THE RIGHT TO HEALTH AND THE RIGHT TO HEALTH CARE: THE HISTORICAL TRACK THAT LED TO THE HEALTH CARE SYSTEMS IN THE UNITED STATES AND THE UNITED KINGDOM

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By

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ABSTRACT

This paper analyzes the historical track that led the United States and the United Kingdom to the current health care system. And the objective is to identify if the United States heading for a nationalized health care system after the introduction of the Affordable Health Care system? To see if this theory is probable, I wanted to compare and contrast the country with the closest historical similarities and with a nationalized health care system; United Kingdom. The right to health and the right to health care are seen in different lenses in the United States and United Kingdom. The view of the right to health and the right to health care, and second, the policies and social environmental changes that affected the perceived understanding of how the health care system should be structured.

In the United Kingdom, the 16th century was the first supposed understanding of a health care industry. As for the United States it was the 18th century, when the health care system was viewed as an essential part of the society. The influence the government and the private sector have on the structure of the health care system for the United States and United Kingdom. The two vital opinions are first that the government would facilitate the health care effectively while the other group sees the private industry would
manage the health care appropriately. In the United Kingdom, the private sector (philanthropist) has had a large influence on the current structure of the health care system and then in later years the government took the role as the sole entity accountable for the health care system. As for the United States it was a combination of both private and government.

The influence of the British Medical Association (BMA) and the American Medical Association (AMA) on the health care system in their perspective countries had a vital role of the structure of the health care system. The AMA had a major influence in the American Health Care System in contrary to the BMA, where the fragmentation and weakness of the BMA allowed the government to pick what health care system would fit their country. The influence of the AMA on the American political system would make those fearing that the United States would head to a nationalized health care system concerns not plausible in the near future.
DEDICATION

To My mother,

for continuing to be an inspiration and a great support
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The most important political question in the United States is the health care system and how much the government should be involved in facilitating this industry. The debate about the Affordable Care Act and if the President Barack Obama is overstepping his boundary as the president has been debated for years, ever since he was first elected as president of the United States. The fear of rationing and a nationalized health care system were discussed as the ultimate outcome of the ACA. The Republican Party has warned that if this policy is passed, the U.S. would ultimately nationalize the health care system. The fear of rationing and the government dictating and running the health care system created a partisan environment in the U.S. and a government shutdown that lasted over two weeks.

The daunting question as to the U.S. heading to a nationalize health care system can only be determined by comparing the U.S. to a country with strong historical ties; the United Kingdom. The right to health and the right to health care in the U.S and the U.K. and what policies and cultural changes that led to the current structure to the Health Care System in both countries are important to address. The understanding of what right to health and health care means for the U.S. and U.K. and how it affected the polices they adopted for their perspective nations. The history of how the health care shifted and changed over the years and what will be the next phase for health care system for the U.S.

The ACA is the most pivotal policy the American government has developed in recent years and its implication is yet to be seen. The contraceptive clause within the
ACA was the first defeat of the ACA after the law was first developed. The freedom of religion outweighing the access to contraceptive for women who can’t afford to pay for the contraceptive and elective abortion. The Supreme Court decision on the clause was an important decision.

How the health care shifted over the years from the 18th century to the ACA is important to address, where the U.S. health care system was and where it is heading in the near future. The right to health care is not established in the U.S. which makes the argument that a nationalized health care system not possible in the near future especially with the AMA influence in the U.S. political arena. But the question still remains, is the U.S. heading for a nationalized health care system?
I. Why the Right to Health?

In post-World War II, numerous nation’s were leaning towards the improvement of the quality of life for all. During this period, western nations were invested in providing human and monetary capital in areas where human rights were lagging, as a way to find solutions to the most convoluted human rights issues. Multinational institutions were developed to enhance human life across the globe. And with such resources, these institutions have become our central core in detecting and improving areas where human rights were neglected. It is quite complex to fully understand what human rights are and its many facets. Human rights issues are not concentrated in one area or expertise; there are many aspects that fall under the umbrella of human rights. Some consider right to health as a human rights issue while others do not see it as such. With more prevalent diseases and globalized world, the right to health has shifted to the forefront of global issues.

It is quite perplexing to comprehend the significance of the right to health, especially when one does not quite understand what it encompasses. The conversations on the right to health are somewhat new; it was post World War II, when the right to health was introduced and discussed among intellectuals in different fields of professions. And with the rise of globalization, nation-states, multi-national organizations and corporations, there is indeed a need to develop a universal understanding of what the right to health is or ought to be. The millennial goal project had fifteen clauses, with
many penetrating to a better health of citizens of the developing countries. The access to better health for the bottom billion is the goal of many multinational organizations. But with this new advocacy, it is imperative to identify what it means to provide the masses with an adequate access to health, if the right to health applies to them and if right to health is a human rights issue.

II. What is “Right”?

It is essential to examine what ‘right’ is before addressing human rights and right to health. The term “right” is overtly used, but is rarely discussed in such framework. It is quite difficult to comprehend the nuances of such a term and what one means when one says ‘right’ without understanding the definition of ‘right’. The distinction between what is considered ‘right’ and what are considered morally good cannot be easily elucidated, but what we’ve come to assume is that these terms are not synonyms. Many believe these terms have similar meanings, but according to W.D. Ross, ‘right act’ does not mean the same as an act that ought to be done’ or as a ‘morally good act’.¹ The best definition according to W.D. Ross, ‘right’ is what is morally obligatory. Thus, the sense of duty should not be the moral force to do ‘right’, but to do the deed without the sense of obligation. According to G.E. Moore, who claims in ‘Principia Ethica’ that ‘right’ means ‘productive of the greatest possible good’, it is the good that provides the most benefit and, is what creates the best outcome and the right circumstances.² Moore believes that right is analyzable into a product of the greatest possible good. W.D. Ross further states


² Ibid., 8.
that right’ does and can mean nothing but “cause of a good result”, and is thus always identical with “useful”… That the assertion “I am morally bound to perform this action” is identical with the assertion “this action will produce the greatest possible amount of good in the Universe”. Thus, the person makes the decision as to what is good or morally good.

Understanding not just the definition is crucial to comprehend the facets of a certain topic, but also how a definition can be pertained into the real world. The definition is not sufficient for full comprehension, but a further amplification and the application of the definition creates a better understanding of not just the term but also the application of the term. Thus, it is important to recognize what makes “right” act right? According to Professor Moore, “what makes an action right is that it is the product of better than could have been produced by any other action open to the agent”.4

“Prima facie duty or conditional duty as a brief way of referring to the characteristic (quite distinct from that of being a duty proper) which an act has, in virtue of being an act which would be a duty proper if it were not at the same time of another kind which is morally significant”. In that, what is referred to the right is the ‘prima facie’ of the right at the time or preserved right. It is the duty of the individual to understand what is right and then acting upon it. But right always differs from one person to another and from one society to the next. The preserved right thing is the right or what

3 Ibid., 8.
4 Ibid., 16.
5 Ibid., 19.
is understood as being right. This is when conflicts arise, as many developing nations view developed countries meddling in their internal affairs and quite dismissive on their own understanding of right. Donors view right from a European point of view, while many developing nations in Africa, Asia and Latin America see right from their cultural standpoint.

III. The Right to Life

The right to life created the framework for all human rights issues and is the principle of all human rights; it is the most basic right, which without it, none of the other rights exist. Human rights recognize that all human beings are born with an equal degree of freedom, liberties and rights. International documents’ pertaining to rights also recognizes the right to life; to pursue life without torture, suffering inhuman or degrading treatment or punishment. Everyone is equal before the law, and innocent unless proven guilty, protect one’s dignity and self-respect in the face of aggression, freedom of thought, religion and conscience and etc. The survival of the individual is the pivotal component of human right and liberties such as the European Convention for Human Right (ECHR) and other international documents confers. “Everyone’s right to life shall be protected by law” which was included in Article 2 of the ECHR. Therefore, it is the State’s responsibility to protect the life of its citizens. And the State is liable in protecting its citizens against third party aggressors (illegal institutions or terrorists). There are

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7 Ibid.
variations of opinions into when the right of life is restricted. Abortion and euthanasia are
two subjects that do not fall under the classic understanding of the right to life. 8

Article 2 (2) of the ECHR, imposes three different types of obligations. 9 A
negative obligation is to abstain from taking life. Deaths caused by force are prohibited in
Article 2 (2), which requires the State to protect the person from unlawful violence, and
death. However, the use force will only be lawful under certain exceptions and it must be
absolutely necessary for the safety of all. A positive obligation is to take necessary
measures to safeguard the life of the citizens. The European Courts have allowed certain
circumstances, where the positive obligation extends to the protection of the person's life
when at risk from the criminal acts of another individual, other forms of violence, suicide
and environmental hazards. Thus, in the environmental hazards, references to the life and
health of the individual are protected by the State.10

The right to life does come with its limitations; there are viable restrictions to the
right to life. Court decisions against criminal case can strip an individual of his/her right
to life in some countries. In cases where the individual is a threat to the State and the
society, then the State has the authority to strip the individual from his/her rights
including the right to life in some cases. The limitation to the right to life exists, but a
universal understanding to right to life does not exist with its limited forms.

IV. The Institutionalization of the Right to Health

8 Ibid.


10 Ibid.
The history of human rights can be traced back to Thomas Jefferson first draft of the Declaration of Independence in 1776. “We hold these truths to be scared and undeniable, that all men are created equal and independent [sic], that from equal creation they derive rights inherent and inalienable, among which are the preservation of life, liberty and the pursuit of happiness”. Others believe the origin of human rights dates back to the French revolution On the Rights of Man and of the Citizens (1789), declaring that all men ‘are born equal and remain free and equal in rights’. But neither the Declaration of Independence nor the Rights of Man and of the Citizens mentions the right to health as a human right. But what these documents present is the instrument to where the right of health has flourished and developed from. The recognition of the right of the person establishes the appropriate setting for other rights.

The concept of the right to health might seem new, in the past 50 years, there has been great advancement in developing this term. Observing historical track of the right to health is essential to fully comprehend and understand its nuances. There is an undeniable nexus between war, rights, health and peace. It is the times of war when one recognizes the need for change. The Great War helped to develop the League of Nations (LON), and the central theme of the LON was the need to attend to the health of the individual and societies. Article 23 of the Covenant of the LON mentions the need for humane work conditions and protection against public health scares. Article 25 of the LON states that “members of the League agree to encourage and promote the establishment and cooperation of duly authorized voluntary national Red Cross organizations having as a

purpose the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world”.

But after WWII, there were consensuses that the LON covenant was not enough in maintaining peace and health. On April 1945, just weeks before the German forces surrendered, representatives of fifty nations, primarily the Allied powers that had declared war on Germany, Italy and Japan met in San Francisco with the intentions of creating a new international organization; the Unite Nations (UN). The UN’s goals were to create a new world order and find ways to compensate groups that were affected by the war. It was a way to find redemption, for all the atrocious actions that were committed by the Axis powers against minorities. This was the start of a new era of recognition of the individual rights and the rights of groups. With new nations gaining their independence during that period, many groups were curious to see what the new world order will be put in place. With the development of the UN, the new world order was finally recognizing the importance of consensus and hoping this new order will deviate the need for another world war. It was not the UN that addressed the “right to health” but another institution that was more appropriate for this subject; the World Health Organization (WHO). The constitution of the WHO was the first to adapt the concept of the right to health. In the constitution, it states the right to health as “the enjoyment of the highest attainable standard of health is one of the fundamental rights of

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12 Ibid., 23.

every human being without distinction of race, religion, and political belief, economic or social condition”.  

The Universal Declaration of Human Rights (UDHR) was embraced by the United Nations General Assembly on 10 December 1948 at the Palais de Chaillot, Paris. The Declaration surfaced directly from the experiences of the Second World War and signifies the first universal manifestation of rights to which all human beings are innately entitled. In article 25 of the UDHR, it states that (a) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his/her control. (b) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.  

There were two other treaties that were developed that extended human rights issues. It is important to define and understand the distinction between these two treaties; the first is the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR). These covenants were created as a binding agreement, where governments can abide by. In 1954, two drafts were developed and completed; the first covenant was on civil and political rights and the second on economic, social and cultural rights. And in 1966, the covenants were

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14 Tobin, Right to Health, 17.

15 Ibid.
adopted by the U.N.\textsuperscript{16} It was in 1976 that the required number of countries ratified it. “The International Covenant on Civil and Political Rights (ICCPR), though very extensive, proved relatively less contentious, in shielding individuals from forms of discrimination, and persecution. The second, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) contains more binding agreements and is regarded as a more inclusive treaty”. \textsuperscript{17}

The WHO and the ICCPR was only concentrating on the general human rights issue and were not concentrated on the details of how these policies will be constituted. What these policies, appeals for is an adequate standard of living and access to basic health rather than a more inclusive mandate comparable to the ICESCR, which calls for a need to improve the quality of life and a call for the highest attainable standard of health. These declarations did not fall short of its original commitments, but what it needs is to be more is more coherent. Rightly, many of these international government organizations and non-government organizations lack the capabilities to enforce standards on participating parties. The purpose of these policies is to tackle the topic and create more coherent policies. The ICESCR, article 12 states as follows:

1. The State parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
   i. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;


\textsuperscript{17} Ibid., 6.
ii. The improvement of all aspects of environmental and industrial hygiene;
iii. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
iv. The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.\textsuperscript{18}

V. The Perceived Right to Health?

So is there a nexus between human right and health? The conversation on the right to health can be preserved as what right to health means to the population as a whole. Is the right to health only applied to the population in general or to a certain groups within the population? There are strong conversations/discussions of what the right to health really means and who are entitled to these rights. Especially among developing countries, the right of health is shaping and shifting the society into a new direction. It is the western understanding of right that is implied, and dictates the notion to who are entitled to these rights. In the nation states era we currently live in, the question of autonomy of the state to dictate and define their own understanding of the right to health in accordance to their cultural norms and values is modulated.

The office of the United Nations High Commissioner for Human (OHCHR) Rights released a document on the right to health called “The Right to Health- Fact Sheet No. 31” and was in coordination with the WHO. The right to health is not just the right to the enjoyment of the highest attainable standard of physical and mental health, but also, it is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. And it further states that the right to health is the enjoyment of the highest attainable standard of health as a fundamental right of every human being without

\textsuperscript{18} Ibid., 7.
distinction of race, religion, and political belief, economic or social condition. There are key aspects of the right to health, which is also seen as an inclusive right; it is a range of factors that leads to a better life. Access to clean drinking water and adequate sanitation, safe food, adequate nutrition and housing; healthy working and environmental conditions, health-related education and information, and gender equality are considered components within the right to health. It is in reference to the ICESCR assessment of what the right to health is. The right to be free from non-consensual medical treatment, such as medical experiments and research or forced sterilization, and to be free from torture and other cruel, inhuman or degrading treatment and punishment.

In the ICESCR, the right to health also allows certain entitlements, which includes the right to a system of health protection, providing equality of opportunity for everyone to enjoy the highest attainable level of health, the right to prevention, treatment and control of disease, access to essential medicines, maternal, child and reproductive health, equal and timely access to basic health service, the provision of health-related education and information and finally participation of the population in health-related decision making at the national and community level. The conditions of these facilities and accessibilities are also included. The requirements include a functioning public health and health care facilities, goods and services must be available in sufficient quantity within a State. Also, it requires these facilities to be accessible physically; in safe reaching for all.

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19 Ibid., 1.
20 Ibid., 3.
21 Ibid., 4.
sectors of the population (children, persons with disabilities, elderly and vulnerable groups). Accessibility also entails the right to seek, receive and inform health-related information in an accessible format and also allowing the patient to keep his/her documents confidential. Lastly, the care must be scientifically and medically appropriate and of good quality. It requires health professionals to be trained, and the drugs to be scientifically approved and unexpired, it also calls for an adequate hospital equipment, adequate sanitation and safe drinking water. \(^\text{22}\)

The right to health does not mean the right to be healthy. The right to health is facilitating the conditions that will help the ‘person’ have access to these services, and a variety of other goods. The right to be healthy cannot be guaranteed since other factors that are outside the State’s control are present, such as biological make-up and socioeconomic conditions can affect the person’s health. The right to health is not an immediate entitlement, but a goal to strive for. Nonetheless, it does not mean State’s should forgo any attempts to reach these goals. There are immediate goals that will allow the State to achieve it, such as legislatures and assuring the right to health is applied to all citizens without any discrimination. And finally, State must take measures to assure the right to health is accomplished, though not all States have the capabilities and the resources to attain such right, but they are required to maximize the use of the available resources even if it is tight. \(^\text{23}\)

\(^{22}\) Ibid., 6.

\(^{23}\) Ibid.
The right to health is contingent to the enjoyment of other human rights. The right to health and the right to water are two rights that are interrelated. Lack of sanitation and poor management of water resources disturbs the right to health to a certain limit. Most diarrheal diseases in the world are contributing to unsafe water, sanitation and hygiene. In 2002, these three factors contributed to the diarrhea, which in effect resulted in the 2.7 percent (1.5 million) of the death worldwide. 24 Human rights supporter’s advocate for issues that are also interrelated to the right to health, thus these rights are contingent to the right to health and vice versa.

The right to health is incorporated in one way or another in many treaties, such as the 1965 International Convention on the Elimination of All Forms of Racial Discrimination, the 1965 International Covenant on Economic, Social and Cultural Rights which was the first treaty of its kind to recognize the right to health, the 1979 Convention on the Elimination of All Forms of Discrimination against Women, the 1989 Convention on the Rights of the Child, the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, and the 2006 Convention on the Rights of Persons with Disabilities. 25 The American Convention on Human Rights (1969) and the European Convention for the Promotion of Human Rights and Fundamental Freedoms (1950) contain provisions related to health, such as the right to life, the prohibition on torture and other cruel, inhuman and degrading treatment, and the right to family and private life. These treaties are all international and

24 Ibid.

25 Ibid., 9.
regional human rights instruments that address the right to health in various ways. The right to health is also acknowledged in several regional instruments, such as the African Charter on Human and Peoples’ Rights (1981), the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the Protocol of San Salvador (1988), and the European Social Charter (1961, revised in 1996). Finally, the right to health is recognized in at least 115 constitutions. There are six constitutions that set out the duties that is health related, such as the duty on the State to develop health services or to demand a specific budget to them. What these treaties recognizing the right to health indicators is the consensus that such right does exist and needed for a healthier society.

The ratification of the ICESCR treaty required States to produce reports that will entail the progress of the policies that were implemented within their jurisdiction. The ICESCR has set minimum obligations of the State to meet these basic requirements. “The right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; access to the minimum essential food which is nutritionally adequate and safe; access to shelter, housing and sanitation and an adequate supply of safe drinking water; the provision of essential drugs; and equitable distribution of all health facilities, goods and services”. There are three obligations States must accomplish the obligation to respect; which means to respect and refrain from

26 Ibid., 10.

27 Ibid., 23.

28 Ibid., 25.
directly or indirectly interfering with the right to health. Second, the obligation to protect, which is to safeguard against third party intrusion on the right to health and finally, the right to fulfill and to implement appropriate legislature, budgeting, administration, promotion, judicial, and other measures to achieve the right to health.

Though, the U.S has not ratified the ICESCR, nevertheless the U.K. has ratified the treaty and must generate the report for the ICESCR. The last report the U.K. produced for the ICESCR was created in June 2014 and it is believed that the report will be discussed sometime in 2016. ICESCR monitors the progress of the right to health and other human right declarations within the treaty. There is a procedure that the ICESCR uses to ensure the right to health is being constituted by the governments that ratified the treaty. “The ICESCR is monitored by the UN Committee on Economic, Social and Cultural Rights (UN CESCR), a body made of 18 independent experts. These experts are nominated by the Governments who have ratified the ICESCR, and are elected to serve four-year terms. UN CESR meets two or three times a year. Governments who ratified the ICESCR submit reports to UN CESCR every five years. These reports outline on laws and policies they have adopted to implement ICESCR. They should also provide evidence about the effect of these laws and policies on people’s enjoyment of ICESCR rights. These reports are known as the “State Report.”

The ICESCR criteria’s and standard were not in agreements with the U.S. perception of the treaty. The State Department document, titled ‘Observations by the United States of America on The Right to Health, Fact Sheet No. 31’ was established in response to the Office of the OHCHR and the WHO document on the human right to health. In the beginning of the document, the U.S. government states its dedication and commitment to the protection of human rights as a fundamental freedom and the improvement of the health of its citizens and the people worldwide.\textsuperscript{30} But, the U.S government differs with the documents in several points. The first objection to the OHCHR and WHO document is the title, which the U.S. government views as misleading to the reader in conveying that all the information stated in the document, is indeed ‘facts’. The U.S government sees the document title as “far reaching conclusions relating to the ‘right to health’ and the associated obligations of the State”.\textsuperscript{31}

The document states clauses within “The Right to Health, Fact Sheet No. 31” that the U.S. government disagrees with. The first objection is that there is no agreement on the nature or the extent of health-related rights and obligations; the universal declaration of Human Rights as an aspirations “the right [of everyone] to a standard of living adequate for the health and well-being of himself and of his family”.\textsuperscript{32} The right is seen by the United States as the ultimate goal and not an immediate entitlement. The second


\textsuperscript{31} Ibid., 2.

\textsuperscript{32} Ibid.
objection is the lack of references to the “right to health” from the World Health Assembly, the Commission on Human Rights, or the Human Rights Council, which differ in their definition of ‘right to health’ which will further question the validity of the report. The documents should create an ideal scenario for nations to aim for and not basic standards nations must abide by.

The importance of the document is further weighted down by the U.S government is this statement “it clarifies that the “full name” of what the “Fact Sheet” refers to as the “right to health” is the right to the “enjoyment of the highest attainable standard of physical and mental health. This phrasing originates from the International Covenant on Economic, Social and Cultural Rights (“ESC Covenant” or “Covenant”), which was adopted by the United Nations General Assembly in 1966 for ratification or accession by States. Although a number of States have ratified the covenant, a number of states have decided not to endorse. For those non-parties, which include the United States, the covenant does not give rise to international legal obligations.” 33 The legitimacy of the document is only weighted by those nations that initially supported it. Thus, if a nation refuses to ratify a treaty, they are outside the legal obligation to abide by the clauses stated, and these terms will then not be enforced or recognized.

The United States has ratified the WHO constitution, which was established in 1946. In its preamble, it states, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without the distinction of race, religion, and political belief, economic or social condition.” The United States has fully

33 Ibid., 3.
accepted this principle, but it refuses to refer to it as “Fact Sheet”, as an obligation states must abide by. Furthermore, when the United States ratified the WHO, it was understood as unknown in the Constitution of the WHO that will commit the United States to endorse any specific legislative program regarding any matters referred to in the Constitution.\textsuperscript{34} The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) is identified in the “Fact Sheet” as one of the “international human rights treaties recognizing the right to health”.\textsuperscript{35} Article 5 (e) (iv) of the Convention states: “States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law, notably in the enjoyment of… [e] economic, social and cultural rights, in particular… [t] he right to public health, medical care, social security and social services.”\textsuperscript{36} Article 5 (e) identifies these rights, but does not obligate the State to respect, protect, or fulfill these rights to their citizens. The State must prohibit circumstances where discrimination may take place, but it is not obligated to fulfill these principles. The United States views the ICERD as a treaty focusing on eliminating racial discrimination in all its forms, but isn't ensuring the right to health. This does not refute the commitment the United States has toward improving the overall health of its citizens and people across the globe. The legal

\begin{footnotesize}
\textsuperscript{34} Ibid.
\textsuperscript{35} Ibid., 29.
\textsuperscript{36} Ibid.
\end{footnotesize}
obligation that the “Fact Sheet” refers to, and its reasoning for their inclusion is what the United States refuses.

The United State government sees the right to health as a goal nations must strive for and not an entitlement. Treaties enforcing nations to set these principles are not only infringing on their autonomy, but also setting the standards higher than what nations can achieve. But, are the points stated by the State Department valid? And if a nation like the United States sees the right to health as a difficult commitment to fulfill, what can develop nations declare about following these principles? The “Fact Sheet” uses other treaties to point out why the right to health should or does exist. The United States does not reject the need to establish a standard to acquire the right to health, but it rejects the legal obligation it states. 37

VI. The Right to Health in the United States

The United States is seen as a nation capable of shielding its citizens against health disquiets. With its vast resources, the world looks to the United States for guidance in such cases. Hence, it is imperative to determine if the United States is acting on moral duties or if there are written clauses demanding the United States to handle health concerns nationally and/or internationally. The right to health demands certain duties and obligations of the national governments, and certain anticipations citizens assume from their governments. Are there certain duties I must expect from my government, and if so what are they? In the recent Ebola outbreak, criticism from the media outlets and academics on the handling of the outbreak gravitate my attention to what constitute a

37 Ibid., 3.
“good handling,” and why the government failed to meet our “expectation” if there were any, and finally, what will be the consequences or retribution if a government failed to meet these expectations? In numerous media outlets, the expected performance of the Center for Disease Control (CDC) or the federal government as a whole fell quite short. Since there were vast opinions to what these organizations and the federal government should have done, we need to understand how the U.S. government views “the Right to Health.”

The concept of the right to health in the United States has long been eschewed. Applying the right to health into the American health care system will require a greater transformation of the entire health care system and society. And if the quality of care in the United States is superior to many nations, why do they need to add the right to health into their laws. Though the right to health and the right to health care are two separate topics, it is pivotal to discuss the health care system in the United States and to understand if the right to health does exist in practice and in the legal framework. The U.S. health care system is structured so that inequality based on the socioeconomic and place of residence is quite prevalent. These criteria affect the quality of health care one might receive.  

What makes this more predominant in the United States than in any other western country is that employers provide health insurance.  

So if the economy contracts, the number of insured Americans decreases, thus there is a correlation between


39 Ibid.
the unemployment rate and access to health insurances. The uninsured then seek government provided insurance plans. There are two governments provided insurance plan in the U.S.; Medicare, which provides insurance to the elderly and Medicaid, which provides insurance for those who make less than $15,000 annually. Both plans exclude large chunks of the population, who do not fit in either category. As of 2010, the number of uninsured Americans reached a little less than 50 million people. The system excludes working Americans who work at multiple minimal-paying jobs.\textsuperscript{40}

There is no standard of quality or types of care insurance companies must provide to their customers. In the United States constitution, there are no writings that pertain to the right to health. Even at the state level, there is no guarantee of the right to health. In response to enormous disparities in State tort law interpretation of common law rights to care, the U.S government introduced a federal legislative for emergency care, the Emergency Medical Treatment and Active Labor Act (EMTALA). The EMTALA provides limited rights to care, the patient's condition must be stable, but medical bills are not relieved. The EMTALA is the closest legislation; we have to the idea of the right to health.

VII. The Right to Health in United Kingdom

The United Kingdom has a universal health care system; National Health Service (NHS), which is considered the largest publicly funded health care system in the world. The Beveridge report of 1942 welfare principle established the NHS, and it is funded by general taxation. It is estimated that about 3 million people are treated weekly and the

\textsuperscript{40} Ibid., 232.
agency employs around 1.7 million people.\textsuperscript{41} In the U.K., the NHS is under the Department of Health, and in Scotland, Wales and Northern Ireland it is under the devolved administration. The establishment of the nationalized health care system is not in any way a guarantee of the right to health. The right to health was not the prerequisite to universal health care in the United Kingdom. The United Kingdom ratified the ICESCR, but within the British national law, the right to health was not included. \textsuperscript{42}

The highest attainable standard of health is secured in the access to universal health care. Though, right to health is not written in the United Kingdom’s laws, the access to the NHS substitute’s deficiency within the law. The need to establish provisions within British laws is not necessary, since U.K. universal right to health care was already established. Access to free care is available to any UK national, including some hospital services, outpatient, emergency; communicable disease and family planning that are free of charge irrespective of residency status. \textsuperscript{43} The NHS is very much committed in providing health to anyone, and the agency ensured that access to health care is available to all. But, the right to health care is not the same as the right to health.

But many believe access alone is not sufficient to ensure that the right to health is met. The framework the NHS developed is solely concerned with access, and there is no indication that standard of quality is set. Questions about availability, eligibility and the type of treatments received are also not answered. When these questions are specified, 

\textsuperscript{41} Ibid., 209.

\textsuperscript{42} Ibid., 210.

\textsuperscript{43} Ibid., 212.
there are no laws to dispute these subjects. The right to health cannot be enforced in domestic courts in the U.K. The right to health care is guaranteed for UK nationals, and issues of immigrants and access to healthcare seem to be another issue contesting the right to health in the UK. Another predicament is that the compliance with the HRA Act of 1998 and the ECHR is not in any way the same as the realization of the right to health.

VIII. Why the Right to Health

The right to health seemed to be a new concept, and foreign to many countries. We all want to believe that human rights have come a long way from its original setting: in post-World War II. After reading many documents and examining this topic closer than I had ever before, the right to health seems to have shifted from its foreign identity. When countries in Latin America like Brazil, Columbia and Costa Rica incorporated this right into their laws, it is a sign of optimism that even more nations will include this right into their domestic laws. But, what seems to be puzzling is that some western countries seem to have not joined the quest to achieve this right, while developing countries are taking the lead in achieving this right. But, what we also established is that the standard of living in the United State and the United Kingdom is much higher than it is in countries like Brazil, Columbia and Costa Rica. Thus, the sense of awareness that the adequate health and sanitation is more prevalent in developing countries than it is in developed countries. The need for change and improvement of health is called for in these developing countries than it is in developed countries. The United States and United Kingdom are in contrary, calling for access to health care and not right to health.
The right to health in the UK seems more apparent than it is in the US, but it is not quite simple to make these judgments without fully dissecting the existence of this right in these respective countries. I will further discuss this in the latter chapters, but for now, one might conclude that the right to health is more established in the U.K. (whether it is realized or not) than it is in the U.S. The attitudes of the U.S. government and the U.K. government in regards to the right to health differ. While the U.S. seems to avoid any wording that might obligate the State to fulfill the right to health to its citizens legally, the UK seems to minimally address the right and emphasizes the right to health care as an alternative; there is ambiguity to the stance of this right, especially after the government introduced the universal health care. The introduction of the universal health care pushed aside the need to include the right to health. The right to health is not in any way similar or the same as the right to health care. On the contrary, the concepts differ in what they are and what they represent. The human right to health means that everyone is entitled to the highest attainable standard of physical and mental health. The right to health care implies that hospitals, clinics, medicines, and doctors' services must be accessible, available, suitable and of good quality.\textsuperscript{44} The approach the U.S. approach was to fight the legal obligation; avoiding the need to comply with international law and acknowledging that it is not a member of the states that have ratified the ICESCR seems to imply U.S. reluctance to even address the concept.

The achievement of the highest attainable standard of health is one of the fundamental rights of every human being. Though, it is a hard commitment, it must be an

idea to strive for. And acknowledging the ICESCR without having a systematic plan to apply the treaty will only put the U.S. and other countries in legal obligations. Thus, having treaties signed without addressing how the content of these treaties will be applied is the root cause of this predicament. In the United States, the right to health is a huge obligation and an ambiguous right that is hard to apply. The right is a prerequisite to other human right issues and many of the human right issues that are currently discussed cannot stand alone without the right to health. The right to education, work, clean water and other human right issues cannot be applied without having a clear cohesive right to health. As for the United Kingdom, the obligation to include the right into their domestic laws might seem unnecessary, but that would be the case if the right to health care alone can be sufficient. The creation of the NHS has shadowed any discussion on the right to health. The goal of the NHS is access, which is a major component of the right to health and not all.
CHAPTER 2
THE BRITISH HEALTH CARE SYSTEM: FROM THE 16TH CENTURY TO THE NATIONAL HEALTH SERVICE

As one might think that all hospitals in the west are similar, I beg to differ. My cousin worked in a hospital near London Bridge tube station. And I asked to accompany her to work to shadow her for the day. The first time I stepped into a hospital in London, my expectations were unlike what I saw. As someone who lived most her life in the United States, I imagined it to resemble somewhat the hospitals I’m used to, but in contrary, it looked like a hospital lost from the 1920 Ernest Hemingway Farewell to Arms. From outside, it was one large building, exterior brick with Guy’s and St. Thomas in large font on the top floor, though the hospital did not seem large, when I went up the elevator to the seventh floor, I noticed two large doors, one on the left and the other on the right. Each door led to a hallway with offices to the left and to the right. At the end, there was a middle section with computers where nurses and doctors worked side by side. They all seemed busy, and to the right, there was a large double door that led to a ward with many beds, separating them was a large curtain.

This experience inspired the topic for my graduate thesis. The battle for healthcare reform in the United States and conversations among media personnel and politicians to how the health care should be or ought to be gravitated my curiosity to explore what is right for us and what is not. As many advocates for more government interference like the Michael Moore documentary Sicko, others, from the right wing fear rationing and deterioration of the health care quality. Are we heading for a nationalized
health care system? Is history repeating itself? Many would agree, while others will see these two nations far less similar than many would think.

The history of health care in the United Kingdom would explicate the current structure of their health care system and why the country chose to nationalize their health care system. The idea of health and the recognition of the health care system and finally the need to either allow the market to dictate or allow the government to facilitate it are the many questions nations want to establish an answer for. The United Kingdom’s path to nationalized health care system did not come easy. The historical track not only points out the distinctions between the two nations but also explore the likenesses. The United States is a newer nation; with many of the earlier immigrants coming from the United Kingdom similarities are inevitable nevertheless.

I. Stagnant Health in England

The Radical Puritans in the English Revolution (1642-1660) detested many things in the English society and wanted to transform all institutions including the medical professions. William Dell thought privileged clique of physicians who controlled London’s Royal College of physicians had corrupted and reform is the path to a solution. The early 16th century and the 17th century were known for many as tough times for public health and access to health was very limited. The fear of disease and plagues were seen across the population. “Thomas Wentworth, President of Council of the North, in 1631 isolated the city and pulled down the squalid shantytowns suburbs outside the city walls where the poor lived-perhaps explain why York escaped the

pestilence whereas others cities as Bristol and Hull succumbed.” ² There were no efforts to cure any disease, and to save the population; the public relied on politicians to end the outbreak.

The access to trained, educated physicians was very limited and was only in major cities. Admission to English Medical schools was very selective and highly concentrated in London city. For those that were able to afford medical schools were admitted to international medical schools and were mainly educated in either France or Italy. Outside London, academically trained doctors formed a small minority; it was believed that 5 out of 75 practitioners known to have operated in Norwich had been to a university.³ Many believed that universities and medical colleges inhibited the advancement of the medical profession, thus making access to care a luxury, and access to the privilege and elites of the society. These reformers demanded universities to educate more practitioners and open the admission for the larger population, and finally, change the curriculum from Latin to English. They proposed medical science advancement; advocates such as Francis Bacon hoped for changes in the medical professions and were very much an advocate for visible changes.⁴ These were one of the earliest calls for access to health for all. They advocated for public provision of free and cheap medical facilities, including hospitals, for the sick, poor, along lines, which distantly anticipated the National Health Service.⁵

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² Ibid., 17.
³ Ibid., 14.
⁴ Ibid., 13.
⁵ Ibid.
Puritan reformers attempt to change the highly selective, and call for new chemical drugs and change the structure of the organizations was met with great resistance. Historians viewed the eighteenth century as medical stagnation.

In the United Kingdom, the health profession had three types of practitioner, which were, physicians, surgeons and apothecary. Physicians were required to have a college education and were considered at the top of the scale. Surgeons obtained some sort of education from the Barber Surgeon Company of London, which dated back to 1540 and their role was considered more of a craftsman and not scientific. As for apothecary, there was no formal education required and many had other professions and owned their own shops. The College of Physician and the Company of Surgeons suffered some reverses around the turn of the eighteenth century, falling out of the royal favor; they lost the monopoly right to prescribe medicine in London (after the House of Lords judgment in the Rose Case, 1704) and henceforth allowing apothecaries to prescribe medicine. The restriction to admit more people to the College of Physicians restricted the number of licensed physicians and many thought-out educations from Scotland and Holland.

With a growing middle class appropriate to the industrial revolution, the expansions of the healthcare services were inevitable. England’s expanding middle class was composed of growing tradesmen, shopkeepers, clerks, farmers, skilled craftsman and many others. These new middle classes were able to afford services, including access to better health. Charity hospitals did not exist prior to the Georgian century. This era witnessed the largest progress in health services, where many hospitals were established
in response to the growing population of skilled labor. “Their political outlooks, men influenced by the Enlightenment were keen to promote secular welfare, the health as well as the wealth of nations. They also set great store by humanitarianism and philanthropy.”  

6 These foundations opened new hospitals, in addition to the two ancient hospitals, St Thomas and St Bartholomew, five new hospitals were opened; between 1720-1750, the Westminster (1720), Guy’s (1724), St George’s (1733), the London (1740) and Middlesex (1745).  

7 This set off a wave for more institutions in these provinces, where there were no medical hospitals had existed before. The Edinburgh Royal Infirmary was set up in 1729; following was Winchester and Bristol (1736-7), York (1740), Exeter (1741), Bath (1742), Northampton (1743) and some twenty others.  

8 And successfully, by the end of the eighteenth century, all sizable English villages had a hospital. Philanthropist were keener in finding more money to service hospitals, in 1751, St. Luke’s Hospital was the only big mental health asylum in the Kingdom a part of Bethlem. Bethlem was also known as ‘Bedlam’ and was widely criticized for its barbarity and lack of apathy for their patients in the facility.

By 1800 the great towns of Manchester, Liverpool, and York had their own mental health asylum supported and opened by a philanthropist. This was a time of social changes; charity hospitals were also targeting venereal disease patients, which shifted the ideology that disease was a religious punishment for vice. Magdalene Hospital for

6 Ibid., 34.

7 Ibid., 35.

8 Ibid.
Penitent Prostitutes (1759) and maternity hospital (1749) hospital, which did not ask questions about the patient’s marital status. For many, some of these hospitals were less of a medical hospital and more of a refuge. The Foundling Hospital (1741) was London’s first major orphanage, unwanted children was dropped there, anonymously; they were brought up and educated and were helped to learn a skill to find labor.9 By 1800, London hospitals handled 20,000 to 30,000 patients a year. In 1800’s, the fever hospital was opened, designed for infectious diseases; this hospital was known as House of Recovery. It was a result of the Sanitary Act (1866) and the Metropolitan Poor Act (1867). This hospital isolated patients, which helped reduce the spread of infectious diseases. The first dispensaries were opened 1773, which mainly provided outpatient services, supplied advices and free medicine to the sick poor, who had no room for hospitalization.

The voluntary hospitals movement did not create the effect many Puritans anticipated, which was a more complex state-funded medical system they had envisioned. It also did not create the medical, scientific breakthrough many projected. The access to hospitals did not change the quality of care or generate new ideas of how one can manage or cure disease. But, what it did recognize that the health of the population mattered. Many of the philanthropists that funded these hospitals were major business owners, and were considered a common sense and prudent to keep the population’s health fit to work. The concern for public funds even allowed room for insurance companies developing. Josiah Wedgwood was the first to set up private sickness insurance schemes, through which the workforce, in return required a compulsory deduction from their wages. The

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9 Ibid., 36.
eighteenth century was the century for quackery, where medicine was not regulated and allowing the free market to dictate the pharmaceutical medicine. As a result, the eighteenth and nineteenth century were regarded as the height of the self-diagnosing and self-helping, patients running to the next new miracle cures. \(^{10}\) The lack of regulation of the medical profession was creating an anxiety for many advocacy groups. The population of England doubled from 1760 to 1820, going from 6 million to 11.3 million. Many of the General Practitioners were seeking a more accessible medical profession, but the old circles of physicians had a strong hold on the profession and were in government circles, which helped them maintain the status quo. \(^{11}\) But the increasing access to unconventional medicine, the orthodox medicine seemed to be losing status without some sort of government regulation. The Medical Act of 1858 was an Act of the Parliament of the United Kingdom, which developed the General Medical Council (GMC) to regulate doctors in the UK. This allowed some sort of supervision on the medical field and thence it became a legal offense for those not on the medical register to represent themselves as medical practitioners. The GMC had the power to strike a name off the list of registered practitioners. The access to new physician school across the kingdom and access to other European medical schools, helped increase the number of physicians, the surge of new physicians drove wages down. Cases where patients were not paying for services and physicians having a hard time retaining patients were prevalent throughout the country.

\(^{10}\) Ibid., 46.

\(^{11}\) Ibid., 50.
Prickly patients plagued practitioners and the threat of bad debt was inescapable, having the state pay their salaries would be a dream and a great relief for many practitioners. Though it was a possibility for the government to interfere and pay the wages for many of these practitioners, but the dream was not far and took over hundred years to come to light. The Poor Law, which allowed the government to provide some assistance was developed in 1815, but due to its large budget, the government amended the Act and introduced a revised version in 1834, which required the poor to work in government workshop for the some assistance. The government’s new initiatives were portraying a new prospective, where the government is more involved than previous governments. The rise of philanthropist hospitals in the 18th and 19th century demonstrated the change in the public’s view on health and that it is the concern of all people and not just politicians. These philanthropists were concerned with the wellbeing of the workforce and correlation between public health and production makes health prerequisite for successful economy.

II. Did Great Cities Entail Bad Health?

The height of industrial revolution was from 1860 through 1914 and many people from rural towns moved to London and other major cities for jobs. In 1851, half of the country’s population lived in towns, but by 1901, four-fifth of the population did so. These towns and cities were the key for the nation's wealth, but also was the most dangerous for individual health. The death rate was higher in areas with concentrated populations in small spaces. The urban housing meant a higher rate of pollution as a

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consequence to the factories. Though medical observation and research increased the understanding of infectious disease, but as a result of the industrial revolution, new disease were more obvious, patients were diagnosed with respiratory diseases, cancer and heart disease.  

The medical field was shifting; charity hospitals were shifting their mission and gradually becoming more accessible to the general public and not just the impoverished. Subscriber’s letters were no longer essential for admission by the early 20th century. These hospitals were transformed into popular medical facilities, mainly due to doctor’s desire for medically controlled cases, improvements in hygiene and nursing care, increasing respect for medical judgments, perhaps; the causes are more complex. Hospitals alone were not the only health care facilities popular in England; there was a soar in the demand for outpatient clinics, which became more noticeable between 1860 and 1914. The number of outpatient clinics increased from 25,000 to 220,000. The soar in the number of patient’s charitable hospitals and outpatient clinics placed extreme pressure on medical staff.

The access to health improved in the 18th and 19th century, there was visible increase in the numbers of specialized hospitals and dispensaries. In the past, it was the access to health facilities that was the concern of many philanthropists and others, but by the late 19th century and the 20th century, it was the access to better health, to offset the negative effects of the industrial revolution on public health. The British government in the 19th century was moving towards the management of public health. The idea that

13 Ibid., 13.

14 Ibid., 15.
public health was a private matter has shifted, and the state found that it must facilitate the overall state of health. The unregulated urban growth that occurred in the 19th century and increasing rate of the medical profession made it necessary for the government to act in legislatures. The compulsory vaccination of smallpox in 1840 and again in 1871, demonstrated the government inclination to monitor public health. The creation of the Medical Department of the Privy Council was a pivotal step, the first Medical Officer; John Simon played a major role in public health legislatures, and created a new concept ‘state medicine’ scientifically and using the medical approach for public health. When Simone was appointed, public health administration was already being placed. The Public Health Act (1848) had made the appointment of the Medical Officer of Health (MOH’s), a compulsory in cities with a high death rate, a ratio of 25 per thousand, the Metropolis Local Management Act of 1855 set precedent by making their appointment compulsory in all London’s administrative districts.\(^{15}\)

It was easy to track a patient’s use of hospitals, since hospitals were able to track their own progress, but it was difficult for the government to track the number of patients that used private practitioners and it was not until National Insurance Act in 1911 that allowed the government to explore the patient’s use of the General Practitioners. Though, General Practitioners were finding it hard to maintain a living, the number of licensed practitioners double from 20,000 to over 40,000 between 1860 and 1914, which indicate a shift in the practice of medicine. The rise of urban cities improved the ability of practitioners to retain patients. The importance of medical management in preserving

\(^{15}\) Ibid., 30.
public health was officially recognized in 1911 by introducing the National Insurance Act, which became effective in 1913. The National Insurance Act was an act of Parliament in the United Kingdom, and it was often viewed as the foundation of modern social welfare in the United Kingdom, which allowed employees to pay small fee for health coverage. This era was considered the foundational stage for the current structure of the health care system that is placed in the United Kingdom.

III. The Health Care System (From the Great War to World War II)

It is highly regarded that War is bad for public health, but good for medicine. The technological advancement during war transformed medicine from ‘an observational and empirical craft’ to a scientist calling. The influenza epidemic was measured as a tragedy, but overall public health in the United Kingdom was finding its new calls. The demographic did not shift greatly; the birth rate offsets the death rate, which did not disturb the overall population growth. It still remains debatable if the medicine excelled during the Great War. There were new roles and professions that were becoming vital in the field, research scientist, bacteriologist, physiologist, public health men, cardiologist, psychiatrists, specialized in physical rehabilitation, ordinary practitioners and many others all contributed to the war efforts. And, were becoming a major contributor to the health field. Wartime innovation often would take years before it reaches the public. It was the breadth of the impact of this war on medical interest that fed Sir Clifford

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16 Ibid., 44.
17 Ibid., 47.
18 Ibid., 75.
Allbutt’s perception of a radical transformation in the ethos of medicine.\textsuperscript{19} Though, the debate about how the War enhanced the quality of medicine is still in place, there was consensus that innovation in medicine was changing the confidence in the quality of medicine the public were receiving.

In the past, philanthropists were finding ways to improve the overall state of health of the public and the government role was very minimal, and by the late 19\textsuperscript{th} century to the 20\textsuperscript{th} century, the government was having a bigger role in the supervision of public health. And, this also validated the public’s willingness to have the government play a big role in the health care industry. The preparation for the war meant that it was important to have medical services, meeting the demand of the war. The government realized that it was essential to ensure hospital beds was accessible to civilians and service personnel, causality clearing facilities in area that were vulnerable to attack and base hospitals outside them and fully equipped specialist hospitals. In the process for preparation, it exposed the lack the insufficiencies of the country’s fragmented traditional hospital system, which initiated an extensive process of modernization to meet the needs of war.\textsuperscript{20} It also pushed for the development of a national Public Health Laboratory Service (PHLS), the Emergency Hospital Scheme (EHS) and the Emergency Medical Services (EMS).

After World War I (WWI), the fear of influenza or other infectious disease ceased to dominate British health concerns, and with the advancement of medical science, and

\textsuperscript{19} Ibid.

\textsuperscript{20} Ibid., 127.
treatments becoming more effective, the demand for medical services grew.\footnote{Ibid., 77.} After the war, the British government established the Ministry of Health (1919); the goal of the ministry was to create health policy at the national level. The implementation of the health policies prior to the war was not even. From 1918 to 1939, there were many health provisions that were added and at the center of all these provisions was the National Insurance Act (1911). The industrial revolution was prevalent in Western Europe and countries like England and Germany were competing economically, thus the social welfare of the working force was a top priority. The social reforms prior to WWI were implemented after the war, and politicians were capitalizing on making sure social welfare was the top policy outlook. Some of these acts, such as Notification of Births Act 1906 and the establishment of the School of Medical Service in 1907, the Venereal Disease Act 1917, the Maternal and Child Welfare Act 1918, the Midwives Act 1922 and the Cancer Act 1939, the reformed Poor Law in 1929 and the transfer of the Poor Law infirmaries and infectious disease hospitals to the municipal authorities, all fell within the package of modernizing measures of health provision.\footnote{Ibid., 79.} The new shift penetrates the shift in society's view on public health.
IV. The Fundamental Policies that Led to the National Health Service (NHS)

The development of the NHS did not just appear without an extensive historical track that led to this extensive policy. The British welfare state is a product of evolution, centuries of traditions and provisions of health care and the organization of medical practitioners. 23 The British society was mainly concerned with the relief of poverty, the cultural norm made the society more receptive to the NHS. The lack of distinction between ‘care’ and ‘medical care,’ made those with power only concern with the general care of those in need, regardless of the means. There were five events or policies that led to the NHS, the Poor Law, Private Charity and Mutual Aid, the National Health Insurance Act, the initial introduction to the National Health Service, and the National Health Service White Paper. All these events or acts led to the NHS and made the creation of the NHS a national concern.

A. The Poor Law

The laws for relief the poor can date back to Act for the Reliefe of the Poore, which was a legislature that was developed by Elizabeth I in 1598 and enacted in 1601, the structure of the poor law was a way to provide a system where the extremely poor and destitute was cared for. The law provided relief for the elderly and those unable to work. The tax collection was stressed to make sure the program runs. One would think that a surge of people running for these services occurred, but on the contrary, that was not the case. Recipients of the services were required to live in either ‘poorhouses’ or ‘workhouses.’ And ‘unregenerate idlers’ were required to live in ‘houses of correction.’

The residents of these homes were required to accept the rules of living in these homes, which included, silence while eating meals, families might be separated, alcohol, tobacco and visitors were forbidden. Thus, unless the person had no other option, many chose to not live in these homes. But what these homes provided was access to food and some medical services. Though, these medical services were not extensive, but millions of poverty stricken individuals had some access to care through public relief houses.

The funding that these homes required, pushed the government to revise the act, and in 1834 a revised Poor Law was introduced, which required some sort of labor for the services. The massive cholera epidemic in 1866 had created a new duty for authorities responsible for these houses and to contain the spread of the disease became their major concern. The conditions of these homes were debated, and beginning 1867 parishes were urged to form ‘Sick Asylum District’ to support hospitals in which workhouse residents could be treated. 24 Though, it was mainly for the poor, but due to limited access to facilities that could treat the disease, these parishes were admitted anyone. The Poor Law intended for the poor later became accessible for all in times of great need such as the cholera outbreak. The availability of these parishes helped in containing the spread of the disease. The Poor Law, which was initially intended for the poor, became a law that helped the population as whole, thus many after the outbreak had some sort of relation to the Act, which in reverse enhanced the existing support the Act had with the public. The national support of the Act will entail the continuation of the act if financial support is available.

24 Ibid., 6.
B. The Private Charity and Mutual Aid

As mentioned earlier, charity hospitals and dispensaries were a major contributor to the expansion of medical services in the United Kingdom. There were many hospitals that were constructed between the 18\textsuperscript{th} and 19\textsuperscript{th} century. The first was Guy’s Hospital, was endowed entirely by one individual. \textsuperscript{25} These organizations, which were the precursors of the current insurance plan, provided sick pay, medical care and a death benefit to their family members in return for weekly contributions. And, some charitable institutions would hire a doctor for fixed salary, which in return will provide a medical care to society members. The friendly societies were very popular, that by the end of the 19\textsuperscript{th} century, there were over 4 million people belonged to these societies, which was equivalent to over half the adult male population in the United Kingdom. The memberships were not open to anyone, but skilled workers, while others accepted a certain religious groups and others would accept women and children only. These organizations were in danger as the population increased and life expectancy grew. Many were in debt and some were near bankruptcy. But, there political influence was great and their influence was seen when the National Health Insurance Act of 1911 was first shaped.

C. The National Health Insurance Act of 1911

The insurance act was intended for the middle class and lower middle class workers; David Lloyd George, the Chancellor of the Exchequer under the Liberal Government, introduced the legislation. David George was concerned with the cause of

\textsuperscript{25} Ibid., 7.
sickness as a contributor to poverty and his main concern was to make sure the breadwinner is treated if sick, so that he can return to work. \(^{26}\) The cost of the insurance was handled amongst employee, employer and the state. The recipients were obtaining medical treatment, cash benefits for sickness and disability. It also provided institutional care in sanatoria for cases of tuberculosis and in some cases, additional benefits for dental and ophthalmic care. \(^{27}\) Economic theory and empirical evidence insinuate that employment taxes are not truly endured by employers. The three pence the employer contributed to the cost of the health insurance was simply part of the cost of hiring a worker for one week. Thus, the employer had no difference to whether it went to an employee or insurance scheme. So many economists concluded that the cost of tax for the insurance also fell on the employee. In the other hand, the state’s contribution to the health insurance is not entirely true. In the absence of tax, the weekly wage for employees would be three pence higher; the state’s contribution came from the employee. The insurance plan was entirely paid by the worker.

The path to the National Insurance Act was planned and implemented by Lloyd George, who lobbied and attained the support of friendly societies, corporations, commercial insurance companies, and doctors. He was a very skillful negotiator in skilled in finding an agreeable compromise. The bill that was passed in 1911 was quite different, to receive the friendly societies, he promised that the government would not intrude into the field. He also had to compromise with the British Medical Association (BMA), who

\(^{26}\) Ibid., 8.

\(^{27}\) Ibid.
opposed some of the provisions in the bill. They opposed two points in the bill, first the friendly societies will have complete charge in the administration of the bill, the hostility between the friendly societies and doctors were sour, and doctors complained that these organizations would dismiss doctors from their positions and change terms in their contracts to benefit the organization. The second point they opposed of the bill was the income level. “Doctors feared that if this income level were set high, they would lose some of the more lucrative fees they had been able to collect from middle-income patients-fees that were higher than the fees they expected to collect under national health insurance.”

The fear that doctors would not participate in the insurance plan was great, and in effect some changes were initiated, but was not drastic.

D. Introduction to the National Health Service

In 1920-1930, there were talks to expand the national health insurance to include dependents of insured workers, and expand the system to cover hospital bills, which were not included initially and in addition other special cares if needed. All these proposals were rejected; not due to the extended expanses these expansions will require but because the talks of free medical care were being discussed seriously. The momentum shifted, the general consensus was that health care should be available to everyone as a matter of ‘right.’ The rejection was also due to political reasons; the increase in the national health insurance will mean a rise to the tax revenue, which will require the government to impose higher tax to not just the recipient of the insurance plan but also the rest of the

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28 Ibid., 10.

29 Ibid., 12.
population. Thus, a more inclusive plan will entertain everyone in the population rather increasing taxes and offering health insurance to just a portion of the population. In the other hand, the quality of care patients were receiving was not worthy. Doctors complained that they had little incentive to maintain a quality of care for patients. Doctors were paid regardless of the care patients received. Second, since hospital care was not included in the insurance plan, doctors had a higher incentive to push patients to the hospitals to increase their income. And finally, the influence of the friendly societies in the insurance plan, doctors complaining that friendly societies selective memberships were rationing the insurance plan. The shift in the middle class attitude toward nationalized health care services shifted. Their previous stance was to reject welfare benefits, since they viewed it as belittling, but that was not the attitude toward health services.

As early as 1926, the calls for a unified health service separate from the insurance system and supported by public funds were becoming more prevalent. In 1942, the BMA published an interim report supporting nationalized medical services under the government control. Sir William Beveridge, the architect of the modern British welfare system developed the Beveridge Report, which included “comprehensive health and rehabilitation services for prevention and cure of disease and restoration of capacity for work, available to all members of the community.” The following year, Winston Churchill announced in a national broadcast, “You must rank me and my colleagues as

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30 Ibid., 13.

31 Ibid.
strong partisans of national compulsory insurance for all classes, for all purposes, from cradle to the grave”.32 The goal was to nationalize hospitals; set salaries for doctors, and also allow private practices still be permitted in hospitals to attract doctors to the plan.

The BMA was an advocate of a nationalized health care services but with some reservations, they were nervous of the extend the government will have control of the medical profession. The victory of the Labor Party in 1945 and the selection of Aneurin Bevan as the Minister of Health meant the dream of nationalized health care might become a reality. The BMA were eager to negotiate some of the provisions in the Act, but Bevan refused, claiming the sovereignty of the Parliament and consulting the BMA was out of the question.

The BMA had certain demands, first, their members be preserved as independent contractors rather than government employees, second, restrict the coverage to just 90 percent of the population and allow the wealthy to pay for their medical expenses, since they would spend more than the government would allocate for them, thus ensuring that the salaries of the practitioners were not solely from the state. The government refused their provisions and the BMA now were firm in finding solutions to the salaries debate. Bevan was very influential, and his method was ‘divide and conquer’, hospital consultants were not as threaten as physicians. Bevan made two promises; first, he agreed to allow hospital consultants to accept part-time positions, and the second allowed them to have a certain number of beds to be used for private patients. Third, he allowed General Practitioners to be an independent consultant rather than government employees.

32 Ibid.
They would get paid for each patient under the Health Service. And finally, set aside a large sum to compensate them when practitioners retire. There was a noticeable division within the BMA; before the recommendation, less than ten percent of BMA had been supporters of the NHS Act. After the provisions, half were supporters of the Act; BMA reluctantly recommended that its members support the NHS. Though half of BMA opposed the NHS, they went into operation on the ‘appointed day,’ July 5, 1948 and a Bevan message of goodwill to the doctors:

There is no reason why the doctor-patient relationship should not be freed from the money factor, the collection of fees or thinking how to pay fees… My job is to give you all the facilities, resources, apparatus and help I can, and then to leave you alone… to use your skill and judgment without hindrance.  

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33 Ibid., 17.
CHAPTER 3
THE HEALTH CARE REFORM IN THE UNITED STATES

The current structure of the Healthcare system in the United States did not develop without amendments and changes that were prevalent through the ages. The struggles between the private health professions and the government have been present for so many years. The federal or state government attempts to manage, amend or improve the health care system did not just occur in the 20th and 21st century, but much earlier. The structure of the health care system in the United States is that of a system that promotes the private industry and disfavors the meddling of any public entity. But as advocates of more government interferences became more vocal, the debates between them and their opponents became more apparent in recent years. Presently, there are two types of health care provisions, one provided by the government; Medicare, Medicaid and the Affordable Care Act, and the second provided by private companies through the employer. This structure did not develop when this country was first discovered, but it was transition of many policies and public opinions that created this present system. The historical track of the health care system provides us the lenses to see why the health care system in the United States is as such.

I. The Health Care in the American Antebellum

In 1798, the federal government provided health care services with the “Act for the Relief of Sick and Disabled Seamen,” which was a hospital for merchant sailors
provided by the department of the Navy.\textsuperscript{1} This was one of the earliest accounts where the federal government provided health care services for service men. But, as the population increased, the federal government debated on the government’s role in dealing with issues of quarantine and public health. This issue was prevalent as early as 1787, when the Congress questioned the role of the government in dealing with yellow fever and then Rep. William Lyman of Massachusetts made reference that “the rights to the preservation of health is inalienable.”\textsuperscript{2} The private health insurance in the United States is believed to date back to the Civil War era. It was believed that the emergence of commercial health insurance was first offered in Pennsylvania in 1847, then, Massachusetts and New Jersey.\textsuperscript{3} Employer based health coverage can date back as far as the Civil War era, but the exact date to when it was developed is not determined. In 1863, a piano factory, silversmith’s shop, and watchmaker shop introduced a sickness fund for employees. It was an insurance based that was established a fund for employees in case of sickness.\textsuperscript{4} The state aid system in Pennsylvania was the first health care provision, somewhat similar to the Medicaid program. The program was developed before the Civil War, but only pounced into prominence in the 1870’s and 1880’s.\textsuperscript{5}

\textsuperscript{1} Beatrix Hoffman. \textit{Health Care for Some: Rights and Rationing in the United States since 1930} (The University of Chicago, 2012), xxvi.

\textsuperscript{2} Ibid., xxvi.


\textsuperscript{4} Ibid., 74.

\textsuperscript{5} Rosemary Stevens, \textit{The Public-Private Health Care State} (Transaction Publishers, 2007), 9.
II. The Health Care and the American Medical Association

In the early 1900 was known as “Physicians Rise in Power”, and it was mainly due to the improvement of the quality of care in the United States. In 1900, the life expectancy was around 49.2 but by 1930 it was around 59.2, the highest increase seen in centuries. Indoor plumbing reduced diseases; surgeries were more common and performed in hospitals. The number of hospitals rose from 1,400 to 2,100 from 1900 to 1930.6 In the past, the concern with the health care system was access to care and not the quality of care. As the number of hospitals in the United States rose, the number of hospitals that serve only one group rose as well. Immigration emphasized ethnic and religious distinction, which translated to hospitals only serving Catholics, Lutherans, Baptists, and Jews and hospitals only serving Germans, Blacks, Swedes and other ethnic groups.7 Many received their insurances through their communities of origin; immigrant groups would put funds aside to treat other group’s members who are in need of medical assistances. Minority groups opened their own hospitals to treat their patients and separation of treatment and medical services were seen based on place of origin, race and sometimes gender. Segregations in health care became more apparent in the early twentieth century.

In the United States then President Theodore Roosevelt ran for president in the platform “sickness insurance” trying to mimic the health system in German. Though

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Roosevelt lost the election, the health insurance plan, also known “compulsory health insurance” was debated in many states. Progressive reformers, public health physicians, and labor unions representing female unions and immigrant workers supported it. The American Federation of Labor (AFL) leader Samuel Gompers believed that workers should instead fight for higher wages and delivers their own health care insurance. After the United States entered World War I, a health care system mimicking the German system suddenly became unpopular.

In 1906, the American Association of Labor Legislation (AALL) led a campaign for health insurance. They were considered a progressive group that were not opposed to capitalism but rather were keen an effective reform. In 1912, they developed a committee on social welfare, which held its first national conference on 1913. The committee decided to focus their attention on health insurance and drafted a model bill on 1915. The bill was intended to assist only the working class and people making less than $1200 a year and dependent. The coverage included physicians, nurses, hospitals, sick pay, maternity benefits, and a death benefit for fifty dollars to pay for funeral expenses. The cost was divided between the employee, employer and the state. In the beginning, the AMA supported the AALL proposal, and AMA leaders wrote to the AALL “Your plans are so entirely in line with our won that we want to be of every possible assistance” but


9 Karen S. Palmer, A Brief History: Universal Health Care Efforts in the US. Physicians for A National Health Program (Press).
by 1917, due to disagreement to methods of paying physicians, the AMA withdrew their support to the AALL proposal. 10

The Sheppard-Towner Act of 1921 was introduced to fight the surge in maternal and infant mortality rates in the United States. To establish the programs, 1.2 million dollars a year was allocated for states to run the program.11 But, opposition from the medical professions dissolved the program, though it was successful. The American Medical Association (AMA), describing Sheppard-Towner as “tending to promote communism,” successfully is lobbying Congress to cancel the program entirely in 1929.12 But, during the depression, as more people fell into poverty, the charitable institutions were not able to meet the new demand for care.

The Committee on the Cost of Medical Care (CCMC) was developed over high cost of medical care. It was privately funded group, funded by 8 philanthropic organizations including the Rockefeller, Millbank, and Rosenwald foundations. The CCMC were comprised of fifty economies, physicians, public health specialist and major interest groups and they met 1926 to 1932. They published 26 research volumes and 15 smaller reports over a 5-year period ad recommended that more national resources go to medical

10 Ibid.


12 Ibid., xxxiv.
care and saw voluntary, not compulsory, health insurance as a mean to covering these costs.\textsuperscript{13} The AMA viewed the reports as socialist and advocating socialized medicine.

III. The Health Care from the Great Depression through World War II

Advocacy for the right to health care was a result of the improvement of the quality of care in the United States. The call for health care in the United States continued as the access to care became more expensive and unreachable for many people living in rural America. There were changes in the access to care and quality of care people were receiving during the Great Depression. As more people were not able to afford their primary care, many were seeking care from charity clinics and public hospitals. Governments and voluntary hospitals, charitable physicians, private and public clinics and dispensaries had different requirements for admission, when a patient was rejected by one type of care, they might qualify for the other. But with the surge in the number of people not able to pay for private health services, charity hospitals were not able to meet the new demand for care. There were surge in the number of people seeking free health care services. Physician’s charity, private philanthropy, voluntary clinics and hospitals were unable to meet the demand and urged the government to subsidize and pay for hospital and physician fees. Health care professions saw a drastic drop in their income. Initially, some of the doctors were treating patients with either small fee or free, but as the number of patients not able to pay for services increased, doctors were calling for the government to pay for their doctor’s fee.

\textsuperscript{13} Palmer, \textit{A Brief History: Universal Health Care Efforts in the US. Physicians for A National Health Program}. 
The pressure from organizations and the public for federal assistance to pay for medical bills brought the attention of President Hoover. At the early stages of the Great Depression, then the Federal Emergency and Reconstruction Act (IERC) of 1932, signed by President Herbert Hoover authorized $300 million for relief efforts. 14 “By the fall of 1934, the 13 Chicago clinics in the Council of Social Agencies had received $200,000 from the IERC, slightly less than a third of their annual operating budgets. This relief effort helped pay for medical bills and helped hospitals to admit more patients. Though, the cash relief helped many hospitals and allowed people to seek more care, the relief did not last. But by 1936, all direct relief to states ended. When President Franklin Roosevelt (FDR) was elected, he introduced the Federal Emergency Relief Administration (FERA). FDR was not kin of cash relief and preferred work over charity. 15 With the surge of patients in need of treatment and hospitals turning them away, in 1934, an Alabama Supreme Court ruled that it was legal for private hospitals to turn away emergency patients. 16

The Roosevelt administration refused to target the medical professions while developing the New Deal. Initially, president Roosevelt intentions were not to include health care provisions in the social security program. 17 The American Medical Association opposed any government interference with the health care and the AMA

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15 Ibid., 21.
16 Ibid., xxxi.
17 Ibid., 21.
were effective in excluding any health care provisions in the Social Security Act.\textsuperscript{18} The AMA influence came from FDR’s inner circle, two of his top advisors in the White House were doctors; the first was Ross McIntire, who visited the president twice a day and was a renewed brain surgeon. The second doctor was Harvey Cushing, whose daughter married the President’s son James. “When FDR put together Medical Advisory Committee of Physicians, to work on the Committee on Economic Security (CES), on developing health legislation and appointed Dr. Cushing chair, and appointed Dr. McIntire as the President’s liaison to the committee. Cushing and McIntire, both represented the more traditional wing of the medical profession, and Cushing strongly opposed the attempts of his public health-oriented colleagues on the committee to push for an increased government role in health protection”.\textsuperscript{19} Both were his confidants, and advised FDR on issues penetrating to health care. The president was reluctant to endorse any policy that would nationalize health care or require any government interference in the delivery of the health care system. The president was pressured by both sides of the political spectrum, while the AMA seemed to have more connection with the president, but the introduction of the New Deal and the omission of the health care reform in the New Deal encouraged groups who want more nationalized health care to sway or change the government's role in this predicament. New York Senator Robert Wagner introduced a bill for national health insurance. The Bill was unsuccessful; the AMA fought against the bill and was defeated in the floor.

\textsuperscript{18} Ibid., 5.

\textsuperscript{19} Ibid., 25.
In 1943, the Supreme Court accused the AMA of conspiracy when they denied hospital privilege to the Group Association doctors. In the later years of his presidency, FDR was changing his view on national health care. FDR insisted on including these principles in the Atlantic Charter, which was introduced by British Prime Minister Winston Churchill and FDR to lay out aspirations for the postwar world. In FDR’s speech on January 11, 1944, FDR proposed an Economic Bill of Rights, where he outlined essentials in maintaining the four freedoms. “The rights are “self-evident”, which includes the right to a job, the right, the right to adequate food and clothing, farmer’s right to a fair price, the right to free trade, the right decent home, and the right to a good education. The right to adequate protection from the economic fears of old age, sickness, accident, and unemployment, and the right to adequate medical care and the opportunity to achieve and enjoy good health.”\textsuperscript{20} The shift in his view was due to the advancement in the medical field. During the military draft, the military rejected young men due to their poor health, thus access to health is a national security concern. This predicament created a national outcry, U.S. congressmen were expressing frustration and disappointment in the civilian’s state of health, “5 million were unfit for war”, screamed a 1944 New York Times headline.

The health care accessible to armed forces was of a better quality than civilian health services. With the surge in the number of unfit citizens for the war, they were drafted anyway and motivated by the government to try to treat them in military hospitals. The type of health services soldiers were receiving caused smaller causality helping patients

\textsuperscript{20} Ibid., 36.
avoid preventable diseases. The improvement of the quality of health can be seen during World War II. The expansion of health services for veterans during WWII were extensive, by 1942, more than 41,000 of the nation’s 120,000 eligible physicians had joined the armed forces. This created a shortage in the number of doctors that can serve civilians, especially in the rural areas, who had a shortage of doctors before the war.

IV. Origins of the Private Insurance (Blue Cross/Blue Shields)

Hospitals and doctors have been struggling to collect payments for health care services for many years and hospital administrators were constantly complaining about patients reluctant to pay for hospital bills, “they will try to evade payment of . . . Services. A patient will pay for his railroad or steamship tickets in advance, but resents the hospital’s equally logical request for an advance payment”. Some hospitals detained patients until they paid their medical bills. In the 1920’s cases of patients challenging their authority of the hospital to detain them, but the court upheld it, as long as they were not using force. In 1929, Baylor University Hospital in Dallas, Texas developed a pre-payment plan for city teachers, where they were charged a monthly fee for coverage of bills when patients were hospitalized. The fee only covered the hospital bills and not doctor’s bill; Baylor avoided any opposition from the AMA. The American Hospital Association (AHA) observed the success of the plan and the increase in the number of hospitals using their method of pre-payment plan. “In 1933 the AHA, the national trade group to voluntary hospitals, officially endorsed “the principle of insurance against the

21 Ibid., 43.
22 Ibid., 33.
costs of hospital care". The AHA created a Committee on Hospital Services, which was later, called the Blue Cross Commission. It was standardized and creates a multi hospital payment system. By 1938, there were sixty Blue Cross and the largest was in New York, which had about 800,000 members. The reason for the high membership was due to the lower cost and the insurance against high hospital payments. But the success fell short, when patients received bills from the doctor. In 1939, the anger by Blue Cross members for the doctor’s bills encouraged the state of California to introduce the Blue Shields. This was equivalent of Blue Cross but was only created to handle the doctor’s bills. Blue Shields offered to handle doctor’s bills in hospitals and not in doctor’s offices. It avoided any opposition from the AMA, since this was solely handled by the AMA. The Blue Cross and Blue Shields were tied to employment of the individual. This introduced the type of health care handled by private health insurance companies through the employer.

Senator Claude Peper’s Committee on Wartime Health and Education emphasized the need for a national insurance plan in 1943. Also in 1943, the Wagner Murray-Dingell bill for national insurance alarmed the AMA, which pushed them to open the first Washington Lobbying office. Though, FDR later became more apathetic with call for nationalized health care system, he objected the Wagner Murray-Dingell bill. When President Harry Truman was first elected, he was more sympathetic and welcomed the idea of a more nationalized health care. This was due to his experience with the war, when, civilians were rejected due to their poor health. Truman tried to revive the Wagner Murray-Dingell bill, but failed to pass the Republican Congress. In 1949, he went to

\[23\text{ Ibid., 34.}\]
Congress to ask for the adoption of the Health bill, though private insurance, managed to cover millions of Americans, he thought it was not enough to meet the demand for care. Truman told the Congress “will mean that proper medical care will be economically accessible to everyone covered by it, in the country as well as in the city, as a right and not as medical dole”.\textsuperscript{24} The other bill was the Hill-Burton construction act, which called for the construction of new medical facilities, allowing tax money to pay for new hospitals; the bill passed. Medical lobby groups in Washington were not against the construction of new medical facilities by the government, but refused the Wagner Murray-Dingell for its potential to decrease salaries of doctors and allowing the government to dictate the health care system.

V. The Development of Medicare and Medicaid

“The doctors claimed that the fight was over government control of medicine. That wasn’t it at all. The fight was over whether decent medical care is a basic right-like the right to food, shelter, clothing and education. The people and Congress decided it was”.\textsuperscript{25} This was the statement Senator Clinton P. Anderson released after the Medicare bill was passed in July 1965.\textsuperscript{26} Medicare and Medicaid created massive and enduring federal and state insurance system to cover medical bills for the elderly and the poor. But before the victory, the battle to get this bill passed was difficult and long. The battle for

\textsuperscript{24} Ibid., 59.

\textsuperscript{25} Charles J. Dougherty, \textit{American Health Care: Realities, Rights, and Reforms} (Oxford University Press, 1988), 166.

\textsuperscript{26} Ibid., 168.
Medicare and Medicaid were an extension of Truman’s call for nationalized health care system. With the defeat, the focus shifted to a more specific group; senior citizens. The call for health care system that would only serve seniors found its support. The Medicare plan was intended to be an extension of the social security program and financed by payroll taxes. The support for seniors was due to the vulnerability of this demographic group and the poverty level within this particular group. The support for senior groups was creating a movement that made it hard for any group to fight. Rep. Aime Forand (D-RI), initially developed a bill for health insurance tied to the social security in 1957. But, President Eisenhower did not support the bill and was blocked by conservative Southern Democrats.

It did not stop the well of the seniors in the United States; seniors organized themselves and were included in a special Senate subcommittee that studied senior citizens over 65. The Forand bill was re-introduced by Senators Clinton Anderson and John F. Kennedy. Kennedy, who was supporters of health insurance for seniors, and campaigned Medicare for seniors, thought that it is a necessity and in return got the largest support of seniors for his campaign for presidency. The growing popularity of the bill did not go well with the AMA. The AMA introduced an alternative bill, which offered matching grants to assist the elderly poor. This bill was called Kerr-Mills and was introduced by Oklahoma Senator Robert Kerr and Arkansas Rep. Wilbur Mills.27 Both were conservative Democrats, who supported limited government intervention of the health care system. On the other hand, Kennedy relied on support from organized senior

27 Ibid., 167.
and labor groups. The National Council of Senior Citizens (NCSC) were so organized that they were handing out flyers explaining what Medicare is and how it will improve access to health care for seniors. They organized rallies and used major television and radio networks broadcast to explain Medicare to gain support from the masses. But in 1966, AMA were launching “Operation Coffee Cup”, which recruited Hollywood stars like Ronald Regan, explaining that Medicare will socialize the health care system in the United States, and also used posters and flyers to sway public opinion.\textsuperscript{28} As a last resort, the AMA introduced voluntary program that would cover the doctor’s bills. But with all these efforts the AMA put to stall Medicare, it was not successful in shifting public opinion and the bill was passed.

Medicaid and Medicare were simultaneously developed and passed, but both programs are different, especially who it serves. AMA ironically developed Medicaid; they proposed it as an alternative program that would offer health coverage for poor seniors, to offset the imminent support for Medicare.\textsuperscript{29} It was an extension of the Kerr-Mills program that offered to pay for medical bills of welfare recipients. Wilbur Mills drafted the Medicaid program while the debate for Medicare was still present. Medicaid (Title XIX of the Social Security Act) offered grants from the federal government, which in return states to provide medical assistance for low income. The federal government proposed that it will offer 50-83 percent of the expenses. States had the choice to deliver

\textsuperscript{28} Ibid., 168.

\textsuperscript{29} Ibid., 165.
Medicaid or not. By the 1970’s, only two states did not offer Medicaid, Arizona and Alaska.  

VI. The Next Chapter (Affordable Care Act)

The most pivotal health care legislature ever created in the United States was the Patient Protection and Affordable Care Act (ACA), which was signed into law by President Barack Obama in 2010. The law requires uninsured Americans to buy health care coverage or face fines; the government ensured that the coverage will be affordable to all Americans. With over 50 million uninsured Americans when President Barack Obama was first elected, the policy was important and a pivotal point of President Obama’s presidency. The creation of the ACA and how the law was first passed is important to study and understand.

In the White House website, the President states that the purpose of this policy is to create an affordable health plan for working middle class families. This policy also ensures that discrimination against patients pre-existing condition, dropping coverage for sick patients, billing patients into bankruptcy is no longer legal. And finally, insurance companies will cover preventive care like mammograms and other cancer screenings. The ACA allowed parents to keep their young adults in their health plan; about 2.5 million young adults are under their parent’s health plan. “In 2010 and 2011, over 5.1 million seniors and people with disabilities on Medicare have saved over $3.1 billion on

30 Ibid.

prescription drugs; these savings included a one-time $250 rebate check to seniors who
hit the “donut hole” coverage gap in 2010, and a 50 percent discount on brand-name
drugs in the donut hole in 2011. And everyone with Medicare can get key preventive
services like mammograms and other cancer screening tests for free. Insurance
companies can no longer drop your coverage when you get sick, error in an application;
put a lifetime cap on the dollar amount of coverage you can receive or raise your
premiums with no accountability. And finally, insurance companies can no longer deny
coverage to children because of a pre-existing condition.”32

VII. What Led to the Affordable Care Act?

The Clinton health care plan, also known as the Health Security Act, was a 1993
health care reform package introduced by President Bill Clinton, with the help of then
First Lady of the United States Hilary Rodham Clinton. Then candidate Bill Clinton
heavily campaigned for health care reform in the 1992 U.S. presidential election. The
plan was to come up with an extensive universal health care for all Americans. President
Clinton delivered health care speech to the U.S. Congress in September 1993. The core
goal was to enforce a mandate for employers to provide health insurance coverage for all
their employees.33 The bill was crafted by the White House and failed to get the
necessary support for the bill to pass. President Obama took a different approach in the
creation of the ACA bill. Instead of having the executive office, craft the bill that would

32 Ibid.

ultimately be introduced to the Congress, President Obama laid out the broad principles and goals of the health care bill and left the House and Senate to provide legislature details. ³⁴ In March 2009, three chairmen of the House committee with jurisdiction over health care agreed to draft the health care reform bill. After series of hearing in May 2009, the committee chairmen with the guidance of the Speaker of the House Nancy Pelosi released a “discussion draft” proposal for the health care reform in mid-June 2009. “The provision included health insurance exchange, allowing consumers to shop for health care providers; a public health insurance option; an expansion of Medicaid; a mandate for individuals to either have insurance coverage or pay a fee (with hardship exemption); and a mandate for employers to provide insurance or pay a contribution fee (with some exemptions).”³⁵ This proposal did not have funding details.

After ample of hearings in June and July, a bill was introduced House bill 3200- America’s Affordable Health Choices Act of 2009. This version of the bill contained many of the provisions that were in the earlier draft, but also had additional points, for example a surcharge on wealthier Americans to help pay for it. The bill was referred to the same committees who had originally drafted the bill-Education and Labor, Energy, Commerce and Ways and Means, Committee on Oversight and Government reform and on the Budget. The committees marked up the bill and reported them to the House floor on July 17, 2009. Fiscally conservative democrats “Blue Dog” were unhappy with the


³⁵ Ibid.
size and cost of the health care bill. Threaten to withhold their votes, Committee Chairman Henry Waxman, Speaker Pelosi, and White House Chief of Staff Rahm Emanuel, included reduction in the cost and limiting the public insurance plan so that private insurance companies could compete. 36 The Energy and Commerce Committee finalized its work on July 31, 2009, which was a scaled back version of the previous bill, which contained amendments to promote good health behaviors, create an approval process for generic drugs and restrict premium increases. The three versions of the House bill 3200 were reported to the flood on October 14, 2009, the delays were due to the arrangements that were made with Blue Dogs, who were not against rushing a chamber vote. The bill was at a standstill and they were not successful in keeping the bill alive.

On October 29, 2009, new bill was introduced 3962, the Affordable Health Care for America Act. The new bill was the result of negotiation among different fractions of the Democrats in the House. This bill was not different from House bill 3200; it contained many of the provisions that the previous bill had, such as health exchanges, a public option, individual and employer mandates, Medicaid expansion, and a surcharge on those with high income. 37 It also included Medicaid rates that the Blue Dogs wanted and 5.4% surcharge on taxpayers earning more than $1,000,000. But this bill included an additional provision that was not included in the House bill of 3200; a withdrawal of the McCarran-Ferguson Act, which exempts insurance companies from federal antitrust law, and an excise tax on medical devices. House bill 3962 did not go through many of the

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36 Ibid.

37 Ibid.
amendments and process that House bill 3200 went through. It was not referred to the committee for any substantive review; it was not listed on the House Union Calendar and was called up on the House floor on November 7, 2009, less than two weeks after the bill was formed.

The House Rules Committee moved the health care bill to the floor via House resolution 903, a special rule with both procedural and substantive components. 38 “First, House resolution 903 played the traditional role of a rules resolution, providing a procedural road map for how House bill 3962 would consider on the House floor. It waived all points of order, set the time of debate for several hours, and called for a vote for only two amendments. One representative Thomas “Bart” Stupak, prohibiting any federal funding of abortion under the health care bill. The second essentially contained Republican health care proposals”. 39 This version of the bill allowed an ongoing negotiation between House Democratic leaders and various factions of the Democratic Party. Part A was a “self-executing rule,” containing automatic changes to House bill 3962; re-writing the repeal of the McCarran-Ferguson Act’s antitrust exemption for health insurance companies. And Part B was perfecting the amendment, which allowed changes to be made to parts of the legislation and not the entire bill. The resolution was passed on November 7, 2009 after only an hour of debate and was received by the Senate three days later. If the Senate approves the bill as it is, then it will then go to the White House for the President’s signature, if not, it will return to the House for its consensus or to request a

38 Ibid., 142.
39 Ibid.
conference. But, this was not how the bill played out; the Senate took the lead in shaping the current structure of the Affordable Care Act. 40

The bill was passed and sent to the Senate for evaluation and to finalize the bill. When the bill was first drafted back in spring 2009, two Senate committees were in charge with the task of producing the chamber’s version of health care bill; the Committee on Health, Education, Labor and Pensions (HELP) and the Committee on Finance. 41 The Committees were heavily involved in crafting the bill, committee chairmen were in communication, hearings and discussions were held, and the goal was to produce legislation that could be merged together into a single bill that could be brought to the floor. The Senate Committee introduced the bill; the Senate does not have to wait for the chamber to develop the bill, but instead can develop the bill on their own, which was the case, where HELP and Finance developed the health care bill. The Committees were heavily involved in the legislation cost, reviewed by the Congressional Budget Office (CBO). In June 9, 2009, the HELP introduced an unnumbered draft of the bill. The draft required uninsured individuals to buy health insurance through state exchanges or make payments to the government. Individuals who are lower and middle incomes and small business would receive subsidies to help them purchase policies. The CBO first incomplete draft promised that the cost of the bill would be 1 trillion and would decrease the number of uninsured Americans by sixteen million people. 42 They

40 Ibid.

41 Ibid., 143.

42 Ibid., 145.
also added other provisions to the bill, an amendment to the chairman’s mark on July 2, 2009, which included subsidies and public option called the Community Health Insurance Option, which will be managed by the Department of Health and Human Services offered through the exchanges. The final vote for the drafted bill was held on July 15, 2009, but the legislature titled the Affordable Health Choice Act was not reported until months later on September 17, 2009. Senate bill 1679 was sent to the Senate floor without a committee report.

The Senate Finance Committee chairman Max Baucus, Jeff Bingaman, and Kent Conrad and three other Republican senators Mike Enzi, Chuck Grassley, and Olympia Snowe worked on creating the Senate version of the health care bill. The group of six met through from late spring and through summer and early fall of 2009, but we're not able to agree with the final version of the bill. Baucus was trying to negotiate with the pharmaceutical industry on making drugs more affordable, and this was with the blessing of the White House. Though, this deal never came through, the momentum for creating the health care bill did not fade. This version of the bill took a long time to create. There were about 564 proposed amendments, and on October 13, the full committee voted to report out Senate bill 1796, the American Healthy Future Act with the committee report. Harry Reid then started the effort to merge the HELP and the finance committee bill. The three cloture votes fell into place near Christmas times, and senate amendment 3276 passed on December 22. Senate amendment 2786 passed on December 23 and House bill 3590 finally passed on December 24.\textsuperscript{43} The Bill was named Patient Protection and

\textsuperscript{43} Ibid.
Affordable Care Act. The interesting notion in this process was that Senators and Congressmen were using social media, informing the public of every policy step. There was a sense of urgency to complete the bill, the White House and officials were meeting to get the bill going, since they were worried about the Ted Kennedy replacement. The next step for the bill would be the conference committee; however, this option would put the bill in danger for a filibuster, giving Republicans more opportunities to stall the bill. And, Democrats were hoping that they could get the bill finalized by the President’s State of the Union on January 20, 2010. “The negotiations afterward were held behind closed doors, which raised transparency concerns and meant that this important stage would leave no record aside from what was reported to the press.”

The Patient Protection and Affordable Care Act (PPACA) also known as the Affordable Care Act (ACA) or colloquially Obamacare, is a United States federal statute signed into law by President Barack Obama on March 23, 2010.

The legislative history of the ACA might be one of the most important legislative histories in the United States. The process was very extensive, where the Supreme Court decision to keep the law in place indicates the visible division in public opinion and also within political parties. Conservative states were refusing to accept the law and were attempting to find loopholes to not comply with the ACA. The ACA was not an original inspiration from the Obama administration, but was a long historical track that led to this legislature. Early legislatures such as the New Deal, Medicare and Medicaid placed the tracks that led to this law. The health care in the United State is far from perfect, but what

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44 Ibid., 159.
many Americans would agree is that 50 million uninsured Americans is unacceptable for a country in the U.S. position in the global arena. This population equates to over ¾ of the United Kingdom's population and is slightly lower than a quarter of the population in the United States. The signature of President Obama on March 23 did not end the war, but merely changed its course. The entirely of the ACA was accepted, but there was one clause within the ACA that created debates and rejections; the contraceptive and elective abortion within the ACA. In the next chapter, I would like to discuss how the civil society and the Supreme Court reacted to this mandate and if it will allow other clauses within the ACA to be examined.
CHAPTER 4

CONTRACEPTIVE AND ELECTIVE ABORTIONS IN THE AFFORDABLE CARE ACT

I. Overview

The Affordable Care Act (ACA) passed by the United States Congress, and signed into law by president Barack Obama addresses one of the most pivotal topics in American politics; health care. The debate over the government’s obligation to provide health care to its citizens or allowing the private industry to manage the health care system has been debated for many decades. While many believe the market should provide and dictate the health care system, others view the government obligated to, offer an adequate access to an affordable health care. The establishment of the ACA was not without disagreement and interruptions, continues discussion of the actual existence of the Act remains evident in the political arena. While the federal government sees the access to affordable care as necessary, and evidence of the United States being one of the few western nations still struggling with how the health care system should be structured, it is essential to find a solution to this predicament. Opponents of the ACA view any government interference as socialist, and eliminating the private industry’s role in the health care system.

In recent years, the contraceptive clause within the ACA was disputed by many religious organizations that believe it conflicts with the Religious Freedom Restoration Act (RFRA). The clause within the ACA that stimulated the most challenging discussions was the mandate that forces businesses to pay for insurance that could be used for contraceptives and elective abortion for employees. The Department of Health and
Human Services secretary Kathleen Sebelius finalized the mandate on February 10, 2012, which requires businesses to pay for preventive services approved by the FDA, for women that must be included without co-pays or deductibles in nearly most health insurance plans in the country. These contraceptives will be available to employees and their dependents. But, after the mandate was approved, religious institutions, mainly institutions affiliated with the Catholic Church and other religious orders voiced their opposition to the mandate.

II. The Exemptions Permissible within the ACA Mandate.

The Federal government argued that the mandate does recognize the religious burden and it did in fact allow exemptions to be implied for those who qualify. But, not all religious organizations and institutions were exempted from following the mandate, the only groups that can use the exemption implied in the mandate are churches or religious orders, which follow restrict and narrow parameters of the religion. There are criteria’s that need to apply, such as “(1) have the primary purpose of inculcating religious values, (2) primarily employ on those who share its belief, (3) primarily serve individuals of the same faith and, (4) qualify as a nonprofit organization under Section 6033 (a) (1) and 6033 (a)(3)(A)(i) or (iii) of the Internal Revenue Code”. The decision to not comply with the mandate, after an organization failed to meet these exemptions


2 Ibid.,

3 Daniel Rudary, Drafting a Sensible Conscience for Meaningful Conscience Protection for Religious Employers Objecting to the Mandate Coverage of Prescription Contraceptive (Health Matrix, 2013), 360.
will result in fines imposed by the federal government, which will then appear in the federal income tax.

III. The Catholic Dogma and Religious Rationalization

The United States was founded on religious liberty, the ability to believe and not believe, to practice religion freely without interferences or supervision. This is the core believe and custom of what we call the civil religion in the United States, and for that reason, they see the mandate violating their religious liberty. So, what is the Catholic dogma that cannot be broken? What does the church say about abortion, contraceptives, birth control and sterilization? The church uses verses in the bible that verifies their stance.

On abortion, in the Apocalypse of Peter, it states “And near that place I saw another strait… and there sat women. . . And over against them many children who were norm to them out of due time sat crying. And there came forth from them rays of fire and smote the women in the eyes. And there were the accursed that conceived and caused abortion”.4 There are other scriptures from the old and new testaments that were used to defend the church’s stance on abortion, contraceptives and sterilization. For birth control, the Catholic Church perceives them as the only Christian domination that upholds the true doctrine of the faith. On birth control, in apostolic tradition, it states, “In A.D. 195, Clement of Alexandria wrote, “Because of its divine institution for the

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propagation of man, the seed is not to be vainly ejaculated, nor is it to be damaged, nor is it to be wasted” (Instructor of Children 2:10:91:2).\(^5\)

In another verse, it states “this proves that you [Manicheans] approve of having a wife, not for the procreation of children, but for the gratification of passion. In marriage, as the marriage law declares, the man and women come together for the procreation of children. Therefore, whoever makes the procreation of children a greater sin that copulation, forbids marriage and makes the women not a wife, but a mistress, who for some gifts presented to her is joined to the man to gratify his passion” (The Morals of Manichees 18:65 [A.D. 388] Augustine).\(^6\)

There were other verses condemning the use of birth control, contraceptives and sterilization methods. Hence, their stance comes from theological stance, which is viewed as difficult to break. Lastly, on the issue of contraceptive and sterilization, the Church condemned the use of it. All Churches initially condemning the use of contraceptives and sterilization until 1930, when, at its decennial Lambeth Conference, the Anglican Church gave permission for the use of contraceptives in special cases.\(^7\) Soon, after, most Protestant churches changed their stance on contraceptives and sterilizations.\(^8\) But according to this source, the Protestant stance is not clear yet, especially, the mandate

\(^5\) Ibid., Birth Control.

\(^6\) Ibid., Contraceptive and Sterlization.

\(^7\) Ibid.

\(^8\) Ibid.
allowing the purchase of emergency contraceptives such as the morning after, and week after pills and intrauterine devices (IUD).⁹

IV. The Consequences of the Mandate to the Catholic Communities in the United States.

The president of The University of Notre Dame, Fr. John Jenkins felt it was inexcusable for the university to comply with the contraceptive mandate within the ACA. He states “contraception and sterilization in violation of the Church’s moral teaching” or discontinuing employees and student’s health care plan in violation of the Church’s moral social teaching”.¹⁰ The University of Notre Dame is not the only institution that feels this predicament. These institutions mainly serve people who are not from their faith groups. If they choose to not comply with the mandate, they will then only employee or admit students from their faith group, therefore limiting their religious obligation to serve the community at large. The religious obligations are not the only barrier Catholics feel about this mandate within the ACA, Catholics also feel isolated and targeted by this policy. As the largest and most organized groups opposing the mandate, it is their organizations that feel the heat.

It is difficult to fully comprehend the implications of this issue, the effect it has on employees, who have no means to pay for contraceptives and elective abortion, and religious institutions, who feel this mandate violates religious freedom, allowing the federal government to interfere in one’s religious views. The first amendment guarantees

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⁹ Frederick Tassell, RFRA Exemptions From the Contraceptives Mandate: An Unconstitutional Accommodation of Religion (Civil Liberties, 2014).

¹⁰ Rudary, Drafting a Sensible Conscience for Meaningful Conscience Protection for Religious Employers Objecting to the Mandate Coverage of Prescription Contraceptive, 358.
freedom of religion, which contains the right to believe (or to not believe), but also the right to express and to manifest one’s religious or non-religious beliefs.

The mandate allows employees to get an elective abortion through the insurances from their employer, FDA approved services must be provided by the insurances. Elective abortion like surgical, chemical and late term will be covered similarly to any medical procedures done, not all ACA compliant insurances include coverage on abortion premium. Insurance companies should not advertise this information, consequently, employees who seek this service will have to read the fine prints to see if their insurance covers it or not. 11 If the insurance covers it, the employer will be charged with part of the cost. 12

Those who oppose the mandate have implied that if this mandate is necessary and cannot be removed from ACA, then, the federal government should independently pay for these contraceptives and not expect these institutions that oppose the mandate on strong religious grounds to comply. But, the House Republicans used the Hyde Amendment as a way to stop the development of the mandate and find ways to exclude it from the ACA. The Hyde Amendment prohibits the use of public funds for abortions, except in the case of rape, incest, or risk to the life of the pregnant women. 13 Pro-life groups view the enforcement of this mandate as an extension of the defeat of Roe v.

11 Alliance Defending Freedom for Faith, ObamaCare and its Mandate Fact Sheet.

12 Ibid.

The exemptions do not apply to pro-life groups; therefore, they need to comply with the mandate or face fines. The only downside to their argument is that if an individual is employed by a pro-life organization, wouldn’t they have to uphold the institution's philosophy and stance on abortion, thus, they should not expect their employees to demand such services, but it is not always the case.

Contraceptives and elective abortion were very controversial issues before the ACA. Though, the mandate has an exemption for religious organizations and non-profit organizations that have religious affiliations, for profit organizations are not provided with either exemptions or accommodations. Corporations, headed by religious owners who see the mandate violating their religious freedom, brought a case to the U.S. court system. In contrary, supporters of the mandate see that few organizations make claims to being religious and that the vast majority is proceeding with their indisputably secular activities. The dispute is then, if these institutions should be viewed as a “person”, which has the right to exercise their religious liberty or an organization with broad views and stance.

The American court system must then define whose religious liberty is being compromised and how the RFRA is violated for those that oppose the mandate. In Burwell Secretary of Health and Human Service v. Hobby Lobby Stores, the corporation that brought the case to the Supreme Court was using the RFRA as defending point. The

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14 Rudary, Drafting a Sensible Conscience for Meaningful Conscience Protection for Religious Employers Objecting to the Mandate Coverage of Prescription Contraceptive, 359.

15 Tassell, RFRA Exemptions From the Contraceptives Mandate: An Unconstitutional Accommodation of Religion.
decision of the Supreme Court will not only end the dispute, but also create a framework that will solve similar issues in the future. The level of influence the federal government has on imposing such mandates and the power of organizations to overturn the mandate was being tested in this case.

V. Counter argument (The Benefits of the Mandate to Lower Income Families and Individuals)

The other side of the argument sees the issue in a different point of view. There are social and economic benefits to contraceptive and elective abortion, and the government sees that insurances should not discriminate against any service. These institutions' employees do not all share the same religious beliefs and imposing such stances on them might seem as imposing one's beliefs. It was viewed as large organizations abandoning their responsibilities against their employees to manipulate the system and skip on their responsibilities. Is it fair, for these organizations to take away the rights of individuals to receive these services? Can religion be used as a tool to strip the rights of the poor working class? The government sees these services as an opportunity for working class women to concern less on the payment of these expensive services. These services are FDA approved, and carry no eminent harm on individuals.

“Lieutenant-governor Kathleen Kennedy-Townsend- deny a benefit to a whole class of workers, including hundreds of thousands of non-Catholics who want it, need it and are legally entitled to it. It is unfair and unreasonable”.16 By allowing millions of women to

16 Rudary, Drafting a Sensible Conscience for Meaningful Conscience Protection for Religious Employers Objecting to the Mandate Coverage of Prescription Contraceptive, 359.
use contraceptives without paying the high price that are attached to it, is a dream come true for many people.

Contraceptives prevent unplanned/unwanted pregnancies, miscarriages and even abortion.\(^{17}\) Full term pregnancies can be very expensive, costing individuals as high as $8,619, while miscarriage and abortion can cost women up to $1,038.\(^{18}\) Contraceptive can save up to $3.74 in Medicaid expenditures, specifically with unplanned pregnancies, and clinics that serve pregnant women saw great savings through the rise of contraceptives. (That suggests that $5.1 billion dollars were saved in 2008 alone).\(^{19}\) So with the increasing savings for the government and also individuals, it is the logical approach to encourage the usage of contraceptives. It decreases the number of unwanted pregnancies, which can be very expensive and time consuming.

Access to contraceptives is especially important for women, as women use contraceptives more than men. The antagonizing against elective abortion and contraceptives are seen as a way to fight working class women, who benefit the most from these services. They feel selectively attacked, unfairly treated and marginalized by a system, which favors policies that does not relate to them. This mandate will also be beneficial to insurance companies, which in effect will save money (contraceptives cost $60), if women choose to use contraceptives rather than have children.\(^{20}\)

\(^{17}\) Ibid., 360.

\(^{18}\) Ibid.

\(^{19}\) Ibid.

\(^{20}\) Ibid., 361.
Viewing this issue through the economic lenses seems logical and reasonable for Catholic institutions to rethink the mandate. As for elective abortion, the benefit associated with it can be tremendous for women with unwanted pregnancies. Women will not take the eight and plus weeks of maternity leave, which adds a visible economic loss for employers. “In promulgating its final rule, the HHS noted that access to contraceptives improves the social and economic status of women by giving them the option to participate more fully in the economic and political life. Women will not be threatened by the possibilities of pregnancy, which can hinder their careers, and hamper them from accomplishing their goals.

VI. Prenatal Care and its Effects on Mother’s decision

In some cases, the quality of prenatal care women receive plays role in the decision to have children or not. And for unexpected pregnancy, if the prenatal care is not available, it will affect the health of the unborn child. The overall prenatal care women receive in any nation indicates the extent of development the country accomplished. As for the United States, it is not disputed the level of progress it has accomplished in prenatal care, but, as we know, it does not by any means that there is no room for growth. In the U.S., there is a clear discrepancy between the types of prenatal care women receive, women with higher income enjoy the luxury of care that women with lower income don’t. The ACA is an opportunity to shorten the gaps in care. Thus, why is it so important for women receiving prenatal care throughout the pregnancy? Access to prenatal care for women decreases the chance of having complications during the pregnancy and any

21 Ibid., 361, see group Health Plans and Health insurance issues relating to coverage of preventive service under the Patient Protection and Affordable Care Act, 77 Fed.
future problem. There are many preventable diseases that could only be avoided by an adequate prenatal care. The importance of prenatal care cannot be more stressed; the decision for a mother to keep the pregnancy or terminate it can only be determined by the care a mother receives.

In the mid to late 1980’s, 70 percent of American women received an adequate prenatal care. In 2008, 27 areas reporting stated that 71 percent of women giving birth were able to receive prenatal care in the first trimester, while 7 percent of women received prenatal care in the third trimester or did not receive any prenatal care. What these numbers indicate the lack of development in this category. In the past thirty years, the numbers still remained consistent. The report also shows teens, and working class women have the least access to prenatal care due to their income.

Therefore, these numbers narrate the need for government intervention, the stagnation indicates that there were no efforts to change or improve the status quo; it is not working according to plan. The danger associated with not having the appropriate prenatal care can be detrimental to the child and mother’s health. So, having contraceptives and elective abortion becomes a legitimate choice for mothers with limited income. But, is access to prenatal care a deal breaker for many potential mothers? Access to prenatal care is important for any mother, especially when the pregnancy is unexpected. Thus, for certain women’s, limited resources may lead to contraceptives and elective abortion. Thus, if the government were to improve access to prenatal care, will it

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decrease the number of women seeking contraceptives and elective abortion? I’m not sure if this claim can be verified, but for institutions that want to forgo the cost associated with contraceptives and elective abortion, they can in return improve access to prenatal care.

VII. The Religious Freedom Restoration Act (RFRA) and the Supreme Court Case

The Religious Freedom Restoration Act (RFRA) is a United States federal law aimed at preventing laws that would burden the free exercise of religion. The bill was introduced by Congressman Chuck Schumer (D-NY) on March 13, 1993 and was passed by the House and the Senate and signed into law by President Bill Clinton. The purpose of the law was to provide a separation between the government and the public on issues penetrating to religion. The constitution recognizes that we have the unalienable right, secured in the first amendment, which is the freedom of religion. The law applies to all religions, and the aim of the law is to stop the government from burdening the person with laws that conflict with one’s belief. The law states that the government should not burden religious exercise without compelling justification. It might seem vague to what could be defined as burdening one’s faith, and how the government can determine it. The law applies to all federal and state laws, and the implementation of the law, whether applied before or after the enactment of this act. The RFRA is a “permissive” accommodation, that is, a voluntary government accommodation of religion that is not constitutionally required by the Free Exercise Clause. The RFRA’s stated purpose, after

24 Baptist Joint Committee, 20 Years of Protecting our First Freedom.

25 Ibid.
all, is to provide protection for the religion exercise than is provided by the Free Exercise
Clause after employment Division v. Smith. The RFRA therefore must satisfy the various
Establishment Clause limitations on permissive government accommodation of
religion.26

Initially, there were minor changes that the HHS introduced; it delayed the deadline
for the compliance of the mandate for non-profit organizations. Thus, the government
provided an additional time before they must comply with the mandate or face fines from
the federal government.27 The existence of the mandate itself conflicts with the religious
liberty of for profit organizations. The owners of these institutions who follow strict
religious guideline believe the mandate violates the RFRA. The HHS delaying the
deadline for fine payments indicates the government’s attempts to finding solutions to
this predicament. But, these organizations have turned the court systems to find ways out.

The Supreme Court case Burwell, secretary of Health and Human Service, et al., v.
Hobby Lobby Stores, Inc. et al, was considered one of the most critical cases seen in the
public sphere in recent years. It was highly discussed in the media and the outcome of the
case received public attention. The case was on the ACA contraceptive mandate; Justice
Samuel Alito delivered the decision of the case. Initially, Hobby and Lobby stores filled a
case against the federal government, opposing the contraceptive mandate within the

26 Tassell, RFRA Exemptions From the Contraceptives Mandate: An Unconstitutional
Accommodation of Religion, 9.

27 House Committee on Energy and Commerce Majority Staff, The Fight to Preserve
Religious Liberty (United Statesa Congress, 2013).
ACA. 28 The plaintiff, Hobby and Lobby used the RFRA to establish their defense argument. The HHS sees for profit organizations not having a compelling reason to not follow the mandate. The debate is if the institution is seen as a ‘person’ or not. 29

The HHS and other federal agencies were sued under the RFRA, seeking the contraceptive mandate in the ACA to be removed. 30 In the report, it states “the Greens” businesses are ‘person’ under the RFRA, and that the corporation had established a likelihood of success on their RFRA claims since the contraceptive mandate substantially burdened their religious exercise and the HHS had not demonstrated a compelling interest in enforcing the mandate against them; in the alternative, the court held that HHS had not proved that the mandate was the “least restrictive means” of furthering a compelling government interest.” 31 Thus, the court did not see a visible separation between the owner and the corporation, and viewed the owner’s religious liberty being violated by the mandate. The Supreme Court's decision was shocking to many people observing the case. The separation between the corporation and the ownership was argued by the HHS, but the surprising outcome was the Supreme Court recognizes the for profit organization as a ‘person.’ The court’s decision in this case does not just overturn other insurance coverage mandate, such as vaccination and blood transfusion, must necessarily fall if they conflict with one’s faith.

28 Ibid.
29 Ibid.
30 Ibid.
31 Ibid.
VIII. The Right to Health Care and The Implication of this Mandate to this Idea

There are economic and social benefits with contraceptive and elective abortion, but religious organizations were not kin to overturn their religious obligation to follow the contraceptive mandate, and have used the RFRA to argue against the mandate. But, the government has observed the opponents of the mandate view as not comprehensible, to inflict this burden on working class women, who have no means to pay for such expensive services, thus compelling them to forgo the service. It is a difficult choice for both parties, but the court's decision upheld the RFRA and viewed the government's reasoning as not convincing.

It might seem the decision of the court to favor opponents of the mandate and that religious liberty is perceived more importantly than some health services. The development of the mandate perceived the duty of the employer to provide the contraceptives for their employees. But, as exemptions were put in place, the needs for further accommodations from opponents of the mandate seem more prevalent. As more exemptions were introduced, the only group that was not included was for profit organizations, viewing them as separate entity and not a ‘person’. As the courts viewed these organizations as a ‘person’ and not a separate entity, will this create ambiguity for future cases? The government defeat does not imply an end to this predicament. The current case presented to the Supreme Court by the University of Notre Dame might be viewed might be affected by the court's decision on the Hobby Lobby case.

The debate, for which one is more vital, religious liberty or public services, has been the most difficult decision any government must take. The fine line between
personal freedom and social benefits for larger groups within a society is difficult to
determine. The idea that it can be distinguished in the initial phase of developing a policy
can seem naïve. The development of any policy is difficult and there are no policies that
will ultimately benefit the society as a whole. Policy makers have always aimed at
creating policies that will benefit the larger group. In the initial creation of the ACA was
to benefit the millions of Americans who had limited access to care. And the creation of
the contraceptive mandate was to benefit women who have limited resources to buy
contraceptives. But, after the Supreme Court's decision, policy maker must reconsider
reviewing policies that might affect religious liberty.
CHAPTER 5

THE RIGHT TO HEALTH CARE AND THE NATIONALIZED HEALTH CARE SYSTEM IN UNITED STATES AND UNITED KINGDOM

I. Human Right to Health Care

The term right has been overtly used for many decades; an individual right that allows people to not be limited by the government is what many envision when they hear the term ‘right’. There are two types of rights that one must address first, positive and negative right. Negative is a liberty right, a right to be protected from interference with one’s freedom of thought or action. “A positive right is an access right, right to be provided with necessary goods and services”.¹ In the United States, negative rights are highly preserved; the freedom from the government’s interference with one’s personal life and choices. The right to an education, health care and housing are preserved as a positive right.

There is no doubt that the right to health care does not exist in the United States as mentioned in previous chapters, because if it did, then the government would have provided access to health care free of charge to all citizens. The constitution guarantees the rights of the citizens on certain issues like the right to bear arms, right to practice any faith without the government’s interference and etc. The constitution does not state any right to health or health care. “In the U.S. our notion of rights leans more toward the narrower definition, toward personal freedoms, drawn from our country’s earliest beginnings in reaction to the oppressive political regimes of Europe. This stands in sharp

contrast to other democratic nations who view the delineation of “rights” as social entitlements in order to fulfill a larger social purpose. In these countries, certain benefits, like education and health care, are guaranteed as a right to their citizens because they promote social welfare.”² The expansion of social rights means for some groups as expansion of the governments' roles, which limits the role of the private sector within many industries.

There are no statures in the constitution that guarantees right to health or medical care, but the Supreme Court stated that the government is obligated to provide medical care in certain circumstances, such as prisoners. The U.S. health care system acknowledges certain rights; right for seniors and veterans, and emergency room treatment. The congress has enacted numerous statutes, such as Medicaid, Medicare and the Children’s Health Insurance Program, which required the government to facilitate health care services and the congress would allocate certain funds to pay for these services. Most of these statutes have been enacted in agreement that Congress’s has the authority to “make all Laws which shall be necessary and proper” to carry out its mandate “to... provide for the… general Welfare.”³ When debates on health care delivered by the government is addressed, questions about accessibility, coverage, cost and quality of care, and also, if health care coverage is a moral or legal obligation are questioned. There are no legal obligations to the right to health care. Though, there are laws and regulations that forbid


³ Ibid., 2.
the discrimination against person access to health care services due to the person’s religion, race, gender, or any other affiliations. Thus, an obligation to offer health care does not exist, but is there a moral obligation that demands or pushes a society to provide assistance to those with limited access to care. The moral obligation is to limit the amount of bad in one’s life. The utilitarian approach then inspires of guaranteeing universal entitlement to health care due to the significances of having a healthy and productive population. And thus, in utilitarian approach, if the universal health care is not present, the consequences will be bad for the society as a whole. In the egalitarian approach, a person equally is subject to pain, suffering and disability, and death. Thus, it is universally beneficial to have health care because it will benefit the society as a whole. Regards for the equal dignity of the individual, therefore requires an assurance to equivalent access to the means necessary to manage the burden of bad health.

The need for universal health care is questioned, due to the limited resources and the burden of paying for expensive health care system. The struggle for health care has only been relevant as the quality of care progressed. Now, with two sides arguing for different fronts, it is interesting to see how these two groups' arguments have progressed. Private health insurance companies through the employer mainly provide the health care in the United States. The cost of health care in the United States in comparison to other developed countries is very costly. “In 2009, the United States spent nearly $8,000 per person on health care, Canada spent $4,363, Britain $3,487 and Japan 2,878. France,

4 Dougherty, American Health Care: Realities, Rights, and Reforms, 30.

5 Ibid., 31.
which was recently named the best in the world by the World Health Organization, spent less than $4,000 per person”.

The rhetoric for supporters of none ‘socialist’ health care in the U.S. is that health care in the U.S. is of a better quality than other developed countries. The counter argument for market based health care supporters argue that without economic incentive, there will not be any room for innovation and/or improvement in the quality of care. Indication that higher cost equates better quality and innovation in the health care system is yet to be established. In the United States, insurance companies are much more organized, have greater influence than the mass. When local governments are experiencing budget deficits, programs for the poor, such as Medicaid, are the first to see cuts. Medicaid recipients tend to have poor care and fewer options than those with private insurance, thus cuts in the program diminish the access to adequate care. The limited access to state funds in the Medicaid program affects the quality of services the recipients receive and highlights the underlying problems with the system. Non-discrimination and human dignity is a pivotal principle of human rights, including the right to health. But income disparities in the US health care system are visible.

Government insurances meet basic requirements for health care, but the quality of insurances differs; the services that are provided by private insurance differ from services provided by Medicaid. The new predicament is that individuals in these programs merely go from uninsured to under-insured. Urgency to change the system is not acknowledged, especially when individuals are already insured. Politicians are only

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concerned with uninsured citizens and are not aware that under-insured are as dangerous as uninsured. According to Yamin and Carmalt, “the Affordable Care Act’s welcome improvements in quality fall short of providing a systematic change that would address some of the most important root causes of the problems, such as structural incentives to maximize the number of patients seen by a given provider in a given time, and the variable quality of care based upon de facto segregation in neighborhoods and cities.” 7 The author believes the Affordable Care Act (ACA) should change the structure of the American health care system, equal access to all and universal quality of care. This might seem a little premature, since the ACA has only been a law for a few years. And, the policy was first introduced to address the issue of uninsured, and underinsured was never the priority.

II. Rationing Affecting the Quality of Care

The struggle to implement any type of health care coverage is fueled by the fear of the term “rationing”. The concern with rationing has taken over public debates for many years; where politicians are in constant fear of government interference in the health care system, which in their view will alter the overall quality of care. During the national debate on September 2009, former governor of Alaska, Sarah Palin stated that the Affordable Care Act would bring rationing in the American health care system. 8 The term rationing might be loosely used, in any country, medical care is rationed whether by


government or by private market or a combination of both.⁹ Rationing or limit on medical services can occur on many occasions and circumstances. Public rationing occurs by controlling distribution, national budgeting, government setting prices and fees, restriction on services, while private industry rations by prices and insurance coverage.¹⁰ The term rationing has negative connotations dating back to World War II, where the government prioritized war productions. But rationing is also associated with supply and demand, the laissez faire free market principal; rationing arises when corporations are not able to produce enough to meet the demand. Thus, the correlation between government and rationing is not correctly used, implying governments only can cause rationing in the health system is quite naive. Americans have feared certain types of rationing that were seen in the Canadian and European health care systems. The implication then assumes that rationing is top-down, centralized policy, which is imposed by the government, but this notion is not always true.

There are two major types of rationing, the first is explicit rationing, which is when medical services are distributed or denied according to set of official rules. “Explicit rationing occurs when, for example, Medicare or insurance companies create lists of drugs and procedures that will be covered or not covered, or when a national health system establishes waiting list for particular kinds of services”.¹¹ The second is implicit rationing; shortages that are perceived as common and are looked passed at, such

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⁹ Ibid.
¹⁰ Ibid.
¹¹ Ibid., xv.
as shortages of medical personnel, long waits for appointment’s and different access to
different kinds of insurance.12 Both explicit and implicit rationing can occur at the
national levels due to government policy set by health plans or systems. And, it can also
occur at the micro level amongst hospitals and medical personnel’s. During the Nixon
administration, the U.S Congress considered health care reform, but the fear of health
care system similar to the European health care system and the fear of rationing in the
American health system haltered the plan for reform. The fear that a surge in the demand
for health services will not be equated to the supply of doctors and hospitals if the
National Health Service in Britain- including one about a woman who had on a waiting
list for a hip replacement for over fifteen years”. 13 And, stories of Canadians and British
citizens coming to the United States for MRI and other health services were repeated in
American media. Thus, this implied that the American system must be superior to the
Canadian and British Health systems, then why change or alter a system that already
works?

III. The American Medical Association vs. The British Medical Association

Opposition groups supporting an independent health care system were opposed to
any government run health care programs such as Medicare and the ACA. The fear that
the U.S. would nationalize the health care system similar to what had occurred over 70
years ago in the United Kingdom would become a reality in the United States. But, in

12 Ibid.

13 Ibid., xvi.
contrary, that is not the case; the U.S. American Medical Association (AMA) is far more
organized and powerful than the British Medical Association (BMA) in the 1940’s. The
AMA fought every plan to nationalize the health care system. The best chance for a
national health care system in the United States best opportunity was during the Great
Depression and the development of the New Deal. But AMA influence was strong, first,
President Franklin D. Roosevelt top two advisors were physicians, Dr. Ross McIntire,
who visited President FDR twice each day and world-renowned brain surgeon and Dr.
Harvey Cushing, whose daughter married President Roosevelt’s son.14 The AMA quickly
opposed the inclusion of health insurance in the Social Security Act and helped defeat the
Wagner health bill. Second, the AMA objected the idea of third party prepaid insurance
plan and expelled the founder of Ross-Loos Medical Group, which enrolled 60,000
members by the late 1930’s and paid salaries to its physicians. The AMA power was
questioned by the Supreme Court, in 1943; the Supreme Court ruled that the AMA was
guilty of conspiracy in restraint of trade because it denied hospital privileges to Group
Health Association doctors.15

During the Truman era, the AMA fought against a plan for nationalized health
care system. President Truman, health care plan was the first to include all sectors of the
society, an egalitarian system that included not just the working class but everyone. In the
1940’s 1,200 counties, 40 percent of the total population in the country, an estimate of
15,000,000 million Americans was either without a local hospital or a one that does not

14 Ibid., 25.

15 Ibid., 33.
meet minimum standards. The bill was not a socialized medicine, but a national health plan administered by the federal government. Citizens would pay a monthly fee for the plan and public agencies would pay the fee for those who can’t afford the premium. Medical and hospital services would not change and the plan promised the wages for physicians would increase. The AMA fought the plan fiercely and used all plausible tactics to defeat the bill. Senator Robert Wagner (D-NY) and James Muray (D-MT) along with Representative John Dingell (D-MI) proposed a Social Security expansion bill. The bill called Wagner-Murray-Dingall bill and was introduced in 1943. The public had mixed views on the bill, but AMA rejected the bill. They associated the bill as an extension of the Soviet Union influence on the United States and a way to change the U.S. into a communist nation. The nexus between the bill and the Soviet Union increased and many who first supported the bill started to change their view. The chairman of the House Committee was an anti-union conservative and refused to hold hearings, and Republican Senator Taft declared “I consider it socialism” and a clause within the Soviet constitution. The AMA and American Hospital Association expressed that this plan would ‘enslave doctors”, even though the Truman emphasized that doctors would choose

18 Poen, National Health Insurance.
19 Palmer, A Brief History: Universal Health Care Efforts in the US, 5.
their method of payment. 20 When Truman won reelection, they increased the member’s fee to $25 and they spend nearly $1.5 million on lobbying and were considered the most expensive lobbying effort in American history. 21 Pamphlets would say “Socialized medicine leads to a socialist state”. This was the height of the Cold War and anti-Communist movement. The bill failed and public opinion on the Wagner-Murray-Dingell bill falls dramatically.

When Medicare and Medicaid were first developed in 1960’s, the political rhetoric’s were much similar to those that were articulated by British politicians in the 1940’s. The tax burden that is generated by Medicare and Medicaid is somewhat similar to the financial burden felt by middle-class Britons in 1948. But, the AMA put a great political and media war, the propaganda and rallies affiliated with the AMA were very much fighting the Medicare bill. Though, the bill was passed, the AMA fight against the bill were fierce. The AMA equipped their public relations machine into high gear and was employing “every propaganda tactic, it had learned the bitter battles of the Truman era.”22 They were able to utilize television (a new invention at the time) advertisement on radio and records; they were able to employ then Hollywood actor Ronald Regan, launching the AMA show “Operation Coffee Cup”. And Ronald Regan would tell his viewers “Medicare is simply an excuse to bring about... socialized medicine”. The AMA commissioned a study that found a majority of the seniors already had private health

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20 Ibid.

21 Ibid.

coverage, but media group's supporters of Medicare were quick to discredit this report and the *Chicago Defender* newspaper stated the report were about affluent elderly people and advised that “this kind of opposition [to Medicare] in the long run hurt the prestige of the American Medical Association.” In the political front, the AMA proposed an alternative plan and introduced a bill sponsored by the Oklahoma Senator Robert Kerr and Arkansas Representative Wilbur Mills, both were conservative Democrats, and offered matching grants to the states for assistance to the very poor elderly. The Kerr-Mills bill was passed in 1960, but it did not hinder the call for a more inclusive plan that would not only target low-income seniors but all seniors. Kerr-Mills only reached a small population and its strict eligibility requirements were administered through the state. The call for Medicare and not an extensive more inclusive health care plan was due to the drastic increase of the population of seniors. In 1900, there were only three million people over age of 65 in the United States, but by 1958, there were over 15 million elderly Americans, which is about 9 percent of the population.

In 1965, there was a surge in demand for medical care in the United States, and supply was not increasing in response to the demand for medical care. “An earlier University of Michigan study concluded that between 1967 and 1968, physician fees increased by almost seven percent more than they would have without the two programs.

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23 Ibid., 122.
24 Ibid., 118.
25 Ibid., 119.
The price of hospital care rose by more than 14 percent as a result of their impact.”  

Though, there were short comes about the policy, but mainly, it was a success. Though the cost was high, Americans were more concerned with the benefit of the programs for the most fragile and needy group in the United States. When former President Harry Truman himself a senior citizen was issued the first Medicare card in 1966, he announced “For many it is a step from charity, to security with dignity”. The social war between certain politicians and the public against the AMA made the continuation of attacking the Medicare not a right the path to continue to embark and would not help the organization in the long haul.

The difference between the two countries were two major points, first, the United Kingdom chose to nationalize the health care system after the National Health Insurance Act failed to meet the surge in demand for health care. There was no extensive policy created to meet the objection of those opposed to the nationalized health care system. The second point was the fragmentation and weakness of the BMA in comparison to the AMA. The autonomy of the U.K. government made it nearly impossible for the BMA to propose any alternative policy to the NHS. As for the United States, the power and the influence of the AMA of not just the U.S. government, but also the media are also vast in comparison to the BMA. The BMA as early as 1900 had even proposed the formation of a Public Medical Service by the profession itself but opposed the Lloyd George’s the


National Health Insurance (NHI).\textsuperscript{28} Seventy percent of BMA members opposed the NHI and signed a declaration of non-cooperation in which they pledged to not participate in the scheme.\textsuperscript{29} Once the government raised the fee, the major fractions within the BMA mollified and consequently abandoned the opposition to the scheme to get rid of the NHI.\textsuperscript{30} When the NHI was in action, many doctors complained about the approved societies running the scheme and allowing them to dictate their fees. Doctors also complained about the fact that there was little incentive for them to provide a quality of care. Regardless of the services the fees were consistent. The BMA was not just weak but also fragmented.

As early as 1942, the BMA published an interim report, which called for nothing less than a centrally planned public medical service under the government.\textsuperscript{31} In the same year, Sir William Beveridge issued a famous Beveridge Report, and it supported “comprehensive health and rehabilitation services for prevention and cure disease and restoration of capacity for work, available to all members of the community” which initiated the start of the National Health Services (NHS).\textsuperscript{32} The following year Winston Churchill stated “you must rank me and my colleagues as strong partisans of national compulsory insurance for all classes, for all purposes, from cradle to grave”. The notion that the government is convinced enough to address the health as a ‘human right’ and the

\textsuperscript{28} Goodman, \textit{National Health Care in Great Britian: Lessons For the U.S.A.}, 10

\textsuperscript{29} Ibid.

\textsuperscript{30} Ibid.

\textsuperscript{31} Ibid., 13.

\textsuperscript{32} Ibid.
obligation of the government to provide these services makes it difficult for certain BMA members to fight such rhetoric. The victory of the labor party in 1945 worried the BMA, especially when Aneurin Bevan was appointed as the Minister of Health. The majority of the BMA members were not fond of a state run health services, but other BMA members saw it as an opportunity for better conditions of practice. The BMA had little opposition to the administrative provision within the act, but were worried of Bevan and distrusted him. Bevan refused to negotiate some of the clauses they opposed, and claimed that Parliament was the sovereign body; he insisted that while the doctors could be “consulted,” there was no question of negotiation.33 Doctors preserved their clinical and economic freedom and were sought after as “independent contractors”, and hoped the government would hire them as such and not civil services.

The BMA wanted to restrict coverage and allow the top 10 percent of the population to pay out of pocket for health services. This insured that the sole income of a physician was not only from the government and that they will have another source of income. The BMA were worried the government would be the sole monopoly of the health care system in the United Kingdom. The BMA failed the pass the 90 percent coverage provision; they developed a new provision, where patients opting for private care should be given a rebate on their contribution to the Health Service.34 The government refused this provision too, and finally only shifted their attention to fight the salary set by the government. The government was adamant in not allowing the BMA to

33 Ibid., 14.

34 Ibid., 16.
dictate the NHS and the development of the policy. Bevan was quick in finding ways to alienate the BMA, his tactic was to divide and conquer. The hospital consultants (specialist) were less threatened by the salaries in comparison to general practitioners. Certain doctors looked forward to getting paid a consistent salary, and many consultants were less concerned with private practices.  

There were two compromises that Bevan had agreed to; first he allowed hospital consultant to accept part-time positions in which they could continue their private practices along with their work in the NHS. Second, he allowed set aside a certain number of hospital beds for private patients. Bevan allowed general practitioners to be viewed as independent contractors and also allowed to set aside a certain sum for retirement. With these additions to the act, the opposition to the NHS among physicians decreased from initially 40,814 to 25,340, a significant decrease. When the BMA saw a large portion of their members have agreed to accept the act, they reluctantly recommended that its members accept service in the NHS. Although 50 percent of the physicians threaten to boycott the NHS, the law went into effect on July 5, 1945.

The physicians in the BMA were not all in agreement of all the policies and acts that were introduced in the United Kingdom, which made it easier for the government to implement and change the health care services. The division within the BMA was quite opposite to the AMA who was more united against any government policy or interference in the health care system.

35 Ibid.

36 Ibid.
IV. The United States and A National Health Service

Who can distribute the health care better; the government or the private sector? As the rhetoric for advocates of both plans continues, the perplexing question is then, if publicly run health care services is superior, then does NHS offers a superior service in comparison to the privately owned health services offered in the United States? And if the private sector is superior to a publicly run health care system, then why did the U.S. government, establish Medicare, Medicaid and now the Affordable Care Act. When the market fails to allocate the health care to the public efficiently, the public presumes the government will step in and find a solution to this predicament or so it seems. The political rhetoric during the 2008 presidential election was that over 50 million Americans are uninsured and the market did not find a suitable alternative to solve this predicament. This number is unacceptable, especially for a country like the United States. A quarter of the population in the United States does not have an adequate access to health care and are not able to get regular checkup, preventive care and their only access to care is through emergency rooms in major hospitals.

The strength of any nation arises from the strength of the workforce. As many development experts or economist would suggest, the workforce is a core of any nation’s economy. The Solow-Swan Model of Economic growth states given these assumptions, with unchanging technical progress, the production function is

\[ Y = F (K, L) \]
Where Y is income or output, K is capital and L is labor. The condition of constant returns to scale implies that if we divide by L, the production function can be written as

\[ \frac{Y}{L} = F \left( \frac{K}{L}, 1 \right) = L \cdot f(k) \]

This model is taught to every economic student and in 1987; Dr. Robert Solow won the Nobel Prize in Economics.\(^{37}\) The economic growth of any nation is a combination of capital and labor. The government involvement in the health care system is usually to support the most vulnerable groups in the population. In the case for United Kingdom, it was finding a health care accessible to the poor and needy. As for the United States, it was to establish a system that is accessible to the seniors. The U.K. government first initial direct involvement was through the laws was a way to relieve the poor. Initially, most of the hospitals that were opened in the 16\(^{th}\) and 17\(^{th}\) century were through charity institutions. The government was slow in reacting to the rise of the poor population. The poor law was similar to *Act for the Reliefe of the Poore*, which was a legislature developed by Elizabeth I in 1598 and enacted in 1601. The structure of the poor law was a way to provide a system where the extremely poor and destitute was cared for; millions of poverty stricken individuals had some access to care through public relief houses. The National Health Insurance Act of 1911, the insurance act was intended for the middle class and lower middle class workers; David Lloyd George, the Chancellor of the Exchequer under the Liberal Government, introduced the legislation. David George was concerned with the cost of illness. If the breadwinner of the household is afflicted with

\[ ^{37} \text{Robert Solow, A Contribution to the Theory of Economic Growth (The Quarterly Journal of Economics, 1956), 66.} \]
sickness, they can lose their entire wage to medical treatments.\textsuperscript{38} The cost of the insurance was handled amongst employee, employer and the state. The recipients obtained medical treatment, cash benefits for sickness and disability. It also provided institutional care in sanatoria for cases of tuberculosis and in some cases, additional benefits for dental and ophthalmic care.\textsuperscript{39} Though, the plan was successful with high admission rate, it was not accessible to the entire population. The rhetoric changed and a call for universal health care system was becoming more apparent. The development of the National Health Services (NHS) was developed and implemented by the government. Sir William Beveridge, the architect of the modern British welfare system developed the Beveridge Report, which included “comprehensive health and rehabilitation services for prevention and cure of disease and restoration of capacity for work, available to all members of the community”.\textsuperscript{40} And through Health Minister Aneurin Bevan, the NHS became the law of the nation.

“The doctors claimed that the fight was over government control of medicine. That wasn’t it at all. The fight was over whether decent medical care is a basic right-like the right to food, shelter, clothing and education. The people and Congress decided it was”\textsuperscript{.41} This was the statement Senator Clinton P. Anderson released after the Medicare

\textsuperscript{38} Goodman, \textit{National Health Care in Great Britian: Lessons For the U.S.A}, 8.

\textsuperscript{39} Ibid.

\textsuperscript{40} Ibid., 13.

\textsuperscript{41} Dougherty. \textit{American Health Care: Realities, Rights, and Reforms}, 166.
bill was passed in July 1965. 42 In the U.K. the nexus between health care and market were not strong. The view that health care can be a profitable industry and play major role in the national market was not strongly viewed. The changes to the British health care were either through philanthropist or the government, in the U.S. case it was through the private industry. The introduction of the Blue Cross Blue Shields was through private medical professionals who were looking for more efficient ways to manage the Health care system. In the U.S. the health care was a huge part of the market. The strength of the AMA was seen through the influence it had on the national government. Though the AMA was very influential, it did not halt the other side of the argument. There were series of government and other organizations that have attempted to create a national health care plan. The first major government interference was when the government introduced Medicare. The need to have adequate access to care for the seniors was major propriety for the John F. Kennedy and Lyndon Johnson administrations. And finally, the Affordable Care Act (ACA), which targeted the lower middle class in the population. President Obama, who utilized the democratically run House and Senate to pass the bill, first introduced the legislation. Medicare covers the seniors, Medicaid covers the extremely poor and vulnerable in the population and now ACA covers the lower middle class, who were always threatened by the threat of a costly medical bill that could potentially send them to poverty, are we heading to nationalize the health care system? Though the U.K. experience might seem similar to what is going on in the political and social sphere, the vicious fight against the ACA, I’m not sure that a national health care

42 Ibid., 168.
in the United States can be foreseen in the recent years. The political environment in the
U.S. is quite different than that of the U.K. in the 1940’s. The strength of the AMA and a
large portion of the population that have voiced their objections to the ACA, it is not
clear where the rhetoric will take us.
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