

Embedding the Human Right to Health Care in U.S. State Constitutions

A Progress Review and Lessons for Advocates

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The Human Right to Health Program is developing human rights tools to support organizations and coalitions across the U.S. in their efforts to achieve rights-based health care reform at the local, state and federal level. For more information please visit the following websites www.nesri.org and www.healthlaw.org, or contact Anja Rudiger at 212-2851723.

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Executive Summary

Neither the U.S. federal nor state governments have recognized the basic human right to health care. But activists across the country have been building a growing popular movement for the recognition of the right to health care in practical, policy, and legal settings. An explicit inclusion of such a right in state constitutions is one vehicle for this effort.

This report reviews constitutional amendment efforts that have taken place in a number of states over recent years. Based on internet research and information provided by amendment advocates via phone and email, it studies the cases of Massachusetts, Michigan, Minnesota, and Oregon, briefly reviews North Carolina and Florida, and analyzes key challenges and barriers faced by state-based advocates.

The purpose of this review is to inform future constitutional amendment efforts by offering an analysis of key lessons learned. While acknowledging the significant challenges facing advocates for constitutional amendments, this report suggests steps that can be taken to address and overcome these challenges. Moreover, the review also reveals that constitutional amendment campaigns, whether or not formally successful, may in fact be a useful vehicle to provoke legislatures into adopting health care reform measures.

Based on evidence from recent right to health care amendment initiatives, the report concludes that advocates should:

- adopt a human rights approach in their analysis and messaging;
- employ clearly defined and enforceable standards in their proposed amendment language;
- build a broad-based movement for the human right to health care;
- assess the potential impact of their proposed constitutional provision; and
- explain the value added by a constitutional right in relation to other health care reform efforts.

Introduction

The human right to health and health care has been recognized and codified in a number of international declarations and treaties. There is an expectation that these standards be incorporated by every country into their domestic law. Given the nature of the U.S. federal system, state constitutions are a clear and viable vehicle for such implementation.

State constitutions and the processes to amend them are also far more populist in nature than the quite rare and rarified federal constitution amendment process. In most cases, petition drives – which provide many opportunities for public education and organizing – are the first step towards state constitutional change. These efforts are therefore an effective component of building and demonstrating social movement support for basic human rights protections in areas like health.

While having had important impacts, state constitutional amendment initiatives for the right to health care have yet to realize their full potential. The case studies in this report examine these efforts and, based on the insights of activists leading those efforts, identify strategies to overcome challenges to using this powerful legal and political tool.

THE HUMAN RIGHT TO HEALTH CARE IN INTERNATIONAL LAW

The Universal Declaration of Human Rights (1948)

“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services...” (Article 25.1)

American Declaration of the Rights and Duties of Man (1948)

“Every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing and medical care, to the extent permitted by public and community resources.” (Article 11)

International Convention on the Elimination of All Forms of Racial Discrimination (1969)

“States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: [...] The right to public health, medical care, social security and social services...” (Article 5 (e) (iv))

The International Covenant on Social and Economic Rights (1976)

“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.” (Article 12)

Convention on the Elimination of All Forms of Discrimination against Women (1981)

“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.” (Article 12)

Convention on the Rights of the Child (1990)

“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 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.” (Article 24)

Case Studies

The Case of Massachusetts

Proposed Amendment

“Petition for a Constitutional Amendment Relative to the Provision of Health Insurance (Official Language with Footnotes)

Section 1: The People of the Commonwealth of Massachusetts hereby declare it necessary and expedient to alter the Constitution by the adoption of the following Article of Amendment:

Upon ratification of this amendment and thereafter, it shall be the obligation and duty(1) of the Legislature and executive officials, on behalf of the Commonwealth, to enact and implement such laws, subject to approval by the voters at a statewide election(2), as will ensure that no Massachusetts resident lacks(3) comprehensive(4), affordable(5) and equitably financed(6) health insurance(7) coverage for all medically necessary(8) preventive, acute and chronic health care and mental health care services, prescription drugs and devices(9).”¹

Process to Amend the State Constitution

The initial petition initiative has to be signed by ten qualified voters, submitted to the attorney general, who examines the initiative to make sure it is suitable for a popular vote (i.e. not in contradiction with constitutional requirements). Then it is opened for signature gathering. A certain percentage of votes cast in the last gubernatorial election is required; in this case the activists had to secure around 68,500 signatures. After submission, the legislature then must give it a 25% ‘yes’ vote twice at Constitutional Conventions. Only then can an amendment be put on the ballot and, if approved by a majority of voters, be ratified.

What Happened to the Amendment

The coalition gathered more than 71,000 valid signatures for the amendment and submitted it to the Constitutional Convention for the first time in 2004. The Constitutional Convention approved the amendment by 153 “yes” votes. But the Constitutional Convention did not vote on it a second time in their 2005-2006 Assembly. They voted 92-101 against discharging it from the committee it was referred to by the July 2006 Constitutional Convention. They would have had to vote on it a second time and get 50 ‘yes’ votes for it to be put on the ballot.²

The Health Care for Massachusetts Campaign brought the case before the Massachusetts Supreme Court, since the legislature is obliged to vote twice on every constitutional initiative, but the court said it had ruled previously that there is “no presently articulated judicial remedy for the Legislature’s indifference to, or defiance of, its constitutional duties....”³

Supporters and Opponents

The Health Care for Massachusetts Campaign was the coordinating group of the amendment process, which was supported by 150 organizations representing over 500,000 people, ranging from medical associations, faith-based organizations, social justice groups to various labor organizations and businesses. More than 90,000⁴ registered Massachusetts voters signed the petition. In the first Constitutional Convention 153 out of 200 representatives voted in favor of the amendment.⁵

¹ <http://www.healthcareformass.org/about/amendment.shtml>, consulted on Dec 8th 2008; see the appendix to this paper for a copy of the original footnotes which entail definitions of the terms used.

² <http://www.healthcareformass.org/>, consulted on Dec 5th 2008.

³ Ibid.

⁴ Not all signatures were considered valid because too many were collected in one county. This explains the difference between the 90,000 gathered signatures and the 71,000 valid signatures.

⁵ <http://www.healthcareformass.org/about/faqs.shtml>, consulted on Dec 8th 2008.

The insurance industry opposed the amendment and favored the Health Care Reform Act, which was eventually passed. As one amendment supporter explains, “Blue Cross Blue Shield initially supported the amendment but then wanted to kill it as new reform legislation was discussed in the legislature and they got what they wanted without having to accept the much more deeper reforms that the constitutional amendment would have demanded.”⁶

Policy context

In April 2006 the legislature adopted a major health care reform plan, called the "Act providing access to affordable, quality, accountable health care".⁷ This law mandated individuals to buy insurance coverage and was expected to secure coverage for an estimated 500,000 uninsured Massachusetts residents. According to expert assessments, it did succeed in cutting the number of uninsured in half, but failed to address the financial unsustainability of the system.⁸ Insurers and hospitals supported this reform of the system. Insurers in particular expected to benefit from receiving many thousands of new customers but were not interested in bringing down the cost of premiums.⁹

The constitutional amendment campaign is credited as a key driver for passing this reform, despite its own failure.

Reasons Why the Initiative Did Not “Succeed”¹⁰

- Insurers poured \$2 million into lobbying against the amendment and for the Health Care Reform Act. (There were also rumors of jobs being offered to legislators by insurance companies).
- Blue Cross Blue Shield, other insurers and the Massachusetts Hospitals Association made the rejection of the amendment a condition for their support of the Health Care Reform Act.
- The Health Care Reform Act guaranteed insurance companies new clients, since it included an individual mandate, while not forcing them to engage in cost saving and efficiency reforms.
- The principle of “affordability” of care was not attractive to insurance companies and hospitals.
- The campaign for the amendment “lost momentum,” according to the *Boston Globe*, following the signing into law of the Health Care Reform Act.¹¹ A coalition of supporters (Affordable Care Today) announced it would support implementation of the Health Care Reform Act and abandon efforts to put the amendment on the ballot.¹²

Opponents’ Arguments

Two of the authors of the Health Care Reform Act - Sen. Richard Moore (D-Uxbridge) and Rep. Patricia Walrath (D-Stow) - spoke against the amendment during the Constitutional Convention, urging lawmakers to allow for the Act’s implementation before putting the amendment to a popular vote. Walrath said that the adoption of the amendment would restrict legislators from quickly making inevitable tweaks to the Health Care Reform Act, forcing them instead to adhere to the difficult constitutional amendment process, which takes at least four years. “Do we really want to subject each legislative move to improve health care coverage to a statewide referendum?”¹³

Lessons Learned

- Movement and voter support: A broad-based movement for the amendment in the districts of legislative leaders is important to ensure smooth and swift passage through the legislature. Representatives’ support of the amendment needs to become a touchstone issue for voters in an election campaign.

⁶ Interview with Barbara Waters Roop, Co-Chair of Health Care for Massachusetts.

⁷ <http://www.mass.gov/legis/laws/seslaw06/sl060058.htm>, consulted on Dec 8th 2008.

⁸ Barbara Waters Roop, Co-Chair of Health Care for Massachusetts Campaign, interviewed by phone on Dec 15th 2008.

⁹ Ibid.

¹⁰ Unless mentioned otherwise, this section is based on a phone interview with Barbara Waters Roop, Health Care for Massachusetts, on Dec 15th 2008.

¹¹ <http://www.medicalnewstoday.com/articles/47420.php>, consulted on Dec 8th 2008.

¹² Ibid.

¹³ State House News Service, Jim O’Sullivan/ Priscilla Yeon, “Lawmakers Nix Petition Guaranteeing Health Care Access” (<http://www.healthcareformass.org/press/documents/LAWMAKERSNIXPETITIONGUARANTEEINGHEALTHCAREACCESS.pdf>).

- Human rights approach: The amendment did not explicitly include a right to healthcare, although proponents conceived it as a rights-based effort. This omission may have stifled advocates in drawing a distinction between the amendment effort and the Health Care Reform Act.
- Policy context: A right to health amendment can be perceived as competing with pending health care reform legislation. While this can help put pressure on lawmakers to pass some type of reform, it may be an obstacle to taking the more fundamental step of a constitutional amendment that guarantees health care for all. Reform legislation can be used as an excuse not to act on the amendment by characterizing the amendment as a distraction from concrete reform plans, or as a politicization of the process that would make the passing of reforms more difficult. While the introduction of an amendment might be a catalyst for the adoption of some type of reforms, such reforms may not meet comprehensive human rights standards. Ideally, a constitutional amendment effort avoids obstructive competition with policy reform proposals and is instead aligned with the development of a proposal, or at least a scenario, that illustrates how the amendment's principles can begin to be implemented.

The Case of Minnesota

Proposed Amendment

“Every Minnesota resident has the right to health care. It is the responsibility of the Governor and the legislature to implement all necessary legislation to ensure affordable health care.”¹⁴ A bill with this language was introduced in the state senate in March 2007 by Laura Berglin (DFL) and in the state house by Thomas Huntley (DFL) (HF683/SF2097).

“Every Minnesota resident has the right to a basic set of essential, effective health care services. It is the responsibility of the governor and the legislature to implement all legislation necessary to ensure timely and affordable access to these services.”¹⁵ A bill with this language was introduced in January 2007 by Senators Torres Ray, Moua and Olson. This proposal stalled in committee.

Process of Amending the State Constitution

The amendment has to be introduced by a representative, rather than through a petition. “The process begins when the legislature passes an act proposing a change in the constitution. Although a constitutional amendment is proposed in the form of a session law, it does not require the governor’s signature and cannot be vetoed. The act includes the statement of the question the legislature wants placed on the ballot.”¹⁶ Once a constitutional amendment is on the ballot, voters must support it by an extraordinary majority. “The extraordinary majority requirement means that in order to be adopted, an amendment must be approved by a majority of everyone voting at the election, not just of those voting on the amendment. The effect of this requirement is to count nonvoters on the question as “no” votes. This in turn means that a larger proportion (“extraordinary majority”) of those who do vote on an amendment must approve it in order for the amendment to be adopted. The rule of thumb is that a question must receive a 60 percent “yes” vote to be ratified.”¹⁷

What Happened to the Amendment

HF683/SF2097: HF0683 received a second reading in the House but then was returned to the Committee on Rules and Legislative Administration, where it died. SF2097 stalled in committee.

Supporters and Opponents

Minnesotans for Affordable Health Care, a broad coalition of organizations, and the Minnesota Nurses Association supported the amendment actively. Trade unions (e.g. AFL-CIO) also supported the amendment. The Minnesota Medical Association opposed the effort when other health care reform legislation emerged. The Chamber of Commerce was also in opposition.

Policy Goals

The amendment was considered a starting point for health care reform and a way to put political pressure on both the legislature and the governor to take action. The intention was to set a standard for health care reform and to show - through obtaining the people’s approval for a right to health care amendment - that comprehensive health care reform enjoys strong support from the public.¹⁸

Policy context

Health care reform legislation was adopted in 2008 (SF3780).¹⁹ The Chief of Staff of the Minnesota AFL-CIO put this in the context of the proposed amendment: “As you all know Minnesota unions have supported an amendment to the Minnesota Constitution guaranteeing health care for all. We have done so the last few years as we have become frustrated that the legislature and governor seemed unwilling or unable to act. However, it was very encouraging to see the 2007 legislature try and put us on the path to health care for all. We encourage you to continue those efforts and encourage the

¹⁴ <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=H0683.0.html&session=ls85>, consulted on Dec 4th 2008.

¹⁵ Ibid.

¹⁶ <http://www.house.leg.state.mn.us/hrd/pubs/mnconst.pdf>, consulted on Dec 8th 2008.

¹⁷ Ibid.

¹⁸ Interview with Jennifer Schaubach, Legislative Director of AFL-CIO Minnesota.

¹⁹ <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=S3780.1.html&session=ls85>, consulted on Dec 4th 2008.

governor to engage in this path as well. This does not mean we will drop our efforts for a constitutional amendment but will keep it out there as an incentive, if you will, that the governor and legislature continue the good work you started this year.”²⁰

Reasons Why the Initiative Did Not “Succeed”²¹

- A lack of support even from “friends” (supporters of universal, comprehensive health care reform) for a variety of reasons:
 - Health care issues are not seen as constitutional matters.
 - An amendment brings no concrete reform; the difficult part remains to be done. A constitutional amendment may not be an important step for health care reform.
 - Concerns about the fiscal implications of the amendment (Representatives Kalin and Morrow, DFL)
- Legislators did not want to be pressured into policy action by a constitutional article that would have created an obligation on them to act.
- There were promising health reform efforts in the legislature at that time and supporters of those efforts feared that a constitutional amendment might polarize and politicize the discussion on health care reform and distract from concrete reform issues (Minnesota Medical Association).²²

Opponents’ Arguments

“The Minnesota Medical Association supports current efforts and commitments to advance meaningful and timely health care reform, including efforts to achieve universal coverage. Adoption of a constitutional amendment of any type, at this time, will only serve to derail current cooperation and to distract and polarize policy makers and other relevant stakeholders from implementing and advancing reform during the 2008 legislative session. The MMA, therefore, will continue to provide leadership to advance health care reform and will actively oppose efforts that serve to distract attention from that important work, including passage of any constitutional amendment, such as the amendment proposed in 2007/2008 (HF683/SF2097).”²³

Two democratic state representatives, who voted to re-refer the amendment to a committee rather than passing it, said their concerns were mostly of a fiscal nature. Since such an amendment does not set forth a concrete plan or define methods of implementation, there may be too many uncertainties linked to the question of financing such a constitutional obligation.

Statement of the Minnesota Chamber of Commerce: “Constitutional amendments that ensure access to affordable health care might make for good sound bites, but the reality is that Minnesota already leads the nation in insured citizens; only 7 percent of Minnesotans are uninsured. In addition to being unnecessary, the proposal is silent on two very important questions: Who will define ‘affordable’? Who will pay for this universal coverage?”²⁴

Lessons Learned

- Broad-based support/movement: If there is insufficient public awareness and pressure, and no broad-based supporting movement, it is relatively easy to bury such an amendment in committee. Thus it is important to convince potential partners and supporters, especially groups and representatives who support comprehensive health care reform, of the necessity and usefulness of a constitutional amendment before initiating it.

²⁰ Health Care Access Commission Testimony given on July 11, 2007 by Brad Lehto, Chief of Staff of the Minnesota AFL-CIO (<http://mn.aflcio.org/statefed?action=downloadasset&assetid=7a6b9e84-13de-4ec8-957f-d6bb1e7f0fac>).

²¹ Unless mentioned otherwise, this section is based on a phone interview with Jennifer Schaubach, Legislative Director of AFL-CIO Minnesota, on Dec 9th 2008.

²² <http://www.minnesotamedicine.com/PastIssues/December2007TableofContents/MMAnewsDecember2007/tabid/2406/Default.aspx>, consulted on Dec 9th 2008.

²³ <http://www.minnesotamedicine.com/PastIssues/December2007TableofContents/MMAnewsDecember2007/tabid/2406/Default.aspx>, consulted on Dec 4th 2008.

²⁴ http://www.mnchamber.com/priorities/HealthCare_FAQ.cfm, consulted on Dec 4th 2008.

- Policy arguments and evidence: Proponents have to address concerns about the perceived vagueness of an amendment and uncertainties about its implementation. This can be done by either presenting specific health care reform proposals that apply the general framework set out by the amendment, or by demonstrating the potential implications of the amendment's provisions through feasibility studies and other research evidence. In particular, information should be provided about the resources needed to meet the obligations created by the amendment.
- Policy context and timing: Depending on the ultimate goal of a proposed amendment, it may or may not be useful to introduce it at the same time as concrete health care reform legislation.

The Case of Michigan

Proposed Amendment

Existing constitutional provision (Art 4, Section 51): “The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the promotion and protection of the public health.”

Proposed amendment: “The state legislature shall pass laws to make sure that every Michigan resident has affordable and comprehensive health care coverage through a fair and cost-effective financing system. The legislature is required to pass a plan that, through public or private measures, controls health care costs and provides for medically necessary preventive, primary, acute and chronic health care needs.”²⁵

Process of Amending the State Constitution

A petition needs to gather signatures of registered voters representing 10% of the total votes cast in the last gubernatorial election.²⁶ In this case this meant 380,000 valid signatures had to be gathered in 6 months, from January to June 2008. The Michigan Constitution can also be amended through a bill in the legislature.²⁷

Supporters and Opponents

The Michigan Universal Health Care Action Network (MichUHCAN), which includes a broad coalition of organizations, launched the initiative together with the Health Care for Michigan ballot committee. It was supported by a number of trade unions, ACORN, Michigan Legal Services, faith-based groups and many other organizations. The Chamber of Commerce was a key opponent.

Goals²⁸

- Move the Legislature to enact health care reform (replicating the impact of the Massachusetts campaign) and thereby contribute to the growing pressure on the federal government to make sweeping national health care reforms.
- Build a constituency and movement for health care reform in Michigan. Asking voters to sign a petition can serve to organize and build political support for the Legislature to enact health care reform. The campaign may generate hundreds of volunteers who could become part of a greater progressive movement in Michigan.
- Initiate a statewide discussion on the impact of out of control health care costs and cost shifting, the challenges for business competing on an uneven international playing field, the impact on jobs and organized labor, and thus the need for health care reform. The momentum generated should put pressure on the Legislature to enact reform.

Context

Democratic presidential primaries took place at the time of the collection of signatures; however, Michigan was excluded from this process by the DNC, so no real campaigning took place. Primaries can be a great opportunity for launching petitions, firstly by enabling awareness raising of an issue and forcing candidates to address it, and secondly by using the many opportunities for signature gathering that emerge during a particularly active period in public life. However, during high profile election campaigns fundraising for a ballot initiative is much more competitive.

What Happened to the Amendment

With 133,000 signatures, the coalition fell short of gathering the 380,000 signatures needed.

²⁵ <http://www.healthcareformichigan.org/Pages/HealthCareForMichiganPetition.pdf>, consulted on Dec 16th 2008.

²⁶ [http://www.legislature.mi.gov/\(S\(qnk5bnfreholn45uxv5mx55\)\)/mileg.aspx?page=getObject&objectName=mcl-Article-XII-2](http://www.legislature.mi.gov/(S(qnk5bnfreholn45uxv5mx55))/mileg.aspx?page=getObject&objectName=mcl-Article-XII-2), consulted on Dec 16th 2008.

²⁷ [http://www.legislature.mi.gov/\(S\(va5xbcyce2eokn3f5eab3c55\)\)/mileg.aspx?page=getObject&objectName=mcl-Article-XII-1](http://www.legislature.mi.gov/(S(va5xbcyce2eokn3f5eab3c55))/mileg.aspx?page=getObject&objectName=mcl-Article-XII-1), consulted on Dec 16th 2008.

²⁸ According to John Freeman’s (MichUHCAN) plan for the ballot initiative (<http://michuhcan.com/>).

Reasons Why the Initiative Did Not “Succeed”

The Health Care for Michigan ballot committee said they had trouble raising the money needed for such a huge signature collection due to the fact that a lot of potential donors were the same as those tapped by the democratic candidates in the lengthy primary process.²⁹

Opponents’ Arguments

- Business groups: Too expensive for businesses³⁰
- Chamber of Commerce³¹:
 - Constitutional amendment is unnecessary to act on health care reform.
 - Lack of definitions: “Because the language contained in the Constitutional Amendment is broad and undefined, it could be interpreted differently by different people. Every key word found in this Constitutional Amendment (e.g., ‘affordable,’ ‘comprehensive,’ ‘fair,’ ‘cost effective,’ etc.) could be subject to years of litigation. As a result, court opinions – not legislators – would ultimately be writing these laws [...]”
 - Concern that “affordable and comprehensive health care coverage” would entail a significant tax increase or move Michigan in the direction of a single-payer state.

Lessons Learned

- Preparation and timing of the initiative: Advocates should allow sufficient time to build a volunteer or membership movement for signature collection if funding opportunities are limited.
- Policy arguments and evidence: Proponents need to address concerns about the perceived vagueness and uncertain impact of the amendment by using well-defined terms (e.g. with legal precedents) or including definitions, and by presenting proposals or scenarios on how to meet the obligations arising out of the constitutional amendment.
- Human rights frame: Influenced by the Massachusetts effort, the amendment language did not explicitly mention the right to health care, which may have hampered human rights based advocacy.

²⁹ http://blog.mlive.com/kzgazette/2008/06/michigans_november_ballot_will.html, consulted on Dec 10th 2008.

³⁰ Ibid.

³¹ <http://www.michamber.com/mx/hm.asp?id=2008ballot>, consulted on Jan 8th, 2009.

The Case of Oregon

The Proposed Amendment

Art. 1, Section 46: “The people of Oregon find that health care is an essential safeguard to human life and dignity and that access to health care is a fundamental right. In order to implement that right, the Legislative Assembly shall establish by law a plan for a system designed to provide to every legal resident of the state access to effective and affordable health care on a regular basis.”(HJR-100)³²

Process of Amending the State Constitution

A legislative resolution, passed by both houses with a simple majority, can put an amendment to voters for approval. This can also be done through a ballot initiative process, which requires valid signatures equaling 8% of votes cast in the last gubernatorial election. In this case, the collection of 100,840 valid signatures would have put the amendment on the ballot for a popular vote in November 2006.

Supporters and Opponents

There have been different attempts to amend the constitution, both through legislative action and through a ballot initiative. In 2005, a ballot petition was launched by a group called “Hope for Oregon Families,” led by Representative Mitch Greenlick (D) and Senators Ben Westlund (D) and Alan Bates (D), together with a coalition of seniors groups, health care providers, labor and human services advocates.³³ Representative Greenlick also introduced legislative resolutions in 2007 and 2008, which received support from all Democratic representatives. All Republican representatives voted against the resolutions.

Policy context

The Oregon Health Fund Board (OHFB) was created in 2007 through Senate Bill 329. The seven-member committee of the OHFB is tasked to gather data, evaluate sub-committee reports and make final recommendations for health care reform legislation. These recommendations will be considered in the 2009 legislative session.³⁴

What Happened to the Amendment

HJR-18 introduced by Mitchell Greenlick (D-Portland) in 2007 and HJR-100, introduced by Rep. Greenlick in 2008, were approved by the House but stalled in the Senate Rules Committee. The 2006 ballot initiative attempt failed to get the required 100,840 valid signatures (81,058 valid signatures were collected).

Opponents' Arguments

- Republican Rep. Dennis Richardson expressed concerns that the implementation of the amendment would cost at least \$3 billion per year and that no plan was offered as to how to pay for this. If Oregonians rejected tax increases, funds might be taken away from programs not mentioned in the constitutional, such as education, public safety, seniors and children. He also asked, “What will prevent Oregon from becoming a magnet for sick people from other states who move to Oregon to become eligible for Oregon’s universal health care benefits?” Moreover, he was concerned that the amendment would “nullify the progress being made by the Oregon Health Fund Board, under the purview of SB 329.”³⁵
- Conservative think tank (Steve Buckstein at the Cascade Policy Institute): “More and more people will say: ‘I have a right to not care about the costs, because I have an unqualified right to health care.’”³⁶

³² <http://www.leg.state.or.us/08ss1/measpdf/hjr100.dir/hjr0100.intro.pdf>, consulted on Dec 11th 2008.

³³ http://www.leg.state.or.us/greenlick/pr_052505.pdf, consulted on Dec 11th 2008.

³⁴ <http://media.www.dailymerald.com/media/storage/paper859/news/2008/02/22/News/The-State.Of.Health.Care-3228869.shtml>, consulted on Dec 5th 2008.

³⁵ http://www.leg.state.or.us/richardson/newsletter_021808.htm, consulted on Dec 5th 2008.

³⁶ <http://www.oregoncatalyst.com/index.php?/archives/1146-Is-health-care-a-fundamental-right.html>, consulted on Dec 5th 2008.

Lessons Learned

- Voter support and movement building: If a legislative route is taken, it may have to be supplemented with strong pressure from voters in key legislators' districts to gain the support of legislative leaders.
- Policy arguments and evidence: Proponents need to address fiscal and budgetary concerns by offering an analysis of potential fiscal impact and scenarios for budget allocations.

Other Cases

North Carolina

Proposed Amendment

Article 1, new Section 38: “Health care is an essential safeguard of human life and dignity, and there is an obligation for the State to ensure that every resident is able to realize this fundamental right. Not later than July 1, 2009, the General Assembly shall provide by law a plan to ensure that by July 1, 2013, every resident of North Carolina has access to appropriate health care on a regular basis.”³⁷

Process of Amending the State Constitution

An amendment can be introduced by a representative in the legislature. If passed by both Houses of the General Assembly, it is put to a popular vote.

Supporters

Representative Verla Insko (D) and 37 co-sponsors introduced H.B. 901 on March 20, 2007, with support of Health Care for All North Carolina and 83 organizations (including medical, faith-based, community, political, labor and consumer organizations).³⁸

Policy Goals³⁹

- Achieving stability and continuity: Without establishing health care as a right, health care would remain “conditional on political winds, and the yearly rounds of budgetary cuts.”
- Inclusiveness of health reform: Establishing a right means that reforms would have to be for everyone, not just for 90 or 95% of the people.

What Happened to the Amendment

The amendment stalled in the Committee on Rules, Calendar, and Operations of the House, despite a Democratic majority in the chamber and a sympathetic Speaker of the House. Health Care for All announced in late 2008 that it had suspended its work on the constitutional amendment but might take it up again at a later stage.⁴⁰

³⁷ <http://www.ncleg.net/Sessions/2007/Bills/House/HTML/H901v1.html>, consulted on Dec 5th 2008.

³⁸ http://www.healthcareforallnc.org/legislation/endorsers.cfm?temp_id=99999 and <http://www.righttohealthcare.org/Work/Caro.htm>, consulted on Dec 5th 2008.

³⁹ http://www.healthcareforallnc.org/legislation/why_right.cfm?temp_id=99999, consulted on Jan 8th, 2009.

⁴⁰ http://www.healthcareforallnc.org/legislation/CurrentLeg.cfm?temp_id=99999, consulted on Jan 8th, 2009.

Florida

Proposed Amendments

An amendment proposed in 2004 reads as follows.⁴¹ Article I, Declaration of Rights, New Section: “1. Every permanent resident of the State of Florida has a right and is entitled to affordable health insurance. The insurance shall provide full and comprehensive benefits for medically necessary prescriptions, doctor’s visits, hospital costs, medical equipment, physical and mental therapy and all dental care. It shall have one million dollars (\$1,000,000) in maximum benefits. Starting with the adoption of this Amendment, the maximum limit shall be adjusted by the annual cost of living each year.

2. Each permanent resident shall be offered the comprehensive health plan described in Paragraph 1 at a rate equal to the lowest rates offered to members of the largest private group health plan offered by a commercial insurance company or not for profit pre-paid health care provider or insurer in the State of Florida. This offer shall be made through an open enrollment period lasting thirty days beginning the first day of August each year. No applicant’s coverage shall be limited, denied or debit rated as a result of any pre-existing health condition.

3. If the private insurance companies or not for profit pre-paid health care providers offering health insurance or coverage in the State of Florida do not offer the plan in Paragraph 1, the State of Florida shall establish a not for profit Trust to take effect on August 1, 2005, and the Trust shall offer the plan. The Trust shall not contract with any insurance company or organization controlled by any insurance company to perform any functions for the Trust. Any deficit in the Trust shall be eliminated through the levy of a general sales tax on all sales in the State, but no tax shall be levied on clothes used for work, pharmaceuticals, medical equipment or raw food stuffs.”

Around the same time, a group called Floridians for Health Security proposed an amendment for single-payer health care, which included the right to health care. Article 1, new Section 26: “By General Law the Legislature shall prescribe and thereafter enact single payer health care, which in clear and concise language shall set forth the right of all persons to comprehensive health care services from a health care provider of that person’s choice.”⁴² Key terms, such as “comprehensive”, were defined in subsequent sections.

Process of Amending the State Constitution

Proponents must collect at least 8% of the total number of statewide ballots cast in the previous Presidential election. The signatures remain valid for 4 years. The Florida Supreme Court has to approve the language of the initiative, i.e. check for its compatibility with the state constitution, and its respect of the single-subject rule.⁴³

What Happened to the Amendments?

Information is not readily available but it appears that not enough signatures were gathered for either amendment.

⁴¹ <http://www.peoplesamendments.org/right%20to%20affordable%20health%20insurance.pdf>, consulted on Dec 16th 2008.

⁴² <http://www.ffhs.org/>, consulted on Dec 9th 2008.

⁴³ http://ballotpedia.org/wiki/index.php/Florida_Initiative_and_Referendum_Law, consulted on Dec 15th 2008.

Challenges and Barriers

The most fundamental challenge faced by state constitutional amendment efforts for the right to health care has been the widespread conviction that health care issues are questions of policy and not rights. Opponents argue that constitutions and courts are inappropriate vehicles for addressing access to care and raise fiscal and other concerns to support their position. This challenge arises out of an overall context in the United States that fails to acknowledge or understand economic and social rights and how to implement them. There are models and precedents that demonstrate how courts and legislatures can and do play different, and complimentary, roles in ensuring these rights, including the right to health care. However, these are not widely known within the United States. There is clearly a need to build a greater understanding of the value and role of constitutionally embedded economic and social rights.

Still, overall, where state constitutional initiatives gained serious momentum, they appeared to fuel legislative reform efforts that improved access to health care but fell short of the more comprehensive goals set out in the proposed amendments. Thus, activists face a challenge of aligning legislative and constitutional strategies so that they do not become oppositional in practice.

Key challenges and barriers can be summarized as follows:

- A constitutional amendment consists of general principles that do not specify how health care reform should be implemented. This is a strength in so far as those principles, based on the human right to health care, reflect a broad consensus and their implementation allows democratic participation and contextual variations. However, it can also be a challenge, since no concrete solutions are offered. In two of the five states surveyed, this was a major obstacle, and in other states it was a contributing factor to legislative resistance. Legislators were skeptical about general provisions that could be subject to different interpretations, especially by the courts. They expressed concern that courts would be given the power to define and decide what legislative action has to be taken. Moreover, legislators suspected that the broad-based provisions of a constitutional right could entail incalculable and uncertain fiscal burdens. Only one state, Massachusetts, defined the general provisions further, commissioned a study on fiscal implications and was thus able to respond to concerns about the amendment's potential impact.
- While an amendment can be introduced by an elected representative or a citizens' group, without broad-based support it is unlikely to progress very far, either in the legislature or as a ballot initiative. In most states proponents had difficulties gaining and sustaining broad-based popular support. They failed to collect sufficient signatures, raise enough funds, obtain large-scale volunteer support, or put strong pressure on representatives in their electoral districts. While many proponents were able to build large coalitions, those coalitions did not always include representatives from business groups or from the health care sector.
- If concrete health care reform bills are introduced at the same time as an amendment, these initiatives can be perceived as in competition with each other unless explicit linkages are made. A constitutional provision can be seen as superfluous in light of pending reforms, or as unnecessarily politicizing, which happened particularly in Massachusetts and Minnesota. This challenge is exacerbated when proponents fail to apply an analytical and normative human rights frame to their messaging and instead focus on health care reform issues, without offering a human rights analysis of such issues. In two states, Massachusetts and Michigan, the amendment did not even explicitly refer to a right to health care but focused on the government's duty. In most states the rationale for establishing a constitutional right to health care was not sufficiently explained. Advocates should clarify the role of an amendment in securing a system based solely on the principle of health protection, in guaranteeing democratic accountability of this system and removing it from the vagaries of politics.

- The influence and resources of key opponents, especially the insurance industry, are often underestimated. This was a particular problem in Massachusetts, but also affected other states. Proponents need to develop better tactics to counter the industry's influence, particularly on elected officials. Proponents often lack an active and influential constituency that could match the corporate lobby and that could force legislative leaders to move a measure through the legislature.

Five Important Lessons for Advocates

1. HUMAN RIGHTS FRAMING AND MESSAGING

Advocates should consider using an explicit human rights approach, based on a sound analytical framework that outlines key standards of the human right to health care. It is crucial to raise awareness about the human right to health care in order to educate both supporters and the general public about the value added by adopting a constitutionally rights based approach to health care reform. A human rights frame enables advocates to embed the principles of universality, equity, and accountability as the foundation of a system of health protection, while building a consensus through the legislature on the best technical solutions for implementing such a system. Advocates must engage in clear messaging about the distinct role and value of a constitutional right to health care, such as its role in securing accountability and sustainability, as well as articulate the relationship to concrete health care reform efforts. Advocates should offer a human rights analysis of existing and proposed reform efforts and explain how a constitutional right could help shape health policy.

2. CLARITY OF PRINCIPLES

Language used in a proposed constitutional amendment should be chosen very carefully, with a view to facilitating effective implementation and enforcement of rights. Principles and standards used in the provision should be clearly articulated and defined, anticipating potential interpretations by the courts. Principles used in the amendment should reflect the cornerstones of a health care system compatible with human rights, without prescribing a specific policy solution.

3. MOVEMENT BUILDING

Advocates must build a broad-based coalition and movement. Whether an amendment is introduced in the legislature or through a ballot petition, large-scale support is essential for both strategies. For the legislative route, strong constituency support is needed in the districts of key representatives (legislative leaders, committee chairpersons). A ballot petition can support this process, or serve as a stand-alone people's initiative. A ballot initiative requires a large-scale organizing effort and can also be a vehicle for human rights base-building and for creating a sustainable movement for rights-based health care reform.

4. IMPACT ASSESSMENT

Advocates must be clear about what the adoption of a constitutional amendment would entail in practice. They need to assess the potential impact of such an amendment and offer scenarios for its implementation. A human rights analysis of potential implementation scenarios can remove uncertainties and address concerns about feasibility and fiscal impacts. Such scenario analysis should not advocate for a particular technical solution but outline different options from a human rights perspective. There would be a significant risk in presenting a specific reform plan in conjunction with the amendment, because if this plan failed to gain approval, support for the amendment might suffer in turn. To avoid this, proponents in Massachusetts commissioned an expert report that assessed a range of policy options for meeting potential constitutional requirements, with a focus on fiscal impacts.⁴⁴

5. HEALTH CARE REFORM CONTEXT

A constitutional right to health care has to be distinguished from and presented as complementary to concrete health care reform efforts. Advocates must avoid creating a competitive relationship with pending reform efforts. Especially in a context where major health care reform bills are under consideration, amendment proponents should position themselves first and foremost as human rights advocates, highlighting the role of a constitutional right as a guarantor of sound health care policy for decades to come.

⁴⁴ http://www.healthcareformass.org/materials/documents/Thorpe_Action_Dec14.pdf, consulted on Dec 15th 2008.

Key State-Based Contacts

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Florida

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Appendix

Massachusetts: Interpretation of amendment language⁴⁵

INTERPRETATION OF LANGUAGE**

1. "obligation and duty"

This mirrors the Supreme Judicial Court's interpretation of the Article of the Massachusetts State Constitution that it held created an enforceable right to a public K-12 education for every child in the Commonwealth in *McDuffy v. Secretary of Education* (382 Mass. 545 (1993))

Creates an enforceable right for the Commonwealth's residents in the aggregate.

Does not create an individual right to specific health services, treatments or coverage.

2. "voter approval"

Added by the 2004 Constitutional Convention to ensure voters would have the opportunity to approve any specific plan developed to meet the requirements of this constitutional mandate before the plan is implemented.

3. "no Massachusetts resident lacks"

Goes to the issue of universality of coverage, which is a prerequisite to improving quality of care, improving the health status of all Massachusetts residents, reducing disparities in health status among Massachusetts residents, containing costs, preventing cost shifting and simplifying administration of our health care system. Requires the Commonwealth to ensure there is at least one place where every resident can obtain coverage whether in the private market or through a public program or programs.

Does not require the Commonwealth to be or preclude it from being an insurer but probably does require the Commonwealth to at least "make a market" in insurance as it does for public employees through the Group Insurance Commission.

Leaves elected officials free to define residency based on any of a variety of variables including duration of physical presence and intent for moving to Massachusetts.

4. "comprehensive"

Implies a significantly broad benefit package to ensure the best value for resources allocated.

Should be read with "preventive, acute and chronic health and mental health care, including prescription drugs and devices" to include a full range of cost-effective, coordinated, evidence-based medical, surgical and mental health care services to prevent and treat illness and injury.

Requires coverage for effective screening and disease prevention services.

Should be read with "affordable" and "medically necessary" to establish limits which could change over time to reflect changes in evidence-based best practices, available resources and innovative technologies.

Does not include or preclude access to new and unproven technologies.

5. "affordable"

Applies equally to all stakeholders - individuals, employers, insurers, providers and hospitals, to name a few - that currently finance or subsidize the health care system whether as consumers of insurance or services, taxpayers or providers of uncompensated or under-compensated care.

Requires pricing that does not create an unreasonable financial barrier to obtaining the coverage essential for access to timely, cost-effective care.

Implies some form of subsidy for low- and middle-income residents and their families, the self-employed and their families, and for businesses with limited or negative cash flow - just as employers that offer insurance and their workers currently receive public subsidies through the tax system.

Requires cost containment, including, perhaps, some form of overall cap to real spending.

Encourages, if not requires, cost savings through:

Administrative simplification, streamlining and modernization;

Incentives to providing timely, cost-effective, evidence-based care in appropriate settings;

Improved quality and safety to reduce medical errors and avoidable hospitalizations;

Consumer education about how to lower costs by seeking appropriate care early, making life-style changes, following treatment programs;

Consumer education about the relative benefits and cost-effectiveness of different interventions, etc;

Reimbursement system reforms to encourage prevention, coordinated care, follow-up to reduce the need for expensive, high tech interventions;

Bulk purchasing where applicable;

Elimination of redundant health insurance components of workers compensation, auto and other liability insurance products.

6. "equitably financed"

⁴⁵ The following section is a verbatim quote, cf. <http://www.healthcareformass.org/about/amendment.shtml>

Assumes that every stakeholder who benefits, either directly or indirectly, from a universal health insurance system contributes to financing it whether through direct payments, taxes or tax expenditures.
Implies some sort of sliding-scale premium mechanism based on ability to pay.
Assumes an end to cost shifting among stakeholders.
Implies creation of a reserve fund to ensure adequate resources to provide coverage during periods of unusually high demand for services or subsidies and/or revenue shortfalls.

7. "insurance"

Insurance, whether public or private, is the standard mechanism used to spread risk and control the costs of unpredictable and/or episodic events. The word itself does not suggest a private or public system as our current patchwork of private and public health insurance programs demonstrates.

8. "medically necessary"

Well-litigated term used by all public and private insurers to define coverage, utilization and costs that will minimize the likelihood of further litigation on coverage issues.
Implies the inclusion of benefits based on medical evidence and/or consensus medical opinion.

9. "health care services"

The MassHealth Standard benefit package would represent a reasonable interpretation of this language.
It implies that "gap" insurance would be available to the underinsured, including a medigap plan for Medicare beneficiaries.