Roslyn Solomon, JD, has served as a private practice lawyer and administrative law judge for the state of Washington and is the principal of IA Consulting, which focuses on promoting comprehensive and equitable health care reform through innovative advocacy. Please address correspondence to the author at 1700 36th Ave., Seattle, WA, 98122, email: rozsolo@comcast.net.

Competing Interests: None declared.

GLOBAL GOES LOCAL: INTEGRATING HUMAN RIGHTS PRINCIPLES INTO A COUNTY HEALTH CARE REFORM PROJECT

Roslyn Solomon

ABSTRACT

In the United States, city and county governments are often responsible for implementing health policies and programs on behalf of state and federal governments. However, local jurisdictions have generally not capitalized on their own expertise or on local knowledge to advocate rights-based health care reform. Working with local public health officials to develop a rights-based health care reform advocacy plan is a way to integrate human rights principles into local government policy and practice at the grassroots level. The concrete policy objectives found in human rights principles can also be the basis of local government advocacy efforts toward state and federal government for reform that addresses local and regional health needs. This article presents a first-person, "hands-on" account of efforts to operationalize a human rights framework in public health advocacy and action in a local setting, King County, a jurisdiction of Washington, USA, that includes the city of Seattle.

INTRODUCTION

I am an attorney who, through a series of volunteer activities, became exposed to international human rights law, particularly with regard to the right to health. I was drawn to human rights concepts because of their recognition of the mutually sustaining relationship between the individual and the community. Human rights ideas also appealed to me because of their practicality. Although I had no prior experience in public health work, I decided to join an effort to integrate the right to health into local policy and programs in the community where I live, King County, Washington, USA. I now work as an independent contractor for the King County Board of Health, where my colleagues and I are using human rights principles to develop and implement the Board's health care reform project. The health care reform project aims to clarify health care options and build momentum for a rights-based reorganization of health care delivery in our local area. This article describes the work that my colleagues and I have done over a period of some 18 months to integrate human rights principles and analysis into the local policy and advocacy processes connected with the King County health care reform effort.

This article's aims are modest and concrete. It presents a first-person, "hands-on" account of efforts to operationalize a human rights framework in public health advocacy and action in a local setting. It explores the tangible successes and missteps in this process and formulates a set of lessons learned. Recognizing that each jurisdiction is unique and poses distinct challenges and opportunities, I hope that the lessons learned in King County can nonetheless provide practical ideas and options for groups undertaking similar work elsewhere.

The article starts by presenting some brief background information on King County, which includes the city of Seattle. It then describes the steps that were taken to create conditions for a rights-based health care reform effort in this setting. The article looks in detail at how we worked with specific local institutions and stakeholders to build buy-in for a rights-based framing of public health policy issues. It explores the main obstacles encountered and describes how we sought to overcome them. The later sections describe the progress achieved and where the health care reform project stands now. The conclusion offers a set of lessons learned from the process to date.

BACKGROUND

The geography and demography of King County are diverse. The population is approximately 1.8 million, making it the thirteenth most populous county in the United States. It is both urban — some of the largest international corporations are based within its limits — and rural — with over 1,500 farms, most of which are less than 50 acres in size. Individuals of European ancestry constitute 70% of the population, Asians and Pacific Islanders 11%, and African Americans and Hispanics 10%. Fifty languages are spoken in King County and 16% of the population are recent immigrants. It is the medical center for Alaska, Montana, Idaho, and Washington, and has 19 acute care hospitals and over 7,000 medical professionals.[1]

THE PROJECT: BUILDING MOMENTUM FOR RIGHTS-BASED HEALTH CARE REFORM

Identifying institutional partners and entry points

Every state in the United States administers health programs. Some programs are run at the state level, but under state law, most are managed by counties. The most useful institutional settings for promoting a rights-based approach throughout the project described in this article have been two local government agencies: the King County Board of Health (the Board) and the Seattle & King County Public Health Department (the Department). The two entities are closely aligned but serve different functions.

In Washington State, every county has a Board of Health that is charged with maintaining and promoting the wellbeing of its residents.[2] The King County Board consists primarily of elected officials: three King County Council members, three Seattle City Council members, and two mayors from outlying cities. The non-elected members are the director of the Department, the Board administrator, and two medical professionals.[3]

State law requires that the Board hire a local health officer (commonly called the director of public health, who is also the director of the Department) to carry out public health duties as delegated by the Board. The Board sets county public health policy with input from the director. It establishes the annual public health budget and oversees the director's implementation of its directives. The director of public health and his or her staff make up the public health department. The Department differs from the Board in that it does not consist of elected officials but rather of health professionals.[4]

In seeking to advance a human rights approach to health across local government, I decided that these two public health entities would be natural entry points. More clearly than some other health stakeholders, public health officials understand the types of health problems that impact different communities, the interventions that achieve the strongest health impacts in the field, and the ways in which communities are affected by cuts in public services. Importantly, people who work in public health, whether elected laypersons or non-elected professionals, generally support the idea that all members of society should have equitable access to health care. In light of these factors, I focused on public health bodies as the appropriate channels through which to promote local government action on the right to health.

Concrete steps to advance the agenda

The elected officials who serve on a board of health confront many issues simultaneously. For rights-based health care reform to gain traction, the relevant Seattle and King County officials had to be convinced that this project was appropriate and that pursuing it would benefit their political interests. Persuading elected officials requires persuading their respective staffs. I first developed relationships with city staff. As described below, I then expanded my connections to county staff and still later to individual Board members. My colleagues and I attended meetings, made presentations, and prepared reports. Through this incremental process, we created an environment in which moving forward on rights-based health care reform began to seem plausible to local health officials. The following sections describe this process in detail.

Getting started: Childhood asthma in Seattle

I assumed that any new approach to a long-term problem like health care access would likely be met with skepticism. This assumption was correct. The city staff I met first thought that the idea of advocating for health care reform using international human rights standards was unrealistic. In order to familiarize the city staff more fully with human rights concepts and their potential practical applications, my colleague Jean Carmalt and I prepared a simple white paper entitled *Five reasons to use international human rights law for the City of Seattle to implement Measure 1*.[5] This report sought to demonstrate how using human rights standards could improve health policymaking and programming on a local level.

We were able to base our arguments on a recent city ballot initiative, Measure 1, which 70% of Seattle voters had approved in November 2005.[6] Measure 1 expressed support for considering equitable, high-quality health care as a right for all United States residents. In our white paper, we argued that passage of Measure 1 demonstrated community support for a health care system that reflected ethical values and that met international standards. Seattle had separately adopted the Healthy Communities Initiative Policy Guide (the Guide) in February 2006.[7] Both Measure 1 and the Guide use language and describe procedures found in international human rights law (for example, the Guide directed the city to employ strategies to lessen health disparities). As such, we could make the case that Seattle was already on its way to using international human rights norms in its efforts to improve community health. We also showed how international human rights laws provided a framework for meeting the city goals listed in the Guide. Finally, we appealed to city lawmakers' political interests by arguing that adopting international human rights principles would provide them political and strategic benefits because they would be seen as innovative leaders in the area of health and health reform.[8]

To illustrate these concepts and to show that compliance with international human rights standards was not onerous, we attached to our white paper an appendix that described a hypothetical health program designed to reduce childhood asthma hospitalizations. Our scenario drew upon the Department's own health disparities data. As is the case in most US jurisdictions, poorer communities within King County show a higher incidence of diabetes, asthma, obesity, hypertension, heart disease, and injury from assault than do wealthier areas. We noted that there was also a higher rate of childhood hospitalization for asthma in one of the poorest areas of the city. Hospitalizations are expensive, creating a natural incentive for the city and county to seek to reduce them. Using this shared, practical objective as our starting point, we then argued that human rights principles provide a valuable guiding framework for designing a cost-effective program that would use existing facilities and community relationships to reduce asthma hospitalizations in the target area over a two-year period.

We derived the human rights standards that formed the basis of our analysis from General Comment 14 of the UN Committee on Economic, Social and Cultural Rights.[9] As human rights practitioners know well, General Comment 14 provides an accessible set of criteria by which to evaluate how well health care services meet the requirements of the right to health. These five key criteria are availability, accessibility, appropriateness, quality, and community participation. Our plan for a rights-based program to reduce asthma hospitalizations translated these criteria into strategies for practical program implementation, taking into account the specific features of the political, social, and public health context in Seattle. We demonstrated that not only was it possible to design an ambitious local public health program in accordance with international human rights standards, but also that there were good reasons to believe that a rights-based program would achieve better results than alternative approaches.

After reviewing our report and the appendix, city staff asked us to prepare a human rights analysis of the widely discussed Massachusetts state health plan, as well as the health care proposals put forward by the Bush Administration. Staff members found these additional analyses helpful because they illustrated how the two health plans would actually operate in practice and showed how, in different ways, they failed to meet both human rights standards and Seattle's public health policy objectives as outlined in the 2006 Guide.

Our analyses were presented in short white papers, no longer than ten pages in length and complemented by bullet points and tables for easy reference.[10] These reports dispelled the view that human rights standards were esoteric or too theoretical to serve as a useful analytical tool. The reports also gave us credibility. We produced work that was helpful, was easy to understand, and which could be used by staff to expand support for a health reform agenda.

We believed that the next step was to describe our approach to a broader audience. We proposed to conduct a presentation to additional staff and city council members regarding health and human rights. The staff agreed, and they set up the meeting. Through the reports and the presentation, we showed how human rights standards provide practical guidance to policymakers who are regularly asked to support one program or approach over another. Likewise, we showed how human rights standards provide useful design parameters to public health officials who increasingly face the difficulty of allocating limited resources across a range of needs.

We acknowledged that the application of human rights standards could increase costs in some areas. For example, the provision of new, multilingual materials on asthma would increase preparation, printing, and distribution expenses; increased staff expenses could be associated with an effort to increase the participation of community members in health decisions and in program design; and taking programs out of clinics and moving them to venues such as schools and community centers, as we proposed, could carry added expense. However, we made the case that the potential payoff, in more effective programming and improved community health, made a rights-based strategy a wise investment. The response to the presentation was very positive. As our staff contacts described it, we were "gaining traction."

Translating human rights standards into local program structures

Over the next few months, I made presentations to a range of organizations in an attempt to build on this initial momentum. However, despite interest in the topic, city staff explained that they were unable to integrate human rights principles into health programming. The sticking point was the relationship between the city and the county. The two had just completed a public health strategic planning process — of which I had previously been unaware — and had adopted a Public Health Operational Master Plan (OMP). Understandably, the city was not willing to adopt new policies unless they fit within the OMP and also met with county approval.

City staff recommended that we broaden the approach and work at the county level. Thanks to an introduction and support from city staff, the county Board proved receptive. They asked us to show how human rights principles could be used to implement portions of the OMP.

The OMP required King County to assure that all residents have access to affordable, appropriate, high quality health care. The goal of this requirement over the long term was to increase healthy life expectancy for county residents. In the short term, King County was to convene and lead "improved community strategies" to provide greater access to health services. The OMP used, but provided no definitions for, the terms *access*, *affordable*, *appropriate*, and *quality*.[11] I explained to Board staff that these terms could be defined using international human rights concepts. The effort here was to translate human rights standards into actual program parameters. I defined the terms and their related concepts as follows:

Access and *affordable*: These terms mean that health services are available to all regardless of factors such as the ability to pay, pre-existing medical conditions, race, age, ethnicity, or immigration status. In addition:

- Health facilities are conveniently located and sufficiently equipped to provide services to treat prevailing community health conditions;
- Information about available health services is widely and effectively disseminated; and
- Payment mechanisms are straightforward and simple to use.

Quality and *appropriate*: These terms mean that health care meets the highest scientific and medical standards using evidence-based best practices. In addition:

- Health care and health information are provided in a way that makes them understandable, and sensitive and responsive to cultural norms;
- Open communication exists between health practitioners and their patients about health care services and options, which are patient-focused and include preventive care, without third party interference; and
- There exists effective wellness and care coordination, which means the health system rewards improved health outcomes and efficiencies and controls costs.

Improved community strategies means, in part:

- Promotion of a rights-based approach to health care services;
- Commitment to not reducing or eliminating health services without replacing them with equal or better programs; and
- Participation of target beneficiaries in program design, implementation, and evaluation.

Our simple document, which closely resembled the preceding list, contained clear bullet points showing how adopting human rights principles would not divert energy, but, in fact, facilitate the implementation of the OMP. The staff agreed, and they adopted the definitions without discussion.[12]

Confronting budget constraints

One of the action items in the OMP directed the Department to advocate for health care financing reform. Once staff had agreed to the definitions of the key terms outlined above, I floated an additional idea: a county-based effort to advance the health reform goals of the OMP by conducting advocacy toward state and federal lawmakers. The aim would be to press for health care financing reform incorporating human rights concepts.

Just as I was ready to introduce the project to the Board in the summer of 2008, the County learned that it faced substantial and unanticipated revenue shortfalls. King County turned its attention to the next budget cycle and to the reality that it would have to cut programs and services in order to balance its 2009 budget. The Board and Department believed that progress on the OMP was impossible in light of these circumstances. The challenge then became how to restructure the advocacy proposal so that it could simultaneously help alleviate the Department's budgetary problems.

I rearranged my work plan to include raising the profile of the Department among county residents. Polling data showed that the idea of health care reform was popular with voters. Taking this data into account, my proposal changed to include not only advocacy for health care reform with state and federal lawmakers but also a community communications component. The assumption was that the public would be glad to see the Board and Department tackling an issue that ordinary people considered important and that the appreciation would translate into votes for increased funding at the ballot box.

Framing an advocacy plan

In constructing an advocacy plan for rights-based health care reform, the first step was to develop the principles that the Board and Department staff would use when communicating with the general public and with lawmakers. I drafted the principles in the form of a table that once again drew from the content of General Comment 14 and from an evaluation of the US presidential candidates' health care reform proposals prepared by the National Economic and Social Rights Initiative.[13] The first draft of the principles was circulated among Department, city, Board, and county executive staff who added more detail. For example, staff decided to include financial sustainability as an additional structuring principle and to separate the discussion of preventive care from the analysis of quality. The principles were then presented to a subcommittee of the Board.

Political divergences play a significant role in the dynamics of Board meetings. King County Council members from rural areas tend to argue that policy solutions should be distinctively "American." These members are often skeptical of practices used in other countries and of concepts espoused by the United Nations. The Board members from urban areas tend to have the opposite view. They see Seattle and the county as trade-oriented, global communities that should seek to increase international ties as much as possible. Gaining broad support for the principles among Board members in light of this political gap was the first challenge. At the subcommittee meeting where the principles were first discussed, we explained that the principles were derived from international human rights norms and from the original thinking of our Department staff. By emphasizing these sources, both international and entirely local, the two wings of the Board were satisfied. The subcommittee perceived the final compilation as their own, and the members unanimously recommended that the principles be adopted by the entire Board. The Board did so in September 2008.[14]

The ongoing work

The Board's health reform project, formally adopted at its March 2009 meeting, is now underway.[15] The project has three major components. The first consists of developing advocacy and communications content. The second is establishing regular communication with local organizations, media, academia, and business, and holding regular meetings with the state legislators and the members of Congress who represent King County.[16] The third component consists of establishing relationships with other public health departments around the state and potentially across state lines with the goal of forming a public health voice for health care reform that incorporates King County's principles.

As part of developing advocacy content, I analyzed five health plans currently under consideration by the Washington State Legislature. The legislature is reviewing these plans as part of an ongoing state-based health reform process. The five plans range from a private, free market option to universal coverage provided through a public single-payer mechanism.[17] The legislature had previously received an analysis of the plans from an independent consulting firm, Mathematica Policy Research, Inc. My analysis used the County's rights-based principles, in contrast to the criteria used by Mathematica.[18]

The information in my analysis, with additional information regarding the OMP and the content of the principles, presently informs the substance of Board and Department communications with state legislators and the general public. Separately, I prepared an analysis of the Obama Administration's health reform principles. This analysis informs the content of communications between Board members and federal legislators. In an ongoing six-month dissemination process, the content of the communications with state and federal legislators is being presented and discussed at panels at university campuses, in community meetings, and through newspaper articles published across the county.

We see value in bringing together different public health departments to advocate jointly for health care reform while also equipping these departments to disseminate relevant information to the residents of their respective counties. This project could be the beginning of a new model of public health advocacy. One of the project goals, therefore, is to demonstrate that advocating for health and human rights, and specifically for health care reform that meets international human rights standards, fits within the public health mission of promoting community health.

LESSONS LEARNED

Our work to date in Seattle/King County highlights a number of ways to improve the likelihood of successfully promoting health and human rights concepts among local government officials and of establishing a health care reform project that begins to put these concepts into practice. Based on our work so far, we can formulate several practical recommendations for groups seeking to integrate human rights principles into public health advocacy and action at the local level.

First and foremost, identify your allies. In Seattle and King County, the Board of Health and the Public Health Department were natural entry points for a health and human rights agenda. However, in another jurisdiction, it may make more sense to work with a specific city or county elected official, with the insurance commissioner, or with others. Seek out these allies and determine who the key decision makers are. Develop a strategy for establishing mutual trust and gaining interest and support for the project at an early stage. Meet with lawmakers one-on-one, learn about their political concerns, and propose how your project may help address some of these concerns.

Another way to gain allies is to align your work with ongoing efforts or initiatives — for example, with a city or county's strategic public health plan. If a plan exists, demonstrate how your work serves to promote and implement it. Articulate your long-term goals in a way that posits them as consonant with the goals of your jurisdiction.

Express to policy makers and allies the benefits of communication with and dissemination to the public. Remind lawmakers and staff that communicating regularly with the public raises the profile of the local government agencies involved and serves the public interest. People benefit from an understanding of what good health care and effective public health strategies should be. Knowing that an agency is advocating on their behalf to improve well-being in their communities provides community members with the opportunity to support it.

Encourage participation. Ownership of and investment in the effort by the local government entity

adopting and promoting health and human rights principles will likely translate into long-term support. Work through a process that allows public health and elected officials to take into account the local context and include context-specific detail or additional points to the standard categories used in human rights analysis in health, such as *availability*, *accessibility*, *appropriateness*, *participation*, and *quality*.

Persistence and patience are vital. Developing relationships with the individuals who determine whether or not a project moves forward takes time. In the case of the project described in this article, considerable trial and error were involved in identifying key actors; in establishing who really supported the project and who did not; and in determining how to bring on board those actors whose support was essential for success. The process outlined here took place over approximately 18 months.

Finally, be able to describe in simple terms how implementation of human rights concepts would change the delivery of health care services in the field. Such a description might state, for example, that every individual would have a primary care provider, that he or she would not have to postpone or forego care because of financial concerns, that payment systems would be easy to use, and that clinics would be conveniently located.

As work proceeds, we are now in contact with the Obama Administration, the National Association of Local Boards of Health, and five counties adjacent to King County. We have launched a website that provides the public with information about our activities and links to presentations and documents (http://www.kingcounty.gov/healthservices/health/BOH/HealthReformProject.aspx). Interestingly, we are now finding that members of the King County Congressional delegation are very interested in our "principles first" approach to reform. And so, a final lesson learned: "Build it and they will come."

REFERENCES

1. Information regarding King County population demographics and medical information came from several online sources: King County Public Health official website (http://www.kingcounty.gov/healthservices/health); "HistoryLink.org Online Encyclopedia of Washington State History, King County — Thumbnail History." Available at http://www.historylink.org/index.cfm?DisplayPage=output.cfm&file_id=7905; and the website of the US Census Bureau (http://www.census.gov/).

2. Washington State Legislature, *Chapter 70.05 RCW Dispositions: Local health departments, boards, officers — regulations*. Available at http://apps.leg.wa.gov/Rcw/dispo.aspx?cite=70.05.

3. For further details about the King County Board of Health, see http://www.kingcounty.gov/healthservices/health/BOH.aspx.

4. Public health professionals have expertise in medicine, statistics, and program evaluation. They provide health care services, map demographic trends, collect health data, promote health education, and disseminate health information to the public. The Department is the tenth largest metropolitan health department in the United States. It has 1,900 employees, 39 sites, and an annual budget of US$296 million (http://www.kingcounty.gov/healthservices/health/about/description.aspx).

5. R. Solomon and J. Carmalt, *Five reasons to use international human rights law for the City of Seattle to implement Measure 1* (Seattle, WA: Uplift International, September 2007). Available at http://hhrjournal.org/blog/wp-content/uploads/2009/08/five-reasons-to-use-intl-hr-law.pdf.

6. The official text of Measure 1 is available at http://www2.seattle.gov/ethics/vg/20051108/05genl.pdf, pp. 70, 71.

7. "The City of Seattle Healthy Communities Initiative: Policy Guide for the City's Public Health Efforts and Investments, February 7, 2006." The full text of the Guide and other city public health initiatives are available for review at http://www.seattle.gov/humanservices/foodhealth/publichealth/HCI_PolicyGuide.pdf.

8. City and King County officials have a history of adopting and implementing international standards. Doing so has proven to be politically advantageous. For example, Mayor Nickels adopted the Kyoto Protocol in Seattle in 2005 when it went into effect for nation states around the world. Since then, 600 US mayors have done the same, and the US Conference of Mayors has formally adopted a US Mayors Climate Protection Agreement. Although initially ridiculed for grandstanding when he adopted the Protocol, Mayor Nickels now receives

accolades. City residents recycle, compost, and share city-provided vehicles as part of the local implementation process. Mayor Nickels has subsequently been elected president of the US Conference of Mayors. Independent of Mayor Nickels' initiative, former King County Executive Ron Sims also adopted certain quality and best-practices requirements for health practitioners in King County. His approach was subsequently adopted throughout the Puget Sound region. Mr. Sims now works for the Obama Administration.

9. Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000). Available at http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En.

10. R. Solomon and J. Carmalt, A *Human Rights Analysis of the 2007 Bush Healthcare Proposal* (Seattle, WA: Uplift International, February 2007). Available at http://hhrjournal.org/blog/wp-content/uploads/2009/08/human-rights-analysis-of-bush-2007-proposal.pdf; and R. Solomon and J. Carmalt, *Missing the mark: A human rights analysis of the Massachusetts Universal Healthcare Plan* (Seattle, WA: Uplift International, March 2007). Available at http://hhrjournal.org/blog/wp-content/uploads/2009/08/human-rights-analysis-of-massachusetts-health-plan.pdf.

11. Seattle & King County Public Health, *King County Operational Master Plan Final Report and Recommendations — August 2007*. Available at http://www.kingcounty.gov/healthservices/publichealth-masterplan.aspx (via link to "Final OMP Report and Recommendations"). Seattle and King County both provide public health services. Seattle residents receive the same services from King County as do all County residents. City residents also receive "enhanced services" that go beyond the basic County services. How these enhanced services are financed and distributed is delineated in the Healthy Communities Initiative Policy Guide (see note 7). The City's Guide was one of the documents County staff members reviewed in preparation of the OMP.

12. I am not certain but I believe that the staff adopted my definitions because these definitions addressed an ongoing internal problem. No other definitions for the OMP terms had been developed, yet having them was essential in implementing the OMP. The definitions that I offered were simple, made sense, and served the purpose.

13. CESCR General Comment No. 14 (see note 9); see also, A. Rudiger, *Pursuing A New Vision For Health Care: A Human Rights Assessment of the Presidential Candidates' Proposals* (New York: National Economic and Social Rights Initiative [NESRI], January 2008). Available at http://www.nesri.org/Human_Rights_Assessment.pdf.

14. King County Board of Health Resolutions. Notice Resolutions #08–10 (King County, OR: Board of Health, 2009). Available at http://www.kingcounty.gov/healthservices/health/BOH/resolutions.aspx.

15. King County Board of Health meeting, *Meeting proceedings* (March 2009). Available at http://www.kingcounty.gov/healthservices/health/BOH/proceedings.aspx.

16. Seven of the nine members of the delegation represent all or portions of King County.

17. The five proposals are as follows: a Connector plan modeled on the current Massachusetts plan; a standardized universal plan; a single-payer plan; a small employer and young adult free market plan; and a preventive care/catastrophic care plan proposed by the Washington State Insurance Commissioner. See Washington State Senate Bill 6333 (2007). Available at http://apps.leg.wa.gov/billinfo/summary.aspx?bill=6333&year=2008.

18. The Mathematica analysis included the extent to which each proposal promoted 1) improved health outcomes; 2) prevention and early intervention; 3) chronic care management; 4) services based on empirical evidence; 5) incentives to use effective and necessary services; 6) disincentives to discourage use of marginally effective or inappropriate services; and 7) a team medicine approach overseen by a primary care provider.