ADVANCING THE HUMAN RIGHT TO HEALTH: ELEANOR KINNEY'S SEMINAL CONTRIBUTIONS TO THE DEVELOPMENT AND IMPLEMENTATION OF HUMAN RIGHTS FOR PUBLIC HEALTH

BENJAMIN MASON MEIER & LANCE GABLE

Professor Eleanor Kinney long served as a foundational scholar at the intersection of law and public health, pushing scholarship forward across the fields explored in this special issue. Yet, while this special issue is largely confined to the domestic legal space, Professor Kinney also served as an early and influential scholar on the international human right to health, and this contribution has proven central to the field of health and human rights over the past two decades. Having worked alongside Professor Kinney throughout these years, drawing on her research in framing our own scholarship, it is an honor to reflect on her seminal works that have defined the field and influenced rights-based health policy – developing the right to health under international law and implementing that right in U.S. health policy.

Eleanor Kinney and the Authors at the American Public Health Association Annual Meeting

I. DEVELOPMENT OF THE RIGHT TO HEALTH UNDER INTERNATIONAL LAW

Professor Kinney was already a leading scholar of U.S. health law and public health law when she sought to advance understanding of the international human right to health. This development of the right to health, bringing together theoretical conceptualization and comparative analysis, provided an early American effort to understand the scope and content of this human right as a framework for public health.

A. Conceptualizing a Human Right to Health

As the Co-Director of the Center for Law and Health at the Indiana University School of Law-Indianapolis, Professor Kinney used the inaugural lecture of her Samuel R. Rosen Professorship to frame an international legal mandate for government responsibilities in health, looking to the human right to health as a basis for governmental accountability. Where the United Nations (UN) Committee on Economic, Social and Cultural Rights ("CESCR") had adopted in 2000 a "general comment" on the content of the right to health under the International Covenant on Economic, Social and Cultural Rights,[1] Professor Kinney sought to elaborate the meaning of this newly interpreted right. This lecture at the turn of the century, expanded upon and published in 2001 in the *Indiana Law Review*, provided an early academic examination of the development of the human right to health under international law and offered a forceful argument for its implementation in the United States.[2]

With the field of health and human rights just coming into focus,[3] this early academic effort sought to conceptualize the development of the human right to health under international law.[4] Although this right had long been dormant in international legal developments throughout the Cold War—with the dueling Cold War Superpowers split on the existence and obligations of economic, social, and cultural rights[5]—the end of the Cold War provided an opening to see the right to health as indivisible from other rights.[6] As nations embraced health-related human rights in a post-Cold War world, the CESCR's General Comment 14 on the right to health established a broad and encompassing view of rights to underlying determinants of health, assessing the realization of these determinants on the basis of their availability, accessibility, acceptability, and quality.[7] Professor Kinney looked to these international legal developments as a foundation for the future of health and human rights, tracing the origins of the right to health from Enlightenment thinkers through UN treaties. In defining the content of the right to health, she examined the codification of the right to health

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1. Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14: Right to the Highest Attainable Standard of Health (Art. 12), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment 14].

2. Eleanor D. Kinney, *The International Human Right to Health: What Does This Mean for Our Nation and World?*, 34 IND. L. REV. 1457 (2001).

3. *See generally* HEALTH AND HUMAN RIGHTS: A READER (Jonathan M. Mann et al. eds. 1999).

4. Kinney would go on to work with ethicists to clarify the non-legal "Foundation for a Natural Right to Health Care." *See generally* Jason Eberl, Eleanor Kinney & Matthew Williams, *Foundation for A Natural Right to Health Care*, 36 J. MED. & PHIL. 537 (2011).

5. *See generally* Stephen P. Marks, *The Past and Future of the Separation of Human Rights into Categories*, 24 MD. J. INT'L L. 209 (2009).

6. World Conference on Human Rights, *Vienna Declaration and Programme of Action,* ¶ 5, U.N. Doc. A/CONF.157/23 (June 25,1993).

7. General Comment 14, *supra* note 1, at 4-5.

under international treaties, recognizing that the United States had not ratified many of these international human rights treaties but noting that customary international law (based on existing treaty ratifications and national laws) could fill these legal gaps to implement the right to health in U.S. policy.

The implementation of this right—in the United States and beyond—would serve as a basis to refine the normative content of the right to health through national practice. Yet, this focus on national practice would require attention to national health resources. Reflecting on the "principle of progressive realization" under international law,[8] Professor Kinney conceptualized the obligations of the right to health "on a continuum" – contingent upon the resources and cultures of individual countries.[9] This continuum of obligations would require clarification to support states in their interpretation, implementation, and enforcement of the right to health at various stages of development. In assuring accountability for these implementation efforts, Professor Kinney quickly recognized that the judiciary would not be central to the enforcement of progressive realization, looking beyond these "legalistic visions"[10] to assure the maximum available resources for health through legislative processes. Such accountability for health could be structured through measurement, assessing "indicators" of human rights realization and comparing these indicators – across national public health outcomes, in the work of international lending institutions, and through implementation measures in national law.

B. Comparative Analysis Across Countries

This focus on national law would be taken up in the first cross-national examination of legal provisions for health and health care across all the countries of the world. Through Professor Kinney's empirical research on national laws, this study would be explicitly framed to assess human rights implementation, opening with the statement: "[a]t a time of renewed interest in the international human right to health, it is useful to identify and examine the provisions of the constitutions of the world regarding health and health care."[11] Having focused

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8. Under the "principle of progressive realization," codified in the ICESCR, a state is only obligated to: "take steps, individually and through international assistance and co-operation, especially economic and technical, *to the maximum of its available resources, with a view to achieving progressively the full realization of the rights* recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures" (emphasis added) G.A. Res. 2200A (XXI), International Covenant on Economic, Social & Cultural Rights, Art. 2 (Dec. 16, 1996). As the CESCR has noted, the principle of progressive realization is a recognition that the full realization of economic, social, and cultural rights will be dependent on resources and that states will differ in their realization of rights based upon those resources. Comm. on Econ., Soc. & Cultural Rights, General Comment No. 3: The Nature of States Parties Obligations, ¶ 9, U.N. Doc. E/1991/23 (1991).

9. Kinney, *supra* note 2, at 1457.

10. *Id.* at 1467.

11. Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in*

previously on the importance of national constitutions to the development and implementation of the right to health, Professor Kinney recognized how these national constitutions had increasingly established health-related obligations—especially those constitutions developed since the end of World War II—drawing from international human rights standards in their domestic rights elaboration.[12]

The study of these national constitutions would mark an early effort to bring empirical research methods into legal research on the right to health. Professor Kinney described this research in the manner of a scientific research paper—including tables and graphs in a law review publication—with a methods section that elucidated the procedures taken in her analytic coding study: narrowing the constitutions in her sample and categorizing the types of constitutional provisions that address health.[13] Categorizing these constitutional provisions provided Professor Kinney with a basis to give meaning to the right to health and to assess the influence of constitutional protections on indicators of health sector performance.[14] This empirical coding at the intersection of health and human rights would soon become a model for research on rights-based national laws,[15] human rights litigation,[16] and human rights treaty bodies.[17]

Professor Kinney argued that the constitutional codification of health and health care obligations reflects an explicit government commitment to implement the international human right to health. However, while Professor Kinney found that over two-thirds of constitutions have expressed a national commitment to health, she nevertheless concluded that "the national commitment to health and health care is not highly related to whether or not a nation's constitution specifically addresses health or health care."[18] This conclusion, highlighting a

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the Constitutions of the Countries of the World, 37 CORNELL INT'L L.J. 285, 285 (2004).

12. *Id.* at 291-93, 296-97.

13. *Id.* at 289-90.

14. *Id.* at 301 (recognizing that "policy imperatives created by constitutional provisions and international human rights treaties can be used as standards for the evaluation of government's performance with respect to the realization of economic and social human rights").

15. *See* Jody Heymann et al., *Constitutional Rights to Health, Public Health and Medical Care: The Status of Health Protections in 191 Countries*, 8 GLOB. PUB. HEALTH 639, 641 (2013) ("In order to obtain the information on health rights necessary for this study, a coding team fluent in several official UN languages reviewed the constitutions of 191 UN member states as amended to two points in time: August 2007 and June 2011.").

16. *See generally* Colleen M. Flood & Aeyal Gross, *Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach?*, 16 HEALTH & HUM. RTS. J. 62 (2014).

17. Benjamin Mason Meier, Marlous De Milliano, Averi Chakrabarti & Yuna Kim, *Accountability for the Human Right to Health through Treaty Monitoring: Human Rights Treaty Bodies & the Influence of Concluding Observations*, 13 GLOB. PUB. HEALTH 1558, 1562-64 (2018) (describing the coding methodology employed to analyze the content of state reporting on the right to health and concluding observations of the CESCR).

18. Kinney & Clark, *supra* note 11, at 287. This counterintuitive conclusion reflects the fact

weakness in the causal chain linking the state ratification of international treaties with the lived experience of public health, would frame a new comparative research agenda on the human rights implementation process.[19] (This imperative to understand human rights implementation would lead future researchers to investigate the country-specific processes by which human rights are translated from international ratification to national implementation.[20]) With this new understanding of right to health implementation in national laws throughout the world, Professor Kinney would return her focus home, examining the implementation of the right to health in U.S. health care policy.

C. Application to the United States

The political acceptance and policy implementation of the right to health remained uncertain in the United States, leaving it as the only developed nation without policies to realize universal health coverage. Although the U.S. government played a key role in the early development of the right to health under international law,[21] it had long faltered in the implementation of these rights-based norms through U.S. health care policy.[22] As other nations moved to establish universal health care systems, the expanding U.S. system of private employer-sponsored insurance and the strident opposition of the American Medical Association repeatedly blunted calls for sweeping government action.[23] Yet, despite the failure of these early efforts to bring about universal health care, such rights-based advocacy spurred incremental efforts to expand government involvement in health care in the United States—universal access to emergency care, coverage for the needs of the elderly and indigent, and access to basic services for children—offering evolving government recognition of rights-based obligations for the health of the most vulnerable members of society.[24] However, these increasingly expansive efforts failed to codify a universal right to comprehensive health care.

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that "the most resounding constitutional commitments to health and health care are in poor countries with tenuous democracies." *Id.* at 294.

19. *Id.* at 298.

20. Gillian MacNaughton & Angela Duger, *Translating International Law into Domestic Law, Policy, and Practice*, *in* FOUNDATIONS OF GLOBAL HEALTH & HUMAN RIGHTS (Lawrence O. Gostin & Benjamin Mason Meier eds., forthcoming 2020).

21. *See* Benjamin Mason Meier, *Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement*, 46 STAN. J. INT'L LAW 1, 3-5 (2010).

22. Anja Rudiger & Benjamin Mason Meier, *A Rights-Based Approach to Health Care Reform*, *in* RIGHTS BASED APPROACHES TO PUBLIC HEALTH 69, 72-73 (Elvira Beracochea et al. eds., 2010).

23. *See* Anne-Emmanuelle Birn et al., *Struggles for National Health Reform in the United States*, 93 AM. J. PUB. HEALTH 86 (2003).

24. Benjamin Mason Meier & Lance Gable, *US Efforts to Realise the Right to Health through the Patient Protection and Affordable Care Act*, 13 HUM. RTS. L. REV. 167, 168-73 (2013).

Corresponding with international law, Professor Kinney found a right to health care to exist as a "statutory right" under U.S. law, framed by domestic legislation that had progressively realized access to health care in the United States.

Professor Kinney's analysis would arrive just as a debate was beginning on what would become the largest leap forward in realizing the right to health through U.S. law – the 2010 Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA").[25] Presidential candidate Barack Obama was asked for the first time in the debates preceding the 2008 U.S. elections whether health care is a human right. Focusing on inequities in insurance coverage, Obama responded:

> I think it [health care] should be a right for every American. In a country as wealthy as ours, for us to have people who are going bankrupt because they can't pay their medical bills – for my mother to die of cancer at the age of 53 and have to spend the last months of her life in the hospital room arguing with insurance companies because they're saying that this may be a pre-existing condition and they don't have to pay her treatment, there's something fundamentally wrong about that.[26]

In meeting the government's obligation to secure the health of every American, the Affordable Care Act would draw on the "internationally recognized conception of a human right to health, seeking to progressively realize the highest attainable standard of physical and mental health through policies that ensure the availability, accessibility, acceptability, and quality of health care."[27]

II. IMPLEMENTATION OF THE RIGHT TO HEALTH UNDER U.S. POLICY

While others had begun to examine the right to health, Professor Kinney recognized that the weakness of this right extended to its implementation in the United States:

> U.S. health policy makers do not look to international human rights law for mandates or guidance when it comes to domestic health policy. In fact, it would probably surprise many U.S. health policy makers that a body of international law exists that has concrete implications for domestic policy making regarding health.[28]

Raising an imperative to implement the right to health in U.S. policy, Professor Kinney continued to expand her scholarship on the recognition and implementation of the right to health by addressing aspects of this right in the

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25. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

26. *October 7, 2008 Debate Transcript*, COMM'N ON PRESIDENTIAL DEBATES (Oct. 7, 2008), https://www.debates.org/voter-education/debate-transcripts/October-7-2008-debate-transcrip/ [https://perma.cc/7B7L-73MV].

27. Meier & Gable, *supra* note 24, at 167.

28. Kinney, *supra* note 2, at 1458.

United States. Her scholarship sought to implement the right to health under U.S. law and presciently highlighted areas—including international trade, for-profit insurance, and immigrant health—where the limited application of the right to health in U.S. law has continued to imperil the public's health.

A. Recognition of the Right to Health in the United States

Professor Kinney began to lay the foundations for U.S. health policy reforms in 2008 with her development of a far-reaching analysis on the recognition of the right to health in various aspects of U.S. law. As a natural extension of her work on the right to health under international law, Professor Kinney chronicled the many areas in which the United States fell far below other high-income countries in health indicators in spite of far larger per capita expenditures on health. She acknowledged that structural impediments within the United States prevented an explicit analysis of U.S. obligations under the right to health - with limited recognition of the right to health in the U.S. Constitution and forestalled ratification of international human rights treaties that include the right to health. Yet, despite these limitations, she observed that the United States could nevertheless realize many aspects of the right to health through statutory and regulatory means, finding that "express recognition of the international human right to health in a constitution is by no means essential to achieve national recognition."[29]

Professor Kinney articulated a clear connection between her scholarship on the U.S. health care system and the international human right to health by demonstrating both the deficiencies in U.S. health policies that undermine the right to health and the opportunities to remedy these shortcomings through legislative reforms. In doing so, she outlined a series of recommendations to realize the right to health in the United States, including formal ratification of international human rights treaties that include the right to health and modification of domestic health care policies that could effectively implement the right to health even without formal treaty recognition.

Drawing from Professor Kinney's scholarship, the ACA would create a framework for health care reforms in the United States and a model for realizing universal health coverage pursuant to the right to health – even without formally recognizing the right.[30] As argued by Professor Kinney, the enactment of the ACA moved the United States closer to realizing many aspects of the right to health. When the U.S. government reported on its human rights obligations before the U.N. Human Rights Council's Universal Periodic Review, this 2011 U.S. report heralded the promulgation of the ACA as a foundation for realizing the right to health:

> The Act [ACA] makes great strides toward the goal that all Americans

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29. Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 364 (2008).

30. Lance Gable, *The Patient Protection and Affordable Care Act, Public Health, and the Elusive Target of Human Rights*, 39 J. L. MED. & ETHICS 340 (2011).

> have access to quality, affordable health care. The law is projected to expand health insurance coverage to 32 million Americans who would otherwise lack health insurance, significantly reduces disparities in accessing high-quality care, and includes substantial new investments in prevention and wellness activities to improve public health.[31]

However, absent formal recognition of a right to health under U.S. law, these statutory gains have remained susceptible to future revocation through executive orders, legislative repeals, and judicial challenges, leaving an uncertain future for health and human rights in the United States.[32]

B. Trade in an Economically Integrated North America

Focusing additionally on the implications of international trade agreements for implementing the right to health in the United States, Professor Kinney examined the historic changes ushered in by the North American Free Trade Agreement (NAFTA). This analysis, published just at debates were beginning on the ACA, served not only as an opportunity to highlight the deficiencies of the U.S. health system in upholding the right to health, but also as a platform for comparative analysis of the respective health systems in the United States, Canada, and Mexico.[33] NAFTA's lowering of trade and commercial barriers between countries (with vastly different health insurance and delivery systems) raised concerns that private entities would seek to undermine the government health care systems in place in Canada and Mexico.

Professor Kinney's analysis articulated a clear assessment of some of the unresolved health policy questions raised by NAFTA, including whether for-profit business interests would be able to use NAFTA to challenge public benefits systems and whether individuals would still receive health insurance coverage while in neighboring countries.[34] Examining the possibility that the provision of health care by the private sector could violate the right to health, Professor Kinney proposed an explicit limitation on such efforts: "[p]rivate insurers and for-profit providers should not be able to profit from the care of the healthy and wealthy in ways that compromise the viability of public programs that serve the

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31. Human Rights Council, National Report Submitted in Accordance with Paragraph 15 (a) of the Annex to Human Rights Council Resolution 5/1, ¶ 70, U.N. Doc. A/HRC/WG.6/9/USA/1 (Aug. 23, 2010).

32. *See* Meier & Gable, *supra* note 24.

33. *See generally* Eleanor D. Kinney, *Health Care Financing and Delivery in the United States, Mexico, and Canada: Establishing Intentional Principles for Sound Integration*, 26 WIS. INT'L L. J. 934 (2009). This comparative analysis of the right to health across the United States, Canada, and Mexico related to Professor Kinney's earlier comparative work on the right to health. *See* Kinney & Clark, *supra* note 11. *See also* Lance Gable, Brooke Courtney, Robert Gatter & Eleanor D. Kinney, *Global Public Health Legal Responses to H1N1*, 39 J.L. MED. & ETHICS 46 (2011) (extending Professor Kinney's focus on health challenges in Mexico).

34. Eleanor D. Kinney, *Realization of the International Human Right to Health in an Economically Integrated North America*, 37 J.L. MED. & ETHICS 807, 812-13 (2009).

poor and seriously ill."[35] She also suggested that the NAFTA framework could be used to expand health insurance coverage for those traveling between countries, noting that "[m]uch could be done if public and private health insurance on the continent were more portable and the coverage was available regardless of immigrant status."[36]

These proposals, coming on the cusp of the passage of the ACA, would prove influential in the years that followed. Although attempts by private health care entities to challenge the validity of Canada's government health insurance system were dismissed,[37] many of the other issues highlighted by Professor Kinney remain unresolved. As the countries of North America continue to integrate economically under new international trade agreements, regulating trade in ways that may undercut health and human rights, the public health impact of these policies must be taken into account in protecting human rights from violation by the for-profit health care system.[38]

C. The Challenge of For-Profit Health Care

Flowing from her critique of free trade agreements, Professor Kinney sought to address the complex issue of how to reconcile the for-profit health care model in the United States with the realization of the international human right to health. While the provision of health care through the private sector has a major role in the health systems of many countries, human rights treaties that codify government obligations under the right to health do not address the private sector.[39] However, profit motives pursued by private-sector entities may conflict with or undermine the realization of the right to health. Professor Kinney's concerns about the continued influence of for-profit entities on the realization of the right to health invoked a timely warning as the U.S. Congress was debating the ACA. Although the final ACA expanded health insurance coverage through significant regulations on for-profit health insurers, congressional debates ultimately rejected proposals that would have presented government competition to private health insurers – a so-called "public option" that would have made the government directly responsible for assuring access to health care.

Professor Kinney recognized the failure of private markets as an imperative for government initiatives to realize the right to health. She found that "[p]rivate competitive markets for health care, in particular, have proven unable to provide

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35. *Id.* at 813.

36. *Id.*

37. Gov't of Can., *Centurion Health Corp. v. Government of Canada*, GLOB. AFFAIRS CAN. (Dec. 12, 2017), https://www.international.gc.ca/trade-agreements-accords-commerciaux/topics-domaines/disp-diff/centurion.aspx?lang=eng [https://perma.cc/SC95-KB67].

38. *See generally* Ronald Labonte et al., *USMCA (NATFA 2.0): Tightening the Constraints on the Right to Regulate for Public Health*, 15 GLOBALIZATION & HEALTH 35 (2019).

39. *See generally* M. Gregg Bloche, *Is Privatisation of Health Care a Human Rights Problem?*, *in* PRIVATISATION AND HUMAN RIGHTS IN THE AGE OF GLOBALISATION 207 (Koen De Feyter & Felipe Gómez Isa eds., 2005).

affordable and high quality health care for all people. Throughout the world, governments have assumed part of the burden of providing or financing health care services for their populations."[40] To alleviate these threats to health from the private sector, Professor Kinney proposed incorporating specific provisions in trade agreements to allow countries to protect public health care systems from private competitors, take measures to limit profit-seeking in the health care sector, and expand "universal access to affordable and portable health coverage."[41] Further, with skilled health care professionals lured away from low-income countries to serve more lucrative for-profit systems in the Global North, Professor Kinney concluded that trade agreements should incentivize strategies to backfill these positions and support educational institutions in the countries that are experiencing shortages of human resources and health expertise. Finally, Professor Kinney recommended additional efforts to ensure that low-income countries have access to essential medicines despite international trade protections for intellectual property, looking to the right to health to prioritize public health over patent protections.[42]

While the subsequent implementation of the ACA has expanded access to health insurance and health care, private-sector health care entities have retained their power and privilege within the U.S. health care system, leaving many of the concerns raised by Professor Kinney to persist. As a result, the trends of privatization and financialization of health care insurance and services have continued in the United States, often to the detriment of stable health care programs, as private competitors siphon off customers and increase costs within the health care system. Moreover, as right-leaning governments and austerity policies have depleted the public sector, with populist governance rejecting universal rights as a foundation for health, the conflicting motives of for-profit entities and the right to health continue to manifest in countries around the world.[43] The rights-based promise of Professor Kinney's ideas have yet to be realized in assuring universal health coverage.

D. Realizing Health for Non-Citizens

In protecting the most vulnerable through the right to health, Professor Kinney sought to link the right to health to the treatment of immigrants – in the United States and throughout the world. While the ACA represented a significant

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40. Eleanor D. Kinney, *Realizing the International Right to Health: The Challenge of For-Profit Health Care*, 113 W. VA. L. REV. 49, 59 (2010).

41. *Id.* at 66.

42. This argument served to support others in the health and human rights movement who were looking to implement a human right to essential medicines, challenging the international patent regime to assure compulsory licensing of pharmaceutical patents in the context of a public health emergency. *See* Lisa Forman, *Trade Rules, Intellectual Property, and the Right to Health*, 21 ETHICS & INT'L AFF. 337 (2007).

43. *See* Audrey Chapman, *The Impact of Reliance on Private Sector Health Services on the Right to Health*, 16 HEALTH & HUM. RTS. J. 122 (2014).

step in the progressive realization of the right to health in the United States, non-citizens were explicitly excluded from ACA provisions that expanded access to health insurance.[44] Professor Kinney expertly navigated the complicated landscape of non-citizen eligibility for U.S. federal health programs and private insurance, drawing on the right to health to call attention to the substantial gaps and inconsistencies in access to health insurance and health care for immigrants.

Professor Kinney's forward-looking analysis provided several practical yet aspirational recommendations to expand health insurance to non-citizens and move law and policy into alignment with the right to health.[45] Citing examples from the European Union's policies on cross-border health insurance reciprocity, she urged the three largest North American countries, already bound together by NAFTA, to extend the portability of health insurance to non-citizens in their respective countries.[46] She also cited approvingly to proposals that would allow the same sort of cross-border reciprocity in the private health insurance market.[47]

In clearly recognizing the universality of human rights and the interconnectedness of the right to health with immigration and trade law, Professor Kinney proved once again that her insights ran well ahead of her contemporaries. In so doing, she articulated the importance of migrant health in realizing the right to health, presaging more recent global debates on the rights of non-citizens to health care under international human rights norms.[48] Her recognition of the inherent disparities in health care access faced by non-citizens—due to the public charge rule in the United States—also predicted the contemporary legal challenges to current U.S. policies to prevent documented immigrants from accessing public insurance programs.[49] These efforts to protect the health of those who lack legal status but have human rights continues to be an urgent necessity in U.S. policy and global governance.[50]

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44. *See* Patient Protection and Affordable Care Act, 42 U.S.C.A. §18032(f)(3) (2010). *See also* Helen B. Marrow & Tiffany D. Joseph, *Excluded and Frozen Out: Unauthorised Immigrants' (Non)Access to Care after US Health Care Reform*, 41 J. ETHNIC & MIGRATION STUD. 2253 (2015).

45. Eleanor D. Kinney, *Realizing the International Human Right to Health for Non-Citizens in the United States*, 1 NOTRE DAME J. INT'L COMP. & HUM. RTS. L. 94, 112-13 (2011).

46. *Id*. at 109–12.

47. *See* Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way to Cover Those Left Out of Health Reform*, 84 S. CAL. L. REV. 859 (2010-2011).

48. *See* Kristine Husøy Onarheim, Andrea Melberg, Benjamin Mason Meier & Ingrid Miljeteig, *Towards Universal Health Coverage: Including Undocumented Migrants*, BMJ GLOBAL HEALTH (Oct. 8, 2018) https://gh.bmj.com/content/3/5/e001031?utm_campaign=bmjgh&utm_content=consumer&utm_medium=cpc&utm_source=trendmd&utm_term=1-A#block-system-main [https://perma.cc/CY6W-55W7].

49. *See* Wendy E. Parmet, *The Trump Administration's New Public Charge Rule: Implications for Health Care and Public Health*, HEALTH AFF. (Aug. 13, 2019) https://www.healthaffairs.org/do/10.1377/hblog20190813.84831/full/ [https://perma.cc/MH3D-5NHT].

50. *See* INT'L ORG. FOR MIGRATION (IOM), INTERNATIONAL ORGANIZATION FOR MIGRATION, MIGRATION AND THE RIGHT TO HEALTH: A REVIEW OF INTERNATIONAL LAW (2013)

III. CONCLUSION

Through her important scholarly contributions to the field of health law, Professor Eleanor Kinney's research has proven influential in academic discourse and policy debates, with this engaged scholarship serving as an inspiration to the field and a framework for policy. Her tireless devotion and thoughtful insights have provided unique perspectives, supported by rigorous research and innovative thought, on the development and implementation of the human right to health. In reflecting on her legacy, we recognize Professor Kinney's enduring contributions to the intersection of health law and human rights, which were not only ahead of her time in understanding the importance of international law, but also continue to have relevance in these uncertain times for the realization of health and human rights in the United States.

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