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Oregon's Senate Joint Resolution 12: Understanding the Implications of a Constitutional Right to Healthcare

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Oregon's Senate Joint Resolution 12: Understanding the Implications of a Constitutional Right to Healthcare

Cover Page Footnote

Thank you to Dr. Bruce Gilley for mentoring me through the publication process with your guidance, insight, and support.

INTRODUCTION

Healthcare policy in the United States has been an ongoing proverbial tug-of-war for well over a century, fraught with controversy and tumultuous discourse. While there have been major federal successes, such as the landmark passages of Medicare, Medicaid, and the Affordable Care Act, the U.S. still fails to implement universal coverage at a national level. As the U.S. confronts the ironic reality of spending more on healthcare than any other developed country, it continues to grapple with millions of uninsured, overwhelming medical costs, and simultaneously ranks the lowest in many major health outcomes compared to its industrialized counterparts.

While the U.S. boasts “the best healthcare system in the world,” including some of the most advanced technology and treatments in existence, many reject this claim based on increasing and persistent poor health outcomes that are prevalent nationwide. When compared to other developed nations, the U.S. has higher infant mortality rates, lower life expectancy, higher occurrences of preventable deaths, and higher maternal deaths, among others (Schneider, et al 2021). Furthermore, an estimated 28 million people remain uninsured (Keisler-Starkey and Bunch 2020). Not only does the U.S. fall short in terms of individual health but it ranks lowest overall in access to and affordability of services (Schneider, et al 2021). High spending and the availability of advanced technology has not translated into better health outcomes for the U.S.

Over half the world’s countries have implemented constitutional provisions to guarantee health or healthcare, the United States has not (Heymann, et al 2013, 651). While amending the federal constitution would be an arduous and convoluted task, an alternative solution exists in a state constitutional amendment. This provides an easier way for policy makers to bypass the difficulties associated with a federal constitutional amendment, as there is arguably better access to the political process at the state level, more opportunities to affect policy within a single state versus the entire country at large, and there is better representation to constituent needs and concerns by local representatives that may be different for other state populaces at the national level (Leonard 2010, 1342, 1399). Understandably, healthcare needs and priorities in the United States are variable and diverse across states.

Oregon has been a nationally recognized leader for its innovative healthcare reforms (Leonard 2010, 1390). Over the last several decades, Oregon legislators and experts together have made large strides in improving access to healthcare services, increasing affordability, reducing the number of uninsured, and creating

more equitable health systems thanks to the creation of Continuing Care Organizations and the creation and transformation of the Oregon Health Plan (Stock and Goldberg 2017, 3-5). In addition, Oregon has made several attempts to amend its state constitution to include healthcare as an explicit human right under House Joint Resolutions in 2007, 2008, 2015, and 2018; though not yet successful.

However, a bill has been reintroduced to the ballot under Senate Joint Resolution 12 that Oregonians will vote on in November. Originally titled “The Hope Amendment,” it would establish healthcare as a fundamental human right. If successful, this will be the first constitutional amendment in any state to make healthcare an explicit right (Ballotpedia 2022). Although some U.S. states have constitutional provisions that include “health,” none exist for healthcare specifically. Even so, such rights have been narrowly defined as courts have all but steered away from interpreting them broadly to include rights to access myriad services, free healthcare, or health insurance coverage (Leonard 2010, 1328, 1381-1384). Most interpretations have revolved around public health, such as vaccinations, and include environmental concerns like sanitation, clean air, and clean drinking water (Leonard 2010, 1381).

There are two components to this amendment. It mandates that “access to cost-effective, clinically appropriate and affordable health care” would be “the obligation of the state” and that it “should be available to everyone” (81st Oregon Legislative Assembly 2021). It also mandates respecting a “balance” between the provision of healthcare and other “public interests” such as the funding of public schools and other “essential public services” to ensure that funding healthcare does not impede the funding of other important programs and services in Oregon (81st Oregon Legislative Assembly 2021). This means the state would have an absolute responsibility to provide healthcare services and enforce this right within healthcare systems, while also maintaining a balance in conjunction with other social programs. This creates a series of important questions to consider, such as what specific services will people be entitled to, how to define “affordable,” and who will pay?

WHAT IS A RIGHT?

Conceptualizing rights is far more complex than one might initially imagine. There are many types of rights from a general, categorical perspective such as political, criminal, or civil. But at a fundamental level, there are two basic types of rights--positive and negative. It is important to understand the difference. Positive rights can be described as the provision of entitlements which are backed by government

enforcement, who has an obligation to ensure such entitlements are received by individuals and provided by specific entities, like public education or access to clean water (Stone 2001, 525). Negative rights typically ensure individuals are free from interference from government or others, such as free speech and securing private property (Velasquez, et al 2014). Therefore, endowing individuals with rights to access healthcare services is largely a positive right. However, it could also be considered a negative right, as it would also bestow a right to be free from denial of treatment (Sandhu 2007, 1175).

This becomes complicated, as healthcare rights are not self-executing like civil or political rights; individuals depend on healthcare being provided to them by others, such as providers or healthcare institutions (Sandhu 2007, 1168). Additionally, rights must be uniform; it must apply equally to everyone, which can diminish individual choice (Littell 2002, 311). Simply defining the “type” of right is not enough. What exactly does a right to healthcare entail? What the scope and extent will be persists in political discourse (Matsuura 2014, 37). A narrowly defined right would entitle individuals to specific healthcare services, while a more broadly defined right, such as a right to general health, could mandate other entitlements like housing, transportation, or food security. Furthermore, who should be obligated to provide these entitlements? It is important that the right to healthcare be thoughtfully defined for rights-holders, healthcare entities, and the judiciary. Also, what healthcare services are individuals entitled to? Only emergency services, or cosmetic and experimental procedures too? What about high-tech equipment? Would providers and healthcare facilities lose their ability to reject Medicaid patients? Clearly, translating healthcare into a legally enforceable right is complicated.

INTERNATIONAL PUSH FOR A RIGHT TO HEALTH

In 1946, the World Health Organization (WHO) created its own constitution that declared health as a fundamental human right and that “every human being is entitled to...the highest attainable standard of health...” which was affirmed and translated into a series of international treaties by the United Nations (UN) in 1948. (World Health Organization 2017). Since then, countries around the world have implemented constitutional rights to health and healthcare, though at varying degrees, to include public health, medical care, and general wellbeing (Heymann, et al 2013, 651). Mexico’s constitution mandates a right to universal health insurance coverage while Japan’s constitution mandates a right to general health and wellbeing which includes social welfare and social security programs (Columbia Public Health 2021; Health and Global Policy Institute 2021).

Healthcare as a right has been widely accepted around the world and is largely based in ethical principles in accordance with perceptions of basic human rights (Christopher and Caruso 2015). U.S. discourse appears more focused on concerns surrounding the financing of healthcare rights, the adjudication of services, government overreach, and the suppression of free market enterprise; and ethical perspectives vary across political party affiliations (Christopher and Caruso 2015). Nearly all other developed nations view healthcare as fundamental responsibility, not as a condition of employment or income earning as in the U.S. (Christopher and Caruso 2015). Although all UN members have recognized a right to health, the WHO constitution and UN declarations and treaties are not legally binding or enforceable, and as a result many countries still lack constitutionally guaranteed rights to healthcare (Littell 2002, 313).

DOES A RIGHT TO HEALTH TRANSLATE INTO BETTER HEALTH OUTCOMES?

In theory, this amendment could lead to decreases in the rates of uninsured, increase access to services, and make services more affordable, thus leading to better health outcomes for Oregonians. But are these assumptions substantiated by evidence? Many proponents of a constitutional right to healthcare assume or expect doing so translates to better health outcomes. Understandably, the goal is to ensure more equitable access to healthcare services and treatments to increase the health of individuals, leading to better quality of life. On the surface, the inference seems reasonable- a right to healthcare should reasonably improve access to healthcare services, which logically could be presumed to improve both individual health and collective health. However, research into this topic has provided mixed results (Gunnarsson 2019).

One study out of the University of Pennsylvania found constitutionally embedded rights to health improved overall population health because the provision secured access to more healthcare services and fostered better service delivery (Kavanaugh 2016, 346, 355). Another study found a constitutional provision led to an increase in public healthcare expenditures but improvements to certain statistical health measures were mixed (Rosevear 2017, 330-332). A third found no correlation between the two (Littell 2002, 309).

MILL'S METHOD: A CAUTIONARY PERSPECTIVE

Regression analysis with a large-N data set is outside the scope of this piece. However, a basic analysis can be done with a small-N data set using a “Mill’s Method” comparison, created by the English philosopher John Stuart Mill (Pavone 2015). Out of five possible methods, this analysis uses just one. A sample of six OECD countries is presented in Figure 1.1, with two significant health outcomes in light grey columns as dependent variables juxtaposed with possible independent variables that may explain those health outcomes in dark grey columns.

Figure 1.1

	Life Exp Birth	Adult Mort	Right to Health	Poverty	Obesity	Crime	Universal Healthcare
U.S.	77.3	138	No	0.18	73.1	5.5	No
Canada	81.7	84	No	0.116	59.8	1.3	Yes
Finland	82.2	87	Yes	0.065	67.6	1.3	Yes
Spain	82.4	72	Yes	0.147	50.2	0.6	Yes
Australia	83.0	73	No	0.124	65.2	1.1	Yes
Japan	84.7	64	Yes	0.157	27.2	0.2	Yes

Source: Data from the Organization for Economic Cooperation and Development (2022).

The data above can be coded in a more simplistic table to make comparisons easier to visualize:

Figure 1.2

	Life Exp Birth	Adult Mort Rate	Right to Health	Poverty	Obesity	Crime	Universal Healthcare
U.S.	0	0	0	0	0	0	0
Canada	1	1	0	1	0	1	1
Finland	1	1	1	1	0	1	1
Spain	1	1	1	1	0	1	1
Australia	1	1	0	1	0	1	1
Japan	1	1	1	0	1	1	1

Initially, there appear to be a couple connections including universal healthcare and life expectancy at birth. However, it appears that a right to health may not be associated with higher life expectancy at birth. Notice several of the countries have similar life expectancy and adult mortality rates, though the constitutional provision of health is different among them. However, different

factors can influence those outcomes beyond a right or no right to health and thus is worth further examination.

MILL'S METHOD OF AGREEMENT

This method of comparison examines the absence of variation in the dependent variables, adult mortality rates and life expectancy at birth. Using this method, two countries with different “systems” (a right or no right to health) with the same health outcomes are examined. The goal is to isolate the independent variable that is consistent for both countries.

Figure 1.3

	Life Exp Birth	Adult Mort Rate	Right to Health	Poverty	Obesity	Crime	Universal Healthcare
Australia	1	1	0	1	0	1	1
Japan	1	1	1	0	1	1	1

Japan and Australia, who have a right and no right to health respectively, experience similar health outcomes, but have variations in other explanatory variables. This allows an examination of the “right or no right to health” on health outcomes while controlling for other possible influences-poverty, obesity, crime, and universal healthcare. Using Mill’s method of agreement, a right to health, poverty, and obesity can all be rejected as possible causes of health outcomes since Japan and Australia experience different rates among those variables, rendering them casually irrelevant. After elimination, crime rates and universal healthcare are left as the sole possible factors since they are the only variables Japan and Australia have in common.

This is correlative evidence, however, and correlation does not inherently imply causation, so a more detailed analysis is necessary. Regardless, it could be casually concluded that the most likely influence on their shared health outcomes is the existence of a universal healthcare system or crime rates (Pavone 2015).

LESSONS FROM ABROAD

Overall, outcomes from constitutional rights to health or healthcare have manifested in different ways across the globe, and the results offer insight to prospective audiences. Many of the concerns brought-forth in American political and social discourse have played out in other countries. Across the spectrum of

outcomes experienced by a diverse array of countries, they provide a multitude of lessons to be learned about where to place caution and where to elicit optimism.

SOUTH AFRICA

The South African constitution provides an explicit right to access healthcare (World Health Organization 2012). Interestingly, healthcare is both a positive and a negative right there; the right to access basic healthcare services and the right to be free from denial of emergency services (Sandhu 2007, 1175). Over the last decade, South Africa has been navigating the judicial implications from policy implementation. Courts have emphasized a “collective and holistic decision-making about the right to healthcare,” whereby they balance the rights of individuals with the constraints of resource limitations. They choose to prioritize the needs of society at large over the specific needs of individuals” (Sandhu 2007, 1175). Incidentally, litigation led to an updated policy on AIDS/HIV which improved health outcomes in South Africa (Gunnarsson 2019).

This is a consequence that Oregonians would have to consider. If the government is going to be charged with providing healthcare to everyone, that will entitle it to considerable decision-making power, something many Americans are leery of. More specifically, it could expand the decision-making power of the judicial branch and extend its ability to influence and shape policy. It could also diminish the healthcare options of individuals since resource limitations would also exist here at home. Small government and individualism are two commonly shared American values among many in the U.S. Oregonians would have to understand that the delicate balance of individual wants and needs against collective society may not always lean in their favor.

BRAZIL

The Brazilian constitution goes beyond a mere general right to health, and details more specific mandates of social and economic policies aimed at reducing poor health outcomes (Teixeira 2021). However, many assert that negative outcomes have transpired in Brazil as a result. The country has seen massive increases in litigation costs and hundreds of thousands of court cases, which have led many to believe that the constitutional right to healthcare has led to a less fair and less efficient public health system (Rosevear 2017, 314). Generally, a right to individual health has trumped rationing decisions and has led to middle and upper classes using Brazilian courts to secure access to expensive, non-urgent services, which some assert has resulted in a decrease in financial resources for more vulnerable populations and distortions in the country's health budget (Gunnarsson 2019; Yamin and Parra-Vera 2009, 0147).

Brazil's experience represents two distinct potential problems: increases in litigation and class inequality. Many U.S. critics of a constitutional right to healthcare stress an inevitable increase in lawsuits, especially in a country that already has uniquely high rates of litigation. Many fear this would translate into higher healthcare costs potentially resulting from increases in liability insurance for medical providers. Others may be concerned courts would be largely filled with individuals from higher socioeconomic classes, who may advocate unnecessary and expensive services, which would negatively and disproportionately affect marginalized individuals, such as the poor and people of color.

COLOMBIA

Although Colombia has seen an increase in coverage, the health system has fallen short in improving efficiency and quality (Yamin and Parra-Vera 2009, 0147). The right to health has led to a significant increase in annual litigation, with an estimated 80% of court cases granted in favor of the plaintiffs (Yamin and Parra-Vera 2009, 0147). Courts have historically decided cases with little regard for resource implications which, could be argued, distorts budgets for the greater population. As a result, a significant portion of the health budget has been invested in individual insurance cases at the expense of public health issues such as promotion and prevention (Yamin and Parra-Vera, 2009 0149). Additionally, many court cases have been brought for services that are already covered under the universal health plans offered to Colombians, rendering some litigation unnecessary and inefficient use of the courts systems.

These issues have translated into problems with budgeting, cost-containment, priority setting, and high litigation, but have also increased the power of the Colombian judicial system at the expense of its legislative and administrative bodies (Yamin and Parra-Vera 2009, 0147). This has included budget revisions, modifications of the universal health systems, and the restructuring of health benefit plans (Yamin and Parra-Vera 2009, 0148). For Oregonians, in a country whose fundamental structure and values include a system of checks and balances, how would they feel about increasing power to one single branch?

Interestingly, in Colombia, healthcare rights have been specifically enforced for individuals who are members of vulnerable groups, such as children or the elderly, and those who cannot afford the services when a clear need is expressed (Yamin and Parra-Vera 2009, 0148). Because of this, incredibly expensive treatments and services have been granted, including HIV and cancer treatments, which some argue have improved equity in a country that is still plagued with high inequities. Unlike South Africa, who has leaned towards considerations for resource limitations and the collective good, Colombian courts have leaned

towards individuals. In the U.S., could Oregonians of lower socioeconomic classes afford the costs of litigation should they want or need adjudication?

IS A RIGHT TO HEALTHCARE NECESSARY?

Even though many countries have implemented constitutional rights to health and healthcare, there are plenty that have not who boast excellent healthcare systems that are cost-effective, largely accessible, and score high on statistical health outcomes. One could argue that a constitutional right to healthcare is neither absolutely necessary nor an inherent guarantee.

CANADA

Canada has no explicit constitutional right to health or healthcare, and experts there question the assumption it will lead to better health outcomes (Gunnarsson 2019). Furthermore, there is hesitation to implement amendments (Sandhu 2007, 1181). In lieu of such rights, Canada instead has two statutes- the Canada Health Act and the Charter of Rights and Freedoms. The former provides provinces with federal funding for healthcare services and requires they provide publicly funded healthcare that is universal, comprehensive, portable, and accessible; which means the government has a statutory obligation to provide its citizenry with healthcare coverage and services (Sandhu 2007, 1181-1182; Martin, et al 2018, 1720-1721; Tikkanen, et al 2020). The latter acts as a Canadian “bill of rights” that details civil and political rights (Government of Canada 2020). Interestingly, Canadian conflicts often arise as the inverse compared to other countries, more issues pertain to individual rights versus governmental healthcare policy, and less to individual access to services. There, individual constitutional civil rights trump collective statutory healthcare rights (Sandhu 2007, 1181-1182).

The important question in this case is how necessary is a right to healthcare in a country that provides universal healthcare? Under the Canadian system, “core” medical and hospital services are free at point of care, coverage is portable across the country, and it is bestowed upon all Canadians, provided by the 13 provinces (Martin, et al 2018, 1718). These services include primary care, acute hospital care, in-patient prescriptions, and public health prevention services such as immunizations (Tikkanen, et al 2020). Even so, issues persist. Long wait times for surgeries, access to services not covered by the public system, such as mental health and out-patient prescriptions, and barriers for indigenous groups still exist (Martin, et al 2018, 1726-1729; Tikkanen, et al 2020). Even though Canada’s healthcare system is highly regarded around the world, improvements are needed including equity and timely access (Schneider, et al 2021).

GERMANY

Germany created the world's first social health insurance system, with the creation of Chancellor Otto von Bismarck's Health Insurance Act of 1883 (Tikkanen, et al 2020). Even though its healthcare system has been developing and evolving well over one hundred years, there remains no "health-related obligation" in the German constitution, although there are recent instances of limited constitutional interpretations, such as reimbursement for emergency medical services not covered by the national health plan (Hofling 2009; Library of Congress 2017). A recent study by the Commonwealth Fund found Germany to be a high performing country, ranking 3rd in access to care and 2nd in equity (Schneider, et al 2021). All Germans are afforded healthcare coverage that provides a robust package of benefits that include preventative services, hospital services, primary care services, dental, vision, rehabilitation and physical therapy, and maternity care, among others (Tikkanen, et al 2020). So, is a right to healthcare truly necessary in a country with universal healthcare? Perhaps not. An analysis of the efficacy of universal healthcare in relation to improving health outcomes is needed to ultimately answer this question.

CONCLUSION: WHY IT MATTERS FOR OREGON

Senate Joint Resolution 12 would grant Oregonians a largely positive right. Under section 47, it would be "the obligation of the state to ensure that every resident of Oregon has access to cost-effective, clinically appropriate and affordable healthcare" (81st Oregon Legislative Assembly). The most pressing question is how would Oregon pay for this should it pass? So far, no specifics have been disclosed, and healthcare in the U.S. is notoriously expensive. Furthermore, healthcare systems are incredibly complex and multifaceted, with many different institutions, businesses, and providers who make up a wide range of sub healthcare systems. The bill itself does not detail how healthcare services will be funded within the complex healthcare systems in the state of Oregon, which is especially significant in the context of Continuing Care Organizations and private insurance companies. Policymakers must detail how they will fund delivery systems and where the money to fund mandatory healthcare services will come from.

The bill also does not explicitly define what a right to healthcare entails. Would it be a package of basic, necessary services, as seen in Germany and Canada; or would it be loosely defined to include even cosmetic and elective surgeries? What about long-term, life-saving treatment for chronic illnesses such as HIV or cancer? A lack of specification leaves this right open to interpretation and will inevitably lead to later conflict, as seen in the cases of Brazil and Colombia.

One strength is the bill's clear constraint on state-funded healthcare's potential impact on other social programs and public services. Section 47 states that a right to healthcare "must be balanced against the public interest in funding public schools and other essential public services" and that "any remedy arising from an action brought against the state to enforce the provisions of this [section] may not interfere with the balance described in this section" (81st Oregon Legislative Assembly). This stipulation is imperative. It is important that healthcare provisions not distort the budgets of other vital social programs and public services and may help the state maintain more balanced budgets and reduce the risk of over-spending, and the explicit language set forth by the policymakers assure constituents that they will not lose funding or access to other important programs and services.

In addition to a comprehensive funding plan and considerations for a narrowly or broadly defined right to healthcare, policymakers will have to formulate a balance between individual wants and collective needs. Constituents will need to understand the depth and breadth of decision-making power that will be inherently delegated to the judicial branch, which will include balancing individual wants with collective needs, as seen in the case of South Africa. And the judicial branch will have the pain-staking job of figuring out how to maintain that balance. Are constituents willing to accept that there may be instances where their individual wants or needs, perceived or substantiated, are rejected in favor of larger groups or the greater good?

Clearly a constitutional right to healthcare is complex. There are many important considerations that must be addressed, such as how to define the right in terms of entitlements, how to enforce it, how mandatory services will be financed, in addition to how the provider-patient relationship will change and how to make improvements over time (Sandhu 2007, 1158). While supporting a constitutional right to healthcare may satisfy ethical concerns, constituents, policymakers, and healthcare experts alike should be cautious. Assuming such provisions would guarantee a reduction in inequities, solve access and affordability problems, or improve health outcomes would be naïve, as they are not completely predicated by current empirical research. Constituents and policymakers alike must be cognizant of potential aftereffects, including the overburdening of the judicial system with lawsuits, unfavorable rulings for individuals for the sake of the collective, or a more powerful judicial branch (Littell 2002, 313). Lawmakers will have to thoughtfully develop this amendment further should Senate Joint Resolution 12 pass.

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