENSUS BUREAU 2007, *supra* note 31.

Two additional Articles from the CRC must also be mentioned in the discussion of "health care refugees"—Article 22 concerning child refugees, and Article 23 concerning the rights of mentally and physically disabled children.

Article 23 sets forth the rights of the mentally or physically disabled child and states, *inter alia*, that such a child "should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community."[102] Recognizing the critically important role that health care plays in achieving these goals, Article 23 says further, in relevant part, that:

> 2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.
>
> 3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, **health care services, rehabilitation services**, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development.[103]

Many physically handicapped and mentally challenged children in the United States have to fight insurance companies, HMOs, and even state governments to obtain the health care they need.[104] Many parents of children with physical and mental disabilities often find it difficult to obtain health insurance, and hence treatment, for their children. Parents of mentally and emotionally challenged children have also confronted barriers to obtaining adequate health care for their children, since insurance companies and HMOs have, until recently, refused to provide parity[105] in treatment to people afflicted with mental illness. American

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[102] *See* Convention on the Rights of the Child, *supra* note 65, art. 23(1).

[103] *Id.* art. 23(2) & (3) (emphasis added).

[104] *See generally* John B. v. Menke, 176 F. Supp. 2d 786 (M.D. Tenn. 2001); John B. v. Goetz, 2007 U.S. Dist. LEXIS 75457 (M.D. Tenn. Oct. 10, 2007), *petition for mandamus granted*, 531 F.3d 448 (6th Cir. 2008). This class-action law suit began in 1998 and the approximately 640,000 children who sued the State of Tennessee to receive the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to which they are legally entitled pursuant to Title XIX of the Social Security Act (42 U.S.C. §§1396(a)(43), 1396d(r)), are still waging this legal battle despite the defendants having entered into a Consent Decree in 1998. The plaintiffs in this case are represented by the Tennessee Justice Center. For more information about *John B.* and other cases involving medically fragile children, see Tennessee Justice Center, http://www.tnjustice.org/case/johnb/default.htm (last visited Aug. 19, 2009).

[105] "'Parity' refers to the effort to treat mental health financing on the same basis as financing for general health services. . . . The fundamental motivation behind parity legislation is the desire to cover

parents should not have to fight their children's diseases *and* the American health care system in order to keep their children alive and healthy. Children in the United States should receive health care at least comparable to that given to children in other developed countries[106] as a matter of right. The United States Government owes a duty to each child in America to provide it with an adequate level of health care.

Article 22 of the CRC reads as follows:

> 1. States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures **shall**, whether unaccompanied or accompanied by his or her parents or by any other person, **receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.**[107]

When read in conjunction with Article 24(1), Article 22(1) provides a firm basis to any Party to the Convention on the Rights of the Child to extend humanitarian assistance to any child who might seek health care refugee status in order to receive life-saving medical care. Thus, a child from the United States whose life is in jeopardy because he cannot afford life-saving medical care and whose government refuses to provide him with an adequate level of health care, could be granted "health care refugee" status by any developed country that has the financial wherewithal and heart to help.

7. *Convention on the Rights of Persons with Disabilities (CRPD)*[108]

The United States is not a signatory to the CRPD,[109] Article 1 of which reads as follows:

> The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.
>
> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

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mental illness on the same basis as somatic illness, that is, to cover mental illness fairly." UNITED STATES SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 426 (1999), http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c6.pdf.

106 *See* Toyako Report, *supra* note 1.

107 Convention on the Rights of the Child, *supra* note 65, art. 22 (emphasis added).

108 Convention on the Rights of Persons with Disabilities, *supra* note 65.

109 *See* U.N. Treaty Collection, Status of Convention on the Rights of Persons with Disabilities, http://www2.ohchr.org/english/ (last visited July 1, 2009). As of July 2009, there were 140 Signatories and 59 Ratifications to the Convention.

The CRPD also specifically recognizes health care concerns of disabled persons. Article 25 addresses the right to the "highest attainable standard of health" by enumerating several State Party requirements: provision of the same range and quality of care; early, disability-specific identification of needed health services and interventions; preventative health care; geographically conscious location of care; raising awareness of dignity in care; and preventing discrimination in the provision of health and life insurance, health care, health services, nutrition, and hydration.[110]

The United States has neither signed nor ratified this Convention or its Optional Protocol,[111] both of which entered into force on May 3, 2008. "The Convention . . . does not create new rights but aims to ensure that the benefits of existing rights are fully extended and guaranteed to the estimated 650 million people around the world with disabilities."[112] People with physical and mental disabilities, particularly children, are the most fragile within any society. They need and deserve the comprehensive legal protections set forth in the Convention on the Rights of Persons with Disabilities.

B. Is The Right to Health Care *Jus Cogens*?

The international community has acknowledged that the right to health care is a fundamental human right,[113] and has entered into many international agreements intended to ensure that this right is accorded to human beings everywhere. The duties owed to citizens by their governments are set forth in great detail in General Comment 14,[114] wherein the U.N. Committee on Economic, Social, and Cultural Rights stated, *inter alia*, the following:

- Health is a fundamental human right including certain components which are legally enforceable.[115]
- The right to health is not to be understood as a right to be *healthy*.[116]
- The right to health includes essential elements: availability; accessibility (physical economic, informational, and non-discriminatory); acceptability; and quality.[117]

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110 Convention on the Rights of Persons with Disabilities, *supra* note 65, art. 25.

111 *See* Status of Convention on the Rights of Persons with Disabilities, *supra* note 109; *and* U.N. Treaty Collection, Status of Optional Protocol to the Convention on the Rights of Persons with Disabilities, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15-a&chapter=4&lang=en (last visited Aug. 19, 2009).

112 *Entry Into Force of Disability Pact Closes Major Gap in Rights Protection,* U.N. NEWS CENTRE, June 6, 2008, *available at* http://www.un.org/apps/news/story.asp?NewsID=26931&Cr=disab&Cr1= (last visited Aug. 19, 2009).

113 *See* ICESCR, *supra* note 65, art. 12. For Implementation Guidelines for Article 12, see U.N. Econ. & Soc. Council, Comm. on Econ., Soc. & Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights, General Comment No. 14,* ¶ 1, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter *General Comment No. 14*].

114 *General Comment No. 14, supra* note 113.

115 *Id.* ¶ 1.

116 *Id.* ¶ 8.

117 *Id.* ¶ 12.

- Economic accessibility means the "[p]ayment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups."[118]
- To comply with Article 12 of the International Covenant on Economic, Social and Cultural Rights [ICESCR], State Parties must "prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law."[119]
- States Parties have a core obligation to: ensure the right of access to and equitable distribution of health facilities, goods and services on a non-discriminatory basis.[120] These core obligations are nonderogable, and a State Party cannot, under any circumstances, justify its non-compliance with them.[121]
- "A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12."[122]
- Violations can occur through acts of omission, including the "failure to take appropriate steps towards the full realization of everyone's right to the enjoyment of the highest attainable standard of physical and mental health . . . ."[123]
- "Violations of the obligation to fulfill occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health."[124]
- Victims of a violation of the right to health should have access to effective remedies, judicial or otherwise, at the national and international levels.[125]
- The role of the WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/ Red Crescent, UNICEF, and other non-governmental organizations is of particular importance in providing humanitarian assistance to refugees.[126]

It is clear from the above-described obligations that the International Covenant on Economic, Social and Cultural Rights ("ICESCR") creates legal obligations

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118 *Id.*

119 *Id.* ¶ 39.

120 *Id.* ¶ 43.

121 *Id.* ¶ 47.

122 *Id.*

123 *Id.* ¶ 49.

124 *Id.* ¶ 52.

125 *Id.* ¶ 59.

126 *Id.* ¶ 65.

for parties thereto and gives legally enforceable rights to citizens who live in countries that have ratified the agreement. However, there are countries, including the United States, that are not parties to the ICESCR,[127] yet are parties to other international agreements that include a right to health as a fundamental human right. If nearly all the world's countries agree that every human being has the right "to the highest attainable standard of health,"[128] has the human right to health, which subsumes the right to health care, reached the norm of *jus cogens*?

Article 53 of the Vienna Convention on the Law of Treaties ("VCLT")[129] defines a peremptory norm (aka *jus cogens*) of international law as a "norm accepted and recognized by the international community of states as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character."[130] To achieve peremptory status a norm must, therefore, have four elements. It must be a norm: (1) of general international law; (2) accepted by the international community of States as a whole;[131] (3) incapable of derogation; and (4) incapable of being modified except by a peremptory norm of the same status.[132] Article 12 of the ICESCR requires that, "[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Examining said article through the lens of Article 53 of the VCLT, it appears that Article 12 of ICESCR is a norm: (1) of general international law;[133] (2) accepted by the international community;[134] (3) incapable of

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[127] As of August 19, 2009, Belize, Comoros, Cuba, Sao Tome and Principe, South Africa, and the United States of America had not ratified the International Covenant on Economic, Social and Cultural Rights. U.N. Treaty Collection, Status of International Covenant on Economic, Social and Cultural Rights, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited Aug. 19, 2009).

[128] ICESCR, *supra* note 65, art. 12; *General Comment No. 14, supra* note 113.

[129] *See* Vienna Convention, *supra* note 62, art. 53.

[130] *Id.*

[131] *See* Eva M. Kornicker Uhlmann, *State Community Interests, Jus Cogens, and the Protection of the Global Environment: Developing Criteria for Preemptory Norms*, 11 GEO. INT'L ENVTL. L. REV. 101, 112 (1998) for a discussion of identifying a norm as jus cogens. "Identifying a norm as jus cogens does not require recognition by each and every member of the international community, but only the consent of a very large majority of states reflecting the essential components of the international community. The prevailing doctrine extends the binding effect of peremptory norms even to those states that from the very beginning have objected to such a norm ('persistent objectors')." *Id.* (internal citations omitted).

[132] Vienna Convention, *supra* note 62, art. 64 ("If a new peremptory norm of general international law emerges, any existing treaty which is in conflict with that norm becomes void and terminates.").

[133] The right to the highest attainable standard of health has been enshrined in many international treaties. *See, e.g.*, Jamar, *supra* note 64; G.A. Res. 45/158, *supra* note 66; and G.A. Res. 217A (III), *supra* note 69.

[134] As of August 19, 2009, 160 countries had ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR), of which Article 12 is a part. Status of International Covenant on Economic, Social and Cultural Rights, *supra* note 127.

derogation;[135] and (4) incapable of being modified except by a peremptory norm of the same status.[136]

Therefore, the right to health enunciated in Article 12 of the ICESCR and more fully explained in General Comment 14,[137] does appear to be *jus cogens*, and therefore is binding even on non-parties.[138] As one scholar has noted:

> As a descriptive matter, it seems clear that there are elements of the present international legal system that are not based on the consent of the states involved. The concept of *jus cogens*, that is, peremptory law, is an example. *Jus cogens* norms are seen by scholars as a sort of superinternational law, trumping other forms of law and only able to be changed by the evolution of a new rule of *jus cogens*. Moreover, these norms are viewed as **capable of** [being] **binding by all and against all (not just by and against those who have consented to the creation of the norms)**.[139]

Another scholar has examined *jus cogens* in light of human rights and has concluded:

> In the context of the sweeping language of human rights, certain human rights principles are recognized as *jus cogens* peremptory norms of international law. *Jus cogens* norms are fundamental tenets of international law **considered accepted by and binding on all states**, from which no derogation is permitted.[140]

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[135] *See General Comment No. 14, supra* note 113, ¶¶ 43, 47 (explaining generally the depth and breadth of Article 12 of the ICESCR, which includes paragraph 47 stating that paragraph 43 contains core, non-derogable obligations).

[136] There are very few peremptory norms of higher status than the fundamental human right to health embodied in Article 12 of the ICESCR, *supra* note 65, except perhaps the fundamental right to life itself, as expressed in Article 6(1) of the International Covenant on Civil and Political Rights [ICCPR], *supra* note 65. For a general discussion of the fundamental rights expressed in the International Bill of Human Rights, see Fact Sheet No. 2 (Rev.1), The International Bill of Human Rights (June 1996), http://www.ohchr.org/Documents/Publications/FactSheet2Rev.1en.pdf (explaining that the International Bill of Human Rights consists of the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights; and the International Covenant on Civil and Political Rights).

[137] *See General Comment 14, supra* note 113 (addressing the need to establish health as a fundamental human right that creates legally enforceable obligations).

[138] *But see* Prosper Weil, *Towards Relative Normativity in International Law?* 77 AM. J. INT'L L. 413, 420 (1983) (questioning the wisdom of having *jus cogens* norms and asserting that international law requires voluntarism to perform its functions).

[139] Eduardo Moises Peñalver, *The Persistent Problem of Obligation in International Law*, 36 STAN. J. INT'L. L. 271, 282 (2000); *see also* Uhlmann, *supra* note 131, at 113 (stating that the consent of a large number of nations is necessary to create a binding effect of a specific norm and that no nation, small group of nations, or persistent objector can veto the formation of the norm if its purpose is to protect a state community interest, as that is the essence of *jus cogens*).

[140] *See* Stacy Humes-Schulz, Limiting Sovereign Immunity in the Age of Human Rights, 21 HARV. HUM. RTS. J. 105, 110 (2008) (emphasis added) (arguing that sovereignty needs to change for the twenty-first century legal model by shifting towards individual rights and should be applicable only to acts consistent with global ideals and denied for acts that are in direct violation of international law).

Furthermore, in distinguishing customary international law[141] from *jus cogens* norms, a United States Circuit Court for the Ninth Circuit has observed that:

> *[J]us cogens* 'embraces customary laws considered binding on all nations,' and 'is derived from values taken to be fundamental by the international community, rather than from the fortuitous or self-interested choices of nations.' Whereas customary international law derives solely from the consent of states, **the fundamental and universal norms constituting** *jus cogens* transcend such consent . . . Because *jus cogens* norms do not depend solely on the consent of states for their binding force, they 'enjoy the highest status within international law.'[142]

This author posits the following additional argument: If one believes the fundamental human right to life encompasses the fundamental right to health, then the United States may be bound by treaty as well as *jus cogens* to provide an adequate level of health care to all its citizens. The ICESCR (enunciating Article 12 on the right to health) came into force on January 3, 1976.[143] The International Covenant on Civil and Political Rights (ICCPR) (enunciating Article 6 (1) on the right to life) came into force on March 23, 1976.[144] The United States is a party to the ICCPR which, as a document that came into force later in time, could be viewed as enunciating a new peremptory norm that subsumes a prior peremptory norm, *i.e.*, the right to life subsumes the right of health. Thus, the ICCPR would bind the United States both by treaty obligation and *jus cogens* to provide an adequate level of health care to all its citizens.

C. Legal Remedies Available for Failure of the U.S. Government to Provide An Adequate Level of Health Care to All Its Citizens[145]

The United States has not ratified the ICESCR and ratified the ICCPR subject to a declaration of non-self execution,[146] which means Congress must pass ena-

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141 Customary international law is a source of international law set forth in Article 38 of the Statute of the International Court of Justice. *See e.g.*, U.N. Charter arts. 92-96, 59 Stat. 1031 (1945). The ICJ Statute provides that the Court's function is to resolve disputes by applying a prescribed hierarchy of international laws to the facts in a given matter.

142 Siderman de Blake v. Republic of Arg., 965 F. 2d 699, 715 (9th Cir. 1992) (internal citations omitted) (remanding the case to the district court for a more complete investigation of the jurisdictional basis for the plaintiffs' claims of torture against the Argentine government because the lower court applied sovereign immunity to Argentina, without the government's appearance, when it needed to offer some evidence that it acted in its sovereign capacity for engaging in tyrannical, anti-Semitic and torturous acts).

143 ICESCR, *supra* note 65.

144 ICCPR, *supra* note 65.

145 Paragraph 59 of *General Comment 14, supra* note 114, states that "[a]ny person or group victim of a violation of the right to health *should have access to effective judicial or other appropriate remedies at both national and international levels.*"

146 *See generally* David Sloss, *The Domestication of International Human Rights: Non Self-Executing Declarations and Human Rights Treaties*, 24 YALE J. INT'L. L. 129, 135 (1999). Sloss argues that "[non-self-executing] declarations, properly construed, permit courts to apply the treaties directly to provide a judicial remedy in some, but not all, cases that raise meritorious treaty-based human rights claims." *Id.*

bling legislation before the ICCPR can be enforced in this country. The Supreme Court of the United States has recently stated:

> [When treaty] 'stipulations are not self-executing they can only be enforced pursuant to legislation to carry them into effect.' In sum, while treaties 'may comprise international commitments . . . they are not domestic law unless Congress has either enacted implementing statutes or the treaty itself conveys an intention that it be 'self-executing' and is ratified on these terms.'[147]

The Supreme Court defines a "self-executing" treaty as one that "has automatic domestic effect as federal law upon ratification," and a "non-self-executing" treaty as one that "does not itself give rise to domestically enforceable federal law."[148] "Whether such a treaty has domestic effect depends upon implementing legislation passed by Congress."[149]

The ICCPR is non-self-executing and Congress has enacted no legislation to implement it. Thus, an American citizen in need of life-saving medical care, who lacks health insurance and the money with which to purchase medical care, and who earns too much to qualify for any of the government insurance programs,[150] would likely be unsuccessful were she to invoke the ICCPR as a legal basis in a suit to require the federal government[151] to pay for her medical care. Furthermore, the consensus of opinion among legal scholars and jurists in the United States is that, "[e]ven when treaties are self-executing in the sense that they create federal law, the background presumption is that '[i]nternational agreements, even those directly benefiting private persons, generally do not create private rights or provide for a private cause of action in the domestic courts.'"[152] Thus, low or middle-income Americans in dire medical and financial straits might be

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147 Medellín v. Texas, No. 06-984, at 8-9 (U.S. Mar. 25, 2008) (internal citations omitted) (holding, *inter alia*, that a decision of the International Court of Justice is not directly enforceable in the United States as domestic law in the absence of implementing legislation).

148 *Id.* at 9 n.2.

149 *Id.*

150 *See* Current Population Survey, *supra* note 44.

151 This article does not examine the issue of sovereign immunity. Suffice it to say that there are limited circumstances under which an American citizen may sue the United States Government. The Federal Tort Claims Act provides such a limited grant of authority.

> The Federal Tort Claims Act (FTCA), 28 U.S.C. §§1346(b), 2671-2680, is the statute by which the United States authorizes tort suits to be brought against itself. . . . [B]y enacting the FTCA, Congress waived sovereign immunity for some tort suits. With exceptions, it made the United States liable: 'for injury or loss of property, or personal injury or death caused by the negligent or wrongful act or omission of any employee of the government while acting within the scope of his office or employment, under circumstances where the United States, if a private person would be liable to the claimant in accordance with the law of the place where the act or omission occurred.' 28 U.S.C. § 1346(b).

Henry Cohen & Vanessa K. Burrows, CRS Report for Congress: Federal Tort Claims Act 1 (2007), http://www.fas.org/sgp/crs/misc/95-717.pdf; *see also* Humes-Schulz, *supra* note 140 (asserting that an individual's ability to enforce *jus cogens* human rights should not be precluded by outdated notions of sovereign immunity. The case involved a domestic court that should have awarded damages, based on violations of the *jus cogens* human right prohibiting torture, to one of its citizens who had been tortured by a foreign government).

152 Medellín v. Texas, No. 06-984, at 9 n.3.

required to look beyond the shores of the United States when they need life-saving medical care.

Conclusion

To provide an adequate level of health care to all its citizens is a *jus cogens* norm of international law to which all member states of the United Nations are bound. When a government refuses to fulfill this obligation toward its citizens, such persons should be permitted to apply for health care refugee status to United Nations member states with developed economies. Given the willful failure of the United States government to provide an adequate level of health care to all its citizens, many low and middle-income Americans have a well-founded fear that they might die because their government will not fulfill its international legal obligation to provide them with an adequate level of health care. Furthermore, given that low and middle-income Americans would likely be unsuccessful in U.S. courts in invoking international law as a basis to require the federal government to provide such care, they have no effective judicial remedy at the national level.[153] Therefore, an appropriate remedy at the international level[154] would be to grant them health care refugee status.

The U.N already recognizes complementary refugee status[155] for some persons based on humanitarian grounds. For a given developed country to grant a health care refugee protection within its borders for the purpose of providing her with life-saving medical treatment would fall well within the meaning of the complementary refugee status recognized by the United Nations. It would also be consistent with the trend in the European Union to grant subsidiary protection to individuals who have a "well founded fear of violation of [their] human rights."[156] It is time for the community of nations to extend their hearts and hands to health care refugees.[157]

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153 *See General Comment 14*, *supra* note 113, art. 59 ("Any person or group victim of a violation of the right to health *should have access to effective judicial or other appropriate remedies at both national and international levels.*").

154 *Id.*

155 *See* GLOBAL TRENDS, *supra* note 7, at 4 n.8.

156 *See* Council Directive 2004/83/EC, *supra* note 12, art. 15(a)-(c).

157 The United States will weather the financial storm currently pummeling its shores. When the storm has passed, hopefully the United States Government will be ready to honor its international law obligations by taking measures now to ensure that all Americans receive adequate levels of health care. Unless and until such legislation is passed, however, low and middle-income Americans may require help from their fellow human beings in countries with well-developed health care systems and economies.