International Human Rights as a Vehicle for Achieving Rural Health

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I. INTRODUCTION

International human rights are under strain. One of the stressors is cynicism about the ability of human rights to make a difference. The gap between
rights on paper and rights in practice can be so vast as to undermine confidence in human rights as a vehicle for achieving human dignity. Perhaps nowhere is this more true than when it comes to the human right to health. More than half a century ago, the United Nations General Assembly recognized a right to health in the Universal Declaration of Human Rights (UDHR).\textsuperscript{1} Roughly two decades later, that right was codified in the International Covenant on Economic, Social, and Cultural Rights (ICESCR),\textsuperscript{2} one of two covenants that, along with the Universal Declaration, form the International Bill of Rights.

Twenty years into the 21st Century, the right to health is far from a reality. For example, in 2020, 149.2 million children around the world under five years old were stunted, 45.4 million were wasted, and ironically, 38.9 million were overweight.\textsuperscript{3} Deaths from preventable causes associated with childbirth and pregnancy averaged 810 women per day in 2017.\textsuperscript{4} The gap between right and reality is particularly wide in rural areas. This is true in developed and developing countries alike.\textsuperscript{5} West Virginia provides a prime example. In 2017, West Virginia ranked first in the United States for deaths by diabetes and by accidents.\textsuperscript{6} And while infant mortality nationwide was 5.8 per 1,000 live births in 2017, in West Virginia that rate was 7.0.\textsuperscript{7} Worldwide it was 2.9%.\textsuperscript{8} The impact of these statistics is highly personal. Consider the


\textsuperscript{5} See, e.g., Roger Strasser, Rural Health Around the World: Challenges and Solutions, 20 FAM. PRACT. 457, 459 (2003) ("Despite the substantial differences between developing and developed countries, the key themes in rural health are the same around the world. Access is the major rural health issue.").


\textsuperscript{7} Id.

situation of Melissa Kennedy, a resident of Williamson, West Virginia, who suffers from type 2 diabetes, arthritis, and hypertension. In 2020, her local hospital, the Williamson Memorial Hospital, closed its doors. The closure left her community, which sits in the second-least healthy county in West Virginia, without an emergency room, without specialty care, and finally, without hospital services. With no hospital and no treatment plan, Kennedy “made preparations to die,” believing she could not go on. Fortunately, Kennedy has been able to work with the Williamson Health and Wellness Center, which is now the primary healthcare provider for her community, to address her diabetes. But Kennedy and others in the community must travel 35 minutes to reach the nearest in-state hospital. Kennedy’s story is not unique. The right to health is far from realization in rural West Virginia.

One answer to the gap between right and reality might be increased judicial enforcement of the international right to health. After all, one of the first tools to which the law turns to achieve its objectives is litigation. There are well recognized difficulties with judicial enforcement of economic, social, and cultural rights such as the right to health. Moreover, judicial enforcement may be uniquely challenging in rural settings. As a result, while judicial enforcement has clear benefits, it is unlikely to provide a comprehensive solution to the challenges of rural health.

This should not lead us to give up on the international human right to health as a means of achieving rural health, however. As developed, the human right to health includes four key elements: availability, accessibility, acceptability, and quality, or AAAQ. This AAAQ framework provides a valuable lens for crafting comprehensive health policy in order to achieve the right to health, particularly in rural areas where availability, accessibility, acceptability, and quality are often sorely lacking.

To drive home this point, Part I of this paper introduces the right to health in international law, including the AAAQ framework. Part II discusses why judicial enforcement of the right to health is an incomplete avenue for achieving the right to health, especially in rural areas. Using West Virginia as a case study,
Part III illustrates how the right to health’s AAAQ framework can help identify barriers, and guide the creation of policies and programs, to achieve rural health.

II. THE INTERNATIONAL HUMAN RIGHT TO HEALTH

As briefly noted, the right to health is recognized in the UDHR, the foundational document of the modern human rights system. Article 25 of the UDHR proclaims 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.”16 While, as a General Assembly resolution, the UDHR was not immediately binding, the right to health was enshrined as a treaty obligation in the ICESCR, which was adopted by the United Nations General Assembly in 1966.17 Today, 171 states are parties to the ICESCR.18 The right to health is addressed in article 12 of the ICESCR, which states that “[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”19

Several additional international treaties,20 regional agreements,21 and international instruments22 likewise address the right to health. The Convention on the Rights of the Child, for example, obligates states parties to “recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.”23

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16 UDHR, supra note 1, art. 25(1).
19 ICESCR, supra note 2, art. 12(1).
23 CRC, supra note 20, art. 24(1).
Moreover, the right to health has been recognized in many state constitutions. Indeed, a right to overall health is guaranteed in roughly 36% of constitutions worldwide, while free medical care is protected in roughly 9%. As but one example, Bolivia's robust protections of the right to health include recognition that guaranteed access of everyone to health is an essential purpose of the state. While many sources might be cited in support of the international human right to health, the core source remains article 12 of the ICESCR. Article 12 recognizes a lofty right—"the enjoyment of the highest attainable standard of physical and mental health." Yet, beyond obligating states to take steps to achieve certain non-exhaustive ends, such as "the reduction of the stillbirth-rate and of infant mortality," Article 12 provides minimal detail on the content of this right.

Fortunately, the Committee on Economic, Social, and Cultural Rights (CESCR), which oversees states parties' compliance with the ICESCR, has worked to fill the gap. Through its General Comment 14, adopted in 2000, CESCR has elaborated on the right to health under Article 12. Notably, General Comment 14 explains that "the highest attainable standard of physical and mental health" is not confined to the right to health care. Rather, it encompasses many conditions which contribute to a healthy life, "such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment." That said, General Comment 14 explains that the right to health is not the right to be healthy, but "a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health." Most significantly for present purposes, General Comment 14 breaks the right to health down into four interconnected elements: availability, accessibility, acceptability, and quality, or AAAQ.

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25 CONSTITUCIÓN POLÍTICA DEL ESTADO [C.P.], art. 9.
26 See CESCR, General Comment No. 14, supra note 15, ¶ 2.
27 ICESCR, supra note 2, art. 12(1).
28 Id. art. 12(2)(a).
29 The CESCR was created by the United Nations Economic and Social Council (ECOSOC) to assist it in fulfilling its Covenant responsibilities. See Economic and Social Council Res. 1985/17 (May 28, 1985).
30 CESCR, General Comment No. 14, supra note 15, ¶ 4.
31 Id.
32 Id. ¶ 9.
33 Id. ¶ 12.
A. Availability

Availability demands a sufficient quantity of health facilities, services, goods, and programs. What this looks like in any particular state will turn on its developmental status and other factors, but certain fundamentals must be available, including “the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.”

B. Accessibility

The same facilities, services, goods, and programs that must be available must also be accessible. Accessibility imposes four conditions: non-discrimination; physical accessibility; economic accessibility, or affordability; and information accessibility. Lack of accessibility is one of the greatest hurdles to realizing the right to health, particularly in rural communities. Approximately 40% of the world’s population lives in rural communities, a figure which increases significantly in developing countries, such as Afghanistan and the Philippines, so that accessibility is a particular barrier to the enjoyment of the right to health for many in the world.

1. Non-discrimination

Accessibility first requires equality. The ICESCR prohibits “discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.” In both law and fact, “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population . . . without discrimination.” Even indirect discrimination, which can occur through allocation of healthcare resources to benefit a privileged few rather than the

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34 Id. ¶ 12(a).
35 Id.
36 Id. ¶ 12(b) & n.6.
37 Id. ¶ 12(b).
39 Id. (74%).
40 Id. (53%).
41 ICESCR, supra note 2, art. 2(2).
42 CESC, General Comment No. 14, supra note 15, ¶ 12(b)(i).
larger population, is prohibited.\textsuperscript{43} Thus, in a South African case involving the distribution of the lifesaving drug, Nevirapine, to reduce HIV transmission between mother and child, the Constitutional Court found that the government program was unreasonable because the drug was made available to an unnecessarily small segment of the population.\textsuperscript{44}

The prohibition on discrimination has particular application in rural areas. In a General Comment focused on non-discrimination, CESCR emphasized that “[t]he exercise of Covenant rights should not be conditional on, or determined by, a person’s current or former place of residence; e.g. whether an individual lives or is registered in an urban or a rural area.”\textsuperscript{45} “Disparities between localities and regions should be eliminated in practice by ensuring, for example, that there is even distribution in the availability and quality of primary, secondary and palliative health-care facilities.”\textsuperscript{46} CESCR has followed through on this principle in its oversight of state parties to the ICESCR. In reviewing Azerbaijan’s report on its compliance with the ICESCR, for example, the Committee noted its concern over “inequalities in the enjoyment of the right to health in rural and urban areas” and called for remedial action.\textsuperscript{47}

2. Physical Accessibility

Physical accessibility, a second aspect of general accessibility, is also of special significance for rural populations. As General Comment 14 explains, physical accessibility requires that facilities, services, goods, and the “underlying determinants of health, such as safe and potable water” “be within safe physical reach for all sections of the population,” “including in rural areas.”\textsuperscript{48}

\textsuperscript{43} See Committee on Economic, Social and Cultural Rights, General Comment No. 20: Non-discrimination in Economic, Social and Cultural Rights, U.N. Doc. E/C.12/GC/20, ¶¶ 15, 24 (2009) [hereinafter CESCR, General Comment No. 20] (“Article 2, paragraph 2, lists the prohibited grounds of discrimination as ‘race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.’ The Committee states that ‘other status’ encompasses social origin, which includes economic status.”).

\textsuperscript{44} Minister of Health v. Treatment Action Campaign 2002 (5) SA 721 (CC) ¶¶ 4, 45, 80, 92, 135 (S. Afr.).

\textsuperscript{45} CESCR, General Comment No. 20, supra note 43, ¶ 34.

\textsuperscript{46} Id.


\textsuperscript{48} CESCR, General Comment No. 14, supra note 15, ¶ 12(b). Physical accessibility also “includes adequate access to buildings for persons with disabilities,” which may be a particular challenge in rural areas. Id.
international documents have likewise emphasized the importance of geographic reach.49

One of the greatest challenges for accessibility in rural areas is the distribution of health facilities and providers. As CESCR stated in concluding observations to Algeria, “people living in rural areas face considerable difficulties in accessing health care, owing to an unequal geographic distribution of care facilities and medical practitioners.”50 The World Health Organization (WHO) similarly explained accessibility as the “equitable distribution” of health care workers, considering the needs and demographic composition of rural and urban areas.51

The issue of accessibility is not one of mere convenience. Studies have shown that greater distance from health care services, goods, and facilities inhibits the use of primary and secondary care, which is associated with “a range of poor health outcomes, from higher than expected numbers of deaths from asthma to lower than expected five year survival from cancer.”52

Moreover, the problem of accessibility extends beyond bricks and mortar. Inaccessibility may result from lack of transportation, poor public transportation, or insufficient funds. Thus, CESCR praised Afghanistan for establishing “mobile health teams aimed at providing health services in the rural areas” and urged the state to “increas[e] the number of mobile health teams to reach a larger proportion of the population.”53

3. Economic Accessibility

A third essential element of accessibility is affordability. As with other elements of the right to health, affordability is particularly critical in the rural context given linkages between poverty and illness on the one hand and ruralness

49 Article 25 of the U.N. Convention on the Rights of Persons with Disabilities, for example, states that healthcare services for disabled individuals must be provided as close as possible to the disabled person’s community, including in rural areas. CRPD, supra note 20, art. 25(c).


on the other.\textsuperscript{54} "About 79\% of the world’s poor live in rural areas. The poverty rate in rural areas is . . . more than three times higher than in urban areas."\textsuperscript{55} Moreover, the world’s poorest populations may have some of the greatest health needs. For example, malaria, HIV/AIDS, and tuberculosis—some of the most fatal communicable diseases in the world—are disproportionately present in the poorest populations around the globe.\textsuperscript{56}

General Comment 14 demands that "health facilities, goods and services must be affordable for all," including "services related to the underlying determinants of health."\textsuperscript{57} The Comment goes one step further to assert that "poorer households should not be disproportionately burdened with health expenses as compared to richer households."\textsuperscript{58} The principle of affordability is also protected by the requirement of non-discrimination discussed above. General Comment 20 indicates that discrimination based on income, or lack thereof, is prohibited.\textsuperscript{59}

Some states seek to ensure affordability by guaranteeing free healthcare as a constitutional matter. Access to free healthcare has been enshrined in approximately 9\% of constitutions around the world.\textsuperscript{60} For example, the Constitution of Uruguay guarantees that the state will provide free medical and preventative treatment for those unable to pay.\textsuperscript{61} On the other hand, CESCR has been troubled when states' practices do not secure affordability. In Concluding Observations to Bangladesh, the Committee expressed concern regarding "[t]he limited access to affordable health-care services by disadvantaged and marginalized individuals and groups, including residents of informal settlements, Dalits and ethnic minorities" and "recommend[ed] that the State party intensify its efforts to . . . [i]mprove the availability, affordability and quality of health-care services for all people in the State party, particularly at the primary health-care level."\textsuperscript{62} To Australia, the Committee emphasized that adequate drinking

\textsuperscript{54} Michele Statz & Paula Termuhlen, \textit{Rural Legal Deserts Are a Critical Health Determinant}, 110 \textit{Am. J. Pub. Health} 1519, 1520 (2020) (observing that "[r]ural US poverty rates have exceeded urban poverty rates every year since 1959, and persistently high-poverty counties are overwhelmingly rural").


\textsuperscript{57} CESCR, General Comment No. 14, \textit{supra} note 15, ¶ 12(b).

\textsuperscript{58} \textit{Id}.

\textsuperscript{59} CESCR, General Comment No. 20, \textit{supra} note 43, ¶ 25.

\textsuperscript{60} Heymann et al., \textit{supra} note 24, at 639, 646–47.

\textsuperscript{61} CONSTITUCIÓN DE LA REPÚBLICA ORIENTAL DEL URUGUAY [C.P.], art. 44.

water, an underlying determinant of health, must be affordable – particularly for indigenous populations,\(^{63}\) which make up 32% of Australia’s rural population.\(^{64}\)

4. Information Accessibility

The final component of general accessibility is information accessibility. Information accessibility includes “the right to seek, receive and impart information and ideas concerning health issues.”\(^{65}\) Former U.N. Special Rapporteur on the Right to the Highest Attainable Standard of Health, Paul Hunt, explained that information accessibility is critical because it is the method by which “individuals and communities [may] promote their own health,” whether alone or in receiving healthcare.\(^{66}\) Information accessibility has also found a place within state constitutions. The South African Constitution includes a provision that declares that everyone has the right to access “information that is held by another person and which is required for the exercise or protection of any rights.”\(^{67}\) Again, however, access to health information is likely to be more limited in rural than urban areas, whether due to a paucity of health and education facilities and personnel or limited access to technology.

C. Acceptability

The third component of the right to health is acceptability. Acceptability focuses not on the medical standard of care, but on its cultural and ethical appropriateness.\(^{68}\) “All health facilities, goods and services must be . . . respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements,” respectful of confidentiality,


\(^{65}\) CESCR, General Comment No. 14, supra note 15, ¶ 12(b) (footnote omitted).


\(^{67}\) Ebi Achigbe Okeng Ebi, Enforcing the Right of Access to Healthcare Services in South Africa 68 (June 2016) (Masters of Laws dissertation, University of South Africa), https://uir.unisa.ac.za/bitstream/handle/10500/23257/dissertation_ebi_eao.pdf?isAllowed=y&sequence=1#:~:text=The%20right%20to%20have%20access%20to%20healthcare%20services%20is,rights%20protected%20by%20his%20Constitution (citing Section 32 of the South African Constitution).

\(^{68}\) CESCR, General Comment No. 14, supra note 15, ¶ 12(c).
and designed to improve health status.69 CESC found that Afghanistan violated this requirement by failing to “respond adequately to the needs of women,” leading to “detrimental impacts on . . . women’s health.”70 Among other things, CESC recommended that Afghanistan remedy the problem by “train[ing] and recruit[ing] female medical staff, in particular midwives, nurses, obstetricians and gynaecologists, especially in rural areas.”71

D. Quality

The quality component of the right to health picks up where appropriateness left off by focusing on the medical quality of care. The right to health insists that “health facilities, goods and services . . . be scientifically and medically appropriate and of good quality,” which “requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”72 Some, such as the Medical Human Rights Network, interpret this requirement to mean that health facilities should not merely be of good quality, but rather “of the highest quality.”73 In numerous concluding observations, CESC has expressed concern about the quality of healthcare available in states parties. In a Concluding Observation to Bolivia, for example, CESC recommended that the state “adopt a global health policy” to “ensure that the poorest sectors of the population have access to free, high-quality and universal primary health care, including dental care.”74 CESC similarly urged Mexico to “[r]edouble its efforts to ensure that the entire population, especially persons on low incomes, has access to appropriate, affordable and high-quality healthcare services.”75

Availability, accessibility, acceptability, and quality—or AAAQ—are four essential elements of the international right to health. While the above discussion has treated each independently, they clearly overlap.76 Indeed, the WHO elaborated on the interrelatedness of AAAQ, writing, “Without sufficient availability – accessibility to health workers cannot be guaranteed; if they are

69 Id.
70 CESC, Considerations of Reports Submitted by States: Afghanistan, supra note 53, ¶ 40.
71 Id.
72 CESC, General Comment No. 14, supra note 15, ¶ 12(d).
76 CESC, Considerations of Reports Submitted by States: Afghanistan, supra note 53, ¶ 12.
available and accessible, without acceptability, the health services might not be used; when the quality of the health workforce is inadequate, improvements in health outcomes will not be satisfactory.\textsuperscript{77}

III. LIMITATIONS OF JUDICIAL ENFORCEMENT

The AAAQ framework helps to highlight the expansiveness of the human right to health. The flip side of expansiveness, however, can be failure to secure the right in all its dimensions in practice, particularly in rural areas. One of the law’s most common remedies for narrowing the gap between rights in principle and practice is judicial enforcement.

Two judicial systems have been particularly active in seeking judicial enforcement of the right to health: those of India and South Africa. The United States judiciary, by contrast, has not been, as the United States is not a party to the ICESCR\textsuperscript{78} and does not recognize a general constitutional right to health.\textsuperscript{79} The experiences of India and South Africa illustrate how litigation may help to achieve AAAQ. Consider examples from each state.

In \textit{Minister of Health and Others v. Treatment Action Campaign and Others}, the Constitutional Court of South Africa addressed a state-operated program to provide a lifesaving drug, Nevirapine, to HIV-positive pregnant women.\textsuperscript{80} The Court found that, as a result of government restrictions, the program only covered “approximately 10% of all births in the public sector,” leaving the vast majority of women in South Africa unable to access the treatment.\textsuperscript{81} The Court found this unreasonable under South Africa’s Constitution and ordered South Africa to expand the program, thus ensuring greater accessibility.\textsuperscript{82} The Court also instructed that the drug be provided to HIV-positive expectant mothers after the women had been appropriately counseled about the drug, respecting the requirement of information accessibility.\textsuperscript{83}

In \textit{Rakesh Chandra Narayan v. State of Bihar}, the Supreme Court of India addressed reports that a state-run mental hospital in Bihar lacked light,
adequate food, water, and medicine, and even running toilets. Emphasizing both availability and quality, the Court responded: "[I]t is the obligation of the State to provide medical attention to every citizen. . . . The State has to realize its obligation and the Government of the day has got to perform its duties by running the hospital in a perfect standard and serving the patients in an appropriate way." Even lack of funding could not excuse the state of Bihar from fulfilling its obligations. In *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor.*, the Supreme Court of India likewise emphasized that financial constraints cannot excuse the state's "constitutional obligation . . . to provide medical aid to preserve human life."

As these cases illustrate, courts can play a role in the achievement of AAAQ. Courts provide a forum where individuals may vindicate their rights against powerful entities like the state. Many have argued in favor of the judicial enforceability and enforcement of economic, social, and cultural rights. Yet their arguments arise in part from justifiable concerns about what courts can do to achieve these rights. Some of these concerns are applicable to economic, social, and cultural rights generally. Such rights often require significant policy and resource decisions, which judges are not necessarily trained to make. When it comes to the right to health, for example, judges will generally lack both medical and public health expertise, not to mention expertise in public administrative matters such as budgeting. Moreover, at least in some countries, judges cannot simply take up broad issues such as health care or housing; they decide particular cases that parties choose to litigate. In addressing the specific

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85 Id. at 318.
86 See id.
89 INTERNATIONAL COMMISSION OF JURISTS, supra note 88, at 90.
90 See id. at 83-84, 90.
91 See id. at 90. Article III of the U.S. Constitution, for example, limits federal courts to deciding cases or controversies. See U.S. CONST. art. III, § 2, cl. 1.
injuries alleged in the cases they hear, courts do not have a comprehensive view of competing interests that call for public resources.\textsuperscript{92} In a case regarding health rights, for example, the court will not know the demands on the public fisc from other rights, or from other priorities such as national defense or diplomacy. Even as to the issue presented in a case, the court may be limited by the rules of discovery, the rules of evidence, and the strategic decisions of the parties in the information it receives.\textsuperscript{93} As a matter of structure, then, courts are imperfectly positioned to ensure the achievement of economic, social, and cultural rights.

Judicial enforcement of economic, social, and cultural rights also raises governance concerns. As the ICESCR recognizes, public resources are finite.\textsuperscript{94} The ICESCR obligates states “to take steps . . . to the maximum of [their] available resources.”\textsuperscript{95} There are strong arguments to be made that democratic processes should be used to decide how to allocate scarce resources, arguments that would have force even if all public resources were dedicated to achieving individual rights.\textsuperscript{96} Democratic processes may also be more appropriate for giving content to vaguely worded economic, social, and cultural rights and for formulating remedies for violations, even if judges could also handle these tasks.\textsuperscript{97} In addition to securing the right of participation in governance, democratic processes are more transparent than judicial decisions. Legislatures generally hold public sessions, keep legislative records, and note votes, whereas judicial deliberation usually occurs in private, deliberately insulated from public influence.

In addition to these general concerns about judicial enforcement of economic, social, and cultural rights, relying on judicial enforcement may be particularly problematic in seeking to achieve rights in rural areas. As noted, poverty and ruralness often go hand in hand.\textsuperscript{98} Both present barriers in accessing the judicial system. Even in the criminal justice system where there is a right to representation, aid is limited.\textsuperscript{99} The problem is worse in the civil system where

\begin{itemize}
\item \textsuperscript{92} \textit{INTERNATIONAL COMMISSION OF JURISTS}, \textit{supra} note 88, at 90.
\item \textsuperscript{93} \textit{Id.} at 92.
\item \textsuperscript{94} \textit{See} ICESCR, \textit{supra} note 2, art. 2(1).
\item \textsuperscript{95} \textit{Id.}
\item \textsuperscript{96} \textit{INTERNATIONAL COMMISSION OF JURISTS}, \textit{supra} note 88, at 73, 83.
\item \textsuperscript{97} \textit{Id.} at 81.
\item \textsuperscript{98} As likewise noted above, rural inhabitants may also have poorer health, which itself can be a barrier to accessing justice. \textit{See} Statz & Termuhlen, \textit{supra} note 54, at 1520.
\item \textsuperscript{99} \textit{See, e.g.}, LEGAL SERVICES CORPORATION, \textit{THE JUSTICE GAP: MEASURING THE UNMET CIVIL LEGAL NEEDS OF LOW-INCOME AMERICANS} 9 (2017) [hereinafter \textit{THE JUSTICE GAP}] (noting the right to criminal representation); Statz & Termuhlen, \textit{supra} note 54, at 1519 (noting that “rural criminal defendants in Wisconsin have to wait as many as two months before receiving a public defender”).
\end{itemize}
there generally is no such right. As a result, it is easier for wealthy individuals to pursue civil litigation to enforce their rights. Reliance on judicial enforcement might mean that courts are employed more frequently to direct public resources to fulfill the rights of wealthier individuals rather than of those with the greatest need.

Relatedly, civil justice is less accessible in rural areas regardless of personal wealth. The challenges in accessing the judicial system in rural areas parallel those of accessing healthcare. As one study summarized, “across the United States, geographic distance, declining and aging populations, outdated technology with slow or nonexistent Internet connectivity, and problems attracting and retaining judicial officers, court staff, and legal professionals all present significant challenges that threaten the ability of Americans living in rural communities to access the justice system.” When it comes to legal professionals, for example, the same study noted “that only 85 of the 357 towns in North Dakota have an attorney, while six rural counties in South Dakota and 12 in Nebraska have no attorneys at all.” The problem is only likely to increase as existing attorneys retire. In rural Inyo and Mono counties in California, for example, excluding government attorneys... there are approximately 22 attorneys currently in private practice,” of whom “only a handful are under the age of 62.” As a separate study has shown, “the absence of rural attorneys has significant impacts on public health,” in part because “the most common type of legal issue low-income rural residents report is access to health care.” Interestingly, the paucity of health resources also reduces the effectiveness of the judiciary in achieving the right to health as it may leave the judiciary unable to

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100 The Justice Gap, supra note 99, at 9, 14 (concluding that “[e]ighty-six percent of the civil legal problems faced by low-income Americans in a given year receive inadequate or no legal help”).

101 This may result not only because wealthier individuals have greater access to justice, but because courts choose remedies that benefit the particular plaintiff and those similarly situated. See Landau, supra note 88, at 191–92, 199–201.

102 See Statz & Termuhlen, supra note 54, at 1520 (“Simply put, the same sociospatial aspects that affect rural community members’ access to health care—vast distances, professional shortages, insufficient or nonexistent public transit, a lack of reliable communication tools—also limit their access to justice.”).

103 Conference of State Court Administrators, Courts Need to Enhance Access to Justice in Rural America 1 (2018), https://cosca.ncsc.org/_data/assets/pdf_file/0026/23399/policy-paper-1-28-2019.pdf [hereinafter JUSTICE IN RURAL AMERICA]. Geographic distance may exist not only to courts themselves but to organizations that offer legal aid, law school clinics, and large firms willing to provide pro bono assistance. Statz & Termuhlen, supra note 54, at 1520.

104 JUSTICE IN RURAL AMERICA, supra note 103, at 3.

105 Id.; Statz & Termuhlen, supra note 54, at 1519.

106 JUSTICE IN RURAL AMERICA, supra note 103, at 3.

107 Statz & Termuhlen, supra note 54, at 1519 (citing The Justice Gap, supra note 99, at 48).
rely on inputs from, or referrals to, health resources. Given these dynamics, it is improbable that judicial enforcement alone could secure rural health.

IV. THE VALUE OF THE HUMAN RIGHTS LENS

Even if courts are an imperfect avenue for achieving AAAQ, the AAAQ framework remains valuable in efforts to achieve the right to health, including in rural areas. To illustrate, this Part applies the AAAQ lens to health challenges in rural West Virginia. The goal is not to provide a comprehensive blueprint for achieving rural health in the state or to suggest that achieving rural health will be easy. Instead, the goal is to explore certain possibilities for advancing rural health that are suggested by the AAAQ framework, demonstrating the framework’s utility. Thus, this part addresses a range of health issues and potential solutions, from mental health and obesity to telemedicine and quality measurement.

A. Availability

Availability is such a persistent concern when it comes to rural health that the AAAQ framework is not essential to identify it. Yet the focus on availability can help identify the range of health areas where lack of availability is an issue, such as mental health. While urban areas average 134 subspecialists across various medical fields per 100,000 patients, rural areas average only 40 subspecialists per 100,000 patients. Mental illness is widespread in these rural communities, yet fewer mental health providers are available for these populations. As might be expected, the effects can be devastating. One study in Australia demonstrated that people in rural areas with mental illness are three times more likely than the total population to die prematurely from physical health conditions.

West Virginia is no exception when it comes to mental health needs, lack of available care, and resulting consequences. In 2021, almost 19% of adults in

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108 See id. at 1520–21.

109 The United States is not a party to the ICESCR. See supra note 79 and accompanying text. Yet, whether or not a state is bound by international law to respect the right to health, the AAAQ framework can assist a state in achieving health as a matter of policy.

110 As but one example, the section does not address access to justice issues, notwithstanding the recognition in the prior part that access to justice is intertwined with the achievement of health. See supra Part III.


West Virginia reported experiencing poor mental health at least 14 days each month, while about 25% of Medicare beneficiaries experienced depression. When comparing U.S. rates of depression by county, the five counties with the worst scores all appear in West Virginia. Several factors contribute to the state's poor mental health, including the high poverty rate, widespread substance abuse, and a deep-seated independence that stigmatizes resort to psychological help.

Notwithstanding the need, mental healthcare is not sufficiently available in West Virginia, exacerbating the problem. West Virginia ranks third worst in the nation for number of mental health providers. With so few providers available, adults and children routinely wait months to access one. West Virginia has seen an "increase in child and adolescent suicide attempts, and even for these patients, outpatient psychiatric care has been difficult to obtain." In an attempt to grapple with this need, Professors Robert Bossarte and Ronald Kessler are researching ways to support mental health in rural West Virginia where healthcare providers are not available. Bossarte and Kessler have developed artificial intelligence software to provide an electronic form of cognitive based therapy ("eCBT"), a proven therapeutic technique, to isolated patients. They are currently studying this therapy's effectiveness at helping people "learn new ways to think about tricky situations," using mental exercises and videos on an app to reframe patients' thoughts. This cutting edge technology has great potential to minimize the problem of availability.

One reason mental health providers are unavailable may be the perception among professionals, including a variety of healthcare providers, that West Virginia lacks opportunity, leading to a "brain drain" of practicing young professionals in the state. Changing this perception may be the key to improving availability of mental health and other healthcare providers in West Virginia.

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114 Id.
115 Id.
117 Williams, supra note 113.
118 Id.
119 Id.
120 Id.
121 Id.
122 Id.
123 Id.
Investing in programs that train these healthcare professionals and incentivize them to remain in the state and integrate into the community could be invaluable. This investment could include building on programs that provide financial aid and student loan forgiveness for graduates who practice in underserved communities. Kentucky and Oklahoma have successfully offered stipends to medical students, residents, and primary care providers to incentivize practice in underserved areas.124 Georgia has similarly attracted providers through school debt relief payments.125 Incentives could also include investing in schools, libraries, and businesses in more isolated areas to attract these healthcare professionals to the improved communities in these regions.126

B. Accessibility

Improving the availability of healthcare services is of limited utility if these resources are not accessible. Again, accessibility covers a range of issues including non-discrimination; physical accessibility; economic accessibility, or affordability; and information accessibility.127 Investing in the accessibility of resources that are available has great potential to improve a wide range of health outcomes.

1. Non-discrimination

The ICESCR prohibits discrimination in the guarantee of the right to health.128 Residents of rural areas tend to be older than those of urban areas, raising the specter of age-based discrimination in a largely rural state like West Virginia.129 Another form of discrimination that is more unique to West Virginia is discrimination against persons from Appalachia.

125 Id.
127 See supra text accompanying note 37.
128 See CESCR, General Comment No. 20, supra note 43, ¶ 15. (“Article 2, paragraph 2, lists the prohibited grounds of discrimination as ‘race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.’”) 129 State Findings: West Virginia, 2021, UNITED HEALTH FOUND., https://www.americashealthrankings.org/explore/annual/measure/pct_rural/state/WV (last visited Mar. 3, 2022).
In fact, one of the oldest examples of geographic prejudice is against the Appalachian, poor, white, "hillbilly" minority. This population is often defined as those who work to harvest the rich resources of the Appalachian mountains but who are ultimately excluded from the wealth these resources bring. This "Legacy of Neglect" includes sub-par healthcare services for those whose accent and socio-economic position suggest "hillbilly" status. Yet despite this documented discrimination, apparently the Cincinnati Human Rights Ordinance is the only U.S. civil rights law to treat Appalachians as a protected class. West Virginia might follow suit with legal protections, or at least work to eradicate this prejudice through education and training.

Even if not tied directly to individuals from Appalachia, the threat of discrimination based on poverty is real and might be addressed in similar ways. Efforts to address the economic disparity itself might include high school completion programs that provide students with marketable skills through vocational training, as well as life skills through social-emotional skills classes, mentoring, and counseling.

Racial discrimination is also a problem in West Virginia, where the population is 93.08% White, 3.69% Black or African American, and 0.80% Asian. West Virginia’s 2020 annual survey found that per capita income of black citizens was under $19,000, or 27% less than that of white citizens. The survey also found that black West Virginians faced disproportionate unemployment as well as employment in low wage jobs.

Moreover, between 2017 and 2019, the infant mortality rate for black mothers in West Virginia (12.3 per 1,000 live births) was almost double that of white women in the state (6.5 per 1,000), which was already higher than for all mothers nationwide (4.8 per 1,000). Doctor Lauri Andress has studied this reality extensively. Interestingly, she has observed that even though black women’s access to prenatal care has significantly improved, infant mortality has

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131 Id. at 571.
132 Id. at 571, 575.
133 Id. at 583.
136 Id.
not—even for mothers with elevated education and income levels.\textsuperscript{138} Andress explains that while both white and black women may experience poverty, living with the added chronic stress of racism and discrimination increases certain hormones which, when experienced long-term, “can cause physiologic changes in the body.”\textsuperscript{139}

Andress’s findings indicate that discrimination may violate the right to health not only by hindering access to health resources, but also by harming physical health. In 2020, the City Council of Wheeling, West Virginia unanimously declared racism to be a “health crisis.”\textsuperscript{140} Consistent with this resolution, to achieve the right to health, the state must not only eradicate racial discrimination in the field of health, but racial discrimination to secure health.

2. Physical Accessibility

By their very nature, rural areas are less physically accessible than concentrated metropolitan areas. This physical inaccessibility is perhaps the hallmark challenge for rural healthcare. Its consequences are significant. Reduced access to healthcare in rural areas is associated with a 23% increase in mortality and a 40% increase in preventable hospitalizations.\textsuperscript{141} Addressing the physical barrier to providers and services may be the most effective way to realize a rural individual’s right to health, including in West Virginia.

West Virginia’s mostly rural, mountainous, and forested topography lends to minimal public transportation except in major metropolitan areas.\textsuperscript{142} This makes traveling to healthcare appointments a “major issue” for many


\textsuperscript{139} Id.


\textsuperscript{142} Williams, supra note 113.
patients throughout the state. Investing in infrastructure, including roads, public bus routes, gas stations, and internet services, could improve access to healthcare for much of West Virginia's population. Yet the cost to implement might be insurmountable. A less costly option could be organizing mobile health teams to bring the providers to the patients.

Perhaps the most promising solution to overcoming physical inaccessibility is telehealth, which has already produced impressive improvements in healthcare. Not only can it reach remote communities, it can also be employed in non-traditional settings, including homes, schools, and childcare centers. This in turn can minimize burdens on parents and caregivers who would otherwise miss work, or children who would otherwise miss school. Telehealth reduces both costs and risks involved with physical travel. It can also mitigate emergency room use for non-emergent problems. Several studies have shown an association between telehealth and improved health outcomes in a wide range of healthcare specialties.

Asthma, for instance, is the most prevalent chronic pediatric condition throughout the country. Studies show that telemedicine visits from asthma specialists directly into rural schools can improve symptom control and quality of life at similar rates to face-to-face encounters with providers.

Diabetes is another widespread disease that can be addressed through telehealth. West Virginia ranks worst in the nation for diabetes. Monthly video conferences with children in school nurses' offices have yielded improved hemoglobin A1c levels (a long-term indicator of elevated blood sugar) and overall quality of life. They also have resulted in "fewer urgent calls for diabetes care by the school nurse, as well as reductions in [ER] visits and hospital admissions." Moreover, these children grow up equipped with tools to manage their diabetes throughout life, despite their ultimate income or educational attainment.

Emergency medicine has also documented promising benefits from the use of telehealth. The frequency of medication errors among children receiving telehealth consultations in the emergency department ("ED") was markedly reduced (3.4%) compared to medication errors among children who only

143 Id.
144 Marcin et al., supra note 111, at 169.
145 Id.
146 Id.
147 Id. at 171.
148 Id.
149 Id.
150 West Virginia Summary, supra note 141.
151 Marcin et al., supra note 111, at 171.
152 Id.
received telephone consultations (10.8%) or no consultations at all (12.5%) in the ED.\textsuperscript{153} Furthermore, in general, telehealth both resulted in more appropriate rates of admission and reduced risky transfers and other over-triaging of cases that could properly be seen at closer hospitals.\textsuperscript{154}

Maternal-fetal medicine ("MFM") can particularly benefit from telehealth services. When MFM specialists dial-in virtually, they can assist a provider at a remote location monitor and care for a high-risk mother and delivery, as well as the subsequent management of high-risk infants.\textsuperscript{155} The University of Arkansas's telemedicine-intensive model decreased the incidence of very-low-weight infant births in nine of its participating hospitals without neonatal intensive care units from 13% to 7%.\textsuperscript{156} The model includes rounds on obstetric patients via telemedicine twice a week, neonatal rounds and interactive education conferences three times a week, and 24/7 access to specialists. As another plus, the need for mothers to travel from rural areas to tertiary centers for in-person evaluations decreased by almost 50% when using telemedicine.\textsuperscript{157}

West Virginia University researchers are studying best practices for telehealth for chronic conditions. Many conditions such as diabetes, high blood pressure, and foot ulcers require monitoring and quick intervention to prevent hospitalizations from exacerbations such as infection, stroke, and diabetic ketoacidosis.\textsuperscript{158} Remote monitoring of indicators such as blood pressure and blood sugar by nurses at a central location can prevent these costly hospitalizations. West Virginia University Professors, including Jennifer Mallow, Laurie Theeke, and Steve Davis, are researching how frequently telehealth visits should be scheduled to prevent these escalating conditions.\textsuperscript{159} They found that telehealth monitoring (including videoconferencing, message exchanges between providers and patients, and remote monitoring from devices like glucometers) over 51 weeks produced positive results, while telehealth limited to 37 or 38 weeks showed only neutral or mixed results.\textsuperscript{160} This groundbreaking research could be key to reducing costs and improving accessibility for a wide range of at-risk patients.\textsuperscript{161}

\textsuperscript{153} Id. at 172.
\textsuperscript{154} Id.
\textsuperscript{155} Id. at 173.
\textsuperscript{156} Id.
\textsuperscript{157} Id.
\textsuperscript{158} See generally, Too Much, Too Little, or Just Right: WVU Researchers Study Proper "Dosing" of Telehealth, WVU TODAY (May 6, 2021), https://wvutoday.wvu.edu/stories/2021/05/06/too-much-too-little-or-just-right-wvu-researchers-study-proper-dosing-of-telehealth.
\textsuperscript{159} Id.
\textsuperscript{160} Id.
\textsuperscript{161} Id.
Overall, telemedicine has been successfully used in a variety of subspecialties and has consistently resulted in strong provider, caregiver, and patient satisfaction. Its effectiveness turns on availability of partnering specialists, beneficial financial arrangements for providers, broadband internet services, and a patient population that has access to and feels comfortable using the technology. One of the great barriers in West Virginia is internet services. In 2021, West Virginia ranked 44th in the country for households with high-speed internet. Improving internet access may therefore be the first step in advancing physical accessibility.

3. Economic Accessibility

Evaluating affordability can highlight high-risk areas that would benefit from resources, and pinpoint what resources might have the biggest impact on a population’s health. The need for affordability is particularly acute in West Virginia, where poverty presents a significant challenge.

In 2018, the state’s poverty rate was estimated at 17.8%, the fourth highest nationally. Statewide, the median income per household was $44,097, which was lower than the national average by $17,840. Adjusting for inflation, West Virginia’s median income per household did not increase from 2007 to 2018.

The need for affordability results not just from poverty, but from poverty’s link to health problems. The percentage of adults in West Virginia who reported their health was “excellent” or “very good” decreased markedly from 63.6% for those who made $75,000 per year down to 23.7% for those with income levels under $25,000 per year. Consistent with its high level of poverty, in 2021 West Virginia ranked worst in the nation among adults for smoking, diabetes, cardiovascular disease, chronic kidney disease, chronic obstructive pulmonary disease, high blood pressure, and high cholesterol.

Ensuring the right to health in poorer areas may require drawing resources from outside those areas, promoting the financial sustainability of those areas, and developing strategies that address concerns that other areas may take for granted, such as the availability of basic necessities like clean water and affordable healthy food. On this last point, West Virginia recently ranked first in

162 Marcin et al., supra note 111, at 170–71.
163 West Virginia Summary, supra note 141.
165 Id.
166 Id.
167 West Virginia Summary, supra note 141.
168 Id.
the nation for adult diabetes prevalence.\textsuperscript{169} Considering that food insecurity affects roughly 20% of diabetic patients and is tied to poor glycemic control, perhaps the first step to addressing this population’s health is facilitating access to affordable healthy food.\textsuperscript{170}

Evaluating economic accessibility may also reveal barriers to more traditional healthcare services. For example, nonparticipation of subspecialists in health insurance plans, particularly Medicaid, poses barriers to subspecialty care for lower-income patients, as does provider refusal to accept uninsured patients.\textsuperscript{171} Ensuring access to care, whether through comprehensive health insurance or other means, is important for patients who otherwise cannot afford basic healthcare. Facilitating patients’ access to health insurance while also incentivizing providers to accept lower-income, uninsured, and Medicaid patients may help these populations access resources that are otherwise already available.

4. Information Accessibility

Information empowers individuals to control the course of their health. As previously noted, information accessibility includes “the right to seek, receive and impart information and ideas concerning health issues.”\textsuperscript{172} Promoting the accessibility of scientifically backed information about drugs, providers, diseases, conditions, and even diagnoses may have far-reaching impacts.

Information accessibility is key to providing preventative or early-stage care of many diseases, such as hepatitis C. Acute hospitalization figures reveal that U.S. diagnoses of hepatitis C between 2004 and 2011 more than tripled, with hospitalization costs rising from $0.9 billion to $3.5 billion.\textsuperscript{173}

West Virginia’s hepatitis C rate is nine times greater than the national average.\textsuperscript{174} This is due in large part to use of injectable drugs.\textsuperscript{175}

\textsuperscript{169} See id.


\textsuperscript{171} Beth A. Pletcher, Mary Ellen Rimsza, William L. Cull, Scott A. Shipman et al., \textit{Primary Care Pediatricians’ Satisfaction with Subspeciality Care, Perceived Supply, and Barriers to Care}, 156 J. PEDIATRICS 1011, 1014 (2010).

\textsuperscript{172} CESCR, General Comment No. 14, \textit{supra} note 15, ¶ 12(b)(iv) (footnote omitted).


\textsuperscript{174} Id. at 2.

\textsuperscript{175} See id. at 2, 7.
Harm reduction programs provide information about hepatitis C and have proven effective in managing this blood-borne disease. These programs provide information regarding the disease, drug use, and prevention strategies like syringe exchange programs. Awareness of needle exchange programs—which remain controversial for not focusing on the underlying drug problem—has led drug addicts to get tested, access treatment programs, use clean needles, and reduce their risk of hepatitis C infection. This has had a dramatic impact on the spread of hepatitis C. Mercer County, which accounted for almost one fourth of West Virginia’s acute hepatitis C infections, but only 3% of its population, saw its hepatitis cases almost cut in half (from 400 to 207 between 2018 and 2020) after implementing a needle exchange program. New state-wide restrictions have resulted in the closure of the County’s clinic, and other clinics around the state, threatening gains in hepatitis reduction.

In addition to preventing the spread of hepatitis, early detection is key because oral medications taken early in the disease process can reduce the risk of later liver cancer and even death. If Hepatitis C progresses undetected and patients go untreated, the likelihood they will sustain a response to later treatment decreases. Promoting access to information about the prevalence of hepatitis C, its spread, its prevention, its early signs and symptoms, its end-stage clinical course, the treatment options available, and the benefits of its early detection can provide health and financial benefits for the entire community.

C. Acceptability

Even if resources are available and accessible, they may not be acceptable. Acceptability requires that “[a]ll health facilities, goods and services ... be ... respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements,” and designed to improve health status. Employing healthcare practices that are acceptable to a population is key to supporting that population’s right to health. Yet

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176 See id. at 7; Harm Reduction Programs, W. VA. OFF. OF EPIDEMIOLOGY & PREVENTION SERVS. [hereinafter Harm Reduction Programs], https://oeps.wv.gov/harm_reduction/Pages/default.aspx (last visited May 23, 2022).

177 See generally Harm Reduction Programs, supra note 176.


179 Id.

180 See id.

181 Phillips et al., supra note 174, at 2, 8.

182 Id. at 2-3.

183 CESCR, General Comment No. 14, supra note 15, ¶ 12(c).
acceptability may be uniquely difficult in a region (Appalachia) marked by medical avoidance, particularly for early and preventative care.184

Consider the issue of acceptability in addressing obesity. In 2018, the West Virginia obesity rate was the highest rate in the nation at 37.7%.185 Over two-thirds of the adult population was overweight or obese, the second highest percentage nationally.186 West Virginia also has the highest rates of heart attacks (7.5%) and coronary artery disease (8.0%), both of which are associated with obesity.187

To address this, weight loss has been achieved through mobile health (mHealth) interventions that can be performed using devices such as Fitbits and smartphones.188 These devices permit real-time monitoring of health information for providers while simultaneously providing wearers with tools for lifestyle management.189 Given that West Virginia has the 17th fastest average download speed in the country, mHealth has the potential to benefit patients throughout the state.190

However, even with the infrastructure to support smartphone use of mHealth, West Virginians were 82% less likely to use mHealth than the rest of the country.191 In response, providers can play a role in increasing familiarity with and use of new technologies. This might include basic tactics such as providing tablets in waiting rooms for patients and taking time to explain apps and wearable devices during visits.192 Health plans may consider offering free or reduced-price wearable devices to low-income populations. Engaging popular influencers to promote the use of these products could also be considered. Smartphones may not even be necessary. Research has shown that text messaging combined with web-based resources can produce at least short-term weight reduction for adults.193

184 Peter Giacobbi Jr., Patrick Cushing, Alexis Popa, Treah Haggerty et al., Mobile Health (mHealth) Use or Non-Use by Residents of West Virginia, 111 S. MED. J. 625, author manuscript at 4 (2018).
186 Id.
187 Id.
188 Peter Giacobbi Jr. et al., supra note 184, at 1–2.
189 Id. at 2, 4.
190 Id. at 4.
191 Id. at 1, 3, 7.
192 Id. at 4.
193 Id. at 2. Smoking cessation has also been achieved through programs that use text messaging; indeed, such “programs may be as effective as nicotine replacement therapy.” Id.
Interestingly, engaging a population in participatory research can also promote acceptance. One Yale research study found that “[p]eople [with a say in research] overwhelmingly focused on seeing concrete meaningful changes in their communities and lives and wanted to know how research [could] be more closely aligned with these goals.”

Beyond just acceptance of patients, acceptance of providers is also critical. Providers’ lack of familiarity with, or wariness of, “outsider” providers, new resources, or innovative health care practices can slow adoption by patients. Marketing efforts could be directed to both providers and patients and tailored to the particular medical avoidance, or other detrimental tendency. As healthcare tools and services become more acceptable to a community’s patients and providers the likelihood of these services impacting the community’s health only improves.

D. Quality

In addition to acceptability, adequate quality of health facilities, services, and goods is essential to the human right to health. Harmful, or even substandard, facilities, services, and goods fall short of the recognized right. Quality is likely to improve as policymakers focus on the “AAA” portion—availability, accessibility, and acceptability—of the AAAQ model. For instance, as policymakers secure available, accessible, and acceptable facilities, they are also likely to ensure a level of skilled medical personnel, safe and approved drugs, equipment, and water in those facilities. Yet a focus on quality is important in its own right. Interestingly, even measuring quality can help improve quality. For example, through a collaboration with Alaska and Oregon, West Virginia is working to demonstrate “how a core set of children’s quality measures can be used to improve quality of care for children.” Among other things, the effort will involve gathering and monitoring health data on a “set of children’s quality measures” from participating practices. This will help


195 Id. (quoting Miraj Desai, Ph.D.).


198 Id.
identify opportunities for improvement, including how to provide services consistent with a particular approach to care—the medical home model.199

As regions focus on measuring the quality of their populations’ health and then identifying opportunities to improve, the overall quality of the healthcare, including supplies, providers, and collaborative tools, can progress. As quality improves the quest to establish the recognized right to health can be realized.

V. CONCLUSION

International law has long recognized a human right to health. The gap between right and reality, however, remains troubling, especially in rural areas like those in West Virginia. While increased judicial enforcement of the right to health might reduce the gap, reliance on judicial enforcement is an inadequate remedy, especially in rural areas. The international right to health—understood through the AAAQ lens—provides a helpful framework for addressing the challenges of rural health. The framework emphasizes both the expansiveness and the interrelated aspects of health, helping to identify not only hurdles but solutions that may make the right to health a reality for increasing numbers at home and abroad.

199 Id.