

# Human Rights and the Political Economy of Universal Health Care: Designing Equitable Financing

ANJA RUDIGER

## Abstract

Health system financing is a critical factor in securing universal health care and achieving equity in access and payment. The human rights framework offers valuable guidance for designing a financing strategy that meets these goals. This article presents a rights-based approach to health care financing developed by the human right to health care movement in the United States. Grounded in a human rights analysis of private, market-based health insurance, advocates make the case for public financing through progressive taxation. Financing mechanisms are measured against the twin goals of guaranteeing access to care and advancing economic equity. The added focus on the redistributive potential of health care financing recasts health reform as an economic policy intervention that can help fulfill broader economic and social rights obligations. Based on a review of recent universal health care reform efforts in the state of Vermont, this article reports on a rights-based public financing plan and model, which includes a new business tax directed against wage disparities. The modeling results suggest that a health system financed through equitable taxation could produce significant redistributive effects, thus increasing economic equity while generating sufficient funds to provide comprehensive health care as a universal public good.

---

ANJA RUDIGER, PhD, is a political theorist and advisor to the National Economic and Social Rights Initiative (NESRI), New York City, where she served on staff from 2007 to 2015.

Please address correspondence to Anja Rudiger. Email: [anjarudiger@hotmail.com](mailto:anjarudiger@hotmail.com).

Competing interests: None declared.

Copyright: ©Rudiger. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>), which permits unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

## Introduction

Universal health care is about more than our health—it is also a prescription for economic transformation, budget and tax reform, and public sector strengthening. It can catalyze economic redistribution in countries with fragmented market-based health systems, and resist austerity and privatization policies where universal systems already exist. If the human rights framework is to have a role in shaping this high-stakes political project, the right to health care has to be turned into a conceptual tool to guide systems change.

Health systems goals put forward at the international, national, or sub-national level are not usually measured against human rights standards, and the policy instruments that implement reforms are not assessed for their consistency with the right to health care. In policy terms, universal health care is decidedly under-defined, which opens up space for periodic re-framing efforts based on evolving political contexts and interests, as the transition from the Alma-Ata Declaration's Health For All to universal health coverage (UHC) illustrates.<sup>1</sup> There is a lack of rights-based policy guidance to assess this shift from “care” to “coverage” and its apparent preference for an insurance business model over public service provision. To guide debates about the political economy of universal health care and inform the design of universal systems, it is incumbent on human rights advocates to establish the right to health care as a workable policy tool and engage with policymaking beyond general statements of values or legal defenses of individual rights. Right to health advocates must be able to define both the goals of a health system and the instruments and mechanisms conducive to achieving those goals. A rights-based framework of policy-relevant principles and standards for health system design, and particularly for financing, is needed to set parameters for modeling, implementing, and improving universal health care systems.

This article presents a human rights approach to financing health care, along with the design of a financing mechanism for a sub-national universal system in the United States, including a predictive model simulating equitable revenue generation.

This work, developed—with the author's involvement—by the Vermont Workers' Center's (VWC) Healthcare Is a Human Right campaign (HCHR) between 2008 and 2015, includes a system assessment tool that evolved from a rights-based analytical framework designed to evaluate the most recent round of federal health care reform in the United States.<sup>2</sup> Although grounded in international legal human rights norms, the example presented here does not make a legal case but offers a normative policy framework, informed by economic analysis and empirical data. All tools were developed collaboratively, with community participation, to advance grassroots human rights campaigns and foster the broad movement building—the coordinated developmental process that creates, strengthens, and sustains social movement infrastructure, membership and strategy—that is required to amass the political power necessary to effect systemic transformation.

## Human rights and the US health care market

Over the last decade, rights-based advocacy for universal, publicly financed health care has been gaining traction in the United States, notwithstanding the century-old resistance of industry interests and the failure of the recent federal reform, the Affordable Care Act (ACA), to challenge those interests.<sup>3</sup> Although the ACA expanded access to the public Medicaid program, its mandate on individuals to purchase private insurance policies served to channel customers—and public subsidies—to the insurance industry, thus consolidating the private insurance market. While many health advocates responded with plans for improving the ACA, human rights campaigners pointed to the structural inequity of market-based health insurance and redoubled their organizing for a public health care system. The growing movement for the right to health care is best reflected in the Healthcare Is a Human Right Campaign Collaborative, a national movement building initiative inspired by the success of the eponymous campaign in Vermont, which became the first US state to enact a universal

health care law and attempt a transition to a publicly financed universal system.<sup>4</sup>

The focus on health care financing by both policy makers and campaigners has its roots in the particular nature of the US health care crisis. In the only affluent country without a universal health system, the abundance of resources invalidates any argument for a progressive realization of human rights. Health care funding is plentiful (17% GDP in 2013), yet the mechanisms for raising and allocating those funds are deeply inequitable.<sup>5</sup> While total health expenditure is twice as high as in most European countries, health disparities abound and outcomes are poor, with up to 100,000 deaths annually considered amenable to health care.<sup>6</sup> Financial barriers are a key predictor of poor access to and quality of health care (oftentimes correlated with structural racism) and a leading cause of debt and impoverishment. The private, market-based insurance system does not function as an effective pre-payment mechanism, even with the public subsidies introduced by the ACA. Because of substantial user fees at the point of service, insurance coverage fails to correlate sufficiently with either improved access to care or ability to pay.<sup>7</sup> Low-income people with private insurance rather than public (Medicaid, Medicare, or military) not only spend more of their income on health care than the wealthy, they are also more likely to have lower value insurance plans and delay or avoid getting needed care.<sup>8</sup>

It follows that universal health care advocacy is centered on promoting redistributive health care financing that facilitates both universal, equitable access to care and equity in the payment for care. Advocates have turned to human rights principles to inform the analysis and development of health-related economic and fiscal policies. The right to health care has been configured as a tool for shaping decisions about equity and resource redistribution.

During the federal health reform debate, right to health advocates confronted the subjugation of health needs to market imperatives by pointing to the root causes of injustice in health care. Against the hegemony of the market paradigm with its twin

tropes of consumer choice and corporate competition, and against the thinly veiled racist denigration of public services and their users, human rights advocates envisioned health care as a public good shared equitably by all.<sup>9</sup> Human rights principles inspired the development of a heterodox concept of public goods, defined as the essential goods, services, and infrastructure needed to satisfy human needs and realize human rights, in contrast to the exclusions and inequities entailed in treating health care as a market commodity.<sup>10</sup> Grounded in the understanding that “no individual person can alone satisfy their human needs, and thus no individual can flourish and achieve their full human potential alone,” Vermont’s HCHR campaign pursued a vision of democratic communities sharing resources collectively and providing public goods to meet fundamental needs.<sup>11</sup> Whereas single payer health care advocates traditionally employed cost-savings arguments for universal health care, thus relying on the same fiscal prudence and economic efficiency frame as their private market opponents, human rights advocates emphasized the antagonism between market individualism and collective public goods. Moreover, while the mainstream debate focused on access to “coverage”, human rights advocates elevated the goal of providing “care”, replacing the insurance industry concept of risk protection with a public service model of meeting human needs.<sup>12</sup>

Although the passage of the ACA confirmed that federal health reform was largely a market management exercise shaped by the medical-industrial complex that stood to benefit, human rights advocates had sown the seeds for very different discussions in their own communities. The emerging HCHR movement began organizing people most impacted by health care injustice, and developed human rights tools that enabled everyone to participate in state-based health policy initiatives that followed in the wake of the ACA.

### Human rights standards for health systems

To achieve emancipatory outcomes, the application of human rights to policymaking must be

grounded in an analysis of the power structures that prevent the collective realization of rights. If rights are conceived solely as legal rights conferred on individuals, they risk depoliticizing collective action and instead legitimize the state as the arbiter of rights claims. In recognition of the history of struggles that have used human rights as an emancipatory tool against the abuse of power, the HCHR movement explicitly conceives of rights as a political strategy for addressing unjust power relations. This approach couples a normative vision of an equitable society that realizes rights for all with the practical use of rights to analyze and politicize power and build people's agency and alignment. The human rights frame thus occupies the intersection between universal values and vision on one side, and particular political demands and policy prescriptions on the other. Though rights derive their strength from their universalizing gesture, their meaning is defined through an analysis of the particular conditions that perpetuate unjust power. In the quest for universal health care, rights can be marshaled both as a normative and as an analytical force to be deployed on a politically contested terrain.

Vermont's HCHR campaign initially developed normative principles—universality, equity, accountability, participation, and transparency—to guide their organizing and advocacy, before refining these into an analytical human rights tool for evaluating health reform designs, inspired by a rights-based assessment framework developed by the National Economic and Social Rights Initiative (NESRI).<sup>13</sup> While these tools are anchored in international right to health norms, the dearth of existing rights-based policy perspectives on health reform prompted the development of tailor-made guidance. The necessarily general nature of international instruments (for example, General Comment 14 and reports by the Special Rapporteur on the right to health) has required advocates to add political and economic analysis, substantiated by empirical evidence, to render right to health approaches relevant to their own political contexts.<sup>14</sup> Although the World Health Organization (WHO) has recently supported an effort to link health system design with human rights—after largely

ignoring human rights in its health financing report—its new UHC monitoring framework lacks explicit human rights references.<sup>15</sup>

When the HCHR campaign designed its analytical tool for assessing the consistency of health reform proposals with human rights norms, it had already achieved a significant win on the path to universal health care.<sup>16</sup> In 2010, Vermont passed a law that mandated the design of three options for establishing a universal health system in the state.<sup>17</sup> Notably, the law included the principles championed by the HCHR campaign, thereby setting a precedent for integrating human rights norms into domestic law and giving advocates an important accountability tool. This achievement signaled the campaign's early success in shifting the public discourse toward a recognition of health care as a human right and public good, and infusing state policy with rights-based language.

The HCHR campaign's assessment tool empowered its members to analyze the system design options mandated by the law and shape policy positions. Anchored by the five human rights principles and the concept of public goods, the tool contains 60 evaluation questions, grouped by principle as passed into law. These questions, with varying level of detail, cover basic right to health care norms such as equal access to care, monitoring of disparities, investments in underserved communities and primary care, as well as policy concerns that remain contentious in the US context, such as elimination of user fees, income-based financing, and full inclusion of immigrants. The tool intends to address all critical system design issues that impact the right to health care, including needs-based allocation of funds, access to all needed health services, price controls, and public administration. Assessment questions were developed based on an analysis of international norms and measured against access barriers and disparities reported in state and federal data.

By taking normative principles as its foundation, rather than the more analytical standards of General Comment 14 (accessibility, affordability, acceptability, and quality), this assessment framework serves as the missing link between general

human rights norms, which inspire vision and values, and specific policy solutions, which define and operationalize universal health care.

The tool can be adapted and applied to any health system reform effort, and it has been shared with other rights-based campaigns to support member education and policy advocacy. Its evaluation questions can be turned into implementation standards to guide the development of policy solutions. The HCHR campaign proceeded to prepare policy standards for both health benefits and financing, which ultimately enabled the campaign to design its own universal health care financing plan.

### Human rights standards for equitable financing

The debate over universal health care financing raises macro-economic questions of taxation, public sector involvement, and the role of industry and employers. The Vermont example shows that the human rights framework can offer practical guidance for addressing these political economy challenges of health care reform.

The transition to universal health care in Vermont hinged on the design of an economically feasible and politically acceptable health care financing plan. In 2011, the HCHR campaign was instrumental in achieving the passage of Act 48, the country's first law for a universal, publicly financed health care system, to be established by 2017.<sup>18</sup> While the law required health care to be financed equitably and provided to all residents as a public good, it did not specify revenue sources and instead mandated the preparation of a separate financing plan by January 2013. Health reform advocates, including the HCHR campaign, usually attempt to write at least the outline of a financing mechanism into a health reform law to achieve greater control over the transition process and prevent implementation from being mired in a revenue debate. Yet in the United States, advocates have not had sufficient power to secure the passage of a universal health care law that specified financing, and the HCHR campaign settled for the inclusion of the equity principle in the financing mandate of Act 48.

The design of a financing mechanism determines equity in access to and payment for health care. To inform the preparation of a financing plan, the HCHR campaign looked to the human rights standards in its system assessment tool and to the equity principle in Act 48. The goal was to produce actionable guidance for realizing the principle of equity in financing in a way that generated sufficient revenue for meeting all residents' health needs.

This focus on equity coincided with the Occupy movement's protests against rising inequality, which catalyzed an ongoing debate in US politics about the largest concentration of wealth since the 1930s and the greatest income inequality since the late 1970s.<sup>19</sup> Regressive health care financing is a significant contributor to economic inequality, producing an inverse correlation between household income and household health care spending.<sup>20</sup> Conversely, a redistributive universal health care system in the United States would deliver significant financial relief to lower- and middle-income families.<sup>21</sup> Providing health care as a public good could also pave the way for a broader paradigm shift toward universal public programs, replacing the threadbare safety net of means-tested benefits. Health care could function as a strategic lever for building a more equitable society through the universal provision of the goods and services needed to exercise economic and social rights. In turn, increased equity would further improve health outcomes.<sup>22</sup> It follows that health reform goals should reflect the direct correlation between health and equity by measuring not only health but also equity indicators.

This broader equity vision characterizes the HCHR campaign's approach to financing, which aims to disrupt the vicious circle of inequity and poor health fueled by unequal access to care based on income, wealth, and employment. International health systems research confirms that commercialized health systems with significant private sector involvement both impede access to care and deepen inequities.<sup>23</sup> The market-based insurance system in the United States demonstrates that private pre-payment schemes are neither intended nor equipped to guarantee equity in access to and payment for care. Any redistributive potential of

pre-payment is lost when the insurance business model incentivizes access restrictions by means of cost-sharing, narrow provider networks, and prior authorization processes, and when even a slightly more progressive premium structure for low-income policyholders, as mandated by the ACA, requires the channeling of sizable public subsidies to private insurance companies.

When the HCHR campaign set out to propose rights-based financing standards, the Special Rapporteur on the right to health had just called on states to “implement a progressively structured system of general taxation to fund health” in order to comply with right to health norms.<sup>24</sup> Buoyed by this intervention and informed by research evidence of improved health and equity outcomes in health systems financed publicly through direct taxes, the HCHR campaign developed detailed implementation standards for financing health care, applying human rights norms to the US context. The campaign’s 10 financing standards, released in a report on Human Rights Day 2012, can be summarized with reference to the three principles of universality, equity, and accountability: 1) financing must be based on health needs and sufficient to meet all needs; 2) it must ensure equitable payment through progressive taxes and guarantee free access to care at the point of service; and 3) it must be public to achieve full accountability for the effective and efficient use of resources necessary to fulfill human rights.<sup>25</sup>

These standards formed the basis for an analysis of state revenue sources consistent with the principle of equity. Assessing the equity impact of each revenue source and their potential to produce sufficient and stable revenue yields, the HCHR campaign’s report recommended a mix of progressive taxes on earned and unearned income, a wealth tax, and a progressive corporate tax, possibly levied on payroll but graduated by business size and wage scales.

With this report, the HCHR campaign turned general human rights norms into workable tools for revenue design, thus enabling the development of robust policy positions on health care financing. Their intervention exemplifies that human rights

advocates need not remain silent on the political economy of universal health care.

## Human rights and the political economy of health care

The proactive engagement with the question of health system financing places right to health care campaigners squarely in the contested terrain of budget and revenue policies. This has long been uncharted territory for human rights advocates, despite the importance of fiscal and economic policymaking to economic and social rights issues. However, since the 2008 economic recession and with the increasing use of neoliberal austerity policies by many governments, the application of human rights standards to fiscal, monetary, and economic policies has become more widespread. Starting with human rights budget analysis to monitor states’ progress in meeting treaty obligations, human rights have now been applied to macroeconomic assessments and used by the UN High Commissioner of Human Rights to caution against austerity measures.<sup>26</sup>

In Vermont, the health care financing challenge gave rise to the People’s Budget Campaign (a joint VWC-NESRI effort), which developed a human rights approach for re-envisioning budget and tax policies in preparation for shifting health care funding to the public realm.<sup>27</sup> The People’s Budget Campaign promoted human rights budgeting as a new policy paradigm that makes human needs the focus of fiscal policymaking. This entails inverting the budget process, which customarily starts with a revenue estimate and proposes spending initiatives based on available funds, thus focusing on balancing the budget with little consideration for meeting fundamental needs. By contrast, a human rights approach requires budgeting to begin with an assessment of needs, then develop a needs-based budget and mobilize the maximum amount of resources in an equitable way to meet budget obligations. Needs assessments, spending initiatives, and tax proposals have to be designed in a participatory way with guidance from human rights principles

and measured by an accountability system centered on rights-based indicators.

Universal health care, a quintessential needs-based system, entails this inversion of the budget process in order to secure equitable, sufficient, and sustainable funding. Funding has to be appropriated based on health needs and the cost of services to meet those needs. It has to be raised in a way that secures both health and financial protection, replacing employment dependent coverage or contributory schemes with a needs-based and tax-funded public service. The process of assessing needs, accountable decision-making based on the scope and depth of need, mobilizing public funds through equitable taxation, and strengthening public sector capacity, is a requisite for fulfilling economic and social rights obligations.

Promoting needs-based, equitable taxation as a rights-based instrument for achieving universal health care, especially in a context where the distribution of resources rather than their availability is at stake, opens up an economic and social rights perspective on health policy. A focus on the redistributive nature of health systems recasts health care reform as a broader economic policy intervention. It serves as a reminder that health care is one of several social and economic rights—alongside housing, food, and education, all key social determinants of health—whose realization is thwarted by the commodification of human needs and the failure to distribute resources equitably to meet those needs. This understanding is reflected in the HCHR movement’s vision of economic and social justice that reaches beyond the right to health and health care and drives a long-term movement building project. Universal health care and human rights budgeting are seen as working in concert to advance an equitable society that funds and delivers the public goods needed to fulfill economic and social rights.

The road toward realizing this vision of equity entails both successes and setbacks, even in the small state of Vermont. In 2012, only one year into the lengthy transition toward publicly financed health care, the People’s Budget Campaign won

new statutory language requiring the state budget to address needs and advance equity.<sup>28</sup> This law, another first in the Vermont “laboratory,” could have lent crucial support to universal health care financing, but effective implementation never happened. However, the principles of human rights budgeting, combined with rights-based health care financing standards, equipped advocates with a powerful toolset for developing a health care financing plan.

### Rights-based modeling of health care financing

Transforming a multibillion-dollar health care market into an equitably financed public good demands a robust policy plan that can secure economic viability as well as sustain the significant political power required to achieve change. The example of Vermont affords an opportunity to assess the effectiveness of the human rights framework in informing the design of a health care financing plan that is fiscally sound, economically feasible, and meets the political goals of improved health and equity outcomes.

The six-year transition process following the 2011 passage of Vermont’s universal health care law depended on the development of a public financing plan. Yet when the state’s governor finally published a plan on December 30, 2014—missing the law’s deadline by almost two years—it was accompanied by an official statement denouncing the plan’s feasibility and withdrawing the administration’s support for universal health care.<sup>29</sup> This announcement effectively ended the state’s transition efforts, despite the legal mandate of Act 48.

The governor’s financing plan included revenue sources centered on income and payroll taxes, and cost projections that largely extended current expenditure trends forward. It offered several cost-benefit scenarios with different combinations of health benefits and tax rates. Some scenarios—including the one presented as the governor’s option—predicted the system would develop a negative fiscal position within five years of im-

plementation. This forecast served as the official justification for abandoning the transition to a universal system. Yet the plan also showed that nine out of ten families would see their incomes rise in a universal health care system, while the system overall would be less costly than a continuation of market-based health care.<sup>30</sup>

Ultimately, the governor's plan lacked both financial and political viability as its tax designs failed to fully take into account individuals' and businesses' ability to pay. Disregarding the rights-based financing standards offered by the HCHR campaign in 2012, the governor's plan was not guided by the principle of equity. Instead, it proposed to cap tax payments for the wealthy and impose a flat payroll tax regardless of business size, thus disadvantaging the state's over 75% of small businesses with fewer than 10 workers.

In response to the governor's report, the HCHR campaign swiftly developed its own financing plan, aiming to demonstrate the feasibility of a universal system based on human rights principles.<sup>31</sup> Although to date this plan has not revived the transition process in Vermont, the solutions it presents are instructive for rights-based efforts elsewhere, as it models ideas for implementing rights-based standards, simulates financial impact, and invites a further examination of techniques for operationalizing rights. Methodologically, this plan utilizes much of the governor's data as a baseline to enable comparability; however, new data sources were identified to develop a micro-simulation for an equitable business tax design.

### *Rights-based revenue sources*

The HCHR campaign's financing plan uses the principle of universality to design Green Mountain Care (GMC) as a comprehensive public system providing all medically necessary health services for all residents (except those covered by federal programs), adding dental, vision, and hearing care to the governor's proposed benefits. It applies the principle of equity to determine the revenue mix, with progressive income and wealth taxes and a graduated payroll tax on businesses as the main new funding sources.

Income taxes form the backbone of the financing plan, as they did in the governor's proposal (exempting Medicare, military health care recipients, and those earning less than the Medicaid threshold of 138% of the Federal Poverty Level (FPL)). Yet while the governor's tax rate increased steeply to 9.5% for earners reaching the 400% FPL threshold, but decreased at the top end due to a cap on payments by the wealthy, the HCHR campaign redesigned this tax with a more gradual increase and no cap. As a result, 65% of lower- and middle-income residents would pay lower taxes than under the governor's proposal. The tax rate for three-quarters of families would be lower than 9%, with many paying much less. While this figure remains higher than the tax proposals offered by single payer advocates for a federal universal system, the projections show that a family with an annual income of US\$50,000 would pay an average of 40% less in health care costs than in a market-based insurance system.<sup>32</sup> To capture unearned income and reduce wealth inequity, the HCHR campaign's tax plan includes a new wealth tax on stocks, dividends, capital gains, interest, and the trading of stocks and derivatives. The tax design augments a 5% rate with sliding scale credits up to an income threshold of US\$200,000, and an exemption for incomes under \$50,000. More than three-quarters of the revenue from this tax would come from those earning more than \$200,000.

The HCHR campaign's solution for maintaining health care payments from businesses illustrates an innovative application of the principle of equity to tax design. In the current system, employer-sponsored health insurance drives inequity, as lower-earning employees pay a greater share of income in premium contributions than higher earners, yet benefit less from tax exemptions. While employers pay the majority of premium costs, they reduce wages accordingly. A rights-based system would decouple access to care from employment, yet without foregoing businesses' contributions to the public good that protects workers' health. An equitable tax would require companies to contribute based on their ability, measured through profit or surplus revenue. Yet corporate income taxes are



levied only on a minority of businesses, loopholes are numerous, and tax avoidance is widespread.<sup>33</sup>

This challenge pointed the HCHR campaign to a payroll tax, with its risks of disincentivizing hiring, depressing wages, and disadvantaging small businesses—the very problems that doomed the governor’s proposal of a flat 11.5% payroll tax. To design an equity mechanism for business contributions, the HCHR campaign’s plan introduces a graduated payroll tax, levied on employers only, that takes into account company size and wage disparity. Tax obligations would be lower for small businesses and for those with low wage difference between top and bottom earners, and higher for larger corporations and those with a greater top-to-bottom wage ratio.

The following design creates a tax that promotes equity based on business size and wage disparity, thereby protecting small businesses, guarding against negative wage effects, and even incentivizing wage increases for the bottom half of wage earners:

- a sliding scale tax rate capped at 20% of payroll, increasing with company size and wage ratio;
- nine size-based tax categories, from businesses with four or fewer full-time equivalent employees to more than 1,000 employees, resulting in gradually increasing tax rates by company size;
- a wage ratio formula that reflects the difference between the wages of the top 1% and the bottom 50% of wage earners in a company, resulting in higher tax rates for companies with greater wage disparity.

The principle of equity is the guiding factor for this design. Only if businesses are asked to pay based on their ability—with size and high executive salaries as proxies—and only if they are encouraged to raise rather than depress the wages of those paid the least, can a payroll tax meet both economic feasibility and rights-based criteria.

Linking public spending and revenue policies to private wage policies is not entirely novel; for example, some economic subsidy programs require businesses to offer above-minimum-wage jobs, and

advocacy is growing for “low-wage employer fees” levied on minimum-wage employers.<sup>34</sup> Yet the idea of using wage disparity, a true equity criterion, as a variable in tax design may be unprecedented.

The HCHR campaign’s wage ratio model is designed to promote income equality and prevent negative wage and hiring effects. It provides an incentive for increasing wage equity, since a company can lower its tax rate by reducing executive wages or raising workers’ wages. It prevents negative wage effects for average workers, which are commonly assumed to occur due to a transfer of tax costs onto employees. If a company seeks to pass on costs by reducing the wages of the bottom 50% of workers, its wage ratio will increase and result in a higher tax rate. The wage ratio factor thus prevents the lowering of the wages of the bottom half of workers. If a company passes the cost of taxation onto all workers (including executives) by reducing wages across the board, their tax contribution will be lowered through the decrease in payroll size, yet their tax rate stays the same. Since company size has lower weight in this model than in a size-only tax design, the wage ratio factor also helps mitigate against hiring slowdown and workforce reduction incentives produced by the size variable.

To achieve these equity effects, company-level tax rates have to be calculated according to a formula presented by the HCHR campaign’s plan. Since the modeling was limited to industry-level data, it could only approximate actual tax rates and yields, and it could not calculate compliance costs. For these reasons, the campaign recommended that the state produce a more accurate revenue projection and test compliance challenges by conducting a survey requiring all companies to submit their calculated tax rates for review prior to GMC implementation. The HCHR simulation predicts sufficient tax revenue, with 60% of companies paying an average tax rate of 4%. All companies with fewer than 50 workers—the vast majority of Vermont businesses—would pay a lower tax rate than the governor’s proposed 11.5%.

### *Economic feasibility, political challenges*

The HCHR campaign’s plan models a publicly

financed health care system that guarantees comprehensive care for all and dramatically increases equity in access to and payment for care, compared to both the current system and the governor's model. It improves GMC's fiscal position by more than US\$200 million over the governor's projection—despite adhering to the governor's highly conservative administrative savings forecasts—and it recommends further system expansions in line with human rights principles after the first year of operation. Overall, the HCHR campaign's plan makes a strong case for the fiscal and economic viability of publicly financed universal health care and creates a rights-based tax design that advances income equality.

This financing plan was delivered to state legislators along with an open letter from over 100 economists. "As economists," the letter reads, "we understand that universal, publicly financed health care is not only economically feasible but highly preferable to a fragmented market-based insurance system. Health care is not a service that follows standard market rules; it should be provided as a public good."<sup>35</sup> A group of legislators introduced a health care financing bill in the 2015 legislative session, consisting of the tax measures proposed by the HCHR campaign to fund the universal system.<sup>36</sup> Yet the bill died in committee, and the proposals have not yet received closer scrutiny.

The setback in Vermont, which may yet prove to be temporary, reflects the political challenge of shifting an entire industry from the market to the public realm. Corporate interests have a sizable stake in maintaining the status quo, which means the political will for change must be shared widely among the population, not just vested in prominent champions. The power to achieve systemic transformation requires broad popular support, which the HCHR campaign built in its early years but struggled to sustain and grow during the lengthy transition process.

From a policy perspective, the debates in Vermont have revealed a number of challenges that advocates in the United States must be prepared to address as the struggle for universal health care continues. For example, campaigners are well-ad-

vised not to foreground the efficiency argument championed by single payer advocates, particularly for reforms at the sub-national level. Since federal health care programs cannot be readily integrated into a state-level universal system, and since smaller states have limited leverage to achieve strong price controls, high expenditure levels are likely to persist, and advocates must not undermine the willingness for public investment by focusing on hard-to-predict savings that may occur gradually over time. Equally important, advocates must be ready to explore ways for severing the link between employment and access to care, while holding businesses accountable and preventing a cost-shift to individuals. The HCHR campaign's rights-based proposals offer valuable examples for tackling such policy challenges.

### Learning from Vermont

The battle over universal health care financing in Vermont offers ideas and lessons for rights-based advocacy elsewhere. It exemplifies how human rights can shape both the process of moving toward universal health care and the content of system design and financing. Moreover, it brings into focus the range of policy and political obstacles, the specific power relations producing these obstacles, and the systemic factors contributing to human rights denials.

Anchored in local movement building efforts, the momentum for state-level universal health care reform in the United States continues to grow. Prior to the passage of the ACA, health reforms in a number of states created an impetus for federal legislation, and a domino effect of state-based universal health care initiatives could well catalyze the next federal reform wave. Universal health care campaigns in several states, including Oregon, New York, and Colorado, have put forward financing studies, proposals, and bills, influenced by the movement building in Vermont. Learning from Vermont could inspire a principled advocacy approach, combined with mass organizing, that tackles political resistance through rights-based redistribution models rather than efficiency estimates, and that shifts from a health insurance focus to a

broader lens of public goods. This is the approach adopted by the Healthcare Is a Human Right Campaign Collaborative (currently consisting of groups in Maine, Maryland, and Pennsylvania, in addition to Vermont), which pursues a long-term organizing strategy that links the struggle for universal health care to a transformative agenda for economic and social rights.<sup>37</sup>

The Vermont experience shows the value of using human rights both as a normative frame for organizing and campaigning, and as an analytical toolset for identifying the barriers to realizing rights and providing policy solutions. Human rights advocates cannot afford to stand on the sidelines of the political economy debates over universal health care. The human rights framework can help determine the factors that continue to thwart the realization of universality and equity, develop policy strategies for health care financing, and strengthen universal health care advocacy by connecting it to rights-based visions for public goods and economic equity.

## Acknowledgments

The author would like to thank David Kreindler, based in Hardwick, Vermont, for his assistance in preparing this paper and, more importantly, for supporting Vermont's Healthcare Is a Human Campaign in developing many of the ideas presented here.

## References

1. Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, September 6-12, 1978; UN Resolution, UN General Assembly, 67th Session, Global Health and Foreign Policy, December 12, 2012.
2. A. Rudiger and B. M. Meier, "A rights-based approach to health care reform," in E. Beracochea, C. Weinstein, and D. Evans (eds.), *Rights-based approaches to public health* (New York: Springer Publishing Company, 2011), pp. 69-86.
3. See Rudiger and Meier (see note 2). See also A. Rudiger, "Beyond Obamacare: In many states, the Health Care Is a Human Right Movement is growing," in *The Huffington Post*, December 5, 2013. Available at [http://www.huffingtonpost.com/anja-rudiger/beyond-obamacare-in-many-states\\_b\\_4378433.html](http://www.huffingtonpost.com/anja-rudiger/beyond-obamacare-in-many-states_b_4378433.html).
4. See [www.healthcareisahumanright.org](http://www.healthcareisahumanright.org); A. Rudiger, "Reviving progressive activism: How a human rights movement won the country's first universal health care law," in *New Politics*, November 2011. Available at <http://newpol.org/content/reviving-progressive-activism-how-human-rights-movement-won-country-s-first-universal-health>.
5. See World Health Organization, Global Health Expenditure Database. Available at <http://apps.who.int/nha/database/Select/Indicators/en>.
6. E. Nolte and C. Martin McKee, "Measuring the health of nations: Updating an earlier analysis," *Health Affairs* 27/1 (2008), pp. 58-71.
7. S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *How high is America's health care cost burden? Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, July-August 2015* (Commonwealth Fund Issue Brief, November 2015).
8. S. R. Collins, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Too high a price: Out-of-pocket health care costs in the United States. Findings from the Commonwealth Fund Health Care Affordability Tracking Survey, September-October 2014* (Commonwealth Fund Issue Brief, November 2014); M. Majerol, J. Tolbert, and A. Damic, *Health care spending among low-income households with and without Medicaid* (Kaiser Family Foundation, February 2016).
9. See Rudiger and Meier (see note 2).
10. Human Rights at Home Campaign, *A human rights vision for society: Core principles* (February 2012). Available at [http://healthcareisahumanright.org/wp-content/uploads/2015/06/Principles\\_for\\_a\\_Human-Rights\\_Vision\\_for\\_Society-1.pdf](http://healthcareisahumanright.org/wp-content/uploads/2015/06/Principles_for_a_Human-Rights_Vision_for_Society-1.pdf).
11. *Vermont Declaration of Human Rights* (September 2012). Available at [http://healthcareisahumanright.org/wp-content/uploads/2015/04/vt\\_declaration\\_of\\_human\\_rights.pdf](http://healthcareisahumanright.org/wp-content/uploads/2015/04/vt_declaration_of_human_rights.pdf).
12. See Healthcare Is a Human Right Campaign, "From coverage to care: re-envisioning our healthcare system" (January 2013). Available at <http://healthcareisahumanright.org/wp-content/uploads/2015/04/BenefitsPositionStatement-final.pdf>
13. Healthcare Is a Human Right campaign, *Human rights assessment tool* (2010). Available at <http://healthcareisahumanright.org/wp-content/uploads/2015/04/9-Detailed-Human-Rights-Standards-for-Healthcare-Systems.pdf>; Rudiger and Meier (see note 2).
14. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000); UN General Assembly, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt, A/HRC/7/11, January 2008.
15. See World Health Organization, *Anchoring universal health coverage in the right to health: What difference would*

it make? (Geneva: WHO, 2016); World Health Organization, *The world health report 2010. Health systems financing: The path to universal coverage* (Geneva: WHO, 2010); World Health Organization and World Bank, *Tracking universal health coverage: First global monitoring report* (Geneva: WHO, 2015).

16. See Rudiger 2011 (see note 4); G. MacNaughton, F. Haigh, M. McGill, et al., "The impact of human rights on universalizing health care in Vermont, USA," *Health and Human Rights Journal* 17/2 (2015).

17. General Assembly of the State of Vermont, *No. 128. An act relating to health care financing and universal access to health care in Vermont* (2010). Available at <http://www.leg.state.vt.us/docs/2010/Acts/ACT128.pdf>.

18. General Assembly of the State of Vermont, *No. 48. An act relating to a universal and unified health system, 2011*. Available at <http://www.leg.state.vt.us/docs/2012/Acts/ACTo48.pdf>.

19. A. Kiersz, "The sad state of American inequality in 12 charts," *Business Insider* (November 2014). Available at <http://www.businessinsider.com/income-and-wealth-inequality-charts-2014-11?op=1>.

20. US Bureau of Labor Statistics, *Consumer Expenditure Survey* (September 2012). Available at <http://www.bls.gov/cex/2011/Standard/income.pdf>.

21. For example, G. Friedman, *Funding HR 676: The Expanded and Improved Medicare for All Act* (July 2013). Available at [http://www.pnhp.org/sites/default/files/Funding%20HR%20676\\_Friedman\\_7.31.13\\_proofed.pdf](http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf).

22. See, for example, K. Pickett and R. Wilkinson, *The spirit level: Why greater equality makes societies stronger* (London: Bloomsbury Press, 2009).

23. For example, M. Koivusalo and M. Mackintosh, *Health systems and commercialisation* (Geneva: UNRISD, 2004); A. Marriott, *Blind optimism: Challenging the myths about private health care in poor countries* (Oxfam International, 2009); R. Yates, "Universal health coverage: progressive taxes are key," *The Lancet* 386 (July 2015), pp. 227-229.

24. UN General Assembly, *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, A/67/302, August 2012, p. 20.

25. Healthcare Is a Human Right Campaign, *Toward equitable financing of Green Mountain Care* (December 2012). Available at <http://healthcareisahumanright.org/wp-content/uploads/2015/06/GMCFinancingPlan-VWCproposal.pdf>.

26. UN High Commissioner for Human Rights, *Report on austerity measures and economic and social rights* (Geneva: OHCHR 2013).

27. For human rights budgeting tools, see <http://www.nesri.org/programs/what-is-human-rights-budgeting> and [https://www.youtube.com/watch?feature=player\\_embedded&v=paK8Ylo29p8](https://www.youtube.com/watch?feature=player_embedded&v=paK8Ylo29p8).

28. See Vermont Statutes, 32 V.S.A. § 306a. Available at <http://legislature.vermont.gov/statutes/section/32/005/00306a>.

29. State of Vermont/Office of the Governor, *Green Mountain Care: A comprehensive model for building Vermont's universal health care system* (December 30, 2014). Available at [http://hcr.vermont.gov/GMC\\_Report\\_2014](http://hcr.vermont.gov/GMC_Report_2014).

30. *Ibid.*, pp. 54 and 56.

31. Healthcare Is a Human Right campaign, *Equitable financing plan for Vermont's universal healthcare system* (NESRI/Vermont Workers' Center: 2015). Available at [http://healthcareisahumanright.org/wp-content/uploads/2015/04/HCHR-Financing-Plan-2015-final\\_o.pdf](http://healthcareisahumanright.org/wp-content/uploads/2015/04/HCHR-Financing-Plan-2015-final_o.pdf). All subsequent examples and figures refer to this source, unless noted otherwise.

32. For a national estimate, see Friedman (see note 21).

33. HCHR campaign (2012, see note 25), pp. 11-14.

34. See Jobs with Justice and National People's Action, *The case for a low-wage employer fee* (2015). Available at <http://conference.jwj.org/wp-content/uploads/2015/12/The-Case-for-a-Low-Wage-Employer-Fee-with-Chart-of-Options.pdf>.

35. Open Letter to the Vermont Governor and Legislature from Economists in the US: In support of universal, publicly financed health care in Vermont (February 2015). Available at <http://www.nesri.org/resources/open-letter-from-100-economists-urges-vermont-lawmakers-to-finance-universal-health-care>.

36. Vermont Legislature, H. 475 (May 2015). Available at [http://www.nesri.org/sites/default/files/H-0475\\_As\\_Introduced.pdf](http://www.nesri.org/sites/default/files/H-0475_As_Introduced.pdf).

37. See [www.healthcareisahumanright.org](http://www.healthcareisahumanright.org).