A Human Rights Assessment of the Presidential Nominees' Health Plans

The Human Right to Health Care:
Nominees' Plans Lag Behind Public Demands

The U.S. public overwhelmingly believes in the human right to health care,[1] yet nationwide untreated illness, unnecessary suffering and even death show that our health care system fails to respect that right. Both presidential nominees, Senators Barack Obama (D) and John McCain (R) have responded to this crisis with campaign promises for health care reform. Economic and moral imperatives prompt them to issue ambitious proclamations, with McCain declaring that *"everybody should obviously have access to affordable healthcare in America",*[2] and Obama asserting that *"every American has the right to affordable, comprehensive and portable health coverage."* [3] To make good on these promises, campaign rhetoric must be turned into principles and plans for a serious restructuring of our current system. With the public clamoring for the government to protect our health from market imperatives, this is not the time to fear change.

Yet despite reform ambitions both nominees remain caught in a market-based debate that treats health care as a commercial product. Although their health care plans are very different - with Obama's plan potentially increasing access to insurance coverage, and McCain's plan likely to ration necessary care – both reinforce the status quo, where protecting health is far from what drives today's health care industry. On the contrary: every day, more people lose their health insurance, and others delay seeking care because their insurer refuses to pay for needed services. In fact, tens of thousands of people are dying unnecessarily each year. As the wealthy buy the most technologically advanced diagnostics on the market, everyone else struggles to get the treatment and drugs they need, at a price they can afford. Our health system is segregated, unequal, and in violation of basic human rights. There is a clear role for health rights advocates to raise the bar for health care reform so that it breaks the chokehold of market imperatives and ensures that our health needs are fully met.

Almost three quarters of the U.S. public recognize that health care is a human right,[4] and that our exercise of this right must be protected. Many elected representatives follow this groundswell of opinion and assure us that, in the words of Senator Baucus (Chairman, Senate Finance Committee), "*we will continue to work to advance the right to health care*." [5] Yet, advances fail to materialize. While politicians realize that our rights are practical, and not merely abstract, they have not yet taken the steps needed to implement human rights standards in practice. Beyond rhetoric, our representatives have not tackled the fundamental problem that much of the health care industry is designed to protect profit rather than health. Doing so would require them to recognize health care as a public good, with costs and benefits shared by all.

Through a Human Rights Lens: How the Plans Compare

Human Rights Principles		Obama's Plan	McCain's Plan
Universal access to care	Universality	◒	○
	Affordability	◒	○
	Equity	○	○
	Comprehensiveness	◒	○
Availability of care infrastructure and services everywhere		◒	○
Acceptability and dignity of care		◒	○
Quality of health care		◒	◒

KEY: ● fully meets human rights standards; ◒ partially meets human rights standards; ○ fails to meet human rights standards

Human rights principles offer a roadmap for policymakers to take steps towards protecting health care as a public good, thus ensuring that everyone in the United States is able to get the care they need.

NESRI National Economic & Social Rights Initiative

nesri.org
healthlaw.org

NHeLP NATIONAL HEALTH LAW PROGRAM

What Is the Human Right to Health?

Every person has basic human rights that are common to all human beings, regardless of sex, race, ethnicity, national origin, language, income, religion, sexuality, age, or disability. These rights exist independent of government recognition and are the same for everyone.

The human right to health is indispensable to our inalienable rights to life, liberty, and the pursuit of happiness. Health is fundamental to the well-being of all human beings and to our pursuit of fulfilling lives. While we cannot claim a right to be healthy, we do have the right to be as healthy as possible, within the limits posed by our bodies and behaviors.

Many external factors influence our health, such as our environment, housing and workplace conditions, and medical care. In so far as all these are shaped by society, government has an obligation to protect our health and to help us be as healthy as possible.

- ► The human right to health guarantees a system of health protection.
- ►To protect health, everyone has the right to appropriate health care, and to living conditions that give us the opportunity be healthy, such as adequate food, housing, and a healthy environment.
- ► Health care is a public good, with costs and benefits shared by all. We have a right to get the health care we need, and a responsibility to ensure that everyone else can do the same.

Key Principles of the Right to Health Care

The right to health care means that hospitals, clinics, medicines and doctor's services must be **accessible**, **available**, **acceptable,** and of good **quality** for everyone, on an equitable basis, where and when needed.

Health care must be financed and delivered in a **non-discriminatory** way that enables the **participation** of individuals and communities, provides access to **information**, ensures **transparency** of institutions and processes, and has effective mechanisms to hold both private sector and government agencies **accountable**.

These human rights principles set the parameters for health care reform. They enable advocates to raise the bar for reform efforts and develop a roadmap for moving toward a health care system in which everyone in the United States is able to get the care they need. Human rights principles can be implemented progressively, step by step, but there must never be regression from existing policy gains.

Reform, Regression, or Rhetoric?

Key Findings of the Human Rights Assessment

The ongoing health care reform debate can appear complex and daunting. Human rights principles offer straightforward guidance, starting not with calculations of financing mechanisms but a basic understanding: everyone must be able to get appropriate health care in order to protect their own and other people's health. The presidential nominees, in their general pronouncements, seem to agree with this premise, as they call for better access to and quality of care. Yet their reform plans largely fail to meet these goals, as our human rights assessment shows. When measured against human rights principles, the policies laid out in their reform plans fall short of key standards and of the nominees' own campaign promises.

Even though the health care plans put forward by Senators McCain and Obama differ substantially from each other, neither meets human rights standards. Focusing on financing mechanisms, one proposes an expansion of the individual market coupled with further privatization, the other a mixed public-private coverage system within a regulated marketplace. Neither of these approaches is likely to achieve adequate health protection for all. At best, more people will be able to buy an insurance product, at worst, access to care will be further restricted to the wealthy and healthy.

If the nominees really want to address the public's demand for meaningful reform,[6] human rights standards can point them in the right direction. These standards are neither complicated nor unrealistic, and they draw on the same social contract principles that inform, for example, our Social Security system. A few decisive steps toward recognizing our rights and responsibilities will be more meaningful than a haphazardly assembled patchwork of new subsidies, coverage mechanisms, tax code changes, and similar measures.

McCain's Health Care Plan: Endangering Health Through Market Imperatives?

Senator McCain's plan focuses on reducing health care expenditures. As a key area of concern the plan singles out high costs to companies, which it deems detrimental to business profitability and economic growth. Consequently, McCain's plan seeks to shift health care financing from employer-sponsored insurance to direct, subsidized purchasing of coverage in the individual market. A human rights analysis shows that this is problematic on several accounts. At the most basic level, the human right to health requires that health policies and health care systems focus on health protection. Much of McCain's health care plan seeks to achieve economic rather than health objectives. More specifically, the proposed shift of responsibility from businesses to individuals reduces economic risk to employers while increasing health and financial risks to individuals. This is exacerbated by McCain's proposals for cuts to public health insurance programs, such as Medicare and Medicaid, and for the further privatization of coverage services supplied by these programs. The combined thrust of these initiatives is directed at releasing government and businesses from their shared responsibility for protecting the health of the people, leaving individuals to fend for themselves in the private insurance market. Moreover, this would be accompanied by market deregulation, rendering state-based rules obsolete. Insurers everywhere could discriminate against applicants on health and other grounds, for example by denying coverage because of a pre-existing health condition, or charging higher premiums for young women. The impact of these measures cannot be neutralized by the proposed flat tax credit and is likely to lead to a reduction in the number of people able to access care, thus endangering health protection. Such a regressive step would constitute a human rights violation.

In international comparisons the United States already has the most privatized, market-based health care system of all industrialized countries, sustained by significant public subsidies to the

Impact on Low-Income People

Many low-income people cannot afford to see a doctor, yet public programs designed to meet their needs exclude single adults and many working families.

McCain's Plan proposes to cut and privatize public programs, which would diminish the safety net and further reduce low-income people's access to care. The proposed flat tax subsidies would be insufficient to make comprehensive coverage affordable in the individual market.

Obama's Plan seeks to strengthen Medicaid and the State Children's Health Insurance Program (SCHIP). It also proposes a public plan with sliding subsidies; however, this plan does not appear to be available to low-income people, e.g. those unhappy with or ineligible for Medicaid/ SCHIP. Private insurance premium prices are not regulated. Access to care remains tiered, with some getting better care benefits than others.

Human Rights Implication: Low-income people have a right to equal access to care. Yet neither of the plans offers an equitable financing structure, with everyone sharing costs, risks and benefits based on their ability to pay.

► *Make a public plan with comprehensive benefits available to everyone, and provide income-based sliding scale subsidies that do not require any payment from those with incomes under 200% FPL.*

Impact on Immigrants

Immigrants face significant problems accessing health care. Many tend to work in low-wage jobs or small businesses that do not offer insurance. Public insurance programs are restricted to those immigrants with over 5 years of legal residency. Both documented and undocumented immigrants have been deported by hospitals, which in the case of severely ill people has meant sending them to their certain deaths.

McCain's and Obama's Plans do not address how immigrants can better access the care they need.

Human Rights Implication: Everyone has the right to health and health care by virtue of being human. Neither nominee recognizes the universality of this right.

► *Repeal the 1996 exclusion of immigrants from Medicaid and ensure that public programs are open to all who need them.*

private sector. This system also produces some of the worst health outcomes among industrialized countries, and accounts for the highest health care costs in the world. Any further expansion of the private market is likely to exacerbate this poor performance, as it fails to address the ***direct link between poor health outcomes and high market spending.***

It is the problem of high costs, not poor health outcomes, that preoccupies McCain's plan. Yet the proposals identify neither the underlying reason for high spending, nor the unequal distribution of costs and gains, characterized by waste and excess on one side, and scarcity on the other. In fact, insurance industry profits and administrative expenses are driving the growth in U.S. health care spending, with an annual increase of 12%, compared to the average health expenditure growth of 8.6% (between 2000 and 2005).[7] This indicates a redistribution of financial resources from ordinary people, who fund this spending through rising insurance premiums and cost-sharing, to insurance executives with exorbitant salaries, and to big corporations boasting billion-dollar profits. Any expansion of the private insurance business will likely result not in reducing overall spending but in further shifting profits to companies and costs to individuals. Corporations in the private market - insurers, hospitals, pharmaceutical firms - exist to maximize their profits (or surpluses, in the case of non-profit corporations), and therefore the drive for profits will always, without fail, trump the delivery of care services, which are recorded as financial losses on company balance sheets. Declining access to care and rising prices for individuals are dictated by market imperatives.

Most market-based reformers agree that the only way to effectively contain costs within a market system is through tighter controls and restrictions on the actual use of health care. Therefore, McCain's plan, through moving individuals from employer group plans into the individual market, deregulating the industry, and shrinking public programs, will restrict access to treatments, drugs, and other health services for those unable to afford them, and thus effectively ration care. At the same time as controls are imposed on people in need of care, rather than corporations in search of profits, some people will still be able to buy themselves the freedom to get the care they want. In proposing to replace a system in which certain care benefits are secured for all policyholders

(defined-benefit system), to one in which each person gets what they are able to pay for (defined-contribution system), McCain's plan privileges the few who can afford to buy adequate care, while leaving behind those who cannot - the vast majority of us.

Obama's Health Care Plan: Subsidizing a Product or Sharing a Public Good?

Senator Obama's health care plan focuses not primarily on cost reduction, but on increasing access to coverage through a mixed public-private patchwork of insurance options. His proposals consider insurance as the main vehicle for accessing care, without questioning whether the insertion of such a "middleman" facilitates or obstructs access to care. Therefore, the plan seeks to increase market access to those who sell insurance products rather than actual access to those who provide care. Even if everyone were able to buy some kind of insurance product, this would indicate little about their ability to visit a doctor, and even less about their experience during that visit.

The focus on coverage as opposed to care does not automatically improve access, but it does create more consumers for a market product offered through profit, non-profit, or public vendors. This is not only problematic in that it essentially provides new public subsidies for private insurance companies (through tax subsidies to those who purchase private coverage), but also because it reinforces the model of health insurance as business, as distinct from a social insurance model. Unlike in any other industry, profits of insurers depend on avoiding the provision of services. ***Insurers thrive only when rationing or denying access to care and reducing or refusing payment to providers***. In principle, this dynamic also applies in a social insurance system, but since that model relies on everyone sharing risks, costs, and benefits in a single large pool, any "surpluses" or savings are immediately redistributed to areas of need to care for the sick. In a market-based insurance system, however, insurers shift costs to patients and providers to maximize their own savings.

Shifting, Not Sharing, Risks and Costs

In our current system, market imperatives fuel a common misunderstanding of what insurance actually is supposed to be. If policyholders are required to pay their own actual or expected

Impact on Women

In the insurance market system, women are denied coverage for health conditions such as breast cancer and even for having given birth via C-section. Some insurers refuse to cover maternity services for women who are already pregnant. Moreover, women are usually charged more than men during most of their lives. Their coverage is often linked to their spouse and thus places them in a dependent role.

McCain's Plan allows insurers to discriminate against women by denying coverage or charging higher premiums. The availability of dependent coverage through a spouse's employers may be reduced, but no viable alternative is offered. Without needs-based subsidies, women are disadvantaged in the more expensive individual market, as they use more services due to reproductive health needs, and continue to earn less than men for the same work.

Obama's Plan requires insurers to issue policies to all applicants, regardless of health risks. However, it allows higher premium prices based on gender, and does not address the issue of dependent coverage.

Human Rights Implication: Women have a right to affordable, comprehensive care. This is not guaranteed in the private insurance system, on which both nominees' plans are based.

► *Prohibit discrimination by insurance companies.*

Impact on People of Color

People of color are more likely to be uninsured, yet even with coverage they have greater difficulty finding a doctor. Moreover, they tend to receive lower quality of care than White people.

McCain's Plan does not address disparities in access, quality of care, and health outcomes. Moving more resources into the individual market is likely to have a disproportionately negative effect on people of color, as the market is already neglecting their health needs, for example by not making sufficient services available in communities of color.

Obama's Plan requires insurers and providers to monitor and report disparities, which could improve quality. Yet the insurance system remains segregated into different tiers. No proposals are made to shift resources into underserved areas and communities.

Human Rights Implication: People of color have a right to equal access to care and quality treatment, regardless of where they live. Yet the market-based system does not adequately serve people of color.

► *Support resource allocations, infrastructure improvement, and workforce development to ensure that people of color have facilities and doctors adequate to meeting their health needs.*

health care costs in premiums, they are not protected from the potential financial consequences of serious illness. Rather than being insured against sickness, policyholders are part of a payment plan based on their expected use of health care. By charging everyone different rates, depending on their presumed health risk, age or gender, each person has to pay their own way, and those who end up needing more care due to illness or accident may be bankrupted as a result. In such a payment system, costs are shifted to a small number of sick people, rather than spread across a large population. Without sharing risks and costs, and collecting contributions based on the ability to pay, not on health needs, an insurance system is no more than an inequitable, price inflating mechanism for administering provider payments, without delivering the protection promised.

The destructive role played by much of today's health care industry does not go unrecognized by Senator Obama. In fact, he has stated that *"every American has the right to affordable health care. […] [N]o amount of industry profiteering and lobbying should stand in the way of that right any longer."*[8] To secure this right in the face of active denial and resistance from the industry, Obama's plan would have to meet the government's responsibility for protecting health by vigorously asserting its authority over the insurance industry.

Although Obama's plan proposes some measures to curtail insurers' practices of denying care, it perpetuates the misunderstanding of insurance as a payment plan. Yet some decisive steps could be taken to move beyond this model, primarily by regulating the insurance industry to minimize profiteering and waste: for example, community ratings that prohibit insurance companies from discriminating on the grounds of age, gender, or occupation (not just on health status, as Obama's plan proposes); requiring insurers to spend most of our premium payments on actual health care, as Medicare does (Obama's plan requires this only in markets with little competition and does not specify a minimum percentage); setting a ceiling on nonprofit insurers' surplus; controlling premium prices (as opposed to approving above average increases); and mandating a standardized comprehensive health benefits package that is the same for everyone (as opposed to setting a floor with buy-in options that segregate people into separate pools). While Obama's plan mentions most of these regulatory measures, it falls short of giving them the teeth needed for effectively holding corporations in check. Overall, his plan remains firmly anchored in the market-based insurance model with its poor record on health protection.

Health Care Debates: The Specter of Dislocation

The current state of the health care reform debate may explain the focus of Obama's plan on improving, but not systematically changing the existing health care marketplace. The aspirations of most current reform proposals, including those put forward by many health care advocacy organizations, are curtailed by fears of disrupting the existing system, despite its acknowledged malfunctioning. The political imperative is to avoid so-called dislocation wherever possible, primarily in order to increase the chances of achieving any reform at all, however minor. Yet this fear of dislocation may instead induce paralysis and ignore the very real disruption that people already face when trying to obtain adequate health care. With more and more people losing coverage, suffering from poor health, dying prematurely, or facing health care related bankruptcy, dislocation has in fact become a constant in people's lives. Ironically, at this point in the presidential campaign, the only reform plan that would truly change the health care system is Senator McCain's – but in a way that would further ration care for many. Shifting risk from employers and insurers to individuals would cause significant additional disruption to people's access to health care.

To stem these forces of regression, reforms need to move beyond a piecemeal re-organization of existing health insurance markets, and instead take meaningful steps toward a progressive realization of the human right to health care. Just as the 1965 establishment of Medicare was preceded by fear mongering about disruptive changes, reformers today face resistance when attempting to push back the market's encroachment on people's basic rights. But just as advocates then succeeded in carving out health rights and protections for everyone in old age, the bar needs to be raised until those rights become universal and equitable.

Next Steps: Everyone Included, Everyone Equal
A key first step must be to conceive any reform measure, however small, in a way that includes everyone. Structural inequities that underlie the current system are most apparent from the disparities in both access to care and health outcomes, and their elimination should be at the top of any reformer's agenda. Yet, both McCain's and Obama's plans perpetuate, or even exacerbate, inequities and exclusions, firstly by maintaining distinct tiers of access to different levels of care, and secondly by excluding the health needs of some groups, for example immigrants, rural and inner city residents, and women of reproductive age, from the debate. Any rhetoric of "access for all" quickly disintegrates in the face of fragmented measures designed to protect what some people already have.

Strength in Numbers: Reemergence of Public Protection

Health care advocates have a responsibility - in this election campaign and beyond – to ensure that preconceptions and fears do not derail reform efforts before they even start. Any serious reform plan must reflect that everyone has the right to get the medical care they need to protect their health, which far exceeds the right to purchase a market product from vendors who have a vested interest in obstructing access to care. This entails recognizing that health care is not a consumer product but a public good, with risks, costs, and benefits shared by all.

Public responsibility for organizing, or at least overseeing, collective financing mechanisms may be exercised in different ways, including through a public insurance plan. Obama's proposal includes a public plan, although merely as one component within a fragmented system. Yet if this plan were to be made available to every person living in the United States, access to care might be significantly improved. As proposed, however, the plan appears to exclude people on multiple grounds: those who have insurance from an employer, those too poor to purchase even a subsidized plan (the proposal does not suggest full exemptions from premium payments for the poor) and those with undocumented immigration status.

In conceiving public responsibility within the constraints of a multi-tier marketplace that segregates its health care "consumers", Obama's plan misses an important opportunity for change. High costs and limited access to care have contributed to a new public awareness of rights and responsibilities: people now see government in a protective role, as evidenced by their support for the government's obligation to protect human rights, including the right to health care.[9] They are even ready to pay higher taxes in exchange for guaranteed health care,[10] while also recognizing that a shift, not an increase, in spending is needed to protect health care from the predatory imperatives of the private market.[11] As corporate profits are rising, people themselves are battling an economic downturn and suffer from the failures of market-based health care. Politicians would be well advised to take this into account when seeking support for their health care reform plans.

References

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ACCESS

Access to care must be **universal**, and protect everyone's health on an **equitable** basis. Facilities, goods, and services must be **affordable** and **comprehensive** for all, and physically accessible where and when needed.

Universal

Health care must be equally accessible to every person living in the United States, guaranteed and continuous throughout people's lives.

Standards	Obama's Plan	McCain's Plan
Health care should be recognized as a public good, to which everyone has guaranteed access	• Views access as dependent on purchasing private insurance (e.g. mandates buying coverage for children) or qualifying for public insurance • Sets universal *coverage* as a goal, but not universal access to actual *care* • Does not guarantee access to care • Provides public subsidies, yet does not make care free at the point of access	• Views health care as a market commodity and makes access dependent on market forces • Seeks to make access to coverage available for all to buy, but universal access is not a policy goal • Does not guarantee access to care • Provides public subsidies for the purchase of private goods
Access to care should be easy, continuous, and integrated	• Does not provide direct and automatic access to care • Facilitates market access by creating a National Health Insurance Exchange • Relies on a fragmented/tiered system of coverage that includes employers, public plan, safety nets, and the private market • Makes a public plan and private plans in the Exchange portable (but not employer plans and Medicaid/SCHIP) • Does not address application barriers to Medicaid/SCHIP	• Does not provide direct and automatic access to care • Restricts individuals to applying for private insurance plans, which can impose conditions, require tests, deny coverage, revoke policies, etc. • Seeks to increase portability by moving from employer-sponsored to individual plans • Does not address eligibility and application barriers to Medicaid/SCHIP
Publicly financed care should be strengthened and expanded as a step toward meeting public responsibility	• Supports increased access to public insurance programs (but these may contract with private insurers): through a new public plan (but only for those not covered by employers), protection of Medicare, and expanded eligibility for Medicaid/SCHIP (yet no specific proposals)	• Supports further privatization of health care: e.g. seeks to privatize veteran's care, promotes use of private insurance in Medicaid and Medicare • Seeks to balance budget through cuts to Medicare and Medicaid
Insurers, providers, and public agencies should operate transparently, accessible to all	• Requires providers to report cost and quality data • Requires insurers to disclose percentage of premiums that goes to care • Requires exchange to evaluate private plans and make differences clear	• Requires providers to make information available on medical outcomes, quality of care, costs, and prices • Requires pharmaceutical companies to disclose how drugs are priced • Does not place requirements on insurers
Private companies and public agencies should be held accountable for ensuring universal access to care	• Seeks to hold hospitals and insurance plans accountable for differences in care quality for disparity populations • Commits government to carry out public health impact assessments • Fails to hold government or private sector accountable for ensuring access to care	• Seeks better enforcement of laws against collusion, unfair business actions, and deceptive consumer practices • Considers patients responsible for staying healthy and deciding what health care they can afford • Fails to hold government or private sector accountable for ensuring access

Affordable

Health care must always be affordable for everyone, with charges based on the ability to pay, regardless of how health care delivery is financed.

Standards	Obama's Plan	McCain's Plan
Health care should be affordable for everyone, with contributions (or exemptions) based on the ability to pay	• Aims to achieve universal affordability of coverage, yet does not require insurers to offer sliding scale premiums • Mandates that employers provide insurance or pay into public plan • Offers subsidies to employers for catastrophic costs (reinsurance)	• Aims to make individual insurance market more affordable • Seeks to move away from employer-sponsored coverage • Risks more people becoming uninsured and underinsured, as they may not be able to afford adequate individual plans
Premiums, out-of-pocket costs, deductibles, and drug prices should be publicly regulated when insurance is provided by the market	• Calls on insurers to charge "fair and stable" premiums, independent of health status, but allows difference in premiums based on age and gender • Does not regulate prices, but requires insurers to justify above-average premium increases • Allows Medicare to negotiate price of prescription drugs, but does not provide for general drug price negotiation or regulation	• Allows private corporations to determine prices; allows insurers to raise premiums at will and charge higher prices according to health status, age, gender, etc. • Encourages high deductible plans that shift all initial health care costs to the individual • Does not regulate prescription drug prices
Public subsidies, when offered, should have the same value for everyone, and include incentives to select coverage and care according to quality	• Provides sliding scale subsidies based on income to individuals who do not qualify for Medicaid/SCHIP but need assistance buying into the public plan or purchasing private insurance through the Exchange • Does not mandate that employees' contributions to employer-sponsored coverage be sliding scale, and does not set a cap on tax exemptions for high earning employees	• Eliminates tax exemption for employer-sponsored coverage to move people into open market • Provides refundable $2,500 flat tax credit for everyone to buy private coverage (paid directly to insurers), which may be less valuable to low-income people (as they are not tied to actual costs or inflation) and to older and sicker people (who are usually charged higher premiums) • Seeks to expand health savings accounts, which studies show benefit healthier and wealthier people
Private health care industry should be regulated to maximize spending on care and minimize profits and administrative costs	• Calls on insurers to pay out a "reasonable share" of premiums for health care (but only in states where there is little competition among insurers)	• Seeks to deregulate insurers by creating nationwide market, no limits on profits or administrative costs
In an insurance system, risk pools should be as broad as possible to share costs and risks equitably and increase affordability for all	• Provides for a new public plan with a potentially large risk pool, but this is only available to those not covered by an employer and not eligible for Medicaid/SCHIP, and it could be subject to adverse selection • Creates National Health Insurance Exchange to act as a purchasing pool	• Eliminates tax exemption for employer-sponsored coverage, which may dissolve employer-based risk pooling and push people into the individual market without pools • Establishes high risk pools through subsidized nonprofit Guaranteed Access Plan to help insurers sell policies to people with health risks

Equitable

Health care facilities, goods, and services must be distributed equitably, with resources allocated and accessed according to needs and health risks.

Standards	Obama's Plan	McCain's Plan
Disparities in access to care should be eliminated	• Requires hospitals and insurers to collect and report data on care quality for disparity populations, and seeks to hold them accountable	• Does not address disparities
Access to care should be on the basis of clinical need, not privilege, payment, health or immigration status, or any other factor	• Prohibits insurance plans from discriminating on health status, but allows discrimination on other factors • Requires guaranteed issue and renewal of insurance policies • Allows higher paid employees to have better coverage than others • Does not address limited access for immigrants to public programs	• Allows insurers to discriminate based on health status, age, and other factors, making access more difficult for sicker and older people • Undermines state efforts to protect against discrimination by allowing insurers to trade across state lines • Does not address limited access for immigrants to public programs
Access to care should be the same for everyone (e.g. equally easy, affordable, and comprehensive for all)	• Creates a health system with different tiers, in which access will be different for different populations	• Supports control of access through the market, which makes it different for each individual
Access should not be impeded by distance, business hours, disabilities, language, etc.	• Does not address physical access barriers	• Does not address physical and cultural access barriers

Comprehensive

Everyone must get all screening, treatments, therapies, drugs, and services needed to protect their health.

Standards	Obama's Plan	McCain's Plan
Incentives for comprehensive care should replace market incentives for limiting care	• Allows market incentives to continue, but under stricter regulations	• Does not curb market incentives for limiting care, and relies on market to reduce costs of comprehensive care
All private and public plans should meet comprehensive standards for coverage benefits, including preventive care, mental health, dental and vision care, and reproductive health	• Requires coverage benefits of public plan to be similar to those for federal employees; does not specify benefits for employer-sponsored plans • Requires private plans regulated by the Exchange to be "at least as generous" as the new public plan	• Sets no minimum standards, e.g. mental or reproductive care are not required • Calls for more low-benefit, high deductible plans • Seeks to compensate Medicare providers for preventive care
Health care services should not be restricted for certain groups, and no one should be penalized for their health status or behavior	• Does not lift restrictions imposed by public programs on comprehensive care for women and immigrants	• Allows insurers to reward wellness, and penalize those who most need care • Does not lift restrictions imposed by public programs on comprehensive care for women and immigrants

AVAILABILITY

Adequate health care infrastructure (e.g. hospitals, community health facilities, trained health care professionals), goods (e.g. drugs, equipment), and services (e.g. primary care, mental health care) must be available in all geographical areas and to all communities.

Standards	Obama's Plan	McCain's Plan
Health care should be available where it is needed	• Proposes information technology for rural and underserved areas	• Supports "telemedicine" and community clinics in underserved areas if cost-effective • Promotes walk-in clinics in retail outlets
Health care infrastructure and resources should be distributed equitably	• Does not address equitable distribution of infrastructure and resources	• Does not address equitable distribution of infrastructure and resources
Health care professionals should be brought into underserved areas and fields	• Seeks more funding for primary care providers, e.g. for loan repayments, training grants, infrastructure support	• Does not address shortage of professionals
Hospitals should be supported in underserved areas	• Seeks to expand the capacity of safety net institutions	• Does not address shortage of hospitals in underserved areas
Patients should be able to see any provider in their area	• Seeks adequate reimbursement for doctors, but fails to address limited networks offered by insurers	• Does not address patients' choice of providers

ACCEPTABILITY and DIGNITY

Health care institutions and providers must respect dignity, provide culturally appropriate care, be responsive to needs based on gender, age, culture, language, and different ways of life and abilities. They must respect medical ethics and protect patient confidentiality and privacy rights.

Standards	Obama's Plan	McCain's Plan
Health services should be responsive to patients' needs and culturally appropriate	• Promotes culturally effective care through workforce diversification	• Does not address responsiveness to diverse needs
Discrimination (intentional and unintentional) by insurers, providers, and agencies should be eliminated	• Seeks to reduce health disparities but does not directly address discrimination	• Does not address discrimination
Translation/ interpretation should be routinely provided	• Does not address language access issues	• Does not address language access issues
Workforce diversity should be developed at all levels	• Seeks to diversify workforce	• Does not address workforce issues
Patient privacy rights should be strengthened	• Supports privacy protections for electronic records but proposes no enforcement mechanism	• Promotes information technology without considering privacy rights
People should be able to participate in health system decision-making	• Promotes stronger doctor-patient links • Does not address participation in health care planning and institutions	• Does not address participation in health care planning and institutions

QUALITY

All health care must be medically appropriate and of good quality, guided by quality standards and control mechanisms, and provided in a timely, continuous, safe, and patient-centered manner.

Standards	Obama's Plan	McCain's Plan
Market incentives should be realigned to favor quality, safe, patient-oriented, and timely care	• Seeks to reform market by creating rules and standards and regulating private insurance plans through an Exchange	• Allows insurers to cover only healthy people and to limit the provision of care • Seeks to incentivize home care provision for long term care
Uniform quality standards and independent quality control should be enforced for all insurers and providers	• Sets quality standards for providers in public plan • Sets quality standards for private plans to equal public plan, monitored by the Exchange • Establishes independent institute on comparative effectiveness	• Sets standards for measuring clinical effectiveness, but not for institutional performance across a fragmented system
Disparities in health outcomes, and in quality of care received by different population groups, should be eliminated	• Requires hospitals and insurers to collect and report data on quality of care for disparity populations; seeks to hold them accountable	• Does not address disparities in health care quality and outcomes
Provider payments should be linked to performance, patients' conditions, and health outcomes, and encourage efficient use of maximum available resources	• Seeks to reimburse providers in line with performance and outcome measures • Promotes chronic care management and medical homes • Seeks new ways for addressing physician errors • Does not consider outcomes and needs-based budgeting (e.g. global budgets)	• Seeks to reimburse providers for quality care, outcomes, and coordinated care • Seeks to bar Medicaid/Medicare from paying for preventable medical errors or mismanagement (now already an administrative rule); does not ensure that patients are not billed instead • Does not consider outcomes and needs-based budgeting
A public health strategy should be in place that pays attention to socio-economic health determinants	• Seeks to develop a national and regional strategy for public health, with a focus on health promotion, not socio-economic determinants of health	• Seeks to tackle obesity, diabetes, and smoking; focuses on personal behaviors, not on socio-economic determinants of health

The Human Right to Health Program, run jointly by the National Economic and Social Rights Initiative (NESRI) and the National Health Law Program (NHeLP), develops human rights tools to support organizations and advocates in their efforts to advance the human right to health care in the U.S. The program is carried out in collaboration with the FXB Center on Health and Human Rights at the Harvard School of Public Health, Ipas, the Opportunity Agenda, and the Human Rights Implementation Project. Special thanks to the U.S. Human Rights Fund and the Herb Block Foundation for their support.

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