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## Positive Health: The Human Right to Health Care Under the New York State Constitution

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# POSITIVE HEALTH: THE HUMAN RIGHT TO HEALTH CARE UNDER THE NEW YORK STATE CONSTITUTION

*Alan Jenkins\* & Sabrineh Ardalan\*\**

## I. INTRODUCTION

In his first State of the State address, former New York Governor Eliot Spitzer recognized the urgent need to “reform our health care system.”<sup>1</sup> He explained that “when 2.8 million New Yorkers can’t afford health insurance, that affects not only them and their families, it affects everyone,” and promised to take steps to make health care more affordable and accessible to all New Yorkers.<sup>2</sup>

As the governor recognized, access to quality health care is essential to realizing our full potential as individuals, families, communities, and as a society. Our children learn more effectively when they come to school healthy and strong. Our workforce is more productive and our economy more robust when workers and their families receive quality health care. Affordability of care promotes not only good health, but also economic security. In addition, the affordability and quality of the health care that all of us

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1. Press Release, Governor Eliot Spitzer, Governor Spitzer Delivers First State of the State Address (Jan. 3, 2007), <http://www.ny.gov/governor/press/0103073.html>.

2. *Id.*

receive improves drastically when our system prevents and treats health problems early and through regular, rather than emergency, care.<sup>3</sup>

Conversely, the entire state suffers when people and whole communities are denied meaningful access to care. Those ill effects are exacerbated when some communities are repeatedly burdened with multiple barriers to quality care, and when the racial or economic make-up of communities plays a role in determining who has access to care.<sup>4</sup>

Equal access to quality health care for all New Yorkers is a top priority for the State's residents.<sup>5</sup> An overwhelming majority of New Yorkers believe that everyone in the State has a right to health care,<sup>6</sup> and hold federal, state, and local government responsible for fulfilling that right.<sup>7</sup>

Despite these views, many New York communities lack access to basic health care services. Neighborhoods with the greatest health care needs, disproportionately low-income and communities of color, often have the fewest health care resources.<sup>8</sup> These condi-

3. See, e.g., Susan Adler Channick, *Come the Revolution: Are We Finally Ready for Universal Health Insurance?*, 39 CAL. W. L. REV. 303, 311-12 (2003); Sara Rosenbaum et al., *Symposium Articles: Foreword: National Health Reform and America's Uninsured*, 32 J.L. MED. & ETHICS 386 (2004); Alicia Ely Yamin, *Not Just A Tragedy: Access to Medications As A Right under International Law*, 21 B.U. INT'L L.J. 325, 341-42 (2003); The Opportunity Agenda, *Health Care and Opportunity*, [http://www.opportunityagenda.org/site/C.MWL5KKN0LvH/b.1428199/k.47C2/Healthcare\\_Fact\\_Sheet.htm](http://www.opportunityagenda.org/site/C.MWL5KKN0LvH/b.1428199/k.47C2/Healthcare_Fact_Sheet.htm) (last visited Mar. 28, 2008).

4. See generally INST. OF MEDICINE, *CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE* (2002), available at [http://www.nap.edu/catalog.php?record\\_id=10367#toc](http://www.nap.edu/catalog.php?record_id=10367#toc) [hereinafter CARE WITHOUT COVERAGE]; INST. OF MEDICINE, *COVERAGE MATTERS: INSURANCE AND HEALTH CARE* (2001), available at [http://www.nap.edu/catalog.php?record\\_id=10188#toc](http://www.nap.edu/catalog.php?record_id=10188#toc) [hereinafter COVERAGE MATTERS]; BRIAN D. SMEDLEY ET AL., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* (2003), available at <http://www.nap.edu/openbook.php?isbn=030908265X> [hereinafter UNEQUAL TREATMENT]; Timothy Stoltzfus *Just, Our Broken Health Care System and How To Fix It: An Essay on Health Law And Policy*, 41 WAKE FOREST L. REV. 537 (2006).

5. Press Release, The Opportunity Agenda, *New Poll: 77% of New Yorkers AGREE Hospital Closures Would Be BAD for New York's Health Care System* (Nov. 20, 2006), <http://www.opportunityagenda.org/site/c.mwL5KKN0LvH/b.1406015/apps/s/content.asp?ct=1956799>.

6. *Id.*

7. *Id.*

8. See, e.g., BRONX HEALTH REACH, *SEPARATE AND UNEQUAL, MEDICAL APARTHEID IN NEW YORK CITY* 18 (Oct. 2005), [http://www.institute2000.org/policy/medical\\_apartheid.pdf](http://www.institute2000.org/policy/medical_apartheid.pdf) [hereinafter SEPARATE AND UNEQUAL]; THE OPPORTUNITY AGENDA, *DANGEROUS AND UNLAWFUL: WHY OUR HEALTH CARE SYSTEM IS FAILING NEW YORK AND HOW TO FIX IT* 47 (2006), <http://www.opportunityagenda.org/atf/cf/%7B2ACB2581-1559-47D6-8973-70CD23C286CB%7D/>

tions are dangerous for New Yorkers. They threaten our lives, stymie our economic growth, and violate the very principle of American opportunity: that everyone should have a fair chance to achieve his or her potential.<sup>9</sup>

In this Article, we argue that the New York State Constitution creates a legal right to equal access to quality health care for all New Yorkers.<sup>10</sup> As we set forth below, both the historical context and the legislative history of the State Constitution support this interpretation.

In Part II, we look at the legislative history and historical context of the 1938 New York Constitutional Convention. We also outline the dimensions of the right to health care required under the text and history of the State Constitution, as informed by parallel provisions, international and federal law, as well as social science research. In Part III, we provide an overview of additional laws that guarantee equal access to quality health care, focusing on racial, linguistic, socioeconomic, and geographic equity. Considered together with the New York State Constitution, these laws establish that all New Yorkers have a legal right to equal access to quality health care. The State must ensure that all New Yorkers have access to health care, remedying the absolute deprivations of health care that many low-income New York communities currently face, and ensuring that health care services are equitably distributed to meet health care needs.

In Part IV, we demonstrate that New York State is currently failing to live up to its obligations to protect and promote New Yorkers' health, and in Part V we suggest a series of remedies that can help ensure that the State fulfills its obligations.

At a time when New York State and the nation as a whole are engaged in extended debate about the future of our health care system,<sup>11</sup> it is especially important to acknowledge the constitu-

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Full%20Dangerous%20and%20Unlawful%20Report.pdf [hereinafter DANGEROUS AND UNLAWFUL]. Areas with high concentrations of African Americans, Latinos, and Asian Americans are most likely to have serious shortages of primary care physicians. Hospital closures and downsizing in New York City have disproportionately affected low-income communities and communities of color.

9. DANGEROUS AND UNLAWFUL, *supra* note 8, at 1.

10. *See infra* Part II.

11. *See, e.g.*, Fred Barnes, Editorial, *S-chip of Fools*, WKLY. STANDARD, Oct. 15, 2007; Cathleen F. Crowley, *Call in to Comment on Health Coverage*, TIMES UNION (ALBANY, N.Y.), Oct. 10, 2007, at D3; Henry L. Davis, *Health Care Coverage Debated*, BUFFALO NEWS (N.Y.), Oct. 4, 2007, at C5; Candice Ferrette, *Local Experts Push Universal Health Care at League of Women Voters Event*, J. NEWS (WESTCHES-TER COUNTY, N.Y.), Oct. 11, 2007, at 1B; Micheline Maynard & Mary M. Chapman,

tional and human right to health care that all New Yorkers hold, and that must be a part of the reforms that nearly all agree are greatly needed.

## II. THE RIGHT TO HEALTH CARE UNDER THE NEW YORK STATE CONSTITUTION

Since 1977, when U.S. Supreme Court Justice William J. Brennan called on state courts to take a more active role in protecting human rights,<sup>12</sup> much has been written about the importance of state constitutions and courts in the face of federal courts' increasingly restrictive interpretation of U.S. constitutional provisions.<sup>13</sup> The constitutions of states around the country contain substantive provisions requiring government to ensure their residents' educa-

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G.M. to Pay to Research Health Care, N.Y. TIMES, Oct. 6, 2007, at C1; Paul O'Neill, Editorial, *A Health Care Bargain*, N.Y. TIMES, Oct. 16, 2007, at A23; Richard Pérez-Peña, *Decisions in Albany: A Budget with a Breakthrough in Child Health Care*, N.Y. TIMES, Apr. 2, 2007, at B1.

12. See William J. Brennan, Jr., *State Constitutionalism and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 491 (1977). Prior to being appointed to the U.S. Supreme Court, Justice Brennan was a state court judge for seven years, four of which he served on the New Jersey Supreme Court.

13. See Helen Hershkoff, *State Constitutions: A National Perspective*, 3 WIDENER J. PUB. L. 7 (1993) [hereinafter Hershkoff, *National Perspective*]; Helen Hershkoff, *State Courts and the "Passive Virtues": Rethinking the Judicial Function*, 114 HARV. L. REV. 1833, 1836-38 (2001); Helen Hershkoff, *Welfare Devolution and State Constitutions*, 67 FORDHAM L. REV. 1403 (1998) [hereinafter Hershkoff, *Welfare Devolution*]; Judith S. Kaye, *State Courts at the Dawn of a New Century: Common Law Courts Reading Statutes and Constitutions*, 70 N.Y.U. L. REV. 1, 15-16 (1995) (pointing out the "critical difference" between when courts make constitutional law and when they make common law" and emphasizing that "[o]utside the area of constitutional adjudication, state court decisions 'are subject to overrule or alteration by ordinary statute,'" whereas "when a case is decided on constitutional grounds, the court solidifies the law in ways that may not be as susceptible to subsequent modification either by courts or by legislatures"); Judith S. Kaye, *Dual Constitutionalism in Practice and Principle*, 61 ST. JOHN'S L. REV. 399 (1987). But see James A. Gardner, *The Failed Discourse of State Constitutionalism*, 90 MICH. L. REV. 761, 763-64 (1992) (noting the weakness of the idea of state constitution); Paul W. Kahn, *The New Judicial Federalism: State Constitutionalism and the Problems of Fairness*, 30 VAL. U. L. REV. 459, 465-66 (1996) (pointing to the structural weaknesses confronting state constitutionalism, arguing that the history of constitutional texts is "rarely helpful" and noting the absence of a rich jurisprudence).

tion, shelter, and health.<sup>14</sup> Federal courts have generally declined to recognize these guarantees within the U.S. Constitution.<sup>15</sup>

New York's Constitution is particularly protective of these rights. Among other guarantees, two provisions, the public health and the aid to the needy provisions, explicitly recognize the State's obligations to aid the poor and protect and promote New Yorkers' health.<sup>16</sup> Specifically, the public health provision of the constitution, article XVII, section 3, states:

The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine.<sup>17</sup>

Article XVII, section 1 of the New York State Constitution, the aid to the needy provision, mandates: "The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature from time to time may determine."<sup>18</sup>

Article XVII, known as the "Social Welfare Article," was added to the New York Constitution in the midst of the Great Depres-

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14. See Hershkoff, *Welfare Devolution*, *supra* note 13, at 1407; Antony B. Klapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739 (1993) (advocating for interpretation of state constitutions to support enforcement of rights for the mentally ill); Burt Neuborne, *State Constitutions and the Evolution of Positive Rights*, 20 RUTGERS L.J. 881, 887, 897-98, 901 (1989) ("Federal courts will continue to play a critical role as the enforcers of choice in the areas of traditional negative rights against the State. But it is state courts, with their decided institutional advantages, that provide us with the opportunity to develop a parallel positive jurisprudence of human decency and caring."); Norma Rotunno, Note, *State Constitutional Social Welfare Provisions and the Right to Housing*, 1 HOFSTRA L. & POL'Y SYMP. 111, 121 (1996) [hereinafter Rotunno, *State Constitutional Social Welfare*].

15. See, e.g., *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 37 (1973) (finding that education is not a fundamental right under the U.S. Constitution). It is well-established that state courts may interpret their constitutions and statutes to afford more expansive rights than those established under federal law. See, e.g., *Michigan v. Long*, 463 U.S. 1032, 1040-42 (1983); see also Hershkoff, *National Perspective*, *supra* note 13, at 11-13. State courts may also protect rights that federal law does not. See, e.g., *Horton v. Meskill*, 376 A.2d 359, 371 (Conn. 1977) ("[D]ecisions of the United States Supreme Court defining fundamental rights are persuasive authority to be afforded respectful consideration, but they are to be followed by Connecticut courts only when they provide no less individual protection than is guaranteed by Connecticut law.").

16. See N.Y. CONST. art. XVII, §§ 1, 3.

17. *Id.* § 3.

18. *Id.* § 1.

sion.<sup>19</sup> At the 1938 constitutional convention, delegates drafted a number of provisions addressing public health, social security, insurance, and aid to the needy.<sup>20</sup> Delegates bundled these provisions together as a social welfare amendment to the constitution and presented them to the public for a vote.<sup>21</sup> Voters overwhelmingly approved the amendment by a vote of 1,902,075 to 943,296.<sup>22</sup>

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19. The Great Depression made clear the need for government intervention to address issues relating to health and housing. As a dissenting judge noted in *Asian Americans for Equality v. Koch*:

As early as 1936, the Court of Appeals in [*N.Y. City Housing Authority v. Muller*, 1 N.E.2d 153, 153-55 (N.Y. 1936),] . . . recognized the social evils associated with unsanitary, substandard housing conditions and noted the inadequate supply of housing for persons of low income. . . . The court declared that such conditions “constitute a menace to the health, safety, morals, welfare, and comfort of the citizens of the state . . . [which] cannot be remedied by the ordinary operation of private enterprise.” In language leaving no doubt of the forcefulness of the court’s view, the court determined that it was the State’s obligation through the use of its police powers to remedy this menace. The court stated: “The fundamental purpose of government is to protect the health, safety and general welfare of the public. All its complicated activities have that simple end in view. Its power plant for the purpose consists of the power of taxation, the police power and the power of eminent domain. *Whenever there arises, in the State, a condition of affairs holding a substantial menace to the public health, safety or general welfare, it becomes the duty of the government to apply whatever power is necessary and appropriate to check it.*” . . . One year after the *Muller* decision, . . . prompted by the aftermath of the Great Depression, Article XVII, of the New York State Constitution was adopted, making it a constitutional mandate in New York for the state to provide for the needy.

514 N.Y.S.2d 939, 960-61 (App. Div. 1987) (Carro, J., dissenting) (internal citations omitted).

20. See generally DOUGLAS W. CAMPBELL & VERNON A. O’ROURKE, CONSTITUTION-MAKING IN A DEMOCRACY: THEORY AND PRACTICE IN NEW YORK STATE (1943) [hereinafter CONSTITUTION-MAKING IN A DEMOCRACY]; PETER J. GALIE, ORDERED LIBERTY: A CONSTITUTIONAL HISTORY OF NEW YORK (1996) [hereinafter ORDERED LIBERTY].

21. See Christine R. Ladd, Note, *A Right to Shelter for the Homeless in New York State*, 61 N.Y.U. L. REV. 272, 291 n.132 (1986) [hereinafter Ladd, *Right to Shelter*]. Under a provision of the New York Constitution, the question “[s]hall there be a convention to revise the Constitution and amend the same?” must be placed on the general election ballot every twenty years. N.Y. CONST. art. XIX, § 2. If the electorate responds affirmatively, then a constitutional convention is convened. Delegates submit proposed amendments, which a majority of the elected delegates must approve, and the approved amendments must then be ratified by the voting population to take effect. *Id.* In 1936, voters approved the call for a constitutional convention by a margin of 1,413,604 to 1,190,275. With Republicans comprising the majority of delegates and Democrats divided into New Deal and anti-New Deal factions, the convention was not an obvious forum for major reform. See ORDERED LIBERTY, *supra* note 20, at 25, 230; Warren Moscow, *Fate of the State Constitution Is Weighed*, N.Y. TIMES, Aug. 21, 1938, at 10.

22. See CONSTITUTION-MAKING IN A DEMOCRACY, *supra* note 20, at 237.

The amendment carried the largest total vote of all the 1938 amendments to the constitution.<sup>23</sup> Every major party endorsed the social welfare amendment,<sup>24</sup> as did most newspapers and influential politicians of the day.<sup>25</sup> Once ratified, the social welfare amendment vested in the state government an affirmative obligation to provide for the health of its residents.<sup>26</sup>

### A. The Public Health Provision

The text of the public health provision makes clear that it covers both the “protection” and the “promotion” of health, that it covers all “inhabitants” of the State, and that providing for such protection and promotion by state and municipal governments is

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23. See *id.* This amendment was the eighth of nine amendments voted on by New Yorkers, and read, “[s]hall the proposed amendment, submitted by the Constitutional Convention permitting the use of state money and credit for social welfare, including provision, by insurance or otherwise, against the hazards of unemployment, sickness and old age, be approved?” *Catholics Stress Four Amendments*, N.Y. TIMES, Nov. 7, 1938, at 2.

24. See CONSTITUTION-MAKING IN A DEMOCRACY, *supra* note 20, at 230. Parties as diverse as the American Labor Party, the Communist Party, the Democratic Party, the Republican Party, and the Socialist Party all recommended that voters support this amendment. *Id.*

25. *Id.* Of the eight major newspapers, five came out in support of the amendment: the *Buffalo Evening News*, the *New York Daily News*, the *New York Herald Tribune*, the *New York Times*, and the *New York World-Telegram*. Three did not support the amendment: *The New York Sun*, *The Rochester Democrat and Chronicle*, and the *Syracuse Post-Standard* (published by a delegate). *Id.* At least one critical editorial appeared in the *Wall Street Journal*, which characterized the social welfare article as “dangerous” and as a violation of the principle that the “only ultimate support for taxation is production.” *Inviting Rejection*, WALL ST. J., Aug. 6, 1938, at 4. Thomas E. Dewey, New York City Republican Mayor Fiorello LaGuardia, Mgr. J.F.A. McIntyre, Robert Moses, and Alfred E. Smith came out in support of the amendment. *Id.* The article also received widespread support from public figures such as the President of the City Council and the Bishop of the Archdiocese of New York. See Newbold Morris, *Mr. Morris Reviews the Amendments*, N.Y. TIMES, Oct. 30, 1938, at 74; *Catholics Stress Four Amendments*, N.Y. TIMES, Nov. 7, 1938, at 2.

26. In this discussion, we draw upon Martha Davis’s case study of article XVII, section 3, the public health provision, and Helen Hershkoff’s studies of article XVII, section 1, the aid to the needy provision. Martha Davis, *Part I: The Spirit of Our Times: State Constitutions and International Human Rights*, 30 N.Y.U. REV. L. & SOC. CHANGE 359, 360-61 (2006) [hereinafter Davis, *State Constitutions and International Human Rights*]; Helen Hershkoff, *Positive Rights and State Constitutions: The Limits of Federal Rationality Review*, 112 HARV. L. REV. 1131, 1138-39 (1999) [hereinafter Hershkoff, *Positive Rights*]; Helen Hershkoff, *Rights and Freedoms Under the State Constitution: A New Deal for Welfare Rights*, 13 TOURO L. REV. 631, 634 (1997) [hereinafter Hershkoff, *Rights and Freedoms*].



mandatory.<sup>27</sup> The provision gives the legislature discretion in crafting a system that will effectively fulfill those goals.<sup>28</sup>

Taken together, the text, structure, purpose, and history of the provision make clear that it includes a guarantee of adequate health care as essential to safeguarding the public's health.

### 1. *Health and Health Care in the 1930s: Historical Context of Article XVII*

The legislative history of the social welfare article makes clear that the delegates to the convention drafted the provision to address the health needs of that era.<sup>29</sup> These included both broad public health concerns like sanitation, hygiene, and combating epidemics, and health care in the form of medical services.<sup>30</sup> At the time of the 1938 New York constitutional convention, the science of medical care had made significant advances, but thousands of people in New York and millions across the country could not afford medical care and were not getting the treatment they needed.<sup>31</sup> The public, policymakers, and health care providers

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27. N.Y. CONST. art. XVII, § 3. Courts have generally found that use of the term "shall" establishes a mandate. See *Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 127 S. Ct. 2518, 2531-32 (2007) (finding the statutory language "shall approve" mandatory) (citing *Lopez v. Davis*, 531 U.S. 230, 241 (2001) (noting Congress' "use of a mandatory 'shall' . . . to impose discretionless obligations")); *Lexecon, Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998) ("[T]he mandatory 'shall' . . . normally creates an obligation impervious to judicial discretion"); *Ass'n of Civil Technicians v. Fed. Labor Relations Auth.*, 22 F.3d 1150, 1153 (D.C. Cir. 1994) ("The word 'shall' generally indicates a command that admits of no discretion on the part of the person instructed to carry out the directive."); see also BLACK'S LAW DICTIONARY 1375 (6th ed. 1990) (explaining that "[a]s used in statutes . . . this word is generally imperative or mandatory" and noting that in legal documents "shall" is construed as permissive only when necessary to carry out legislative intent or in cases where no right depends on its being taken in a mandatory sense).

28. N.Y. CONST. art. VII, § 8. This mandate is reinforced by the section of the state constitution on state finance—also adopted as a result of the 1938 constitutional convention—which explains: "Subject to the limitations on indebtedness and taxation, nothing in this constitution contained shall prevent the legislature from providing . . . for the protection by insurance or otherwise, against the hazards of unemployment, sickness and old age." *Id.*

29. See *Davis, State Constitutions and International Human Rights*, *supra* note 26, at 392; see also *infra* Part II.A.2.

30. See *infra* Part II.A.2. Because this Article addresses the right to health care, we do not discuss other public health obligations imposed by the social welfare article.

31. See *Beatrix Hoffman, Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75, 75-85 (2003); R.L. Duffus, *Shall Medicine Be Socialized? A Big Issue Is Joined*, N.Y. TIMES, Dec. 4, 1932, at XX7 [hereinafter *Duffus, Shall Medicine Be Socialized?*]; S.J. Duncan-Clark, Editorial, *Doctors and Laity in Row over Health*, N.Y. TIMES, Apr. 21, 1929, at 51 ("The mounting cost of medical care has become a most serious problem for many persons of moderate means.");

were clamoring for health care reform.<sup>32</sup> The drafters of the state constitutional amendments recognized that this was a problem they had to tackle.<sup>33</sup>

Many of the concerns about public health of the 1930s were similar to those of today. For example, a survey prepared for the New York City Welfare Council during the winter of 1930-31, described “widespread deficiencies in diet [and] postponement of prophylactic measures and of *treatment* for incipient ailments.”<sup>34</sup> The results of the country’s first comprehensive survey of the economics of medical practice revealed that “[m]any persons do not receive service which is adequate either in quantity or quality and the costs of service are inequitably distributed.”<sup>35</sup>

The study made clear that “[t]he common belief that the poor receive necessary medical care is not supported.”<sup>36</sup> Based on “variations in the death and sickness rates in different sections of the country and among different economic groups,” the survey concluded “that there is a close relation between income and health.”<sup>37</sup> Specifically, the “two or three lowest income groups receive far less of nearly every service—care from physicians and dentists, hospitalization, eye care, maternity care and X-ray and laboratory service—than the groups with highest incomes,” despite similar rates of sickness among poorer and wealthier families.<sup>38</sup> Other studies cited by the Constitutional Committee

*Federal Aid Lifts Big Charity Care Load: A.I.C.P. Able to Give Special Services and Health Care to Low Income Group*, N.Y. TIMES, Mar. 27, 1939, at 13.

32. See, e.g., Ronald Andersen & Lu Ann Aday, *Access to Medical Care in the U.S.: Realized and Potential*, 16 MED. CARE 533, 533-46 (1978); Hoffman, *supra* note 31, at 75-85; Harvey C. Sigelbaum, *Business Forum: Universal Health Insurance*, N.Y. TIMES, Sept. 18, 1988 (explaining that “[t]he premise behind our health care financing is a collaborative public and private entitlement system that grew out of Depression-era conditions”).

33. See *infra* Part II.A.2.

34. DAVID M. SCHNEIDER & ALBERT DEUTSCH, *THE HISTORY OF PUBLIC WELFARE IN NEW YORK STATE 1867-1940* 301 (Patterson Smith 1969) (emphasis added).

35. See Duffus, *Shall Medicine Be Socialized?*, *supra* note 31. The study’s recommendations included:

First, that the medical and allied services should be unified and grouped around hospitals; second, that public and private health services should be made “available to the entire population according to its needs”; [and] [t]hird, that “the costs of medical care should be placed on a group payment basis, through the use of insurance, through the use of taxation, or through the use of both these methods.”

*Id.*

36. *130,000,000 Disabled in a Year from Illness*, N.Y. TIMES, Mar. 10, 1932, at 23 [hereinafter *130,000,000 Disabled*].

37. See Duffus, *Shall Medicine Be Socialized?*, *supra* note 31, at XX7.

38. *Id.*

revealed that “[f]our out of ten people who are sick receive no medical care.”<sup>39</sup>

These problems were widespread in the United States. Large areas of the country, predominantly poor areas with significant health needs, were facing a dire shortage of hospital beds.<sup>40</sup> As one Chicago resident testified at the 1938 National Health Conference held by the President’s Interdepartmental Committee to Coordinate Health and Welfare Activities, the shortage of hospital beds and health care facilities was “disgraceful” and Chicago’s health was in “an emergency situation.”<sup>41</sup> In New York, hospitals with indigent patients were finding “an ever-mounting need for free hospital service and a corresponding decline in the number of paying or part-paying patients.”<sup>42</sup> Physicians were receiving only “one-quarter to one-third of the total expenditure for health care.”<sup>43</sup>

At the same time, there was growing recognition of the need for appropriate primary and preventative care. Public officials stressed the importance of children receiving appropriate health care.<sup>44</sup> Studies revealed that conditions like blindness, once thought of as “the affliction of age,” could be prevented by “proper individual and medical care in earlier years.”<sup>45</sup> Similarly, the New York State Commissioner of Health pointed out that “the death rate [from tuberculosis] could be cut in half by earlier diagnosis and better care of patients” and urged the “[e]xtension of health services in New York State to remedy inadequate local care.”<sup>46</sup>

Keeping people healthy and ensuring adequate medical care was a priority for both the government and the private sector. New York City Mayor Fiorello La Guardia preserved funding for the city’s public hospitals, even as he was forced to cut services city-wide during the Great Depression. He recognized that “in keeping

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39. N.Y. STATE CONSTITUTIONAL CONVENTION COMMITTEE, PROBLEMS RELATING TO BILL OF RIGHTS AND GENERAL WELFARE 520 (1938) [hereinafter PROBLEMS RELATING TO BILL OF RIGHTS].

40. See William L. Lawrence, *Says Nation Faces Hospital Shortage*, N.Y. TIMES, Oct. 12, 1940, at 19.

41. William L. Lawrence, *Doctors Pledged to Aid Health Plan*, N.Y. TIMES, July 20, 1938, at 1.

42. *Beekman Hospital Asks City Be ‘Fair’*, N.Y. TIMES, Mar. 7, 1939, at 25.

43. See *130,000,000 Disabled*, *supra* note 36.

44. *Health Care Stressed*, N.Y. TIMES, Apr. 26, 1937, at 11.

45. *Health Care Held Curb on Blindness*, N.Y. TIMES, Dec. 7, 1934, at 19.

46. *Calls Health Care in State Deficient*, N.Y. TIMES, May 14, 1931, at 19.

the poor healthy, the rest of the city would be, too.”<sup>47</sup> As the head of a New York social service agency asserted, “[h]ealthy, [low-income New Yorkers] are a community asset. Sick and unemployed, they must look to public or private welfare agencies for complete support, in addition to the medical care required to bring them back to health.”<sup>48</sup> National business leaders also underscored the need for investment in health care. As Charles Taussig, president of the American Molasses Company, noted: “The annual toll of preventable illness measured in terms of money runs into the billions. Progressive business will regard an adequate health service as a subsidy to industry, not a burden.”<sup>49</sup>

The need for an improved health care system, particularly for low-income people, was, thus, well-recognized at the time of the 1938 constitutional convention. The main debate centered on the extent to which government should be involved in the administration of such a system.<sup>50</sup> The New York State Health Commissioner, Dr. Edward S. Godfrey, explained at an American Public Health Association meeting:

It is time to drop loose talk about “state medicine” and “socialized medicine” and to brush aside the false issue of American democracy which has been injected into the case for and against the extension of medical services to the low income groups of the population. Care must be taken to make sure that new plans [for the extension of medical services] will work well, at a reasonable cost to the public . . . Today, no physician would go back to the old days when the needy were left to fend for themselves medically.<sup>51</sup>

It was in this context that the delegates to New York’s constitutional convention assembled in 1938.

## 2. *The 1938 Constitutional Convention*

The delegates to the 1938 convention dedicated themselves to addressing the public’s health concerns, and health care emerged

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47. David R. Jones, *The Urban Agenda, Health Care: No Access*, N.Y. AMSTERDAM NEWS, Oct. 7-13, 1999, available at [http://www.cssny.org/pubs/urbanagenda/1999\\_10\\_07.html](http://www.cssny.org/pubs/urbanagenda/1999_10_07.html).

48. *Federal Aid*, *supra* note 31.

49. See Lawrence, *supra* note 41, at 1.

50. THE NEW YORK STATE CONSTITUTION: A BRIEFING BOOK, TEMPORARY STATE COMMISSION ON CONSTITUTIONAL REVISION 235 (Gerald Benjamin, ed., 1994) [hereinafter BRIEFING BOOK].

51. *The Real Medical Issue*, N.Y. TIMES, Dec. 2, 1939, at 11.

strongly as a necessary element.<sup>52</sup> As we explain in this section, the record of the constitutional convention and reports from various committees reveal the delegates' intent to create a comprehensive system of health care to meet the health needs of all New Yorkers.

*i. Vision for a Comprehensive Health Care System*

An unofficial committee, set up by New York Governor Herbert H. Lehman to assist convention delegates in gathering information and data,<sup>53</sup> issued a report describing its vision for a health care system:

[P]ublic health in this country has developed from the time when its primary emphasis was one of charity to the present day in which the emphasis is upon *medical care* . . . . The scope of the authority to care for the public health has developed from its initial stage of meeting a present danger of epidemic to that of *treatment and education of individuals in health matters amenable to large-scale community programs*.<sup>54</sup>

This vision invoked a system of preventative medical care equipped to treat people and prevent illness. The report's definition of public health included "organizing these benefits [referring to medical services, preventative treatment of disease, control of infections, sanitation, and the like] in such fashion as to enable every citizen to realize his birthright of health and longevity."<sup>55</sup>

Hearings held before the Committee on Social Welfare of the constitutional convention made it clear that medical care was integral to ensuring the public's health. Social welfare groups that testified at hearings urged the delegates to empower the legislature to create systems for "the future handling of relief, *medical care*, hos-

52. See N.Y. CONST. art. XVII, § 3; REVISED RECORD OF THE CONSTITUTIONAL CONVENTION OF THE STATE OF NEW YORK 2126 [hereinafter REVISED RECORD] ("[T]his State has the finest relief administration of any state in the Union . . . [w]e desire that this record be maintained.").

53. This committee issued a twelve volume publication, known as the "Poletti Report," named for its chair, Judge Charles Poletti, and it included a volume dedicated to the Bill of Rights and General Welfare. See PROBLEMS RELATING TO BILL OF RIGHTS, *supra* note 39. This report states, "[i]n the treatment of controversial subjects, a genuine effort [has been] made to present the facts impartially and to set forth the pros and cons." *Id.* at v; see also ORDERED LIBERTY, *supra* note 20, at 154-55, 232-33; Burton C. Agata, *Amending and Revising the New York Constitution*, in BRIEFING BOOK, *supra* note 50.

54. PROBLEMS RELATING TO BILL OF RIGHTS, *supra* note 39, at 512 (emphasis added).

55. *Id.* at 513.

pitalization and . . . housing.”<sup>56</sup> Mayor La Guardia asked the Committee to adopt a social welfare amendment that “would obligate the State to care for its *sick* and needy, as well as to provide its citizens with adequate wages, working and living conditions and *proper health facilities*.”<sup>57</sup>

The Committee’s vision was an expansive one that went beyond emergency relief and disease control to embrace a system of comprehensive and preventative care that would reach all of the state’s residents and communities.<sup>58</sup> Committee Chairman Thomas F. Corsi, a primary spokesman for the social welfare amendment, emphasized the need for state leadership in creating an effective public health system, noting that “public health as now practiced in this State should be validated in the State Constitution as *a constructive program for the promotion of positive health*.”<sup>59</sup> He observed that “[p]oor health conditions in one locality are a menace to the State as a whole.”<sup>60</sup> He argued that “[e]ffective control of disease and promotion of the health of the citizens of the State are impossible if the scope of health service and the administrative structure is left entirely to the judgment of the local political subdivision.”<sup>61</sup> Accordingly, Corsi highlighted that the public health amendment served the important function of making clear that “public health is primarily a function of the State rather than the localities.”<sup>62</sup>

Corsi presented the amendment in historical context, noting that the concept of public health was very limited when the constitution was drafted in 1894, and the constitution was therefore silent on the subject of public health. According to Corsi, the concept of public health at that time centered on remedial measures such as waste and sewage management, and the use of quarantine measures to contain infectious diseases.<sup>63</sup>

Corsi then noted that since that time, research had expanded the concept of public health beyond sanitation and quarantine to disease prevention and control.<sup>64</sup> Specifically, Corsi explained that public health embraced measures for the “prevention and control

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56. *Ask State to Rule Relief Is Its Duty*, N.Y. TIMES, May 5, 1938, at 10 (emphasis added).

57. *Mayor Advocates Basic Law Change on Relief Powers*, N.Y. TIMES, July 9, 1938, at 1 [hereinafter *Mayor Advocates*] (emphasis added).

58. See REVISED RECORD, *supra* note 52, at 2133.

59. *Id.* (emphasis added).

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.* at 2131.

64. *Id.* at 2132.

of such non-communicable diseases as cancer, diabetes, and heart diseas[e].”<sup>65</sup> He described hospital-based cancer treatments, the administration of immunizations, the prenatal care of pregnant women, and “the conduct of well baby clinics” as part of the Committee’s vision for a modern public health system—all of which require doctors and a functioning health care system.<sup>66</sup>

In Corsi’s discussion of the public health provision before the convention, he emphasized that the provision had been endorsed by “the whole of the medical profession and every health and welfare agency in the State.”<sup>67</sup> In support of the provision, he called upon the widely accepted definition of public health developed by a former president of the American Public Health Association (“APHA”).<sup>68</sup> Under that definition, public health constituted:

*[T]he science and art of preventing disease, prolonging life, and promoting physical health and efficiency through, (1) organized community efforts for the sanitation of the environment; (2) the control of community infection; (3) the education of the individual in principles of personal hygiene; (4) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease; (5) the development of the social machinery which will insure to every individual in the community a standard of living adequate for the maintenance of health.*<sup>69</sup>

At that time, the APHA and the medical community had moved toward an expansive understanding of public health that included government-supported medical care.<sup>70</sup> At the APHA annual conference in 1938, delegates approved a “new deal in public health,” which included “not only an extension of strictly public health services . . . but Federal grants to aid State medical care for individuals in the low income brackets.”<sup>71</sup>

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65. *Id.*

66. *See id.* at 2132-33.

67. *Id.* at 2133.

68. *Id.* at 2132-33.

69. *Id.* at 2133 (emphasis added).

70. Hugh O’Connor, *New Deal Mapping Health Insurance*, N.Y. TIMES, Oct. 26, 1938, at 48 [hereinafter O’Connor, *New Deal Mapping*]; Hugh O’Connor, *Predict an Accord on State Medicine: Duty of Government Likened to that in Education Field*, N.Y. TIMES, Oct. 29, 1938, at 36 [hereinafter O’Connor, *Predict an Accord on State Medicine*].

71. *See* O’Connor, *Predict an Accord on State Medicine*, *supra* note 70.

ii. *An Emerging View of the Importance of Publicly Funded Health Insurance*

Further evidence of the prominence of health care concerns in delegates' minds can be found in the discussion at the convention about the need for a system of health insurance.<sup>72</sup> State provision of health insurance had been the subject of political debate since the time of the 1915 constitutional convention, and the debate continued at the 1938 convention.<sup>73</sup> Mayor La Guardia lobbied for the addition of language to the social welfare amendments that would empower the legislature to create a health insurance program, citing rising costs of medical care and hospitalization.<sup>74</sup> As one drafter of the social welfare amendments underscored, constitutional language was needed that was "sufficiently broad to allow ample scope for the social vision of the future and not restricted to the particular forms of social legislation or insurance" which had developed at that time.<sup>75</sup>

Delegates were given an extensive report prepared by the Committee on Social Welfare on health insurance which outlined the dimensions of the health problem, the current methods for caring for the sick and injured, attempts to reduce the cost of medical care, the adequacies and inadequacies of current methods, possible solutions to the "problem of caring for the sick," including differ-

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72. Public officials declared that "[a] national health insurance plan is 'the last remaining frontier of social security in America.'" *National Program on Health Urged*, N.Y. TIMES, Oct. 20, 1939, at 21. Many asserted "the government was the only agency capable of bringing proper health care within the reach of all and of 'bringing order and efficiency into a field where disorder and inefficiency are primarily due to a lack of coordination of individual effort.'" *Id.* Even the American Medical Association ("AMA"), traditionally opposed to government intervention in health care, publicly stated its support for "any of the efforts which [the government would] make for betterment in the health care of the people of this country." See Lawrence, *supra* note 41, at 1. The AMA's fear of government intervention in health care has been well documented. See, e.g., Eric G. Campbell, Book Review, 294 J. AM. MED. ASS'N 1826, 1826 (2005) (reviewing ALAN DERICKSON, HEALTH SECURITY FOR ALL: DREAMS OF UNIVERSAL HEALTH CARE IN AMERICA (2005)). For example, it opposed a 1921 plan to establish government sponsored health centers in New York, and in the 1940s it opposed President Harry Truman's proposal for an economic bill of rights with health care provisions for increased access. See *id.*

73. See BRIEFING BOOK, *supra* note 50, at 235.

74. *Mayor Advocates*, *supra* note 57.

75. See *id.* at 3; see also *Convention Backs Health Insurance in Welfare Clause*, N.Y. TIMES, Aug. 19, 1938, at 1.



ent models for insurance, and an overview of the systems of health insurance in thirty-one European countries.<sup>76</sup>

The report recommended that the convention delegates revise the Constitution to authorize the State to “pave the way for adequate insurances for the unemployed, the sick and the aged, and enable the State itself, if the legislature so desires to administer all forms of relief directly.”<sup>77</sup> Corsi specifically pushed for a social welfare amendment that gave the legislature the power to “provide for ‘the protection by insurance or otherwise, against the hazards of unemployment, sickness and old age.’”<sup>78</sup>

Corsi asserted that “sickness” ranked next to unemployment as “the greatest single factor contributing to the vast expenditures for relief which this generation and generations to come are forced to bear.”<sup>79</sup> He argued that “the creation of a health system by the State would pay dividends in the long run by creating healthy citizens and would reduce relief rolls.”<sup>80</sup> After much debate, the delegates to the Convention voted in favor of the inclusion of the word “sickness,” paving the way for the legislature to create a system of health insurance.<sup>81</sup>

The amendment permitted the State to establish a health insurance system.<sup>82</sup> Article VII of the State Constitution, which addresses state finances, now reads:

Subject to the limitations on indebtedness and taxation, nothing in this constitution contained shall prevent the legislature from providing for the aid, care and support of the needy directly or through the subdivisions of the state; or for the protection by insurance or otherwise, against the hazards of unemployment, sickness and old age . . . .<sup>83</sup>

The history of the 1938 constitutional convention thus demonstrates the delegates’ intent to include a right to health care as part of a broader right to public health and to give the State both the

76. This was part of the volume in the Poletti Report by the Sub-Committee on Bill of Rights and General Welfare. PROBLEMS RELATING TO BILL OF RIGHTS, *supra* note 39, at 514.

77. REPORT OF THE COMMITTEE ON SOCIAL WELFARE, JOURNAL AND DOCUMENTS, CONVENTION DOC. NO. 7, at 2.

78. *Convention Backs Health Insurance in Welfare Clause*, *supra* note 75, at 20.

79. *Id.*

80. *Id.*

81. *Id.*; see also Jack Elinson et al., *New York Models in Medical Care*, 147 AM. J. EPIDEMIOL. 209 (1998), available at <http://ajc.oxfordjournals.org/cgi/reprint/147/3/209>.

82. See BRIEFING BOOK, *supra* note 50, at 235.

83. N.Y. CONST. art. VII, § 8(2).

responsibility to ensure an effective health care system and the latitude to bring it about through effective means.

### 3. *Judicial Interpretation of the Public Health Provision*

Few court cases have addressed the public health provision,<sup>84</sup> and those that have relate largely to the power of municipal agencies to promulgate rules and regulations to protect the public's health.<sup>85</sup> Indeed, when presented with the opportunity to rule on the scope of the provision, New York courts have generally sidestepped it.<sup>86</sup>

In *Hope v. Perales*,<sup>87</sup> for example, the plaintiffs claimed that because the New York Prenatal Care Assistance Program ("PCAP") excluded abortion from its medical services, it violated both the public health and the aid to the needy provisions of the constitution.<sup>88</sup> The New York Court of Appeals, however, determined that PCAP was not aimed at the protection of public health and therefore the public health provision was not applicable.<sup>89</sup>

Similarly, in *Aliessa v. Novello*,<sup>90</sup> the Court of Appeals avoided ruling on the plaintiffs' challenge to the State's denial of Medicaid to permanent resident immigrants under the public health provision, although it had the opportunity to do so.<sup>91</sup> The *Aliessa* court did refer to the U.S. Supreme Court's characterization of ongoing medical care as a "basic necessity of life,"<sup>92</sup> but it decided the case

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84. See BRIEFING BOOK, *supra* note 50, at 236-38.

85. See, e.g., *Conlon v. Marshall*, 59 N.Y.S.2d 52, 56-57 (Sup. Ct. 1945) (determining that the Board of Health of New York City had the power to adopt a tuberculosis regulation, where the regulation was a necessary and reasonable measure to promote public health); see also *Co-Pilot Enter., Inc. v. Suffolk Co. Dept. of Health*, 239 N.Y.S.2d 248, 253 (Sup. Ct. 1963) (noting that the Suffolk County Department of Health was authorized to enact rules and regulations necessary to ensure public health).

86. See *Davis, State Constitutions and International Human Rights*, *supra* note 26, at 395-96 (noting that New York courts' avoidance of ruling on the scope of the public health provision is not unusual, and that courts in other states have also failed to construe similar provisions).

87. 634 N.E.2d 183 (N.Y. 1994).

88. *Id.* at 188.

89. See *id.* The court's argument seems disingenuous, given that both prenatal care and the medically necessary abortions that plaintiffs sought seem to fall well within the accepted definition of public health. A more likely explanation may be that the court was loathe to interpret the provision in the controversial context of abortion.

90. 754 N.E.2d 1085 (N.Y. 2001)

91. *Id.* at 1093 n.12.

92. *Id.* at 1093 (quoting *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 259 (1974) (holding state statute requiring one year residency in county as a condition to

under the aid to the needy provision, which it found to create an affirmative duty on the State to provide benefits to permanent residents.<sup>93</sup>

Despite the lack of case law under the public health provision, key language in that provision parallels the language in the aid to the needy provision, which, as explained further below, courts have interpreted to create an affirmative and enforceable obligation on the State.<sup>94</sup> As Professor Martha Davis has argued, the public health provision should therefore be construed identically to the aid the needy provision with respect to such an affirmative duty.<sup>95</sup> Moreover, the logic and history of the provision recounted above make clear that the duty includes the obligation to maintain an effective and inclusive health care system.

### B. Aid to the Needy Provision of Article XVII

In addition to its duty to promote and protect the public's health, the New York State government has an affirmative constitutional duty to aid the needy.<sup>96</sup> Article XVII, section 1 of the New York State Constitution mandates: "The aid, care and support of the needy are public concerns and shall be provided by the State and by such of its subdivisions, and in such manner and by such means, as the legislature from time to time may determine."<sup>97</sup>

The provision affords the legislature some latitude in determining how to allocate funds,<sup>98</sup> but it has a clear and unavoidable obligation to ensure that needy New Yorkers receive care.<sup>99</sup> The State

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receiving county-funded medical care unconstitutional under the Equal Protection Clause)).

93. *See id.*

94. *See* Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 391 (citing Akhil Reed Amar, *The Document and the Doctrine*, 114 HARV. L. REV. 26, 30 (2000) (noting that parallel language in several constitutional provisions invites interpretation of the provisions as "an ensemble"))).

95. *See id.*

96. *See* Tucker v. Toia, 371 N.E.2d 449, 451-52 (N.Y. 1977) (holding that article XVII, section 1 of the New York State Constitution is not a matter of "legislative grace" but rather imposes "a positive duty upon the State to aid the needy"); Wilkins v. Perales, 487 N.Y.S.2d 961, 964 (Sup. Ct. 1985) (recognizing that article XVII, section 1's provision for aid to the needy is a fundamental right guaranteed by the New York Constitution and that individuals can seek to enforce that right).

97. N.Y. CONST. art. XVII, § 1.

98. *See, e.g.,* Barie v. Lavine, 357 N.E.2d 349, 352 (N.Y. 1976) (holding that the State has wide discretion in the distribution of public assistance and could deny assistance where plaintiff refused to accept a job referral in violation of subdivision 5 of section 131 of the Social Services Law).

99. *See* McCain v. Koch, 511 N.E.2d 62, 62-63 (N.Y. 1987) (finding that the trial court had power to "issue a preliminary injunction requiring New York City Depart-

cannot deny assistance to New Yorkers whom it acknowledges to be in need, nor create hurdles unrelated to need that deprive aid to those who would otherwise be eligible.<sup>100</sup>

### 1. *Legislative History*

As explained below, the history of the aid to the needy provision makes clear that the drafters sought to respond to the social and economic crisis created by the Great Depression. The provision reflects the influence of reformers in the New Deal period, who called for a new category of legal rights to governmental assistance to respond to what they saw as the failure of the laissez-faire market system.<sup>101</sup> It established a clear source of constitutional authority for state-financed assistance, and a mandate on the State to provide relief to the needy.<sup>102</sup>

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ments of Social Services (DSS) and Housing, Preservation and Development (HPD), when they have undertaken to provide emergency housing for homeless families with children, to provide housing which satisfies minimum standards of sanitation, safety and decency”); see also *Aliessa v. Novello*, 754 N.E.2d 1085, 1098-99 (N.Y. 2001) (finding unconstitutional a state provision requiring immigrants who entered the country after a certain date to wait five years before they could access Medicaid benefits even though they were otherwise eligible for immediate access to benefits); *Tucker*, 371 N.E.2d at 451-53 (“Although our Constitution provides the Legislature with discretion in determining the means by which this objective is to be effectuated, in determining the amount of aid, and in classifying recipients and defining the term ‘needy’, it unequivocally prevents the Legislature from simply refusing to aid those whom it has classified as needy.”). But see *Bernstein v. Toia*, 373 N.E.2d 238, 245 (N.Y. 1977) (holding that “[the legislative grace provision] relates . . . to questions of impermissible exclusion of the needy from eligibility for benefits, not to the absolute sufficiency of the benefits distributed to each eligible recipient”).

100. See *Aliessa*, 754 N.E.2d at 1092-93.

101. See Hershkoff, *Rights and Freedoms*, *supra* note 26, at 636 (approaching article XVII from an internal and historical perspective and “tak[ing] seriously the idea that the New York Constitution is ‘a deliberate, considered expression of fundamental values’”) (citing James A. Gardner, *What is a State Constitution?*, 24 RUTGERS L.J. 1025, 1028 (1993) (rejecting the idea that state constitutions are the product of thoughtful deliberation)). For an overview of the substantive and institutional reform implemented during the New Deal era, see Cass R. Sunstein, *Constitutionalism After the New Deal*, 101 HARV. L. REV. 421 (1987-88). When Franklin Roosevelt accepted the Democratic nomination for president in 1936, he called for the recognition of economic rights, as well as political rights, because “freedom is no half-and-half affair.” *Id.* at 437-38. Roosevelt’s New Deal program culminated with his announcement of a “Second Bill of Rights” at the 1944 State of the Union address. These rights were to include “[t]he right to adequate medical care and the opportunity to achieve and enjoy good health,” “regardless of station, race, or creed.” *Id.* at 423, 438 (internal citations and quotations omitted).

102. See PETER J. GALIE, *THE NEW YORK STATE CONSTITUTION, A REFERENCE GUIDE* 25 (G. Alan Tarr ed., 1991) (explaining that the pervasive unemployment created by the Great Depression brought emergency relief to the forefront of the public

Before the Great Depression, aid to the needy in New York had been a local responsibility.<sup>103</sup> But as unemployment and homelessness grew, cities faced bankruptcy and local governments could no longer bear the burden of relief.<sup>104</sup> As a result, New York restructured its system of relief in 1936 through legislation, shifting the responsibility for relief from local, municipal-level agencies to the State Department of Social Welfare.<sup>105</sup> The aid to the needy provision amended the constitution to codify this shift in power from localities to the state, and to make clear that such aid was a mandatory function of state government.<sup>106</sup>

The provision also sought to fill a vacuum in relief to the needy caused by the dismantling of the Federal Emergency Relief Administration ("FERA") in December 1935.<sup>107</sup> Drafters sought to distinguish New York from other states that failed to fill the financial gap when federal aid ceased.<sup>108</sup> They pointed to the "brutal callousness to human suffering . . . in the State of New Jersey a few years ago," when New Jersey closed its relief council in 1936 instead of increasing state aid to respond to the loss of federal funds.<sup>109</sup>

The explanatory report which the Committee on Social Welfare prepared to accompany its proposal made clear the legislature's obligations to ensure that the needy received financial assistance.<sup>110</sup> The report declared that the amendment would "remove all doubt as to the power of the legislature to authorize relief for those in need and to allocate responsibility therefore to the State and its political subdivisions."<sup>111</sup>

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consciousness and forced public officials to reevaluate their understanding of the role of government in society).

103. See Ladd, *Right to Shelter*, *supra* note 21, at 287.

104. *Id.*

105. *Id.* at 289.

106. *Id.*

107. See Hershkoff, *Rights and Freedoms*, *supra* note 26, at 645; *FERA Comes to End; Spent \$3,041,647,691; Another Billion Used by States and Localities for Direct Relief Since May, 1933*, N.Y. TIMES, Dec. 3, 1935, at 10.

108. See Hershkoff, *Rights and Freedoms*, *supra* note 26, at 645; REVISED RECORD, *supra* note 52, at 2126; *All State Relief Ends in Jersey; Local Areas Must Feed 270,000; Bond Issues Hastily Voted and Other Steps Taken to Provide Funds—Confusion Caused as State Council Turns Machinery Over to Communities—Threats by Needy*, N.Y. TIMES, Apr. 17, 1936, at 1 [hereinafter *All State Relief Ends in Jersey*].

109. See Hershkoff, *Rights and Freedoms*, *supra* note 26, at 645; REVISED RECORD, *supra* note 52, at 2126; *All State Relief Ends in Jersey*, *supra* note 108, at 1.

110. See REVISED RECORD, *supra* note 52, at 1083-86.

111. *Id.* at 1085.

In his remarks introducing the aid to the needy provision approved by the Committee on Social Welfare to the convention, Chairman Corsi described the provision as a “charter of human protection for the underprivileged, the destitute and the handicapped in our state.”<sup>112</sup> The provision, according to Corsi, “set forth a definite policy of government, a concrete social obligation which no court may ever misread.”<sup>113</sup> He explained:

While the obligation expressed in this recommendation is mandatory, in that the Legislature shall provide for the aid, care and support of persons in need, the manner and the means by which [the Legislature] shall do so are discretionary.

The Legislature may continue the system of relief now in operation. It may preserve the present plan of reimbursement to the localities. It may devise new ways of dealing with the problem. Its hands are untied. *What it may not do is to shirk its responsibility which, in the opinion of the committee, is as fundamental as any responsibility of government.*

The State of New York has an admirable record in the care it has provided for its inhabitants in need. In fact, this state has the finest relief administration of any state in the Union, the most adequate budgets, the most competent administrative personnel, and the least amount of waste of any state that I know.

We desire that this record be maintained. We desire that it be maintained not only in periods of great emergency as our present, but even in times of normal employment when the need be reduced in measure but certainly not in nature.<sup>114</sup>

The language responded to criticisms that the previous versions of the State Constitution were too rigid to allow for innovative solutions.<sup>115</sup> The 1874 constitution had purposely limited the State’s ability to appropriate funds through a provision prohibiting the State from making any grants of money or credit in aid of private entities.<sup>116</sup> The State only had clear authority to reimburse local governments for their relief expenditures and localities.<sup>117</sup> The Great Depression, however, exposed the ineffectiveness of this

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112. *Id.* at 2125.

113. *Id.* at 2126.

114. *Id.* at 2126-27 (emphasis added).

115. See Hershkoff, *Rights and Freedoms*, *supra* note 26, at 647.

116. Until 1931, a clause in the municipal charter of New York City, drafted in 1897, prohibited use of public funds for relief. See, e.g., DAVID M. SCHREIBER & ALBERT DEUTSCH, *THE HISTORY OF PUBLIC WELFARE IN NEW YORK STATE 1867-1940* 299 (1991).

117. See PROBLEMS RELATING TO BILL OF RIGHTS, *supra* note 39, at 488-90.

patchwork local system of relief.<sup>118</sup> Delegates to the constitutional convention recognized that in the wake of industrialization, unemployment would be a permanent concern, and the State would need to set up an ongoing system of relief for the needy.<sup>119</sup> The goal of the amendment was to meet “the threat to freedom that comes . . . from poverty and insecurity, from sickness and the slum, from social and economic conditions in which human beings cannot be free.”<sup>120</sup>

The legislative history makes clear that the language “in such manner and by such means” in the aid to the needy provision was intended to provide the legislature with discretion in crafting the means of meeting the social welfare goals set forth in the constitution, not in deciding whether to meet them.<sup>121</sup> In the context of health care, the aid to the needy provision complements the public health provision by removing any doubt that the State must provide health care to those who cannot afford it. The former provision mandates “aid, care and support,” connoting that both financial subsidy and the delivery of care are “public concerns” that “shall” be provided by the State and its subdivisions.<sup>122</sup>

## 2. *Judicial Interpretation of the Aid to the Needy Provision*

Judicial interpretation of the aid to the needy provision has similarly identified a clear, affirmative, and enforceable duty of the State, though the courts have been less clear regarding the nature of the legislature’s discretion. When the New York Court of Appeals considered the aid to the needy provision’s legislative history in *Tucker v. Toia*, the court found “a clear intent that State aid to the needy was deemed to be a fundamental part of the social contract.”<sup>123</sup>

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118. See BRIEFING BOOK, *supra* note 50, at 235 (explaining that when “[l]ocal governments and private agencies could no longer financially meet the social welfare needs of people during the Great Depression in the 1930s,” the state stepped in with a temporary system of relief, which the delegates at the constitutional convention agreed needed to be made permanent).

119. See PROBLEMS RELATING TO BILL OF RIGHTS, *supra* note 39, at 488-90, 502-03, 505-06; REVISED RECORD, *supra* note 52, at 2126, 2133.

120. Hershkoff, *Welfare Devolution*, *supra* note 13, at 1422 (citing a speech by Senator Robert F. Wagner on the floor of the 1938 convention).

121. Hershkoff, *Rights and Freedoms*, *supra* note 26, at 646. The language was not, however, intended to “repeal [ ] a New York court’s duty to check legislative power and to constrain its use for mandated constitutional purposes.” *Id.* at 647. Courts addressing challenges to state programs therefore have the responsibility of ensuring that the legislatures’ choices “actually effectuate Article XVII’s mandate.” *Id.* at 649.

122. N.Y. CONST. art. XVII, § 1.

123. *Tucker v. Toia*, 371 N.E.2d 449, 451-53 (N.Y. 1977) (citation omitted).

In *Tucker*, the Court of Appeals addressed the denial of home relief benefits to minor children living alone, and held that the State Constitution “unequivocally prevents the legislature from simply refusing to aid those whom it has classified as needy.”<sup>124</sup> The court characterized the provision as imposing an affirmative duty on the State.<sup>125</sup>

Similarly, in *Aliessa v. Novello*, the New York Court of Appeals held that denying benefits to immigrants by imposing eligibility requirements that were unrelated to a person’s need violated the letter and spirit of article XVII, section 1.<sup>126</sup> The court in *Aliessa* noted that “care for the needy is not a matter of ‘legislative grace,’ it is a [state] constitutional mandate.”<sup>127</sup>

In *McCain v. Koch*,<sup>128</sup> the Court of Appeals determined that once New York City decided to provide emergency homeless shelter for eligible New Yorkers, such shelter had to meet certain minimum standards.<sup>129</sup> The court affirmed the trial court’s finding that “in providing subminimum shelter the defendants were, in effect, denying *any relief* to the homeless in contravention of their statutory and constitutional obligations.”<sup>130</sup> The court however declined to address the appellate division’s conclusion that “in view

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124. *Id.* at 451-53.

125. *Id.* at 449, 453; *see also* Wilkins v. Perales, 487 N.Y.S.2d 961, 964 (Sup. Ct. 1985) (recognizing that article XVII, section 1’s provision for aid to the needy is a fundamental right guaranteed by the New York Constitution and that individuals can seek to enforce that right).

126. *Aliessa v. Novello*, 754 N.E.2d 1085, 1098-99 (N.Y. 2001) (holding that denial of state-funded Medicaid coverage for five years as a result of immigration status violated the New York Constitution).

127. *Id.* at 1092 (quoting *Tucker*, 371 N.E.2d at 451); *see also* Jiggets v. Grinker, 553 N.E.2d 570, 572-75 (N.Y. 1990) (explaining that “[b]road policy choices which involve the ordering of priorities and the allocation of finite resources, are matters for the executive and legislative branches of government and the place to question their wisdom lies not in the courts but elsewhere” but finding that “when the Legislature directed that shelter allowances ‘shall be adequate’, it imposed a duty on the Commissioner to establish a schedule reasonably calculated for that purpose”); Rotunno, *State Constitutional Social Welfare*, *supra* note 14, at 138.

128. 511 N.E.2d 62 (N.Y. 1987).

129. *Id.* at 65-67. In *McCain*, plaintiffs, homeless families with children, contended that under article XVII, the state was required to provide shelter that met “minimum standards of decency and habitability.” *Id.* The Court of Appeals found that the trial court had power to “issue a preliminary injunction requiring New York City Departments of Social Services (DSS) and Housing, Preservation and Development (HPD), when they have undertaken to provide emergency housing for homeless families with children, to provide housing which satisfies minimum standards of sanitation, safety and decency.” *Id.* at 62-63.

130. *Id.* at 66; Rotunno, *State Constitutional Social Welfare*, *supra* note 14, at 140-41.



of our decision in *Matter of Bernstein v. Toia*, plaintiffs are not likely to 'prove that [N.Y. Constitution] Article XVII substantively guarantees minimal physical standards of cleanliness, warmth, space and rudimentary convenience in emergency shelter.'"<sup>131</sup> The court explained that "whether or not plaintiffs have any right to shelter under State or Federal constitutional or statutory law, [the] Supreme Court had the power to require defendants, once they undertook to provide housing, to make that shelter minimally habitable."<sup>132</sup>

While affirming the legislature's obligations under article XVII, the Court of Appeals has also emphasized the legislature's discretion in fulfilling that obligation.<sup>133</sup> In reviewing a regulation of the State Department of Social Services providing flat housing grants, rather than grants taking into account the needs and individual circumstances of each client, the Court of Appeals in *Bernstein v. Toia* held that the State need not "always meet in full measure all the legitimate needs of each recipient,"<sup>134</sup> provided that the method of distribution of aid to the needy is reasonably calculated to optimize the use of public funds.<sup>135</sup>

In *Hope v. Perales*, the Court of Appeals noted that both the aid to the needy and the public health provisions of the constitution "expressly accord to the Legislature discretion to promote the State's interest 'in such manner, and by such means as the legislature may from time to time determine'" and found that the legislature had not "transgressed its powers" when it decided not to include abortion funding in New York's Prenatal Care Assistance Program ("PCAP").<sup>136</sup> The court in *Hope* explained that plaintiffs' challenge to the PCAP statute under the aid to the needy provision of the constitution failed because the court was "bound to accept the legislative determination that PCAP-eligible women are not indigent or in need of public assistance to meet their medical

131. *McCain*, 511 N.E.2d at 65-66 (citation omitted).

132. *Id.*

133. *Hope v. Perales*, 634 N.E.2d 183, 187-88 (N.Y. 1994); *Bernstein v. Toia*, 373 N.E.2d 238, 244 (1977).

134. *Bernstein*, 373 N.E.2d at 244 (alteration in original).

135. *Id.* at 243-44 (finding that the State Constitution does not require New York to grant public assistance on an individual basis in every case, and that New York's use of a flat-grant system does not violate the state constitution); *see also Barie v. Lavine*, 357 N.E.2d 349, 352 (N.Y. 1976) (holding that state has wide discretion in the distribution of public assistance and could deny assistance where plaintiff refused to accept a job referral in violation of subdivision 5 of section 131 of the Social Services Law).

136. *Hope*, 634 N.E.2d at 188 (quoting N.Y. Const. art. XVII, §§ 1, 3).

needs.”<sup>137</sup> The court further noted that it could not “infer the contrary from the mere fact that PCAP—aimed neither at the protection of public health nor at the support of the needy—was enacted.”<sup>138</sup>

These decisions articulate the bright line rule that the State may not erect criteria unrelated to need that prevent admittedly needy people from obtaining aid, as well as the more subjective rule that, once it has decided to provide a particular type of aid, the method chosen must meet basic standards of decency and “rudimentary convenience.”<sup>139</sup> The decisions raise questions, however, about the limits of the legislature’s duty to serve all needy New Yorkers, as well as its discretion in crafting solutions.

Professor Helen Hershkoff has argued that the Court of Appeals has granted too much discretion to the legislature in determinations regarding aid to the needy.<sup>140</sup> According to Hershkoff, the Court of Appeals’ interpretation undermines the purpose of article XVII. She notes that the Court of Appeals has interpreted the article to “grant the legislature almost unreviewable ‘discretion in determining the means by which this objective is to be effectuated, in determining the amount of aid, and in classifying recipients and defining the term “needy.””<sup>141</sup> Hershkoff offers an alternative reading of the provision, arguing that the aid to the needy provision creates “constraints on legislative discretion.”<sup>142</sup>

Hershkoff explains that the clauses of article XVII “first impos[e] a duty on the legislature, and then empower[ ] the legislature to meet its duty through any chosen device.”<sup>143</sup> The bifurcated structure of article XVII, according to Hershkoff, is “typical of state constitutions that afford guarantees to government services. . . . The state constitution thus commits the state to a particular public end, leaving selection of the means for securing that end to the legislature.”<sup>144</sup> Hershkoff contends that “[t]he legislature can choose the means to carry out a constitutional goal, but

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137. *Id.*

138. *Id.*

139. *McCain v. Koch*, 511 N.E.2d 62, 65-67 (N.Y. 1987); *see also Bernstein*, 373 N.E.2d at 244-45; *Hope*, 634 N.E.2d at 187-88; *Barie*, 357 N.E.2d at 352.

140. *See Hershkoff, Rights and Freedoms*, *supra* note 26, at 636.

141. *See Hershkoff, Positive Rights*, *supra* note 26, at 1139 n.39, 1150; *Hershkoff, Welfare Devolution*, *supra* note 13, at 1408.

142. *See Hershkoff, Welfare Devolution*, *supra* note 13, at 1410.

143. *Id.*

144. *Id.* at 1412.

it cannot claim to meet its constitutional duty if the means chosen evade, undermine, or fail to carry out the prescribed end.”<sup>145</sup>

Surely Hershkoff’s basic point is correct. If, for example, the legislature were to decree that thousands of starving or destitute children in the State were not “needy” within the meaning of the New York Constitution, contrary to demonstrable evidence, it would be incumbent on the courts to declare a violation of section 1 and order the legislative and executive branches to act in whatever effective way they deemed appropriate. The latitude that the provision grants the legislature applies to the method of delivering aid, not to the factual question of whether particular New York residents are needy.

A close reading of *Hope*, *Bernstein*, and *McCain*, however, indicates that they are consistent with this formulation, standing for a narrower principle of rebuttable deference to existing regulatory systems, rather than judicial abdication of evidence-based oversight. While the legislature’s determinations of need are to be judged at a macro level, they remain subject to judicial review. Systems that are ineffective or leave large numbers of needy New Yorkers behind cannot pass constitutional muster.

In *Hope v. Perales*, for example, the court noted that women eligible for the challenged PCAP, by definition, “have income above the poverty level and need not exhaust other resources to establish eligibility,”<sup>146</sup> as well as that “New York has consistently included all medically necessary abortions in its State Medicaid program.”<sup>147</sup> The court found that the plaintiffs—PCAP-eligible women—were “presumptively able to afford an abortion,” but concluded that this “legislative premise [was] *not rebutted on the record before us*.”<sup>148</sup> In other words, the court looked to the actual eligibility requirements of PCAP and to the case record in the case to conclude that the legislature’s determination of need was reasonable. In this context, the court’s statement that it was “bound to accept the legislative determination that PCAP-eligible women are not indigent or in need of public assistance to meet their medical needs”<sup>149</sup> must be seen as a determination of reasonableness based on the record, rather than blind deference to the legislature, as suggested by Hershkoff.

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145. *Id.* at 1414.

146. *Hope v. Perales*, 634 N.E.2d 183, 186-87 (N.Y. 1994).

147. *Id.* at 184-85 (citations omitted).

148. *Id.* at 186-87 (emphasis added).

149. *Id.* at 188-89.

In *Bernstein v. Toia*, the plaintiffs challenged the formula by which the State determined the maximum monthly allowance paid to public assistance recipients for rent.<sup>150</sup> The state-administered system established a maximum shelter allowance “for each district within the state with variations from district to district and for family size within each district.”<sup>151</sup> The plaintiffs did not challenge the overall approach, but only its failure to allow for upward exceptions to the formula for “special circumstances in individual cases.”<sup>152</sup>

The court noted that the legislature had adopted the “flat grant” system “after statistical and qualitative analysis of a fair sampling of individual grants”<sup>153</sup> and finding that its system “will promote greater uniformity and equality of treatment of the recipients of public assistance.”<sup>154</sup> In rejecting the plaintiffs’ challenge, the court held that “[w]hen, as here, the over-all consequence of the method of distribution of aid to the needy . . . is reasonably expected to be in furtherance of the optimum utilization of public assistance funds, there has been no violation of the constitutional command.”<sup>155</sup>

While the *Bernstein* court’s tolerance for a system that did not “always meet in full measure all the legitimate needs of each recipient,”<sup>156</sup> is troubling, it does not amount to blind deference for the legislature’s determination of need. Rather, the court appears to have concluded that the legislature and Department of Social Services’ detailed and fact-based alignment of needs and services was adequate in the circumstances of that case. *Bernstein* does not preclude a finding of liability where the evidence shows a substantial mismatch of needs and services, or where large populations of needy New Yorkers are demonstrably not receiving aid.

Consistent with that approach, the court in *Barie v. Lavine* upheld the denial of aid to “employable persons” who had “wrongfully refused an opportunity for employment,” where the court identified “a reasonable legislative determination” that people in that category were not needy.<sup>157</sup> In that case, as in *Hope* and *Bernstein*, the court evinced a reluctance to micromanage the legisla-

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150. *Bernstein v. Toia*, 373 N.E.2d 238, 239-40 (1977).

151. *Id.*

152. *Id.* at 240.

153. *Id.* at 241.

154. *Id.* at 242.

155. *Id.* at 244.

156. *Id.*

157. 357 N.E.2d 349, 352 (N.Y. 1976).

ture's mechanisms for determining need, but did not abdicate its responsibility to review that determination.<sup>158</sup>

That nuanced approach is reflected in the court's statement in *Tucker*:

Although our Constitution provides the Legislature with discretion in determining the means by which [aid] is to be effectuated, in determining the amount of aid, and in classifying recipients and defining the term "needy," it unequivocally prevents the Legislature from simply refusing to aid those whom it has classified as needy.<sup>159</sup>

Read in context that language bespeaks rebuttable deference to the determination of who is needy, rather than unreviewable authority. Moreover, as *McCain* demonstrates, even the State's discretion to craft a remedy has fact-based limits. If, as in *McCain*, the State's chosen system of affording aid does not meet basic standards of fairness and dignity, the courts are empowered to invalidate it.

### C. Justiciability of the Right to Health Care

While some commentators have raised questions about the judicial enforceability of a constitutional right to health care,<sup>160</sup> the positive economic and social rights established in the New York State Constitution—including the right to health care—are plainly justiciable. As the New York Court of Appeals explained in *Campaign for Fiscal Equity v. State*, "it is the province of the judicial branch to define, and safeguard, rights provided by the New York State Constitution, and order redress for violation of them."<sup>161</sup> It emphasized that courts are "well suited to interpret and safeguard constitutional rights and review challenged acts of our co-equal branches of government—not in order to make policy but in order to assure the protection of constitutional rights."<sup>162</sup> Just as children

158. *Id.*

159. *Tucker v. Toia*, 371 N.E.2d 449, 452 (N.Y. 1977).

160. See Alicia Ely Yamin, *The Right to Health as a Human Right in International Law*, HUMAN RIGHTS QUARTERLY 21.4 (1999) (discussing questions of justiciability); see also RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE? 4 (1997) ("We must be careful not to decree legal rights to . . . health care. We must focus more on the flip side of rights: their correlative costs. We must face the possibility that someone may have to 'do without' in a world of scarcity.").

161. 801 N.E.2d 326, 345 (N.Y. 2003) (defining state's obligation to provide residents of New York City with a sound basic education).

162. *Id.* at 349. But see Paul W. Kahn, *A New Generation: State Constitutionalism and the Problems of Fairness*, 30 VAL. U. L. REV. 459, 466-70 (emphasizing the challenge that state courts face confronting questions with political implications without

in New York have an enforceable right to a sound basic education that meets minimum standards,<sup>163</sup> New Yorkers have a right to quality health care that they may call upon New York's courts to enforce.

Indeed, at the 1938 constitutional convention, delegates likened the government's responsibility to provide access to quality medical care to its duty in the education field. In introducing the Committee's proposed amendment to the delegates of the convention, for example, Corsi noted that "[t]he protection and promotion of the health of the people is of as much public concern as the education of the people."<sup>164</sup> In addition, public health leaders at that time "spoke of health care as something which government should provide for the public just as it now provides education."<sup>165</sup>

Accordingly, the Court of Appeals considered a claim under the public health provision in *Hope v. Perales*, though it ultimately found that the challenged policy was not covered by the provision.<sup>166</sup> The court, moreover, has repeatedly adjudicated claims under the aid to the needy provision,<sup>167</sup> which stems from the same constitutional history and contains parallel, mandatory language.<sup>168</sup>

The notion that a constitutional right to health care is inherently non-justiciable is also belied by cases from sister courts in foreign jurisdictions that have found similar provisions to be justiciable. A line of cases decided by the South African Constitutional Court under that nation's constitution illustrates the justiciability of a right to health care. Section 27 of the South African Constitution provides: "(1) Everyone has the right to have access to . . . health care services, including reproductive health care . . . (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each

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an accompanying political consensus, and highlighting the difficulty state courts face making decisions when "values are deeply contested").

163. The New York Court of Appeals has interpreted the education article to impose "a duty on the Legislature to ensure the availability of a sound basic education to all the children of the state." *Campaign for Fiscal Equity, Inc. v. State*, 655 N.E.2d 661, 665 (N.Y. 1995).

164. REVISED RECORD, *supra* note 52, at 2133 (emphasis added).

165. O'Connor, *Predict an Accord on State Medicine*, *supra* note 70.

166. 634 N.E.2d 183, 188 (N.Y. 1994).

167. *See Aliessa v. Novello*, 754 N.E.2d 1085, 1092 (N.Y. 2001) (citing *Tucker v. Toia*, 371 N.E.2d 449, 451 (N.Y. 1977)); *Wilkins v. Perales*, 487 N.Y.S.2d 961, 964 (Sup. Ct. 1985) (recognizing that article XVII, section 1's provision for aid to the needy is a fundamental right guaranteed by the New York Constitution and that individuals can seek to enforce that right).

168. N.Y. CONST. art. XVII, § 1.

of these rights. (3) No one may be refused emergency medical treatment."<sup>169</sup>

The South African Constitutional Court has had no trouble deciding cases under its constitution's health care provisions. In *Minister of Health v. Treatment Action Campaign*, for example, the Constitutional Court considered whether the government breached its duty under section 27(1) by failing to provide comprehensive anti-retroviral drugs to prevent mother-to-child HIV transmission.<sup>170</sup> The Treatment Action Campaign challenged restrictions on the provision of anti-retroviral drugs to HIV-positive pregnant women under the right to health care provision of the constitution, arguing that the government's actions were leading to tens of thousands of unnecessary infections and deaths.<sup>171</sup> The High Court ruled in favor of the Campaign, ordering the government to make the anti-retroviral drug available to infected mothers at state institutions country-wide and to present to the court an outline of how it planned to extend provision of the medicine to birthing facilities across the country.<sup>172</sup> The Constitutional Court held that the anti-retroviral drug Nevirapine could not be limited to certain pilot sites and that the government could not delay the availability of the drug for a year, because it would deny most mothers access to treatment.<sup>173</sup> The Court ordered the government to extend availability of Nevirapine to hospitals and clinics, to provide counselors, and to take reasonable measures to extend testing and counseling facilities throughout the public sector.<sup>174</sup>

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169. S. AFR. CONST. 2004, § 27, available at <http://www.info.gov.za/documents/constitution/index.htm>.

170. 2002 (10) BCLR 1033 (CC) (S. Afr.); see also Iain Byrne, Making the Right to Health a Reality: Legal Strategies for Effective Implementation, Commonwealth Law Conference, Sept. 2005, [www.interights.org/doc/health%20paper.doc](http://www.interights.org/doc/health%20paper.doc) [hereinafter Byrne, Making the Right to Health a Reality] (surveying countries around the world which provide for a constitutional right to health). Byrne notes that, particularly in the mental health context, courts have most often addressed health issues from a negative civil liberties perspective rather than from the perspective of the state's positive obligations to provide adequate resources or access to treatment for effective enjoyment. *Id.* But see *Soobramoney v. Minister of Health KwaZulu Natal*, 1997 (12) BCLR 1696 (CC) (S. Afr.), available at <http://www.saflii.org/za/cases/ZACC/1997/17.html> (finding that the state had not breached the right to access to medical services in light of the limited resources available and the fact that the treatment would only briefly have prolonged Soobramoney's life). *Id.*; see also *Government of RSA v. Grootboom*, 2000 (11) BCLR 1169 (CC) (S. Afr.).

171. See *Treatment Action Campaign*, 2002 (10) BCLR 1033 (CC) (S. Afr.).

172. *Id.*

173. *Id.*

174. *Id.*

Similarly, in *Azanca Alhelí Meza García*, Peru's Constitutional Court considered the question of whether the country's health ministry had an obligation to provide full medical care, including a permanent supply of drugs and periodic testing, to an HIV-positive person who could not afford treatment.<sup>175</sup> The Constitutional Court ordered government agencies to comply with article 8 of Peru's Law 26626, which mandated that AIDS treatment and prevention should have top budgetary priority.<sup>176</sup> The Court explained that although social rights need to be progressively realized, the state is also required to take concrete and permanent actions aimed at implementing public policies that ensure their realization.<sup>177</sup> In *José Luis Correa Condori*, Peru's Constitutional Court again acknowledged the progressive character of the State's obligation to realize social rights and reiterated its position that, nonetheless, the State had to take immediate steps and direct funds to realize the right to health.<sup>178</sup>

In Venezuela, a group of people with HIV/AIDS who could not afford treatment filed an action against the Health and Assistance Ministry challenging its refusal to deliver medication to them, claiming the government had violated their right to health, among other rights, enshrined in the Venezuelan Constitution and the International Covenant on Economic, Social and Cultural Rights.<sup>179</sup> The Constitutional Court ordered the health ministry to supply the petitioners with the requisite drugs, develop an HIV/AIDS treatment and prevention policy, and allocate necessary financial resources to AIDS prevention and control.<sup>180</sup> These cases make clear that judges are fully competent to adjudicate claimed violations of the right to health care.

While foreign law and jurisprudence are clearly not binding on New York courts in interpreting the New York Constitution, they

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175. *Azanca Alhelí Meza García*, Expediente No. 2945-2003-AA/TC [Constitutional Court] Apr. 20, 2004 (Peru) (English summary available at [http://www.escri-net.org/caselaw/caselaw\\_show.htm?doc\\_id=405156&searchstring=health](http://www.escri-net.org/caselaw/caselaw_show.htm?doc_id=405156&searchstring=health)).

176. *Id.*

177. *Id.*

178. *Id.*

179. *Cruz del Valle Bermúdez v. MSAS s/amparo*, Expediente No. 15.789, Sentencia No. 196, [Supreme Court] May 15, 1999 (Venez.) (English summary available at [http://www.escri-net.org/caselaw/caselaw\\_show.htm?doc\\_id=406005&searchstring=health](http://www.escri-net.org/caselaw/caselaw_show.htm?doc_id=406005&searchstring=health)); *see also* López, Glenda c. Instituto Venezolano de los Seguros Sociales (IVSS) s/ acción de amparo, Expediente 00-1343, Sentencia No. 487, [Supreme Court] Apr. 6, 2001 (Venez.) (English summary available at [http://www.escri-net.org/caselaw/caselaw\\_show.htm?doc\\_id=412539&searchstring=health](http://www.escri-net.org/caselaw/caselaw_show.htm?doc_id=412539&searchstring=health)).

180. *Id.*



do illustrate possible approaches to similar legal questions. Some commentators and U.S. Supreme Court justices argue for the use of foreign law in constitutional adjudication.<sup>181</sup> As Margaret H. Marshall, Chief Justice of the Supreme Judicial Court of Massachusetts, has emphasized, “state judges are uniquely positioned to take advantage of the significant potential of comparative constitutional law.”<sup>182</sup> Marshall presents three main reasons for her argument that state court judges should look to foreign law. First, she explains that as a result of the federal system, state court judges are “seasoned comparatists.”<sup>183</sup> She notes that she and her colleagues have “frequent occasion to look to the constitutional law of fifty other American jurisdictions, even though other states’ interpretations of their constitutions have no precedential weight.”<sup>184</sup> These decisions, Marshall asserts, provide “guidance, perspective, inspiration, reassurance, or cautionary tales.”<sup>185</sup>

Second, Marshall points to the fact that “state court judges work actively in the open tradition of the common law. *Erie Railroad Co. v. Tompkins* removed much of the traditional common-law role from the federal courts, but what Holmes described as expounding from experience is the quintessential role of a state court

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181. As Justice Stephen Breyer noted in a speech at New York University School of Law,

[t]he job before us—as nations increasingly emphasize the rule of law and the role of the judge—is to try to transfer knowledge from one nation to another, so that, despite cultural, historical, or institutional barriers, we can create fairer, more effective judicial systems, including safeguards of institutional integrity where they are now lacking.

Ken I. Kersch, *Citation to Foreign Court Precedent in Domestic Jurisprudence: The Supreme Court and International Relations Theory*, 69 ALB. L. REV. 771, 789 (2006) (quoting Stephen Breyer, Assoc. Justice, Supreme Court of the U.S., Dinner Speech at the International Symposium Co-Sponsored by New York University School of Law and the Law Library of Congress: Democracy and the Rule of Law in a Changing World Order 6 (Mar. 9, 2000)); see also Ruth Bader Ginsburg & Deborah Jones Merritt, Lecture, *Fifty-First Cardozo Memorial Lecture: Affirmative Action: An International Human Rights Dialogue*, 21 CARDOZO L. REV. 253, 255-59 (1999); Ruth Bader Ginsburg & Paul S. Berman, *An Open Discussion with Justice Ruth Bader Ginsburg*, 36 CONN. L. REV. 1033, 1040-42 (2004); see generally Ruth Bader Ginsburg, *The Value of a Comparative Perspective in Constitutional Adjudication*, 99 Am. Soc’y Int’l L. Proc. 351 (2005); Ruth Bader Ginsburg, Lecture, *Looking Beyond Our Borders: The Value of a Comparative Perspective in Constitutional Adjudication*, 40 IDAHO L. REV. 1 (2003).

182. Margaret H. Marshall, *Speech: “Wise Parents Do Not Hesitate to Learn From Their Children”: Interpreting State Constitutions in an Age of Global Jurisprudence*, 79 N.Y.U. L. REV. 1633, 1641 (2004).

183. *Id.*

184. *Id.*

185. *Id.* at 1642.

judge.”<sup>186</sup> Third, Marshall notes that many state constitutions, like the New York State Constitution, have “positive liberty” clauses and explains that “[a]s charters of ‘positive liberty,’ some state constitutions may bear close affinity to the new constitutions of other democracies.”<sup>187</sup>

The decisions by the South African, Peruvian, and Venezuelan high courts thus not only illustrate the justiciability of positive, economic rights like the right to health care but, as explained further below, reflect the role that international norms may play in providing state courts with guidance in considering the government’s obligations under New York’s public health provision.

#### D. Dimensions of the Right to Health Care

The text and structure of the public health provision make clear that health care is a justiciable positive right held by “inhabitants of the state.” Moreover, the purpose and legislative history of the provision, described above, reinforce that the legislature’s obligations under section 3 of the New York Constitution include the maintenance of a health care system.<sup>188</sup> Those principles alone, however, do not establish the necessary elements of that system or the criteria for its maintenance. Nor do they resolve the limits or parameters of the legislature’s discretion in crafting that system.

Answering those questions requires a more thorough analysis of the provision’s origins and of the legal and social science environment within which New York’s existing health care system must operate. Our analysis of those sources reveals a robust constitutional right to a system that is universal, comprehensive, and equitable in the access and care that it must afford New York’s inhabitants.

##### 1. *The Role of Complementary Sources of Law*

Parallel sources of law are appropriate tools for evaluating the dimensions of the right to health care in New York for several reasons.<sup>189</sup> First, New York courts should, when possible, interpret ambiguous provisions in consonance with other applicable laws,

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186. *Id.*

187. *Id.* at 1643.

188. *See supra* Part II.A-B.

189. *See generally* DANGEROUS AND UNLAWFUL, *supra* note 8, at 19-20; The Opportunity Agenda, Human Rights in State Courts, <http://www.opportunityagenda.org> (last visited Mar. 28, 2008).

rather than in tension with them.<sup>190</sup> Second, international human rights laws, in particular, are a powerful source of persuasive authority regarding a matter—the right to health care—that has scarcely been litigated in the United States.<sup>191</sup> Third, any legislative action in this area—or any court-ordered remedy—must fit with applicable federal laws and international treaties.<sup>192</sup>

Under Article VI, Clause 2 of the U.S. Constitution, treaties, like federal law, are the “Supreme Law of the Land,” binding on the “Judges in every State.”<sup>193</sup> The United States has signed and rati-

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190. See *Art Masters Assocs. v. United Parcel Serv.*, 567 N.E.2d 226, 230 (N.Y. 1990) (holding that “[g]iven the close similarity between the Federal and State statutes under consideration and the common purpose served by the two statutes, it is consistent with sound principles of statutory construction, that the statutes be construed harmoniously”); *Burger King v. State Tax Comm’n*, 416 N.E.2d 1024, 1027 (N.Y. 1980) (holding that “courts, in construing apparently conflicting statutory provisions, must try to harmonize them”); see also *infra* Part III; cf. *Murray v. Schooner Charming Betsy*, 6 U.S. 64, 118 (1804) (holding, analogously, that acts of Congress must be interpreted not to contravene international law where possible). In addition, state courts have traditionally drawn on federal jurisprudence for guidance in interpreting state constitutional provisions. See Hershkoff, *Positive Rights*, *supra* note 26, at 1169 (explaining that “state courts, including the New York courts, have borrowed extensively from federal doctrine” in analyzing rights under the state constitution). Federal doctrine, though not binding, is relevant to state constitutional analysis, and U.S. Supreme Court cases are just as relevant to interpreting the state constitution as are cases in other states and other jurisdictions. See, e.g., JENNIFER FRIESEN, *STATE CONSTITUTIONAL LAW: LITIGATING INDIVIDUAL RIGHTS, CLAIMS AND DEFENSES* 1-41, 3-2 (3d ed. 2000); Adira Siman, Note, *Challenging Zero Tolerance: Federal and State Legal Remedies For Students of Color*, 14 CORNELL J. L. PUB. & POL’Y 327, 350-52 (2005) (citing James N.G. Cauthen, *Expanding Rights Under State Constitutions: A Quantitative Appraisal*, 63 ALB. L. REV. 1183, 1185 (2000)).

191. See, e.g., *Roper v. Simmons*, 543 U.S. 551, 575-78 (2005); *Lawrence v. Texas*, 539 U.S. 558, 576-77 (2003) (considering whether practices have “been accepted as an integral part of human freedom in many other countries” or “rejected elsewhere” in construing the constitutional concepts of privacy and due process); *Grutter v. Bollinger*, 539 U.S. 306, 342, 343 (2003) (Ginsburg, J., concurring) (citing United Nations conventions and the “international understanding” as to affirmative action plans).

192. U.S. CONST. art. VI, cl. 2. The State Department’s responses to questions by the Senate regarding the Vienna Convention underscore the priority of treaty law over state law: “*Question. What is the effect of the [Vienna] convention on (a) Federal legislation; and (b) State laws?* Answer . . . . To the extent that there are conflicts with Federal legislation or State laws the Vienna Convention, after ratification, would govern as in the case of bilateral consular conventions.” Brief of International Law Experts and Former Diplomats as Amici Curiae Supporting Petitioner at 22, *Medellin v. Dretke*, 544 U.S. 660 (2004) (04-5928), 2004 WL 2381135, at \*16-17, (quoting S. EXEC. DOC. NO. 91-9, at 18); see also Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 390 (examining “the relevance of transnational law to the interpretation of New York’s article XVII, section 3, which establishes a right to legislative provision for the public health”).

193. U.S. CONST. art. VI, cl. 2. In addition, when human rights principles rise to the level of customary international law, meaning they are “practices and beliefs that are so vital and intrinsic a part of a social and economic system that they are treated as if

fied the International Covenant on Civil and Political Rights and the International Convention on the Elimination of All Forms of Racial Discrimination and is therefore bound by these treaties,<sup>194</sup> as is New York State. As the Office of the Solicitor General recently noted in a brief submitted to the Supreme Court, “by virtue of the Supremacy Clause, Art. VI, Cl. 2, the requirements of [a ratified treaty] supersede state and local laws.”<sup>195</sup>

The United States Supreme Court has held, moreover, that “[i]nternational law is part of our law, and must be ascertained and administered by the courts of justice of appropriate jurisdiction.”<sup>196</sup> The fundamental principle, embodied in the Supremacy Clause, is that absent irreconcilable conflict, international law carries great weight in the interpretation of domestic law.<sup>197</sup>

Even when human rights principles are not directly binding, they can influence New York courts as they define and explain the public health provision of the State Constitution.<sup>198</sup> For example, although the Universal Declaration of Human Rights is not a ratified treaty, it is a formal recognition by the world’s nations—including

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they were laws,” they do not require implementing legislation to be binding in the United States. BLACK’S LAW DICTIONARY 162 (17th ed. 1996); see also *Banco Nacional de Cuba v. Sabbatino*, 376 U.S. 398, 428 (1964); RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 111 (1987). Customary international law is part of federal common law, and as such, it displaces conflicting state laws. RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 111 cmt. d; see also *The Paquete Habana*, 175 U.S. 677, 700 (1900); c.f. *Sosa v. Alvarez-Machain*, 542 U.S. 692, 738 (2004).

194. The federal government has reiterated its commitment to take affirmative steps to guarantee the equal enjoyment of rights to all racial groups and individuals protected by these ratified treaties. President Bill Clinton issued an executive order on December 10, 1998, calling upon federal agencies to respect and abide by the International Covenant on Civil and Political Rights, the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Convention on the Elimination of All Forms of Racial Discrimination, and other relevant treaties concerned with the protection and promotion of human rights to which the United States had become a party. Exec. Order No. 13,107, 63 Fed. Reg. 68,991 (Dec. 10, 1998), available at <http://www.fas.org/irp/offdocs/eo13107.htm>.

195. Brief for the United States as Amicus Curiae Supporting Petitioner at 25, *Mellin v. Texas*, 128 S.Ct. 35 (2007) (No. 06-984), 2007 WL 1909462, at \*25.

196. *The Paquete Habana*, 175 U.S. at 700.

197. See *Weinberger v. Rossi*, 456 U.S. 25, 32 (1982) (“It has been a maxim of statutory construction since the decision in *Murray v. The Charming Betsy*, 6 U.S. 64, 118 (1804), that ‘an act of congress ought never to be construed to violate the law of nations, if any other possible construction remains.’”).

198. See, e.g., Penny White, *Legal, Political, and Ethical Hurdles to Applying International Human Rights Law in the State Courts of the United States (and Arguments for Scaling Them)*, 71 U. CIN. L. REV. 937, 973 (2003) (“State appellate courts, in applying state law, are free to utilize international treaty provisions and customary international law in making” decisions as to the content of constitutional guarantees).

the United States—of the rights that we all hold, by virtue of our humanity.<sup>199</sup> As one federal court in New York has noted, the Declaration is “an authoritative statement of the international community” and “creates an expectation of adherence.”<sup>200</sup> Other declarations, like the American Declaration on the Rights and Duties of Man and the Durban Declaration Against Racism, similarly represent an international consensus on how domestic laws and treaties should be applied and interpreted.<sup>201</sup>

In addition, treaties that the United States has not ratified, like the International Covenant on Economic Social and Cultural Rights (“ICESCR”) or the Convention on the Rights of the Child, are nonetheless persuasive and can provide New York courts and policymakers with guidance in interpreting provisions of domestic law.<sup>202</sup>

Over the past decade, more and more courts have relied on human rights laws as persuasive authority in their decisions, and the U.S. Supreme Court, in particular, has increasingly cited human rights law as persuasive authority for important constitutional rulings.<sup>203</sup> A survey of state courts in fifty states revealed that courts in over thirty states had at least considered arguments based on international human rights instruments.<sup>204</sup> A number of commentators, moreover, have argued that state courts should look to international and comparative law as they explore the

199. The Declaration begins with the premise that “recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.” Universal Declaration of Human Rights, G.A. Res. 217A (III), at 71, art. 25, U.N. Doc. A/810 (Dec. 10, 1948), available at <http://www.un.org/Overview/rights.html> [hereinafter UDHR].

200. *Filartiga v. Pena-Irala*, 630 F.2d 876, 883 (2d Cir. 1980) (“[Declarations] specify with great precision the obligations of member nations under the Charter . . . [and constitute] a formal and solemn instrument, suitable for rare occasions when principles of great and lasting importance are being enunciated. . . . Thus, a Declaration creates an expectation of adherence, and insofar as the expectation is gradually justified by State practice, a declaration may by custom become recognized as laying down rules binding upon the States.”) (internal quotations and citations omitted).

201. United Nations, Human Rights at Your Fingertips, <http://www.un.org/rights/50/game.htm#28> (last visited Mar. 28, 2008); see also CENTER FOR REPRODUCTIVE RIGHTS, SURVIVING PREGNANCY & CHILDBIRTH: AN INTERNATIONAL HUMAN RIGHT 10 (2005), available at [http://www.reproductiverights.org/pdf/pub\\_bp\\_surviving\\_0105.pdf](http://www.reproductiverights.org/pdf/pub_bp_surviving_0105.pdf) [hereinafter SURVIVING PREGNANCY & CHILDBIRTH].

202. See *supra* note 191 and accompanying text.

203. See *supra* note 202.

204. The Opportunity Agenda, Human Rights in State Courts, *supra* note 189. Notably, judges in New York, California, Oregon, Pennsylvania, Washington, West Virginia, and Michigan all considered the Universal Declaration, among other treaties, in interpreting statutory, regulatory, and state constitutional provisions. *Id.*

meaning of positive rights under state constitutions, statutes, and common law.<sup>205</sup> While state courts have not typically enforced treaties directly, they have relied on those principles to inform their interpretation of state law.<sup>206</sup>

## 2. *Elements of the Right to Health Care*

The text, structure, and history of the public health provision, considered in the context of applicable international and federal law, reveal a right to health care that is universal, comprehensive, and equitable. We discuss these elements and their underpinnings in turn.

### *i. Universality*

In order to satisfy state constitutional standards, New York's system of health care must be accessible to all New Yorkers. This conclusion flows from three sources: the public health provision's

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205. See, e.g., Robert Doughten, *Filling Everyone's Bowl: A Call to Affirm a Positive Right to Minimum Welfare Guarantees and Shelter in State Constitutions to Satisfy International Standards of Human Decency*, 39 GONZ. L. REV. 421 (2003); Bert B. Lockwood et al., *Litigating State Constitutional Rights to Happiness and Safety: A Strategy for Ensuring the Provision of Basic Needs to the Poor*, 2 WM. & MARY BILL RTS. J. 1 (1993); Catherine Powell, *Dialogic Federalism: Constitutional Possibilities for Incorporation of Human Rights Law in the United States*, 150 U. PA. L. REV. 245 (2001); Judith Resnik, *Law's Migration: American Exceptionalism, Silent Dialogues, and Federalism's Multiple Ports of Entry*, 115 YALE L.J. 1564, 1627 n.300 (2006) (citing Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 359); see also Catherine Albisa & Shara Sekaran, *Realizing Domestic Social Justice Through International Human Rights: Foreword*, 30 N.Y.U. REV. L. & SOC. CHANGE 351 (2006); Nadine Strossen, *Recent U.S. and International Judicial Protection of Individual Rights: A Comparative Legal Process Analysis and Proposed Synthesis*, 41 HASTINGS L.J. 805, 824-36 (1990).

206. See, e.g., *Am. Nat'l Life Ins. v. Fair Employment & Housing Comm.*, 651 P.2d 1151, 1154 (Cal. 1982); *Santa Barbara v. Adamson*, 610 P.2d 436, 439 n.2 (Cal. 1980); *Bixby v. Pierno*, 481 P.2d 242, 251 n.9, 252 n.12 (Cal. 1971); *Boehm v. Superior Court*, 178 Cal. App. 3d 494 (Cal. Ct. App. 1986); *In re White*, 97 Cal. App. 3d 141, 149 n.4 (Cal. Ct. App. 1979); *State v. Davis*, 695 N.W.2d 45, 54-55 (Mich. 2005) (Kelly, J., dissenting); *Sheridan Road Baptist Church v. State*, 396 N.W.2d 373, 397 (Mich. 1986) (Riley, J., dissenting); *State v. Robert H.*, 393 A.2d 1387 (N.H. 1978), *overruled in part by In re Craig T.*, 800 A.2d 819 (N.H. 2002); *Sterling v. Cupp*, 625 P.2d 123 (Or. 1981); *Commonwealth v. Sadler*, 3 Phila. Co. Rptr. 316 (Ct. C.P. Phila. 1979); *Eggert v. Seattle*, 81 Wash. 2d 840, 841 (Wash. 1973); *Pauley v. Kelly*, 255 S.E.2d 859, 864, 878-79 (W. Va. 1979). A Missouri Supreme Court decision drew on the Convention on the Rights of the Child in striking down the juvenile death penalty. See *Simmons v. Roper*, 112 S.W.3d 397, 411 (Mo. 2003), *aff'd*, 543 U.S. 551 (2005). A concurring opinion in a Connecticut Supreme Court case drew on the International Covenant on Economic Social and Cultural Rights, in addition to the Universal Declaration, to determine the scope of government's obligations to provide for the poor. See *Moore v. Ganim*, 660 A.2d 742, 771 (Conn. 1995) (Peters, J., concurring).

affirmative charge to “protect[ ] and promot[e]” the health of the State’s “inhabitants,” the provision’s pairing with the aid to the needy provision, and from the provision’s historical context.

By articulating the State’s obligation as a duty to protect and promote the health of the State’s “inhabitants,” the framers of the public health provision chose the most inclusive possible language to describe those covered by the act. The language is far broader, for instance, than the categories of children, the needy, or persons suffering from mental illness used in other provisions of the New York State Constitution.<sup>207</sup> On its face, the language covers people of every age, region, and socioeconomic group; citizens as well as immigrants; and people who are ill and who have disabilities as well as those who are presently healthy.

When considered in tandem with the aid to the needy provision, moreover, it is clear that the right to health care cannot depend on one’s ability to pay. To the contrary, the constitutional history reviewed in Part II evinces a special obligation to ensure that low-income residents of New York are adequately served.<sup>208</sup> While the constitution does not demand any particular system of care, it requires one that is accessible to everyone in the state, irrespective of income or wealth.

But what of the Court of Appeals’ statement in *Bernstein v. Toia* that the State need not “always meet in full measure all the legitimate needs of each recipient?”<sup>209</sup> That language does not diminish the universality element of the health care right, for at least two reasons. First, *Bernstein* involved housing, not health care, where the constitutional duty is to all “inhabitants” rather than to “the needy” alone. Second, as described above, the program challenged in *Bernstein* included careful, systemic, fact-based efforts by the legislature to reach all those in need.<sup>210</sup> To say, as the court did in *Bernstein*, that a few individuals with unanticipated needs do not have a right to an exception from an otherwise valid program<sup>211</sup> is not to say that the State may shirk its duty to address the health care needs of all of its inhabitants.

New York legislative policy further reflects the importance of universal health care. For example, New York Medicaid law provides that “[m]edical assistance for needy persons is . . . a matter of

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207. N.Y. CONST. art. XI, § 1, art. XVII, §§ 1, 4.

208. See *supra* Part II.A-B.

209. *Bernstein v. Toia*, 373 N.E.2d 238, 244-45 (N.Y. 1977).

210. *Id.*

211. *Id.*

public concern and a necessity in promoting the public health and welfare and for promoting *the state's goal of making available to everyone, regardless of . . . economic standing, uniform, high-quality medical care.*"<sup>212</sup>

International human rights law is especially informative here.<sup>213</sup> The language which Corsi used to introduce the public health provision of the social welfare amendment to the delegates of the 1938 constitutional convention<sup>214</sup> is very similar to that of the Universal Declaration of Human Rights ("UDHR"), which the United States helped to craft just a decade after the New York constitutional convention, in the wake of the Depression, World War II, and the horrors of the Holocaust.

Indeed, scholars have compared the social welfare article "favorably with the humanitarian goals of the United Nations Declaration of Human Rights."<sup>215</sup> The UDHR, and the international system of human rights that it spawned, support a right to health care that reaches all inhabitants. Article 25 of the UDHR establishes that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services . . . and the right to security in the event of unemployment, sickness, disability, widowhood, old age."<sup>216</sup> Using almost identical

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212. N.Y. SOC. SERV. LAW § 363 (McKinney 2007) (emphasis added). Section 365-a(2) of the New York Social Services Law defines medical assistance as "payment of part or all of the cost of medically necessary medical, dental and remedial care, services and supplies . . . which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap . . ." *Id.* § 365-a(2).

213. The following discussion is adapted from DANGEROUS AND UNLAWFUL, *supra* note 8, at 19-20.

214. See REVISED RECORD, *supra* note 52, at 2133.

215. Hershkoff, *Rights and Freedoms*, *supra* note 26, at 634; see GALIE, *supra* note 102, at 262 (noting that the social welfare article "compares favorably" with the United Nations' Declaration of Human Rights (art. 25, § 1) adopted a decade after these provisions were included in the New York Constitution).

216. See UDHR, *supra* note 199, at 71, art. 25 (emphasis added). Adopted by the United Nations in 1948, the UDHR enshrines some of the essential economic rights that President Franklin D. Roosevelt proposed as part of a "second Bill of Rights" for Americans in his 1944 State of the Union address. President Roosevelt's proposal for a second Bill of Rights included "the right to adequate medical care and the opportunity to achieve and enjoy good health." See CTR. FOR ECONOMIC & SOCIAL RIGHTS, THE RIGHT TO HEALTH IN THE UNITED STATES OF AMERICA: WHAT DOES IT MEAN? 1 (2004), [http://cesr.org/filestore2/download/733/health%20report%20final%20on%20website%20\(oct%202028\).pdf](http://cesr.org/filestore2/download/733/health%20report%20final%20on%20website%20(oct%202028).pdf); Franklin D. Roosevelt, "The Economic Bill of Rights," Excerpt from 11 January 1944 message to Congress on the State of the Union, available at <http://www.worldpolicy.org/globalrights/econindex.html>; Franklin



language, Corsi explained to the constitutional convention that public health included “the development of the social machinery which will insure to *every individual* in the community a *standard of living adequate for the maintenance of health*.”<sup>217</sup> The framers of the UDHR considered a right to medical care an essential element of article 25.<sup>218</sup> As discussed above, delegates to New York’s 1938 constitutional convention also considered the provision of medical care part of the state’s responsibility in promoting and protecting the public health.<sup>219</sup>

The International Covenant on Economic, Social and Cultural Rights (“ICESCR”), which the United States signed in 1977 but has not ratified, elaborates on the meaning of the UDHR’s right to health provision.<sup>220</sup> Recognizing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” the ICESCR requires that governments move toward the “creation of conditions which would assure to *all* medical service and medical attention in the event of sickness.”<sup>221</sup>

The UN Committee on Economic, Social and Cultural Rights (“CESCR”), which is responsible for interpreting the ICESCR, has set forth the minimum core obligations required by the treaty and these include primary health care for the entire population.<sup>222</sup> CESCR has explained that a country party to the ICESCR “in which any significant number of individuals is deprived . . . of es-

D. Roosevelt, “The Four Freedoms,” Excerpt from 6 January 1941 message to Congress on the State of the Union, *available at* <http://www.worldpolicy.org/globalrights/econindex.html>. President Bush embraced article 25 in a 2007 speech to the UN General Assembly. George W. Bush, Address at the United Nations General Assembly (Sept. 25, 2007), *available at* <http://www.whitehouse.gov/news/releases/2007/09/20070925-4.html>.

217. REVISED RECORD, *supra* note 52, at 2133 (emphasis added).

218. CTR. FOR ECONOMIC & SOCIAL RIGHTS, *supra* note 216, at 5 n.17. In fact, they originally crafted the article as a right of “access to medical care,” but then modified the provision to include public health measures. *Id.*

219. *See supra* Part II.A-B.

220. *See* CTR. FOR ECONOMIC & SOCIAL RIGHTS, *supra* note 216, at 4 n.10. Martha Davis draws an interesting parallel between the mandate imposed by the language in the New York Constitution and that imposed by the ICESCR: “[B]oth sections 1 and 3 [of the New York Constitution] are similar to affirmative grants in international human rights conventions.” Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 409 n.154 (citing International Covenant on Economic, Social and Cultural Rights, art. 12: “The steps to be taken by the States parties . . . to achieve the full realization of this right shall include those necessary for . . .”).

221. International Covenant on Economic, Social and Cultural Rights, 1966, art. 12(1), 12(2)(d) U.N. Doc A/6316 (opened for signature Dec. 16, 1966, S. EXEC. DOC. No. D, 95-2 (1978), 993 U.N.T.S. 3) [hereinafter ICESCR] (emphasis added).

222. *See* CTR. FOR ECONOMIC & SOCIAL RIGHTS, *supra* note 216, at 6.

sential primary health care . . . is, prima facie, failing to discharge its obligations under the Covenant.”<sup>223</sup> Violations of the right to health care can be in the form of a state *committing* an act or *omitting* an act.<sup>224</sup>

Other international declarations, adopted at conferences and summits in which the United States has participated, have also recognized a universal right to health care. For example, the American Declaration on the Rights and Duties of Man emphasizes that “[e]very person has the right to the preservation of his health through . . . measures relating to medical care, to the extent permitted by public and community resources.”<sup>225</sup> The Copenhagen Declaration on Social Development, a product of the World Summit for Social Development in 1995, sets forth ten commitments, one of which is the goal of “the highest attainable standard of physical and mental health, and the access of all to primary health care, making in particular efforts to rectify inequalities relating to social conditions.”<sup>226</sup> The foregoing examples illustrate the inherence of universality in modern conceptions of the right to health care.

### ii. *Comprehensiveness*

The concept of “positive health” described by Corsi at the 1938 constitutional convention includes primary and preventative care “designed to help each child to attain *his or her maximum possibilities of health* and efficiency.”<sup>227</sup> As Corsi explained, “the present day health officer . . . is actively interested in the promotion of *positive buoyant health*.”<sup>228</sup>

This language, and the broader history of the provision recounted in Part II.A, mark an important distinction between the comprehensive system of preventative care and treatment required by the New York Constitution and emergency or charity care that many states provide, often unevenly, to the uninsured. The drafters of the New York provision understood that affirmatively “pro-

223. U.N. Committee on Economic, Social, and Cultural Rights, General Comment No. 3: The Nature of States Parties Obligations (art. 2 ¶ 1), U.N. Doc. E/1991/23 ¶ 10 (Dec. 15, 1990), available at <http://cesr.org/generalcomment3>.

224. CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health, ¶¶ 48, 49, U.N. Doc No. E/C.12/200/4 (Nov. 8, 2000) [hereinafter CESCR, General Comment No. 14] (emphasis added).

225. Org. Am. St., *American Declaration on the Rights & Duties of Man*, art. 11, Mar.-May 1948, art. 11, O.A.S. Res. XXX (emphasis added).

226. World Summit for Soc. Dev., Copenhagen, Denmark, Mar. 6-12, 1995, *Copenhagen Declaration on Social Development*, Commitment 6, U.N. Doc. A/CONF.166/9.

227. REVISED RECORD, *supra* note 52, at 2132 (emphasis added).

228. *Id.* (emphasis added).

moting" New Yorkers' health would yield long-term benefits in terms of social and economic prosperity, as well as cost savings.<sup>229</sup> Accordingly, the drafters' vision included preventative and primary care, as well as modern elements like prenatal care and "well baby clinics"<sup>230</sup> that far exceed the notion of emergency care.

Federal courts have recognized that "preserving and protecting the health of the pregnant woman" is an important governmental interest.<sup>231</sup> Moreover, federal Medicaid law requires that eligible pregnant women and children have access to inpatient and outpatient hospital services; family planning services; physicians' services; services furnished by nurse-midwives; and services furnished by certified pediatric nurse-practitioners.<sup>232</sup>

In addition, international human rights principles underscore the importance of comprehensive health care systems to a right to health care, including preventative, prenatal, and other types of necessary care.<sup>233</sup> In 1994, the United Nations Population Division produced the Cairo Program of Action, which protects the "right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."<sup>234</sup> The Cairo Program notes that governments should strive to make reproductive health care available, defining it as including prenatal care, safe delivery, and postnatal care.<sup>235</sup> It also recommends that governments extend reproductive health care and child health services, including safe motherhood programs, to their most vulnerable and underserved groups.<sup>236</sup> Similarly, the 1995 Beijing

229. PROBLEMS RELATING TO BILL OF RIGHTS, *supra* note 39, at 482-570.

230. REVISED RECORD, *supra* note 52, at 2132.

231. *Roe v. Wade*, 410 U.S. 113, 162 (1973).

232. 42 U.S.C. §§ 1396a(a)(10)(A)(i)(III) (2006), 1396d(a), (17), (21), 1396d(n).

233. UDHR, *supra* note 199, art. 25.

234. U.N. Int'l Conf. on Population Dev., Cairo, Egypt, Sept. 5-13, 1994, *Final Program of Action of the UN ICPD*, ¶ 7.1, U.N. Doc A/CONF.171/L.1 (May 13, 1994) [hereinafter Cairo Program]. Even though international declarations adopted at United Nations conferences and summits, are not legally binding, they "contribute to the advancement of international norms and can assist in interpreting the scope of human rights treaty provisions." SURVIVING PREGNANCY & CHILDBIRTH, *supra* note 201, at 10; see Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 398 ("[T]he United States has played a leadership role in developing several international platforms that speak directly to issues of reproductive health and contraception. While not formally binding on the United States or any of the participating nations, these platforms elaborate the international standard for sex education and reproductive information.").

235. Cairo Program, *supra* note 234, ¶ 7.6.

236. *Id.* ¶ 8.17.

Platform for Action Regarding Women and Health recommends that governments provide sexual and reproductive health care, giving particular attention to maternal and emergency obstetric needs.<sup>237</sup> While these laws do not purport to define rights under New York's Constitution, they give authoritative substance to the meaning of protecting and promoting health.

### iii. Equity

In addition to universality and comprehensiveness, compliance with the public health provision requires state attention to equity in the availability of health care. Equity, in this context, is not a matter of non-discrimination or equal protection of the laws (which New York's Constitution and laws also require)<sup>238</sup> but, rather, of ensuring that health care services are responsive to different communities' health care needs. This equity requirement derives both from the inclusive nature and intent of the public health provision's mandate, and from established public health norms that the drafters intended the provision to embody.<sup>239</sup> One might ask why, if the State has an obligation to ensure "positive health" for all of its residents, is an equity dimension necessary. The answer is that economic and social rights like the right to health care inevitably play out in the context of limited public resources. Clearly the State, in its budgetary deliberations, must prioritize the fulfillment of consti-

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237. Fourth World Conf. on Women, Beijing, China, Sept. 4-15, 1995, *Beijing Platform for Action*, ¶ 106(e), U.N. Doc. A/CONF.177/20/Rev.1, ¶ 106(e) (Oct. 17, 1995).

238. N.Y. CONST. art. I, § 11.

239. The public health provision is not limited to the guarantee of an adequate level of health care for all New Yorkers. It goes beyond preventing absolute deprivation and requires that the state also address pervasive inequalities that exist even above a minimum threshold. William S. Koski & Rob Reich, *When 'Adequate' Isn't: The Retreat from Equity in Educational Law and Policy and Why It Matters*, 56 EMORY L.J. 545, 615 (2006) (making the same argument in the education context). Unlike the education article as construed in *Campaign for Fiscal Equity* and *Levittown*, the public health provision should not be interpreted to focus solely on the adequacy of services. Promoting and protecting the public's health requires consideration of equity concerns, as well. In *Levittown*, the Court of Appeals rejected plaintiffs' argument that the education article guaranteed equal or substantially equivalent educational opportunities in every district on the grounds that the education article and its legislative history did not make reference to any such requirement. According to the court, "[w]hat appears to have been contemplated when the education article was adopted at the 1894 Constitutional Convention was a State-wide system assuring minimal acceptable facilities and services." *Levittown Bd. of Educ. v. Nyquist*, 57 N.Y.2d 27, 368-69 (1982). The *Campaign for Fiscal Equity* court nonetheless found that equity principles were relevant to determining minimal adequacy and that is even more the case here, where the standard is higher and lives are at stake. *Campaign for Fiscal Equity, Inc. v. State*, 801 N.E.2d 326, 331 (N.Y. 2003).

tutional obligations like public education and protecting the public's health over unenumerated legislative goals. But it is also the case that, whatever its overall wealth, the State must allocate resources—including health care resources—alongside other budgetary needs and limitations. If the health care needs of significant numbers of New Yorkers are not being met through the State's regulatory regime, while other individuals, neighborhoods, or communities enjoy superior health care services, then the argument that the State is doing all it can with existing resources cannot be sustained.

The “protection and promotion of the health of the inhabitants of the state” mandated by section 3 is an expansive one that, in the context of limited resources, necessarily requires an alignment of health care needs and health care services. While such an alignment does not demand identical services across individuals or communities, a highly inequitable health care system would clearly negate its purpose. This principle is evident in the Court of Appeals' recent interpretation of the New York Constitution's education article, which similarly creates positive and inclusive rights, and imposes affirmative obligations on the State.<sup>240</sup>

Interpreting the education article in *Campaign for Fiscal Equity, Inc. v. State*, the Court of Appeals held that that the State's method of funding its public schools unconstitutionally disadvantaged New York City school children.<sup>241</sup> The court considered principles of equity in its analysis, noting that “with respect to teacher experience and retention, certification and pay[,] New York City schools are inferior to those of the rest of the state.”<sup>242</sup> The court found the State's inequitable school finance system unconstitutional based in part on “a mismatch between student need in New York City and the quality of the teaching directed to that need . . .”<sup>243</sup> as evidenced by, among other things, the fact that the schools with the highest percentages of non-white children had “the least experienced teachers, the most uncertified teachers, the lowest-salaried teachers, and the highest rates of teacher turnover.”<sup>244</sup> In other words, the State's public school finance system failed constitutional

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240. The Education Article provides: “[t]he legislature shall provide for the maintenance and support of a system of free common schools, wherein all the children of this state may be educated.” N.Y. CONST. art. XI, § 1.

241. *Campaign for Fiscal Equity, Inc.*, 801 N.E.2d at 331.

242. *Id.* at 333.

243. *Id.* at 334.

244. *Id.* at 333.

muster in part because it inequitably allocated the least educational resources where the need for those resources was the greatest.<sup>245</sup>

As discussed above, the constitutional history of the social welfare amendment similarly evinces a desire “to enable every citizen to realize his birthright of health and longevity”<sup>246</sup> and to aid the needy in particular. The drafters sought to reach all residents of the State and, especially, those most likely to fall through the cracks of the State’s health care system. Indeed, as previously noted, an important reason for constitutionally vesting public health obligations in the State was the recognition that “[p]oor health conditions in one locality are a menace to the State as a whole.”<sup>247</sup>

The drafters of the public health provision also expressed a strong desire that the State’s obligation be based on contemporary public health and medical expertise, as well as actual health conditions and challenges.<sup>248</sup> That body of expertise overwhelmingly holds that health care *equity* is crucial to protecting and promoting the public’s health. Research has repeatedly shown that equal access to culturally-sensitive, high-quality primary, preventative, pre-

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245. Koski & Reich, *supra* note 239, at 547-50. In the education context, much has been written about the shift in the past two decades from “the rhetoric and policy of providing equal education opportunities to the rhetoric and policy of providing an ‘adequate’ education to all children, irrespective of resource inequalities among schools.” *Id.* Scholars have pointed to serious problems with the adequacy framework in the context of education litigation, noting that it “tolerates wide inequalities above the specified threshold of educational opportunity and proficiency, and inequalities above this threshold . . . disadvantage those in the bottom end of the distribution.” *Id.* A focus on adequacy alone would undermine the goal of the promoting and protecting the health of New York residents. This scholarship and the experience it represents demonstrate that attention to equity is necessary for an effective health care system. *Id.* at 547; see also Peter Enrich, *Leaving Equality Behind: New Directions in School Finance Reform*, 48 VAND. L. REV. 101, 101 (1995) (arguing that education finance policy was “leaving equality behind”); Michael Heise, *State Constitutions, School Finance Litigation, and the “Third Wave”: From Equity to Adequacy*, 68 TEMP. L. REV. 1151, 1152 (1995); Bran C. Noonan, *The Fate of New York Public Education Is a Matter of Interpretation: A Story of Competing Methods of Constitutional Interpretation, the Nature of Law and a Functional Approach to the New York Education Article*, 70 ALB. L. REV. 625, 627 (2007); Bonnie A. Scherer, Comment, *Footing the Bill for a Sound Basic Education in New York City: The Implementation of Campaign for Fiscal Equity v. State*, 32 FORDHAM URB. L.J. 901, 901-02 (2005).

246. PROBLEMS RELATING TO BILL OF RIGHTS, *supra* note 39, at 513.

247. REVISED RECORD, *supra* note 52, at 2133.

248. *Id.* at 2133.

natal, and emergency care with necessary interpretation services is essential to good health.<sup>249</sup>

As part of a congressionally mandated study of racial disparities in health care, the Institute of Medicine of the National Academy of Sciences explained that,

[f]rom a public health standpoint, racial and ethnic disparities in healthcare threaten to hamper efforts to improve the nation's health. . . . [T]he United States is becoming increasingly diverse; while white Americans currently constitute 71% of the population, by the year 2050 nearly one in two Americans will be a person of color. These groups . . . experience a poorer overall health status and lower levels of access to healthcare than white Americans, and experience a disproportionate burden of chronic and infectious illness. This higher burden of disease and mortality among minorities has profound implications for all Americans, as it results in a less healthy nation and higher costs for health and rehabilitative care. All members of a community are affected by the poor health status of its least healthy members . . . .<sup>250</sup>

An initiative by the U.S. Department of Health and Human Services similarly explains that “the health of every community in every State and territory determines the overall health status of the Nation.”<sup>251</sup> The Center for Disease Control has stated:

The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death.<sup>252</sup>

Equity principles are also central to the international human rights norms that should inform the interpretation of the New York

249. For more information on the importance of adequate, geographically accessible prenatal and maternity health care, see The Opportunity Agenda, *Prenatal Care and Opportunity in New York, Eliminating Geographic Barriers to Good Health for Women and Children* (2005), [http://www.opportunityagenda.org/atf/cf/%7B2ACB2581-1559-47D6-8973-70CD23C286CB%7D/prenatal\\_Care\\_and\\_Opportunity.pdf](http://www.opportunityagenda.org/atf/cf/%7B2ACB2581-1559-47D6-8973-70CD23C286CB%7D/prenatal_Care_and_Opportunity.pdf) (last visited Mar. 28, 2008); The Opportunity Agenda, *Geographic Barriers to Hospital-Based Health Care in New York City* (2005), [http://www.opportunityagenda.org/atf/cf/{2ACB2581-1559-47D6-8973-70CD23C286CB}/Geographic\\_Barriers\\_to\\_Primary\\_Care.pdf](http://www.opportunityagenda.org/atf/cf/{2ACB2581-1559-47D6-8973-70CD23C286CB}/Geographic_Barriers_to_Primary_Care.pdf) (last visited Mar. 28, 2008) and works cited therein.

250. UNEQUAL TREATMENT, *supra* note 4.

251. U.S. DEP'T OF HEALTH AND HUMAN SERVS., *HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH* 11 (2000).

252. Office of Minority Health and Health Disparities, Ctrs. for Disease Control and Prevention, *Guiding Principle for Improving Minority Health*, <http://www.cdc.gov/omhd/About/disparities.htm> (last visited Mar. 28, 2008).

health care right. The UN Committee on Economic, Social and Cultural Rights, for example, has determined that violations of the ICESCR include denial of access to health facilities and services to particular groups as a result of de jure or de facto discrimination; misallocation of public resources which results in certain vulnerable or marginalized groups not having access to health care; and the failure to take steps to reduce the inequitable distribution of health facilities.<sup>253</sup>

The racial, socioeconomic, and ethnic diversity of New York State make consideration of health care equity a particularly important element of protecting and promoting the health of all New York residents. The U.S. Census Bureau estimates that New York's non-white and Latino population was over 40% in 2005, while the State's foreign born population at the time of the 2000 census was 20.4%.<sup>254</sup> Approximately 14.5% of New Yorkers lived below the poverty level in 2004.<sup>255</sup> New York City is even more diverse, with 2000 Census figures showing a non-white population of 55.3%, a poverty rate of 21.2%, and a foreign-born population of 35.9%.<sup>256</sup> A system that does not adequately serve any one of these large populations cannot, under the equitable demands of New York's Constitution, be said to promote and protect the health of New York State's inhabitants.

Many proponents of an equitable health care system claim that society has to assure equal access to health care for each person regardless of income and social status, and based solely on each person's needs.<sup>257</sup> This formulation fits well with New York's 1938 constitutional convention mandate to protect and promote the public's health while specifically aiding the needy.

In sum, the New York legislature's discretion in adopting a public health system that protects and promotes New Yorkers' health is cabined by core principles of equity, as well as universality and comprehensiveness.

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253. See ICESCR, *supra* note 221; CESCR, General Comment No. 14, *supra* note 224.

254. U.S. Census Bureau, State and County QuickFacts, <http://quickfacts.census.gov/qfd/states/36000.html> (last visited Mar. 27, 2008).

255. *Id.*

256. U.S. Census Bureau, State and County QuickFacts, <http://quickfacts.census.gov/qfd/states/36/3651000.html> (lasted visited Mar. 27, 2008).

257. See generally Thomas Bodenheimer, *Should We Abolish the Private Health Insurance Industry?*, 20 INT'L J. HEALTH SERV. 199 (1990) (arguing for the abolition of the insurance-based health care system and for the establishment of health care as a right).



### III. EQUAL ACCESS TO QUALITY HEALTH CARE: ADDITIONAL LAWS GOVERNING HEALTH CARE IN NEW YORK

New York's health care system exists within a broader legal and policy framework in which principles of equity—particularly equal opportunity based on race, socioeconomic status, nationality, and language proficiency—are core tenets. In addition to the universality, comprehensiveness, and equity principles inherent in the State Constitution itself, any system adopted by the State must, pursuant to the Supremacy Clause, comply with federal laws, treaties, and binding international laws governing the health care sector.<sup>258</sup> Specifically, New York law and practice must adhere to U.S. civil rights laws barring intentional and unintentional discrimination, international law mandating the affirmative eradication of discriminatory policies, and federal health care laws requiring equitable health care irrespective of income, wealth, or neighborhood. Along with the New York Constitution, these principles must guide the legislature in crafting health care legislation. Alternatively, in the event of successful litigation challenging the constitutionality of the State's health care system, these principles must guide the courts in fashioning a remedy.

The Supremacy Clause of the U.S. Constitution requires state compliance with federal law in the areas of health care and civil rights.<sup>259</sup> In our federal system, moreover, New York is obligated to implement ratified treaties, like the Convention on the Elimination of Racial Discrimination ("CERD") in areas, like health, where it enjoys jurisdiction.<sup>260</sup> The U.S. Constitution and the res-

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258. Part III draws upon and is adapted from DANGEROUS AND UNLAWFUL, *supra* note 8, at 18-24.

259. The Supremacy Clause, Article VI, Clause 2 of the United States Constitution, reads:

This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI., cl. 2. Title VI applies to state health care systems receiving federal funds. U.S. DEP'T OF JUSTICE, TITLE VI LEGAL MANUAL § V(A)(5), [http://www.usdoj.gov/crt/grants\\_statutes/legalman.html](http://www.usdoj.gov/crt/grants_statutes/legalman.html); see *Martin v. Hunter's Lessee*, 14 U.S. (1 Wheat.) 304, 340-41 (1816) (state courts' obligation is "not to decide merely according to the laws or Constitution of the State, but according to the constitution, laws, and treaties of the United States—'the supreme law of the land.'").

260. Because of the United States' federal system,

when the United States assents to a treaty or other international agreement . . . implementation [must] occur [at] the state as well as the federal level. If states fail to implement international treaty provisions that address areas

ervations the U.S. Senate issued when it ratified CERD and the International Covenant on Civil and Political Rights (“ICCPR”) make clear that New York is responsible for implementing those treaties in the health care sector, where the State Constitution designates the State as responsible for regulation.<sup>261</sup> As the federal government explained in the United States’ first report to the UN Human Rights Commission regarding compliance with the ICCPR, “state and local governments exercise[ ] significant responsibilities in many areas, including matters such as . . . public health.”<sup>262</sup>

The ICCPR and CERD are “non-self-executing”—meaning that they cannot be directly enforced in U.S. courts,<sup>263</sup> but nonetheless, they impose concrete obligations on states. Ratified treaties have

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traditionally reserved to them, the United States cannot, as a practical matter, achieve compliance with the treaty provisions to which it is party.

Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 361-64.

261. U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”). Senate ratification of major treaties has been accompanied by the following understanding:

That the United States understands that this Covenant shall be implemented by the Federal Government to the extent that it exercises legislative and judicial jurisdiction over the matters covered therein, and otherwise by the state and local governments; to the extent that state and local governments exercise jurisdiction over such matters, the Federal Government shall take measures appropriate to the Federal system to the end that the competent authorities of the state or local governments may take appropriate measures for the fulfillment of the Covenant.

Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 363 (citing 138 CONG. REC. 8068, 8071 (1992) (understanding for International Covenant on Civil and Political Rights); 140 CONG. REC. 14326, 14326 (1994) (same understanding for International Convention on the Elimination of All Forms of Racial Discrimination); 136 CONG. REC. S17486, S17486 (1990) (same understanding for Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment)).

262. United States, *Initial Report of the United States of America*, delivered to the U.N. Human Rights Comm. (HRC), Addendum, ¶ 3, U.N. Doc. CCPR/C/81/Add.4 (Aug. 24, 1994) (reporting steps taken toward compliance with the ICCPR). The report noted that the United States would implement the Covenant by “appropriate legislative, executive and judicial means, federal or state, and that the federal government will remove any federal inhibition to the abilities of the constituent states to meet their obligations in this regard.” *Id.* ¶ 4. Scholars have interpreted this statement to mean that although the federal government will not encourage states to enforce human rights treaties, it accepts that states are responsible for implementing them. Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 364.

263. U.S. reservations, declarations, and understandings, International Covenant on Civil and Political Rights, 138 CONG. REC. S4781, S4784 (1992); U.S. reservations, declarations, and understandings, International Convention on the Elimination of All Forms of Racial Discrimination, 140 CONG. REC. S7634-02 (1994); U.S. reservations, declarations, and understandings, Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, CONG. REC. S17486-01 (1990). When

“a legal status equivalent to enacted federal statutes. As such, they prevail over previously enacted federal law (to the extent of any conflict) and over any inconsistent state or local law.”<sup>264</sup> As a signatory to treaties, the United States must “refrain from acts which would defeat the object and purpose of a treaty.”<sup>265</sup>

In ratifying the ICCPR and CERD, the Senate added reservations mandating that their protections go no further than corresponding protections in domestic law.<sup>266</sup> Scholars have questioned the validity of such reservations.<sup>267</sup> But this principle, if valid, does

treaties are non-self-executing, individuals cannot sue for violation of rights recognized under the treaties.

264. Davis, *State Constitutions and International Human Rights*, *supra* note 26, at 363 (quoting United States, Initial Report to Comm. on Elim. of Racial Discrim., Addendum, P 50, UN Doc. CERD/C/351/Add.1 (Sept. 21, 2000), available at [http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/4c02eba071d735f4c1256a1700588ba0/\\$FILE/G0044926.pdf](http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/4c02eba071d735f4c1256a1700588ba0/$FILE/G0044926.pdf)) (internal quotations omitted).

265. Janet M. Hostetler, *Realizing Domestic Social Justice Through International Human Rights: Part II: Testing Human Rights: The Impact of High-Stakes Tests on English Language Learners' Right to Education in New York City*, 30 N.Y.U. REV. L. & SOC. CHANGE 483, 492-93, 493 n.53 (2006) (citing Vienna Convention on the Law of Treaties, art. 18, May 23, 1969, 1155 U.N.T.S. 331). The federal government, of course, retains an obligation to ensure state and municipal compliance with international law, insofar as its jurisdiction allows. This includes, in this case, enforcement of the equity and non-discrimination principles in federal Title VI, Medicaid, and Hill Burton statutes and regulations, discussed *infra* Part III.A and III.B.

266. Congress ratified the ICCPR with the following reservations:

(1) That Article 20 does not authorize or require legislation or other action by the United States that would restrict the right of free speech and association protected by the Constitution and laws of the United States.

(2) That the United States reserves the right, subject to its Constitutional constraints, to impose capital punishment on any person (other than a pregnant woman) duly convicted under existing or future laws permitting the imposition of capital punishment, including such punishment for crimes committed by persons below eighteen years of age.

(3) That the United States considers itself bound by Article 7 to the extent that “cruel, inhuman or degrading treatment or punishment” means the cruel and unusual treatment or punishment prohibited by the Fifth, Eighth and/or Fourteenth Amendments to the Constitution of the United States.

(4) That because U.S. law generally applies to an offender the penalty in force at the time the offense was committed, the United States does not adhere to the third clause of paragraph 1 of Article 15.

(5) That the policy and practice of the United States are generally in compliance with and supportive of the Covenant's provisions regarding treatment of juveniles in the criminal justice system. Nevertheless, the United States reserves the right, in exceptional circumstances, to treat juveniles as adults, notwithstanding paragraphs 2(b) and 3 of Article 10 and paragraph 4 of Article 14. The United States further reserves to these provisions with respect to individuals who volunteer for military service prior to age 18.

138 CONG. REC. S4781-01, S4783 (1992); 140 CONG. REC. S7634-02 (1994).

267. Some commentators have argued that such a reservation frustrates the purpose of the treaty and may therefore be invalid under international law and unen-

not frustrate the applicability of international law in this sphere because, as we describe below, federal law requires comparable protections. Moreover, where possible, federal law should be read in consonance with international law. It is an established principle of statutory construction that “an act of Congress ought never to be construed to violate the law of nations if any other possible construction remains, and consequently can never be construed to violate neutral rights, or to affect neutral commerce, further than is warranted by the law of nations as understood in this country.”<sup>268</sup> A fortiori, under the Supremacy Clause, this principle applies as well to state laws in areas in which the state has jurisdiction over the subject of an international law or treaty.<sup>269</sup>

### A. Racial and Linguistic Equity

Federal law requires that states ensure equal access to health care.<sup>270</sup> Under Title VI of the Civil Rights Act of 1964, racial discrimination by recipients of federal financial assistance is prohibited. These recipients include the State and virtually all health care providers through the federally subsidized Medicare and Medicaid programs.<sup>271</sup> Section 601 of Title VI makes clear that “[n]o person in the United States shall on the ground of *race, color, or national origin*, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.”<sup>272</sup> The legislative history

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forceable, although the rest of the treaty may be severable and continue to have legal effect. *See, e.g.,* Penny White, *Legal, Political, and Ethical Hurdles to Applying International Human Rights Law in the State Courts of the United States (and Arguments for Scaling Them)*, 71 U. CIN. L. REV. 937, 950-51, 967-69 (2003) (arguing that state judges have an independent authority to interpret the underlying treaties and reservations); *see also* Jordan J. Paust, *Avoiding “Fraudulent” Executive Policy: Analysis of Non-Self-Execution of the Covenant on Civil and Political Rights*, 42 DEPAUL L. REV. 1257, 1268-70 (1993).

268. *Murray v. Schooner Charming Betsy*, 6 U.S. 64, 118 (1804); *see also* Maria Foscarinis, *Realizing Domestic Social Justice Through International Human Rights: Part II: Advocating for the Human Right to Housing: Notes from the United States*, 30 N.Y.U. REV. L. & SOC. CHANGE 447, 478 n.204 (2006).

269. *See In re The Consuelo*, 7 Haw. 704, 711, 714 (1889) (upholding state law on seizure of ships smuggling opium into the Kingdom of Hawaii on the grounds that “[c]ustoms laws of great severity are found among the statutes of all commercial nations”).

270. *See generally* DANGEROUS AND UNLAWFUL, *supra* note 8, at 22-23.

271. *See* DANGEROUS AND UNLAWFUL, *supra* note 8, at 22 (quoting U.S. DEP’T OF JUSTICE, TITLE VI LEGAL MANUAL, *supra* note 259, § V(A)(5)).

272. 42 U.S.C. § 2000d (2007) (emphasis added). The statute defines programs or activities broadly as all operations of an institution or government entity receiving or distributing federal financial assistance. *Id.* § 2000d-4a.

reveals that the drafters of the law gave serious consideration to prohibiting discriminatory treatment, both intentional and unintentional, in health care.<sup>273</sup>

The New York State Department of Health, a “recipient of federal funds,” must comply with Title VI.<sup>274</sup> In addition, hospitals in New York State that accept federal financial assistance in the form of Medicaid reimbursement are also bound to comply, as are private physicians who treat patients on Medicaid or who otherwise receive federal funds.<sup>275</sup> As with international law, state policies to carry out the public health provision must comply with Title VI.<sup>276</sup>

The U.S. Department of Health and Human Services has promulgated regulations that implement Title VI in the health care context. The regulations prohibit policies or practices by federal fund recipients that, though not intentionally discriminatory, have a disparate impact on particular racial groups or communities that cannot be justified by practical necessities.<sup>277</sup> Additionally, discrimination on the grounds of race, color, or national origin is prohibited, as are policies that have the effect of excluding people with limited English proficiency.<sup>278</sup> The regulations also prohibit decisions in determining the site or location of facilities that have “the

273. See Sara Rosenbaum & Joel Teitelbaum, *Civil Rights Enforcement in the Modern Healthcare System*, 3 YALE J. HEALTH POLICY L. & ETHICS 215, 220 (2003); see generally DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* (1999).

274. DANGEROUS AND UNLAWFUL, *supra* note 8, at 22; see Amanda Masters et al., New York Lawyers for the Public Interest, *Health Care Facilities in the 21st Century: Right Sizing and Investing in Underserved Communities*, prepared for the Commission on Health Care Facilities in the Twenty First Century (Mar. 2006), [http://nylpi.org/pub/Berger\\_Commission\\_White\\_Paper.pdf](http://nylpi.org/pub/Berger_Commission_White_Paper.pdf) [hereinafter Masters, *Health Care Facilities in the 21st Century*].

275. DANGEROUS AND UNLAWFUL, *supra* note 8, at 22 (citing Siddharth Khanijou, *Disentangling Fact from Fiction: The Realities of Unequal Health Care Treatment*, 9 DEPAUL J. HEALTH CARE L. 855, 865-67 (2006) [hereinafter Khanijou, *Disentangling Fact from Fiction*]). Unlike Medicaid, however, Medicare’s payments to physicians, under Medicare Part B, do not constitute “federal financial assistance” as defined by Title VI, and physicians whose only source of federal funds is from treating Medicare patients are not covered by Title VI. *Id.*

276. *Id.* (citing Khanijou, *Disentangling Fact from Fiction*, *supra* note 275, at 865-67).

277. 45 C.F.R. § 80.3(b)(2) (2006). Although the U.S. Supreme Court held there to be no private right of action under these regulations in *United States v. Sandoval*, 532 U.S. 276 (2001), the regulations still provide an important context in which the state constitutional provision must be read.

278. *Id.*; *Lau v. Nichols*, 414 U.S. 563 (1974); see Exec. Order 1,3166: *Improving Access to Services for Persons With Limited English Proficiency*, 65 Fed. Reg. 50,121 (Aug. 11, 2000), available at <http://www.usdoj.gov/crt/cor/Pubs/eolep.pdf> [hereinafter Executive Order 13,166]; U.S. DEP’T OF HEALTH AND HUMAN SERVS., *GUIDANCE TO FEDERAL FINANCIAL ASSISTANCE RECIPIENTS REGARDING TITLE VI*, available at

effect of excluding individuals from, denying them the benefits of, or subjecting them to discrimination.”<sup>279</sup>

Although the Title VI regulations are not enforceable by private individuals in court,<sup>280</sup> they are fully binding on New York State and its subdivisions. Any health care scheme crafted by the State must fully comply with the Title VI statute and regulations, or the State must relinquish all federal funds, including Medicaid and Medicare.<sup>281</sup>

This includes the kinds of discriminatory effects that both the Title VI regulations and CERD prohibit, as well as Title VI’s language provisions.<sup>282</sup> In *Lau v. Nichols*, the U.S. Supreme Court interpreted regulations promulgated by the former Department of Health, Education, and Welfare (the precursor agency to HHS) to mean that Title VI prohibits conduct that has a disproportionate effect on people with limited English proficiency because such conduct constitutes national-origin discrimination.<sup>283</sup> In addition on August 11, 2000, President Clinton issued Executive Order 13,166, mandating that every federal agency that provides financial assistance to non-federal entities publish guidance on how their recipients can provide meaningful access to Limited English Proficiency (“LEP”) persons and thus comply with Title VI regulations.<sup>284</sup>

State health care systems must also comply with Title VI of the Public Health Service Act, commonly known as the Hill-Burton

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<http://www.hhs.gov/ocr/lep/revisedlep.html> [hereinafter U.S. DEP’T OF HEALTH, GUIDANCE].

279. 45 C.F.R. § 80.3(3) (2006).

280. *United States v. Sandoval*, 532 U.S. 275, 285-86 (2001).

281. 68 Fed. Reg. 47,321 (Aug. 8, 2003) (“[I]f a case is fully investigated and results in a finding of noncompliance, HHS . . . must attempt to secure voluntary compliance through informal means. If the matter cannot be resolved informally, HHS must secure compliance through termination of federal assistance . . .”).

282. See Executive Order 13,166, *supra* note 278; U.S. DEP’T OF HEALTH, GUIDANCE, *supra* note 278.

283. 414 U.S. 563 (1974). The Supreme Court in *Lau* concluded that a San Francisco school district with many non-English speaking students was required to take reasonable steps to provide them with a meaningful opportunity to participate in federally funded educational programs. *Id.*

284. See Executive Order 13,166, *supra* note 278 (directing recipients of federal assistance to “take reasonable steps to ensure meaningful access to their programs and activities by LEP persons”); U.S. DEP’T OF HEALTH, GUIDANCE, *supra* note 278; N.Y. COMP. CODES R. & REGS. tit. 10, §§ 405.7(7), 751.9 (2006); see also THE N.Y. IMMIGRATION COAL., STATE HEALTH REGULATION REQUIRES HOSPITALS TO IMPROVE COMMUNICATION WITH PATIENTS: CIVIL RIGHTS COMPLAINTS BRING ABOUT REFORMS (2006), [http://www.thenyic.org/images/uploads/FINAL\\_NYIC\\_Lang\\_Regs\\_Update\\_091106.pdf](http://www.thenyic.org/images/uploads/FINAL_NYIC_Lang_Regs_Update_091106.pdf).

Act.<sup>285</sup> Hill-Burton prohibits discrimination based on insurance status by states that have accepted federal grants and loans to build and modernize hospitals.<sup>286</sup> In order to receive these grants, states must provide assurances that the facilities that receive the funds are (1) “available to all persons residing in the territorial area of the [facilities]” and (2) that “a reasonable volume of services” are made available to persons unable to pay.<sup>287</sup> The first requirement—that the facilities be made available to all persons living in the area—is known as the community service obligation or regulation.

The Hill-Burton community service regulations provide that hospital facilities receiving federal funds must be made available to all members of the community in which the facility is located, regardless of the race, color, national origin, or creed.<sup>288</sup> The regulations outlaw discrimination against participants in a governmental third-party payor program such as Medicaid or Medicare.<sup>289</sup> They also prohibit facilities from adopting admissions policies that have the effect of excluding persons on grounds of race, color, or national origin.<sup>290</sup> Collectively, the above-mentioned laws require that any

285. Hill Burton Act, 42 U.S.C. § 291 (2007).

286. *Id.*

287. 42 U.S.C. § 291c(e); *see also* Kenneth R. Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C. L. REV. 577, 577 (1982).

288. 42 U.S.C. § 291; 42 C.F.R. § 124.603 (2007).

289. 42 C.F.R. § 124.603(c)(2).

290. *Id.* §§ 124.603(a)(1), (d)(1). A number of state and municipal laws complement these protections, outlawing discrimination in public facilities, including health care facilities. These include the New York State Human Rights Law and the New York City Human Rights Law, as well as the Equal Protection clause of the New York Constitution. DANGEROUS AND UNLAWFUL, *supra* note 8, at 22-23 (citing N.Y. EXEC. LAW § 290 (Consol. 2006)). The New York State Human Rights Law protects people from discrimination in places where the public is served, including doctors’ offices, hospitals, nursing homes, and clinics. *Id.* (citing N.Y. EXEC. LAW §§ 291(2), 292(9), 296(2) (Consol. 2006)); *see also* Cahill v. Rosa, 89 N.Y.2d 14, 21-22 (1996). The New York City Human Rights Law similarly prohibits practices by hospitals, clinics, and private providers that result in inferior access or service based on race, color, or national origin. DANGEROUS AND UNLAWFUL, *supra* note 8, at 23 (citing N.Y.C. ADMIN. CODE §§ 8-107(4), (17)(a)(1), 8-102(9) (2006)). Local Law 85, The Local Civil Rights Restoration Act of 2005, amended the New York City Human Rights Law to ensure that “the provisions of this title [of the City Human Rights Law] shall be construed liberally for the accomplishment of the uniquely broad and remedial purposes thereof, regardless of whether federal or New York State civil and human rights laws, including those laws with provisions comparably-worded to provisions of this title, have been so construed.” *Id.* (citing N.Y.C. ADMIN. CODE § 8-130 (2006)). The Equal Protection Clause of the New York State Constitution provides that

[n]o person shall be denied the equal protection of the laws of this state or any subdivision thereof. No person shall, because of race, color, creed or religion, be subjected to any discrimination in his or her civil rights by any

public health care system the New York Legislature enacts must provide care to all people equally without respect to racial or linguistic difference.

### B. Socioeconomic and Geographic Inequality

Any health care system adopted by the State must address socioeconomic and geographic inequality.<sup>291</sup> Medicaid, enacted under Title XIX of the Social Security Act, provides access to affordable and comprehensive health care for low-income working families, the elderly, and people with disabilities to fill gaps in Medicare coverage.<sup>292</sup> The program, a partnership between the federal government and the states, offers care to especially vulnerable people.<sup>293</sup>

Under federal Medicaid law, New York must reimburse health care providers who treat Medicaid recipients at a level that ensures those patients and the general population access to local care. The statute specifically requires states to “assure” that they will “provide such methods and procedures” related to reimbursement rates for Medicaid service providers so that their payments are “consistent with efficiency, economy, and quality of care,” and that they are “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”<sup>294</sup> This important requirement, known as the equal access provision, requires New York to maintain Medicaid reimbursement rates that ensure equitable access and avoid a two-tiered health care system.

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other person or by any firm, corporation, or institution, or by the state or any agency or subdivision of the state.

N.Y. CONST. art. I, § 11.

291. This section is adapted from DANGEROUS AND UNLAWFUL, *supra* note 8, at 18-19.

292. *Id.* at 18. Medicaid is an entitlement program that uses both federal and state funds to provide health care and long-term care for eligible recipients. *Id.* at 18 n.68 (citing 42 U.S.C. § 1396a (2006); 42 C.F.R. § 430.10 (2007)).

293. *Id.* (citing John V. Jacobi, *Dangerous Times for Medicaid*, 33 J.L. MED. & ETHICS 834 (2005); Sara Rosenbaum & David Rousseau, *Medicaid at Thirty-Five*, 45 ST. LOUIS L.J. 7 (2001)).

294. *Id.* (citing 42 U.S.C. § 1396a(a)(30)(A) (2006); *see also* 42 C.F.R. § 447.204 (2006) (“The agency’s payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.”)). The Department of Health and Human Services has interpreted the “geographic area” requirement to “include county or other appropriate substate area.” *Id.*



When Congress enacted the equal access provision, it explained that Medicaid eligibility for pregnant women, infants, and poor children would “not have [its] intended effect if physicians are not willing to treat Medicaid patients.”<sup>295</sup> Congress also observed that “without sufficient payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program.”<sup>296</sup>

In order to satisfy the equal access provision, Medicaid recipients must have the same amount of health care services available to them as do people with public or private insurance in their geographic area.<sup>297</sup> Courts have considered barriers to obtaining care, including time and distance to health care facilities, delays in obtaining appointments, and long waiting periods in providers’ offices, as factors in determining whether a state has violated the equal access provision.<sup>298</sup> Under this provision, Medicaid recipients in New York have a right to the same medical services as residents with private insurance or Medicare.<sup>299</sup>

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295. Okla. Chapter of the Am. Acad. of Pediatrics v. Fogarty, 366 F. Supp. 2d 1050, 1104 (D. Okla. 2005) (quoting H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2116).

296. *Id.*

297. DANGEROUS AND UNLAWFUL, *supra* note 8, at 18-19 (citing 42 U.S.C. § 1396a(a)(30)(A) (2006); Ark. Med. Soc’y v. Reynolds, 6 F.3d 519, 519, 527 (8th Cir. 1993) (finding that the statute requires plaintiffs to assert that their access to health care services is not equal to that of the *insured* population in the same “geographic unit”); Clark v. Richman, 339 F. Supp. 2d 631, 644 (M.D. Pa. 2004); Equal Access for El Paso, Inc. v. Hawkins, 428 F. Supp. 2d 585, 613-14 (W.D. Tex. 2006)).

298. The Equal Access provision does not explicitly “grant recipients a right to speedy delivery of services.” *Equal Access*, 428 F. Supp. 2d at 614 (internal quotations omitted). But “long waits constitute at least some evidence that services are not available to Medicaid recipients in [a geographic unit] to the extent that services are available to the general population.” *Id.* Courts have directed states to look at private insurer reimbursement rates for guidance and to use Medicare reimbursement rates as a minimum threshold. *Fogarty*, 366 F. Supp. 2d at 1107.

299. *See* DANGEROUS AND UNLAWFUL, *supra* note 8, at 18-19. Since the U.S. Supreme Court decision in *Gonzaga Univ. v. John Doe*, 536 U.S. 273 (2002), courts are, however, increasingly reluctant to find a private right of action under the equal access provision and have rejected attempts to enforce Medicaid’s provisions under section 1983. *See* Jane Perkins, National Health Law Program, Update on section 1983 Enforcement (Jan. 2007), available at <http://www.healthlaw.org/search/attachment.94516>; *see also* Equal Access for El Paso, Inc. v. Hawkins, 509 F.3d 697 (5th Cir. 2007) (reversing the district court and holding that the Equal Access provision does not confer individual rights enforceable under section 1983); Okla. Chapter of Am. Acad. of Pediatrics v. Fogarty, 472 F.3d 1208, 1214 (10th Cir. 2007) (citing *Mandy R. ex rel. Mr. and Mrs. R. v. Owens*, 464 F.3d 1139 (10th Cir. 2006); *Bruggeman v. Blagojevich*, 324 F.3d 906, 910 (7th Cir. 2003)); *Westside Mothers v. Olszewski*, 454 F.3d 532 (6th Cir. 2006); *Sanchez v. Johnson*, 416 F.3d 1051, 1058-62 (9th Cir. 2005) (holding that in light of *Gonzaga*, neither providers nor beneficiaries could bring suit under section 30(A) and noting that since *Gonzaga* no federal court of appeals had concluded that section 30(A) provided Medicaid recipients or providers with a right enforceable under sec-

Additionally, federal law mandates that the State set Medicaid reimbursement rates at “a sufficient level to attract enough providers such that health care services are available to [Medicaid recipients] at least to the extent that those services are available to the insured population.”<sup>300</sup> New York “cannot set rates solely on the basis of the available budget;” rather, it must consider “equal access, efficiency, economy, and quality of care” when setting reimbursement rates.”<sup>301</sup>

Other provisions of the federal Medicaid Act also guarantee Medicaid recipients equal access to quality care. For example, the Act requires states to make Medicaid programs available state-wide. The “state-wideness” provision requires that state medical assistance plans “shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them.”<sup>302</sup> A “State plan must provide that . . . the plan will be in operation

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tion 1983); *Long Term Care Pharm. Alliance v. Ferguson*, 362 F.3d 50 (1st Cir. 2004). In addition, one New York state court has opined that no private right of action is created under section 1396a(a)(30)(A) for providers. *Home Care Ass’n v. Bane*, 643 N.Y.S.2d 231, 234 (App. Div. 1995). But at least one circuit court of appeal has interpreted the equal access provision, as “creat[ing] a clearly established federal right to *equal access to quality care*.” *Pediatric Specialty Care v. Ark. Dep’t of Human Serv.*, 364 F.3d 925, 930 (8th Cir. 2004), *aff’d* 443 F.3d 1005, 1016 (8th Cir. 2006) (finding § 1396a(a)(30)(A) enforceable through a section 1983 private cause of action, even in light of *Gonzaga*) (emphasis added).

300. *Home Care Ass’n*, 643 N.Y.S.2d at 234 (citing 42 U.S.C. § 1396a(a)(30)(A) (interpretive notes); 42 C.F.R. § 447.204).

301. *Id.* As HHS has noted in the context of serving people with disabilities, “[o]f fundamental importance to any healthcare service delivery system is the ability of enrollees to access appropriate services in a timely manner.” 42 U.S.C. § 12101 (2007); 29 U.S.C. § 794 (2007). HHS further explains that to ensure access, states must comply with “relevant Federal statutes regarding persons with disabilities (e.g., the [ADA]) when designing, implementing and monitoring its care delivery systems.” Judy Panko Reis et al., *It Takes More than Ramps to Solve the Crisis of Healthcare for People with Disabilities* (Sept. 2004), [http://www.ric.org/community/RIC\\_whitepaper\\_final82704.pdf](http://www.ric.org/community/RIC_whitepaper_final82704.pdf); see also Dep’t of Health and Human Servs., *Health Care Financing Administration, Guidance for States Considering the Development of Medicaid Managed Care Programs for Persons With Special Health Care Needs*, Oct. 5, 1998, <http://library.findlaw.com/1998/Oct/8/130735.html>.

302. See 42 U.S.C. § 1396a(a)(1) (2006). Recipients and providers in California successfully challenged a plan under which counties were allowed to choose whether to provide methadone services or not, on the grounds that this practice violated the requirement for state-wide availability of services. See, e.g., *Sobky v. Smoley*, 855 F. Supp. 1123, 1133-36 (E.D. Cal. 1994) (finding the state-wide provision enforceable under section 1983). But see *Equal Access*, 428 F. Supp. 2d at 619-20 (concluding that the state-wide provision does not create a private right of action on the grounds that the provision “lacks any ‘rights creating language, making no specific mention of either Medicaid recipients or providers’”). The *Equal Access* district court relied on *Gonzaga Univ. v. Doe*, 536 U.S. 273, 287 (2002) (stating that “‘rights-creating language’ is ‘critical to showing the requisite congressional intent to create new rights’”).

statewide . . . under *equitable* standards for assistance and administration that are mandatory throughout the State."<sup>303</sup>

In reviewing the international and federal provisions that complement New York's public health and aid to the needy provisions, it is important to distinguish between private enforceability and applicability. While the Title VI and Hill-Burton statutes are judicially enforceable by private parties, as explained above, the CERD treaty and Title VI regulations are not. The private enforceability of Medicaid's provisions is in flux.<sup>304</sup> There is, however, no question that each of these provisions is binding upon the State through the Supremacy Clause. As such, New York's legislature, executive branch, and courts must adhere to them insofar as those branches participate in the development or maintenance of health care policy.<sup>305</sup> We next examine how New York's current health care policy and conditions fare in meeting those standards.

#### IV. NEW YORK'S HEALTH CARE CRISIS: OVERVIEW AND STRUCTURAL PROBLEMS

Conditions in New York show a clear violation of the right to health care.<sup>306</sup> Despite the State's investment of significant resources in the health care system, many people still lack basic health insurance and therefore cannot seek the care that they need. Many others receive unequal treatment, depending on the type of insurance they have.<sup>307</sup> As we describe below, communities of

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303. 42 C.F.R. § 431.50(b)(1) (2006) (emphasis added). In addition, the Medicaid Act requires that each state provide, with reasonable promptness and effectiveness, specific services enumerated in the Act, including "early and periodic screening, diagnostic, and treatment ("EPSDT") services for individuals who are eligible under the plan and are under the age of 21." 42 U.S.C. § 1396d(a)(4)(B) (2006). The EPSDT provision requires that states ensure that the services provided are reasonable effective and promptly provided. These services create a "comprehensive child health program of prevention and treatment." *Katie A. v. Los Angeles County*, 481 F.3d 1150, 1154-55 (9th Cir. 2007) (internal quotations omitted). Furthermore, under section 1396a(a)(8), "a State plan for medical assistance must . . . provide . . . that such [medical] assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8) (2007).

304. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 18-19.

305. Additional laws govern the health care sector from a human rights perspective, including the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101, and the Rehabilitation Act of 1973, 29 U.S.C. § 791 (2006). See DANGEROUS AND UNLAWFUL, *supra* note 8, at 19. The legal frameworks discussed here are not intended to be exhaustive.

306. Part IV is adapted from DANGEROUS AND UNLAWFUL, *supra* note 8, at 25-57.

307. Although we do not go into detail about unequal treatment, Bronx Health Reach has extensively documented it. See SEPARATE AND UNEQUAL, *supra* note 8, at 21.

color, low-income New Yorkers, immigrants and people for whom English is not a first language often do not receive quality, culturally competent care. State policy and practice distributes health care resources inequitably, with low-income communities and communities of color facing a stark shortage of care. Discussing all the policies and practices that might infringe upon New Yorkers' right to health care is beyond the scope of this Article. Because two areas in particular—the uninsured and the geographic distribution of health care facilities—have attracted particular attention over the last several years,<sup>308</sup> we will focus our discussion on those concerns.

The growing number of New Yorkers lacking health insurance has been a persistent concern of government as well as the public.<sup>309</sup> In contrast, the distribution of health care resources came to the fore more recently. The New York State Commission on Health Care Facilities in the 21st Century, for example, recommended a series of hospital closures and downsizing, based primarily on financial considerations in 2006.<sup>310</sup> As described below, the State has consistently allowed hospitals and clinics to close with little regard for New Yorkers' health care needs. Particularly in New York City, the mismatch between health care resources and health care needs, violates all the elements of the state constitutional right to health care: universality, comprehensiveness, and equity.<sup>311</sup> The State has a clear obligation to address New Yorkers' health care needs more effectively and to ensure that comprehen-

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308. Former Governor George Pataki, for example, established the New York State Commission on Health Care Facilities in the 21st Century—known as the Berger Commission for its chair, Stephen Berger—to “undertake a rational, independent review of health care capacity and resources in New York State.” COMM’N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, A PLAN TO STABILIZE AND STRENGTHEN NEW YORK’S HEALTH CARE SYSTEM 64 (2006), available at <http://www.nyhealth-carecommission.org/docs/final/commissionfinalreport.pdf>. The Commission recommended a slate of hospital closings and service reductions around the State, including in New York City. See *id.* at 59.

309. See, e.g., Sarah Kershaw, *Gap In Illness Rates Between Rich and Poor New Yorkers Widens, Study Says*, N.Y. TIMES, Sept. 28, 2007, at B3; Lauren Stossen, *Op-Ed, Cover Less to Cover More*, N.Y. TIMES, Dec. 2, 2007, at 13.

310. See COMM’N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, *supra* note 308.

311. As described in Part II, in *Campaign for Fiscal Equity, Inc. v. State*, the Court of Appeals concluded that plaintiffs prevailed due to a “unique combination of circumstances: New York City schools have the *most* student need in the state and the *highest* local costs yet receive some of the *lowest* per student funding and have some of the *worst* results.” 801 N.E.2d 326, 350 (N.Y. 2003) (emphasis in original). New York City’s health system suffers from the same set of circumstances.

sive, quality health care is available and accessible to all New Yorkers.

### A. The State's Role in the Health Care System

Pursuant to its authority under the State Constitution, the state government is intimately involved in the regulation of health care, including public and private insurance, the authorization, location, and scale of public and private hospitals and clinics, the certification of public and private health providers, and reimbursement rates under public programs.<sup>312</sup> With few limitations, the State is responsible for the present condition of health care in New York and wields the regulatory and financial tools that are necessary to protect and promote the health of its inhabitants.

The State Department of Health ("DOH") has the power to approve or reject the construction, expansion, conversion, downsizing, and closure of all hospitals in the State.<sup>313</sup> DOH is required to assess public need in determining whether to grant a Certificate of Need application for the construction, expansion, or conversion of hospitals,<sup>314</sup> but the agency has not historically done so.<sup>315</sup>

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312. See Social Security Act tit. XIX, 42 U.S.C. §§ 1396-1396v (2008) (establishing the Medicaid and Medicare programs); Social Security Act tit. XXI, 42 U.S.C. §§ 1397aa-jj (2008) (establishing the State Child's Health Insurance Program); N.Y. PUB. HEALTH LAW §§ 2800-20 (Consol. 2007) (regulating New York hospitals); N.Y. COMP. CODES R. & REGS. tit. 10, §§ 710-17, 751 (2007) (granting the Department of State regulatory authority over most aspects of hospital construction and management); N.Y. INS. LAW §§ 4301-27 (Consol. 2007) (regulating private health insurers in New York); New York Health Care Reform Act of 1996, 1996 N.Y. Laws 639 (setting reimbursement rates under public programs).

313. The Department of Health approves the opening and closure of all hospitals, and regulates providers and clinics. The Certificate of Need ("CON") process is used by DOH to regulate the establishment and construction of health care facilities in New York State. See N.Y. COMP. CODES R. & REGS. tit. 10, § 710.1(c)(2) (2007); see also New York State Department of Health, <http://www.health.state.ny.us/nysdoh/cons/about.htm> (last visited Mar. 28, 2008). "Health care facilities that propose construction, acquisition of major medical equipment, changes in ownership," and addition of services must submit CON applications subject to DOH approval. *Id.* Facilities required to submit CON applications include hospitals, diagnostic centers, treatment centers, and residential healthcare facilities. See N.Y. PUB. HEALTH LAW § 2801(1) (Consol. 2007).

314. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 83 n.282.

In determining whether an application for construction, expansion, conversion should be granted, DOH is required to consider public need, as well as financial feasibility, character and competence, and construction. In determining whether to revoke an operating certificate, DOH is also required to consider public need; but in its approval of voluntary closures DOH has argued that it need not consider health needs.

*Id.* (citing Dep't of Health website, [http://www.health.state.ny.us/nysdoh/cons/cons\\_application/page\\_02\\_con\\_review\\_criteria.htm](http://www.health.state.ny.us/nysdoh/cons/cons_application/page_02_con_review_criteria.htm) (last visited Mar. 28, 2008)).

A statewide system for health care planning existed in New York until the 1990s, but the system has been largely defunct for the last decade without state or federal funding.<sup>316</sup> As a result, there is no mechanism currently in place to assess communities' health needs and to ensure an adequate and equitable distribution of resources.<sup>317</sup>

### B. The Uninsured in New York State

Nearly 2.8 million New York State residents—fifteen percent of the State's total population—do not have health insurance.<sup>318</sup>

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315. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 61, 83 n.283-85.

In the mid-1980s, in response to a Title VI complaint filed by Legal Services of New York and New York Lawyers for the Public Interest, DOH entered negotiations with advocates and agreed to add a form to its Certificate of Need application that would address concerns about access to health care. The form, at the time identified as Schedule 18, required health care facilities to address access to facilities, including language access, in their applications and obligated DOH to weigh such issues in deciding whether to approve applications. But this requirement was only enforced for a short time, while legal and community groups reviewed DOH procedures . . . . Schedule 18 no longer addresses health care access issues; it now applies to Residential Health Care Facilities.

*Id.* (citing Schedule 18—CON Forms Specific to Residential Health Care Facilities, [http://www.health.state.ny.us/nysdoh/cons/cons\\_application/data\\_ready\\_con/sch\\_18.doc](http://www.health.state.ny.us/nysdoh/cons/cons_application/data_ready_con/sch_18.doc) (last visited Mar. 28, 2008)); see Telephone Interview with Judy Wessler, Director, Commission on the Public's Health System (Nov. 16, 2006) (on file with authors).

316. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 59, 59 n.260-61.

The federal government established Health Systems Agencies (HSAs), pursuant to the National Health Planning and Resources Development Act of 1974, to help states and localities plan health care services. The New York State Legislature amended the Public Health Law to include provisions for the system in 1983. In 1987, federal funding was dismantled but the HSAs in New York continued their activities with state grants and other non-federal funding. Then in 1996, the state legislature did not authorize funding for the HSAs in New York and the HSAs suspended operation.

*Id.* (citing Commission on the Public's Health System in New York City, Recommendations on the Health Planning (undated, on file with authors) [hereinafter Recommendations on the Health Planning]).

317. DANGEROUS AND UNLAWFUL, *supra* note 8, at 59, 59 n.259 (citing Recommendations on the Health Planning, *supra* note 316; N.Y. PUBLIC HEALTH LAW § 2904-b (Consol. 2007)). "[T]he laws creating the Health Systems Agency are still on the books." *Id.*

318. DANIELLE HOLAHAN ET AL., UNITED HOSPITAL FUND, A BLUEPRINT FOR UNIVERSAL HEALTH INSURANCE COVERAGE IN NEW YORK 2 (2006), available at [http://www.uhfny.org/usr\\_doc/Blueprint\\_for\\_Universal\\_Coverage.pdf](http://www.uhfny.org/usr_doc/Blueprint_for_Universal_Coverage.pdf). The problem of the uninsured is not unique to New York; across the country, a large portion of the population is not able to access health care in a systematic medically competent manner due to a lack of insurance. See SUSAN STARR SERED & RUSHIKA FERNANDOPULLE, UNINSURED IN AMERICA: LIFE AND DEATH IN THE LAND OF

Health insurance status is a major determinant of health care access. People who are uninsured are less likely than people with insurance to receive the care they need, and when the uninsured do receive medical care, it is often too late.<sup>319</sup> People who are uninsured face an increased risk of death.<sup>320</sup> They are sicker and have more severe conditions that could have been prevented with timely and adequate care.<sup>321</sup> When uninsured people are hospitalized, they often receive fewer services, and are more likely to die in the hospital than their insured counterparts.<sup>322</sup> Over 18,000 Americans under the age of sixty-five die prematurely each year because they lack health insurance.<sup>323</sup> In February 2006, the Center for Health Care Policy Research and Analysis reported “that New York State allows 1260 state residents to die needlessly each year” due to lack of health insurance.<sup>324</sup>

The uninsured are more likely to report not having a regular source of health care.<sup>325</sup> In addition, “[p]atients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care.”<sup>326</sup>

Lack of insurance coverage not only takes a toll on the health of the uninsured, it also negatively affects the community as a whole. Safety-net hospitals and health care providers suffer financially and

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OPPORTUNITY 4 (2005); M. Gregg Bloche & Lawrence O. Gostin, *Health Law and the Broken Promise of Equity*, in *LAW AND CLASS IN AMERICA: TRENDS SINCE THE COLD WAR* 310, 310-30 (Paul D. Carrington & Trina Jones, eds., 2006).

319. See CARE WITHOUT COVERAGE, *supra* note 4, at 12; COVERAGE MATTERS, *supra* note 4, at 21-23.

320. See CARE WITHOUT COVERAGE, *supra* note 4, at 12; COVERAGE MATTERS, *supra* note 4, at 21-23.

321. CARE WITHOUT COVERAGE, *supra* note 4, at 12; COVERAGE MATTERS, *supra* note 4, at 21-23.

322. CARE WITHOUT COVERAGE, *supra* note 4, at 12; COVERAGE MATTERS, *supra* note 4, at 21-23.

323. INST. OF MEDICINE, HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA 13-14 (2003), available at [http://www.nap.edu/catalog.php?record\\_id=10719#toc](http://www.nap.edu/catalog.php?record_id=10719#toc) [hereinafter HIDDEN COSTS].

324. Press Release, Ctr. for Health Care Policy, Research & Analysis, 1260 People Die Needlessly in New York State (Feb. 10, 2006), <http://www.healthcarepolicyresearchanalysis.org/PressReleases.htm>; see also Ctr. for Healthcare Policy, Research & Analysis, Number of Uninsured Pop. Deaths, Under 65, By State of Residence, <http://www.healthcarepolicyresearchanalysis.org/spreadsheet1.htm> (last visited Mar. 28, 2008).

325. The Opportunity Agenda, Health Care and Opportunity, *supra* note 3.

326. *Id.*

are often forced to close due to inadequate reimbursements.<sup>327</sup> The strain on the health care system limits providers' ability to respond to disasters and serve the entire community.<sup>328</sup> For these reasons and those described below, New York's inadequate and inequitable system of health care coverage falls short of the State's constitutional obligation to protect and promote the health of its inhabitants.

The state-created system of health care coverage in New York is inequitable as well as inadequate. Under this system, which is largely employer-based, racial and ethnic minority and immigrant communities are disproportionately uninsured.<sup>329</sup> Non-elderly people of color constitute thirty-nine percent of the New York State population, but fifty-nine percent of the uninsured.<sup>330</sup> Over forty percent of non-elderly immigrant New York State inhabitants are uninsured.<sup>331</sup> In New York City, about seventeen percent of white New York City residents are uninsured, while nearly thirty percent of Black, Latino, and "Other" New York City residents lack coverage.<sup>332</sup> Because insurance status is so closely tied to race and ethnicity in New York, it is also a factor in racial health disparities.<sup>333</sup>

### C. Inadequate and Inequitable Distribution of Health Care Services in New York

In addition to insurance coverage, the public's health depends on available and accessible health care resources in every community. Proximity to primary care services helps ensure that people receive regular check-ups and non-emergency care, including prevention of

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327. See, e.g., Sidney D. Watson, *The Urban Crisis: The Kerner Commission Report Revisited: Health Care in the Inner City: Asking the Right Question*, 71 N.C.L. REV. 1647, 1664 (1993).

328. INST. OF MEDICINE, A SHARED DESTINY: EFFECTS OF UNINSURANCE ON INDIVIDUAL FAMILIES AND COMMUNITIES 29 (2003), available at <http://books.nap.edu/openbook.php?isbn=0309087260>.

329. COMM'N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, UNINSURED IN NEW YORK 16 (2006), [http://www.nyhealthcarecommission.org/docs/uninsured\\_in\\_new\\_york.pdf](http://www.nyhealthcarecommission.org/docs/uninsured_in_new_york.pdf).

330. *Id.* at 13.

331. *Id.* at 14.

332. SEPARATE AND UNEQUAL, *supra* note 8, at 18. Black and Latino New York City residents are more than twice as likely as white residents to be either uninsured or publicly insured. *Id.* See DANIELLE HOLAHAN ET AL., UNITED HOSPITAL FUND, HEALTH INSURANCE COVERAGE IN NEW YORK, 2001 18 (2003), [http://www.uhfnyc.org/usr\\_doc/chartbook2003.pdf](http://www.uhfnyc.org/usr_doc/chartbook2003.pdf).

333. SEPARATE AND UNEQUAL, *supra* note 8, at 18.



common illnesses like diabetes and heart disease.<sup>334</sup> Without access to primary care, people suffer “complications from illness that can reduce productivity and increase financial insecurity; most alarming, it can lead to early or premature death.”<sup>335</sup> In addition, having a hospital nearby has been shown to increase survival rates from heart attacks and unintentional injuries suffered at home.<sup>336</sup> When hospitals close, it can take patients months or years to find new doctors; thirty percent simply stop receiving inpatient care.<sup>337</sup> For pregnant women and mothers, distance to health services can determine the health of mothers and their children: “[F]or each mile a child must travel to reach a hospital, there is a three percent decline in the probability of the child having a checkup.”<sup>338</sup>

Research shows that the distribution of hospitals and other health care services in New York State is inadequate, incomplete, and inequitable, violating all three prongs of the right to health

334. See SARA ROSENBAUM ET AL., *LAYING THE FOUNDATION: HEALTH SYSTEM REFORM IN NEW YORK STATE AND THE PRIMARY CARE IMPERATIVE* 6 (2006), [http://www.chcanys.org/clientuploads/downloads/advocacy/Laying\\_the\\_Foundation\\_for\\_Primary\\_Care\\_fullreport082906t.pdf](http://www.chcanys.org/clientuploads/downloads/advocacy/Laying_the_Foundation_for_Primary_Care_fullreport082906t.pdf)? [hereinafter ROSENBAUM, *LAYING THE FOUNDATION*]; see also The Opportunity Agenda, *Primary Care and Opportunity in New York Eliminating Geographic Disparities in Primary-Care Services*, <http://www.opportunityagenda.org/atf/cf/%7B2ACB2581-1559-47D6-8973-70CD23C286CB%7D/Geographic%20Disparities%20in%20Primary%20Care.pdf> (last visited Mar. 28, 2008).

335. DANGEROUS AND UNLAWFUL, *supra* note 8, at 13 (“All communities need access to health care services, including primary, prenatal, emergency, nursing home and long-term care, and certain specialty services, such as dialysis for patients with kidney disease.”); see also John Farley, *Spatial Mismatch and Access to Physicians*, EDWARDSVILLE J. OF SOC., July 2004, at 3-4, available at <http://www.siue.edu/SOCIOLOGY/journal/v4farley.htm>; Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOKLYN L. REV. 239, 250-51, 264 (1994).

336. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 15-16 (“A one-mile increase in distance to a hospital results in a nearly 6.5% increase in the number of deaths from heart attacks. According to the American Heart Association, ‘the survival probability after cardiac arrest decreases by 7 to 10% for every minute without treatment.’ A ‘one-mile increase in distance to the nearest hospital is associated with an 11 to 20% increase in the number of deaths from unintentional injuries.’”) (citing Thomas C. Buchmueller et al., *How Far to the Hospital? The Effect of Hospital Closures on Access to Care*, 25 J. HEALTH ECON. 740, 740-61 (2006)).

337. See Joshua Brustein, *Hospitals in Crisis*, GOTHAM GAZETTE, Sept. 26, 2005, <http://www.gothamgazette.com/print/1600>; Mike McPhate, *City Hospital Crisis: Residents Fear Closures Will Target Minorities*, RESIDENT PUBLICATIONS, Nov. 8, 2006, <http://74.54.115.114/node/338>.

338. DANGEROUS AND UNLAWFUL, *supra* note 8, at 15. “The study found that ‘among central-city black children, a longer distance to the nearest hospital reduces the probability of checkups.’” *Id.* at 70 n.45 (citing Janet Currie & Patricia Regan, *Distance to Hospital and Children’s Use of Preventive Care: Is Being Closer Better, and for Whom?*, 41 ECON. INQUIRY 378, 390 (2003)).

care.<sup>339</sup> Many communities in New York do not have access to primary care, prenatal care, or hospital-based services.<sup>340</sup> In some instances, services are too far away and are inaccessible for people who lack private transportation or who, for medical reasons, cannot travel long distances to receive care.<sup>341</sup> In other cases, providers and health care facilities may exist nearby, but do not accept uninsured patients or those covered by Medicaid.<sup>342</sup> Some do not provide services—such as interpretation and translation—necessary for proper care, forcing patients either to receive inadequate care or to travel long distances to find the services they need.<sup>343</sup>

### 1. *Primary and Preventative Care*

The U.S. Department of Health and Human Services' Health Resources and Services Administration ("HRSA") has designated many areas across New York State as medically underserved.<sup>344</sup> The availability of primary care physicians and the health needs of communities—specifically, infant mortality rates in communities, as well as income and age of residents—determine whether an area is designated as medically underserved.<sup>345</sup> Approximately 1.8 million New York State residents were medically underserved in 2001.<sup>346</sup>

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339. See generally DANGEROUS AND UNLAWFUL, *supra* note 8.

340. *Id.*

341. *Id.*

342. See NANCY LAGER ET AL., PRIMARY CARE DEVELOPMENT CORP. & N.Y. CITY HEALTH & HOSPITALS CORP., A PRIMARY CARE CAPACITY SHORTAGE IN NEW YORK CITY AND THE POTENTIAL IMPACT OF HOSPITAL CLOSURES 5 (2006), <http://www.nyc.gov/html/hhc/downloads/pdf/pcdc-report.pdf> [hereinafter LAGER, A PRIMARY CARE CAPACITY SHORTAGE].

343. See, e.g., Nina Bernstein, *Language Barrier Called Health Hazard in E.R.*, N.Y. TIMES, Apr. 21, 2005, at B1.

A survey conducted at Flushing Hospital by Korean Community Services of Metropolitan New York, for example, showed that 40 percent of patients with limited English reported that they had received no interpreter services, and 47 percent reported that the language assistance provided was inadequate. A follow-up late last year found no improvement, the complaint said.

*Id.* See also N.Y. IMMIGRATION COAL., LANGUAGE ACCESS TO HEALTH CARE—A SURVEY OF FOUR NEW YORK HOSPITALS (2004), [http://thenyic.org/images/uploads/Hospitals\\_Findings\\_Final\\_022404.pdf](http://thenyic.org/images/uploads/Hospitals_Findings_Final_022404.pdf).

344. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 25, 76 n.149 (citing Bureau of Health Professions, Guidelines for Medically Underserved Area and Population Designation, <http://bhpr.hrsa.gov/shortage/muaguide.htm> (last visited Mar. 28, 2008)).

345. *Id.*

346. *Id.* (citing THE INST. FOR URBAN FAMILY HEALTH, NEW YORK STATE HEALTH PROFESSIONALS IN HEALTH PROFESSIONAL SHORTAGE AREAS: A REPORT TO THE NEW YORK STATE AREA HEALTH EDUCATION CENTERS SYSTEM 1 (2004),

In addition, many parts of New York State have been designated as Health Professional Shortage Areas (“HPSAs”) by the HRSA.<sup>347</sup> “The federal government recommends a minimum of one primary care physician per 3500 people, and no more than 3000 people per primary care physician in areas with high needs.”<sup>348</sup> In 2001, an estimated 3.6 million people in New York State lived in these HPSAs<sup>349</sup> and “[b]etween 2001 and 2005 the number increased by an estimated 13.23%.”<sup>350</sup>

While inadequate access to quality care touches a variety of New York communities, residents of color face disproportionately high and inequitable barriers.<sup>351</sup> In New York City, there are particularly stark racial disparities in access to care.<sup>352</sup> Areas with high concentrations of African Americans, Latinos, and Asian Americans face serious shortages of primary care physicians.<sup>353</sup> Nearly 60% of New York City’s zip codes have an inadequate supply of

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available at <http://www.ahec.buffalo.edu/newsletters/NYS%20Health%20Professionals%20in%20HPSAs.pdf> [hereinafter NEW YORK STATE HEALTH PROFESSIONALS]).

347. *Id.* In New York City, thirteen areas—Port Richmond and St. George in Staten Island; Long Island City and South Jamaica in Queens; Washington Heights-Inwood and West Central Harlem in Manhattan; Williamsburg, East New York, Crown Heights, Bushwick, and Bedford-Stuyvesant in Brooklyn, and Hunts Point-Mott Haven and Highbridge in the Bronx—have been designated HPSAs. *Id.* at 26 (citing U.S. Dep’t of Health and Human Serv., Find HPSAs, <http://hpsafind.hrsa.gov/HPSASearch.aspx> (last visited Mar. 28, 2008); Testimony of Mary J. Mitchell to the New York City Regional Advisory Committee of the New York State Commission on Health Care Facilities in the 21st Century (Mar. 30, 2006), <http://www.ahec.buffalo.edu/Advocacy/RAC-%20Testimony-MSI%20AHEC.doc>). “The numbers . . . do not include mental health and dental health HPSAs or prisons, community health centers or immigration centers.” *Id.* at 77 n.159.

348. *Id.* at 25.

In making such a designation, HHS looks at (i) whether the “area is a rational area for the delivery of primary medical care services;” (ii) the ratio of full-time, primary care physicians to the population; and (iii) whether “[p]rimary medical care professionals in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.”

*Id.* at 76 n.151 (quoting Bureau of Health Professionals, U.S. Dep’t of Health and Human Serv., Health Professional Shortage Area Primary Medical Care Designation Criteria, <http://bhpr.hrsa.gov/shortage/hpsacritpcm.htm> (last visited Mar. 28, 2008)).

349. NEW YORK STATE HEALTH PROFESSIONALS, *supra* note 346, at 5.

350. DANGEROUS AND UNLAWFUL, *supra* note 8, at 3. “The report, which looked at all 50 states, ranked New York 29.” *Id.* at 75 n.153 (citing Ctr. For Enterprise Dev., 2006 Development Report Card for the States, Trend Indicators: New York, [http://www.cfed.org/imageManager/\\_documents/drc\\_2006/trendindicator/new\\_york.pdf](http://www.cfed.org/imageManager/_documents/drc_2006/trendindicator/new_york.pdf) (last visited Mar. 28, 2008)).

351. *Id.* at 47-57.

352. *Id.*

353. *Id.*

primary care physicians willing to see Medicaid patients, a disproportionate share of whom are people of color.<sup>354</sup>

Communities with the greatest shortage of health care, predominantly low-income communities of color, also often have the highest rates of common preventable illnesses, such as diabetes, asthma, and heart disease.<sup>355</sup> In contrast, areas with significant health care resources often are the healthiest and wealthiest.<sup>356</sup> In other words, the basic standard of matching health care resources to health care needs is unfulfilled within the state.

354. *Id.* at 25 (citing LAGER, A PRIMARY CARE CAPACITY SHORTAGE, *supra* note 342).

355. *Id.* at 47. Highbridge and Morrisania, located in the Bronx, provides an example of a low-income community of color with significant health needs that faces a stark shortage of services. The neighborhood is predominantly comprised of people of color: “57% are Hispanic; 38% are African American; 1% are Asian American or Pacific Islander American; 1% are white . . . . [T]hree out of ten residents were born outside the United States . . . .” *Id.* The neighborhood “is ranked as one of the bottom ten” in New York City with respect to general health. *Id.* at 51. It has some of the highest rates of infectious diseases and chronic diseases. *Id.*

Over one-third (35%) of the neighborhood’s residents do not consider themselves in good health, in contrast to the citywide rate of 19%. General hospitalization rates for the neighborhood are 65% higher than the citywide rate. Heart disease is the leading cause of adult hospitalization among Highbridge and Morrisania residents. Neighborhood admission rates for heart disease are 40% higher than the city as a whole. In 2001, the rate of childhood asthma hospitalization was also higher than the citywide rate: 10% versus 6%.

*Id.* at 51 n.212-13 (citing DEP’T OF HEALTH & MENTAL HYGIENE, COMMUNITY HEALTH PROFILES. TAKE CARE EAST HARLEM 1-16 (2d ed. 2006), available at <http://www.nyc.gov/html/doh/downloads/pdf/data/2006chp-303.pdf>). But, despite the neighborhood’s overwhelming health needs, this impoverished area—69.5% of its residents live under 200% of the poverty line—has severely limited health services. The zip code 10456 of Highbridge and Morrisania only has one primary care provider per 3843 residents. *Id.* The beds at the sole hospital within the zip code—Bronx-Lebanon Hospital Center, Fulton Division—are devoted to alcohol detoxification, alcohol rehabilitation, drug detoxification, and psychiatric/mental illness. *Id.* The hospital offers no prenatal or OB/GYN services and only limited primary and preventive care. *Id.* (citing New York State Department of Health, New York State Hospital Profile, <http://hospitals.nyhealth.gov> (last visited Mar. 28, 2008)).

356. *Id.* at 47 n.211. At the same time, residents of the zip code 10021 on the Upper East Side have one primary care physician for every 149 people, a rate that is more than 25 times that of the zip code 10456 in Highbridge and Morrisania. *Id.* (citing Analysis by The Opportunity Agenda based on 2004 New York State Area Health Education Center and 2000 U.S. Census Bureau data obtained via <http://infoshare.org> (last visited July 13, 2006)).

The demographic composition of this neighborhood stands in sharp contrast to other New York City communities. Over four in five residents, or 82%, are white; only 6% are Hispanic; 6% are Asian American; 3% are African American. This particular zip code also has some of the lowest health care needs in the city; the rate of ACS conditions is 269 per 100,000 people.

*Id.* at 47.

## 2. Hospitals

Hospital closures and downsizing in New York City have left many neighborhoods with a stark shortage of services. When community hospitals close, the distance to the nearest hospital increases, “[t]his imposes significant burdens [on people who seek to access services], particularly for the elderly, people with disabilities, and low-income people who rely on public transportation.”<sup>357</sup>

In Central Brooklyn for example, in the Fall of 2005, “the State Department of Health allowed St. Mary’s Hospital to close, rejecting an offer from another hospital” to keep the facility open.<sup>358</sup> With the closure, the community lost an array of health services that are unlikely to be replaced. Between 1936 and 2005, twenty-seven Central Brooklyn hospitals closed removing 3689 beds.<sup>359</sup> “Despite significant population increases in Central Brooklyn, the State has allowed the number of hospital beds to shrink by 40% over the past 40 years.”<sup>360</sup>

This pattern of closures cannot be attributed to a lack of need for health care. Central Brooklyn, which is 80% African American and 11% Latino and where twenty-five percent of the population lives in poverty, has significant health care needs.<sup>361</sup> For example, “in 2004, HIV-related deaths in 2004 were 200% higher in Central

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357. *Id.* at 15 (citing Lisa Bonstock, *Pathways of Disadvantage: Walking as a Mode of Transport Among Low-Income Mothers*, 9 HEALTH & SOC. CARE IN THE COMMUNITY 1, 11-18 (2000)).

358. *Id.* at 52.

359. DANGEROUS AND UNLAWFUL, *supra* note 8, at 52 (citing Jeff Vandam, *Lights Out*, N.Y. TIMES, Oct. 16, 2005). This amount does not include St. Mary’s hospital.

360. *Id.* See also COMM. TO SAVE OUR HEALTHCARE, HOSPITAL LOSSES (2006) (on file with authors). Similarly, southeast Queens has the highest concentration of minority residents in the borough of Queens and its population has significant health care needs, but there are no hospitals in most of the area. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 55. Furthermore, the three hospitals in the area have exceeded their psychiatric care capacity: Mary Immaculate’s occupancy rate for psychiatric beds in 2004 was 128.8%; Queens Hospital was at 135%; and Jamaica Hospital was at 103.8%. *Id.* Inpatient beds were at or near capacity at two hospitals in 2004: Queens Hospital (with 120 inpatient beds) had an occupancy rate of 89.5%; Jamaica Hospital (with 245 beds) had an occupancy rate of 96.9%. *Id.* (citing N.Y. STATE COMM’N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, 2004 INSTITUTIONAL COST REPORT, available at [http://www.nyhealthcarecommission.org/docs/2004\\_icr\\_commission\\_data.pdf](http://www.nyhealthcarecommission.org/docs/2004_icr_commission_data.pdf) (last visited Mar. 29, 2008); statement of Southeast Queens in Support of Health Services in Furtherance of the Debtors’ Bidding Procedures with Respect to the Sale of Mary Immaculate Hospital and St. John’s Queens Hospital, and Related Assets, and in Response to the Official Creditors’ Committee’s Statement and Reservation of Rights with Respect Thereto, Chapter 11, Case No. 05-14945).

361. DANGEROUS AND UNLAWFUL, *supra* note 8, at 52 (citing N.Y. CITY DEP’T. OF HEALTH & MENTAL HYGIENE, TAKE CARE CENTRAL BROOKLYN: NYC COMMU-

Brooklyn than in New York City as a whole. The diabetes rate was 33% higher, and the rate of . . . HIV/AIDS [cases] was 60% higher.<sup>362</sup>

Communities of color have suffered disproportionately from cuts in hospitals in New York City.<sup>363</sup> Between 1995 and 2005, the New York State Department of Health approved twelve hospital closures in New York City, two-thirds of which served predominantly people of color.<sup>364</sup> Three hospitals closed in Brooklyn during this period—Interfaith Medical Center, Jewish Hospital of Brooklyn; Brooklyn Hospital Center, Caledonian Campus; and St. Mary's Hospital.<sup>365</sup> Ninety percent of the patients at these three Brooklyn hospitals were people of color.<sup>366</sup>

### 3. *Comprehensive Care*

New York's system of health care has also made certain categories of essential care—especially reproductive care—inadequately and inequitable available. In Central Brooklyn, for example, Interfaith Hospital in Bedford-Stuyvesant closed its maternity ward in late 2004, followed by the closing of St. Mary's Hospital in 2005.<sup>367</sup> More than 250,000 women live in Central Brooklyn, but there are only 104 obstetric beds in the entire neighborhood.<sup>368</sup>

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NITY HEALTH PROFILES 1-16 (2d ed. 2006), available at <http://www.nyc.gov/html/doh/downloads/pdf/data/2006chp-203.pdf>.

362. *Id.*

363. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 52.

364. *Id.*

365. *Id.*

366. *Id.* (citing Analysis by Darrell Gaskin, Johns Hopkins University, Bloomberg School of Public Health, 1995-2005 SPARCS data, Nov. 2006).

367. *Id.* at 35.

368. See *id.* at 42 (citing MASTERS, HEALTH CARE FACILITIES IN THE 21ST CENTURY, *supra* note 274, at 5-6). Zip code 11692 in Rockaway, Queens, where almost half the population is low income and over 70% of the population is African American, provides another stark example. *Id.* The neighborhood has no maternity beds, and there are only 2.75 OB/GYN providers per 10,000 women of reproductive age. *Id.* Thirteen and a half percent of the women there received late or no prenatal care in 2001-03 and nearly 10% of babies born in that same period were low birth weight. *Id.* (citing Analysis by Steve Schreiber of New York State SPARCS and Area Health Education Center data; analysis by The Opportunity Agenda based on 2004 New York State Area Health Education Center and 2000 U.S. Census Bureau data obtained via <http://infoshare.org> (last visited Mar. 29, 2008)). In the 11368 zip code in West Queens, a neighborhood that is over three-quarters people of color and where three in five residents are foreign born, there was one OB/GYN provider for every 12,117 women of child-bearing age living in the zip code in 2001. *Id.* at 37 (citing N.Y. CITY DEP'T. OF HEALTH & MENTAL HYGIENE, TAKE CARE WEST QUEENS: NYC COMMUNITY HEALTH PROFILES (2d ed. 2006), available at <http://www.nyc.gov/html/doh/downloads/pdf/data/2006chp-402.pdf>). "Twelve percent of women in this com-

In addition there are significant racial and ethnic disparities in access to prenatal care in New York.<sup>369</sup> On average, low-income communities and communities of color in the five boroughs of New York City (Brooklyn, Queens, Manhattan, Staten Island, and the Bronx) have the fewest obstetrics and gynecology providers.<sup>370</sup> But women of color tend to have greater health needs.<sup>371</sup> New York's communities of color have a high percentage of babies born with low birth weight.<sup>372</sup> While many complex factors cause low birth weight, access to good prenatal care and hospital-based delivery services can improve health outcomes of low birth weight children.<sup>373</sup>

A study of new mothers in New York City pointed to transportation problems and distance of providers from women's homes as common barriers to prenatal care for low-income women.<sup>374</sup> In a survey of inner-city mothers, twenty-six percent listed transportation as a barrier to care.<sup>375</sup> The farther a woman must travel—

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munity received late or no prenatal care between 2001 and 2003." *Id.* (citing Analysis by The Opportunity Agenda based on 2004 New York State Area Health Education Center and 2000 U.S. Census Bureau data obtained via <http://infoshare.org> (last visited Mar. 29, 2008); analysis by Steve Schreiber of New York State SPARCS and Area Health Education Center data). Three in five residents of the neighborhood are foreign born, the neighborhood is over three-quarters people of color, and it has a higher proportion of Asian and Hispanic residents than the city over all. *Id.* By contrast, women in zip code 10021, located in Manhattan's predominantly white Upper East Side, had one OB/GYN physician for every 194 women of child-bearing age in their community, over sixty times as many. *Id.* Only about 1% of pregnant women in this community received late or no prenatal care, and the infant mortality rate was almost half that of the City as a whole. *Id.*

369. *See id.* at 37, 42.

370. *Id.* at 37-39.

371. *Id.* at 42.

372. *Id.*

373. *Id.* (citing Samuel Echevarria & William Parker Frisbie, *Race / Ethnic-Specific Variation in Adequacy of Prenatal Care Utilization*, 80 SOC. FORCES 633, 634, 643, 647 (2001); Andrew J. Healy et al., *Early Access to Prenatal Care: Implications for Racial Disparity in Prenatal Mortality*, 107 OBSTETRICS & GYNECOLOGY 625, 625-31 (2006); Paul Krueger & Theresa Scholl, *Adequacy of Prenatal Care and Pregnancy Outcome*, 100 J. AM. OSTEOPATHIC ASS'N 490, 485, 490 (2000); Cynthia Loveland Cook et al., *Access Barriers and the Use of Prenatal Care by Low-Income, Inner-City Women*, Mar. 1999, at 129-39 [hereinafter Cook, *Access Barriers*]; Janet D. Perloff & Kim D. Jaffee, *Late Entry into Prenatal Care: The Neighborhood Context*, SOC. WORK, Mar. 1999, at 116-27).

374. THE OPPORTUNITY AGENDA, *GEOGRAPHIC BARRIERS TO HOSPITAL BASED HEALTH CARE IN NEW YORK* 1-2 (2006), available at <http://www.opportunityagenda.org/atf/cf/%7B2ACB2581-1559-47D6-8973-70CD23C286CB%7D/Geographic%20Barriers%20to%20Primary%20Care.pdf> (citing Debra Kalmus & Katherine Fennelly, *Barriers to Prenatal Care among Low-Income Women in New York City*, FAMILY PLANNING PERSPECTIVES, Sept.-Oct. 1990, at 215-18, 231).

375. *Id.* (citing Cook, *Access Barriers*, *supra* note 373).

particularly if she is low income, juggling family and work demands, and faces transportation barriers—the less likely it is she will receive the care she and her baby need.<sup>376</sup>

#### D. Language Barriers to Care

There are approximately 4.2 million foreign-born New Yorkers, placing New York fourth among all states in terms of the percentage of its population that speaks a language other than English.<sup>377</sup> Close to one million New York City residents are Limited English Proficient (“LEP”).<sup>378</sup> In addition, fifty percent of New Yorkers speaks a language other than English at home.<sup>379</sup> English is the dominant language of the U.S. health care delivery system, and linguistic minorities are therefore at a significant disadvantage when it comes to accessing the same high-quality health services as English speakers.

Medical literature has documented how language barriers impede access to health care for language minorities and perpetuate racial and ethnic disparities in health outcomes. For example, researchers have found that the lack of competent language assis-

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376. THE OPPORTUNITY AGENDA, PRENATAL CARE AND OPPORTUNITY IN NEW YORK, ELIMINATING GEOGRAPHIC BARRIERS TO GOOD HEALTH FOR WOMEN AND CHILDREN 2 (2005), available at <http://www.opportunityagenda.org/atf/cf/%7B2ACB2581-1559-47D6-8973-70CD23C286CB%7D/Prenatal%20Care%20and%20Opportunity.pdf>.

377. This represents more than 20% of the state’s population, a tremendous increase from just ten years prior, when 2.8 million state residents, or 15.5%, were foreign-born. CTR. FOR AN URBAN FUTURE AND THE SCHUYLER CTR. FOR ANALYSIS AND ADVOCACY, BETWEEN HOPE AND HARD TIMES: NEW YORK’S WORKING FAMILIES IN ECONOMIC DISTRESS 8 (Nov. 2004); see U.S. Census Bureau, United States and States - R1601, Percent of People 5 Years and Over Who Speak a Language Other Than English at Home, [http://factfinder.census.gov/home/saff/main.html?\\_lang=en](http://factfinder.census.gov/home/saff/main.html?_lang=en) (using the left sidebar, select “People”; then select “Origins and Languages”; then select “Ranking of Population who Speak a Language Other than English” hyperlink) (last visited Mar. 29, 2008) [hereinafter U.S. Census Bureau, Percent of People 5 Years and Over Who Speak a Language Other Than English at Home]; see also Testimony of Maysoun Freij, Health Advocacy Associate Before the New York Council Committee on Health, Oversight Hearing: Overcoming Language Barriers in Health Care Provision, Apr. 11, 2007, <http://www.thenyic.org/templates/documentFinder.asp?did=697>.

378. THE HUMAN RIGHTS PROJECT AT THE URBAN JUSTICE CTR., RACE REALITIES IN NEW YORK CITY 100 (2007), <http://antibiaslaw.com/RaceRealities.pdf> (citing U.S. Census Bureau, American Factfinder, Fact Sheet: New York City 2006, <http://factfinder.census.gov> (search for “New York, New York”) (last visited Mar. 29, 2008)) [hereinafter RACE REALITIES IN NEW YORK CITY].

379. U.S. Census Bureau, Percent of People 5 Years and Over Who Speak a Language Other Than English at Home, *supra* note 377.



tance services can create a substantial risk of misdiagnosis,<sup>380</sup> higher likelihood of adverse drug events or serious medical events,<sup>381</sup> lower patient satisfaction,<sup>382</sup> and difficulty obtaining patient compliance with treatment regimens.<sup>383</sup> Studies have also shown that the failure to provide language assistance services is inefficient for the health care system as a whole; language barriers are associated with higher utilization of costly or invasive procedures<sup>384</sup> and lower utilization of preventative and primary care.<sup>385</sup>

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380. Glenn Flores, *Language Barriers to Health Care in the United States*, 355 NEW ENG. J. MED. 229-31 (2006).

381. See Adam L. Cohen et al., *Are Language Barriers Associated With Serious Medical Events in Hospitalized Pediatrics Patients?*, 118 PEDIATRICS 575-79 (2006); Tejal K. Gandhi et al., *Drug Complications in Outpatients*, 15 J. GEN. INTERNAL MED. 149 (2000); Elisabeth Wilson et al., *Effects of Limited English Proficiency and Physician Language on Health Care Comprehension*, 20 J. GEN. INTERNAL MED. 800-06 (2005).

382. See Olveen Carasquillo et al., *Impact of Language Barriers on Patient Satisfaction in an Emergency Department*, 14 J. GEN. INTERNAL MED. 82-87 (1999); Alicia Fernandez et al., *Physician Language Ability and Cultural Competence: An Exploratory Study of Communication with Spanish-speaking Patients*, 19 J. GEN. INTERNAL MED. 167 (2004); Linda J. Lee et al., *Effect of Spanish Interpretation on Method of Patient Satisfaction in an Urban Walk-in Clinic*, 17 J. GEN. INTERNAL MED. 641 (2002); Leo S. Morales et al., *Are Latinos Less Satisfied with Communication by Health Care Providers?*, 14 J. GEN. INTERNAL MED. 409 (1999).

383. See David W. Baker et al., *Use and Effectiveness of Interpreters in an Emergency Department*, J. AM. MED. ASS'N, Mar. 13, 1996, at 783-88; Joshua Sarver & David W. Baker, *Effect of Language Barriers on Follow-up Appointments After an Emergency Department Visit*, 15 J. GEN. INTERNAL MED. 256 (2000); Lynne Sears Williams, *Study of New Mothers Looks at Language and Cultural Barriers Facing Immigrant Women*, CAN. MED. ASS'N J., May 15, 1996, at 1563-64.

384. See Louis C. Hampers et al., *Language Barriers and Resource Utilization in a Pediatric Emergency Clinic*, 103 PEDIATRICS 1253-56 (1999); Louis C. Hampers & Jennifer E. McNulty, *Professional Interpreters and Bilingual Physicians in a Pediatric Emergency Department: Effect on Resource Utilization*, 156 ARCH. OF PED. & ADOLESC. MED. 1108, 1108-13 (2002); Ava John-Baptiste et al., *The Effect of English Language Proficiency on Length of Stay and In-hospital Mortality*, 19 J. GEN. INTERNAL MED. 221 (2004).

385. See Glenn Flores et al., *Access Barriers to Health Care for Latino Children*, 152 ARCH. PED. & ADOLESC. MED. 1119 (1998); Linda C. Harlan et al., *Cervical Cancer Screening: Who is Not Screened and Why?*, 81 AM. J. PUB. HEALTH 885-90 (1991); Elizabeth A. Jacobs et al., *Impact of Interpreter Services on Delivery of Health Care to Limited-English Proficient Patients*, 16 J. GEN. INTERNAL MED. 468 (2001); Kathryn Pitkin Derosé & David W. Baker, *Limited English Proficiency and Latinos' Use of Physician Services*, 57 MED. CARE RES. & REV. 76 (2000); Julia M. Solis et al., *Acculturation, Access to Care, and Use of Preventative Services by Hispanics: Findings from HHANES 1982-84*, 80 AM. J. PUB. HEALTH SUPP. 11 (1990); Judith A. Stein & Sarah A. Fox, *Language Preference as Indicator of Mammography Use Among Hispanic Women*, 82 J. NAT'L CANCER INST. 1715, 1715-16 (1990); Richard C. Wasserman et al., *Preschool Vision Screening in Pediatric Practice: A Study From the Pediatric Research Office in Office Settings (PROS) Network*, 89 PEDIATRICS 834 (May 1992); Robin M. Weinick & Nancy A. Krauss, *Racial/Ethnic Differences in Children's Access to Care*,

Federal, state, and local laws mandate that health care providers make language assistance services available to LEP patients, but non-compliance is widespread.<sup>386</sup> In a recent government-sponsored study, nearly seventy-five percent of hospitals in New York City did not provide consistent and meaningful language access during health care delivery.<sup>387</sup> Additionally, a recent study by the New York Academy of Medicine revealed that two-thirds of New York City pharmacies do not translate drug labels for patients who do not speak English well.<sup>388</sup> These failures occurred even though eighty percent of pharmacies reported that they have the capacity to produce labels in languages other than English and eighty-eight percent stated that they served LEP patients on a daily basis.<sup>389</sup> Another study has documented a prevalent lack of compliance with language access laws at New York City's Medicaid offices.<sup>390</sup>

Given New York's historic status as an international gateway to America, and the decision of the framers of New York's Constitution to protect and promote the health of all "inhabitants" there is a strong argument that the failure to address language barriers to health care is a constructive denial of that care in violation of the public health provision of the New York Constitution.

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90 AM. J. PUB. HEALTH 1771 (2000); Steven Woloshin et al., *Is Language a Barrier to the Use of Preventative Services?*, 12 J. GEN. INTERNAL MED. 472 (1997).

386. See RACE REALITIES IN NEW YORK CITY, *supra* note 378 (citing *inter alia* Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-1 (2008); Dep't of Health & Human Servs., Regulations implementing Title VI, 45 C.F.R. § 80.1 (2008); Exec. Order No. 13,166, *supra* note 278 ("Improving Access to Services for Persons with Limited English Proficiency"); Dep't of Health & Human Servs., Guidance Regarding National Origin Discrimination Affecting Limited English Proficient Patients, 68 Fed. Reg. 47,311 (Aug. 8, 2003); N.Y. CITY HUMAN RIGHTS LAW, ch. 1, §§8-107; New York City Emergency Room Interpreter Law, N.Y.C. ADMIN. CODE § 17-174 (McKinney 2007)).

387. OFFICE OF POLICY MGMT., N.Y. CITY OFFICE OF THE COMPTROLLER, GETTING IN THE DOOR: LANGUAGE BARRIERS TO HEALTH SERVICES AT NEW YORK CITY'S HOSPITALS (2005).

388. RACE REALITIES IN NEW YORK CITY, *supra* note 378, at 100 (citing *Many New York Pharmacies Fail to Translate Prescription Labels for Patients Who Do Not Understand English*, N.Y. ACAD. OF MEDICINE, Apr. 27, 2007, <http://www.nyam.org/news/2878.html>).

389. *Id.*

390. *Id.*; see IMMIGRANT HEALTH CARE ACCESS COLLABORATIVE, N.Y. IMMIGRATION COAL., SEEN BUT NOT SERVED: THE NEED FOR MEANINGFUL ACCESS TO LANGUAGE SERVICES FOR LIMITED ENGLISH PROFICIENT MEDICAID BENEFICIARIES AT NEW YORK CITY MEDICAID OFFICES (2003).

## V. IMPLEMENTATION OF A RIGHT TO HEALTH CARE IN NEW YORK

As described in Part IV, New York State is failing to ensure universal, comprehensive, or equitable access to quality health care, to the detriment of all New Yorkers. Contrary to the constitutional mandate, the current health care system fails in multiple respects to protect the health of the State's inhabitants. There are, however, concrete steps that the state government can take to fulfill its constitutional obligations and implement the right to health care in New York.

In doing so, there is no question that the legislature and state agencies enjoy considerable discretion in choosing among and executing effective solutions. But the solutions chosen must be truly effective in ways that the State's current system is not. It must serve all of New York's diverse communities, including those who could not afford care under a purely market-based system. It must ensure comprehensive care that includes preventative, prenatal, and other necessary services. In addition, it must guarantee equitable care, in which health care services match actual health care needs, and identifiable racial, socioeconomic, geographic, and linguistic communities do not face lesser access or poorer quality care.

What follows are policy recommendations based on applied research and experience from around the country that promise to move the State toward compliance with its constitutional obligations.

To ensure basic access to care, New York State must move to a system of universal health coverage for all its residents. Such a system has been debated since the 1938 constitutional convention and the delegates to the convention amended the State Constitution to pave the way for the development of a comprehensive insurance system.<sup>391</sup> Affordable, universal health insurance coverage will greatly reduce financial barriers to effective and equitable distribution of health care resources, because it will equalize incentives for hospitals, health care systems, and private providers to serve a range of communities regardless of their wealth or poverty.

Health care institutions serving poor and minority communities are often financially vulnerable because they serve many uninsured patients or patients on Medicaid, which has lower reimbursement

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391. *See supra* Part II.

rates.<sup>392</sup> These “safety net” institutions are likely to fare better in a universal health insurance coverage system.<sup>393</sup>

Even reform efforts toward universal health coverage with the best of intentions may, however, inadequately and inequitably serve communities of color, immigrants, and low-income populations. Thus, New York must assess how policies such as individual mandates and affordability standards impact different communities and take steps to correct policies that may have a disproportionate negative impact. For example, universal health coverage could be implemented in a way that maintains “lower-tier” health plans that limit services, offer fewer covered benefits, have smaller provider networks, and disproportionately enroll people of color.<sup>394</sup> In its reform efforts, New York should require that its proposals improve access to the same health care products and services, regardless of coverage source.

In order to ensure that the public’s health needs play a central role in the State Department of Health’s decisions regarding hospital openings and closures, whether voluntary or involuntary, the Governor must work closely with the Department.<sup>395</sup> Before granting a hospital a Certificate of Need (“CON”)—the regulatory prerequisite for service changes—the Department should consider

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392. See KAISER COMM’N ON MEDICAID & THE UNINSURED, STRESSES TO THE SAFETY NET: THE PUBLIC HOSPITAL PERSPECTIVE, JUNE 2005, available at <http://www.kff.org/medicaid/7329.cfm>; J. Hadley et al., *Would Safety-Net Expansions Offset Reduced Access Resulting from Lost Insurance Coverage? Race/Ethnicity Differences*, 25 HEALTH AFF. 1679, 1679-87 (2006).

393. See UNEQUAL TREATMENT, *supra* note 4; see also D.P. Andrulis & L.M. Duchon, *Hospital Care in the 100 Largest Cities and Their Suburbs, 1996-2002: Implications for the Future of the Hospital Safety Net In Metropolitan America*, SUNY Downstate Medical Center, Aug. 2005, available at <http://www.rwjf.org/pr/product.jsp?id=14910> (last visited Mar. 29, 2008). Currently, state and local subsidies provide about thirty-nine percent of the cost of unreimbursed care that public hospitals provide, but state and local safety net financing varies considerably across jurisdictions; over fifteen percent of public hospitals receive no state or local support, and for an additional third of public hospitals, state and local subsidies represent less than ten percent of net revenues. KAISER COMM’N ON MEDICAID AND THE UNINSURED, *supra* note 392.

394. See generally UNEQUAL TREATMENT, *supra* note 4.

395. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 61 (explaining that voluntary hospital closures are governed by NYCCRR Title 10, Sections 401.3(g) and 401.3(h). Section 401.3(g) describes a notice requirement, while Section 401.3(h) provides for the specific exercises a hospital must go through in order to close. See NEW YORK COMP. CODES R. & REGS., tit 10, §§ 401.3(g), (h) (2006). In addition, the Commissioner has the power to revoke, limit, or annul a hospital’s operating certificate. See N.Y. PUB. HEALTH LAW § 2806 (Consol. 2006)).

whether the changes sought would reduce racial and economic health care inequality.<sup>396</sup>

Historically, the purpose of the CON process has been to control health care costs and eliminate duplication in capital and technology investments in the health care industry.<sup>397</sup> The CON process, however, has great potential to encourage a better distribution of health care resources that reflect community and statewide need.

The State should also institute a system of community-driven health planning, drawing on the lessons learned from health planning in the 1980s and 1990s.<sup>398</sup> Community health planning seeks to strengthen communities by actively involving residents in the planning, evaluation, and implementation of the health care and public health programs in their communities.<sup>399</sup> Without health

396. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 61 (citing DAVID BARTON SMITH, ELIMINATING DISPARITIES IN TREATMENT AND THE STRUGGLE TO END SEGREGATION 17 (2005) (noting that “[c]urrently, specialized services such as open-heart surgery are moving from the inner suburbs of most urban areas to the outer ones, following white flight and urban sprawl. Market and convenience justifications mask a resegregation of care that increases the cost of health care and reduces its quality”), available at [http://www.cmwf.org/usr\\_doc/775\\_Smith\\_ending\\_disparities\\_in\\_treatment.pdf](http://www.cmwf.org/usr_doc/775_Smith_ending_disparities_in_treatment.pdf)).

397. For additional analysis and history of the CON process, see generally *Joint Fed. Trade Comm’n & Dep’t of Justice Hearing on Health Care and Competition Law and Policy: Quality and Consumer Protection: Market Entry* (June 10, 2003) (PowerPoint presentation of Thomas R. Piper, Am. Health Planning Ass’n, “Certificate of Need: Protecting Consumer Interests”), <http://www.ftc.gov/ogc/healthcarehearings/docs/030610piper.pdf>; Salvatore J. Pacella et al., *Certificate-of-Need Regulations in Outpatient Surgery and Specialty Care: Implications for Plastic Surgeons*, 116 PLASTIC & RECONSTRUCTIVE SURGERY 1103, 1103-11 (2005); Michael Romano, *Pros and Cons of Certificates*, 33 MODERN HEALTHCARE 4, 4-6 (2003); Mark Gafney & Martin Zimmerman, *An Old-Fashioned Way to Control Costs*, 32 MODERN HEALTHCARE 32, 32-33 (2002).

398. As noted above, the laws creating the New York Health Systems Agency, a statewide network established to study and recommend improvements in the delivery of health care services in local communities, specifically the establishment and construction of hospitals and long-term home health care, are still on the books. DANGEROUS AND UNLAWFUL, *supra* note 8, at 59 (citing N.Y. PUBLIC HEALTH LAW § 2904-b (McKinney 2007)). This agency should be reinstated, fully funded, and given the authority to engage in concrete community-driven health care planning. See *id.* at 59 n.260-61 (citing Recommendations on the Health Planning, *supra* note 316).

399. For additional analysis, history, and examples of community health planning, see generally Eve R. Cagan et al., *Partnering with Communities to Improve Health: The New York City Turning Point Experience*, 78 J. URB. HEALTH 176, 176-80 (2001); D. Buchanan et al., *The Holyoke Community Health Planning Commission: A Model of Academic-Practice-Community Collaboration in Massachusetts*, 116 PUB. HEALTH REP. 499, 499-502 (2001); Herbert H. Hyman, *Reagan’s Impact on Health Planning*, 4 J. PLAN. LITERATURE 259, 259-69 (1989); Susan McClennan Reece, *Community Analysis for Health Planning: Strategies for Primary Care Practitioners*, NURSE PRACTITIONER, Oct. 1998, at 46-59; Shoshanna Sofaer, *Community Health Planning in the United States: A Postmortem*, FAMILY COMMUNITY HEALTH, 1-12, (1988); William J.

planning, market forces often dictate the distribution of resources, leaving low-income communities of color without adequate quality health care.<sup>400</sup>

The State should immediately embark on a Health Care Opportunity Impact Planning process that ensures that all communities have access to high-quality affordable care. An effective plan should include incentives, like increased Medicaid reimbursement rates, for health care providers to serve low-income communities. It should include new investments in preventive, primary, and, especially, maternal health care services, and it should allow for public participation, so that the diverse voices and perspectives of New Yorkers are included in the planning process. Research shows that the State could save hundreds of millions of dollars if it ensured adequate preventative, primary, and maternal health care for all New Yorkers.<sup>401</sup>

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Waters, *State Level Comprehensive Health Planning: A Retrospect*, 66 AM. J. PUB. HEALTH 139, 139-44 (1976); Oklahoma Rural Health Works, Community Engagement Process, <http://www.okruralhealthworks.org/chep77.asp> (last visited Mar. 29, 2008) [hereinafter Oklahoma Rural Health Works, Community Engagement Process]; Mobilizing for Action through Planning and Partnerships, <http://mapp.naccho.org/fulltextintroduction2.asp> (last visited Mar. 29, 2008) [hereinafter Mobilizing for Action].

400. See D. Buchanan et al., *supra* note 399, at 499-502; Waters, *supra* note 399, at 139-44; Oklahoma Rural Health Works, Community Engagement Process, *supra* note 399; Mobilizing for Action, *supra* note 399.

401. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 59 (citing ROSENBAUM, LAYING THE FOUNDATION, *supra* note 334, at 9-10); Ngozi Moses, Executive Director, Brooklyn Perinatal Network, Inc., Infant Death Statistics for Calendar Year 2004 from NYCDOHMH Vital Statistics (Nov. 17, 2006) (on file with authors); see also Citywide Coalition to End Infant Mortality, New York City Infant Mortality Fact Sheet for 2005 (on file with the authors); Helen Klein, *High Infant Mortality Rates Strike at the Heart of Brooklyn Babies; Barriers to Health Care Cited as Contributing Factor*, COURIER LIFE PUBLICATIONS, Nov. 2, 2006 (on file with authors) (citing interview with Ngozi Moses, Executive Director, Brooklyn Perinatal Network, where Ngozi Moses explained that inadequate prenatal care may cost taxpayers millions of dollars just for one child); Helen Klein, *Infant Mortality Plagues Central Brooklyn*, COURIER LIFE PUBLICATIONS, Nov. 6, 2006 (citing interview with Ngozi Moses, Executive Director, Brooklyn Perinatal Network, where Ngozi Moses explained that the average cost of medical and follow up care for a healthy normal weight baby is \$6000 and that if a mother does not receive proper care and gives birth to "a premature baby or a low birth-weight baby, or if the mother has risk factors, costs start at about \$90,000, [and f]or a very low birth-weight baby, that doubles to \$180,000"). New York City's Health and Hospitals Corporation (HHC), which runs the City's public hospitals, has seen the wisdom of this approach. It has assigned some 240,000 uninsured patients to personal primary care doctors, enabling them to obtain checkups and preventive care. As HHC President Alan Aviles told the *New York Times*: "For most preventative efforts there is an upfront expense," but "over the long term it saves money." Erik Eckholm, *Hospitals Try Free Basic Care for Uninsured*, N.Y. TIMES, Oct. 25, 2006, at A1.

Next, the State must take steps to implement and meet benchmarks that safeguard high quality care for all New Yorkers. The State should require health care providers to assess the needs of the patient populations served and provide culturally and linguistically competent services for an increasingly diverse population. The State should ensure that public and private health systems collect data and monitor disparities in health care access and quality on the basis of income, race, ethnicity, gender, primary language, and immigration status. Much of the data currently collected nationally still focuses primarily on the differences between blacks and whites.<sup>402</sup> Data collection should include all races and ethnic groups, as well as immigrant communities, with a special recognition of their unique cultural, language, and health concerns.<sup>403</sup> This is crucial to matching services to actual needs.

Indeed, such data collection and monitoring are required under federal civil rights laws. The bipartisan U.S. Commission on Civil Rights emphasized in its 2002 report that states must establish “quality assurance measures to ensure that minorities and women benefit equally from state recipients’ programs.”<sup>404</sup> The New York Department of Health is, in fact, already required to implement a Title VI compliance program, including data collection and record maintenance, to ensure that both DOH and the facilities to which DOH provides federal assistance meet the nondiscrimination requirements of Title VI of the Civil Rights Act of 1964.<sup>405</sup>

Health professionals should be trained in cross-cultural medicine to improve provider-patient communication and eliminate pervasive racial and ethnic disparities in medical care.<sup>406</sup> Research shows, moreover, that the State should also work to increase the

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402. Healthy People 2010 Midcourse Review, at 13, available at <http://www.healthypeople.gov/data/midcourse/pdf/ExecutiveSummary.pdf>.

403. See DANGEROUS AND UNLAWFUL, *supra* note 8, at 66; Letter to Tommy Thompson, Secretary, U.S. Dep’t of Health and Human Servs., from John Lumpkin, M.D., M.P.H., Chair, Nat’l Comm. on Vital and Health Statistics, Mar. 27, 2003, available at <http://www.ncvhs.hhs.gov/030327lt.htm>.

404. DANGEROUS AND UNLAWFUL, *supra* note 8, at 61 (citing U.S. COMM’N ON CIVIL RIGHTS, TEN-YEAR CHECK UP: HAVE FEDERAL AGENCIES RESPONDED TO CIVIL RIGHTS RECOMMENDATIONS?, v. I, ch. 2 (2002). <http://www.usccr.gov/pubs/10yr02/vol1/ch2.htm> (last visited Mar. 29, 2008)).

405. *Id.* (citing 28 C.F.R. § 42.410 (2006)). Although federal agencies do not regularly monitor them, state agencies are required to comply with the minimum standards established for federal agencies, including maintaining the records necessary for federal agencies to evaluate the compliance of a state agency and its subrecipients. U.S. COMM’N ON CIVIL RIGHTS, TEN-YEAR CHECK UP: HAVE FEDERAL AGENCIES RESPONDED TO CIVIL RIGHTS RECOMMENDATIONS, v. I, 20 (2002).

406. UNEQUAL TREATMENT, *supra* note 4, at 203.

racial and ethnic diversity of the health care workforce. Studies have documented that racial and ethnic minority health care providers are more likely to work in minority and medically underserved communities, and a diverse group of professionals is more likely to provide patients of color with satisfactory care.<sup>407</sup> Furthermore, increased diversity at the top levels of hospital administration can have a positive impact on the care provided, including more culturally and linguistically appropriate services.<sup>408</sup>

In addition, civil rights agencies must strengthen their enforcement efforts. The Office of the Attorney General should direct new resources toward challenging systemic inequities in the health care system. The Attorney General has broad authority under *parens patrie* standing to sue to protect the health of New York's residents.<sup>409</sup> The New York State Division of Human Rights should initiate its own investigations, file its own complaints, and conduct studies in order to promote human rights awareness and prevent and eliminate discrimination.<sup>410</sup> Similarly, the New York City Commission on Human Rights should investigate practices by hospital chains that appear to have a discriminatory effect on communities of color, and initiate its own complaints where unlawful

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407. DANGEROUS AND UNLAWFUL, *supra* note 8, at 60 (citing Lisa A. Cooper & Neil R. Powe, *Disparities in Patient Experiences, Health Care Processes, and Outcomes: The Role of Patient-Provider Racial, Ethnic, and Language Concordance*, THE COMMONWEALTH FUND, July 2004, [http://www.cmwf.org/usr\\_doc/Cooper\\_disparities\\_in\\_patient\\_experiences\\_753.pdf](http://www.cmwf.org/usr_doc/Cooper_disparities_in_patient_experiences_753.pdf)).

408. DANGEROUS AND UNLAWFUL, *supra* note 8, at 60 (citing Annette Fuentes, *Condition Critical: The Absence of Latinos Among Policymakers in New York City's Voluntary Hospitals*, P.R. LEGAL DEF. AND EDUC. FUND, Dec. 2004, at 3, 8-9). Greater diversity can be stimulated through scholarships that reduce or eliminate financial barriers to attaining a health professions degree, training agreements that place new professionals in underserved communities for a defined period, and improved math and science education to prepare school children for health professions careers. *Id.* The State must also take steps to improve diversity in hospital leadership. *Id.*

409. DANGEROUS AND UNLAWFUL, *supra* note 8, at 61 (citing Dennis D. Parker, *State Reform Strategies*, in *AWAKENING FROM THE DREAM* 317, 322 (Denise Morgan et al., eds. 2006)).

410. The Division is empowered to develop human rights plans and policies for the state and to assist in their execution. *Id.* at 62. The Division may convene, advisory councils, local, regional or state-wide . . . to study the problems of discrimination in all or specific fields of human relationships or . . . specific instances of discrimination because of age, race, creed, color, national origin, sexual orientation, military status, sex, disability, or marital status and [to] make recommendations to the division for the development of policies and procedures.

*Id.* (citing N.Y. EXEC. LAW § 295(8), (6)(b), (9) (Consol. 2006)).



discriminatory practices appear to be occurring.<sup>411</sup> The City Commission can also use its power to require that health care providers keep records documenting access to and quality of health care broken down by patients' race, ethnicity, immigration status, income, gender, and primary language.<sup>412</sup> Through effective collection of data on health care access and quality levels segmented by demographics, the City Commission can better target systemic practices that have a disparate impact on the enjoyment of equal health care services by racial and ethnic populations of New York City.

New York can also look to other states for models for combating discriminatory effects. For example, California's anti-discrimination statute outlaws policies and practices in health care having a discriminatory purpose or effect and explicitly provides that the law "may be enforced by a civil action for equitable relief, which shall be independent of any other rights and remedies," such as an administrative complaint proceeding.<sup>413</sup> In New York, creating a right to civil action by victims of discrimination in health care would provide efficient remedies while allowing the State Division of Human Rights to initiate actions to eliminate health care discrimination.<sup>414</sup>

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411. *Id.* at 64 (citing N.Y.C. ADMIN. CODE §§ 8-109(a), (c) (2006)). The Commission can order "such affirmative action as, in the judgment of the [C]ommission, will effectuate the purpose of this chapter including, but not limited to . . . extension of full, equal and unsegregated accommodations, advantages, facilities and privileges." N.Y.C. ADMIN. CODE §§ 8-120(a)(5) (2006). The Commission can also order "[p]ayment of compensatory damages to the person aggrieved by such practice" and "[s]ubmission of reports with respect to the manner of compliance." N.Y.C. ADMIN. CODE §§ 8-120(a)(8), (9). The New York City Human Rights Law (NYCHRL) prohibits hospitals, clinics, and private health care providers from instituting policies that have the effect of providing inferior access or service based on gender, marital status, partnership status, or sexual orientation. N.Y.C. ADMIN. CODE §§ 8-107(4), (17)(a)(1), 8-102(9) (2006).

412. N.Y.C. ADMIN. CODE § 8-105(6) (2006) ("[The powers and duties of the City Commission shall be] . . . to require any person or persons who are the subject of an investigation by the commission to preserve such records . . . and to continue to make and keep the type of records that have been made and kept by such person or persons in the ordinary course of business . . . which records are relevant to the determination whether such person or persons have committed unlawful discriminatory practices . . .").

413. CAL. GOV'T CODE § 11139 (West 2005) (prohibiting discrimination on the basis of race, national origin, ethnicity, color, religion, age, sex, or disability in any program or activity that is conducted, operated, administered, funded, or receives any financial assistance from the state).

414. In addition, "[t]he federal government must considerably step up civil rights enforcement in the health care sphere. The Department of Justice can initiate litigation on behalf of an agency, like the U.S. Department of Health and Human Services

## VI. CONCLUSION

It is time to make the 1938 constitutional convention's expansive and inspiring vision of a right to health care a reality in New York State. Just as the New York Constitution is a leader among the states in its protection of economic rights and social security, New York's government can and should set a promising example for the nation by covering all of the State's inhabitants and ensuring full and equitable access to quality, comprehensive care for all. The New York Constitution's text and history, relevant international and federal laws, public health and epidemiological research each help to shape the dimensions of the right to health care, as well as the most promising methods of implementing it. Ultimately, however, it is the New York Legislature that must craft new, more effective laws and the executive branch that must carry them out. If they continue to fall short of that responsibility, the courts will, inevitably, be called upon to force a solution.

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(HHS), for a violation of Title VI. . . ." DANGEROUS AND UNLAWFUL, *supra* note 8, at 8 (citing Timothy Stoltzfus Jost, *Disentangling Fact From Fiction: The Realities of Unequal Health Care Treatment: Article: Racial and Ethnic Disparities in Medicare: What the Department of Health and Human Services and the Centers for Medicare and Medicaid Services Can, and Should, Do*, 9 DEPAUL J. HEALTH CARE L. 667 (2006); 45 C.F.R. § 80.8 (1) (2006)).

