

The Impact of Human Rights on Universalizing Health Care in Vermont, USA

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Abstract

In 2010, Vermont adopted a new law embracing human rights principles as guidelines for health care reform, and in 2011, Vermont was the first state in the US to enact framework legislation to establish a universal health care system for all its residents. This article reports on the Vermont Workers' Center's human rights-based approach to universal health care and the extent to which this approach influenced decision makers. We found the following: (1) by learning about the human right to health care and sharing experiences, Vermonters were motivated to demand universal health care; (2) mobilizing Vermonters around a unified message on the right to health care made universal health care politically important; (3) using the human rights framework to assess new proposals enabled the Vermont Workers' Center to respond quickly to new policy proposals; (4) framing health care as a human right provided an alternative to the dominant economics-based discourse; and (5) while economics continues to dominate discussions among Vermont leaders, both legislative committees on health care use the human rights principles as guiding norms for health care reform. Importantly, the principles have empowered Vermonters by giving them more voice in policymaking and have been internalized by legislators as democratic principles of governance.

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Introduction

In the US, unlike other high-income countries, there is no system of universal health care coverage.¹ Instead, there is a maze of private and public health insurance, including employer-supported private health insurance schemes, public health insurance programs for people over 65 years of age (Medicare) and very poor people (Medicaid), and several smaller public programs, including the Indian Health Service and the Veterans Health Administration.² This patchwork of health care financing leaves over 37 million people uninsured.³ Millions more are underinsured and unable to access health care due to high deductibles and co-payments. This complex and fragmented health care financing system is the most expensive in the world, and yet achieves among the worst health outcomes of high-income countries.⁴ A 2014 report by the Organisation for Economic Co-operation and Development (OECD), for example, ranks the US 27th out of the 34 OECD countries for life expectancy at birth.⁵

Crucially, health care is not recognized as a human right under US constitutional or statutory law, and the federal government has not ratified the key international human rights treaty that enshrines the right to health, the International Covenant on Economic, Social and Cultural Rights.⁶ Moreover, no state in the US has recognized health care as a human right in its constitution or by statute.⁷ As a result, there is no avenue via the courts to seek remedies for the millions of people who do not have access to affordable health care. The most promising path to universal health care is, therefore, through legislation.⁸ Yet, it has proven difficult to make much progress at the federal level, despite polls showing that the majority of people in the US “strongly” believe that access to health care should be considered a human right.⁹ Indeed, the picture is bleak at the national level, as the individual health insurance mandate—introduced in the 2010 federal health care reform law, the Patient Protection and Affordable Care Act (PPACA)—has reinforced the notion that health care is a commodity to be purchased from private insurance companies through

a market exchange that provides a bewildering array of benefit packages.¹⁰

In this context, Vermont—a small, rural state in the northeastern US—has emerged as a leader in moving toward a human rights-based system of universal health care. For over 20 years, Vermont advocates have struggled to achieve a single-payer system of health care in which the government is the sole insurer and there is a single package of health care benefits available to all.¹¹ Such a system would save millions of dollars due to its simplicity and make health care universal and affordable for all.¹² Despite advances toward universal health care, in 2008 almost 10% of Vermonters—more than 66,000 residents, including 11,000 children—remained uninsured, and thousands more were underinsured.¹³ That year, the Vermont Workers’ Center launched the Health Care Is a Human Right campaign to educate Vermonters about the human right to health care and to mobilize support for universal, equitable, and affordable health care.¹⁴ Following this campaign, in 2010 and 2011 Vermont adopted two laws—Act 128 and Act 48, respectively—that recognize health care as a “public good.”¹⁵ These laws also enshrine the human rights principles of universality, equity, participation, transparency, and accountability to guide state health care reforms.¹⁶

The Vermont path to universal health care provides a promising alternative to the federal scheme and has been the subject of several publications. Some reports maintain that the Vermont breakthrough was made possible by the Vermont Workers’ Center’s human rights-based approach (HRBA), including intensive grassroots organizing coupled with human rights education and human rights-based policy advocacy.¹⁷ Other reports have focused on the single-payer financing scheme and the cost savings it promises.¹⁸ A recent comprehensive review of the 1992–2011 Vermont health care reforms concluded that a “supportive social movement spearheaded by the Vermont Workers’ Center” was one of seven factors that made possible the passage of Act 128 in 2010 and Act 48 in 2011.¹⁹ The authors note, however, that “gauging

the contribution of this movement to the ultimate legislative outcome is difficult to assess.”²⁰

In this light, this article documents the results of an explanatory case study on the impact of an HRBA to universalizing health care in Vermont. Following this introduction, the article explains the design and methodology of the study. Drawing on related literature, legislative history, media coverage, and interviews, it then examines the Vermont Workers’ Center’s Health Care Is a Human Right campaign, including the reasons the Center decided to use an HRBA to advocate for universal health care and the strategies it employed to educate and mobilize Vermonters. The article then looks at the 2010 and 2011 health care legislation, which includes human rights principles, and considers how these principles have influenced decision-makers and discussions on health care reform. Finally, the article summarizes lessons learned from the study, including the impacts of an HRBA to universalizing health care in Vermont and reflections on the study methodology.

Research design and methodology

The aim of this research project was to evaluate the impact of an HRBA to universalizing health care in Vermont. Specifically, the study sought to address two questions: How did the Vermont Workers’ Center use human rights in its Heath Care Is a Human Right campaign? And how did the HRBA influence decision-makers in the government? Although there is no single accepted definition of an HRBA, the Worker’s Center campaign meets the common criteria of most definitions.²¹ Specifically, it includes the three components of the United Nations Common Understanding on a Human Rights Based Approach to Development Cooperation. First, the goal of the campaign is to realize the right to health care for all Vermonters; second, human rights principles guided all actions—organizing, messaging, advocacy, and policy analysis—of the campaign; and, third, the campaign contributed to building the capacity of rights-holders to claim their rights and duty-bearers to meet their obligations.²²

Using multiple qualitative methods, our study sought to investigate and describe what happened, explore corollary and causal relationships, and develop a theory of explanation.²³ Qualitative methods were elected for their ability to generate understanding and analysis of meaning in social context. As Jamie Baxter and John Eyles explain, we “set out to learn to view the world of individuals or groups the way they themselves see it.”²⁴ We had three initial theories: (1) human rights provided a unifying concept and focus for the campaign; (2) human rights provided a compelling moral and normative argument for mobilizing Vermonters and for influencing legislators; and (3) human rights provided a consistent framework for assessing and responding to policy proposals.

Our interdisciplinary research team was composed of five scholars in global public health, social science methodology, and international human rights law with substantial experience collaborating on interdisciplinary right-to-health projects. Two of us had carried out previous research on the Vermont case in 2010 and 2011, following the adoption of Act 128 and Act 48. The earlier research was based on analysis of various bills, proposed amendments, and final legislation; reports commissioned by the legislature; media coverage; interviews with staff and volunteers at the Workers’ Center; and a review of the Center’s extensive documentation of the campaign on its website. This research is summarized in several articles, including a 2012 article in this journal.²⁵

The initial step for our 2015 research project was to update the review and analysis of legislative history, media coverage, and the Center’s website. For the second step, we employed semi-structured in-depth interviews to update the earlier project on how the campaign worked to educate and mobilize Vermonters, and to consider how the campaign influenced leaders on health policy reform in Vermont. We selected leaders to interview from the legislature, the executive, and nongovernmental organizations based on their visible role in leading health care reform in Vermont. During March 2015, one member of the team interviewed twelve of

these leaders (five advocates, three legislators, and four staff in the executive branch). This allowed for the triangulation of interview findings from different participant types. While the interviews focused on the two main research questions and drew on a 15-question guide developed by our team, each interview was tailored to the specific role—activist, legislator, or executive staff—of the interviewee. Participants were asked about the role and influence of human rights on the health care reform discussions and legislation, and were prompted to explain their perspectives in more detail (where necessary). Moreover, the interviews were semi-structured, such that the interviewer probed participant responses to capture additional insights.

All 12 interviews were transcribed in full. The transcripts were first analyzed by a social scientist, who used software (QSR NVivo 10), and then by two Vermont lawyers with expertise on the international human right to health, HRBAs, and Vermont health care reform, who drew out excerpts relevant to our research questions and emergent themes. We then categorized and coded the findings using narrative analysis and prepared a draft report. All five members of our team reviewed the draft, and the lead author made substantial revisions based on their feedback. The full report of over 16,000 words, submitted to the World Health Organization in June 2015, is summarized in this article.

The Health Care Is a Human Right campaign (2008–2010)

Although the Vermont health care system has consistently ranked among the top four state health care systems in the country, a survey found that about 25% of Vermonters lived in families that had experienced difficulty paying health care bills in 2008.²⁶ In this context, the Vermont Workers' Center launched the Health Care Is a Human Right campaign.²⁷ In addition to advocating for the human right to health care, the campaign adopted five human rights principles to guide its work, which includes education, advocacy, and policy analysis. The five principles are as follows:

- Universality is the principle that human rights must be afforded to everyone, without exception. It is by virtue of being human, alone, that every person is entitled to human rights.
- Equity is the principle that every person is entitled to the same ability to enjoy human rights. Healthcare resources and services must be distributed and accessed according to people's needs, not according to payment, privilege or any other factor. Disparities and discrimination in healthcare must be eliminated, as must any barriers resulting from policies or practices.
- Accountability is the principle that mechanisms must exist to enable enforcement of human rights. It is not enough merely to recognize human rights. There must be means of holding the government accountable for failing to meet human rights standards.
- Transparency is the principle that government must be open with regard to information and decision-making processes. People must be able to know how public institutions needed to protect human rights are managed and run.
- Participation is the principle that government must engage people and support their participation in decisions about how their human rights are ensured.²⁸

There were two main reasons why the Workers' Center chose to use an HRBA for its campaign. First, the Center viewed human rights as an alternative rationale for universal health care that contrasted sharply with, while still complementing, the arguments based on economics. James Haslam, executive director of the Vermont Workers' Center, explained in an interview:

We thought a very strong case had been made, an economic case about the benefits of moving to a universal, publicly-financed system that decoupled health care from employment. But there were a bunch of things that we saw as missing from the health care movement. One was really a focus on the impact on people, on our communities, on families, and the fact that if you added up what was happening to people all over the state, in the richest country in the history of the world, in the 21st century, that there was a health care crisis that could be avoided by having a system that was geared towards meeting different goals than the ones that we currently have is.²⁹

Second, human rights provide a way to mobilize and empower communities to demand universal health care. Mary Gerisch of the Vermont Workers' Center explained that to effect change, the campaign needed many people at the grassroots level to tip the balance of power held by lobbyists, big business, and those with money.³⁰ As described by Haslam, these two rationales were translated into campaign activities:

There's a couple of components to what we were doing—one is changing how people think about health care, thinking of it as a right instead of a benefit or a commodity, [and another is] thinking about how people think about democracy in different ways and that we can create change if we come together. And those two things go together, we believe, because human rights are not things that anyone gives us or because they're gifts from the powerful. They're things people get by coming together and demanding them.³¹

Based on these rationales, the Center developed a multi-year campaign strategy. For the first year (2008–2009), the campaign focused on educating Vermonters about health care as a human right and providing a forum for residents to share stories about their experiences with the health care system. The campaign implemented these strategies by staffing tables at farmers' markets, marching in local parades, writing letters to the editor, and canvassing neighborhoods. The Center also carried out a short survey, collected stories about how the current health care system jeopardized the health and finances of Vermonters, and held human rights hearings throughout the state at which Vermonters testified about their experiences with the state health care system. On December 10, 2008, in celebration of the 60th anniversary of the Universal Declaration of Human Rights, the Center released the report *Voices of the Vermont Healthcare Crisis*.³² Finally, on May 1, 2009, the Center held a rally at the Vermont Statehouse, at which 1,200 people attended—the largest weekday rally in the state's history.

In the second year (2009–2010), the campaign began a concerted effort to convince legislators

that there was a health care crisis in Vermont, that universal health care was the best policy response, and that such a policy was politically feasible. The Center's strategies included organizing a series of "people's forums" in 10 counties, which were attended by more than 70 legislators; preparing a "people's toolkit" with analytical and advocacy tools, including a human rights report card, which provided a guide to compare the various health care proposals put forward at the beginning of the 2010 legislative session; delivering thousands of postcards to the Statehouse on the first day of the 2010 legislative session, calling for legislative action to make health care a human right in Vermont; and forming "people's teams" with a daily presence on the legislature floor and in committee rooms, increasing transparency and fostering the participation of ordinary Vermonters.

For five reasons, the Center's grassroots HRBA was seen as distinguishing this campaign from previous attempts to advocate for universal health care in Vermont. First, Vermonters learned about the human right to health care and shared their experiences with the health care system. This approach was seen as motivating people to actively demand universal health care. Robin Lunge, director of health care reform for the Shumlin administration, described it this way:

I think the human rights discourse played a very large part of the grassroots development. It gave people something that they could understand and feel attached to. It ... allowed for people to feel passionately about the issue, which I think sometimes the issue can feel a little dry, and so putting it in a human rights framework, I think it really helped develop some of that passion and participation and groundswell.³³

Similarly, Sarah Copeland Hanzas, House majority leader, stated:

[T]he Health Care Is a Human Right campaign really did a great job of getting out ... , neighbor to neighbor, talking to people about health care and really giving them ... permission to say "Yeah. I should have health care. Yeah. There is no reason why just because I work for a small business that

can't afford to offer health benefits that I should be going uninsured." And that kind of peer-to-peer outreach I think was helpful in getting ... grassroots support.³⁴

This motivation was also seen as sustainable because once people are educated and believe that they have the right to universal health care, they continue to engage in the process of claiming their rights. Ellen Oxfeld, vice president of Vermont Health Care for All, explained, “[E]ach effort builds more base of people who are educated and receptive to the next effort, right? So that helped, and from multiple directions.”³⁵

Second, by mobilizing large numbers of Vermonters with a unified message, the campaign increased the power of citizen voice. As a result, legislators became aware of Vermonters’ demands for universal health care, which became an increasingly important subject on the political agenda. Daniel Barlow of Vermont Businesses for Social Responsibility recounted, “They were the only group that supported health care reform that could bring hundreds of people, hundreds of ordinary Vermonters, to the Statehouse, and that really had a big impact.”³⁶ Gerisch of the Vermont Workers’ Center explained that the campaign was “able to gain momentum and organize in ever stronger numbers for Act 48” because people were empowered by knowing that health care is a human right and because the human rights framework gave them “total unity.”³⁷

The unifying message of human rights also helped build partnerships with other advocacy groups concerned with human rights issues. Gerisch described it this way:

[O]ne interesting thing that human rights also does is it allows us to become close allies with people who are interested in other human rights issues, whether it's unions or migrants' rights issues or whatever, and it enhances our people power incredibly. So that if, for example, the early educators have something coming up and they want everybody to call in, everybody from the health care campaign also calls in. If we have a bill coming up, everyone from early educators, migrant justice, Teamsters, you know,

everyone, the Vermont State Employees' Union, they all call in.³⁸

However, the human rights approach was reported to be divisive with some other universal health care advocacy groups. As Barlow from Vermont Businesses for Social Responsibility recounted:

[I]t really draws a hard line in the sand, and that has some positives and also some negatives. ... I certainly had a lot of members say to me, “I support health care reform, but I don't think health care is a human right.” And so I guess that's also the negative side ... you're potentially turning off some allies who could be attracted by other messages around health care reform when you focus exclusively on that one.³⁹

Third, as part of its campaign, the Center asked people to share their personal experiences with the health care system, which appears to have had an effect on people telling their stories and on the legislators who listened to them. As Barlow reported:

[T]he committees heard so many horror stories about ... the way our current health care system treats people kind of like they're meat, and people driving up huge health care bills, going into bankruptcy because of... just genetics or an accident. So those were incredibly compelling stories.⁴⁰

Fourth, using the human rights framework to assess new proposals enabled the Vermont Workers’ Center to respond quickly and consistently to new developments. For example, in 2011, the Senate made a last-minute amendment to the universal health care legislation that would have excluded undocumented immigrants from coverage. The Center was able to quickly assess the proposal based on the human rights principles, declare that the amendment did not conform to the principle of universality, and mobilize Vermonters to respond with petitions and lobbying. Gerisch of the Vermont Workers’ Center recounted her interaction with her senator concerning the amendment:

[H]e was furious because we, of course, did lots of grassroots information dissemination, and he was

getting lots of calls calling him a racist and that sort of stuff . . . [S]o finally, at the very end, he withdrew his support . . . from the amendment, . . . and Act 48 actually passed without that amendment. I don't think that would have happened without the human rights framework, . . . if we hadn't all been committed to those five human rights principles that transcended all the other petty arguments people had been getting into for 10 years in Vermont.⁴¹

Fifth, framing universal health care as a human right or “public good” made it an ethical imperative and provided an alternative to the economics-based discourse. While most interviewees stated that both discourses are important to achieving universal health care, they perceived economics to be the dominant discourse in the government while human rights was the dominant discourse in the streets. Ellen Oxfeld of Vermont Health Care for All explained, “Moral argument works with some people. Others need to see the practicality, the enormous waste of our present system, that it is so expensive.”⁴² Similarly, Cornelius “Con” Hogan of the Green Mountain Care Board stated, “The cost drives us to get it done. Human rights drive us to get it done. ‘Public good’ pulls us together to get it done. That’s kind of how I think of it.”⁴³

The adoption of human rights principles into Vermont law (2010–2011)

The Vermont Workers’ Center campaign achieved victories in the legislature in 2010 and again in 2011. In 2010, the legislature adopted Act 128, which states that health care is a “public good for all Vermonters” and incorporates the five human rights principles advanced by the Center “as a framework for reforming health care in Vermont.”⁴⁴ Act 128 also called for a joint legislative commission to hire a consultant to design three options for a health care system that satisfied all five principles.⁴⁵ The consultant hired, William Hsiao, presented three options later that year, and the legislature then adopted Act 48 establishing a framework for a public-private, single-payer system of health care based on one of the options proposed by Hsiao.⁴⁶ Act 48 also states that health care is a “public good” for all

Vermont residents and incorporates the five human rights principles as a framework for health care reform in Vermont.⁴⁷ The law, however, left both the financing system and the benefits package to be determined in subsequent legislative sessions, as the new federal PPACA required the state to implement a health care insurance market exchange in 2014. Under the PPACA, Vermont could not obtain a waiver to implement universal single-payer health care until 2017.⁴⁸

While it is difficult to assess definitively the influence of the Vermont Workers’ Center campaign on the legislative victories, some insight can be drawn from the explicit language of the laws and the interviews. First, it is clear that the Vermont Workers’ Center was the organization that promoted the human rights principles—derived from international law—that were adopted into Vermont law. This achievement alone indicates that the campaign was successful in influencing the legislature. Additionally, legislators reported that Vermonters’ demand for universal health care was a persuasive factor in their decision making. Copeland Hanzas, House majority leader, explained in an interview:

Vermont is a small state, and we’re very connected to our constituents as House and Senate members, so any time [that] 20 or 30 constituents contact you and say, “Yup. We think this is a good idea,” it’s a good idea. You know? Or at least it’s something that you can’t just turn a blind eye to.⁴⁹

She continued, “[T]hat organization was so good at turning people out to public meetings when we went on tour . . . They would show up in force, and it offered a different narrative to the press coverage of those meetings.”⁵⁰ Similarly, Virginia “Ginny” Lyons, vice chair of the Senate Health and Welfare Committee, found the Vermont Workers’ Center campaign to be effective in influencing legislators. She reflected:

[At] the time that Act 48 was being drafted, I think they were very effective. . . . It was a group of Vermonters who had experiences in the health care system, who understood the needs that we face and who understood what’s happening in other countries in the world in terms of health care, and who

could communicate effectively, so I thought they were very helpful during Act 48.⁵¹

On the other hand, one of the compromises reached in 2010 between advocates, legislators, and Governor Douglas was to recognize health care as a “public good” rather than as a human right. For some interviewees, the concept of “public good” was understood to be more familiar to Vermonters than “human rights” and also less controversial. Other interviewees used health care as a “human right” and health care as a “public good” interchangeably. Senator Lyons introduced this language into the legislation. She explained:

[O]ne of the most heated discussions was whether or not we could put, as a principle, that health care was a human right, and I actually made the suggestion that we say “public good,” which in my mind is similar. I thought ... talking about a “public good” would resonate with Vermonters and would also serve the purpose that we needed it to serve. In other words, that people should have access to quality, cost-effective health care. And so that went into legislation, and so I think that principle has really driven the human rights aspect of our health care initiative.⁵²

While Lyons viewed the government’s responsibility to ensure health care as a “public good” as akin to the responsibility to provide clean air and water, Lunge, director of health care reform for the Shumlin administration, saw the “public good” language as subject to a variety of interpretations. She stated:

[S]ome people will interpret that to mean human rights, other people will interpret that to mean you have to have a universal system, however you get there, and that there has to be a regulatory component to make sure that the system as a whole operates for the benefit of Vermonters and not necessarily for the benefit solely of industry. ... The “public good” language was certainly less controversial than human rights language, in part because it does mean different things to different people.⁵³

Finally, while framing health care as a human right may have seemed controversial to some leg-

islators, it was well accepted by others. Moreover, the Vermont Workers’ Center is not the only voice in Vermont asserting that health care is a human right. William Lippert, chair of the Vermont House Health Committee, noted:

I think the framing of the issue of health care as a human right has become and was an effective framing of the issue. But I would not solely attribute that to the Vermont Workers’ Center. As I said, I think Bernie Sanders [Vermont senator in the US Congress] and others have articulated that for a long time.⁵⁴

It is not yet clear what impact the “public good” language will have on health care reform in Vermont. The dismissal of health care as a “human right” is consistent with the dismissal of economic and social rights more generally in the US. Unfortunately, this makes it more difficult for advocates to use international human rights standards on the right to health persuasively on substantive issues regarding health care. On the other hand, the human rights principles, which encompass civil and political rights, align more closely with US tradition and therefore appear to have been easier for legislators to incorporate into Vermont law.

The influence of human rights principles on health care reform (2012–2015)

The five human rights principles proposed by the Vermont Workers’ Center—universality, equity, participation, transparency, and accountability—are now enshrined in Vermont law, and interviewees indicated that decision-makers rely on these principles to guide policymaking on health care. In fact, it is generally accepted by the main players in health care reform that the principles guide decision making in the legislature. Lippert stated:

[T]hey’re pretty much accepted as a given at this point. They’re not points of debate ... if we had met at the Statehouse, you would have seen the principles of Act 48 actually are printed out and posted on the wall of the committee room in the House Health Care Committee.⁵⁵

Indeed, the principles have been internalized by legislators who do not view them as human rights principles drawn from international law but rather as Vermont principles of democratic governance. Copeland Hanzas, House majority leader, described the role of the principles:

[W]hen we were working on Act 48, ... we started with the principles first ... we want it to be fair, we want it to be universal, we want it to be publicly funded, we want people to be able to be involved and know what they're getting for their health care dollar. And so, in setting the principles, that really helped us to figure out how we were going to put all the moving pieces together, the establishment of the Green Mountain Care Board, whose job it would be to help us bring our health care spending into alignment, to serve as an independent board to be able to say to either the legislature or the governor, "Yes, that's a good idea, or no that's a bad idea." Or to say to the insurance companies and the hospitals ... , "You will rein in your rate of growth, you will make sure you're passing on the health care dollars in the form of benefits to Vermonters." So the principles really were kind of fundamental to helping us figure out how we're going to craft a completely different health care system.⁵⁶

Similarly, Senator Lyons stated, "Yes, they're used consistently. I think they are the underpinnings for many of the policy decisions that are being made." Lobbyists also saw the principles as part of the fabric of Vermont policymaking tradition. Barlow from Vermont Businesses for Social Responsibility also noted that the human rights principles were posted on the wall of the House Health Committee room:

[I]t's a good reminder at times of why we're doing what we're doing. I know there are certain times in the campaign where you kind of get bogged down in the nuance of health care policy in whatever bill you're looking at, and those statements, those values, really were useful both for myself, going back and saying, "Okay, what's the real goal here," but also reminding lawmakers about what they voted on a few years ago.⁵⁷

Beyond the legislature, the five human rights principles also guide the work of the Green Mountain

Care Board, the administrative unit that oversees Vermont's health care system. There, too, the principles are viewed positively and even recommended to other divisions of the government as guidelines for good governance. Hogan, a member of the Green Mountain Care Board, stated:

Transparency has turned out to be, I think, one of our real strengths in terms of overall credibility. Our credibility in the legislature is excellent. And I think, in the general public, it's solid. ... I would really recommend it for other governmental agencies because the world is so complex now, you've got to have that interaction between the folks out there and what we're doing.⁵⁸

In sum, the adoption of the principles of transparency and participation into Vermont law has advanced opportunities for Vermonters to have meaningful participation in policymaking on health care reform at multiple levels. The principles of universality, equity, and accountability remain policy goals for health care in Vermont, which continues to move gently toward health care as a human right for all.

Numerous obstacles to universal health care in Vermont confronted advocates and supporters over the past seven years. First, the PPACA blocked the momentum that was generated in 2010 and 2011. Senator Lyons recalled, "I felt like we had to stop and march in place until the Affordable Care Act provisions had been accommodated through the exchange. And we are still working on that."⁵⁹ Second, the implementation of Vermont Health Connect, the health insurance market exchange required by the PPACA, has been extremely unsuccessful in Vermont.⁶⁰ Gerisch of the Vermont Workers' Center remarked:

I can't think of any one of the five principles that are met by Vermont Health Connect. And that's why it's a shame that we had to go through this phase. ... I know some of the states have had Medicaid expansion, and it's been great for them, but for us, it sort of interrupted our path to universal health care. And what's worse is sometimes now people are confusing the Vermont Health Connect with the health reform that they worked for so hard and saying, "Oh my

god. We worked so hard for this and it's a disaster." And so we're in the process of trying to educate folks and saying, "This is not a human rights-based system. This is not what you worked for or what you wanted. This is something that intervened, that we can get rid of, if we continue forward despite the governor's hesitation.⁶¹

Third, in December 2014, Governor Shumlin, who campaigned on a platform for single-payer health care, announced that he was not going forward in implementing a single-payer universal health care system because he believed that it was too costly at this time.⁶² Reports on the cost of implementation indicate that Shumlin selected the most expensive option for universal health care and that acceptable less expensive options were feasible.⁶³ Moreover, experts agree that the single-payer system would clearly have economic advantages by simplifying the system—one payer, one benefit package—and would also save on fraud and abuse detection.⁶⁴ Importantly, Vermont's legislature has not abandoned moving forward on universal health care. Indeed, the legislature adopted a bill in May 2015 calling for Vermont's Agency of Administration to study the cost of providing universal primary care, without cost-sharing, beginning in 2017, when the PPACA allows a waiver from the health insurance market exchange.⁶⁵ In addition, Governor Shumlin announced on June 8, 2015, that he would not seek another term as governor, leaving the 2016 election open to a candidate willing to recognize health care as a human right. While a full universal single-payer system of health care may not be realizable this year in Vermont, all of our interviewees indicated that Vermont would continue to move, at least incrementally, toward this goal.

Lessons learned and recommendations for future research

Impacts of the human rights-based approach

The case study on the Vermont Workers' Center's Health Care Is a Human Right campaign demonstrates several impacts from its HRBA to universal health care. First, Vermonters learned that they have a human right to health care. As Gerisch

noted, "[P]eople didn't know that they had a human right to health care here in Vermont."⁶⁶ This alone—the capacity-building of rights-holders to claim their rights—is an important impact of the HRBA. Second, almost all interviewees recognized that the Vermont Workers' Center's ability to mobilize Vermonters was based on the unifying concept of "health care as a human right," and that massive grassroots participation was one of the key factors that converged in 2010 and 2011 to make it possible to pass legislation providing a pathway to universal health care. As Gerisch recalled:

I don't think that would have happened without the human rights framework . . . [I]t really allowed us to have a victory that nobody thought we could possibly achieve. The insurance companies, I think, were caught unaware because they never dreamed that this was actually going to pass—because they underestimated the power of democracy, of people claiming their rights. And so everybody that was involved was just on board with exactly the same thing, and that's how we had the success of Act 48.⁶⁷

Third, using the human rights framework allowed the Vermont Workers' Center to respond quickly to new policy proposals in a principled manner, which helped mobilize allied organizations and individual Vermonters to support the Center's position. Fourth, the Vermont Workers' Center was successful in convincing the legislature to adopt the human rights principles into Vermont law as guidelines for health care reform. On the other hand, legislators had mixed reactions to the moral and normative argument of health care as a human right and preferred to recognize health care as a "public good." Fifth, once adopted, the human rights principles have been internalized by policy makers as the guidelines for health care reform in Vermont. Thus, duty-bearers also learned to fulfill their obligations, at least with respect to transparency and participation in governance. These findings are plausible in that they are consistent with previous research on the impact of the Vermont Workers' Center's HRBA, were supported by most interviewees in this case study, and align with multiple disciplinary perspectives on the evidence, thereby ruling out other potential explanations.⁶⁸

In short, the HRBA used by the Workers' Center was plausibly effective in many respects.

Importantly, these human rights principles have empowered Vermonters by giving them a more powerful voice in policymaking and have been internalized by legislators and the Green Mountain Care Board as democratic principles of governance. The universal right to health care has not yet been achieved in Vermont; however, the campaign is not over, and the Workers' Center continues to use a human rights framework to advocate for health care as a human right. This case study demonstrates that an HRBA to health has the potential to positively shape laws and policies on health care, and may be implemented at the subnational level even where the national government has not recognized the right to health.

Reflections on methodology

This case study benefitted from the interdisciplinary nature of our research team in several ways. According to Bernard Choi and Anita Pak, “[i]nterdisciplinarity analyzes, synthesizes and harmonizes links between disciplines into a coordinated and coherent whole.”⁶⁹ Here, our team had expertise in health policy, applied social science research methods, HRBAs to health, and Vermont constitutional and civil rights law. Across disciplines, we share a common goal to advance the health and human rights of individuals, communities, and populations, and an assumption that by working together, we can achieve greater insights from our research toward reaching this goal.⁷⁰ The design, methods, and analysis of this case study were informed by this understanding, and our disciplinary perspectives and approaches infused discussions on the formulation of research questions, methods, and data analysis as the project progressed, ensuring that each step made sense across the disciplines. Further, the multi-method qualitative approach strengthened the study, as our analyses of the legislative history, media coverage, and interviews from multiple perspectives complemented one another and deepened our understanding of the impacts of the HRBA. Finally, the interdisciplinary nature of our team ensured

that our case study report would be understandable to a wide audience of people from different fields.

Nonetheless, there were several limitations to this study. First, we faced time and resource constraints, and thus all interviews had to be compressed into the month of March 2015, an extremely busy time at the Vermont legislature. Consequently, it was difficult to schedule interviews for longer than 20–25 minutes with most leaders, and two important leaders were not available at all that month. While it might have been useful to interview more leaders, the responses we received were largely consistent with one another and with the literature, indicating convergence. We also reached a point of data saturation at which interviewees began to share similar elements in their narratives. This made the small number of interviewees less important than it might otherwise have been. Finally, the study was both retrospective and concurrent, requiring the team to be flexible in adjusting the study to constantly changing circumstances. Just after our study proposal for funding was granted in November 2014, Governor Shumlin announced his decision not to pursue single-payer health care legislation that legislative session; however, the negotiations over this legislation had been one of the key subjects of our proposed study. Moreover, each week during the study, there was another major development at the Statehouse to fill this gap in leadership. Despite these difficulties, the results of the study, particularly the recognition among leaders that these human rights principles are regularly used to guide health care reform in Vermont, add substantially to the previous literature on this case.

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References

1. K. Davis, K. Stremikis, D. Squires, et al., *Mirror, mirror on the wall, 2014 update: How the US health care system compares internationally* (New York: Commonwealth

- Fund, 2014), p. 8.
2. A. K. Hoffman, "A vision of an emerging right to health care in the United States: Expanding health care equity through legislative reform," in C. M. Flood and A. Gross, (eds), *The right to health at the public/private divide* (New York: Cambridge University Press, 2014), pp. 348-350.
3. M. E. Martinez and R. A. Cohen, *Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–September 2014* (Washington, DC: US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, 2015), p. 1.
4. Davis et al. (see note 1), p. 7; Organisation for Economic Co-operation and Development, *OECD health statistics 2014: How does the United States compare?* (Paris: OECD, 2014), p. 8.
5. OECD (see note 4), p. 8.
6. See International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), (1966), Art. 14.
7. But see A. Jenkins and S. Ardalan, "Positive health: The human right to health care under the New York State Constitution," *Fordham Urban Law Journal* 35/3 (2008) pp. 479-559
8. Hoffman (see note 2), pp. 368-369.
9. See Belden, Russonello, and Stewart, *Human rights in the U.S.: Findings from a national survey* (Washington, DC: Belden, Russonello, and Stewart, 2007). Available at <https://opportunityagenda.org/pdfs/HUMAN%20RIGHTS%20REPORT.PDF>, p. 4.
10. *The Patient Protection and Affordable Care Act of 2010*, Public Law 111-148, US Statutes at Large 124 (2010), § 1101.
11. H. M. Leichter, "Health care reform in Vermont: A work in progress," *Health Affairs* 12/2 (1993), pp. 71-81; H. M. Leichter, "Health care reform in Vermont: The next chapter," *Health Affairs* 13/5 (1994), pp. 78-103; A. M. Fox and N. J. Blanchet, "The little state that couldn't could? The politics of 'single-payer' health coverage in Vermont," *Journal of Health Politics, Policy and Law* 40/3 (2015), pp. 447-485.
12. See W. C. Hsiao, "State-based single-payer health care: A solution for the US?" *New England Journal of Medicine* 364/13 (2011), p. 1188. See also W. C. Hsiao, A. G. Knight, S. Kappel, and N. Done, "What other states can learn from Vermont's bold experiment: Embracing single-payer health care financing," *Health Affairs* 30/7 (2011), pp. 1236-1237.
13. M. McGill, "Using human rights to move beyond the politically possible," *Clearinghouse Review Journal of Poverty Law and Policy* 44 (2011), pp. 459-460.
14. M. McGill, "Human rights from the grassroots up: Vermont's campaign for universal health care," *Health and Human Rights Journal* 14/1 (2012), p. 106.
15. *An act relating to health care financing and universal access to health care in Vermont*, 2010 Vt. Acts & Resolves, § 9401, Act No. 128. Available at <http://www.leg.state.vt.us/DOCS/2010/ACTS/ACT128.PDF>; *An act relating to a universal and unified health system*, 2011 Vt. Acts & Resolves § 1, Act No. 48. Available at <http://legislature.vermont.gov/assets/Documents/2012/Docs/ACTS/ACTo48/ACTo48%20As%20Enacted.pdf>.
16. Act No. 128 (see note 15) § 2; Act. No. 48 (see note 15) § 1a.
17. McGill (2012, see note 14), pp. 106-117; A. Rudiger, "Reviving the progressive activism: How a human rights movement won the country's first universal health care law," *New Politics* (2011). Available at <http://newpol.org/content/reviving-progressive-activism-how-human-rights-movement-won-country's-first-universal-health>; J. Kissam, "The Vermont breakthrough: Grassroots organizing moves a state towards health care for all," *Social Policy* 41/2 (2011), pp. 4-8.
18. Hsiao (see note 12); Hsiao et al. (see note 12); A. R. Wallack, "Single payer ahead: Cost control and the evolving Vermont model," *New England Journal of Medicine* 365/7 (2011), pp. 584-585.
19. Fox and Blanchet (see note 11), p. 477.
20. Ibid.
21. See P. Twomey, "Human rights-based approaches to development: Towards accountability," in M. B. Baderin and R. McCorquodale (eds), *Economic, social and cultural rights in action* (Oxford: Oxford University Press, 2007), pp. 45-49.
22. United Nations Development Group, *The human rights based approach to development cooperation: Towards a common understanding among UN agencies* (NY: UNDG, 2003).
23. R. K. Yin, *Case study research: Design and methods*, 4th ed. (Thousand Oaks, CA: Sage Publications, 2009).
24. J. Baxter and J. Eyles, "Evaluating qualitative research in social geography: Establishing 'rigour' in interview analysis," *Transactions of the Institute of British Geographers* 22/4 (1997), p. 506.
25. McGill (2011, see note 13); McGill (2012, see note 14); G. MacNaughton and M. McGill, "Economic and social rights in the US: Implementation without ratification," *Northeastern University Law Journal* 4/2 (2012), pp. 365-406.
26. D. C. Radley, D. McCarthy, J. A. Lippa, et al., *Aiming higher: Results from a scorecard on state health system performance, 2014* (New York: Commonwealth Fund, 2014), p. 12; Hsiao et al. (see note 12), p. 1234.
27. See McGill (2011, see note 13); McGill (2012, see note 14); Rudiger (see note 17); Vermont Workers' Center, *Building a grassroots movement for the human right to healthcare*. Available at <http://www.workerscenter.org/building-grassroots-movement-human-right-healthcare>.
28. Vermont Workers' Center (see note 27).
29. Interview with James Haslam, Executive Director, Vermont Workers' Center, March 5, 2015.
30. Interview with Mary Gerisch, Steering Committee

and Health Care Committee, Vermont Workers' Center, March 12, 2015.

31. Haslam (see note 29).

32. Vermont Workers' Center, *Voices of the Vermont healthcare crisis: The human right to healthcare* (Burlington, VT: Vermont Workers' Center, 2008). Available at http://workerscenter.org/sites/default/files/Voices_of_the_Vermont_Healthcare_Crisis.pdf.

33. Interview with Robin Lunge, Director of Health Care Reform, Shumlin administration, March 23, 2015.

34. Interview with Sarah Copeland Hanzas, House Majority Leader, Vermont House of Representatives, March 11, 2015.

35. Interview with Ellen Oxfeld, Vice President, Vermont Health Care for All, March 12, 2015.

36. Interview with Daniel Barlow, Public Policy Manager, Vermont Businesses for Social Responsibility, March 16, 2015.

37. Gerisch (see note 30).

38. Ibid.

39. Barlow (see note 36).

40. Ibid.

41. Gerisch (see note 30).

42. Oxfeld (see note 35).

43. Interview with Cornelius "Con" Hogan, Member, Green Mountain Care Board, March 11, 2015.

44. Act No. 128 (see note 15) §§ 2, 8.

45. Ibid. § 6.

46. Act. No. 48 (see note 15).

47. Ibid. §§ 1, 1a.

48. *The Patient Protection and Affordable Care Act of 2010* (see note 10) § 1332.

49. Copeland Hanzas (see note 34).

50. Ibid.

51. Interview with Virginia "Ginny" Lyons, Vice Chair, Health and Welfare Committee, Vermont Senate, March 25, 2015.

52. Ibid.

53. Lunge (see note 33).

54. Interview with William Lippert, Chair, Health Committee, Vermont House of Representatives, March 23, 2015.

55. Ibid.

56. Copeland Hanzas (see note 34).

57. Barlow (see note 36).

58. Hogan (see note 43)

59. Lyons (see note 51).

60. A. Goodnough, "In Vermont, frustrations mount over Affordable Care Act," *New York Times* (June 4, 2015).

61. Gerisch (see note 30)

62. J. E. McDonough, "The demise of Vermont's single-payer plan," *New England Journal of Medicine* 372/17 (2015), pp. 1584–1585.

63. Fox and Blanchet (see note 11); but compare McDonough (see note 62).

64. Hsiao et al. (see note 12); McDonough (see note 62).

65. *An act relating to health care* (S. 139), passed May 16, 2015.

66. Gerisch (see note 30).

67. Ibid.

68. J. P. Habicht, C. G. Victoria, and J. P. Vaughan, "Evaluation designs for adequacy, plausibility and probability of public health programme performance and impact," *International Journal of Epidemiology* 28/1 (1999), pp. 10–18; F. Bustreo, P. Hunt, S. Gruskin, et al., *Women's and children's health: Evidence of impact of human rights* (Geneva: World Health Organization, 2013), pp. 88–89.

69. B. C. K. Choi and A. W. P. Pak, "Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness," *Clinical and Investigative Medicine* 29/6 (2006), p. 351.

70. See Bustreo et al. (see note 68), p. 6.

