

**TAKING HEALTH CARE SERIOUSLY: THE ROLE OF FOR-  
PROFIT IN THE JUST ALLOCATION OF HEALTH CARE  
RESOURCES**

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# **TAKING HEALTH CARE SERIOUSLY: THE ROLE OF FOR-PROFIT IN THE JUST ALLOCATION OF HEALTH CARE RESOURCES**

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Western health care systems are currently facing serious scarcity and access issues. These problems can only be tackled by first unpacking the rationales that underlie legislators' enactments of laws producing suboptimal outcomes for the distribution of health care resources. Thus, this dissertation proposes to analyze the motives behind the drafting of health care allocation laws in the United States and in the United Kingdom. In particular, it examines the influence of justice principles and the role played by the for-profit sector in the development of distributive norms in these jurisdictions.

I begin my analysis by arguing that the special nature of health care mandates that its resources be justly allocated. To form a theoretical framework for the analysis of health care financing and provision laws, I flesh out four philosophical archetypes that elaborate this assumption. The libertarian, egalitarian, utilitarian, and communitarian conceptions of justice collectively form the reading grid that I apply to analyze discourses in key legislative

preparatory work and debates to appraise whether justice principles have participated or guided the legislative process.

Using the same discourse-analysis method, I also assess the role played by for-profit actors in the negotiations and drafting of these laws and conclude that the for-profit sector plays a crucial role in their elaboration and has, over time, set a path of dependence affecting health care policy-making in both of these welfare states.

The goal of this dissertation is not to provide concrete prescriptions for health care lawmaking, nor is it to assess how one unique conception of justice should supersede others for the allocation of health care resources. Rather, it maps out the presence (or the absence) of multiple conceptions of justice and their influence on the for-profit sector during the creation of health care reforms.

This project calls attention to a dimension of justice in health care law through a philosophical analysis of the legislative process and hopes to provide a stepping-stone for future research to determine which conception of justice leads to the most optimal allocation processes and will finally tackle scarcity and access issues affecting western health care systems.

## **BIOGRAPHICAL SKETCH**

Sabrina Germain was born in Montreal, Canada. She holds a B.A. from McGill University, a D.E.S.S. from l'Institut d'Études Politiques de Paris (SciencesPo), an LL.M. from Cornell University, and is a licensed New York State attorney. From 2010 to 2015 she was a J.S.D. Candidate at Cornell University.

*In every tragedy there is a possibility for triumph...*

You gave me the strength to never give up.  
You gave me the power to never stop pursuing my ambitions.  
Every page written here has a little bit of you.  
Thank you for being the friend you were and always will be.  
To you, my dearest Valerie  
Forever in my heart.

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## **LIST OF ABBREVIATIONS**

ACA: Patient Protection and Affordable Care Act.

AFL-CIO: American Federation of Labor and Congress of Industrial Organization.

AHA: American Hospital Association.

AMA: American Medical Association.

BMA: British Medical Association.

CCG: Clinical Commissioning Groups.

ERISA: Employee Retirement Income Security Act.

FT: Foundation Trust.

GP: General Practitioner.

HMO: Health Maintenance Organization.

MAA: Medical Assistance to the Aged Program.

NHS: National Health Service.

NICE: National Institute for Health and Care Excellence.

OAA: Older American Act.

PCT: Primary Care Trust.

PFI: Private Finance Initiative.

PMI: Private Medical Insurance.

RAND: Research and Development Corporation.

## INTRODUCTION:

Misconceptions About Health Care Policy and Allocation Laws

*Assessing the Role of Justice and Stakeholders in the Drafting of Health Care Laws*

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Health care systems around the world work to extend, save, and protect lives. More than simply reducing pain and bettering human physical and mental conditions, these systems aim to improve the quality of life of many people. Unfortunately a multitude of factors have led to skyrocketing health care costs and to scarce health care resources, which now negatively impact the functioning of health care systems.<sup>1</sup>

In most western welfare states, policy experts respond to these issues by proceeding to a pragmatic arbitrage between extreme budgetary constraints and the population's growing health care needs. Health care policy-making is often portrayed as the result of an unfair political game in which a few self-motivated stakeholders hold the pen in the drafting of laws affecting the health status of many individuals.<sup>2</sup> But in reality, are the decisions affecting the distribution of health care resources the result of incentivized choices, or are higher moral and philosophical grounds underwriting the crafting of

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<sup>1</sup> Einer Elhauge, *Allocating Health Care Morally*, 82 Cal L.Rev. 1449 (1994).

<sup>2</sup> Ellen M. Immergut, *Health Politics: Interests and Institutions in Western Europe* (1992); Daniel P. Carpenter, Kevin M. Esterling & David MJ Lazer, *The Strength of Weak Ties in Lobbying Networks Evidence from*

these laws? Answers to this twofold question must be provided to formulate solutions to the scarcity and access issues affecting western health care systems. Indeed, to construct more optimal patterns of distribution, it is now time to unpack the rationales that underlie legislators' enactments of health care laws producing suboptimal outcomes.

In this dissertation I determine whether justice or other driving forces impact the allocation of health care resources. For this, I evaluate the influence that conceptions of justice and actors belonging to the for-profit sector have had on the drafting of laws that finance and provide health care services in western welfare states, but I do this without criticizing or assessing each system's fulfillment of these conceptions. I also assess whether these principles and actors can account for the different allocation choices made across western welfare states and for the differences present in the organization and structure of western health care systems. To lead this analysis, I chose to present two representative case studies: the American and English health care systems.

My analysis begins with a philosophical approach to demonstrate that the resources of health care, as a unique requirement for attaining the Common

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*Health-Care Politics in the United States*, 10 *Journal of Theoretical Politics* 417 (1998).

Good, should be distributed according to principles of justice, be it libertarian, egalitarian, utilitarian, or communitarian. These four archetypes constitute the theoretical framework through which I examine discourses in key legislative preparatory work and debates, to appraise whether justice principles have inspired or guided the legislative process in the United States and the United Kingdom. Through this analysis, I also shed light on the role played by for-profit actors in the negotiation and crafting of health care laws, to uncover particular paths of dependence responsible for the current patterns of allocation in western health care systems.

It should be duly noted that the goal of this dissertation is not to provide concrete prescriptions for policy and lawmakers, nor is it to assess how one unique conception of justice should supersede others for the allocation of health care resources. Rather, it proposes to describe and map out the presence through time of multiple conceptions of justice and their potential influence on the for-profit sector.

Finally, bridging the two case studies, I explain why and how allocation patterns in both of these systems are now converging. I present partial conclusions on the reasons that underlie the American Congress's modest shift towards a universalized system of allocation and Westminster's radical

reform potentially leading to some privatization within the National Health Service of England (NHS).

**I. Health Care Systems, the For-Profit Sector, and Justice as Objects of Study**

The examination of motives underwriting laws for the financing and provision of health care services requires defining health care systems as an object of study and fleshing out their common characteristics. Determining who among the actors operating within the confines of these systems constitutes the for-profit group is also important in order to evaluate their impact on the drafting of health care allocation laws. Finally, to determine whether health care allocation laws are just or simply include some elements of justice, the contours of this concept must also be clarified.

**A. Fleshing Out the Features of Western Health Care Systems**

Built on Weberian principles, western welfare states assume the duty of protecting and promoting the well-being of their citizens by making decisions regarding the distribution of all public goods, including health care.

These patterns of allocation inevitably influence the organization and the structure of health care systems.

The World Health Organization defines health care system as

(i) all the activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health.<sup>3</sup>

The definition makes no mention of the degree of public or private involvement in these activities. Nonetheless, for the most part, states operate mixed systems in which the public and private sectors' participation varies.<sup>4</sup> Universal health care systems such as the NHS strike a different balance, in which the public sector takes on most duties and provides health care based on needs and not on means, in contrast to private health care systems, in which the financing and provision of most health care services is left in the hands of the private sector.<sup>5</sup> In western welfare states, the processes

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<sup>3</sup> World Health Organization Glossary, [http://www.who.int/healthsystems/hss\\_glossary/en/index5.html](http://www.who.int/healthsystems/hss_glossary/en/index5.html).

<sup>4</sup> Thomas Foubister et al., *Private Medical Insurance in the United Kingdom* (2006).

<sup>5</sup> William R. Lassey et al., *Health Care Systems Around the World* (1997).

governing the distribution of health care resources reflect social choices and negotiations between the government and certain interest groups.<sup>6</sup>

Despite differences in structure, organization, and ideology, it is possible to assess the performance of any health care system based on how well it achieves the following key functions:<sup>7</sup> *stewardship*, the oversight and governance of the system; the *financing* of services through the allocation of revenue and fund pooling; the *delivery* of services to the population; and *resource generation* for investments in human resources and technology.<sup>8</sup> In this dissertation I focus on the financing and delivery of health care services, as these two functions constitute the core of the allocation process.

Health care analyst Dov Chernichovsky argues that modern health care systems are now converging as they adopt a universal paradigm for the financing, organization, and management of their resources.<sup>9</sup> Although these systems have different origins, the new paradigm has led health care policy-makers to adopt similar allocation patterns.

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<sup>6</sup> David Hunter, *The Health Debate* (2008), p.4.

<sup>7</sup> *ibid.*, p.6, according to Hunter this includes “Balancing multiple competing influences and demands while system I objectives; establishing clear policy priorities; Ensuring the necessary regulation of prices, professional practice, standards and so on; Influencing the behavior of the stakeholders involved through performance assessment and the provision of intelligence.”

<sup>8</sup> *ibid.*

<sup>9</sup> Dov Chernichovsky, *Health System Reforms in Industrialized Democracies: An Emerging Paradigm*, *Milbank Q.* 339 (1995).

Bearing in mind their common features and inherent differences, I compare two representative health care systems to draw a similar conclusion. I show that, despite being rooted in quasi-antithetical ideologies, the American and British health care systems have converging policies in some aspects.

### **B. The For-Profit vs. Not-For-Profit Classification**

Health care services involve an array of for-profit and not-for-profit activities. The for-profit sector has traditionally been involved in the manufacturing and marketing of pharmaceuticals and the sale of medical equipment rather than in the financing and delivery of health care services.<sup>10</sup> More recently, however, the not-for-profit sector has outsourced many services to for-profit private providers in the hopes of increasing competition and efficiency in health care.<sup>11</sup>

This dissertation aims to determine the for-profit sector's influence on the crafting of health care reforms but also to examine the notion of profit in itself and to assess its impact on the structure and functioning of health care systems.

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<sup>10</sup> *IOM Home - Institute of Medicine*, last accessed 3 January 2014.

<sup>11</sup> *ibid.*

Thus, for the purpose of this study, the for-profit sector encompasses all entities that are formed and operated with the intention of earning profits, but it is not limited to entities legally defined as for-profit groups.<sup>12</sup> In the United States it includes corporate employers, insurers, and private health care providers. In the United Kingdom, particularly in England, the for-profit sector does not form a distinct class, as most for-profit actors are corporate entities that operate in parallel and outside of the NHS, and these entities reinject profits within their structures. Nonetheless, general practitioners (GPs) as independent contractors and medical consultants (specialists) engaging in the private practice of medicine as well as any other medical professional providing health care services privately can be considered as part of the for-profit sector.

*De facto* and for the purpose of this study, the not-for-profit sector includes all public entities involved in the organization, financing, and provision of health care services.<sup>13</sup>

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<sup>12</sup> David Logan Scott, *The American Heritage Dictionary of Business Terms*, (2009); Dan W. Brock & Allen Buchanan, *Ethical Issues in for-Profit Health Care*, For-Profit Enterprise in Health Care 224 (1986).

<sup>13</sup> Scott, *The American Heritage Dictionary of Business Terms*, supra 12.

### C. Defining the Contours of Justice

Philosophy defines the concept of justice as a representation of the principle of moral rightness and defines its role as the upholding of what is “just.” Justice is conceived as the essential condition for harmonious life in society; without it, no effective system can function.<sup>14</sup>

Legal naturalists were the first to posit that equitable relationships among people of the same society represent an idea of justice.<sup>15</sup> More generally, justice is explained in relation to the concepts of fairness, desert, and entitlement and is defined as the fair and appropriate treatment offered to a person owed repair or a due. Justice is thought to produce the necessary standards to evaluate and remedy the particular circumstances of claimholders, to make harmed parties whole, and to penalize wrongdoers.<sup>16</sup>

Thus, the archetypes of justice presented in the first chapter of this dissertation each exemplify an interpretation of the features of the idea of justice. To analyze health care allocation laws, all these conceptions should be equally weighed and valued given that health care systems require that different forms of justice prevail. No single principle can address all the

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<sup>14</sup> Paddy McQueen, *Key Concepts in Philosophy*, (2010), p.112-113.

<sup>15</sup> James E. Penner & Emmanuel Melissaris, McCoubrey & White's Textbook on Jurisprudence (2012).

scarcity and rationing problems affecting health care systems; to create more just solutions, several principles and conceptions of justice merit acceptance. Thus, it is necessary not to exclude or privilege any of the justice archetypes that form the analytical framework crafted, to evaluate whether any justice principles have impacted health care allocation laws.<sup>17</sup>

## II. Bridging a Gap in Literature

Health care rationing issues affecting western welfare states are analyzed through the prism of many disciplines.<sup>18</sup> This dissertation aims to unveil the link present between these different perspectives. With tools provided by four different fields of research, health care law, management theory, political science, and comparative health care law, I hope to provide conclusions on the roles of justice and the for-profit sector in the distribution of health care resources and to offer a stepping-stone for the elaboration of more optimal health care allocation laws.

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<sup>16</sup> Tom L. Beauchamp & James Franklin Childress, *Principles of Biomedical Ethics* (2001), p. 241.

<sup>17</sup> *ibid.*

<sup>18</sup> See generally, Norman Daniels & James E. Sabin, *Setting Limits Fairly: Can we Learn to Share Medical Resources?* OUP Catalogue (2002); Robert H. Blank, *Regulatory Rationing: A Solution to Health Care Resource Allocation*, 140 *University of Pennsylvania Law Review* 1573 (1992); David Orentlicher, *Rationing Health Care: It's a Matter of the Health Care System's Structure*, 19 *Annals Health L.* 449 (2009); Howard Davies & Hugh Powell, *How to Ration Health Care-and be Re-Elected: The UK Experience*, 3 *Stan.L.& Pol'Y Rev.* 138 (1991); Martin A. Strosberg et al., *Rationing America's Medical Care: The Oregon Plan and Beyond* (1992).

In this section I conduct a brief literature review to illustrate how this dissertation hopes to bridge research on health rationing issues, the legal history of health care systems, and theories on stakeholderism and paths of dependence. I then present the methodological challenges posed by this topic and the methods and materials I gathered to conduct my study.

### **A. Situating the Current Research**

In his article “Allocating Health Care Morally,” Einer Elhauge<sup>19</sup> establishes a remarkable foundation for a philosophical discussion on rationing issues in western health care systems. He acknowledges the impact that scarce resources have had on these systems, and he presents health law and policy through the prism of a moral paradigm.

Elhauge sensibly concludes that no health care system can be sustained without adjusting the distribution of resources according to certain guidelines. For him, morality provides necessary but limited guidance, as it cannot alone dictate the norms for the allocation. He proves this by rebutting the absolutist claim that “no beneficial health care should ever be denied” and by arguing that the minimum entitlement to health care principle lacks concrete affirmative meaning.

In establishing his analysis, Elhauge only briefly acknowledges the special nature of health care, even though it is a crucial point for theorizing about the role of morality and justice in the allocation process. In this dissertation I stress the importance of first proving this assumption as a crucial step in a philosophical analysis of health care laws.

In contrast to Elhauge's research, this dissertation focuses on the role of justice, rather than of morality, in the distribution of scarce health care resources. Although issues of morality are relevant to discussions at a micro level, I believe that distributive justice principles are more relevant for discussing allocation issues at a macro level.

Carina Fourie also proposes an approach based on distributive justice to solve scarcity issues affecting health care systems. In her article "What Do Theories of Social Justice Have to Say About Health Care Rationing? Well-Being, Sufficiency and Explicit Age-Rationing,"<sup>20</sup> she argues that, despite being criticized for providing only broad guidelines with no concrete application, principles of distributive justice can help to situate health care in an ethical framework and thus to achieve fair rationing decisions. Specifically, she identifies four tests to assess the fairness of a health care

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<sup>19</sup> Elhauge, *Allocating Health Care Morally*, 1449 , supra 1.

rationing decision and applies them to specific disputes. She proves that broad principles of egalitarian justice are relevant to the most concrete rationing cases.

Fourie also makes a clear distinction between the direct and indirect assessments of justice. The direct approach gauges the fairness of a decision according to the influence it may have on an individual or a population and considers how the allocation process fits into a broader social framework. This approach assumes that the distribution of health care resources impacts other aspects relevant to justice and posits that principles of justice should apply to the design of health care systems and not merely to allocation decisions. Thus, the distribution of other resources must also be accounted for in this analysis.

The indirect approach is more limited. It analyzes only the influence of health care on determinants of well-being and ignores other external aspects of justice that might be relevant to rationing decisions. It embraces a broad conception of justice to determine how social institutions should operate and fairly allocate health care as a public good.

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<sup>20</sup> Carina Fourie, *What do Theories of Social Justice have to Say about Health Care Rationing?* (2012).

In this dissertation I adopt the indirect approach to analyze the role of justice in the drafting of laws governing the allocation of health care resources. In this study I am not interested in demonstrating how health care services should be prioritized over other public goods; rather, I examine only the choices made in the allocation of health care resources.

My work certainly echoes philosophical debates relayed by the literature on health care rationing and allocation issues, but it also offers a more pragmatic perspective on these questions, thanks to my analysis of legislative preparatory work. Ultimately I hope to unfold a more philosophical aspect to the lawmaking process, but also, by unveiling the motives behind previous health care reforms in the United States and the United Kingdom, I hope to participate in the elaboration of concrete solutions for scarcity and access issues affecting health care resources in western welfare states.

In the literature addressing health care law in the United States, George Annas et al. in *American Health Law*<sup>21</sup> outline the main features of the American health care system and provide great insight on the policy trends that have led to the most important health care reforms of the twentieth century. These health law experts also address the role of physicians in the

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<sup>21</sup> George J. Annas et al., *American Health Law* (1990).

construction of the system, the importance of health maintenance services, and the different types of payment available to patients.

To present health care policy in the United States, this dissertation draws significantly from the work accomplished in *American Health Law*. The research of Annas et al. was helpful for selecting major health care laws to be analyzed in the American case study. Unfortunately, however, *American Health Law* provides only a surface study of philosophical debates in health care and only briefly addresses health care rationing issues. This dissertation expands the analysis of both of these themes to provide a thorough assessment of the influence of justice principles on the elaboration of health care allocation laws in the United States.

Also fundamental is Jill Quadagno's *One Nation, Uninsured: Why the U.S. Has No National Health Insurance*, which provides a politico-historical perspective on the role played by influential stakeholders in the creation and evolution of the American health care system. Quadagno's precise analysis of archives and unpublished sources offers unprecedented insight on why the United States has failed to implement a universal health care system. The book covers the entire twentieth century and identifies many historical details that influenced the development of American health care policy. Specifically, the

book addresses the role of physicians and employers in the policy-making process.

*One Nation, Uninsured: Why the U.S. Has No National Health Insurance* also provides invaluable information on the development of major health care reforms from a political and historical perspective. This dissertation benefits from Quadagno's work but offers a different, more legal perspective on the negotiation and enactment of crucial health care laws, and it further emphasizes the role played by all for-profit actors in the evolution of the American health care system.

Most of the literature relating to health care in the United Kingdom addresses the history of health care policy in the NHS, whereas issues of rationing in health care are addressed only implicitly. Nevertheless, a complete analysis of health care laws in the United Kingdom requires consideration of the work of Charles Webster, the most prolific modern medical historian in Britain. His books *The National Health Services Since the War*<sup>22</sup> and *The National Health Service: A Political History*<sup>23</sup> relate in great detail the entire history of the NHS. Webster describes the political, economic, and social contexts giving rise to all NHS reforms, from the Beveridge and

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<sup>22</sup> Charles Webster, *The Health Services since the War*. 1, 1,(1988).

Bevan era to the reforms led by the Blair government. His account of health care politics highlights the difficulties in health services over the past century.

Complementary to his work is David Hunter's book *The Health Debate*,<sup>24</sup> in which the author offers his perspective as a political scientist on themes transcending health care policy in the United Kingdom. He explains how the NHS has dealt with a tremendous amount of pressure, leading to many complex health care reforms over its 60 years of existence.

Both of these authors cover valuable ground that is necessary for a thorough analysis of health care laws that have reformed the NHS. In this dissertation I, too, address major policy trends in health care policy in England and the historical context surrounding the development, negotiation, and enactment of each of the Acts analyzed in the English case study. I combine both authors' approaches to examine the role of the for-profit sector and particularly of the medical association in the elaboration of NHS reforms.

In addition, very similar to the research presented in this dissertation is the work of Rudolf Klein in his latest edition of *The New Politics of the NHS: From*

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<sup>23</sup> Charles Webster, *The National Health Service: A Political History* (2002).

<sup>24</sup> Hunter, *The Health Debate*, supra 6.

*Creation to Reinvention.* Klein's book focuses on the management, structure, and funding of the NHS. Specifically, he presents the challenges that services have faced over the course of the last 60 years and highlights the culture of continuity in the NHS. This dissertation builds on his analysis of the roles played by the medical association and by influential groups in policy-making, and through analysis of key legislation, it further justifies his findings.

The management literature on stakeholder theory and the political science literature on paths of dependence are central to an analysis of the role played by for-profit actors in crafting allocation laws in western welfare states. These social sciences help to explain how the sequencing of historical events and how influential groups within health care systems can have a crucial impact on the allocation of health care resources.

Both the stakeholder and the path of dependence theories have attempted to explain health care policy-making; nevertheless, neither has yet been applied specifically to health care allocation laws. In this dissertation I propose to apply these theories to the work of legislative institutions, to explain how certain events and particular actors have participated in the drafting of laws giving rise to health care reforms.

In 1984, R. Edwards Freeman revolutionized management scholarship with his landmark book *Strategic Management: A Stakeholders Approach*, in which he identifies and models groups, inside and outside corporations, that affect or are affected by the achievement of the corporations' goals.<sup>25</sup> A decade later, in his article "The Stakeholder Theory of The Corporation: Concepts, Evidence, and Implications,"<sup>26</sup> ethicist Thomas Donaldson fleshes out a typology of stakeholder approaches. The *descriptive* approach "presents a model describing what the corporation is";<sup>27</sup> the *instrumental* approach "establishes a framework for examining the connections, if any, between the practice of stakeholder management and the achievement of various corporate performance goals";<sup>28</sup> the *normative* approach considers "stakeholders [as] persons or groups with legitimate interests in procedural and/or substantive aspects of corporate activity";<sup>29</sup> and finally, the *managerial* approach "recommends attitudes, structures, and practices that, taken together, constitute stakeholder management."<sup>30</sup> These, he claims, are better suited to explain the diverse and, at times, contradictory perspectives in the literature on stakeholder theory.

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<sup>25</sup> Freeman R. Edward, *Strategic Management: A Stakeholder Approach*, 46 Boston: Pitman (1984).

<sup>26</sup> Thomas Donaldson & Lee E. Preston, *The Stakeholder Theory of the Corporation: Concepts, Evidence, and Implications*, 20 *Academy of Management Review* 65 (1995).

<sup>27</sup> *ibid.*

<sup>28</sup> *ibid.*

<sup>29</sup> *ibid.*

<sup>30</sup> *ibid.*

In his article “The Stakeholder Theory and the Common Good,”<sup>31</sup> Antonio Argandoña builds on this foundational research and criticizes the stakeholder theory’s lack of ethical dimension. He argues that stakeholder theory should be based on the idea of the Common Good and that stakeholders should participate in the corporation’s achievement of this goal.

Expanding on Argandoña’s idea, I wish to determine whether stakeholders in a broader organization, the health care system, also bear the duty to promote the Common Good through the just distribution of health care resources. Indeed, health care stakeholders might not only be motivated by their own incentives, but they could also be influenced by a sense of justice guiding the decision-making process for the allocation of health care as an aspect of the Common Good.

Contributing to discussion of the *normative vs. instrumental* approach, Heather Elms et al. in “Ethics and Incentives: An Evaluation and Development of Stakeholder Theory in the Health Care Industry”<sup>32</sup> apply the stakeholder theory to the health care sector by exploring decision-making dynamics in health maintenance organizations. In this article, the history of American

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<sup>31</sup> Antonio Argandoña, *The Stakeholder Theory and the Common Good*, 17 J. Bus. Ethics 1093 (1998).

<sup>32</sup> Heather Elms, Shawn Berman & Andrew C. Wicks, *Ethics and Incentives: An Evaluation and Development of Stakeholder Theory in the Health Care Industry*, Business Ethics Quarterly 413 (2002).

health care provision and recent legal cases are examined to assess the influence of ethics and incentives on the prioritization made by stakeholder groups. These authors determine whether medical decisions are based solely on incentives influencing medical professionals or whether the anormative ethics that place the patient at the center of the medical decision-making process in fact prevail. They conclude that incentive structures provided by managed-care organizations do not alone guide medical professionals in their decision-making process and that ethical standards and moral obligations also shape their clinical decisions.

Stakeholder theory has also been transposed to the realm of politics to explain the roles of political pressure groups that lobby their interests through political parties, administrative departments, and legislative institutions.<sup>33</sup> In fact, some political analysts are convinced that policies result from political struggles among competing groups.

Stakeholder theory is also used to shed light on the evolution of health care policy and to explain the role of organized medicine in the development of health programs.<sup>34</sup> Indeed, Harry Eckstein analyzes the formation of the

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<sup>33</sup> Harry Eckstein, *Pressure Group Politics*, 35 *Academic Medicine* 1069 (1960).

<sup>34</sup> Michael Shalev, *The Social Democratic Model and Beyond: Two Generations of Comparative Research on the Welfare State*, 6 *Comparative Social Research* 315 (1983).

American health care financing system by identifying the political battles between reformers and powerful stakeholder groups that were politically mobilized against national health insurance.

This explanation is most convincing. Thus, I adopt this perspective to expose the political events leading to the enactment of health care financing and provision laws in the United States and to unveil the influence of stakeholder groups on the establishment of all the NHS reforms discussed in this dissertation.

I ultimately demonstrate that the allocation of health care resources at a global level is impacted by the input of stakeholders acting within health care systems. I also show that an idea of justice animates these stakeholders when promoting their interests to legislators.

Coupled with stakeholder theory, path of dependence theory can help to shed light on the evolution of health care policy in western welfare states. Many political scientists have evoked this theory to explain policy-making patterns.

More than a mere description of historical phenomena, this theory accounts for the significance of social variables to explain how health care policy “got

to where it is.” It focuses on how a sequence of events can lead a country to adopt a particular trajectory in its policy. This does not mean that changes in direction will not be enacted; indeed, policy-makers often deviate from the original policy’s trajectory.<sup>35</sup>

Political scientist Margaret Levi explains that paths of dependence create phenomena that, once triggered, have a very high cost of reversal. Divergence from policy channels is therefore possible, but it is often prevented by certain institutional arrangements.<sup>36</sup>

Paul Pierson also explains that sequencing is crucial. Earlier events matter more than later ones<sup>37</sup> because earlier occurrences are only amplified as history develops.<sup>38</sup> Events link up to form a positive feedback loop, and “initial moves in a particular direction encourage further movement along the same path.”<sup>39</sup> Nonetheless, as Douglas North states, the path is not

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<sup>35</sup> Paul Pierson, *Increasing Returns, Path Dependence, and the Study of Politics*, *American Political Science Review* 251 (2000).

<sup>36</sup> Margaret Levi, *A Model, a Method, and a Map: Rational Choice in Comparative and Historical Analysis*, 28 *Comparative Politics: Rationality, Culture, and Structure* (1997).

<sup>37</sup> Pierson, *Increasing Returns, Path Dependence, and the Study of Politics*, 251, supra 35.

<sup>38</sup> Paul Pierson, *Not just what, but when: Timing and Sequence in Political Processes*, 14 *Studies in American Political Development* 72 (2000).

<sup>39</sup> *ibid.*

frozen; it only gets narrower, and reversal is possible at all points if the circumstances permit.<sup>40</sup>

Mahoney and Thelen further confirm that changes in the feedback loop signal major policy events.<sup>41</sup> In this dissertation I provide proof that a path of dependence dictates health care reforms in the United States and the United Kingdom. I also demonstrate that these paths are not irreversible. In fact, crucial events in health care policy are signaled by the enactment of health care laws that at times deviate slightly from the initial policy path.

In the article “The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy,” political scientist and health care reform specialist Jacob Hacker explains that the existence of paths of dependence governing health care policy has led to the absence of a national health insurance scheme in the United States and to a universal health care system in the United Kingdom.<sup>42</sup>

According to Hacker, debates and changes in health care can only be understood in the light of the particular political, economic, and social

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<sup>40</sup> Douglass C. North, *Institutions, Institutional Change and Economic Performance* (1990).

<sup>41</sup> James Mahoney, *Path Dependence in Historical Sociology*, 29 *Theory and Society* 507 (2000); Kathleen Thelen, *Historical Institutionalism in Comparative Politics*, 2 *Annual Review of Political Science* 369 (1999).

<sup>42</sup> Jacob S. Hacker, *The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and US Medical Policy*, 12 *Studies in American Political Development* 57 (1998).

contexts that favored these reforms. Historical events and their sequencing are also crucial, as they provide specific market structures and give rise to policy ideas favoring the presence of interest groups, and all of these factors impact the crafting of health care reforms. The particular shift of focus in certain areas of health care policy across western welfare states can be explained by these critical junctures.<sup>43</sup> Indeed, health care policy and particularly national health insurance programs are not the product of a single event but of a constellation of political and social factors taking place at particular points in time.<sup>44</sup>

David and Wilsford push the analysis even further and explain that paths of dependence have led many welfare states to make suboptimal health care policy decisions.<sup>45</sup> I, too, believe that structural forces and particularly the for-profit sector have at times created paths of dependence leading to the crafting of suboptimal health care allocation laws in the United States and the United Kingdom. I also posit that justice itself can create its own path of dependence that guides the allocation of health care resources in western welfare states.

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<sup>43</sup> *ibid.*

<sup>44</sup> *ibid.*

<sup>45</sup> Gwyn Bevan & Ray Robinson, *The Interplay between Economic and Political Logics: Path Dependency in Health Care in England*, 30 *J. Health Polit. Policy Law* 53 (2005).

Finally, most of the available literature on health care law remains tenaciously local and treats only domestic themes. Yet, issues affecting health care systems could benefit from a comparative discussion. In his article “Comparative and International Health Law,”<sup>46</sup> Timothy Jost also acknowledges the importance of adopting a comparative perspective to identify shared philosophical and religious perspectives but also to shed light on divergent opinions regarding ethical issues in health care. He asserts that observing the experience of other western welfare states could allow health law scholars to further understand the exceptional characteristics of health care financing and provision in the United States and that the study of universal care systems could reveal different and more efficient approaches for addressing health care issues. He further mentions that cultural and political differences influencing health care policy in these countries should also be taken into consideration in these analyses.

*Justice and Health Care: Comparative Perspectives*<sup>47</sup> by Andrew Grubb and Maxwell Mehlman is also remarkable, as it is one of the few books addressing from a comparative perspective issues of justice in the provision of health care. The book’s thematic analysis provides a snapshot of certain

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<sup>46</sup> Timothy Stoltzfus Jost, *Comparative and International Health Law*, 14 Health Matrix 141 (2004).

<sup>47</sup> Andrew Grubb & Maxwell J. Mehlman, *Justice and Health Care: Comparative Perspectives* (1995).

issues affecting the American, Canadian, and British health care systems. Nonetheless, it does not provide an account of the legislative work surrounding the allocation of health care resources in these countries.

I also adopt a comparative approach to address the main research question of this dissertation. I believe that there is much to be learned by observing two different but similarly situated welfare states and that this comparative analysis might help to solve the health care conundrum. My work ultimately aims to fill a gap present in the current literature by reviewing health care legislation from a historical and comparative perspective.

## **B. Methodological Considerations**

The first chapter of the dissertation presents a framework for analyzing discourses of justice present in the drafting of health care allocation laws. I begin the dissertation by establishing the basic premise that, in theory, health care mandates justice for the allocation of its resources. This premise guides the entire project, as I later seek to confirm whether this assumption is verified in practice. This demonstration constitutes the first step in creating a framework for the analysis of health care allocation laws.

Indeed, from this assumption follows the idea that the analytical framework should encompass all pertinent conceptions of justice preferred by theorists for the allocation of health care resources. Thus, the analytical framework comprises four conceptions of justice: the libertarian, egalitarian, utilitarian, and communitarian archetypes.

The framework acts as a reading grid, which I later apply to the two case studies I have chosen as examples of western health care systems. To apply the grid, I use a discourse-analysis methodology. When the methodology is applied to both case studies, the dissertation takes a comparative dimension, as I contrast and bridge the findings for both health care systems. This discourse-analysis methodology mandates that historical elements be taken into consideration, as, on many levels, they influence discourses. The social sciences help to clarify the potential influence of these elements on interlocutors. Therefore, in an effort to address the role played by the for-profit sector in the allocation process, political science theories, such as the path of dependence, and stakeholder theories help me nourish the analysis of these actors' discourses.

I consciously chose to focus my analysis on only a few watershed moments in the history of the American and British health care systems and to shed

light on specific health care policy trends, to better elucidate the influence of justice and the for-profit sector on the crafting of the most crucial health care reforms in these two welfare states.

I do not claim to present an exhaustive legal history of these two systems, nor do I claim to offer a comprehensive archival study of primary sources. Nonetheless, I believe that my analysis of preparatory work may provide sufficient historical evidence to uncover the origins of health care reforms in both of these countries and, in the process, to reveal the importance of discourse in advancing social changes.

Overall, this project calls attention to a dimension of justice in health care law through a philosophical analysis of the legislative process. Nonetheless, the purpose of this research is not to evaluate the distribution resulting from the application of those laws, nor is it to determine whether one conception of justice should prevail over others for the allocation of health care resources in western societies. Rather, this study proposes that all conceptions of justice for the distribution of resources should be examined equally to determine whether any form of justice underlies the inception of health care allocation reforms.

*i. Framing the Issue With Legal Philosophy*

In this dissertation I demonstrate that, in theory, the special nature of health care calls for the just allocation of its resources. My goal is to confirm that this assumption has also been accepted in practice. Therefore, I provide a detailed framework of analysis to study health care laws in the United States and in the United Kingdom.

First, theories of distributive justice dealing with the allocation of common goods need to be examined to construct a reading grid to assess the role played by justice in the drafting of laws governing the allocation of health care resources. The libertarian, egalitarian, utilitarian, and communitarian justice archetypes together form the essence of my theoretical framework.

This framework is the main point of reference around which I build my comparison. It also helps me to assess the influence of the for-profit sector on the drafting of health care laws and, more particularly, to determine whether a desire to promote principles of justice has animated the discourse of for-profit actors when lobbying their interests before legislative institutions.

It is essential to note that no single principle can address all scarcity and rationing problems affecting health care systems; several principles and conceptions of justice merit consideration to create more just solutions. Thus, it is necessary to not exclude or privilege any of the justice archetypes that form the analytical framework crafted to determine whether any justice principles have impacted health care allocation laws.<sup>48</sup>

*ii. An Important Historical and Comparative Dimension*

This dissertation is an inherently comparative project given that evaluating the influence of principles of justice and the for-profit sector on the drafting of laws relating to health care requires a comparison of western health care systems, legislative institutions, and most importantly the health care legal corpuses of similarly situated countries.

A comparison of two similarly situated jurisdictions can provide a new perspective on health care reforms and their origins and can offer valuable insight on the effectiveness of health care laws by looking at the reasons underlying the drafting and enactment of norms. Building on this dissertation's findings and its alternative perspective, future research might be better able to determine whether certain conceptions of justice or certain

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<sup>48</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16.

laws are more efficient than others in providing solutions to scarcity and access issues. This dissertation may very well help to advance more effective health care reforms in the near future.<sup>49</sup>

This research contrasts neither the strengths and weaknesses nor the similarities and divergences characterizing the American and British legislative institutions. Instead, the study focuses on the operation of norms governing the allocation of health care resources. Thus, to derive valuable conclusions from this comparison, the socio-historical context influencing legislative institutions as they decide to enact particular health care reforms needs to be closely examined.

A comparison can also demonstrate that historical sequencing and timing greatly matter in the development of health care reforms. In both case studies, different events have provided opportunities or a lack thereof for the creation of new health care allocation laws. Through this analysis, by contrasting the events that gave rise to major health care reforms in the United States and the United Kingdom, I wish to determine whether distinct paths of dependence have limited the development of health care policy in

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<sup>49</sup> Rudolf Klein & Theodore R. Marmor, *Reflections on Policy Analysis: Putting it Together Again*, The Oxford Handbook of Public Policy 892 (2006), p.905.

these countries. I ultimately want to emphasize the importance of historical institutionalism in the legislative process.

Furthermore, great explicative value would have been lost had the analysis been limited to a single country or health care system. Indeed, it is important to compare the impact of certain events in similarly situated countries to determine whether certain laws are the product of national policy or whether comparable approaches have also been taken in other western welfare states. For this reason, I parallel the drafting of health care laws in both countries during the same time period.

For practical reasons, I chose to limit the scope of the analysis to the post-World War II era until the present day. The end of World War II, with the discovery of penicillin, marks the beginning of modern medicine and a crucial turning point for western welfare systems. Thus, I analyze a 70-year period, from the 1940s until the present time.

The history of national legal systems runs parallel to nations' histories; nonetheless, to understand how laws respond to specific events, it is also important to make sense of the events and the contexts influencing the

functioning of legal institutions.<sup>50</sup> Thus, this dissertation embraces David Ibetson's perspective on comparative history in that it does not aim to advance a methodology for the study of legal change but rather to expose a theory of legal development.<sup>51</sup> Although the use of historical archives and history is crucial for unpacking issues surrounding the role of for-profit actors in the drafting of health care laws, this dissertation does not aspire to be a full-fledged historical project.

### *iii. Representative Case Studies*

Political scientists often use culturalist explanations to justify differences in health care and social policy across welfare states.<sup>52</sup> Among many other scholars, Hacker explains that political elites and the public are cultural agents that conceive differently the importance of health care services in their respective societies. Their common understanding of an ideal health status shapes their opinion about health care policy<sup>53</sup> and enters the

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<sup>50</sup> David Ibetson, *Comparative Legal History: A Methodology*, in *Making Legal History: Approaches and Methodologies* Anonymous Anthony Musson & Chantal Stebbings eds., 2012).

<sup>51</sup> *ibid.*

<sup>52</sup> Clifford Geertz, *The Interpretation of Cultures: Selected Essays* (1973).

<sup>53</sup> Hacker, *The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and US Medical Policy*, 57, *supra* 42.

legislative arena through the discourse they present to the nation's political institutions.<sup>54</sup>

This cultural perspective certainly adds another dimension to the analysis of health care provision and financing laws. To specify the parameters of the study and to neutralize any culturalist influence, I analyze two countries that share a common cultural background. Even though the organization of their political, legislative, and judicial institutions differ, the United States and the United Kingdom still share many Anglo-Saxon roots.

A close look at the only privately run health care system in the world is indispensable for a study on the role of for-profit actors in the crafting of just health care laws. It is equally important to contrast this analysis with a study of the legislative history of the first universally run health care system in the world. The American and British health care systems are certainly dissimilar, but they also share many features. It is only through a functionalist comparison that conclusive observations can be made on the role of justice and for-profit sectors in their respective legislative processes. The analysis of the American case study is limited to federal law, and the

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<sup>54</sup> *ibid.*

analysis of the British case study is limited to England and laws relating to the NHS of England.

In this dissertation I contrast issues of cost control and access affecting the American health care system with those of waiting lists and underfunding that afflict the NHS of England. I also compare the managerial and competitive trend present in American health care policy throughout the twentieth century with the universal, egalitarian philosophy characterizing the NHS.

#### *iv. Material Gathered*

Secondary sources encompassing prominent literature in the field of political history and health law help to represent the context surrounding the enactment of each Act analyzed in the case studies. To check against reality the conclusions derived from these readings, it is crucial to make use of primary sources. Only these sources can attest to the legislative intent animating the legislator and the pressure groups involved in the crafting of health care financing and provision laws. Indeed, the study of archived legislative preparatory work helps to determine whether the for-profit sector really impacted the drafting of health care laws and whether any of the actors

involved in the negotiations of these health care Bills were inspired by principles of justice.

Specifically, the American Congress creates formal, specialized committees that collect and organize testimony by its members, officials of the executive branch, policy experts, interest groups, and sometimes the general public. The reports of these hearings constitute influential information necessary for drafting legislative proposals, and they are the principal tool used to understand surrounding controversies during the early stages of policy-making. Indeed, Committee reports have the most probative value in determining the Congress's legislative intent.

Because of the high level of the discussions these hearings involve, I focus solely on the reports and do not consider the narrower discussions about the wording of these acts taking place on the House of Representative or the Senate's floor.

In England the legislative process is sometimes ignited by an inquiry requested by the government or a political group. This review leads to the drafting of a White Paper, an authoritative report presenting the issues,

potential solutions, and a tentative timeline to implement a new legislative project.<sup>55</sup>

All reforms of the NHS of England presented in this dissertation have been preceded by the publication of White Papers or special reports ordered by the government. These documents constitute the first stage of the legislative process and therefore need to be analyzed, as they expose the issues at stake and the government's justification for proposing a reform. White Papers reveal many elements leading to the drafting of health care Bill later presented before Parliament, and they shed light on the reactions of different groups at the time of their publication.

Following a White Paper's publication and before a law receives royal assent, a draft Bill is read three times in Parliament and is subjected to the committee, report and later stage. For the purpose of this study, I focus my analysis on the Second Reading of the Bill. Depending on the activity of each House the Bill is read for the second time either in front of the House

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<sup>55</sup> *Michael Stelzner's Book: Writing White Papers: How to Capture Readers and Keep them Engaged*, last accessed 3 January 2014.

of Commons or the House of Lords, and during this process the Members of the Houses debate the main principles of the future law.<sup>56</sup>

In particular, I pay attention to the reports of these Second Readings to reveal the role played by Members of Parliament and indirectly by pressure groups in the crafting of health care law in England but also to unveil, if present, the discourse of justice animating these debates.

For both case studies, I offer a thorough analysis of each legislative piece and limit the study to certain watershed moments leading to the enactment of laws that have changed the architecture of the health care system. Although this project does not pretend to present an exhaustive panorama of all federal health care laws in the United States or in England, nonetheless, with the analysis of 7273 pages of Committee Hearings for the United States and 465 pages of White Papers and reports on the Second Reading of each Bill in England, it provides sufficient evidence to draw probative conclusions on the role played by the for-profit sector and the influence of justice principles on the drafting of financing and provision laws.

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<sup>56</sup> Cabinet Office, *Legislative Process: Taking a Bill through Parliament: An Overview of the Process by which Bills Become Law*, 2013, at 1.

*v. A Discourse-Analysis Methodology*

Our language and communication styles reflect our vision of the world, our identities, and the roles we play in social relations. Discursive practices are socially embedded and structured according to different patterns: they reflect social movements and a perception of society at a precise time and place. Thus, discourses analyzed in different contexts, social domains, or different institutions may reveal factors that contribute to social change.<sup>57</sup> In the present case, the language and dialogues comprising legislative preparatory work can help to shed light on the reasons underlying the enactment of allocation laws that have led to suboptimal outcomes in health care.

Thus, this project conducts discourse analysis by examining some of the concrete linguistic occurrences that indicate one or more justice archetypes involved in the theoretical framework presented in the first chapter of this dissertation. For both case studies, instances in which for-profit actors use these discourses to negotiate the drafting of major health care reforms are examined. For each archetype, words emblematic of the discourse associated with this conception of justice have been selected. A keyword search among the primary sources helped to refine the results for the influence of each archetype on the discourse leading to the final draft of a Bill. A chart

summarizing all keywords and related justice archetypes is presented in the appendix of the dissertation.<sup>58</sup>

The purpose of the discourse analysis is not to determine whether the statements and utterances of individual actors are right or wrong, nor is it to evaluate the content of the discourse. Rather, its main goal is to reveal whether principles of justice have infiltrated discourses and whether the language of actors has impacted the drafting of health care allocation laws.

Exploring patterns in and across statements made during legislative preparatory work may provide partial explanations for the social consequences of these laws and may account for the suboptimal outcomes of certain reforms. Textual analysis alone is evidently not sufficient to draw these implications; thus, secondary sources are also analyzed to reveal the essential historical background and events that have led to these reforms.

I ultimately wish to show the existence of a link between discursive practices and a broader social context surrounding the negotiation of each Act. I hope to reveal that, through everyday practices, individuals and groups are given the power to actively create a rule-bound world. Using a discourse-analysis

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<sup>57</sup> Marianne W. Jørgensen & Louise J. Phillips, *Discourse Analysis as Theory and Method* (2002).

<sup>58</sup> See appendix for the detail of textual occurrences analysed in the primary sources.

methodology, I presuppose that language and discourses influence democratic institutions and can effectively provoke change in the legal system.

### **III. Overview of the Chapters**

I begin my analysis of the role played by the for-profit sector in the drafting of just health care laws by elucidating the special nature of health care. In the first chapter of this dissertation, I establish that the distribution of health care resources must be governed by principles of justice, by explaining how and why health care helps to achieve the Common Good. This initial step allows me to build a theoretical framework composed of four philosophical archetypes that, in theory, should be used for the just allocation of health care resources. In subsequent chapters, I use this conceptual framework as a reading grid to analyze legislative preparatory work leading to the enactment of health care allocation laws in the United States and in the United Kingdom.

Thus, the second chapter of the dissertation is dedicated to the analysis of the first case study: the American private health care system. After presenting a brief historical overview and the main policy trends in American

health care policy, I reveal the roles played by for-profit entities at the pooling and financing levels to reveal their influence on the structure and evolution of the American health care system. Finally, I analyze specific historical events and related pieces of legislation to determine whether distributive justice has influenced the drafting of health care financing and provision laws from the post-World War II era to the present in the United States.

In the third chapter of the dissertation, I analyze the second case study: the publicly funded NHS of England. I highlight the main policy trends leading to the development of a path of dependence set by the foundational principles of the NHS. Presenting the organization's defining themes, I unveil the past, present, and future roles played by the for-profit sector in and outside this health care system. Again using the theoretical framework developed in the first chapter, I analyze key legislative pieces to determine whether distributive justice has impacted the drafting of health care allocation laws in the United Kingdom during the past 70 years.

In the last chapter of the dissertation, I bridge both case studies to present conclusions on the influence of justice principles and on for-profit actors' roles in the drafting of health care allocation laws in the United States and

the United Kingdom. To suggest prospects for further research, I also provide observations on the notion of profit in health care and on the convergence of health care policies in western welfare states.

## CHAPTER ONE:

### The Analytical Framework

#### *A Philosophical Approach to the Distribution of Health Care Resources*

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#### **I. Introduction**

In their foundational book *Principles of Biomedical Ethics*, Tom Beauchamp and James Childress flesh out four principles governing the health care decision-making process in modern societies: *autonomy*, encompassing the principles of self-governance, liberty, privacy, and freedom of choice; *non-maleficence*, encompassing the moral duties of doctors not to execute acts of torture or to behave harmfully towards their patients; *beneficence*, encompassing the moral duties of doctors to act for the benefit of others; and *justice*, the duty to treat like cases alike when allocating resources to patients.<sup>59</sup>

At the clinical level, all four principles guide physicians in a two-phase decision-making process. First they proceed to select treatments based on an assessment of the disease. Second, they run a cost-benefit analysis for each treatment option. In both stages, questions of justice and solidarity are

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<sup>59</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16.

weighed.<sup>60</sup> Thus, allocation is not simply the product of a pragmatic compromise; it also involves higher and more philosophical considerations.<sup>61</sup>

Perhaps it is the particular nature of health care that calls for the consideration of philosophical elements. Indeed, to state that health care is special is to make a moral claim regarding the distribution of its resources, and this claim is an essential first step in theorizing on a larger systemic scale the role of justice in the distribution process.<sup>62</sup>

Of the four principles guiding health care decision-making, only the idea of justice captures the collective dimension of the process and the impact of the doctor-patient relationship on society. The medical ethics literature further refines this idea and distinguishes four justice archetypes (libertarian, egalitarian, utilitarian, and communitarian) that are preferred for the allocation of health care resources.<sup>63</sup> These models are not mutually exclusive and often give rise to hybrid models designed to achieve a more just distribution of resources.<sup>64</sup>

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<sup>60</sup> Rogeer Hoedemaekers & Wim Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 11 *Health Care Analysis* 325 (2003).

<sup>61</sup> Will Kymlicka, *Contemporary Political Philosophy : An Introduction* (2002).

<sup>62</sup> Norman Daniels, *Health Care Needs and Distributive Justice*, in *In Search of Equity* 1 (Anonymous 1983).

<sup>63</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325 , supra 60.

<sup>64</sup> Elhauge, *Allocating Health Care Morally*, 1449 , supra 1.

Bearing in mind all these paradigms, I begin this chapter by demonstrating how and why health care is special. I then present a philosophical argument to further reveal the specialness of health care and to qualify it as a constituent of the Common Good. During this analysis, I pay particular attention to the concepts of solidarity and subsidiarity, which are often associated with the notion of Common Good in the western health care policy debate.

Because the idea of the special nature of health care automatically implies that principles of justice should govern its allocation, I decided that, rather than making initial normative claims on the role that justice should play in the allocation of health care resources, I would instead flesh out a descriptive conceptual framework that advances the four philosophical archetypes. In Chapters Two and Three, I use these theories as a reading grid to analyze the legislative work dictating the distribution of health care resources in the United States and in the United Kingdom. I decided not to present any one archetype as superior to other conceptions of justice. I believe that all conceptions of justice should be equally presented and tested against each of the laws, to determine if any principles of justice, irrespective of the conceptions they belong to, have impacted the drafting and negotiation of the laws.

## II. Why Should Health Care Be Justly Allocated?

Much of the bioethics and medical law literature on rationing and allocation issues focuses on discussions at a micro/individual level. In particular, the dynamics affecting doctor-patient relationships and the decisions surrounding treatment options have been given significant attention.<sup>65</sup> Yet, the central role of health care in our society mandates that we now elevate the debate to a macro level. Issues that need to be addressed include the type of health services to be provided, the level of access that should be granted, the institutions that should provide services and access, and, of course, how to bear the cost of these services.<sup>66</sup> All of these questions impact one's health status and are central to the functioning of any health care system.<sup>67</sup>

Also relevant to questions of allocation is the underlying philosophical debate present in the realm of health care policy-making. Discussions regarding processes for a more optimal distribution of health care resources often evoke the concept of solidarity, referring to a benevolent attitude towards weaker social groups, the fair distribution of health services for

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<sup>65</sup> Norman Daniels, *Just Health Care* (Cambridge University Press ed., 1985), p.1.

<sup>66</sup> *ibid.*, p.2.

<sup>67</sup> *ibid.*

society as a whole, and the equally important philosophical concept of subsidiarity, which refers to the power of individuals and non-state institutions to provide and finance their own health care needs.<sup>68</sup>

All of these considerations can be addressed only after having examined the attributes of health care that distinguish it from other goods and that mandate the allocation of its resources according to principles of justice.

### **A. Health Care is Special**

It is undeniable that health care possesses features that distinguish it from consumer goods. For some philosophers it is undisputable utility, whereas for others, the strategic importance of health care for achieving life plans makes it a special resource.<sup>69</sup> Thus, health care cannot simply be subject to regular allocation processes driven by market forces, without any legislative intervention or governmental input. The care required for maintaining good health is something that cannot be distributed in a simple selective way.

Although resource egalitarian theorists pioneered the conceptualization of health care as a unique social good and offered a great starting point for theorizing the special features of health care, it is essential to adopt a more

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<sup>68</sup> Hans-Martin Sass, *The New Triad: Responsibility, Solidarity and Subsidiarity*, 20 J. Med. Philos. 587 (1995).

objective standpoint on all theories regarding the appropriate distribution of this good that significantly contributes to the Common Good. Indeed, a broader view will establish that health care is special not only because it is an atypical good but also because it contributes to the achievement of a greater Common Good for society.

*i. Health Care is Not a Can of Peas or Broccoli*

In his book *The Righteous Mind: Why Good People Are Divided by Politics*, Jonathan Haidt offers an interesting analogy. He states that public powers should not address health care and that, in fact, its allocation should be left to the market. According to him, health care possesses all the characteristics of produce. He goes so far as to equate it to “a simple can of peas.”<sup>70</sup>

He explains that, central to making this produce available to the general public is the chain of makers and suppliers involved in its production and marketing. Farmers, truckers, supermarket employees, and even miners and metalworkers contribute to making the good available at an extremely low price. He attributes the affordability of the peas to the presence of

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<sup>69</sup> Daniels, *Just Health Care*, supra 65, p.39-42.

<sup>70</sup> Jonathan Haidt, *The Righteous Mind: Why Good People are Divided by Religion and Politics*, (2012), p. 303.

competition among the suppliers at every stage of production and to the innovative techniques that helped to reduce the aggregate price of the can.<sup>71</sup>

Haidt imagines, to help consumers with the purchase of their groceries, a food insurance scheme with a substantial premium of \$2000 and a co-payment fee of \$10 payable at every shopping session.<sup>72</sup> According to him, a certain point will be reached where food insurance prices will inevitably rise because supermarkets will only be willing to stock the produce that rewards them with the highest insurance payments and not the ones that provide the greatest value to the insured.<sup>73</sup> An uncontrollable spiral of price increases will then be unleashed, and the price of a ‘subsidized’ can of peas will reach \$30. A contribution to a tax-based subsidized scheme to cover all consumers’ inflated grocery bills will then be imposed.<sup>74</sup>

With this comparison, Haidt makes the case for allocating all resources through the market. He strongly believes not only that health care is a simple consumer good but that its allocation would be most optimal and the price would be most lowered through the operation of supply and demand.<sup>75</sup>

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<sup>71</sup> *ibid.*, p. 304.

<sup>72</sup> *ibid.*

<sup>73</sup> *ibid.*

<sup>74</sup> *ibid.*

<sup>75</sup> *ibid.*

Haidt is not isolated in his views on health care. The debate surrounding the most recent health care reform in the United States reveals many critiques of the Affordable Care Act (ACA) that have made similar analogies. In some of these critiques, health care was then likened to another consumer good: a crown of broccoli. Nonetheless, it is incorrect and too simplistic to reduce health care to the purchase and consumption of vegetables.

In the words of Justice Ginsburg, it is “the inevitable yet unpredictable need for medical care and the guarantee that emergency care will be provided when required [that provide] conditions [that are] non-existent in other markets. That is so of the market for cars, and of the market for broccoli as well.”<sup>76</sup> Furthermore, in the case of health care, “[patients] never quite know when they will need, and in the case of severe illnesses or emergencies generally will not be able to afford [health care services],”<sup>77</sup> and health care “has few (if any) parallels in modern life.”<sup>78</sup>

Indeed, health care is neither a can of peas nor broccoli; it is a special good. Egalitarian theorists have been pioneers in defining its extraordinary contours. The egalitarian view posits that the special status of health care

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<sup>76</sup> *National Federation of Independent Business Et Al. V. Sebelius, Secretary of Health and Human Services, Et Al.* 567 (U.S. Supreme Court 2012).

<sup>77</sup> *ibid.*

<sup>78</sup> *ibid.*

imposes that the distribution of its resources be made in isolation from the distribution of social goods. Thus, health care resources should be justly distributed and not treated as any other commodity.<sup>79</sup>

According to Norman Daniels, the importance of health care in our societies makes it special. Even in communities that tolerate or glorify significant inequalities in the distribution of social goods, most members feel that an equal distribution of health care resources is justified.<sup>80</sup> The capacity of health care to enable all of us to pursue our life plans gives it its strategic importance. The moral significance of health care derives directly from the importance of health in our lives.<sup>81</sup> As a result, for the defenders of the equality of opportunity rule, such as Daniels, the distribution of and the access to health care resources should be granted on a non-discriminatory basis. Discrimination on account of financial inferiority or superiority should be forbidden.<sup>82</sup>

Schramme and Stern take a different stance. They believe that the specialness of health care does not stem from the opportunity or advantages it creates but from its potential to alleviate suffering and absolute harm. The

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<sup>79</sup> Shlomi Segall, *Is Health Care (Still) Special?\**, 15 *Journal of Political Philosophy* 342 (2007).

<sup>80</sup> Daniels, *Health Care Needs and Distributive Justice*, 1, supra 62.

<sup>81</sup> Daniels, *Just Health Care*, supra 65.

<sup>82</sup> Segall, *Is Health Care (Still) Special?\**, 342, supra 79.

indisputability and seriousness of health care needs make the distribution of health care resources stand out from the distribution of any other good. Essential to the pursuit of life opportunities, health resources are most special.<sup>83</sup>

Both of these theories rely on individualistic assumptions and do not encompass a collective understanding of health care's specialness. Issues of distribution affect individuals and society as a whole and need to be addressed collectively. This is because health care is collectively special, as it also participates in the achievement of a larger Common Good.

*ii. It Participates in the Common Good*

The randomness of illness and suffering as a result of health impediments is common to all human beings, and the achievement of good health is a goal shared by all societies. Sickness and diseases do not discriminate on the basis of wealth, race, or geography. All human beings can suffer from ill health, and all are mortal. Among the many determinants that can help to achieve good health, health care systems certainly contribute the most.

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<sup>83</sup> Thomas Schramme, *On Norman Daniels' Interpretation of the Moral Significance of Healthcare*, 35 J. Med. Ethics 17 (2009).

In the Aristotelian sense, good health is a Common Good as “it is a condition of life in society that allows the different groups and their members to achieve their own perfection more fully and more easily,”<sup>84</sup> and it is “attainable only by the community, yet individually shared by its members.”<sup>85</sup> An array of common goods is required for the achievement of this great Good. Health care is one of the most significant common goods that contribute to the achievement of good health; thus, in this respect it is also special.

Health care provides a set of means necessary for the realization of personal goals. It is a human being’s inherent entitlement, and with it comes certain duties and a sense of solidarity with the community.<sup>86</sup> Health care is both an individual and collective prerogative. Indeed, one’s health status is personal and cannot be shared by other individuals. Like other common goods, however, if health care is shared by all individuals in a collective, it also benefits society as a whole.

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<sup>84</sup> Argandoña, *The Stakeholder Theory and the Common Good*, 1093, supra 31.

<sup>85</sup> Thomas W. Smith, *Aristotle on the Conditions for and Limits of the Common Good*, *American Political Science Review* 625 (1999).

<sup>86</sup> B. Andrew Lustig, *The Common Good in a Secular Society: The Relevance of a Roman Catholic Notion to the Healthcare Allocation Debate*, 18 *J. Med. Philos.* 569 (1993).

iii. *Its Specialness Has Already Been Recognized as an International Human  
Right to Health*

National constitutional law and international law have acknowledged the specialness of health care by elevating health to the ranks of a constitutional entitlement or a full-fledged human right.

Among the most prominent examples is the fundamental value given to the right to health through a broad interpretation of the right to life included in Article III of the Universal Declaration of Human Rights (UDHR).<sup>87</sup> Discourses based on dignity and the right to life have led nations such as France to include the right to health in the preamble of their constitutions. Indeed, the 1946 preamble to the French Constitution gives “to all, notably to children, mothers and elderly workers, protection of their health, material security, rest and leisure.”<sup>88</sup> In addition, a forerunner in the domain of socio-economic rights, the South African Constitution goes further and recognizes the specialness of health by providing South Africans a justiciable right to health care to guarantee a “minimum level of human dignity”<sup>89</sup> for all.

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<sup>87</sup> UN General Assembly, *Universal Declaration of Human Rights*, 10 Resolution Adopted by the General Assembly (1948).

<sup>88</sup> *Constitution De 1946, IVe République*, last accessed 3 January 2014.

<sup>89</sup> Nicholas Haysom, *Constitutionalism, Majoritarian Democracy and Socio-Economic Rights*, 8 S.Afr.J.on Hum.Rts. 451 (1992).

The emergence of an international right to health dates from the aftermath of World War II, when the World Health Organization (WHO) pioneered the first conception of health in terms of a human right. In its Constitution, the WHO recognized that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”<sup>90</sup> and defined health as a state of “complete physical, mental and social well-being, and not merely the absence of disease or infirmity.”<sup>91</sup> Only two years later, the UDHR established a human right to health through its Article 25, which states,

Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services (...)<sup>92</sup>

Following this groundbreaking definition, the right was elaborated upon and incorporated into many international and regional treaties and conventions.<sup>93</sup>

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<sup>90</sup> Preamble to the Constitution of the World Health Organization par, as published in World Health Organization, *Basic Documents*, 41st ed., Geneva, 1996. The WHO Constitution was signed in 1947 and entered into force on 7 April 1948.

<sup>91</sup> *ibid.*

<sup>92</sup> Assembly, *Universal Declaration of Human Rights*, , supra 87.

<sup>93</sup> The International Convention on the Elimination of all forms of Discrimination Against Women, the Convention on the Rights of the Child and conventions adopted within the context of the International Labour Organisation. On a regional level, the European Social Charter, the African Charter on Human and Peoples' Rights and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights. Reference should also be made to the European Convention on Human Rights and Biomedicine which proclaims a right to equitable health care.

Most important, the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which constitutes one limb of the hard law version of the UDHR, provides its own definition of a human right to health in Article 12, which reads as follows:

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 control.<sup>94</sup>

With this definition, health services' input became a component of the right to an adequate standard of living, but the definition is not limited to medical care. This conceptualization of health recognizes that states can realize this right "progressively" with "the maximum of the available resources."

The terms of the implementation might be intentionally broad to allow some flexibility, but the Committee on the ICESCR has specified with "minimum core obligations" to ensure that economic, social, and cultural rights are not interpreted as mere ideals.

The concept of the minimum core makes each state a party to the Covenant and responsible for fulfilling at least the minimum essential levels of each

right. Bearing in mind potential limitations in resources, the Committee nevertheless requires that priority be given to satisfy the basic needs of the people.<sup>95</sup>

In my opinion, the minimum core requirement creates an impediment to rationing health care resources at the national level because no clear guideline is offered regarding the content of the core. It is difficult to define precisely a minimal core obligation to be fulfilled by the state and the number of resources needed to satisfy this requirement. This “minimal level of health” is bound to vary from one country to the next. Furthermore, it is perilous to attempt to set an international/global benchmark to realize the right to health. Rationing at a macro level is highly impractical because resources and income vary greatly among countries. It is certainly the government’s duty to respect the human right to health care and to try to achieve it, but this needs to be done either with clearer guidelines or at a national level with rationing of health care resources tailored to a population’s needs.

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<sup>94</sup> *International Covenant on Economic, Social and Cultural Rights*, (1966): .

<sup>95</sup> General Comment No 3 *The Nature of States Parties’ Obligations* (art 2(1) of ICESCR) (5th session, 14 December 1990).

It is not surprising that even the progressive Constitutional Court of South Africa has rejected this approach in its adjudication of socio-economic rights cases. In both the *Grootboom*<sup>96</sup> and *T.A.C.*<sup>97</sup> cases, the Court explained that the minimum core concept can help to determine whether measures taken by the state to realize a given socio-economic “reasonable” right<sup>98</sup> and whether states adequately respond to the needs of those in desperate circumstances, or whether they altogether exclude a significant segment of society. The Constitutional Court reinterprets the concept in the light of a higher moral principle of human dignity and the right to a minimum standard of decency in life. Inevitably, questions of allocation tie into the minimum core debate because the enforcement of the right to health and health care in certain jurisdictions such as Brazil and South Africa has led to judicial rationing, but this will not be the subject of this dissertation. This study is not concerned with the *ex post* rationing dilemma taking place at the

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<sup>96</sup> *Government of the Republic of South Africa and Others V Grootboom and Others* (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000), (*Grootboom*).

<sup>97</sup> *Minister of Health and Others V Treatment Action Campaign and Others (no 2)* (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721; 2002 (10) BCLR 1033 (5 July 2002), (*T.A.C.*).

<sup>98</sup> In *Grootboom* the Court mentions that “A society must seek to ensure that the basic necessities of life are provided to all if it is to be a society based on human dignity, freedom and equality. To be reasonable, measures cannot leave out of account the degree and extent of the denial of the right they endeavour to realise. Those whose needs are the most urgent and whose ability to enjoy all rights therefore is most in peril, must not be ignored by the measures aimed at achieving realisation of the right.” It further clarifies in *T.A.C.* that “This minimum core might not be easy to define, but includes at least the minimum decencies of life consistent with human dignity. No one should be condemned to a life below the basic level of dignified human existence. The very notion of individual

judiciary level concerning the enforcement of a right to health or health care, but rather, it explores the *ex ante* rationing processes happening at the legislative level.

Ultimately, a human and constitutional right to health indicate the importance and specialness of health care. For a right to health to endure, some means must be deployed to guarantee the just allocation of health care resources. Indeed, conceptualizing health as a right and health care as a necessary element for the achievement of the Common Good is a first step in taking a broader and more objective philosophical perspective on health care allocation issues. This upstream approach helps to clarify that, in theory, the atypical nature of health care calls for just patterns of allocation.

### **B. ...And Therefore Requires Taking a Philosophical Approach to Welfare**

Conceptualizing health care as a common good implicitly leads to a philosophical understanding of welfare institutions. The two key notions of solidarity and subsidiarity have helped to structure the financing and delivery of health care services in all modern western welfare states. These notions

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rights presupposes that anyone in that position should be able to obtain relief from a court.”

have also transcended the idea of justice at the origin of the allocation process. Therefore, it is crucial to further explore these notions in relation to health care in order to, in turn, refine the presentation of the four philosophical archetypes.

*i. Health Care Requires Solidarity*

The work of Emile Durkheim first brought to prominence in Europe the idea of social solidarity. His interest lay more particularly with the idea of justice, which he conceived as the obverse of charity. According to Durkheim, charity can function only in traditional societies because it is the significant similitude among members that allows individuals to feel the need to provide charity to their peers. For him, solidarity is the ultimate source of morality, a necessity in our modern society. His innovative vision provided western democracies with the essential underpinnings to construct welfare systems.<sup>99</sup>

Indeed, in the 1930s, as Europe was facing a chaotic situation in the realm of health care, two organizational models embracing the idea of solidarity emerged. On the one hand, there was the German Bismarkian model of

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<sup>99</sup> Eugen Schoenfeld & Stjepan G. Meštrović, *Durkheim's Concept of Justice and its Relationship to Social Solidarity*, 50 *Sociology of Religion* 111 (1989).

social insurance, which took a right-based approach to allocating health care resources, focusing on the provision of services at the local level; on the other hand, there was a public service model focusing on public authorities' duty to universally provide the public good of health care.<sup>100</sup>

The models relayed an idea of solidarity that was conceived in terms of a vertical relationship, by having the “strong” help the “weak” through the redistribution of burdens and benefits, or along the lines of a horizontal relationship, in which the “strong” and the “weak” join forces and share risks to jointly contribute to the common welfare.<sup>101</sup>

More generally, solidary feelings of reciprocal sympathy encourage mutual support among members of the same society and foster a sense of responsibility for other members. By adopting either a vertical or horizontal approach to solidarity, certain welfare states have been able to determine who should be given equivalent entitlements and to what extent the state's protection must guarantee and safeguard these entitlements.<sup>102</sup>

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<sup>100</sup> Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (2010), p.4.

<sup>101</sup> Wil Arts & John Gelissen, *Welfare States, Solidarity and Justice Principles: Does the Type really Matter?* 44 *Acta Sociologica* 283 (2001).

<sup>102</sup> *ibid.*

Overall, solidarity implies a benevolent attitude towards weaker social groups and a commitment to fair distribution of health care resources.<sup>103</sup> It is central to debates on global health care packages and the prioritization process involved in the creation of social programs for the aged, the chronically ill, the disabled, the poor, and other vulnerable groups.<sup>104</sup> Often, its principles collide with the notions of freedom of choice and responsibility, which are also part of the reform of health systems. The need to account for differences in life goals, risk aversion, and lifestyle choices impacting individuals leads to this ideological confrontation and some hybrid distributive choices.<sup>105</sup>

*ii. Health Care May Also Mandate Subsidiarity*

Subsidiarity encourages the execution of individual and personal plans through the means of the community and with the help of lower levels of power, without recourse to higher governing bodies' resources.<sup>106</sup> Its principles dictate minimal state intervention in the social sphere and prohibit state institutions from interfering with family and individual life plans. The state's involvement is marginal to ensure that its scarce resources and

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<sup>103</sup> Rob Houtepen & Ruud ter Meulen, *The Expectation (s) of Solidarity: Matters of Justice, Responsibility and Identity in the Reconstruction of the Health Care System*, 8 Health Care Analysis 355 (2000).

<sup>104</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325, supra 60.

<sup>105</sup> Sass, *The New Triad: Responsibility, Solidarity and Subsidiarity*, 587, supra 68.

individual autonomy are preserved. The principle of subsidiarity stresses both personal commitment to life goals, thanks to the services of others, and limited bureaucratic power.<sup>107</sup>

The principle also grants a central role to associations. Charities and other associations actively participate in society by promoting voluntary interaction among individuals and by helping their members develop greater dignity. Those with lesser means are assisted with the achievement of their life goals and with finding their individual social roles. All of this is possible with active social interaction and without the intervention of state institutions.<sup>108</sup>

The subsidiarity principle is also at the center of health care debates, as it encourages charities to take over the state's role for the provision and financing of health care services. In a subsidiary health care system, decisions for the allocation of health care resources should be made at the appropriate level by assigning a maximum authority to smaller groups and individuals instead of delegating distribution choices to centralized authorities within the state.

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<sup>106</sup> Andreas Føllesdal, *Survey Article: Subsidiarity*, 6 *Journal of Political Philosophy* 190 (1998).

<sup>107</sup> Sass, *The New Triad: Responsibility, Solidarity and Subsidiarity*, 587, *supra* 68.

<sup>108</sup> Føllesdal, *Survey Article: Subsidiarity*, 190, *supra* 106.

Although the idea of solidarity is still prominent in discussions relating to health care allocation issues, policy-makers now also focus on the importance of a subsidiary means of allocation. Across western welfare states, distribution choices are made according to both principles, but greater importance is now given to patient choice and autonomy.<sup>109</sup>

Having now established the special nature of health care, we can reflect on the allocation processes that should govern the distribution of its resources. Justice must certainly be involved, thus it is important to examine the four archetypes preferred, in theory, for the allocation of resources contributing to the achievement of the Common Good. This will help to better understand how these conceptions may have impacted, in practice, the distribution of health care resources.

### **III. Four Archetypes for the Just Allocation of Health Care Resources**

By definition, justice is concerned with human relationships in the social order and, consequently, with issues of distribution. Indeed, justice is essential for balancing the needs and desires of members of society with the

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<sup>109</sup> Sass, *The New Triad: Responsibility, Solidarity and Subsidiarity*, 587 , supra 68.

claims of the collectivity.<sup>110</sup> Fairness and equity are necessary to reach an appropriate distribution of resources and to create norms to govern the process.<sup>111</sup>

Thus, distributive justice theories provide a framework for the allocation of responsibilities, services, and public goods, including health care.<sup>112</sup> Political theorists and legal philosophers have attempted to find principles to connect property with a morally justifiable allotment of burdens and benefits, and they have created specific rules of social cooperation to allocate those rights and responsibilities. All institutional policies derived from these theories either accept or reject some of these principles.<sup>113</sup>

Therefore, to analyze the presence or absence of justice in legislative work, we need a more comprehensive account of distributive justice. It is essential to define the characteristics of the four most prominent distributive justice archetypes so that we can later determine whether the distribution of health care resources has been underwritten with any of these conceptions and their principles.<sup>114</sup> All four conceptions constitute the core of the analytical framework necessary for analyzing discourses in the following chapters.

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<sup>110</sup> Penner & Melissaris, *McCoubrey & White's Textbook on Jurisprudence*, supra 15.

<sup>111</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p. 241.

<sup>112</sup> *ibid.*, p. 244.

<sup>113</sup> *ibid.*, p. 243.

None of these conceptions can be excluded from the framework, nor can one conception of justice supersede others because all relay different but equally important principles of just distribution.

### **A. The Libertarian Justice Archetype**

Libertarian theorists strongly condemn the interference of the state with individual property rights and any infringement on individual liberty. Thus, they strongly object to redistributive taxation. Indeed, libertarians perceive the levy of taxes as a violation of the right to property and any social intervention in the market as a limitation on individual liberty. In a libertarian state, the government is never justified to acquire the property of its citizens or to redistribute it for the benefit of others. Taxation is in no way a tool for obtaining equality or creating justice.<sup>115</sup>

The libertarian archetype also rejects any right or entitlement to welfare.<sup>116</sup> The state should never force its citizens to participate in collective welfare schemes. Welfare services should only be financed and offered to the needy through charitable contributions.<sup>117</sup> Libertarians are therefore vigorously opposed to obligatory, state-funded, universal coverage. Private and

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<sup>114</sup> Daniels, *Just Health Care*, supra 65, p.9.

<sup>115</sup> Jonathan Wolff, *An Introduction to Political Philosophy* (1996), p.147-149.

voluntary insurance are the most predominant form of coverage available in libertarian health care systems, as they help to promote patients' choice and offer the freedom to choose coverage and, indirectly, the services they wish to receive.<sup>118</sup>

No inherent right or claim to health care exists under the libertarian theory of justice. Personal autonomy and liberty are the only necessary foundations of a just health care system, and the privatization of health care services is the utmost protected value.<sup>119</sup> From a libertarian perspective, health is valuable and justifies action against those who are trying to harm or interfere with the health of others, but it remains a negative interest that requires protection, not a positive right. Health care systems based on libertarian principles are therefore “individual-oriented” and focus on personal necessities rather than on collective health care needs.<sup>120</sup>

*i. Market Freedom and Competition in Health Care*

Over the course of the twentieth century, American libertarian policy-makers have created market tactics and strategies to guarantee the just allocation of

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<sup>116</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16.

<sup>117</sup> Robert Nozick, *Anarchy, State and Utopia* (1974).

<sup>118</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61, p. 97.

<sup>119</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16.

<sup>120</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325 , supra 60.

health care resources. Callahan and Wasunna report three “market promises” potentially informing the construction of the American allocation system: “(1) Increased competition in the health sector will lower health costs by reducing unit prices. With lower unit prices, a more efficient system could better meet health needs per dollar spent. (2) Competition among drug plans (...) is to lower costs and improve access to drugs for the elderly. (3) [markets are able to] export items to developing countries, namely that the introduction of user fees and the encouragement of a private sector [these] will increase health care resources in underfunded systems at the same time as they [will] undercut moral hazard.”<sup>121</sup>

Indeed, for libertarian theorists, health care is a source of profit, and medicine is a money-making instrument; therefore, markets can create enough incentives to generate an optimal level of competition, leading to better performing and more efficient health care systems.<sup>122</sup> According to libertarians, the free market is the most prosperous economic engine to attain a universal standard of living; thus, it should also be employed to operate a more just health care system.<sup>123</sup>

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<sup>121</sup> Norman Daniels, *Broken Promises: Do Business-Friendly Strategies Frustrate just Healthcare*, Denis G. Arnold (Eds.) 35 (2009).

<sup>122</sup> Daniel Callahan & Angela A. Wasunna, *Medicine and the Market: Equity V. Choice* (2008).

<sup>123</sup> *ibid.*

Personal freedom should also supersede the need for equity in health care. Thus, the market is ideal, as it provides a vehicle for the expression of individual choices. The freedom provided by the exchange makes it a democratic institution in which everyone can participate. The market is an essential political and economic institution that aims at maximizing freedom.<sup>124</sup> Evidently, health care as a contributing element for the achievement of the Common Good must also be “traded” on this platform. The invisible hand can distribute these resources more efficiently and more freely than the government’s monopoly can.<sup>125</sup>

*ii. The Importance of Charity for a Subsidiary Allocation of Health Care Resources*

The libertarian theory makes a clear distinction between the notions of justice and charity. Justice does not create a duty to support the sick and the needy, as these responsibilities are a matter of charity.<sup>126</sup> According to Robert Nozick, compensation for the consequences of luck or misfortune should not give rise to redistribution. Government resources should not be

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<sup>124</sup> *ibid.*

<sup>125</sup> *ibid.*

<sup>126</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325 , *supra* 60.

allocated to improve lives or to relieve human suffering, because aid and assistance should strictly result from the voluntary actions of others.<sup>127</sup>

The concept of subsidiarity is a strong element of the libertarian doctrine. Individuals must take charge of the provision of health care because they are capable of contributing to the system without resorting to the help of higher-level authorities. Governmental intervention in the realm of health care is judged unnecessary, as human relationships can satisfy health care needs by relying on charity.

Libertarian theorists also believe that, in the near future, charities will play a bigger role in western health care systems. Governments will start rationing a wider range of health care services, and some medical treatments will no longer be offered in the public system or by the private sector, for lack of profit. Inevitably, charities will have to take over many of those services.<sup>128</sup>

## **B. The Egalitarian Justice Archetype**

The egalitarian archetype is based on the notions of equity, equality, and solidarity. It posits that because we are fundamentally unequal as a result of the life lottery, equality must be reestablished through the just allocation of

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<sup>127</sup> Julian Lamont, *Distributive Justice*, H a Ndb Ookof 223 (2004).

resources. This, of course, implies the possibility of achieving equality in health and well-being.<sup>129</sup>

The egalitarian archetype is increasingly contrasted with the libertarian justice theory because of its similar focus on individual health care needs. Nevertheless, compared with their libertarian counterparts,<sup>130</sup> egalitarians take a more objective and collective approach to the distribution of resources, as they articulate the notion of solidarity, rather than subsidiarity, with the idea of justice.<sup>131</sup>

Indeed, egalitarian theorists are capable of conceptualizing equality in health only as an idea embedded in a larger understanding of justice. Perhaps this is because health is a prerequisite for achieving all life opportunities, the most critical constituent of human capabilities, and the most essential life condition.<sup>132</sup>

In absolute terms, equality in health can never be achieved, but equality in health care is possible. This requires paying particular attention to the versatility of these resources and the impact of different policy choices. To

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<sup>128</sup> Sass, *The New Triad: Responsibility, Solidarity and Subsidiarity*, 587, supra 68.

<sup>129</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325, supra 60.

<sup>130</sup> *ibid.*

<sup>131</sup> Daniel Callahan, *What Kind of Life: The Limits of Medical Progress* (1995).

<sup>132</sup> Amartya Sen, *Why Health Equity?* 11 *Health Econ.* 659 (2002).

achieve their equalizing goals, egalitarian theorists prioritize different objectives: equality in resources, equality in welfare, equality in access, equality in opportunities, and equality in treatment.<sup>133</sup>

Under the egalitarian doctrine, absolutist claims have proven to be unattainable and even, at times, unorthodox.<sup>134</sup> Therefore, alternatives to address scarcity issues in health care resources have been developed along the lines of a minimum “decent,” “reasonable,” “basic,” “essential,” or “adequate” right to health care. A concept of justice that embraces a “minimum entitlement” to health care attempts to avoid committing to open-ended financing programs.<sup>135</sup> Unfortunately, defining the content and contours of this right has proven to be challenging.<sup>136</sup>

My presentation of the egalitarian archetype focuses on two trends: resource egalitarianism and welfare egalitarianism. Resource egalitarians are critical of welfare egalitarianism because it requires an unlimited use of resources to reestablish equality in welfare for the victims of misfortune. Instead, resource egalitarians choose to focus on creating equality in resources, irrespective of the result of the life lottery. Welfare egalitarians, for their part,

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<sup>133</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325, supra 60.

<sup>134</sup> Mark S. Stein, *Distributive Justice and Disability: Utilitarianism Against Egalitarianism* (2006).

<sup>135</sup> Elhauge, *Allocating Health Care Morally*, 1449, supra 1.

<sup>136</sup> Amy Gutmann, *For and Against Equal Access to Health Care*, in *In Search of Equity* 43 (Anonymous 1983).

propose to equalize individual capabilities rather than resources, to increase individual welfare.<sup>137</sup>

*i. Equity in Health Care Resources For Equal Life Opportunity*

Resource egalitarians believe that inequalities in health can be resolved only through the just allocation of resources and by giving content to a right to health care.<sup>138</sup> This right must be understood in relation to a Rawlsian conception of justice in which fairness is a norm of cooperation that equalizes and liberates human beings to help them become active members of society.<sup>139</sup> In essence, the resource egalitarian theory rests on Rawls's fiction of the *initial position*.

Rawls imagines a state of nature in which individuals are unaware of their social status (fortune, class position, etc.) or any assets received at birth (abilities, intelligence, strengths, etc.). In this fictional state of "ignorance," individuals are rational agents driven by the desire to establish a process for

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<sup>137</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61.

<sup>138</sup> Daniels, *Just Health Care*, supra 65, p.35.

<sup>139</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, pp.339-341.

the fair allocation of resources through contract. By removing bias and requiring unanimity, Rawls hopes to attain equality and freedom for all.<sup>140</sup>

For this he identifies five primary goods that are essential to achieving justice and that must be the object of the social contract: (i) basic liberties, (ii) freedom of movement and choice of occupation, (iii) powers and prerogatives of offices and positions of responsibility, (iv) income and wealth, and finally, (v) social bases of self-respect.<sup>141</sup>

Health care, of course, participates in the production of many of these primary goods and, thus, has to follow the distribution principles dictated by the norms of justice. Therefore, as for any of these primary goods, society must equalize health care resources.

Rawls offers guidelines for the distribution of these primary goods:

First principle - Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all. Second Principle - Social and economic inequalities are to be arranged so that they are both: (a) to the greatest benefit of the least advantaged, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity.<sup>142</sup>

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<sup>140</sup> John Rawls, *A Theory of Justice* (1999).

<sup>141</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61.

<sup>142</sup> Rawls, *A Theory of Justice*, supra 138.

The *difference principle* allows for some inequality in distribution, but only to benefit the worst-off members of society. In addition, resource egalitarianism advocates equality of resources regardless of any differences among individuals, because interpersonal comparisons of welfare cannot be drawn due to these differences. Only each individual's level of material resources should be measured. These arguments had led Rawls to adopt a justice principle based on the equality of resources rather than on welfare.<sup>143</sup>

The benefit that individuals may derive from these resources or their capacity to better achieve their life plans thanks to the resources is irrelevant in the distribution. Each individual is responsible for the choices made with his or her resources. Primary goods are only tools to aid the choice of a life plan.<sup>144</sup>

A normal range of opportunity is the set of life plans a person can reasonably hope to pursue with his or her talents and skills. Through allocation processes, institutions indirectly affect an individual's fair share of opportunities and, consequently, his or her potential to pursue life plans. To guarantee the equality of opportunities necessary for the pursuit of everyone's life plans, resource egalitarianism calls for government

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<sup>143</sup> *ibid.*, p.302.

intervention in allocating the resources most crucial to the achievement of these projects. The state, as a neutral actor, does not use subsidies or penalties to encourage or discourage the use of resources but must safeguard their equal distribution.<sup>145</sup>

In an influential interpretation and extension of Rawls's theory, Norman Daniels argues for a just health care system based on "fair equality of opportunity." Although Daniels offers no explicit defense of this principle, he relies implicitly on the importance of health care needs for achieving life plans and believes that fair opportunity is central to any acceptable theory of justice.<sup>146</sup>

Resource egalitarian justice theory has clear humanitarian and solidary foundations. Daniels and many others have proposed the priority rule to help guarantee a minimal level of care to the worst-off patients.<sup>147</sup> To guarantee equal opportunity, it is incumbent on institutions governed by Rawlsian principles of justice to enforce a right to health care.<sup>148</sup> Social benefits should not be distributed on the basis of undeserved, advantageous property; on the contrary, the distribution of health care resources should

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<sup>144</sup> John E. Roemer, *Theories of Distributive Justice* (1998), pp.192-193.

<sup>145</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16.

<sup>146</sup> *ibid.*.

<sup>147</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325 ,supra 60.

follow the priority rule of “those who suffered the greatest reduction in their opportunity range, as the result of health problems, should receive the highest priority in the allocation of health care resources.”<sup>149</sup> Indeed, health inequalities resulting from an unjust distribution of health determinants during the *initial position* should not be tolerated.<sup>150</sup>

Welfare states that embrace resource egalitarian principles for the allocation of resources invest governmental institutions with the duty to promote just distribution and to provide individuals with equal opportunities to achieve their life plans.<sup>151</sup> In addition, ill health and the impossibility of perfecting one’s health status because of inadequate social arrangements are negatively relevant to social justice.<sup>152</sup> Thus, health care systems must meet the needs of all patients and strive to prevent diseases, illnesses, and injuries regardless of the life choices made by patients after the allocation of these resources.

The resource egalitarian doctrine also advocates a non-discriminatory right to health care and prescribes that health care services be provided based on needs. Whether an individual takes the responsibility to seek treatment or

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<sup>148</sup> Daniels, *Broken Promises: Do Business-Friendly Strategies Frustrate just Healthcare*, 35 , supra 121.

<sup>149</sup> See Daniels, *Just Health Care*, ; Stein, *Distributive Justice and Disability: Utilitarianism Against Egalitarianism*, supra 134.

<sup>150</sup> Daniels, *Broken Promises: Do Business-Friendly Strategies Frustrate just Healthcare*, 35 , supra 121.

<sup>151</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.341-343.

<sup>152</sup> Sen, *Why Health Equity?* 659 , supra 132.

reverts to unhealthy habits after treatment is irrelevant to the initial distribution. Resource egalitarian policies promote personal autonomy and prioritize the least-favored and vulnerable groups in the distribution of health care resources.<sup>153</sup>

*ii. Responsibility for a More Solidary Distribution of Care*

Resource egalitarianism is also preoccupied with issues of responsibility in the initial allocation stages. Specifically, Ronald Dworkin's conception of justice requires individuals to be compensated for the situational disadvantages hampering their achievement and the disadvantages for which they are not responsible. Individuals must, however, take a responsible and active role in the allocation process. Dworkin distinguishes tastes, ambitions, and circumstances.<sup>154</sup> Individuals are responsible for their preferences as long as they identify with them.<sup>155</sup> Indeed, the importance he ascribes to responsibility in distributive justice is unique.<sup>156</sup>

Dworkin imagines a world in which rational individuals exist under a thin veil of ignorance, as they are conscious of their talents and preferences but unaware of their handicaps. Every agent is given an opportunity to purchase

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<sup>153</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.341-343.

<sup>154</sup> John E. Roemer, *Equality of Opportunity* (1998).

coverage to hedge the risk associated with his or her potential handicaps. Thus, it is expected that once the veil is lifted, some individuals suffering from a handicap and some fully able individuals will purchase coverage. Others, having elected not to purchase coverage, will be the victims of their own preferences.<sup>157</sup>

According to Dworkin, the life lottery procures fair results, as it perfectly reflects an individual's degree of aversion to risk and his or her preferences. Dworkin prefers this ambition-sensitive solution to a resolution leading to endowment-sensitive outcomes.<sup>158</sup> For him “[t]he presence of insurance markets transforms events of brute luck into events of option luck. [In his view] it is fair for persons to suffer the consequences of option luck, and for persons to decide how much to insure against those kinds of event.”<sup>159</sup>

Individuals must be given the fair chance to palliate disadvantages that are not the result of their wrongdoings. No one shall be held responsible for his or her illnesses. Thus, for Dworkin, it would be the greatest injustice not to give everyone the means and social benefits necessary to level the playing

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<sup>155</sup> Roemer, *Theories of Distributive Justice*, supra 142, p.192-193.

<sup>156</sup> *Egalitarianism* (Stanford Encyclopedia of Philosophy), last accessed 3 January 2014.

<sup>157</sup> *ibid.*

<sup>158</sup> Roemer, *Theories of Distributive Justice*, supra 142; for other discussions on responsibility and an “opportunity-egalitarian” distribution of resources focusing on inputs rather outputs, see Robert C. Hockett, *Justice in Time*, 77 *George Wash L Rev* 1135 (2009).

<sup>159</sup> *ibid.*, p.248.

field or not to provide everyone with the same opportunity to achieve life plans. Granting the opportunity to access health care resources, regardless of initial endowments, is reasonable, achievable, and profoundly just.<sup>160</sup>

Dworkinian egalitarianism prescribes the allocation of resources based on a solidary system of risk sharing. Although they are put under a thin veil of ignorance at the initial stage of the allocation process, individuals must take responsibility to yield misfortune and make choices that will enable them to achieve their life plans. This trend of resource egalitarianism embraces a liberal view of solidarity in which an individual performs reciprocal duties while respecting a collective right.<sup>161</sup>

### *iii. Equality of Capabilities*

Welfare egalitarian theorists prescribe equality of *capabilities* to achieve *functionings*, or to grant individuals better access to advantages. In contrast to resource egalitarians, they are more concerned with the benefits a person can derive from resources than with the resources themselves.<sup>162</sup>

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<sup>160</sup> *ibid.*, p.192-193.

<sup>161</sup> Houtepen & ter Meulen, *The Expectation (s) of Solidarity: Matters of Justice, Responsibility and Identity in the Reconstruction of the Health Care System*, 355, *supra* 103.

<sup>162</sup> Stein, *Distributive Justice and Disability: Utilitarianism Against Egalitarianism*, *supra* 134.

This doctrine principally draws upon the work of Amartya Sen and the theory he proposed in reaction to Rawls's primary good theory of equality and averseness to welfarism. For Rawls, it was unthinkable to conceive justice in welfare egalitarian terms because some persons derive welfare from "offensive tastes" and others from "expensive tastes" and because conceptions of welfare are so diverse as to be incommensurable. Although both philosophers agree with this point, Sen shifts the debate on primary goods as *maximanda*<sup>163</sup> towards a debate focusing on the impact that primary goods can have on individuals.

Escaping morbidity, being adequately nourished, mobile, and achieving self-respect and happiness are core *functionings* that are achievable through primary goods. These *functionings* are essential states that constitute a person's being. Together, they form a person's *capability*. The welfare egalitarian justice archetype mandates that the redistribution of resources equalize *capabilities* among people.<sup>164</sup> This is where the line between health achievements and the ability to achieve good health is drawn.<sup>165</sup> A simple example illustrates this distinction. If we consider two people, the first insured but avoiding medical screening out of fear and the second uninsured

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<sup>163</sup> Human definition of maximization mechanisms.

<sup>164</sup> Sen, *Why Health Equity?* 659, supra 130.

<sup>165</sup> Roemer, *Theories of Distributive Justice*, supra 142, p.192-193.

but skipping a medical visit because of financial incapability, it is clear that these two people's welfare outcomes are the same. Nonetheless, the insured person is significantly advantaged compared to the uninsured, as she has more options and therefore greater capability. Welfare egalitarianism greatly emphasizes equality of real freedom commensurate with equality of condition. The ability to choose among options is instrumental, as it reflects a person's *capability* of achieving life plans. Thus, to achieve justice, *capabilities* must be equalized.<sup>166</sup>

Individuals are not responsible for opportunities based on their ability, but they are responsible solely for their choice of functioning vector and agency goals (life plans). This may be problematic in cases in which a person's agency goals are socially determined in a way that precludes the individual from taking responsibility for them. Welfare egalitarianism does not appear to account for the significance of personal responsibility.<sup>167</sup>

Welfare egalitarianism is also often criticized for the importance it assigns to the notion of freedom, specifically for being insensitive to the potentially negative situations that freedom can produce. Nonetheless, because the welfare egalitarian allocation process always accounts for the common good

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<sup>166</sup> *Egalitarianism* (*Stanford Encyclopedia of Philosophy*), last access (June 2014).

of the community, freedom cannot possibly be primordial in achieving justice.<sup>168</sup>

Health policies committing to the welfare egalitarian idea of justice provide equal access to health care, which grants everyone equal ability to achieve good health.<sup>169</sup> Welfare egalitarianism is more content with providing equal access to all available health care resources than to committing to the unreachable goal of providing every patient with equal health care resources.<sup>170</sup>

*iv. Equality in Treatment vs. Equality in Outcome*

In practice, a debate within the egalitarian conception of justice draws a sharp contrast between collectivist and individualist egalitarian health care policies.<sup>171</sup> Both trends agree that equality in health care is an entitlement, but collectivists posit that social institutions and the state should provide a standard package of care to the entire population irrespective of one's ability to pay for such services. The content of the health care package is fixed and provides equal resources to all individuals.

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<sup>167</sup> Roemer, *Theories of Distributive Justice*, supra 142, p.192-193.

<sup>168</sup> *ibid.*

<sup>169</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325, supra 60.

<sup>170</sup> Roemer, *Theories of Distributive Justice*, supra 142, p.192-193.

<sup>171</sup> Ronald Dworkin, *Sovereign Virtue* (2002).

Individualist egalitarians conceive of social institutions and the state as minimal insurers guaranteeing the “plain vanilla” or “bog standard” of health care services. Each individual can supplement this bare minimum by purchasing additional health care services. This trend is preoccupied with equality in outcome rather than equality in treatment. Thus, health care policies adopting an individualist egalitarian approach usually advocate voucher systems supplemented by complementary insurance schemes.

### **C. The Utilitarian Justice Archetype**

The egalitarian and utilitarian justice archetypes converge on certain aspects. For example, under both conceptions of justice, the “worse-off” individual in society is in many ways the one who can benefit the most from the allocation process. Still, fundamental differences also separate these two theories. Indeed, egalitarianism is more concerned with helping those who are the least favored in society, whereas utilitarianism is more preoccupied with helping those who can benefit the most.<sup>172</sup>

In a nutshell, utilitarianism rests on the principle that morally right policies are those that produce the greatest utility.<sup>173</sup> Utility encompasses notions of

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<sup>172</sup> Stein, *Distributive Justice and Disability: Utilitarianism Against Egalitarianism*, supra 132.

<sup>173</sup> Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* (1879).

pleasure, satisfaction, happiness, well-being, the absence of pain, and, of course, good health. Justice is the paramount and most stringent form of obligation created by the principle of utility. An act will be qualified as just only if it maximizes the sum of all individual utility.<sup>174</sup>

*i. Equal Footing of All Preferences*

Utilitarianism grants equal footing to all preferences. This conception of justice requires the production of the greatest good for the greatest number. It also gives equal weight to the legitimate interests of all affected parties.<sup>175</sup> Moral rules and norms of allocation must therefore be tested for their potential to maximize the aggregate level of utility.<sup>176</sup>

Some utilitarian theorists argue that the maximization of values goes beyond happiness to encompass knowledge, health, success, understanding, enjoyment, and personal relationships.<sup>177</sup> Therefore, utility should be measured in terms of the intrinsic value that certain actions can produce. Other theorists argue that intrinsic good lies within the preferences of the

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<sup>174</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325, supra 60.

<sup>175</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.336-337.

<sup>176</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61.

<sup>177</sup> James Griffin, *Well-being: Its Meaning, Measurement, and Moral Importance* (1988), p.67.

greatest number of individuals and, therefore, that aggregate utility is an optimal benchmark for allocation.<sup>178</sup>

Regardless of the *maximanda*, to proceed to the just allocation of resources, each person's interest must be externally and impartially considered. No preference is set aside, even if it were to produce negative externalities, and morally questionable outcomes are therefore justified on account of utility maximization. In addition, individuality has no independent force; individuals are only variants in the calculus of utility.<sup>179</sup>

The utility maximization rule is often criticized for its extreme consequentialism. Indeed, utilitarianism holds that an action is right or wrong based only on the action's consequences for aggregate utility. Ultimately, the promotion of utility determines the rightness or wrongness of the allocation process.<sup>180</sup>

Norms and rules of allocation can also be set aside to attain a higher utility level. Any action can be justified through a direct appeal to the utility principle.<sup>181</sup> This may be helpful in the formulation of "acceptable"

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<sup>178</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.337.

<sup>179</sup> *ibid.*, p.340.

<sup>180</sup> *ibid.*, p.336.

<sup>181</sup> *ibid.*, p.339.

preferences, as morality problems may arise from the maximization of immoral preferences.<sup>182</sup>

Also objectionable is utilitarianism's tolerance for unequal distribution. The interests of the majority can potentially override the rights of the minority. For example, an already prosperous group could be given priority over resources that would also benefit an indigent group, based on the fact that the prosperous group's aggregate utility is greater than the utility the indigent group could derive from these resources.<sup>183</sup>

Thus, utilitarianism has the potential to create a "tyranny of the majority." The majority's preferences may override those of the minority if an increase in aggregate utility justifies those preferences, regardless of the minorities' rights. This is because utilitarianism is indifferent to oppressive distribution. It validates the empowerment of the majority to see its preferences fulfilled while potentially crushing the minority. Just distribution does not imply a fair distribution, only a utility-maximizing process.<sup>184</sup>

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<sup>182</sup> *ibid.*, p.341.

<sup>183</sup> *ibid.*, p.342.

<sup>184</sup> *ibid.*

*ii. Priority-Setting and the Ranking of Patients' Needs*

Utilitarian policies in health care justify the maximization of the aggregate utility and the ranking of patients' needs to establish prioritization processes. An assessment of the burden that a disease creates is irrelevant. The only objective of utilitarian health care systems is to provide cost-efficient health services.<sup>185</sup>

Furthermore, priority access to health services is given to patients who have the most potential to improve society's aggregate health status. Treatments and health care services are empirically tested for their utility, and results are interpreted in numbers of life years gained (indexed to the quality of life of those years). The greater the number of years gained as a result of the treatment, the higher it ranks on the priority list. Treatment and health care services bearing high costs or that benefit only a small group of individuals are more likely to be relegated to the bottom of the ranking. Consequently, individuals requiring the "lowest-priority" treatments receive the least care.<sup>186</sup>

Although utilitarianism in practice does raise some ethical questions, it is not exclusively the doctrine of health care managers and technocrats. Many

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<sup>185</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325, supra 60.

<sup>186</sup> *ibid.*

advocates of social programs for the protection of public health and the equal and universal distribution of basic health care also adopt this approach.<sup>187</sup>

#### **D. The Communitarian Justice Archetype**

Love and solidarity are the foundations of the communitarian justice theory. Communitarianism posits that fairness and equality should not preclude individuals from forgoing their rights to help other individuals, their community, or society as a whole. Justice is simply a vehicle that enables individuals to make genuine voluntary decisions by providing them with an appropriate structure to construct loving relationships free of domination, subordination, and corruption.<sup>188</sup>

Communitarians define the community as a small group of individuals or institutions with set goals, roles, and obligations. The community exists in the form of common social practices, cultural traditions, and shared social understanding. The smallest communal unit is the family, in which parents and children join together in the realization of their goals, roles, obligations,

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<sup>187</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61, p.9.

<sup>188</sup> *ibid.*, p.199.

social practices, and traditions.<sup>189</sup> Members of the community must appreciate their shared history, culture, and common attitude towards welfare in order to establish principles for the just allocation of communal resources.<sup>190</sup>

Communitarian theorists believe that the idea of community precedes the idea of justice, because the latter is a tool to achieve greater solidarity. Attending to the needs of the community supersedes the realization of personal achievements or the satisfaction of individual needs for liberty or equality.<sup>191</sup> To achieve justice, resources must be employed strictly to fulfill community-endorsed social goals.<sup>192</sup>

Moreover, the communitarian doctrine rejects liberal social models based on interpersonal relationships, rights and contracts, and thus the private provision and financing of health care resources. Access to health care should be based neither on an individual right nor on wealth. With the goal of benefitting the community as a whole, health care resources must be distributed in proportion to illness at the local and the community level.<sup>193</sup>

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<sup>189</sup> *ibid.*, p.209.

<sup>190</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.357.

<sup>191</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61, pp.210-211.

<sup>192</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.337-399.

<sup>193</sup> Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (1983), pp.86-94.

*i. The Importance of Solidarity with Respect to Relative Social Values*

Shared practices and their understanding within a community are the essential underpinnings of a just distribution of resources.<sup>194</sup>

Communitarianism is not concerned with building an identity *de novo*; to the contrary, it favors the natural emergence of justice from values of social goods already ingrained within the community.

According to Michael Walzer, “a society is just if it acts in accordance with the shared understanding of its members, as embodied in its characteristic practices and institutions. Hence identifying principles of justice is more a matter of cultural interpretation than of philosophical argument.”<sup>195</sup>

Although ideal, the complete consensus required by the communitarian doctrine is virtually unattainable. Therefore, for the doctrine to endure and to achieve the just allocation of resources for the community, allocation issues must be addressed with some novelty.<sup>196</sup> Thus, in recent years a new form of communitarianism has emerged that combines a liberal and more

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<sup>194</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61, p.209.

<sup>195</sup> Walzer, *Spheres of Justice: A Defense of Pluralism and Equality*, supra 193.

<sup>196</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325 , supra 60.

individualist conception of justice with the idealistic goals of communitarianism.<sup>197</sup>

Initially, communitarian theorists were unable to see the benefits of adopting a more liberal approach for the distribution of resources, perhaps because they perceived the liberal doctrine as incapable of promoting values of cooperation or of conceiving free goals and obligations derived from communal ideals. To them, liberalism did not present individuals as parts of a global socio-economic environment.<sup>198</sup>

Despite these critiques, communitarianism has enacted a moderate shift towards liberalism. It now perceives the community as an active participant in the upbringing of self-governing individuals. The community should provide sufficient resources for individuals to function and develop as independently as possible from community boundaries in order to achieve their life goals.<sup>199</sup>

Finally, health care systems adopting a communitarian approach for the allocation of resources emphasize the role of primary care medicine at the community level. For this, these systems monitor and cater to the health care

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<sup>197</sup> Amitai Etzioni, *The Essential Communitarian Reader* (1998).

<sup>198</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.357-358.

needs of populations located in secluded, rural areas and promote the decentralization of health care services.

In some western welfare states, medical homes emerged in the 1960s from a communitarian approach to the practice of medicine.<sup>200</sup> Medical offices were slowly transformed into small clinics and started to centralize medical records, which made it easier to provide primary care services at the community level. During this time, the importance of serving children and families in an environment that encouraged deeper relationships between health care providers and their patients was recognized. The innovative idea of medical homes reflected a bottom-up, grassroots approach to the delivery of care. Today, medical homes still provide primary care services and promote wellness and early prevention.<sup>201</sup>

*ii. Common Good Before Individual Entitlements*

The communitarian justice theory proposes a contextualized approach to allocation issues<sup>202</sup> by focusing on conventions, traditions, and loyalties within the community.<sup>203</sup> Protecting rights to equality and liberty is

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<sup>199</sup> Etzioni, *The Essential Communitarian Reader*, supra 197.

<sup>200</sup> Calvin Sia et al., *History of the Medical Home Concept*, 113 *Pediatrics* 1473 (2004).

<sup>201</sup> *ibid.*

<sup>202</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61, p.209.

<sup>203</sup> Beauchamp & Childress, *Principles of Biomedical Ethics*, supra 16, p.356.

secondary to attending to the community's needs.<sup>204</sup> A duty to protect the Common Good is also incumbent on all members of the community. Thus, individual rights and freedoms may be forfeited to ensure that the "politics of the Common Good" endure. Individual preferences are given more or less weight, depending on their contribution to the Common Good. They can also be discarded if they conflict with the community's idea of the Common Good.

Accordingly, in the realm of health care, the distribution of resources should not be based on individual needs but should reflect the community's idea of what constitutes necessary health care. Public consultations are often used to survey the community and to set goals in these health care systems. Thus, within a single communitarian health system, different allocation processes might emerge to palliate different conceptions of need.<sup>205</sup>

#### **IV. Conclusion**

In theory, distributive justice archetypes provide guidelines to enact the just allocation of health care resources. Indeed, the nature of health care and its contribution to the Common Good grant health care resources a special attribute. Because of this, health care mandates the just allocation of its

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<sup>204</sup> Kymlicka, *Contemporary Political Philosophy : An Introduction*, supra 61,p.209-273.

resources, and no single conception of justice appears more just for this task. Therefore, to verify whether this assumption has been adopted in practice, it is important to test each of these archetypes against the discourses that have led to the enactment of health care allocation laws.

Thus, the analytical framework developed in this chapter provides the essential reading grid to determine whether just motives were at the origins of the most crucial health care reforms in the American and British systems over the past 70 years.

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<sup>205</sup> Hoedemaekers & Dekkers, *Justice and Solidarity in Priority Setting in Health Care*, 325 , supra 60.

## CHAPTER TWO:

### A Case Study: The American Health Care System

*The Role of Justice and the For-Profit Sector in the Construction and Evolution of a Private Health Care System*

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#### I. Introduction

Health care in the United States confronts a series of related, conflicting, yet distinct problems. These issues divide the nation politically, not because of the nature of these problems but because of the controversy surrounding the potential solutions.<sup>206</sup> Issues affecting the accessibility, adequacy, costs, and efficacy of health care services result from a multiplicity of historical events. Even though solutions have been proposed to palliate these ills, a path of dependence installed by a prominent for-profit sector has impeded efforts to adequately cure the system.

Contrary to many politicians and academics who consider American health care legislation to result from purely pragmatic and market-driven choices,<sup>207</sup> I believe that the allocation of health care resources in the United States is partly inspired by ideas of justice. Thus, in this chapter I evaluate whether the four conceptions of justice composing the analytical framework have

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<sup>206</sup> Annas et al., *American Health Law*, supra 21, p.2.

<sup>207</sup> Carpenter, Esterling & Lazer, *The Strength of Weak Ties in Lobbying Networks Evidence from Health-Care*

influenced the negotiation and drafting of crucial health care reforms in the United States.

At first glance, it seems that despite the Congress's desire to produce just laws for the allocation of health care resources, the resulting policies have generated suboptimal outcomes. According to the definition of justice developed in the introduction, American health care allocation laws can be deemed just, as they are concerned with rectifying an "unjust" distribution of resources to produce a more harmonious society. All the reforms discussed in this chapter aim to correct the unfairness of being deprived of health care services, whether the goal is to provide health care resources to a vulnerable group or to a community struggling to access care.

Perhaps failures in the realm of health care should not be attributed to a lack of justice but to a path of dependence ingrained in the system's structure. This is why examining the role of justice in the distribution of health care resources alone is insufficient to explain these outcomes. The analysis must include an inquiry on the roles played by the three most influential actors in American health care policy: corporations, insurers, and the medical association. This inquiry is essential in order to understand whether these

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*Politics in the United States*, 417, *supra* 2.

actors have impacted the drafting of these reforms and/or whether they were inspired by any conception of justice during negotiations. We must shed light on the pressures placed on the legislative apparatus during the preparatory stages.

I begin the chapter with a brief historical overview to flesh out the main policy trends leading to the development of this path of dependence. I pay particular attention to the role played by corporations at the pooling and financing levels, to expose their influence on the construction of the health care system. Through this analysis, I also shed light on how insurers and the medical association have participated in the construction and evolution of this privately run system. Finally, using the analytical framework developed in Chapter One as a reading grid, I analyze specific policy moments and discourses in the preparatory work leading to pieces of legislation in order to determine the impact, if any, of these conceptions of justice on the drafting of health care laws in the United States.

## II. The American For-Profit Sector: The Instigator of a Dangerous Path of Dependence

During the course of the twentieth century, medical technology expanded, prompting a shift in the American population's expectations and an increase in the provision of health care services. Health care expenses had reached an unprecedented high. Simultaneously, social relations became more deeply embedded, and physician-dominated private insurance plans crystalized vested interests. This sequence of events and its development significantly informed the consolidation and institutionalization of health care in the United States. The way in which these phenomena interacted with more fluid elements of a broader social context must be elucidated.<sup>208</sup>

Analyzing the role of the for-profit sector in financing and providing health care services in the United States begins with but is not limited to an assessment of the roles of employers, doctors, and insurers in this system. The analysis also implies particular attention to the government's involvement in constructing this private health care system so that we can ultimately determine whether theories of justice have underwritten the

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<sup>208</sup> Pierson, *Not just what, but when: Timing and Sequence in Political Processes*, 72 , supra 38.

negotiation and initial drafting stages of health care financing and provision laws in the United States.

### **A. Employers vs. Unions: The Creation of Pooling and Insurance Mechanisms**

Examining the for-profit sector's role in the American private health care system requires a historical and thematic analysis rather than proceeding with a raw legislative chronology. Nonetheless, some basic chronological benchmarks must still be presented.

From the early twentieth century until the end of the 1920s, the demand for health care was small, and insurance needs were nonexistent. As treatment options began to develop, life expectancy remained low. A universal health care project mimicking health reforms in Europe was then nipped in the bud. Advances in technology and increasing health care costs due to the development of hospitals<sup>209</sup> drove private insurers, which until that point had been reluctant to enter the health market for fear of moral hazard and adverse selection, to propose private coverage alternatives.<sup>210</sup>

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<sup>209</sup> Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (1995).

<sup>210</sup> Melissa A. Thomasson, *From Sickness to Health: The Twentieth-Century Development of US Health Insurance*, 39 *Explorations in Economic History* 233 (2002).

Insurance premiums based on community ratings that distributed the cost of health care among most of the population were created in the 1930s. In the 1940s and until the 1950s, employers also increasingly began to provide coverage for their employees. In the interest of keeping costs low, premiums were based on the use of health care services by each employee group.<sup>211</sup>

Indeed, in the 1940s, private and employer-based insurance took a great leap forward. The economy was moving towards full employment, manufacturing methods were improving, and urbanization was accelerating. The Internal Revenue Service also made a crucial administrative decision: Insurance benefits were deemed taxable services to be repaid with pre-tax dollars to corporations. Thereby, the cost of private coverage was reduced, thanks to the tax savings.

It was only in the 1950s that health care coverage combining both private action and public programs through tax subsidies was brought to the middle class.<sup>212</sup> This period also marked the heyday of American medicine. Competition was properly controlled, support for medical education came from public and philanthropic sources, and licensing laws ensured

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<sup>211</sup> Randall R. Bovbjerg, Charles C. Griffin & Caitlin E. Carroll, *US Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 *The Journal of Law, Medicine & Ethics* 141 (1993).

<sup>212</sup> *ibid.*

protection. Third-party payment schemes were also developed to provide the efficient reimbursement of services. Thanks to this system, the practice of medicine escaped any form of “socializing.” Paradoxically, state and federal moneys were spent on public health services, welfare medicine, research, and hospital construction.<sup>213</sup>

In the 1960s, the system of private insurance was in full force, but certain vulnerable groups remained uninsured. Medicaid and Medicare were then enacted to cater to the aged and those who were medically indigent.<sup>214</sup> In the 1970s, the system took another step towards private coverage. To reduce costs, large enterprises opted for self-funding or self-insurance. They were able to use corporate funds to pay the costs of their employees’ health care coverage and thereby reduce the insurers’ role to mere administrative functions. Narrower insurance pools slowly led to a price increase and began to constitute a substantial threat to the entire system’s stability. Many self-insured employers feared the financial consequences of having chronically ill employees. Risk-spreading was limited to a small category of individuals who

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<sup>213</sup> Jill Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance* (2005).

<sup>214</sup> Thomasson, *From Sickness to Health: The Twentieth-Century Development of US Health Insurance*, 233 , supra 210.

could neither bear nor dilute the costs. A shift towards a wider pool of insurance was imminent.<sup>215</sup>

During the 1980s, America discovered AIDS; a decade later the country became aware of the disease's impact on the insurance system. Although health insurance schemes have dramatically and negatively affected seropositive and chronically ill, insured people, AIDS and chronic illnesses have posed only a minor threat to the health insurance industry. There has always been a fundamental inevitable and irresolvable contradiction between society's need to establish equity in the provision of health care and the insurance industry's need to safeguard its profitability and efficiency.<sup>216</sup>

Currently, the financing of care in America remains largely operated by private insurers. Their capacity to reduce liability and to increase their profit margins by applying drastic underwriting rules guides health policy and has left a great portion of the population in the hands of publicly funded programs that exhaust governmental budgets.<sup>217</sup>

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<sup>215</sup> Robert A. Padgug & Gerald M. Oppenheimer, *AIDS, Health Insurance, and the Crisis of Community*, 5 Notre Dame JL Ethics & Pub.Pol'Y 35 (1990).

<sup>216</sup> *ibid.*

<sup>217</sup> In 2011, together Medicare and Medicaid represented 49% of the total National Health Expenditure, leaving only 33% of the spending on private care and many uninsured, *NHE Fact Sheet*, Centers for Medicare & Medicaid Services, 2011, last accessed 2 October 2013.

*i. The Role of the Labor Unions in the Creation and Organization of Employer-Sponsored Insurance*

For a majority of Americans, employer-sponsored insurance constitutes the main financing source of health care services.<sup>218</sup> Understanding its operations and evolution is central to an analysis of the role of for-profit organizations in constructing the American health care system.

Over the years, employers have created a work-based risk pool in which healthy, low-risk participants subsidize the health care costs of higher-risk employees.<sup>219</sup> In many respects, employer-based insurance has provided the essential underpinnings for the current insurance system and has become a form of private social security. If it were to disappear, health care coverage for many employees and many Americans would be seriously compromised.<sup>220</sup>

History reveals that two wartime tax laws clearly contributed to the privatization of insurance services. First, the Revenue Act was enacted in 1942 to prevent profiteering through the taxing of excess profits made on

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<sup>218</sup> In 2012, 54.8% of Americans received health care coverage from their employers according to the U.S. census bureau.

<sup>219</sup> David Blumenthal, *Employer-Sponsored Health Insurance in the United States-Origins and Implications*, 355 N. Engl. J. Med. 82 (2006), the population of uninsured in 2010 was of 49.9 million.

<sup>220</sup> Paul Starr, *The Social Transformation of American Medicine* (1982).

corporate earnings. Only profits higher than pre-war levels were taxable, and employer contributions to health insurance were excluded from the calculation. The goal was to create an incentive to reduce excess profits through the creation of fringe benefits, while the funds were kept in trusts.<sup>221</sup> Second, the National War Labor Board's 1943 decision to make employers' contributions to employees' benefit plans a substitute for wage increases also accelerated the privatization of health insurance.

The private insurance plan phenomenon also resulted from a revolution driven by the mining sector. In fact, the 1946 strike led by John L. Lewis, President of the United Mine Workers, triggered a major change in workers' health coverage. The risk of lung disease and work accidents for mine workers weighed heavily on their families and became the object of great concern among the workforce.

Mine owners were thus urged to contribute to the coverage of their workers' medical costs. In the event of death or a work accident, employer insurance would offer a stable source of income to the worker's family. A precedent was set, and many other unions followed, but unfortunately insurance prices skyrocketed. The unions' political averseness discouraged them from seeking

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<sup>221</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 211, p.50.

governmental help and led them to negotiate health and accident coverage as part of collective bargaining benefits.<sup>222</sup>

Over more than two decades, from 1940 to 1966, the number of privately insured people increased from six to more than 75 million.<sup>223</sup> This sudden upsurge was due to two factors. First and most important was the Great Depression. Although the federal government was forced to ration goods, factories ramped up production and needed more workers. Thus, insurance and benefit packages became the only way to attract and retain a much-needed workforce.<sup>224</sup>

Second was the emergence of trade unions. By 1946 nearly one-third of American workers belonged to a union.<sup>225</sup> The efforts of unions to enroll their members in various insurance plans had paid off. The demand for coverage pushed the labor movement to seek alternative solutions in addition to the already existing state-run welfare programs.

Nonetheless, when President Truman turned to union leaders for support and the endorsement of his national health insurance project, he was given the cold shoulder. Thus, in 1946 Congress passed a resolution calling for

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<sup>222</sup> *ibid.*, p.48.

<sup>223</sup> *ibid.*, p.49.

“Security Through Bargaining”; from then on, unions were to secure health benefits through collective bargaining contracts. The shortage in coverage and an accident of history drove organized labor away from federal programs and led it to pursue a private benefit system instead.<sup>226</sup>

The rough aftermath of the war made businesses more hostile to the unions’ rising ambitions. In an era characterized by labor-management struggles, collectively bargained health benefits became a weapon of choice to recruit and retain unionized employees. Although trade unions had been unsuccessful in obtaining higher wages and were bound by the no-strike pledge, health and pension benefits were still negotiable through collective bargaining agreements.<sup>227</sup>

Simultaneously, commercial insurers were aggressively marketing group health insurance policies. These plans became popular with employers because they allowed them to provide benefits to employees while building their corporate identity independently from the unions.<sup>228</sup> In non-unionized firms, employers purchased insurance packages on a massive scale in the hopes of keeping the unions at bay. In unionized firms, employers also

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<sup>224</sup> *ibid.*

<sup>225</sup> *ibid.*, p.46-76.

<sup>226</sup> *ibid.*, p.51.

<sup>227</sup> *ibid.*

offered health coverage to dissuade other employees from joining the ranks of a union that offered health benefits.<sup>229</sup>

Later in history, the Employee Retirement Income Security Act (ERISA) became law in 1974. ERISA was intended to offer protection to employees against pension funds and benefits investors. Although the Act was never meant to target employer-sponsored insurance, it had a profound impact on the health insurance sector. Employers covering their employees' health care costs benefitted from significant advantages due to the state regulation exemption.<sup>230</sup> Self-insuring employers were able to avoid the cost linked to the state mandates that required particular services to be covered, and they were free to design insurance packages without obtaining any regulatory approval.<sup>231</sup>

In the 1980s, the difficult economic context of the post oil-shock period triggered another increase in insurance prices. Large corporate employers were keen on finding solutions; they knew that cost-containment measures had to be established. Thus, they decided to circumvent insurance

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<sup>228</sup> *ibid.*, p. 52.

<sup>229</sup> *ibid.*

<sup>230</sup> Donald W. Moran, *Whence and Whither Health Insurance? A Revisionist History*, 24 *Health Aff.* 1415 (2005); Sylvester J. Schieber, *The Future of Retiree Health Benefits in Higher Education in the United States*, Recruitment, Retention and Retirement in Higher Education: Building and Managing the Faculty of the Future 101 (2005).

<sup>231</sup> Blumenthal, *Employer-Sponsored Health Insurance in the United States-Origins and Implications*, 82, *supra* 219.

companies to become autonomous.<sup>232</sup> Directly entering rate negotiations with hospitals and physicians, employers saw their administrative costs drop. Over the course of only 10 years, self-insurance increased by 40% and became the main market trend.<sup>233</sup>

For their part, insurance companies began to aggressively pursue alternative markets to compensate their losses.<sup>234</sup> Insurers wanted to impose managed-care plans to force employers into complex negotiations with the providers. They promoted network providers and health maintenance organizations to increase their sales of prepaid insurance products.<sup>235</sup>

In hindsight, it is clear that ERISA was the main destabilizing factor that caused the employer-employee insurance equilibrium to crumble, because it indirectly generated some form of adverse selection on the part of large employers. This law gave large employers the opportunity to remove their healthy and better-paid employees from the mainstream insurance risk pool, driving up smaller employers' insurance prices and thus making it more

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<sup>232</sup> Jon R. Gabel & Alan C. Monheit, *Will Competition Plans Change Insurer-Provider Relationships?* The Milbank Memorial Fund Quarterly, Health and Society 614 (1983).

<sup>233</sup> William G. Weissert, *Medicare Rx: Just a Few of the Reasons Why it was so Difficult to Pass*, 13 Public Policy and Aging Report 1 (2003); Lawrence D. Weiss, *EXCELLENT BENEFITS-CLINTON EMBRACES THE PRIVATE HEALTH-INSURANCE INDUSTRY*, 23 Socialist Review 49 (1993).

<sup>234</sup> Thomas Bodenheimer, *Should we Abolish the Private Health Insurance Industry?* 20 International Journal of Health Services 199 (1990).

<sup>235</sup> Jill Quadagno, *Why the United States has no National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945-1996*, J. Health Soc. Behav. 25 (2004).

difficult for these small employers to participate in the employer-sponsored insurance system.<sup>236</sup>

*ii. The Danger of Having Corporations as Main Pooling and Financing Entities*

More generally and more recently, in the United States, heavy dependence on employer-sponsored coverage has forced the overall structure of social protection to rely indirectly on corporate America's ability to manage and absorb health care expenses. In addition, the cost of acquiring labor now comprises the sum of wages plus health benefit costs. Thus, to remain profitable and cope with increasing health insurance costs, employers are forced to reduce cash wages or their participation in employees' health benefits.<sup>237</sup> With this, the burden of health care financing is shifted to the employee. Total compensation is directly subject to market forces, and the market's fluctuations indirectly influence the price of health care coverage.<sup>238</sup>

Clearly, corporations play a major role in financing but also in fixing health insurance prices. Health care coverage now correlates to the success and fortune of U.S. businesses. If an American employer "closes shop," it takes with it the health insurance benefits of all employees. For the most part,

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<sup>236</sup> Moran, *Whence and Whither Health Insurance? A Revisionist History*, 1415, supra 230.

<sup>237</sup> Blumenthal, *Employer-Sponsored Health Insurance in the United States-Origins and Implications*, 82, supra 219.

circumstances that have nothing to do with the health care system itself profoundly affect the health care coverage of many Americans.<sup>239</sup>

## **B. The Empowerment of the “Blues” and the Rise of Commercial Health Coverage**

After the 1932 elections, President Roosevelt abandoned his universal health care plan, which had been inspired by the work of the Committee on the Cost of Medical Care. The idea was to unite the prepaid financing of health care services with a system of physicians’ group practice, to combat the financing problems triggered by the Great Depression and to create a rational universalization of the American health care services. Roosevelt and the New Dealers believed that these solutions could potentially better finance the system and make health care available for the entire population;<sup>240</sup> nonetheless, the President could not afford to turn his back on the medical profession. He knew that if he did not abandon his universal project, the American Medical Association (AMA) would doom the passage

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<sup>238</sup> *ibid.*

<sup>239</sup> *ibid.*

<sup>240</sup> Lawrence David Brown, *Politics and Health Care Organization: HMOs as Federal Policy* (1983); Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, *supra* 211.

of the entire 1935 Social Security Act in order to protect the association's autonomy and its interests. Thus, the project was nipped in the bud.<sup>241</sup>

This decision left a void in coverage and health protection options. Private insurance companies promptly emerged to fill the gap. First to offer alternatives were the non-profit "Blues": Blue Cross and later Blue Shield; their success paved the way to commercial for-profit insurers.<sup>242</sup>

*i. The Great Depression: a Fertile Ground for the "Blues"*

The harsh times of the Great Depression brought hospitals to the brink of financial ruin. The American Hospital Association (AHA) had to stabilize sources of income without allowing external forces to impose any form of control over the delivery of health care services. Adequacy of care and cost issues coupled with the AMA's opposition to the publicly sponsored health care system led to the advent of prepayment insurance.<sup>243</sup>

Physicians were initially opposed to third-party financing schemes. The AMA believed that the economic advantages generated by this insurance system could not offset a potential loss of control or autonomy. Later,

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<sup>241</sup> Richard Harris, *A Sacred Trust* (1966).

<sup>242</sup> Thomasson, *From Sickness to Health: The Twentieth-Century Development of US Health Insurance*, 233, *supra* 208.

acceptance of private prepayment schemes to cover hospitalization costs resulted from a compromise and with the assurance that the traditions and ideology of American medicine would remain carefully protected.<sup>244</sup> This explains why the initial Blue Cross plan included no provision regarding the role or duties of physicians.

The plans were basic but efficient: in exchange for a small monthly fee, Blue Cross would provide its subscribers with coverage for the cost of hospital care, and in the event of hospitalization, the company would pay hospitals for their services irrespective of the price of treatment and without limitations.<sup>245</sup> Single-hospital plans disappeared as subscribers were given the opportunity to choose their hospital and physician. The AHA had also been careful in drafting the Blue Cross guidelines, making sure that competition among treatment facilities was reduced to a minimum.

Blue Cross insurers were also awarded the status of non-profit corporations because of the benefits they provided to American society and their charitable purpose, which was to free low-income individuals from the

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<sup>243</sup> Annas et al., *American Health Law*, supra 21, p.17.

<sup>244</sup> *ibid.*, p.15

<sup>245</sup> *ibid.*, p.20.

burden of hospitalization costs. They were offered tax relief through state legislation that excluded them from traditional insurance regulations.<sup>246</sup>

These insurance plans were advantageous for the insured and the service providers. Hospitals were finally getting a fixed and constant source of income, and subscribers were able to afford hospital care.<sup>247</sup> Blue Cross plans spread rapidly. In 1938 only 100,000 out of 1.4 million patients had indemnity coverage; by the end of 1946, nearly one in five Americans was enrolled in a services-benefit plan.<sup>248</sup>

Finally, to preserve their independence and keep the Blue insurers out of their areas of practice, physicians organized a network of prepaid plans to cover their own service fees. The AMA also adopted guidelines preventing Blue Cross hospital service plans from underwriting physician services, but this fueled the ambitions of those who proposed compulsory medical insurance.<sup>249</sup> Thus, voluntary health insurance remained under physicians' supervision, and price discrimination privileges persisted (i.e., the practice of

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<sup>246</sup> Robert D. Eilers, *Regulation of Blue Cross and Blue Shield Plans* (1963).

<sup>247</sup> Thomasson, *From Sickness to Health: The Twentieth-Century Development of US Health Insurance*, 233 , *supra* 210.

<sup>248</sup> Annas et al., *American Health Law*, *supra* 21, p.19.

<sup>249</sup> Fredric R. Hedinger, *The Social Role of Blue Cross as a Device for Financing the Costs of Hospital Care: An Evaluation* (1966), p.82.

charging different rates to different customers based on their ability to pay).<sup>250</sup>

*ii. The Contribution of Blue Insurers to the Success of Their Commercial Counterparts*

Until the 1940s, the indemnity insurance market was not profitable because of unpredictable actuarial losses and moral hazard risks. After the war, however, employer-sponsored coverage had changed the face of the insurance industry and enabled commercial insurers to participate in a new market.<sup>251</sup> Insurance gradually became a vehicle for funds between the patient and health care service providers, but it was not to be used as an instrument to oversee or manage the patient-provider relationship.<sup>252</sup>

The “Blues” had opened the door to commercial health coverage, proving that the insurance market was potentially lucrative. Commercial insurers targeting groups of young and healthy individuals later entered the market, as

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<sup>250</sup> Thomasson, *From Sickness to Health: The Twentieth-Century Development of US Health Insurance*, 233 , supra 210.

<sup>251</sup> Annas et al., *American Health Law*, supra 21, p.20-21.

<sup>252</sup> Donald W. Light, *The Restructuring of the American Health Care System*, Health Politics and Policy 46 (1997).

they understood that these insured represented a great opportunity for profit without adverse selection.<sup>253</sup>

Overall, the limited scope of the Blue Cross and Blue Shield plans and their non-profit status contributed to the rise of commercial insurers. Blue insurers were tied to community ratings, charging a flat fee to all the insured irrespective of their medical history or risk factors. Commercial insurers, in contrast, were not bound by this status and therefore began to engage in experience rating, charging higher premiums to sicker applicants or to customers representing a great health risk. As a result, commercial insurers offered more competitive prices to healthy groups and took a fair share of the Blue insurers' market.<sup>254</sup>

### **C. Conflicting Values: Market, Costs, Access, and Equality**

From its inception, the American health care system and the debate surrounding its organization have generated severe underlying tensions. At this stage of the analysis, it is important to closely examine some of the themes, arguments, and policy trends that have influenced health care policy-makers in the United States for the past 70 years.

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<sup>253</sup> Thomasson, *From Sickness to Health: The Twentieth-Century Development of US Health Insurance*, 233 , supra 210.

<sup>254</sup> *ibid.*

The distribution of power and the allocation choices made by the federal government have constantly impacted states' apportionment of health care resources. Unfortunately, the organization of politics has led to an unbalanced division of powers. Although the states' responsibilities overlap with those of federal powers regarding the implementation of Medicaid, the federal lever alone is accountable for Medicare.<sup>255</sup>

The United States is also the only industrialized nation in the world where medical protection is not universally guaranteed. The insured hold the short end of the stick in a system governed by private insurers. Underwriters govern the system and act as its gatekeeper.<sup>256</sup>

Finally and most interestingly, solutions to issues of access, quality, costs, professional autonomy, government regulation, and market competition have oscillated between opposed policy-making philosophies. At one end of the spectrum is the egalitarian model of distribution, and at the other is the market competition model of allocation.<sup>257</sup>

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<sup>255</sup> Bovbjerg, Griffin & Carroll, *US Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 141, supra 211.

<sup>256</sup> Light, *The Restructuring of the American Health Care System*, 46 ; Timothy S. Jost, Disentitlement?: The Threats Facing our Public Health-Care Programs and a Rights-Based Response (2003).

<sup>257</sup> Annas et al., *American Health Law*, supra 21, p.33-40.

All of these phenomena stem in part from a strict division within the structure of the health care system. Policy-makers have at times adopted conflicting approaches to the allocation of health care resources because of the division between the financing and the delivery of health care services. Adding to this awkward structure, the path of dependence created by the for-profit sector also negatively impacts the American economy and the country's competitiveness.<sup>258</sup>

*i. The Third-Party Payer Issue: The Divorce Between Financing and Health Care Delivery*

During the 1940s and 1950s, the development of the third-party financing system and the fee-for-service reimbursement method planted the seeds of cost-related issues. Initially not apparent, cost issues emerged in the 1960s and became critical in the 1980s. Perhaps consumers were more concerned with the extent of their coverage than with the rising premiums or out-of-pocket payments. Nonetheless, these practices during this period set a dangerous path of dependence.

The reimbursement arrangements built into private insurers' schemes have created incentives to provide marginally beneficial or even unnecessary

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<sup>258</sup> *ibid.*

health care services. Premiums are on the rise now more than ever, and little pressure is placed on the insurers. The insured also receive no guarantees that they will be fully covered if an insurance event were to materialize.<sup>259</sup>

Unlike in any other western welfare state, the American government relies almost solely on the private sector to finance health care services, through employer-sponsored insurance and large insurance companies.

The American health care system divorces the means of financing from the provision of service. In none of the protection structures, whether based on service-benefit plans or on indemnity coverage, does the insurer integrate the provider into the financing scheme. No third-party payer can exercise control over the providers, be they physicians or hospitals.<sup>260</sup>

*ii. Equal Distribution vs. Market Competition*

Two distinct philosophical theories with conflicting principles guide the allocation of health care resources in America. On the one hand, the equality theory adopts resource egalitarian principles of distributive justice and holds that health care should be distributed equally irrespective of race, gender, income, or social status. On the other hand, the market competition theory

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<sup>259</sup> *ibid.*

holds that health care must be subject to “supply and demand forces” and should be purchased on the market, just like any other commodity.<sup>261</sup>

American liberal philosophers have focused on why health care is special and why it should or should not be treated as a commodity, whereas doctors are more interested in getting their fair share of the health industry’s profits and insist on a fee-for-service and cost-based reimbursement approach.<sup>262</sup>

Conservative philosophers, for their part, provide a link between the medical association’s ideology and market competition principles. They posit that if doctors and hospitals are to treat health care as a commodity for their profit, the same should be offered to patients. It would be ludicrous to deny consumers or third-party payers economic leverage by taking health care services outside of the realm of trade.<sup>263</sup> Conservatives believe that only market forces can keep providers in check and grant consumers sufficient freedom.<sup>264</sup>

In reality, it may simply be American society’s craving for efficiency that has led it to commit to the idea of market competition. Unfortunately, this

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<sup>260</sup> *ibid.*

<sup>261</sup> *ibid.*

<sup>262</sup> *ibid.*

<sup>263</sup> Arnold S. Relman & Uwe E. Reinhardt, *Debating for-Profit Health Care and the Ethics of Physicians*, 5 *Health Aff.* 5 (1986).

<sup>264</sup> Annas et al., *American Health Law*, *supra* 21, p. 37-40.

allocation method is unlikely to be generous with subsidies or careful in the implementation of health policies, a point repeatedly confirmed by history.<sup>265</sup> The triumph of this conservative ideology has pushed the American for-profit sector to fulfill social responsibilities that governments provide for in all other western welfare states.<sup>266</sup>

*iii. Are Health Care Costs Putting a Damper on Corporate America's  
Competitiveness?*

The United States spends more than any other industrialized country on health care. An estimated two trillion dollars is allocated annually to the health care budget. Political analysts have argued that such costs are negatively impacting the economy and make American businesses less competitive globally.<sup>267</sup>

It is true that health care is by far the most expensive of employer-sponsored benefits.<sup>268</sup> Small and large corporations are too involved with sponsoring substantial health care insurance bills. Statistics show that employer-

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<sup>265</sup> *ibid.*, p.35.

<sup>266</sup> Blumenthal, *Employer-Sponsored Health Insurance in the United States-Origins and Implications*, 82 , supra 217.

<sup>267</sup> *Health Care and Competitiveness - Health Competitiveness - Chernow and Levy 8-27.Pdf*, last accessed 26 August 2013.

<sup>268</sup> Lee Hudson Teslik & Toni Johnson, *Healthcare Costs and US Competitiveness*, Backgrounder (New York, NY: Council on Foreign Relations (2007)).

sponsored coverage among low-income workers is currently declining,<sup>269</sup> contrasting sharply with the steep 114 percent increase in workers' health premiums over the past decade.<sup>270</sup> The Research And Development Corporation's (RAND) research shows that industries with the highest levels of employer-sponsored coverage have the slowest growth. These swelling figures have placed financial constraints on businesses and have created a serious competitive disadvantage on the international scene.<sup>271</sup>

Employer-sponsored insurance now translates into a "triple-taxation" scheme for businesses. First, employers pay for insurance programs through health benefits; second, they indirectly subsidize federal programs (Medicare and Medicaid); and third, they pay higher insurance premiums for a small pool of insured, whereas a large portion of the population remains uninsured.<sup>272</sup>

It must be noted that some scholars are more optimistic and moderate regarding the negative effects that health care costs might have on the United States' competitiveness. Chernew and Levy argue that it is the integrated global economic context that creates the false impression that

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<sup>269</sup> *High and Rising Health Care Costs - Robert Wood Johnson Foundation*, last accessed August 26, 2013.

<sup>270</sup> *ibid.*

<sup>271</sup> Teslik & Johnson, *Healthcare Costs and US Competitiveness*, *supra* 268.

<sup>272</sup> *ibid.*

America's health care system impairs its ability to compete internationally. According to these authors, even if health care costs affect some sectors more than others, the aggregate American competitiveness is not significantly impacted.<sup>273</sup>

### **III. Legislative Benchmarks in Health Care: An Example of Just Distribution?**

In this section I examine key legislation directly relating to the development of the American health care system. I lay out the historical context surrounding these acts by presenting the for-profit sector's impact on the crafting of these pieces. I also determine whether the for-profit sector's influence was direct, i.e., whether its input was taken into consideration during the negotiation stages, through the work of interest groups, lobbies, or others, or whether it indirectly impacted the legislative process through a series of accidents of history.

Of course, I highlight the importance and place of justice in the crafting of health care financing and provision laws. I establish which theory of distributive justice did or did not inform the final draft of each Act. For this, I use the analytical framework developed in Chapter One as a reading grid to

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<sup>273</sup> *Health Care and Competitiveness - Health Competitiveness - Chernen and Levy 8-27.Pdf*, supra 267.

thoroughly analyze discourses of justice present (or absent) in the Reports of the Congressional Committee debates that occurred during the initial stages of the lawmaking process. I then present my most conclusive findings to draw inferences and determine the influence of justice ideals and of the for-profit sector on the allocation of health care resources at the financing and provision levels.

The legislative pieces presented in this section have been selected for their “watershed moment” qualities. All of them represent a unique moment in the health care system’s history and convey the influence of different currents of distributive justice on the drafting of health care financing and provision laws.

The analysis of the Kerr-Mills Act (1960) reveals the origins of an egalitarian movement that later gave rise to the groundbreaking Social Security Amendments of 1965. These amendments gave birth to the two most prominent federal health programs of the twentieth century: Medicaid and Medicare. The Health Maintenance Organization and Resources Development Act (1973), although most often described as a market-driven initiative, also calls for a deeper analysis to reveal Congress’s unexpected communitarian longings. Finally, the Patient Protection and Affordable Care

Act (2010) and the multitude of debates it generated in its early stages deserve an in-depth analysis. The constitutional controversy surrounding its enactment and the law's implications for the future of the American health care system must be presented in full.

To focus on the legislators' original intent and to present a more accurate snapshot of the historical and legal contexts surrounding the drafting of these Acts, I center my study on original draft Bills presented for the first time before Congress. I have therefore consciously set aside the subsequent developments, amendments, and renegotiations of these acts.

### **A. The Kerr-Mills Act (1960): A Resource Egalitarian Financing Law**

In the 1950s, as the debate on publicly financed health services was taking a back seat, the medical needs of elderly Americans became a prime concern. Struggling to make ends meet because of increasing medical costs, the elderly became an organized group and found a voice on the political scene, thanks to the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO).<sup>274</sup> As a result, the Kerr-Mills Act, which created the Medical Assistance to the Aged Program (MAA), was enacted on

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<sup>274</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.58.

September 13, 1960. The MAA was to provide federal funding to all 42 states to cover the health care costs of the “medically indigent” aged.<sup>275</sup>

*i. The History Behind a New Genre of Act*

The Kerr-Mills Act introduced a simple matching system with no global cap on payment distribution. The program was to increase the funds already available for applicants receiving support under the Older American Act (OAA)<sup>276</sup> and to create a new form of assistance for elderly persons who were not covered by the OAA but still needed financial assistance to pay for their medical bills.<sup>277</sup> The federal payments were to be distributed based on states’ per capita income; the same method would be used later for the allocation of funds under Medicaid.<sup>278</sup>

The range of medical services initially available to the OAA’s recipients was to be increased under the MAA, and coverage would no longer be limited to hospitalization costs.<sup>279</sup> As for the new portion of the program, states were left to determine who, among the medically needy Americans aged 65 and

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<sup>275</sup> Judith D. Moore & David G. Smith, *Legislating Medicaid: Considering Medicaid and its Origins*, 27 *Health Care Financ. Rev.* 45 (2005), p.45.

<sup>276</sup> *Older American Act*, Public Law Pub.L. 89-73, 79 Stat. 218, (1965): . first federal initiative that aimed at providing comprehensive services for older American adults.

<sup>277</sup> Subcommittee on Health of the Elderly, *Medical Assistance for the Aged the Kerr-Mills Program 1960-1963* (Washington: U.S Government,[1963]) (accessed 1963), p.3.

<sup>278</sup> Moore & Smith, *Legislating Medicaid: Considering Medicaid and its Origins*, 45 , supra 275, p.46.

<sup>279</sup> Sidney Fine, *The Kerr-Mills Act: Medical Care for the Indigent in Michigan, 1960—1965*, 53 *J. Hist. Med. Allied*

over and not receiving OAA assistance, was eligible to receive the MAA's funding.<sup>280</sup>

Unfortunately, federal aid was insufficient and could not match the needs of the medically indigent. Thus, an allocation test was adopted to guide the distribution of the scarce resources. The MAA took the AMA's traditional position on resource allocation, granting governmental assistance to persons under a precise income threshold and leaving the self-sustaining part of the population in the hands of the private sector. Naturally, the applicants' financial status became the focal point of the new "means test."<sup>281</sup>

Applicants' income and assets had to be scrutinized.<sup>282</sup> Embarrassed by the queries, many elderly people elected not to seek assistance despite their desperate needs. In most states, the means test became a deterrent.<sup>283</sup> Politicians and a significant part of the American population also bitterly received the assessment method. Despite the general discontent, 12 states decided to adopt a family responsibility provision that also imposed the

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Sci. 285 (1998), p.293.

<sup>280</sup> *ibid.*

<sup>281</sup> *ibid.*

<sup>282</sup> "So that the county board of assistance can decide as fast as possible whether you are eligible for MAA, be ready when you apply to give them the facts on your age, residence, amount of income, and value of property. It may help if you bring papers that give this information. Also have with you the names and addresses of your husband or wife, your sons and daughters", 'If you Need Medical Assistance for the Aged', Informational Leaflet no. 8, Commonwealth of Pennsylvania, Department of Public Welfare (1962).

<sup>283</sup> Subcommittee on Health of the Elderly, *Medical Assistance for the Aged the Kerr-Mills Program 1960-1963*,

means test on an applicant's relatives. This procedure disrupted family relationships and further dissuaded applicants from seeking assistance. Most elderly people worried about the hardship this test might cause their families.<sup>284</sup>

Wilbur Cohen, the main craftsman of the MAA, was harshly criticized for fostering an alliance between welfare and medical care. Protecting only a minuscule portion of the elderly population, the Act failed to meet the demand for a social insurance program for the aged. The labor market had been excluded, and only the vulnerable were covered: the aged, the blind, and women with dependent children.<sup>285</sup>

In the end, only 2% of the elderly population secured coverage with the MAA. Despite its very limited success, the Act had nevertheless laid an important foundation for its successor, Medicaid.<sup>286</sup>

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supra 277, p.4.

<sup>284</sup> *ibid.*, p.4.

<sup>285</sup> Moore & Smith, *Legislating Medicaid: Considering Medicaid and its Origins*, 45 , supra 275, p.46.

<sup>286</sup> Annas et al., *American Health Law*, supra 21, p.29.

ii. *Just Distribution Through Categorization: The “Medically Indigent Age” As a Vulnerable and Least-Favored Group*

The Democrats thought that the Kerr-Mills Act was “inadequate but better than nothing.” The Republicans, for their part, were greatly concerned about the cost management aspect of the program and reluctantly accepted the Bill simply because they thought it was “something they had to do.”<sup>287</sup> Ultimately, a bipartisan consensus emerged along the lines of a Rawlsian distribution of resources, having at its core a stringent means test designed to provide advantages to the least favored: the medically indigent aged.

The most innovative feature of the MAA was certainly the new category of beneficiaries it created. The designated beneficiaries were medically indigent persons aged 65 and over who were not receiving old-age-assistance cash payments but who had insufficient income to meet their health care needs.<sup>288</sup> These applicants could have been regrouped under an already existing public-assistance category, but politicians thought it was too unjust to force them to seek welfare because of medical bills that drove them to poverty.<sup>289</sup>

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<sup>287</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213.

<sup>288</sup> Subcommittee on Health of the Elderly, *Medical Assistance for the Aged the Kerr-Mills Program 1960-1963*, supra 277, p.3.

<sup>289</sup> Moore & Smith, *Legislating Medicaid: Considering Medicaid and its Origins*, 45 , supra 275, p.46.

The concept of medical indigence did not come as a revelation to the craftsmen of the Kerr-Mills Act. Immediately after World War II, persons “who could provide for their ordinary daily needs but [that] could not afford to pay for sizable personal health services”<sup>290</sup> were targeted by state assistance programs. It was only in the 1960s that a greater portion of the population fit that definition.

A negative consequence of the categorization was the inevitable meshing of medical assistance for the poor with general public assistance. The social stigma associated with welfare programs was transposed onto medical assistance.<sup>291</sup> Clearly, too much emphasis was placed on the means and not enough on the medicine.<sup>292</sup> By using the same assessment process as other welfare assistance programs, the MAA was not sufficiently distinguishing the “medically indigent” from the “indigent.” Applicants had to demonstrate their inability to provide for their health care needs to be shrouded in the welfare cloak.<sup>293</sup>

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<sup>290</sup> Odin Waldemar Anderson & Harold Alksne, *An Examination of the Concept of Medical Indigence* (1957), p.1-2, 4.

<sup>291</sup> Moore & Smith, *Legislating Medicaid: Considering Medicaid and its Origins*, 45 , supra 275, p.46.

<sup>292</sup> Subcommittee on Health of the Elderly, *Medical Assistance for the Aged the Kerr-Mills Program 1960-1963*, supra 275.

<sup>293</sup> *ibid.*, p.29.

Despite the controversy surrounding the selection system, the Kerr-Mills Act was a remarkable project, as it was the first and strongest attempt to create a resource egalitarian program for the distribution of health care resources in America. The Act embraces a Rawlsian idea of justice whereby health care was considered to be a primary good that had to be distributed equally. Under the Act, an unequal allocation of resources favoring the most vulnerable and least-favored group was not only tolerated, it was the solution presented by the Congress to help the medically indigent aged.

Under the resource egalitarian theory, primary goods must be protected and prioritized. Equality of liberties should take precedence over equality of opportunities, which itself should take precedence over equality of resources. Individual liberties are indeed an essential component of one's capacity to fulfill certain opportunities and, of course, greatly depend on one's health status. The Kerr-Mills Act was consistent with all of those principles and provided individuals with equal health resources to, in turn, provide them with equal life opportunities. This Act marked the first attempt to equalize all Americans' health opportunities by allocating, in priority, more resources to the vulnerable group of the "medically indigent aged."

According to Rawls's *difference principle*, divergence from an orthodox egalitarian allocation of resources is acceptable inasmuch as the inequality makes the least advantaged in society materially better off. Because all humans are fundamentally unequal with regard to their health status, and in the presented case the medical indigent elderly are the most unequal and least favored, the Act makes an acceptable change favoring this group in the distribution of health care resources. Thus, the terms of the social contract established through the Act should be interpreted as follows: all Americans should be entitled to equal health care resources in order to be equally free. This is why all solidary commit to improve everyone's opportunity to achieve better health. Given that the "medically indigent aged" are materially worse off because medical costs drive them to extreme poverty, it is the government's role to reestablish justice by distributing more health care resources to this vulnerable group. Therefore, the MAA's divergence from strict equal distribution of health resources must be tolerated, as it is necessary for a more just society.

In addition, the "means test" should be interpreted as illustrating the roles played by luck and responsibility in economic life. It could be understood as the practical translation of the priority rule: those who suffer the greatest reduction in their opportunity range as a result of health problems and

health care costs receive the highest priority and the most resources in the allocation process. Thus, the test is instrumental in identifying those who suffer the greatest detriment. Overall, the Act integrates the moral role of society with its duty to take charge of the health care costs of the elderly.

The Kerr-Mills Act was also greatly innovative in its definition of “components of medical care.”<sup>294</sup> Medical assistance was defined, and an entitled, vulnerable group was created thereunder. Surprisingly, the Act shared some traits with the South African Constitution. In a similar but more progressive manner, the jurisprudence produced by the South African Constitutional Court has granted housing, water, and health care rights to significant and specific indigent, disenfranchised groups.<sup>295</sup>

The Kerr-Mills Act also provided a “significant segment of the population” with some resources in an attempt to level the playing field. Nonetheless, the drafters most likely did not intend to give such a progressive dimension to the law. Even loosely interpreted, the Kerr-Mills Act did not go so far as to create a socio-economic right to health.

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<sup>294</sup> Fine, *The Kerr-Mills Act: Medical Care for the Indigent in Michigan, 1960—1965*, 285, supra 277, p.293.

<sup>295</sup> *Government of the Republic of South Africa and Others V Grootboom and Others (CCT11/00) [2000] ZACC 19; 2001 (1) SA 46; 2000 (11) BCLR 1169 (4 October 2000)*, supra 96, a case where the Court talks about a ‘significant segment’ of the South African population being in great need of housing.

iii. *The Foundations of the Act: Analysis of Congressional Debates*

Primary historical sources give a more precise picture of what was at stake during the discussions leading up to the Kerr-Mills Act. Analysis and close examination of discourses in the 1958 Social Security Legislation Hearings before the Committee on Ways and Means of the House of Representatives (Committee Hearings of 1958)<sup>296</sup> and the 1960 Hearings before the Committee on Finance of the Senate (Committee Hearings of 1960)<sup>297</sup> reveal that stakeholders spontaneously and directly discussed issues of just distribution. These sources also provide unique insight into the lobbying that the for-profit sector timidly enacted during the negotiation stages.

During both consultations, politicians<sup>298</sup> and key witnesses presented their questions and points of view to the Committee. The hospital associations,<sup>299</sup> nurses<sup>300</sup> and medical associations,<sup>301</sup> and charity associations<sup>302</sup> were represented. Associations lobbying in favor of many vulnerable groups,<sup>303</sup>

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<sup>296</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives*. Congress. 2nd session (1958).

<sup>297</sup> *Hearings before the Committee on Finance United States Senate on H.R. 12580*. Congress. 2nd session (1960).

<sup>298</sup> Senators (Sen. McNamara, Kennedy, Javits, Leverett), governors (Gov. Rockefeller), congressmen (Cong. Forand, Fino, Engle, Byrd, McDonough, Stephens, Jennings, Van Zandt, Ullman, Hosmer), representatives of the Social Security Department (Mr. Volpan, Mr. Cruikshank).

<sup>299</sup> The University of Minnesota Hospitals (Dir. Amberg).

<sup>300</sup> The American Nurses Association (Ms. Thompson).

<sup>301</sup> The American Medical Association (Dr. Larson), The Texas Medical Association (Mr. Tez), The Medical Society of North Carolina (Mr. Grogan).

<sup>302</sup> The National Conference of Catholic Charities (Rev. O'Grady).

<sup>303</sup> The American Public Welfare Association (Dr. Winston).

such as the blind<sup>304</sup> and the aged,<sup>305</sup> and those representing the for-profit sector (employers<sup>306</sup> and insurers<sup>307</sup>) were present.

Although their presence was discreet and their comments on the substance of the Act were rather limited, the indirect impact that insurers and employers had on the negotiations was remarkable. The development of the for-profit sector in health care did not help to reduce the insurance gap that had thus far left the aged uninsured. Ultimately, the government had to take action and come up with a more just distribution of health care resources. The for-profit sector's influence on the creation of the Kerr-Mills Act was indirect but crucial.

Irrespective of their political allegiance or vested interests, witnesses in both Committee Hearings were eager to promote egalitarian justice ideals. A dialogue concerning society's duty to protect vulnerable groups<sup>308</sup> was dominant. The egalitarian undertone of these discourses denotes a meeting of the minds on the need for a social contract protecting the medically indigent elderly—a social contract to help better allocate resources, create

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<sup>304</sup> The National Federation of the Blind (Pres. Tenbroek & Mr. Schloss).

<sup>305</sup> The National League of Senior Citizen (Pres. McLain).

<sup>306</sup> The National Association of Manufacturers (Mr. Culin).

<sup>307</sup> The American Life Convention, Health Insurance Association of America and Life Insurance Association (Mr. Faulkner), Blue Shield Medical Care Plans (Chair. Stubbs).

<sup>308</sup> See *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives*, supra 296, p.63, 72, 76, 105, 211, 322, 323, 366, 482, 775, 848, 879, 947; *Hearings before the Committee on Finance United*

more equality, and, with it, more justice. At least 16 statements directly refer to vulnerable groups that ought to be protected under a new law.

In the Committee Hearings of 1958, liberal Democratic Congressman Engle eloquently argued that

unless we make some basic changes in our social security law most of our older citizens in a few short years will be consigned to an economically and socially underprivileged group.<sup>309</sup>

Clearly, inequality in health care could not be tolerated in 1960s American society. The life opportunities of the elderly could be greatly affected if resources were not more justly allocated. Engle's discourse relays a well-founded concern that inequality in health care can trigger inequality in opportunities in the long term.

Again, in the Committee Hearing of 1960, Senator Byrd, Chairman of the Senate Finance Committee, reiterated that

it must be recognized that senior citizens of this State and Nation, as a group, have been recognized health and medical care needs which are substantially greater than those of younger age groups, and which, in terms of cost, far exceed the financial means of our aged population.<sup>310</sup>

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*States Senate on H.R. 12580*, supra 295, p.56, 202, 343, 383, 417, 420, 426.

<sup>309</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives*. supra 296, p.482.

<sup>310</sup> *Hearings before the Committee on Finance United States Senate on H.R. 12580*. supra 297, p.343.

In both hearings, the “medically indigent”<sup>311</sup> were recognized as a group that had to have, out of a sense of “equity,”<sup>312</sup> its medical needs recognized and compensated. Clearly, Byrd, among others, recognized and labeled senior citizens as the least advantaged group, thus justifying the unequal distribution of health care resources in favor of this group.

Interestingly, the promotion of egalitarian principles also occurred through a virulent critique of the libertarian approach to health care provision, particularly the subsidiarity principle. These discourses reflect the solidary essence characterizing a resource egalitarian conception of justice, the importance of a benevolent attitude towards weaker social groups, and a commitment to the fair distribution of resources. Subsidiary ideas were attacked with arguments made against the concept of “charitable care.”<sup>313</sup> Mr. Townsend, treasurer for the National Insurance Plan, made his point by stating that

charity, whether public or private, can be tolerated only when it is clear that it is a necessary evil. But here in America it is not necessary. It is within the power of this Congress to

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<sup>311</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives. ; Hearings before the Committee on Finance United States Senate on H.R. 12580. , supra 297 , p.343.*

<sup>312</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives, supra 296, p.261, 1001.*

<sup>313</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives, supra 296, p.127, 260, 290, 325; Hearings before the Committee on Finance United States Senate on H.R. 12580, supra 297, p.128, 197, 211, 394, 395, 438, 44.*

create a system of insurance which would cover all Americans as a matter of right.<sup>314</sup>

Here, Townsend indirectly expressed a Durkheimian conception of solidarity, as he implied that solidarity, in contrast to subsidiarity, could lead American society towards modernity. Subsidiarity should not be a rule but a fallback position; America should aim for a more solidary system.

Similarly, in the Committee Hearings of 1960, Mr. Schloss, legislative analyst for the American Foundation of the Blind, stated that

charity medicine is not conducive to high quality medical care, is not compatible with good doctor-patient relationships, and is often not adequate to the medical needs.”<sup>315</sup>

In turn, Democratic Senator Barlett also pointed out that

a country which prides itself on self-reliance and initiative should be a country where men and women need not to rely on charity or doles to meet medical needs in old age.”<sup>316</sup>

These discourses are true to the Rawlsian conception of justice. All parties to the social contract must be solidary and participate in making society more just, and higher powers must guarantee health care as a primary good to ensure that all are given equal opportunities.

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<sup>314</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives.* , supra 296, p. 290.

<sup>315</sup> *Hearings before the Committee on Finance United States Senate on H.R. 12580.* , supra 297, p.395.

<sup>316</sup> *ibid.*, p 438.

During the Committee Hearings of 1958, Republican Congressman McDonough even stressed the importance of providing all Americans with equal opportunities. He believed that “[the American] wants the opportunity to choose his own profession, to make his own decisions as they regard his own welfare and that of his family.”<sup>317</sup> Mr. Townsend, of course, supported this views and stated that “these benefits [would] affect everybody, giving greater opportunity to all, no matter what their ages or positions may be,”<sup>318</sup> whereas Senator Byrd “want[ed] to give [the aged] the opportunity if they wish[ed] to choose retirement.”<sup>319</sup>

Overall, most of the testimonies offered during these hearings were proposing resource egalitarian justice principles, which informed the final drafting of the Kerr-Mills Act.<sup>320</sup> It is worth noting, however, that even though features of the egalitarian archetype were the most salient, a cluster of instances also relayed some communitarian<sup>321</sup> and utilitarian<sup>322</sup> justice principles.

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<sup>317</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives.* , supra 296, p.676.

<sup>318</sup> *ibid.*, p.298.

<sup>319</sup> *Hearings before the Committee on Finance United States Senate on H.R. 12580.* , supra 297, p.164.

<sup>320</sup> At least 13 instances refer directly to the concept of equality of opportunities, see *Social Security Legislation Hearing before the Committee on Ways and Means House of Representative*, supra 296, p.204, 217, 211, 298, 398, 410, 474, 560, 676; *Hearings before the Committee on Finance United States Senate on H.R. 12580*, supra 295, p.213, 298, 368, 371.

<sup>321</sup> *Social Security Legislation Hearing before the Committee on Ways and Means House of Representatives*, supra 296,

## **B. The Social Security Amendments Creating Medicare and Medicaid (1965): A Welfare Egalitarian Financing Law**

Growing dissatisfaction with the first attempt to create a health care program servicing the elderly<sup>323</sup> prompted the creators of the Kerr-Mills Act, Wilbur Cohen and Wilbur Mills, to push for a new and more complete piece of legislation. The vigorous debate surrounding Medicare cast a shadow on the enactment of its “sister Act.” For the most part, the negotiations leading to the amendments creating Medicaid were kept under wraps, perhaps because most of the program was an extension of the Kerr-Mills Act. Nonetheless, this amendment offered a much more potent option.<sup>324</sup>

On July 30, 1965, the Social Security Amendments were enacted to initiate the most important American health care legislation of the twentieth century.<sup>325</sup> The elderly and the poor were given their own federally funded health care programs, two controversial initiatives that continue to fuel many debates to this day.

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p.173, 260, 261, 479, 618, 856, 941,1019, 1095, 1209; *Hearings before the Committee on Finance United States Senate on H.R. 12580*, supra 295 , p.201, 212, 238, 293, 143, 428.

<sup>322</sup> *ibid.*, p.728, 778, 1024, 1042; p.236, 297, 382, 400.

<sup>323</sup> Subcommittee on Health of the Elderly, *Medical Assistance for the Aged the Kerr-Mills Program 1960-1963*, supra 275.

<sup>324</sup> Moore & Smith, *Legislating Medicaid: Considering Medicaid and its Origins*, 45 , supra 275, p.48.

<sup>325</sup> Annas et al., *American Health Law*, supra 21, p.76.

*i. The Obvious Following Act to an Incomplete Project*

By the 1960s, unions had been successful in claiming health insurance as a fringe benefit for their workers. Their retired members, however, were still left without a means of insurance even though they had enough pension benefits for their leisure years. It was not for lack of trying, but collectively bargained plans could not be structured to provide for retired workers. The inclusion of the retirees would have driven up costs and resulted in important concessions on wages and other crucial elements.<sup>326</sup>

The active workers' concerns had to be acknowledged, but it was equally important to satisfy the pensioners' need for insurance. This balancing act inevitably called for government intervention. Union leaders believed they would have more freedom to negotiate wages and benefits if the government were to finance a program that absorbed part of the retirees' health care costs.<sup>327</sup>

Beginning in 1956, the AFL–CIO decided to lead the debate on elderly people's health benefits and offered a model Bill supporting a public health program for the aged. Unfortunately, despite the efforts of director Nelson

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<sup>326</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.56.

<sup>327</sup> *ibid.*, p.57.

Cruikshank and his assistant director Katherine Ellickson, the draft legislation died in committee. Their failure was due in part to the AMA's opposition to the steelworkers' demand for surgical care coverage and the AFL-CIO's discomfort with the role that commercial insurers could have played under the new plan.<sup>328</sup>

Blue insurers were also uncomfortable with the situation, as they were losing business to price-cutting private insurers. Experience rating was helping commercial insurers to reduce premium prices and attract younger and healthier clients, leaving high-risk applicants to the community-rating Blues. At that point, insurers chose to base their actuarial calculations on risk and experience and thus abandoned community-rating insurance plans.<sup>329</sup>

By the 1960 elections in which John F. Kennedy opposed Richard Nixon, two distinctive camps had formed regarding the proposal for a federal program for the elderly. On the one hand, the northern Democrats, with Kennedy, the AFL-CIO, and senior citizens, supported the Democratic Party's platform and were promoting a new public program called *Medicare*. On the other hand, the Republicans, with Nixon, the AMA, the Health Insurance Association of America, the business community, and even the

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<sup>328</sup> *ibid.*, p.58-59.

southern Democrats, opposed a government-sponsored program for the aged.<sup>330</sup>

President Kennedy made the enactment of Medicare his top priority. By 1962, 69% of Americans were in favor of Medicare. Public support enabled the President to push for the swift passage of his new proposal: the King-Anderson Act.<sup>331</sup>

Although insurers were initially not in favor of the Act, they quickly realized that they could make no real profit by insuring the aged. Ultimately, they backed down and strategically catered to the worst-case scenario, creating a profitable role for themselves under a potential government-sponsored health care system. The AMA joined their ranks to form a strong and organized lobbying group.

Despite all the pressure exercised by the for-profit sector, the public remained supportive of the initiative. With 68% of Americans already

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<sup>329</sup> Sylvia A. Law, *Blue Cross: What Went Wrong?*(1974), p.12.

<sup>330</sup> Annas et al., *American Health Law*, supra 21, p.30.

<sup>331</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.67-69.

receiving some form of coverage through private health insurance, the idea of covering the uninsured became both comprehensible and acceptable.<sup>332</sup>

Unfortunately, a year later Kennedy was gunned down, and Lyndon Johnson had to step in to complete the term. The interim President had also decided to make indigent citizens his top priority. With elections around the corner, Johnson wanted to tackle poverty at its core and gain the people's support. Thus, in January 1965 the draft amendments to the Social Security legislation were introduced to Congress.<sup>333</sup>

In a desperate attempt to contribute, the AMA proposed Eldercare, an altered version of the MAA.<sup>334</sup> Commercial insurer Aetna also added to the legislative mixture by proposing Bettercare,<sup>335</sup> a plan supporting a federally funded private health insurance program.<sup>336</sup>

Thus, a three-tier legislation emerged from in-committee negotiations. Chairman Wilbur Mills decided to combine all approaches.<sup>337</sup> Medicare part

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<sup>332</sup> *ibid.*, p.67-69.

<sup>333</sup> *ibid.*, p.69.

<sup>334</sup> 'Eldercare Branded Empty Propaganda', AFL-CIO News, February 20,1965, RG 233, Records of the House of Representatives, 89<sup>th</sup> Congress, Committee on Ways and Means, Legislative Files, Box 21, File: HR 6675-3 of 94.

<sup>335</sup> Bettercare was written by Aetna lobbyists and sponsored by Representative John Byrnes, the ranking Republican on the Ways and Means Committee.

<sup>336</sup> Irving Bernstein, *Guns Or Butter: The Presidency of Lyndon Johnson* (1996), p.171.

<sup>337</sup> Edward D. Berkowitz & Wendy Wolff, *Disability Insurance and the Limits of American History*, 8 *The Public Historian* 65 (1986), p.196.

A was designed to fund some components of the AFL-CIO hospital insurance plan, which provided for limited skilled-nursing and home care. Medicare Part B was designed to fund some components of Bettercare but would remain an optional program that took charge of physicians' services. Finally, the third part dedicated some funds to Eldercare and was renamed Medicaid under the legislation. The program was to cater to the needs of the "categorically" eligible "deserving poor" through federal and state cash allowances, old-age assistance, and aid to families with dependent children.<sup>338</sup> In the same way as an insurance policy, services would be paid for rather than managed by the government.<sup>339</sup>

Despite the efforts to reconcile all views and reach an optimal solution, Medicare was still leaving a good number of health care services uncovered and required co-payments for many others. This misfortune became the good fortune of private insurers. Relieved to see most of the unpredictable costs associated with insuring the elderly placed in the government's hands, insurers gladly retained the supplemental market of "medigap" policies.<sup>340</sup>

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<sup>338</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.73-74.

<sup>339</sup> WA Jones, *Medicaid 101: History, Challenges, and Opportunities* (2006), p.56.

<sup>340</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.74.

Also relieved of a burden, the Blues immediately followed and lowered their rates across the country.<sup>341</sup>

In contrast to Medicare, Medicaid emerged more spontaneously as part of a compromise that had to be reached quickly to secure the enactment of both amendments.<sup>342</sup> The program delegated a good portion of the policy-making and all of the day-to-day administrative responsibilities to the states. This arrangement would pose critical problems in the 1970s and 1980s.<sup>343</sup>

Notwithstanding certain anomalies, the federal entitlement program was a remarkable political success, as the nation's most vulnerable groups were finally to be granted equal access to health care services.

*ii. Welfare Equality Through Just Allocation*

The Social Security Amendment of 1965 accomplished a remarkable *tour de force* by bridging the traditionally divided domains of private medicine and public health.<sup>344</sup> Medicare and Medicaid created a precedent given that, to that point, no other social security program had made an equally significant commitment to its beneficiaries. Enacted with permanent authorization, the

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<sup>341</sup> *ibid.*, p.75.

<sup>342</sup> Annas et al., *American Health Law*, *supra* 21 , p.31.

<sup>343</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, , *supra* 213, p.75.

open-endedness of these programs and their statutory entitlements suggested a fixed political promise.<sup>345</sup> The government was to allocate virtually unlimited public funds to finance the care of the aged and the poor.<sup>346</sup>

To achieve this, the Administration would step into the shoes of the third-party payer, without taking control of the medical profession or introducing socialized medicine. In fact, the preamble to the original Medicare statute included a clear prohibition against federal

supervision or control over the practice of medicine or the manner in which medical services [are to be] provided...or the administration of any (...) institution, agency, or person [providing, medical services].<sup>347</sup>

The governmental agenda was clear: give the elderly access to health care by buying into the existing institutions. The task division was simple: the government had to be in charge of the financing, whereas the for-profit sector would take charge of the execution. Thus, the private sector was responsible for implementing the program, which included managing the

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<sup>344</sup> Annas et al., *American Health Law*, supra 21, p.30.

<sup>345</sup> *ibid.*, p.31.

<sup>346</sup> Quadagno, *Why the United States has no National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945-1996*, 25, supra 235.

<sup>347</sup> Later amended and included in the act under Title XVIII Section 1801 and 1803.

proceedings relating to quality assessment, day-to-day administrative duties, and supervising fund disbursement.<sup>348</sup>

The work of Congress to minimize the impact of these programs on the medical profession was noticeable. The amendments worked as simple “add-ons” paralleling the third-party payer system, even though the goal was not only to finance health care services for a new portion of the population but also to ensure that all Americans received the same access to care. Indeed, despite the important push and pull during the negotiations, a more disinterested and welfare egalitarian spirit emerged in the final version of the Act.

Section 1901 under the title “Grants to States for Medical Assistance Programs” was certainly drafted to reflect welfare egalitarian precepts:

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or permanently and totally disabled individuals, whose income and *resources are insufficient to meet the costs of necessary medical services*, and (2) rehabilitation and other services to help such families and individuals *attain or retain capability for independence or self-care*, there is hereby authorized to be appropriate fiscal year a sum sufficient to carry out the purpose of this title.<sup>349</sup>

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<sup>348</sup> Annas et al., *American Health Law*, supra 21, p.31-32.

<sup>349</sup> *Health Insurance and Related Provisions of Public Law 89-97, the Special Security Amendments of 1965, Special Committee on Aging United States Senate Title XIX Section 1901.*

The drafting relays the government's open-ended commitment to provide all necessary resources to level the playing field and grant all Americans the same access to health care services. "Necessary medical services"<sup>350</sup> were considered a primary good enabling the beneficiaries of the Act to "retain [their] capability."<sup>351</sup>

The Act was designed to address the government's and the general population's concern for the most needy and aimed to reach equality in *capability* more than equality of resources. The welfare of the aged was certainly the focal point, and emphasis was placed on the capacity of the elderly to access health care services without barriers. The redistribution of resources under the Medicare Amendments could also be interpreted as equalizing the health *functioning* of the "categorically aged and deserving" by giving them greater *capacity* to seek medical care.

Health policies committing to a welfare egalitarian idea of justice provide equal access to health care by giving everyone equal capacity to achieve good health. Welfare egalitarianism is more content to provide equal access to all available health care resources than to commit to the unreachable goal of providing every patient with equal health care resources.

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<sup>350</sup> *ibid.*

Thus, the Act extended coverage to additional groups, thereby guaranteeing that all Americans could equally access hospital and medical care and that all would be on equal “welfare” footing with regard to access to care. Welfare egalitarianism also places great importance on equality of real freedom commensurate with equality of condition, which may explain why Congress opted for a threefold approach. The national problem of adequate care for the aged had not been resolved by previous legislation, or at least to the extent anticipated. Thus, the government believed that it was not optimal to limit assistance to helping the aged once they had reached a certain poverty threshold; it would simply be more adequate and feasible to increase health insurance protection under two separate but complementary programs, to make a significant contribution to economic security in old age.

One purpose of this welfare egalitarian Act was certainly to supplement or even substitute the private/for-profit insurers, to remove barriers to care for the aged and the needy. Yet, contrary to Medicare, Medicaid’s program set no particular goals, nor did it define precise benefits. It had a safety net function and was meant to provide services that were unaccounted for under

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<sup>351</sup> *ibid.*

Medicare. Indeed, the program had been strictly gerrymandered to fit the contours of already existing federal welfare programs.<sup>352</sup>

Medicaid is an example of the resource egalitarian philosophy that animated health care policy in the 1960s. It was the direct heir of the MAA. An assessment of the just allocation of health resources under this amendment follows the analysis previously accomplished regarding the Rawlsian legislation. The same logic certainly applies, even though the deserving poor (the aged, blind, disabled, and families with dependent children) represent a larger vulnerable group compared with the medically aged, and the resources mobilized are far greater than under the MAA. As it fails to amend the controversial means and asset test, this law was still limited by the vestiges of the Kerr-Mills Act.

*iii. The Foundations of the Act: Analysis of the Congressional Debates*

An examination of the discourses of justice in the three-part Executive Hearings before the Committee on Ways and Means of the House of Representatives<sup>353</sup> and the Hearings before the Committee on Finance of the

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<sup>352</sup> Annas et al., *American Health Law*, ; Jones, supra 21, p.56.

<sup>353</sup> *Executive Hearings before the Committee on Ways and Means House of Representatives Part I*. Congress. 1st session (1965) ; *Executive Hearings before the Committee on Ways and Means House of Representatives Part II*. Congress. 1st session (1965) ; *Executive Hearings before the Committee on Ways and Means House of Representatives Part III*. Congress. 1st session (1965) .

United States Senate<sup>354</sup> reveals the tension between the for-profit sector and the government during the drafting of both amendments.

Most strikingly, a libertarian undertone marked all of the committee hearings.<sup>355</sup> Many of the for-profit actors voiced their objections to the federally funded health care program. Among the most fervent interventions was the letter of California doctor John Toth, which offered a plea in favor of a system promoting subsidiarity by inviting all Americans to respect charitable care and to reject a right to assistance. He wrote,

The right of charity resides with the givers of charity, not with the receivers. If the recipients of charity have the right to receive it, then those providing the charity are obligated to give it to them, and it is no longer charity. So if the older folks' need for charity or for medical care becomes a right to charity or medical care, how did they get that right? And why just the older folks, etc.? In our concern over being charitable to those that need it, let's not ignore the just concern of, those providing the charity.<sup>356</sup>

Toth's discourse was very much in line with the classic libertarian conception of justice, advocating limited state interference with individual property, minimal redistributive taxation, and the provision of welfare services through charitable contributions. Indeed, he went on in his letter to criticize the tax-

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<sup>354</sup> *Hearings before the Committee on Finance United States Senate*, Congress, 1st session (1965) .

<sup>355</sup> *Executive Hearings before the Committee on Ways and Means House of Representatives Part III*, supra 353, p. 77, 268, 327, 544, 607, 627, 645, 647, 696, 661; *Hearings before the Committee on Finance United States Senate*, supra 352, p.48, 138, 446, 548, 634, 646, 647.

<sup>356</sup> *ibid.*, p.646.

based financing system associated with the program. To him, this system would violate an individual's right to property. Many other witnesses also raised this point.<sup>357</sup> Specifically, discussing the aid provided to the elderly, Toth wrote,

If he [(the aged)] earns the money, it is his by right (in justice); if he does not earn it, only two ways of obtaining it are possible – either by charity or by force – from someone else who has earned it. There are no other alternatives. Those who would say that they want to receive money, or benefits, or services which they have not earned but say they do not want charity, are actually saying that they want to receive these things from someone else by force (usually by governmental force; i.e., taxation).<sup>358</sup>

Physicians and insurers were appalled at the idea of a tax levied on the smallest portion of the population to finance the needs of a larger vulnerable group.<sup>359</sup> Republican Congressman Broyhill made himself the spokesman of this portion of the for-profit sector and summed up the fears and discontent. For him,

The membership of the House of Representatives, in acting on the medicare political palliative should be cognizant of the meaningful fact that the two groups most knowledgeable of the medical and actuarial implications of the medicare proposal oppose its enactment - these groups are the physicians and the health insurance industry. The concerns expressed by these groups are sustained by events

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<sup>357</sup> *Executive Hearings before the Committee on Ways and Means House of Representatives Part III.* , supra 353, p.607.

<sup>358</sup> *Hearings before the Committee on Finance United States Senate.* , supra 354, p. 647.

<sup>359</sup> *ibid.*, p.646, 647; *Executive Hearings before the Committee on Ways and Means House of Representatives Part III*, supra 353, p. 77, 647, 327, 544, 696.

throughout the world where government health programs have reached the critical juncture of unforeseen increases in, cost and declining quality of medical service. It is not by accident that the U.S. citizens have available to them the highest standard of health care in the world under our free enterprise system. The enactment of medicare will inescapably impair the quality and increase the cost of health care in this country similar to the deteriorating standards and increasing costs being experienced in such countries as Great Britain, France, and Italy.<sup>360</sup>

Nonetheless, a strong counter-discourse inspired by egalitarian principles<sup>361</sup> emerged more than 16 times, scattered in the witnesses' testimonies. Some lobbying groups advanced arguments expressing concern for vulnerable groups<sup>362</sup> and the state's duty to provide them with equal access<sup>363</sup> to health care services in order to, in turn, provide them with equal opportunities.<sup>364</sup> Nonetheless, it is not clear whether a purely welfare egalitarian conception of justice alone inspired these discourses. More generally, a discourse focused on equity, equality, and fairness transpired.

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<sup>360</sup> *Executive Hearings before the Committee on Ways and Means House of Representatives Part III.*, supra 353 p.268.

<sup>361</sup> *Hearings before the Committee on Finance United States Senate.*, supra 354, p.452, 532, 595, 644; *Executive Hearings before the Committee on Ways and Means House of Representatives Part I*, supra 353, p.125; *Part II*, p.260, 365, 372; *Part III*, p. 319, 443, 549, 611, 612, 671, 672, 708.

<sup>362</sup> *Hearings before the Committee on Finance United States Senate*, supra 354, p.168, 308, 319, 367, 705, 706; *Executive Hearings before the Committee on Ways and Means House of Representatives Part I*, supra 353, p. 392; *Part II*, p.11; *Part III*, p.17, 75, 268, 379, 553, 727.

<sup>363</sup> *Hearings before the Committee on Finance United States Senate*, supra 354, p. 41, 129, 261; *Executive Hearings before the Committee on Ways and Means House of Representatives Part I*, supra 353, p.464; *Part III*, p.107, 109, 371.

<sup>364</sup> *Hearings before the Committee on Finance United States Senate*, supra 354, p. 317, 318, 321; *Executive Hearings before the Committee on Ways and Means House of Representatives Part I*, supra 353, p. 392.

William Fitch, Director of the National Retired Teachers Association and the American Association of Retired Persons, summed up the egalitarian argument when he stated,

More comprehensive legislation would give a more just and equal treatment to a deserving group of older citizens who have struggled and who are struggling to maintain their independence and dignity during a period of rising living costs.<sup>365</sup>

He makes a point based on justice but also human dignity. More access to care for this vulnerable group was needed to preserve their dignity and treat the aged as equal citizens able to provide for their own medical care. A representative of the elderly and retired, Mr. Schottland stated that “[t]hese improvements would be in the direction of more adequate and comprehensive coverage; [providing] greater equity among different groups of recipients (...)”<sup>366</sup>

Interestingly, the egalitarian discourse was also exploited by the for-profit sector to lobby in favor of the legislation because of the relief it could offer their businesses. Mr. Hohaus, former Senior Vice President and Chief actuary at the Metropolitan Life Insurance Company, argued,

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<sup>365</sup> *Hearings before the Committee on Finance United States Senate.*, supra 354, p.308.

<sup>366</sup> *ibid.*, p.318.

Where the range of need among the aged is so great, it is especially important to make certain that any aid through Governments is utilized most effectively and in a manner that truly advances the health and welfare of all our citizens.

Employers, for their part, were concerned about their roles under the Act; thus, Wilbur Cohen reassured them by using a counter-egalitarian discourse:

I do not think in this program we should carry the concept of equity so far as to tie the employer's contribution to each individual employee.<sup>367</sup>

Overall, the hearings relayed that the American financing system had reached a point of no return and that the government had to tailor and confine its intervention to the boundaries set by the private sector. The government was forced to do all of the heavy lifting to finance health care services for the deserving poor. The for-profit sector was successful in its venture; it was relieved of the burden and left with a share of the profits and sufficient leeway to remain the most important actor in the health insurance market. Without a doubt, the for-profit sector exploited the discourses of libertarian and egalitarian justice to lead the government to definitively take over the coverage of the neediest.

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<sup>367</sup> *ibid.*, p.308.

### **C. The Health Maintenance Organizations and Resources Development Act (1973): A Communitarian and Libertarian Financing and Provision Law**

In the late 1960s, the health care system had taken a downturn. Growing dissatisfaction had resurrected the national health insurance project. Health Security was to be Medicare's successor. This time, the government was meant to be the single and only payer for all of the population's health care services.<sup>368</sup>

President Nixon was determined to oppose any compulsory federal project, but for fear of being outdone, he offered his own version of a nationalized health plan: the National Health Insurance Partnership Act.<sup>369</sup> He had decided to take a regulatory approach. He proposed a public-private partnership between the government and private insurers, using an employer mandate.<sup>370</sup> The plan also included planning grants and loan guarantees for new prepaid practice groups, which were introduced as Health Maintenance Organizations (HMOs).<sup>371</sup>

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<sup>368</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.110.

<sup>369</sup> Starr, *The Social Transformation of American Medicine*, supra 220.

<sup>370</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.115.

<sup>371</sup> Starr, *The Social Transformation of American Medicine*, supra 220, p.396.

On December 29, 1973, the Health Maintenance Organization and Resources Development Act (HMO Act) became the law as part of Title XIII of the Public Health Service Act.<sup>372</sup> The passage of the HMO Act relayed an important change in the structure of the health care system and a desire to experiment with new forms of organizational schemes for the delivery of health care services.<sup>373</sup> The government committed to a limited trial period to trigger consumers' and providers' interest in the concept and to allow the organizations to develop.<sup>374</sup>

During the 1960s the American health care system comprised medical entrepreneurs conducting small business ventures and service providers controlling a majority of the system. There was little shared management supervising hospital facilities and practitioners, and patients received no real guidance, which caused them to meet a multitude of providers without obtaining pertinent responses to their queries.<sup>375</sup>

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<sup>372</sup> *Public Health Service Act Title XIII 'Health Maintenance Organizations'*, Library of Congress (1973): (accessed 4/18/2013).

<sup>373</sup> Joseph L. Dorsey, *The Health Maintenance Organization Act of 1973 (PL 93-222) and Prepaid Group Practice Plans*, Med. Care 1 (1975).

<sup>374</sup> 'Health Maintenance Organization Act of 1973', Bulletin, March 1974, p.35.

<sup>375</sup> Robert T. Holley & Rick J. Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, Stanford Law Rev. 644 (1972), p.645.

According to Robert Holley and Rick Carls, <sup>376</sup> the model triggered many deficiencies, ranging from the cost of medical services <sup>377</sup> to an overall decrease in the quality of care. <sup>378</sup> It even provoked an increase in discrepancies between different institutions and practitioners, <sup>379</sup> due in part to scarce resources available to poor patients and to those living in rural areas. <sup>380</sup> The public's lack of information and a steep decline in the number of qualified primary care physicians also created access barriers. <sup>381</sup>

Thus, HMOs were intended to help promote a more efficient and free health care system but also to offer cost-efficient and quality health care services. <sup>382</sup>

Conceived as an alternative to the fee-for-service system, they were meant to offer to their subscribers, in exchange for a fixed monthly or annual prepaid installment, a “one-stop shop” with a comprehensive range of health services. <sup>383</sup>

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<sup>376</sup> *ibid.*

<sup>377</sup> Herbert E. Klarman, *Approaches to Moderating the Increases in Medical Care Costs*, *Med. Care* 175 (1969).

<sup>378</sup> Kenneth F. Clute, *The General Practitioner: A Study of Medical Education and Practice in Ontario and Nova Scotia* (1963).

<sup>379</sup> Osler Luther Peterson, *An Analytical Study of North Carolina General Practice, 1953-1954* (1956).

<sup>380</sup> Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 644, *supra* 375, p.646.

<sup>381</sup> *ibid.*, p.647.

<sup>382</sup> Annas et al., *American Health Law*, *supra* 21, p.780

<sup>383</sup> ‘Health Maintenance Organization Act of 1973’, *Bulletin*, March 1974, *supra* 374, p.35.

*i. The Role of Corporate America in the Promotion of Health Maintenance*

*Organizations*

The enactment of the Social Security Amendments that created Medicare and Medicaid changed the landscape of American medicine and jeopardized well-established ideologies in the realm of health care. During the initial stages of the implementation, Democrats were forced to acknowledge the policy's limitations and the costs linked to a federal program financing health care for the poor and the elderly. Republicans, for their part, had to accept that these programs were there to stay and that, although the market might play a role within these governmental programs, it was no longer the most optimal alternative. The entire political spectrum was in agreement: these federal health care programs had to be rationalized; otherwise, the spending and fiscal implications of the open-ended reimbursement system could potentially be catastrophic.<sup>384</sup>

Bearing in mind these concerns, Paul M. Ellwood, Jr., an evangelical physician from Minneapolis and Director of the American Rehabilitation Foundation, created the idea of health maintenance organizations providing a potent solution,<sup>385</sup> as he also sensed that the health care system had been

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<sup>384</sup> Brown, *Politics and Health Care Organization: HMOs as Federal Policy*, supra 240.

<sup>385</sup> *ibid.*, p.206.

corrupted by costly treatments and the fee-for-service system, which was indirectly penalizing efficient and competent physicians who brought their patients back to health. He was inspired by individuals in local communities who were dissatisfied with their purchase or delivery of care through the fee-for-service system and who thus created a model closer to the community and more responsive to its needs.

For Ellwood, the only way out of the crisis was to make primary care doctors the gatekeepers of the system. Primary care physicians would evaluate patients before consulting any other specialists on a course of treatment. Ellwood labeled the idea “HMO” and went on to sell it as a pro-market solution.<sup>386</sup> Sharing the Republicans’ concerns about the problematic incentives of reimbursement schemes under Medicare and Medicaid, he provided them with an attractive solution.<sup>387</sup>

Structured around the prepaid group practice model, HMOs had the potential to revolutionize the financing system. So that the organization could contract with providers and offer a relatively comprehensive range of services, its subscribers would pay fixed, periodic installments.<sup>388</sup> Moreover,

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<sup>386</sup> D. Bennahum, *The Crisis Called Managed Care*, Managed Care (1999); J. Spidle, *The Historical Roots of Managed Care*, *Managed Care: Financial, Legal and Ethical Issues* (1999), p.16.

<sup>387</sup> Brown, *Politics and Health Care Organization: HMOs as Federal Policy*, , supra 240.

<sup>388</sup> Dorsey, *The Health Maintenance Organization Act of 1973 (PL 93-222) and Prepaid Group Practice Plans*, 1 ,

HMOs were to be non-profit organizations and would reinject any profits back into their structure to improve the services and maximize the number of insured.<sup>389</sup>

It might come as a surprise that Nixon, knowing that he owed his electoral success to the support of the AMA, nonetheless supported increased governmental intervention in the health sector; but the introduction of HMOs was part of a calculated strategy.<sup>390</sup> Coming up for re-election, Nixon felt that the Democrats had a solid proposition with their National Health Insurance.<sup>391</sup> Ellwood's project thus became an attractive alternative. It kept the private sector in the loop and did not require the immediate expenditure of large sums of money.<sup>392</sup>

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supra 373, p.1.

<sup>389</sup> Bennahum, *The Crisis Called Managed Care*, ; Spidle, *The Historical Roots of Managed Care*, supra 386, p.16.

<sup>390</sup> Dorsey, *The Health Maintenance Organization Act of 1973 (PL 93-222) and Prepaid Group Practice Plans*, 1, supra 373. In his speech in front of Congress President Richard Nixon indicated publicly the interest of the Administration in fostering HMO development: "In recent years, a new method for delivering health services has achieved growing respect. This new approach has two essential attributes. It brings together a comprehensive range of medical services in a single organization so that a patient is assured of convenient access to all of them. And it provides needed services for a fixed contract fee which is paid in advance by all subscribers. Such an organization can have a variety of forms and names and sponsors. One of the strengths of this new concept, in fact, is its great flexibility. The general term which has been applied to all of these units is "HMO"-Health Maintenance Organization....Patients and practitioners alike are enthusiastic about this organizational concept. So is this administration. That is why we proposed legislation last March to enable Medicare recipients to join such programs".

<sup>391</sup> According to Farah Stockman, *Recalling the Nixon-Kennedy Health Plan*, The Boston Globe, last accessed 27 August 2013, "Ted Kennedy, whom Nixon assumed would be his rival in the next election, made universal health care his signature issue. Kennedy proposed a single-payer, tax-based system. Nixon strongly opposed that on the grounds that it was un-American (...)"

<sup>392</sup> Quadagno, *One Nation, Uninsured: Why the US has no National Health Insurance*, supra 213, p.115-116.

Despite the AMA's unsurprising reluctance to approve the project,<sup>393</sup> the idea gained the support of employers. Troubled by the rising cost of insurance, employers were more open to a new solution. The corporate sector successfully quelled the AMA's opposition and made the HMO legislation a triumph.<sup>394</sup> Nixon's supporters understood that HMOs could significantly lower health expenditures by decreasing fee-for-service payments and that they provided an alternative to the passage of a national health insurance plan. These organizations came to represent the promise that costs would be controlled and that, irrespective of one's health status, income, or place of residence, access to the system would be guaranteed.<sup>395</sup>

There had been no previous direct attempt to change the structure of the delivery system, as all other reforms focused on the financing and purchasing of health care services. Medicare and Medicaid had created an allocation system granting more Americans access to health care services, but neither program was concerned with delivery.<sup>396</sup> The HMO Act was creating another precedent by providing the first initiative that addressed

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<sup>393</sup> *ibid.*, p.117.

<sup>394</sup> *ibid.*

<sup>395</sup> Esther Uyehara & Margaret Thomas, *Health Maintenance Organization and the HMO Act of 1973* (1975), p.1.

<sup>396</sup> Dorsey, *The Health Maintenance Organization Act of 1973 (PL 93-222) and Prepaid Group Practice Plans*, 1, *supra* 373, p.1.

issues surrounding methods of delivery and the structure of health care organizations.

Authorized spending of \$375 million over the course of five years and direct financial assistance through loans and loan guarantees were approved to help develop HMOs.<sup>397</sup> These monies were to provide the financial aid necessary to overcome any impediments to the development of the organizations. Assistance from corporate employers was also mandated.<sup>398</sup> Corporations of 25 employees or more were then required to include an HMO option to any benefit plans, regardless of a state law's prohibition.<sup>399</sup>

The Act clearly defined the nature of these health maintenance organizations. Under sections 1301 and 1302, HMOs were defined as “legal entities that provide (...) basic<sup>400</sup> and supplemental<sup>401</sup> health services to its members”<sup>402</sup> in return for a prepaid payment.<sup>403</sup> The statute established the definition and described the range of services to be provided, the method of

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<sup>397</sup> Uyehara & Thomas, *supra* 395, p.3.

<sup>398</sup> *Public Health Service Act Title XIII 'Health Maintenance Organizations'*, *supra* 372, section 1310.

<sup>399</sup> Annas et al., *American Health Law*, *supra* 21, p.780.

<sup>400</sup> Section 1302 (1) defines basic health services as follows: physician services, inpatient and outpatient services, emergency health services, short-term outpatient mental health services, medical treatment and referral services for alcohol and drug abuse or addiction, diagnostic and therapeutic radiologic services, home health services, and preventive health services.

<sup>401</sup> Section 1302 (2) defines supplemental health services as follows: intermediate and long-term care services, vision care, dental and mental health otherwise under basic health services, long-term physical medicine and rehabilitative services, and the provision of prescription drugs.

<sup>402</sup> *Public Health Service Act Title XIII 'Health Maintenance Organizations'*, *supra* 372.

<sup>403</sup> Uyehara & Thomas, *supra* 395, p.3.

payment to be adopted, the financial responsibilities to be handled by the organization, their enrollment policy, and the organizational requirements.<sup>404</sup>

HMOs were also meant to have a 30-day open-enrollment period every year. This provision created significant controversy. Health maintenance organization managers were convinced that compliance would result in serious hardship because, in contrast to private insurance programs, HMOs were not at liberty to turn down high-health-risk subscribers. This section of the Act was later repealed.<sup>405</sup>

*ii. Management and Cost-Containment Through a Communitarian Distribution of Health Care Resources*

The Act proposed to deal in three ways with the constantly looming issue of cost control. HMOs were designed to be market efficient, to ensure that quality of care would not be sacrificed in favor of efficiency, and, of course, to improve the distribution of health care resources. It was assumed that with financial aid, the mandatory employer mandate, the promotion of the

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<sup>404</sup> *ibid.*, p.3.

<sup>405</sup> Annas et al., *American Health Law*, supra 21, p.780-781.

organization, and the help of a federal override of prohibitive state laws, access barriers to the system would significantly diminish.<sup>406</sup>

Most of the solutions provided by HMOs echoed some principles of distributive justice. The analysis should begin with the central idea of cost containment and the principles of libertarian justice theory that are omnipresent in the legislation.

The maintenance and preventive care approach characterizing the HMO project gave it the potential to help control costs significantly. Preventive care was certainly the most salient feature of the new HMO structure, as it placed patients' responsibility at the center of the decision-making process. Preventive care is the prerogative of communitarian health care systems, and patient responsibility is typically associated with an egalitarian conception of justice, so it is interesting that both ideas were adopted to develop HMOs and to make them more liberal and cost-effective.

In the past, curative care had been emphasized, which relegated patients to a passive role. Thanks to its prepayment scheme, the HMO system was finally granting patients some responsibility for their health. Patients would be

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<sup>406</sup> Uyehara & Thomas, *supra* 395, p.9.

more likely to utilize primary care resources if they had paid for all services beforehand and incurred no additional fee upon consultation.

In addition, if certain symptoms were to arise, the organization's access to empowering education could potentially help patients to take the first step in seeking medical assistance and, thus, to reduce subsequent expenditures.<sup>407</sup>

Nonetheless, specialists still had reservations regarding the cost-effectiveness of preventive care. According to Stuart Schweitzer, preventive care would always come at a higher price because of the great amount of resources it required for minimal impact.<sup>408</sup>

Adopting market logic, the HMO Act promoted business tools to help reduce cost and to maximize efficiency. HMOs were to utilize all of the economic principles of vertical integration, making a sole entity responsible for the chain of command surrounding the treatment of patients and the continuity of care. Along with Holley and Carlson,<sup>409</sup> many others perceived increased quality of care thanks to continuous medical records<sup>410</sup> and

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<sup>407</sup> *ibid.*, p. 11.

<sup>408</sup> Stuart O. Schweitzer, 'The Economic of the Early Diagnosis of Disease', paper presented before a session of the Econometric Society, Toronto, Canada (1972).

<sup>409</sup> Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 644, *supra* 375, p.650.

<sup>410</sup> Robert H. Brook & Robert L. Stevenson Jr, *Effectiveness of Patient Care in an Emergency Room*. 283 N. Engl. J. Med. 904 (1970), p.904-907.

referrals made within the same entity, which eased the internal supervision of professionals and providers.<sup>411</sup>

The Act definitely provided some incentives to reduce costs and increase competition. Under the previous fee-for-service system, physicians had virtually no financial interest in keeping their patients in good health. In contrast, an HMO physician's revenue would be the same irrespective of his patients' health status. Thus, fixed and bundle payments were likely to encourage an active effort on the physician's part to keep enrollees well and avoid unnecessary hospitalization.<sup>412</sup>

In line with libertarian principles promoting individual liberty and prescribing minimal state interference with individual property rights, the Republican Administration intended to provide sufficient help to jump-start the HMO initiative but was still determined to allow market forces to control the allocation of resources. HMOs were to help patient-consumers improve their circumstances through their own initiatives. Patients were to be empowered by information transparency and their capacity to engage one centralized institution contracting all providers. Ultimately, patients were

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<sup>411</sup> Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 644 , supra 375, p.650.

<sup>412</sup> Lester Breslow & Joseph R. Hochstim, *Sociocultural Aspects of Cervical Cytology in Alameda County, Calif*, 79 Public Health Rep. 107 (1964).

meant to be active market agents and, therefore, active participants in the allocation process. Central government authority was not to interfere with the organization's subsidiary power. Individuals would receive care at a lower and decentralized level to better address their needs. The Act directly reflected the change in the administration of health care resources. The general perception was that central planning methods had to be set aside because they failed to reduce costs and did not account for individual choices in the same way that market mechanisms did.<sup>413</sup>

Communitarian ideals were also prominent in the final version of the Bill. Compared with a larger-scale national program, the initiative targeted the needs of communities. HMOs were meant to create benefits at the local level and to involve the community. They embrace the communitarian justice philosophy of having local infrastructures help individuals become more independent and flourish within the community. In fact, HMOs were initially not preoccupied with interpersonal relationships or the typical features of a privately financed system. The communitarian ideas were to be more salient, as sections of the Act were designed to tackle issues affecting health insurance coverage.

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<sup>413</sup> Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 644, supra 375, p.653.

Indeed, HMOs were discouraged from skimming high-risk applicants or enrolling exclusively healthy consumers who were less likely to use their services.<sup>414</sup> Organizations were required, during a minimum period of 30 days every 12 months, to enroll a representative sample of consumers based on the population in their area of service. Age, income, and other characteristics could not be taken into account to select these enrollees. If the organization did not comply, its membership would automatically be denied or revoked on the basis of having an unrepresentative pool of consumers.<sup>415</sup>

Nevertheless, if the HMO could demonstrate that this provision compelled the “[enrolment of] a disproportionate number of individuals who [were] likely to utilize its services more often than an actuarially determined average...”<sup>416</sup> and that it would “jeopardize its economic viability,”<sup>417</sup> or if the HMO “[were] not [to] have a population broadly representative of the various age, social and income groups, within the area it serves,”<sup>418</sup> or if it

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<sup>414</sup> Annas et al., *American Health Law*, supra 21, p.780.

<sup>415</sup> Uyehara & Thomas, supra 395, p.5.

<sup>416</sup> *Public Health Service Act Title XIII 'Health Maintenance Organizations'*, supra 372, §110-108.

<sup>417</sup> *ibid.*

<sup>418</sup> *ibid.*

were beyond the HMO's capacity to increase the enrollment, it could refuse to adopt the open-enrollment policy.<sup>419</sup>

Open enrollment was a cornerstone of HMO's potential contribution to competition in health care. The benefits of HMO membership had to be extended the community to foster competition between HMOs and other insurance carriers.<sup>420</sup> These managed care entities were intended to palliate adverse selection problems.

The Act also established a new pooling mechanism that was no longer based on health risk but that mimicked the 1940s community-rated, employer-sponsored insurance schemes.<sup>421</sup> Indeed, section 1301(b)(1)(C) of the Act called for fixed payments under a community-rating system to reduce adverse selection, providing freer access and cheaper coverage.<sup>422</sup>

In addition, as an insurance scheme based on solidarity, the concept of community rating was later introduced as a market tool to help reduce the cost of insurance and to provide services to a greater number of enrollees. The concept was to follow the precept that the "cost of providing care to the community should be borne equally by all members of the

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<sup>419</sup> Uyehara & Thomas, *supra* 395, p.37.

<sup>420</sup> S. Rep. No. 127 97<sup>th</sup> Cong. 1<sup>st</sup> Sess. at 60.

community.”<sup>423</sup> Healthier groups producing more positive externalities would participate in the common good and subsidize the coverage of less healthy groups.<sup>424</sup>

In theory, communitarian justice prioritizes the needs and goals of the community. Solidarity and justice can only be attained with the collaboration of all members of society. In a similar way, the open-enrollment provision was intended to prioritize the needs of the entire community over the welfare of insured individuals. Solidary HMO consumers were to help improve their community’s health status and participate in a more just society.

The Act also planned for a range of social services.<sup>425</sup> Section 1307 of the Act sets general guidelines for the administration of programs, prioritizing organizations located in medically underserved areas with a clear shortage of personal health services.<sup>426</sup> Control over group practices was assumed to attract more health care professionals and resources to develop service delivery in those remote areas.<sup>427</sup> Congress certainly intended HMOs to be

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<sup>421</sup> *ibid.*, p.37-38.

<sup>422</sup> *ibid.*, p.35-36.

<sup>423</sup> *ibid.*, p.36.

<sup>424</sup> *ibid.*

<sup>425</sup> *ibid.*, p.6.

<sup>426</sup> *ibid.*, p.7.

<sup>427</sup> Holley & Carlson, *The Legal Context for the Development of Health Maintenance Organizations*, 644 , *supra* 375,

better able to improve the distribution of health care resources in underserved communities.

Finally, with regard to the for-profit sector's role under the Act, the most crucial provision is certainly the "mandatory dual choice,"<sup>428</sup> under which employers were required to offer employees the choice of a prepaid practice group or an individual practice system if it were available in the local community. Nonetheless, employers were required to match only the amount offered by traditional health benefits. If the employee elected to enroll in a different plan, he or she would be responsible for the difference in the premium.<sup>429</sup> Even if mandatory dual choice provided each employee with greater autonomy,<sup>430</sup> corporate America would still get the bigger end of the stick. Ultimately, the private system remained untouched, and financial responsibilities were unchanged, despite the enactment of the Act.

*iii. The Foundations of the Act: Analysis of the Congressional Debates*

The five-part Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce of the

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p.651.

<sup>428</sup> *Public Health Service Act Title XIII 'Health Maintenance Organizations'*, supra 372, Section 1301.

<sup>429</sup> Dorsey, *The Health Maintenance Organization Act of 1973 (PL 93-222) and Prepaid Group Practice Plans*, 1, supra 373, p.8.

<sup>430</sup> *ibid.*, p.7.

House of Representatives on HMOs<sup>431</sup> confirm that discourses reflecting two conceptions of justice inspired this Act. Indeed, negotiations surrounding the Act reveal a dominant libertarian discourse but also a strong communitarian trend.

Libertarian precepts advocate using the market to justly allocate resources. To fulfill its “promises,” the market creates competition and enables the expression of individual choices. The witnesses’ testimonies reflect these principles, as they evoke the transparency brought by market forces<sup>432</sup> and the importance of finding cost-containment solutions<sup>433</sup> through increased competitiveness<sup>434</sup> in health care.

Indeed, many instances<sup>435</sup> in all five hearings insist on the importance of having “the HMO compete in the open market with the insurance

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<sup>431</sup> *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part I.* Congress. 2nd session (1972 ; *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part II.* Congress. 2nd session (1972 ; *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part III.* Congress. 2nd session (1972 ; *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part IV.* Congress. 2nd session (1972 .

<sup>432</sup> *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part IV.*, supra 431, p.70.

<sup>433</sup> *ibid.*, p.86, 310.

<sup>434</sup> *ibid.*, p.120; *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part I.* , supra 431, p.314.

<sup>435</sup> At least 13 instances refer to the idea of health care markets, competition in provision and financing of services and referring to patients as consumers, see *Hearing before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part I*, supra 431, p. 190, 314; *Part II*, p.42, 66, 67, 146, 557; *Part IV*, p.19, 70, 86, 120; of 1973, p.83.

industry,”<sup>436</sup> “a market (...) that allows the HMOs to grow and survive on the basis of their ability to attract physicians and consumers.”<sup>437</sup> Statements also emphasized “the maximization of health services in providing effective health care, [and an attempt] to minimize the costs in operating the health system.”<sup>438</sup>

During the negotiation process, doctors and the medical establishment were particularly vocal. For the most part, doctors wanted to share their points of view on the role of hospitals in the community and their duties as physicians. Dr. Frist, Vice President of the Hospital Corporation of America, took a firm libertarian stance on the matter, as he stressed the importance of subsidiarity and local autonomy in dispensing care. Speaking on behalf of his group, he said,

We are great in local control. We believe that every hospital in the community should be a community hospital with local autonomy, not taking directives from a central office, but taking aid in help and consultation from our central office. We are a great believer in not losing local autonomy.<sup>439</sup>

Certainly the most interesting part of this analysis rests on the importance given to communitarian justice principles during the negotiation stages.

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<sup>436</sup> *ibid.*, p.314.

<sup>437</sup> *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part II.* , supra 431 , p.66.

<sup>438</sup> *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part IV.* , supra 431 , p.86.

Particular instances stand out. First, Mr. Morris, President of the AHA, made the case for a communitarian approach within the structure of health maintenance organizations:

Through some process, the community is brought in through representation in a meaningful capacity and have a direct input into the policymaking decision body of that organization. They could be selected in a variety of ways, as long as you assure that there are spokesmen for not only different economic levels within the community, but also different ethnic groups, and so on, and minorities.<sup>440</sup>

This idea is about having an institution cater to the needs of the community in collaboration with the community. Those objectives were dear to the President of the AHA.

Astonishingly, the AMA stepped up to encourage community rating and open enrollment, explaining,

There will be many factors, economic, social, ethnic and racial, which will affect participation in such program. Nevertheless, it is important to attempt to maintain an enrollment of a cross section of society.<sup>441</sup>

With regard to the involvement of the for-profit sector, physicians and managers of hospital facilities were predominantly involved in the negotiations, whereas employers took a secondary role. This might have

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<sup>439</sup> *ibid.*, p.19.

<sup>440</sup> *Hearings before the Subcommittee on Public Health and Environment of the Committee on Interstate and Foreign Commerce House of Representatives, Part II.* , supra 431, p.555.

<sup>441</sup> *ibid.*, p.360.

occurred because corporate America had greatly encouraged the initiative and was satisfied with its outcome.

#### **D. The ACA (2010): A Shift Towards a National-Type of Insurance System with a Welfare Egalitarian Financing Law?**

It is uncertain whether the burden of two wars in the Middle East or the difficult economic times of the financial crisis helped the Democratic Party to achieve its biggest electoral victory since 1964. In any case, when President Obama entered the White House in January of 2009, he had accomplished the incredible tour de force of a Democratic majority in both the House of Representatives and the Senate. Nonetheless, even with complete control of all levers of government, the passage of his emblematic ACA proved to be difficult.<sup>442</sup>

The Obama Administration's proposed health care reform intended to tackle the many issues afflicting the American health care system by "provid[ing] affordable, quality health care for all Americans and reduc[ing] the growth in health care spending."<sup>443</sup> First on the agenda was reducing the number of uninsured, which totaled 50.7 million in 2009, according to the White House. For this, the insurance industry had to be on board and agree to stop

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<sup>442</sup> *The History, Economics and Politics of Obamacare*, last accessed 27 August 2013.

refusing applicants based on pre-existing conditions and to limit raises in premiums. Furthermore, given that employer-based coverage was the most prominent form of insurance in America, large and small employers would also have to provide more coverage to uninsured employees.

Another mission of the reform was to reduce the Medicaid part D prescription drug “donut hole,” which left many seniors unable to afford medication and forced them to pay out-of-pocket fees. Medicaid coverage also had to be extended to meet the health care needs of the 15 million Americans who did not meet the threshold for coverage but could not afford to purchase medical insurance.<sup>444</sup>

A bipartisan compromise was necessary for the proposed Bill to pass Congress’s muster, but unfortunately, political forces seemed to be irreconcilable. Conservatives worried about the repercussions of governmental interference in the realm of health care, and far-right Tea-Party forces created blockage. On the opposite end of the spectrum, Democrats were pushing for a federally funded health care program.<sup>445</sup>

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<sup>443</sup> Patient Protection, *Affordable Care Act of 2010*, Pub L 124 (2010).

<sup>444</sup> Howard S. Berliner, *Medicaid After the Supreme Court Decision*, 8 *Health Economics, Policy and Law* 133 (2013).

<sup>445</sup> *The History, Economics and Politics of Obamacare*, supra 442, last accessed 27 August 2013.

With the 2013 elections in sight, the Obama Administration decided to move quickly to make the Bill a law. After a long negotiation and reconciliation process, the ACA was finally enacted on March 23, 2010. Democrats enjoyed a very short-lived victory, as many states had already started challenging the constitutionality of the law. This uphill battle ended in a triumph for the Democrats when, in the spring of 2012, the Supreme Court heard the case in an expedited manner and upheld the crucial individual mandate.<sup>446</sup> The Obama Administration's project to pass a new and groundbreaking health care law was ultimately successful.

Work now must be done to implement the ACA and to ensure that it endures. The legislation has set the goal of having Americans under the age of 27 remain enrolled in parental insurance, to set up insurance exchanges to reduce costs, to increase the number of Medicaid enrollees, and to have all Americans enrolled in insurance plans regardless of any pre-existing condition. The financial viability of the project is to be safeguarded by having all Americans purchase coverage through their employer or at their own expense, thus increasing the risk pool of insured.<sup>447</sup>

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<sup>446</sup> *ibid.*

<sup>447</sup> *ibid.*

*i. The Role of Employers and Insurers in a New and Quasi-Universal Distribution  
of Health Care Resources*

The new health care reform is an attempt to tackle many of the system's shortcomings. A central tenet of the ACA pivots around the idea that insurance markets should no longer be structured around risk assessment but should focus on improving health care delivery and efficiency. In this respect, the ACA takes a unique and radical approach by greatly modifying the role of the for-profit sector.<sup>448</sup>

Covering more than 60% of the population, employer-sponsored insurance still bears some uncertainties for the future.<sup>449</sup> Commentators predict that, when the ACA takes effect in January 2014, employers might elect to drop all form of employee health coverage.<sup>450</sup> The market is expected to provide many more attractive and affordable options; therefore, employers will become obsolete pooling entities.

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<sup>448</sup> Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?* 97 Va.L.Rev. 125, 147 (2011).

<sup>449</sup> Timothy S. Jost & Commonwealth Fund, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (2010).

<sup>450</sup> David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a 'Game Changer?'*, SSRN Electronic Journal (2010).

The law mandates employers and penalizes those that fail to provide affordable insurance options.<sup>451</sup> At the time of implementation, employers that have more than 50 employees and are not providing affordable coverage will be penalized if one of their full-time employees qualifies for a premium tax credit and makes use of it on the insurance exchange.<sup>452</sup>

It is also possible that the ACA will lead employers to adopt a dumping strategy to reduce their high-risk pool and push unwanted participants to seek coverage through the insurance exchange market.<sup>453</sup> This indirect discrimination would reduce low-risk employees' insurance costs and shared savings for high-risk employees, helping them to acquire coverage through the individual insurance market. The benefits could also extend to the avoidance of tax liabilities for both groups.<sup>454</sup>

Insurers are also directly involved in the reform through the insurance exchange markets platform set up by the federal government. The ACA calls for the creation of state-based American Health Benefit Exchanges and Small Business Health Options Program Exchanges, to be administered by a

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<sup>451</sup> *Employer Mandate*, U. S. Chamber of Commerce, last accessed 27 August 2013.

<sup>452</sup> *ibid.*

<sup>453</sup> Randall P. Ellis, *Creaming, Skimming and Dumping: Provider Competition on the Intensive and Extensive Margins*, 17 J. Health Econ. 537 (1998).

<sup>454</sup> Monahan & Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?* 125, 147, *supra* 448, p.4.

governmental agency or a non-profit organization. Thanks to these exchanges, individuals and small businesses with up to 100 employees will be able to purchase insurance coverage. Businesses with more than 100 employees will also be able to purchase coverage in the Small Business Options Program Exchanges, but only starting in 2017.<sup>455</sup>

The Administration hopes that these exchanges will properly fulfill expectations, expand and improve health insurance coverage, and reduce health care costs overall.<sup>456</sup> In theory, insurance exchanges are more likely to achieve these results. Similar to large employers, exchanges have previously shown that they were capable of creating stable and successful insurance pools with little or no adverse selection.

The insurance exchange programs should extend these advantages to small employers and non-group markets to produce many positive externalities, such as lower transaction costs, increased competition, and more alternatives.<sup>457</sup>

Unfortunately, the implementation of health exchanges is also unlikely to occur without hurdles. Issues relating to market coverage and structure,

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<sup>455</sup> *Summary of the Affordable Care Act*, The Henry J. Kaiser Family Foundation 8/24/2013 (2013).

<sup>456</sup> *ibid.*

transparency and information disclosure, the administration of subsidies and mandates, relationships with employers, and cost control may very well arise.<sup>458</sup>

*ii. Did the Supreme Court Ruling on the ACA Provide Some Guidance for a More Just Distribution of Health Care Resources?*

Creating a political divide even before its implementation, the individual mandate portion of the ACA is by far the most controversial feature of the health care reform. The provision requires that all Americans be covered by an insurance plan by 2014 to meet the Act's minimum requirements. Any individual not in compliance with the mandate will incur financial penalties.<sup>459</sup>

Taking a welfare egalitarian approach to the allocation of health care resources, this provision proposes to reserve part of an American citizen's revenues to increase health *functioning* for the entire population. The mandate's purpose is not to redistribute income levied on salaries but to indirectly install universal coverage by mandating the purchase of health care insurance by all American citizens. Indeed, by improving the prospect of

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<sup>457</sup> Jost & Fund, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues*, supra 449, p.1.

<sup>458</sup> *ibid.*

coverage for uninsured and under-insured Americans, the ACA aims to equalize access to health care services and to increase welfare.

The opposition of Conservatives deemed the individual mandate to be unconstitutional and qualified it as a substantial infringement on individual freedom, which brought the case before the courts. It was argued that the government had no right to interfere with a citizen's property rights by imposing the purchase of a specific good.<sup>460</sup>

Thus, after the health care reform's constitutionality had been challenged four times before federal judges,<sup>461</sup> the fate of the entire reform was placed in the hands of the Supreme Court.<sup>462</sup> On June 28, 2012, four out of five Supreme Court Justices decided that the ACA would survive thanks to the Court's final decision to uphold the individual mandate. Although the Court preserved the most controversial part of the Act, it ruled differently on the expansion of the Medicaid program, which the suit had also brought into

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<sup>459</sup> Matthew Buettgens, Bowen Garrett and John Holahan, *Why the Individual Mandate Matters: Timely Analysis of Immediate Health Policy Issues*, last access 21 August 2013.

<sup>460</sup> *ibid.*

<sup>461</sup> *State of Florida, Et Al., V. United States Department of Health & Human Services, Et Al., no. 11-11021, State of Florida, Et Al., V. United States Department of Health & Human Services, Et Al., no. 11-11021*, (United States Court of Appeals for the Eleventh Circuit 2011); *Margaret Mead V. Eric Holder, no. 1:10-CV-00950, Margaret Mead V. Eric Holder, no. 1:10-CV-00950*, (United States District Court for the District of Columbia 2010); *Liberty University V. Timothy Geithner, no. 10-2347, Liberty University V. Timothy Geithner, no. 10-2347*, (United States Court of Appeals for the Fourth Circuit 2011); *Thomas More Law Center V. Barack Obama, no. 111-148, Thomas More Law Center V. Barack Obama, no. 111-148*, (United States Court of Appeals for the Sixth Circuit 2011).

<sup>462</sup> *Commonwealth of Virginia V. Sebelius, no. 3.10-CV-188, Commonwealth of Virginia V. Sebelius, no. 3.10-CV-*

question. This ruling shook the health policy community and signaled an uncertain future for Medicaid and an important portion of the ACA.<sup>463</sup>

Specifically, with regard to the individual mandate, Chief Justice Roberts offered a long, complex opinion analyzing the reasons behind the surprising judgment. Some saw in his discourse a high-minded approach paving a new way to bridge the Court's ideological divide and restore its reputation. Many others found, to the contrary, that his opinion was merely an impoverished reading of the Commerce Clause jurisprudence, which would further narrow the powers of the federal government in the coming decades.<sup>464</sup>

Many scholars had hoped that the challenge would create an opportunity for high-level constitutional lawyers to raise resource-allocation issues and for the Justices to craft a targeted solution directly addressing the topic of health care. Unfortunately, this decision does not constitute an out-of-the-box judgment. No core issues surrounding the allocation of health care resources were directly addressed or even really argued in front of the Supreme Court. All issues of constitutionality were resolved through a dry reading of the Constitution and some political considerations. The Chief Justice made no

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188, (United States District Court for the Eastern District of Virginia 2011).

<sup>463</sup> Berliner, *Medicaid After the Supreme Court Decision*, 133 , supra 444.

<sup>464</sup> David Harlow, *HealthBlawg*, last accessed 27 August 2013.

real contextualization efforts, despite Justice Ginsburg's attempt to address comments made regarding the extraordinary features of health care.<sup>465</sup>

The Court's ruling makes the individual mandate a mere invitation to buy insurance rather than an order. The mandate was deemed a constitutional Act of Congress and authorized through its power to tax and spend for the welfare of its citizens, and the penalty associated with non-compliance was interpreted as constituting a tax and not a fine, which enabled the individual mandate to be upheld in its entirety. No references to principles of justice or fairness stood out in any of the Justices' opinions. The importance of the just allocation or fair distribution of health care resources was swept under the rug, along with any potential debate on the need to address the importance of a right to health care. The Court cleverly avoided any discussion pertaining to rationing issues.

Again, the Supreme Court failed to grasp the uniqueness of health care as an essential element for the achievement of the Common Good. The judgment was not based on the right to health but on an interpretation of the

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<sup>465</sup> "Unlike the market for almost any other product [(including broccoli)] or service, the market for medical care is one in which all individuals inevitably participate. Virtually every person residing in the United States, sooner or later, will visit a doctor or other health care professional." *in* 567 U.S. 67 (2012).

Constitution that shifted the notion of the universality of care far from any legal debate.

The expansion of Medicaid envisaged under the Act was perceived as the least controversial part of the government's effort to reduce the numbers of uninsured.<sup>466</sup> Indeed, when this provision first came to the public's attention, no one thought to challenge the government's authority to use funding to compel action.<sup>467</sup>

The program's expansion was projected to insure 32 million Americans, with almost half being childless adults. Essentially, the ACA was to create a new mandatory coverage requirement for this population, but if a state chose not to cover the new group, it would lose all of its Medicaid funding. This is why 26 states led the challenge and argued that this portion of the law was coercive. All of these states felt compelled to expand coverage because they could not afford to lose all of their Medicaid funding.<sup>468</sup>

Surprisingly, the Court sided with the states and ruled the expansion impermissible.<sup>469</sup> Seven Justices concluded that even though Congress may attach conditions to federal funds provided to the states, tying new money

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<sup>466</sup> Renée M. Landers, *The Dénouement of the Supreme Court's ACA Drama*, 367 N. Engl. J. Med. 198 (2012).

<sup>467</sup> Berliner, *Medicaid After the Supreme Court Decision*, 133 , supra 444.

and existing Medicaid payments to participation in the expansion violated the 10th Amendment. Chief Justice Roberts further argued that the expansion was “no longer a program to meet the health care needs of the neediest among us but an element of a national plan to provide universal health insurance coverage.” He concluded that the states had not agreed to nor could have anticipated such a drastic change in the Medicaid program.<sup>470</sup>

This ruling now considerably limits the power of Congress. Allowed to spend only for the general welfare, Congress cannot impose a purchase through penalties. With this, the Supreme Court also reduced Congress’s power to address rationing issues because it prohibits Congress from imposing a program for the health care of its most needy population.

Furthermore, this approach to health care policy may lead to inconsistency in states’ health care policies because states are given significant leeway and the power to reject the expansion. Overall, the ruling on the expansion of Medicaid sets a dangerous precedent for the future of health care reforms. The Court abstracts itself from any allocation decisions on this matter but

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<sup>468</sup> *ibid.*

<sup>469</sup> *ibid.*

<sup>470</sup> Landers, *The Dénouement of the Supreme Court's ACA Drama*, 198 , *supra* 466.

also partly prohibits the executive branch from formulating effective rationing policies for health care.

In my opinion, this judgment should certainly be understood in the light of the American constitutional tradition, which refuses to recognize a category of positive rights that might potentially create a socio-economic right to health care. Perhaps this occurs because the judiciary simply assumes that courts will have a lighter burden if they are preoccupied only with the enforcement of negative political and civil rights, or it may be simpler for courts to ban the government's interference with constitutional rights rather than to make intricate budgetary and allocation determinations from the bench. In any case, this judgment testifies to the Supreme Court's inability to directly address health care issues without leaning on the Constitution and avoiding the sensitive issue of rationing.

In this case and over the years, the American Supreme Court has not been keen to recognize the importance of contextualization that a new right to health care could demand or, in this case, that a health care reform enacting a slow turn towards a system of universality of care could justify.<sup>471</sup> If the

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<sup>471</sup> Sabrina Germain, *Taking 'Health' as a Socio-Economic Right Seriously: Is the South African Constitutional Dialogue a Remedy for the American Healthcare System?* 21 *African Journal of International and Comparative Law* 145 (2013).

Supreme Court had examined more closely American health care provision and financing history, it might have understood that the law and its interpretation cannot withdraw from the path paved by health care financing and provision entities and that it must therefore consider the policy implications of the ACA, instead of reverting to a sterile interpretation of the Constitution.

*iii. The Foundations of the Act: Analysis of the Congressional Debates*

The hearings surrounding the ACA were long, heated, and touched on issues determinant for the future of American society. An analysis of discourses of justice in the four-part Hearing before the Committee on Ways and Means of the U.S. House of Representatives<sup>472</sup> and the two-part Hearing of the Committee on Health, Education, Labor, and Pensions of the U.S. Senate, reveals elements both in favor and against the Bill. Most of the 1093 pages of committee hearings include some elements of a conception of justice.

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<sup>472</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I.* Congress. 1<sup>st</sup> session (2009); *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II.* Congress. 1<sup>st</sup> session (2009); *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III.* Congress. 1<sup>st</sup> session (2009); *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part IV.* Congress. 1<sup>st</sup> session (2009); *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part I.* Congress. 1<sup>st</sup> session; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part II.* Congress. 1<sup>st</sup> session.

The Bill's opponents presented libertarian arguments in favor of a competitive, cost-effective,<sup>473</sup> market-run health care system<sup>474</sup> in more than 13 occurrences. For example, Dr. Gratzner, Senior Fellow at the Manhattan Institute for Policy Research, stressed the following in his prepared statement:

Market competition can contain the high cost of insurance- if Congress and the States would only allow it to take place. Efforts at creating equity and fairness in the health insurance market- done with the best intentions- have created dramatic differences in price across the country (...) The Federal Government can promote regulatory strategies that will increase interstate insurance competition.<sup>475</sup>

Firmly reiterating the precepts of the libertarian theory, namely, just allocation through a competitive market without state intervention, these witnesses employed the language of justice to make their arguments. Furthermore, these advocates of the status quo were critical of the federally run project because it might potentially disturb the private insurance market and negatively impact America's competitiveness.<sup>476</sup>

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<sup>473</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*, supra 472, p. 213.

<sup>474</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*, supra 472, p. 10, 49, 268; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II*, supra 472, p.13; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III*, supra 472, p. 13, 25, 29, 35, 79; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part I*, supra 472, p.33, 68, 72

<sup>475</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*. Congress. 1st session (2009) , supra 472, p.49.

<sup>476</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III*, supra 472, p.41; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part I*, supra, p. 57, 43.

Supporters of the initiative, for their part, presented welfare and resource egalitarian arguments<sup>477</sup> in favor of the Bill, pushing for affordable coverage options<sup>478</sup> and universal care for vulnerable groups.<sup>479</sup> To them, the ACA proposed to equalize the capacity to access health care resources rather than the resources in and of themselves, but they still advocated protection for the needy and the vulnerable. Indeed, in more than 14 occurrences, supporters of the Bill also strongly condemned private insurers' treatment of high-risk applicants and requested that the law abolish any discrimination based on pre-existing conditions.<sup>480</sup> Indeed, this concern included even younger groups:

The draft would get us closer to abolishing discriminatory insurance market practice that use a person's age to block

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<sup>477</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*, supra , p. 99, 115, 123, 168, 324, 337, 343, 389, 384, 399; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part VI*, supra , p.13, 16, 22, 42 ;*Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part II*, supra , p.11, 38.

<sup>478</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*, supra 472, p. 201, 130, 131, 133, 235;*Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II*, supra 472, p.27; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III*, supra , p. 121; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part IV*, supra 472, p.44; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part II*, supra 477, p.36, 37.

<sup>479</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*, supra 472, p.119, 143, 149, 217, 324, 333, 336, 339, 343, 347, 399 ; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III*, supra 472 , p.30, 60, 112, 114; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part IV*, supra 472, p.15, 16, 18, 35; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part I*, supra 472, p.55; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part II*, supra 477, p.13, 15, 18, 36, 43, 44.

<sup>480</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*, supra 472, p. 121, 136, 324, 344; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II*, supra 472, p.13, 16; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III*, supra 472 ,p. 6, 115, ;*Hearing before the Committee on Ways and Means U.S. House of Representatives, Part IV*, supra 472, p.17, 85, 144; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part I*, supra 477, p. 35, 36; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part II*, supra , p.36.

access to health coverage or to keep prices too high to make a difference.<sup>481</sup>

In addition, Kathleen Sebelius, U.S. Department of Health and Human Services Secretary, stated the importance of “getting rid of some of the preexisting medical condition barriers that allow a skewed market (...).”<sup>482</sup>

For those advocating a more welfare egalitarian health care system, the market was an inadequate means of distribution<sup>483</sup>; thus, they could only critique the libertarian allocation model. They did so by reflecting on the uniqueness of health care and its “social good” attributes.<sup>484</sup> As Dr. Flowers, Co-Chair of Physicians for a National Health Program, pointed out,

The price we are paying for the profit-driven healthcare market is the squandering of our economic, mental and physical health as a Nation. The market is the wrong model. Healthcare is not a commodity. It is a human right.<sup>485</sup>

Uwe Reihardt also added that

Americans, too believe that our health system ought to be operated on the *Principle of Social Solidarity*, that is, that health care should be viewed as a social good.<sup>486</sup>

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<sup>481</sup> *ibid.*, p.136.

<sup>482</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II.* Congress. 1st session (2009) , supra 472, p.13.

<sup>483</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III*, supra 472, p.28; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part IV*, supra 472, p. 17.

<sup>484</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II*, supra 472, p.75; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part IV*, supra , p.14, 15, 16, 17, 22, 23, 98.

<sup>485</sup> *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part I.* Congress. 1st session (2009) , supra 477.

<sup>486</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part IV.* Congress. 1st session (2009) , supra 472 p.15.

Finally, communitarian justice principles were also advanced through the promotion of primary care and wellness programs.<sup>487</sup> Communitarian projects such as medical homes were certainly a source of inspiration for the initiatives proposed under the ACA. Solidarity in the group and better collective health were the focal points of the reform.

In his prepared statement, Dr. Raskob complimented the efforts made in the Bill's initial draft to meet the community's needs, and he added,

Policies and programs that emphasize both community-based prevention and clinical preventive services as part of primary care should be the foundation of health care reform (...).<sup>488</sup>

Congressman Kennedy also showed his support in favor of a more just and communitarian approach to health care, stating,

in order to achieve optimal health, mental health services must be more fully integrated into non-traditional settings such as schools, juvenile justice settings, early childhood programs, community-based programs, housing and welfare programs.<sup>489</sup>

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<sup>487</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part I*, supra 472, p. 117, 120, 149, 302, 303, 304, 321, 338, 342, 343, 344, 345, 360, 366; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II*, supra 472, p. 75; *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part III*, supra 472, p.123; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part I*, supra 472, p.43, 85; *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part II*, supra 477, p.9, 17, 20, 22, 27, 38, 41, 65.

<sup>488</sup> *Hearing of the Committee on Health, Education, Labor, and Pensions U.S. Senate, Part II*. Congress. 1st session (2009) , supra 472, p.8.

<sup>489</sup> *Hearing before the Committee on Ways and Means U.S. House of Representatives, Part II*, supra 472, p.75.

Negotiations leading to the final draft of the ACA raised pragmatic concerns regarding the financing and delivery of health care. Nonetheless, an underlying social discussion also brought to the surface justice considerations that polarized the debate. A faction of the for-profit sector was keen on protecting its interests, but many other for-profit actors also saw the project as an opportunity to rectify the trajectory of a long path of dependence affecting the health care system.

#### **IV. Conclusion**

Through the prism of distributive justice, this partial review of the American health care system's legislative history reveals the path of dependence that has shaped health care lawmaking in the United States. The powerful for-profit trifecta, physicians, insurers, and corporations, has employed different conceptions of justice to set the pace and modes of distribution from the 1940s on and successfully created a rigid path of dependence that guided health care policy-making.

This analysis makes it easier to assess the roles of justice and of the for-profit sector in the distribution of health care resources in the United States. A simple answer would certainly admit that many political and pragmatic implications influence the drafting of health care laws; nonetheless, a sense

of justice, at times libertarian, egalitarian, communitarian, or even utilitarian, has animated the spirit of the legislator. The influence of lobbies on the drafting process cannot be ignored—lobbies that are also inspired by certain ideals of justice informing their discourse throughout the negotiations that they lead with the public power.

## CHAPTER THREE:

### A Case Study: The National Health Service of England

#### *The History of an Implicit Concordat with the For-Profit Sector*

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#### **I. Introduction**

The NHS prides itself on providing world-class health care services to the entire British population; this accomplishment is possible thanks to a strong commitment on the part of the government but also because of the increasing participation of private partners in the health care sector. Indeed, in the NHS a simple mantra prevails: “what matters is what works.”<sup>490</sup> As long as all permanent residents are provided with free care at every point of service, private entities are allowed to compete with public providers.<sup>491</sup>

Unfortunately, as in many other western welfare states, scarcity issues also affect the functioning of the British health care system. The problems are caused in part by improved life expectancy, which has slowly given rise to an aging population with growing health care needs. Thus, it is projected that in

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<sup>490</sup> Hunter, *The Health Debate*, supra 6, p.37.

<sup>491</sup> Allyson M. Pollock, Declan Gaffney & Matthew Dunnigan, *Public Health and the Private Finance Initiative*, 20 *Journal of Public Health* 1 (1998).

the very near future, the NHS will no longer be able to sustain itself or honor its commitment to offer free and universal health care services.<sup>492</sup>

Although similar in nature to the health care challenges in the U.S., the issues surrounding the allocation of health care resources in the NHS stem from a different cause than those currently afflicting the American private care system. It seems that the NHS has been evolving its own path of dependence, but unlike its American counterpart, the NHS is not the prey of powerful lobbying groups. Problems of increased waiting lists and scarce resources do not result strictly from power struggles. Rather, the egalitarian philosophy governing the allocation of health care resources has constrained most reform in the United Kingdom.

The foundational Beveridgian philosophy has been preventing any extreme redesign or rethinking of the system. This commitment is rooted in the tacit concordat that Westminster entered into with the for-profit sector at the inception of the NHS. This implied agreement has helped to maintain the system's core values and has left limited leeway for radical change.

Historically, debates on health care reforms have always oscillated within the boundaries of this rigid framework, creating significant tensions and

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<sup>492</sup> David J. Hunter, *Desperately Seeking Solutions: Rationing Health Care* (1997).

affecting policy choices in many respects. Specifically, the agreement has led to many debates on the public versus private provision of health care, the role of doctors shifting towards a management role, and the command versus control approaches to the management of health care services.<sup>493</sup>

An examination of the influence of justice principles on the distribution of health care resources within the NHS partially explains why the “ends” of this system are unscathed, whereas the “means” are, more than ever, in flux.<sup>494</sup> The relationship between the public power and for-profit actors must be explored to explain the current state of the British health care system. The role played by the medical association in crafting health care financing and provision laws deserves closer attention.

Thus, I begin this chapter by providing a brief historical overview explaining the development of the unique path of dependence that has guided the health care lawmaking process in Britain over the past 70 years. I also present the themes that have defined the NHS’s organization, to unveil the past, present, and future roles played by the for-profit sector in and outside the health care system. Finally, I offer a reading of key legislative pieces informed by the four conceptions of justice that compose my analytical

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<sup>493</sup> Hunter, *The Health Debate*, supra 6, p.44.

framework, to determine whether any account of distributive justice has impacted the drafting of laws leading to major health care reforms in the United Kingdom.

## **II. A Universal System Giving a Backseat Role to the For-Profit Sector**

The ideological foundations of the NHS set a path of dependence that has been present throughout the organization's entire legislative history. Its core philosophy constitutes both the strength and weakness of the British health care system.

Indeed, many reforms and legislative efforts have failed to contain health care costs in Britain or to provide the population with an efficient delivery of health care services. The ever-growing waiting lists and pressure on medical professionals now create significant access barriers. These issues indirectly result from the constraints these foundational values have placed on the system.<sup>495</sup> Despite the strains, however, the NHS continues to deliver world-class, universal health care services free of charge and based on needs to the entire British population.

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<sup>494</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100.

In this universal care system, the for-profit sector's role can only be understood in transparency of the public sectors' achievements. An analysis of the NHS's foundations and the role of different governments in its organization is crucial to reveal the influence of these core principles on the system. Nevertheless, it is also important to understand the impact of these principles on the for-profit sector.

Therefore, before analyzing in greater detail the legislative history of the NHS, I wish to unveil the historical events that drove insurers and private providers to take a backseat role in the delivery and financing of health care services. For this, I begin with a thematic and historical study of major health care policy trends in Britain.

### **A. The History of a System of Free Health Care**

The state of medical care in pre-war England largely depended on voluntary and municipal hospitals. Run by local governments, the decentralized ambulatory care services were unevenly provided by community doctors to the best of their abilities. Public health and sanitation issues were under the purview of many decision-making bodies, and publicly funded mental health

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<sup>495</sup> Bevan & Robinson, *The Interplay between Economic and Political Logics: Path Dependency in Health Care in England*, 53, supra 45.

services were provided through a system of county asylums. The disparate organization of health care services and the lack of coordination among institutions of care contributed to a poor distribution of health care resources across the country. Furthermore, the financing of this rudimentary system was mostly left in the hands of charities given that health insurance was rare, costly, and mostly reserved for the upper class.<sup>496</sup> The modernization and expansion of technical scientific knowledge called for improving health care services, as such knowledge had already outpaced existing institutions.

According to health care systems historian Charles Webster, by comparison to other advanced countries, including the Kingdom's White Dominions (Canada, Australia, and New Zealand), the United Kingdom's inter-war services were falling behind because of a lack of resources and coordination among the different entities dispensing care.<sup>497</sup>

Yet, compared to its American counterpart, the British health care system had already achieved much with limited means: the creation of voluntary

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<sup>496</sup> Seán Boyle, *United Kingdom (England): Health System Review*. 13 Health Systems in Transition 1 (2011), p.25.

<sup>497</sup> Webster, *The National Health Service: A Political History*, supra 23.

hospitals and some publicly funded hospitals and institutions as early as 1830.<sup>498</sup>

Furthermore, the Labour Party in power at the end of the nineteenth century provided propitious ground for health, education, and welfare reforms. Trade unions seized the moment and propelled the debate on public assistance. Later, in 1911, the Liberal government introduced the National Insurance Act, which offered a health insurance scheme to workers, with the help of employers, state funding, and employee contributions. Although dependents remained uninsured and hospital care was uncovered, GP care, prescriptions, and treatment for tuberculosis were provided free of charge. By 1919, medical and public health functions along with local services in England and Wales were centralized. The government took on the supervision and coordination of all services.<sup>499</sup>

It would therefore be false to portray the emergence of the NHS as a post-war groundbreaking project. Certainly, the socialist ideology of the 1940s and the impression of the wars on socialist architect Aneurin Bevan had helped to spark the idea of a national health care system. It is undeniable that

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<sup>498</sup> Webster, *The Health Services since the War*. 1, 1, supra 22.

<sup>499</sup> Boyle, *United Kingdom (England): Health System Review*. 1, supra 496.

the pre-war National Insurance Act represents a milestone in the development of the future health care system.<sup>500</sup>

During the darkest days of World War II, the Coalition government prepared the groundwork for the creation of a national health service. The publication of the very popular Beveridge report in 1942<sup>501</sup> and the creation of the national Emergency Medical Service during the war fueled the population's desire for a unified health system.<sup>502</sup> Therefore, despite the medical profession's opposition to Bevan's project, the National Health Service Act became the law in 1946. A health care system based on equal and free access to services for all was born,<sup>503</sup> and on July 5, 1948, Britain became the first western country to offer free entitlement to medical care to its entire population.<sup>504</sup>

Consensus on the idea of a universal system continued throughout the 1950s and the 1960s. Unfortunately, by 1970, costs had increased, and new facilities were clearly needed. A reorganization had to take place.<sup>505</sup> Under the Health Service Reorganization Act of 1973, acute, community, and

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<sup>500</sup> Hacker, *The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and US Medical Policy*, 57, supra 42.

<sup>501</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.17.

<sup>502</sup> Douglas Black, *Change in the NHS*, J. Public Health Policy 156 (1992).

<sup>503</sup> Boyle, *United Kingdom (England): Health System Review*. 1, supra 496, p.26.

<sup>504</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.1.

<sup>505</sup> Boyle, *United Kingdom (England): Health System Review*. 1, supra 496, p.26.

preventive services were assembled under 90 newly created Area Health Authorities.”<sup>506</sup> Resources were strained and unequally distributed in the territories; therefore, the Resource-Allocation Working Party assumed the task of distributing more justly financial resources among all areas on the basis of local needs.<sup>507</sup>

A few years later, the victory of Margaret Thatcher with the Conservative Party signaled a new era in the NHS. The government started strong with a series of initiatives targeting the system’s inefficiency. Based on the recommendations of the Griffiths Report (1983), cost-containment measures, performance indicators, and competition stimuli were placed on the agenda. Area Health Authorities were abolished and replaced by District Health Authorities.<sup>508</sup>

The most dramatic change made to the system during the course of the twentieth century was most certainly the 1990 National Health Service and Community Care Act, which created an internal market for health care. The Act separated the commissioning and provision of care, and it gave GPs the opportunity to become “fundholders” and to act as purchasers of care.

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<sup>506</sup> *ibid.*

<sup>507</sup> *ibid.*, p.27.

<sup>508</sup> *ibid.*

Hospitals and community and health services were incorporated into a non-profit trust structure to act as providers. Finally, contracts governed the relationship between purchasers and providers of health care services. This upheaval of the system put the medical profession at the center of the reform and infiltrated a market-driven ideology, promoting more competition in the NHS.<sup>509</sup>

In 1997, a Labour government came into power and was averse to the organization of health care services in the form of an internal market.<sup>510</sup> Surprisingly, when the NHS underwent further changes in its structure, the purchaser-provider division was retained. At this time, the National Institute for Clinical Excellence (NICE) and the Care Quality Commission were created. These agencies were designed to set national health care standards and to improve the allocation of health care resources.<sup>511</sup> During this period, the for-profit sector emerged timidly through the Private Finance Initiative (PFI), as private entities were asked to build and operate facilities on the account of the NHS.<sup>512</sup>

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<sup>509</sup> *ibid.*

<sup>510</sup> Ray Robinson & Anna Dixon, *Health Care Systems in Transition: United Kingdom (1999)*.

<sup>511</sup> Boyle, *United Kingdom (England): Health System Review*. 1, *supra* 496, p.28.

<sup>512</sup> *ibid.*

With the new millennium came policies prioritizing patients in health care. Secretary of State Alan Milburn wanted to put patient choice at the center of the system. He enlisted the help of the for-profit sector, including overseas providers, to decrease the ever-growing wait lists. The Foundation Trust (FT) status was made available to providers willing to acquire more autonomy from centralized management and to help them get closer to their communities. These new entities had to be supervised by a new regulatory agency: Monitor.<sup>513</sup>

Finally, the Coalition government formed on May 11, 2010, brought yet another reorganization of the NHS. Great controversy surrounded the project, and in spite of massive opposition in and outside of Parliament, the Health and Social Care Act became the law on March 27, 2012. It is by far the most extensive reorganization of health care services to date. This revolutionary reform may very well mark the beginning of a hybridized health care system, but only the future will tell.

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<sup>513</sup> Rudolf Klein, *The Twenty-Year War Over England's National Health Service: A Report from the Battlefield*, J. Health Polit. Policy Law (2013), p.851.

## B. An Internal Market Under State Control

Even though GPs were providing primary care services independently from general health authorities, the organization of health services in England was originally based on an integrated model with no separation between the commissioning and provision of services.<sup>514</sup>

The current mixed health care economy of the NHS is a legacy of the Thatcher era. A quasi-market for health care services was established in 1991 to increase efficiency and to create competition among NHS providers.<sup>515</sup>

The market ideology inevitably brought a for-profit dimension to the commission and delivery of health care services. GPs increased their autonomy by becoming contractors to the NHS and were provided the opportunity to form fundholding practices (later abolished by a subsequent health care reform). State-owned hospitals remained public entities but became semi-independent and acquired a not-for-profit trust status.<sup>516</sup> The delivery, purchasing, and planning functions of the NHS were thus separated.<sup>517</sup>

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<sup>514</sup> Boyle, *United Kingdom (England): Health System Review*. 1 , supra 496, p.110.

<sup>515</sup> Pervaiz K. Ahmed & Lynne Cadenhead, *Charting the Developments in the NHS*, 24 *Health Manpow. Manage.* 222 (1998).

<sup>516</sup> Boyle, *United Kingdom (England): Health System Review*. 1 , supra 496.

<sup>517</sup> Helen Dickinson et al., *The Limits of Market-Based Reforms*, 13 *BMC Health Services Research* 11 (2013),

*i. The Managed Trading Place*

The introduction of a quasi-market for health care created significant controversy, even though Margaret Thatcher's government never intended for health care resources to be distributed through a purely libertarian system. The allocation of health care resources was and still is under governmental control in order to safeguard the fundamental values of NHS. This managed "trading place" is perceived as providing the best of two worlds: market efficiency and competition as well as access to care based on needs rather than on means.<sup>518</sup>

Currently, GPs remain independent contractors and generate profits from some of the services they provide to the NHS. Medical consultants, for their part, are directly employed by the NHS but sometimes partner with private health care facilities to provide services. The internal market and its underlying for-profit ideology endure, although the government remains in control of financing health care services in order to protect the NHS's fundamental values.<sup>519</sup>

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p.1.

<sup>518</sup> Christopher Ham, *Management and Competition in the NHS* (1997).

<sup>519</sup> *About the National Health Service (NHS) in England - NHS Choices*, last accessed 4 January 2014.

*ii. The Purchasers and the Providers*

Historically, GP fundholders and strategic health authorities purchased health care services from NHS trusts and the GPs.<sup>520</sup> Organized through block contracts, this transaction was simply the provision of a fixed quantity of health care services over the course of a year in exchange for a set amount of money.<sup>521</sup>

Providers were divided into two categories. First, there were NHS trusts, organizations structured on a business model and run by a board of directors and a chairman appointed by the Secretary of State.<sup>522</sup> Most trusts comprised one or more hospitals and other facilities. NHS trusts have now acquired the status of Foundation Trusts, giving state-owned hospitals more autonomy and the opportunity to administer resources according to the needs of their communities.<sup>523</sup>

Second, there were private providers, the GPs acting as “small businessmen.” Even though GPs were and remain independent contractors and stand alone as a group, they are fully integrated members of the NHS health care professionals’ team. Under the original internal market, funds

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<sup>520</sup> Ham, *Management and Competition in the NHS*, supra 518.

<sup>521</sup> Boyle, *United Kingdom (England): Health System Review. 1*, supra 496, p.110.

transferred from the primary care trusts' (PCTs) entities to the NHS providers and GPs. With the latest health care reform, PCTs have been abolished, and a new system of commission has been put into place.<sup>524</sup>

To purchase health care services, before their abolition in 1998, GP fundholders had the right to acquire health care providers' services on behalf of their patients.<sup>525</sup> With a set budget, fundholders managed their practice staff and prescription expenses and purchased a set amount of hospital services (including elective surgery and outpatient care).<sup>526</sup> Strategic Health Authorities and PCTs used the remaining monies to purchase their share of health care services.<sup>527</sup>

Under the 2012 Health and Social Care Act, Strategic Health Authorities and PCTs are abolished and replaced with Clinical Commissioning Groups (CCGs).<sup>528</sup> These entities are now responsible for allocating the majority of health care resources. Boards composed of hospital representatives and GPs commission primary care and hospital services to local communities.<sup>529</sup>

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<sup>522</sup> Ahmed & Cadenhead, *Charting the Developments in the NHS*, 222, supra 515.

<sup>523</sup> Webster, *The National Health Service: A Political History*, supra 23, p.2.

<sup>524</sup> *ibid.*

<sup>525</sup> Boyle, *United Kingdom (England): Health System Review. 1*, supra 496, p.110.

<sup>526</sup> Ahmed & Cadenhead, *Charting the Developments in the NHS*, 222, supra 515.

<sup>527</sup> *ibid.*

<sup>528</sup> BMA, *The New NHS Structure*, BMA, last accessed 4 January 2014.

<sup>529</sup> *Commissioning*, BMA, last accessed 4 January 2014.

### *iii. The Consumers*

Although *de facto* part of the internal market, NHS patients are not consumers *stricto sensus*. NHS services are available to all, free of charge and based on needs. Thus, patients do not directly purchase services at the point of service. Unlike Americans, “ordinary residents of the U.K.”<sup>530</sup> contribute to the financing of all of their health services through a system of central taxation.<sup>531</sup>

### **C. The Niche Role of Private Partners**

Apart from the omnipresent medical association, the for-profit/private sector has only recently entered the British health care system. Even though, compared to the public sector, private actors exercise a niche and peripheral role, their influence and presence have grown remarkably in recent decades.<sup>532</sup>

Under the current system, the private sector is authorized to deliver publicly financed health care services. In turn, the public sector sometimes finances

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<sup>530</sup> Public Health England, *Entitlements to NHS Care*, 2012, last accessed 4 January 2014.

<sup>531</sup> Tony Delamothe, *NHS at 60: Founding Principles*, 336 *BMJ: British Medical Journal* 1216 (2008).

<sup>532</sup> Ian Kennedy & Andrew Grubb, *Medical Law* (2000), p.131.

privately delivered health care services. Thus, the lines between public and private are now extremely blurred.<sup>533</sup>

Offering voluntary insurance products, private medical insurers act in parallel with the NHS. Their participation in the health care market contributes to the gradual hybridization of the system. Many patients purchase voluntary insurance to improve their experience of health care services. For patients and for NHS purchasers, the desire to avoid endless wait lists and to have a broader choice of specialists when in need of a consultation justified purchasing coverage to supplement the protection offered by the NHS. For other people, these products' higher standard of comfort and privacy leads them to pay for out-of-pocket insurance.<sup>534</sup>

#### *i. Private Finance Initiatives*

Notwithstanding extreme controversy, the Conservative government of John Major introduced PFIs in 1992. The project did not focus only on the health care sector but also involved the defense, transport, education, social housing, and waste management sectors.<sup>535</sup> The goal of the initiative was to

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<sup>533</sup> Webster, *The National Health Service: A Political History*, supra 23, p.11.

<sup>534</sup> *ibid.*

<sup>535</sup> Mark Hellowell & Allyson M. Pollock, *The Private Financing of NHS Hospitals: Politics, Policy and Practice*, 29 *Economic Affairs* 13 (2009).

reduce the government's spending and involvement by contracting out publicly financed services to the private sector.<sup>536</sup>

In 1997, the Labour government took over the project. The NHS Private Finance Act was then enacted. The legislation gave more leeway to the private sector and bound the public power to PFI payments.<sup>537</sup> The Act provided for the creation of 14 new acute care hospitals.<sup>538</sup> With private financing for public sector projects, private investors were to own, design, build, and operate public facilities, and, in the case of the NHS, would rent them out to the government.<sup>539</sup>

Critics described the Act as a form of “privatization by the backdoor,” and their greatest concern was the potential of PFIs to hinder the fundamental principles of the NHS by having the private sector participate in financing the health services' infrastructures.<sup>540</sup>

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<sup>536</sup> Pollock, Gaffney & Dunnigan, *Public Health and the Private Finance Initiative*, 1 , supra 491.

<sup>537</sup> Klein, *The Twenty-Year War Over England's National Health Service: A Report from the Battlefield*, supra 513, p.851.

<sup>538</sup> Hellowell & Pollock, *The Private Financing of NHS Hospitals: Politics, Policy and Practice*, 13 , supra 535.

<sup>539</sup> Pollock, Gaffney & Dunnigan, *Public Health and the Private Finance Initiative*, 1 , supra 491.

<sup>540</sup> *ibid.*

## *ii. Private Medical Insurance*

Private Medical Insurance (PMI) can be substitutive, complementary, or supplementary. With substitutive private insurance schemes, employers purchase coverage for their employees, to account for risks not traditionally covered under the public health care system; with complementary insurance products, they purchase coverage to assist with the cost of services partly covered under public programs; and finally, with supplementary insurance, employees get greater choice and faster access to health care services that are covered under the policy. The latter is the most dominant form of PMI in England.<sup>541</sup>

Available data show that PMI constitutes 25% of the insurance market in the United Kingdom.<sup>542</sup> This market share is most likely to continue growing if the NHS remains unable to eliminate waiting lists and is required to reduce its services.

## *iii. Private Providers*

In the 1980s, the NHS started purchasing health care services from private providers to alleviate capacity problems. At that point, services were

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<sup>541</sup> Boyle, *United Kingdom (England): Health System Review*. 1 , supra 496, p.88.

commissioned directly from NHS to private providers without intermediate NHS purchasers.

In the new millennium, patient choice policies led PCTs to open the provision market to British and overseas providers.<sup>543</sup> The government had mandated that a choice of at least one private-sector provider be offered to all NHS patients in need of elective care.<sup>544</sup>

Currently, the purchasing role of PCTs has been taken over by the CCGs. These groups also turn to the private sector to commission many health care services. Thus, private-provider activity in the NHS is expected to grow extensively in the coming years.<sup>545</sup>

#### **D. Balancing Universality and Cost-Effectiveness Without the Help of the For-Profit Sector**

Arthur Marwick describes “a primitively unstable mixture of class prejudice, commercial self-interest, professional altruism, vested interest, and demarcation disputes”<sup>546</sup> to explain the rudimentary state of the pre-war

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<sup>542</sup> *ibid.*

<sup>543</sup> Foubister et al., *Private Medical Insurance in the United Kingdom*, supra 4, p.7.

<sup>544</sup> Boyle, *United Kingdom (England): Health System Review*. 1 , supra 496, p.114.

<sup>545</sup> Foubister et al., *Private Medical Insurance in the United Kingdom*, supra 4, p.7.

<sup>546</sup> Delamothe, *NHS at 60: Founding Principles*, 1216 , supra 531.

health care system in England. Evidently, alternatives had to be found to offer better services and set new standards in health care.<sup>547</sup>

Aneurin Bevan was therefore put in charge of reviewing the system. He certainly went above and beyond the “task description,” as he imagined a system of health care services that would be “available to the whole population freely”<sup>548</sup> and that would “generalise the best health advice and treatment.”<sup>549</sup> Naively he thought that by improving the population’s general health status, he could eliminate future health care costs. Indeed, at the origin of this unified system was the misconception that a finite amount of ill health existed and that it could be salvaged or removed with efficient health care services.<sup>550</sup> In many ways the NHS has met this challenge, but in others it has also become the victim of its own success. Life longevity has led to significant health care costs with which the system can barely cope.<sup>551</sup>

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<sup>547</sup> *ibid.*

<sup>548</sup> *National Health Service Bill, Official Report of House of Commons*, (1946): 45-49.

<sup>549</sup> *ibid.*

<sup>550</sup> Hunter, *Desperately Seeking Solutions: Rationing Health Care*, *supra* 492, p.20.

<sup>551</sup> *ibid.*

i. “From the Cradle to the Grave”

Among all of its capitalist partners, the British government was first to offer free and comprehensive health care services to its entire population.<sup>552</sup> To this day, the NHS remains one of the best examples of socialized medicine and universal health care in the world.<sup>553</sup> Its financing through general taxation allows for treatments and clinical decisions to be made freely based on physicians’ scientific judgments, not on the patient’s ability to pay for services.<sup>554</sup>

The NHS’s first priority remains to provide health care coverage to all residents of the United Kingdom “from the cradle to the grave,” while maintaining the same standard of quality and care regardless of the region or the resources available.<sup>555</sup> To achieve the goals of social and geographical equality, services are organized through a national and a regional structure,<sup>556</sup> and the distribution of resources is arranged through allocation formulas. The first formula was created in 1976 to help measure health care needs in

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<sup>552</sup> Webster, *The National Health Service: A Political History*, supra 23.

<sup>553</sup> *ibid.*

<sup>554</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100.

<sup>555</sup> Webster, *The National Health Service: A Political History*, supra 23.

<sup>556</sup> *ibid.*

the territory. In 2008, changes were made to further guarantee equal access and to reduce rampant health inequalities.<sup>557</sup>

The use of these allocation formulas illustrates the importance of rationing in the NHS. With its commitment to provide health care services based on needs, the NHS has experienced spiraling costs.<sup>558</sup> Indeed, despite governments' best efforts, backlogs of ills have never diminished.<sup>559</sup>

Surprisingly, the many management and rationing reforms have never eroded the system's foundation and its initial commitment to equal provision of health care. Perhaps this is mostly due to the work and lobbying of a portion of the for-profit sector, namely, the medical profession.

In addition, this commitment of the state to provide equal health care services has been interpreted differently over the years. Discussions around the degree of state involvement in distributing and financing health care were presented in watermark during the creation of the NHS. Bevan argued for the provision of standard health care services financed through public funds for the entire population. Other Labour governments over the years also proposed this line of action. More recently, Conservatives have been

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<sup>557</sup> Boyle, *United Kingdom (England): Health System Review*. 1, supra 496, p.385.

<sup>558</sup> Susannah Jones, *The Failure of the NHS-Distributive Justice and Health Care in Britain*, UCL Jurisprudence

keen to promote equality in health care by focusing on equality in outcome rather than equality in treatment. According to them, the public power should assume only the role of a minimal insurer by providing an equal but basic level of health care services. Additional coverage should remain in the domain of individual responsibility.

*ii. Rationing Health Services Through Management*

During the NHS's 70 years of existence, significant progress has been made in the provision of health care thanks to perfected medical know-how, technological improvements, and pharmacological discoveries. Most lethal diseases have been dramatically reduced, and most chronic conditions can now be managed. Having tackled serious ills, modern medicine now has on the agenda peripheral health issues such as baldness and various physical enhancements. Patients expect more and better care at no cost, despite the fact that resources are becoming scarcer. The political commitment of the NHS's founders has made it virtually impossible to limit the provision of

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Rev. 163 (1997).

<sup>559</sup> Robinson & Dixon, *Health Care Systems in Transition: United Kingdom*, supra 510.

services and even harder to define the contours of the government's responsibilities in health care.<sup>560</sup>

Treatment costs as well as demand for more human resources and better facilities will continue to grow, and sooner rather than later the NHS will be underfunded. Clinical freedom will inevitably be reduced, and decisions will no longer be based on needs.<sup>561</sup> These concerns have preoccupied all governments and have led in recent years to the emergence of a managerial culture within the NHS.<sup>562</sup> Many health care technocrats share the conviction that management strategies and a more competitive approach to the allocation of resources can resolve scarcity issues.<sup>563</sup>

Surprisingly, policies that explicitly prioritize rationing have been surprisingly rare. Although the central government has always set precise budgetary boundaries, it was the duty of health care authorities and now the CCGs to allocate locally the majority of health care resources. At the micro level, physicians also enact some type of rationing through the treatment plans they prescribe to patients.<sup>564</sup> This explains why health care rationing has

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<sup>560</sup> Jones, *The Failure of the NHS-Distributive Justice and Health Care in Britain*, 163 , supra 558.

<sup>561</sup> *ibid.*

<sup>562</sup> Hunter, *The Health Debate*, supra 6, p.37.

<sup>563</sup> *ibid.*

<sup>564</sup> Davies & Powell, *How to Ration Health Care-and be Re-Elected: The UK Experience*, 138 , supra 18.

traditionally been mostly operated behind closed doors and subject to little or no public scrutiny.<sup>565</sup>

Yet, the creation of NICE in 1999 has shed light on rationing processes and made the allocation of health care resources more explicit and transparent.<sup>566</sup>

This special health authority was designed to address postcode lottery issues.<sup>567</sup> Its technology appraisals provide guidance on the use of new medicines, treatments, and procedures and indicate whether their purchase is appropriate for the NHS. In addition, the CCGs are bound to implement all of NICE's guidelines within three months of their publication.<sup>568</sup>

The latest health care reform now involves the medical profession in the allocation process at the macro level. As members of the CCGs, all GP practices are directly involved in commissioning services for their own patients.<sup>569</sup> Unfortunately, by giving all decision-making power to the CCGs, this new process might participate in the postcode lottery phenomenon. There is a serious danger of perceived or actual conflict of interests for GPs as private providers of care because of the financial benefits that could result

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<sup>565</sup> Jones, *The Failure of the NHS-Distributive Justice and Health Care in Britain*, 163, supra, p.167.

<sup>566</sup> Emily Jackson, *Medical Law: Text, Cases, and Materials* (3rd ed. 2013).

<sup>567</sup> Concerns with regards to a difference in access to NHS treatments throughout the country, and concerns that certain geographical areas are given different quality and availability of NHS services have been raised in the 1990s.

<sup>568</sup> Emily Jackson, *Medical Law*, supra 566.

<sup>569</sup> *ibid.*

from the commissioning.<sup>570</sup> Patients may have variable access to treatment, as certain options will no longer be available in parts of the country.<sup>571</sup>

As in any other western health care system, rationing within the NHS is a political minefield. This partially explains why, until the most recent health care reform, no clear or definite guidelines had been adopted. Allocation debates have mostly focused on reducing waste and increasing competition in the system, but never on a precise procedure.<sup>572</sup> In turn, this has had the positive consequence of rationing being associated, in the minds of British citizens, with equity and inclusion rather than with harsh pragmatic decisions. This also accounts for the success and sustainability of the NHS and its core values.<sup>573</sup>

Overall, health care policy trends in the United Kingdom have granted a small role to the for-profit sector. Nevertheless, health care policies in the post-Thatcher era have stressed the importance of patient choice and, for this, have promoted private and for-profit initiatives to create more competition in the realm of health care. Clearly, the public sector remains in the driver's seat, and the private sector is there to supplement public

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<sup>570</sup> *ibid.*

<sup>571</sup> *ibid.*

<sup>572</sup> Jones, *The Failure of the NHS-Distributive Justice and Health Care in Britain*, 163, *supra* 558.

<sup>573</sup> Davies & Powell, *How to Ration Health Care-and be Re-Elected: The UK Experience*, 138, *supra* 18, p.138.

services, set higher standards, and at times to provide much-needed resources to relieve the strains placed on the NHS. Hand in hand, all participate towards the same goal: to provide equally to all British citizens free and universal health care throughout the entire territory.

### **III. The Legislative History of a Tacit Concordat Between Westminster and the For-Profit Sector in Health Care**

The British health care system was set out and reformed through multiple intricate acts, decrees, and quasi-legislative measures such as directives and health circulars.<sup>574</sup> Conscious of the complexity of this body of laws, I chose to center my analysis on the drafting of significant acts reforming the financing and provision of health care services.

For this, I lay out the historical context surrounding each Act, to reveal the for-profit sector's potential impact on the creation of these laws. Through this analysis, I assess whether the influence of the for-profit sector was "direct," i.e., whether the input was considered during the negotiation stages or whether it was in fact "indirect" and participated implicitly in the legislative crafting through a series of accidents of history.

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<sup>574</sup> Kennedy & Grubb, *Medical Law*, supra 532.

I also highlight the importance and the place given to justice in the legislative process. For this, I determine whether any of the philosophical archetypes composing the analytical framework has emerged in the drafting of these laws. I also gauge whether a particular conception of justice was particularly prominent during the negotiation of each Act, by looking at White Papers leading to the formulation of the Bill, and the debates that occurred during the Second Reading of the draft before Parliament (the House of Commons or the House of Lords). Finally, my most conclusive findings help me to draw significant inferences regarding the influence of justice on the allocation of health care resources in England over the past 70 years.

The legislative pieces presented in this section have been selected for their “watershed moment” qualities. All three acts represent a turning point for the organization and financing of the NHS. They also illustrate the influence of three different conceptions of justice.

The NHS Act (1946), which created the NHS, is analyzed first. This Act not only marks the beginning of the unified health care system, but it also includes all the main elements that led to the path of dependence guiding all subsequent reforms of the NHS. Part of the construction of this Act is the

tacit concordat between the state and the medical profession, which ultimately tied the system's fate to that of its providers.

Second, the NHS and Community Care Act (1990) is analyzed because of the groundbreaking reform it installed: separating the financing from the provision of health care, it planted the seed of competition in the management of health care services. This piece of legislation marks another defining moment for the NHS and a turn towards a more libertarian approach to the allocation of health care resources, to better achieve the initial egalitarian goals set by the NHS founders.

Finally, I discuss the main tenets of the latest and most radical health services reform to date. The NHS Health and Social Care Act (2012) and all negotiations leading up to its enactment provide remarkable insight on the slow hybridization that is taking place within the system.

### **A. The NHS Act (1946): Egalitarian Principles Establish a Crucial Agreement with the Medical Profession**

Understanding the historical backdrop leading to the creation of the NHS in 1948 is essential to make sense of subsequent health care reforms in England. Indeed, the post-war principles that inspired the creation of the

NHS have, in the course of its history, created a strict path of dependence that has guided the crafting of all subsequent legislative reforms impacting the health care system.

The NHS Act (1946) was inspired by the wartime Emergency and Medical Service and emerged as the by-product of 50 years of inquiry and intense discussions between the state and the British Medical Association (BMA). An analysis of this Act should start with a close reading of the *Beveridge Report*. This white paper paved the way to Aneurin Bevan's project and initiated reflection on the values that would later become pillars of the NHS. Particular attention also needs to be given to the BMA's role in the negotiations leading up to the final version of the Act. This is of crucial importance for understanding how the medical profession would forever be relegated to a backseat role in negotiations relating to the national health care system.<sup>575</sup>

*i. The Inception: The Beveridge Report*

While the Second World War was still raging, the Minister of Health made a promise to establish a comprehensive hospital service as soon as the conflict

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<sup>575</sup> Kennedy & Grubb, *Medical Law*, supra 532.

was resolved.<sup>576</sup> Preliminary work was initiated in June 1941 as the Committee on Social Insurance and Allied Service was established to inquire on issues affecting the haphazard and piecemeal growth of the social security system.<sup>577</sup>

The strong spirit of solidarity ignited by the war laid the foundation for discussions of potential social reform.<sup>578</sup> These altruistic feelings gave the impression that an efficient health care system was a readily achievable objective. Moreover, solutions had to be found to erase the memory of the Poor Law hospitals' incapacity to cope with the victims of the 1940 bombings.<sup>579</sup>

Sir William Beveridge immediately took charge of the committee. Convinced that he had been given an opportunity to prompt the government's commitment to a post-war social reform, he took it upon himself to direct the review. He intended to rationalize the existing insurance system and to install long-term change in all areas of national social policy.<sup>580</sup> According to him, the war had set the stage for "a revolutionary moment (...) a time for

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<sup>576</sup> Webster, *The National Health Service: A Political History*, supra 23.

<sup>577</sup> Jose Harris, *William Beveridge a Biography* N/E, (1997).

<sup>578</sup> Webster, *The National Health Service: A Political History*, supra 23, p.8.

<sup>579</sup> Harris, *William Beveridge a Biography* N/E, supra 577

<sup>580</sup> *ibid.*

revolutions, not for patching.”<sup>581</sup> He therefore proceeded with an extensive review and compiled his recommendations in a report published on November 20, 1942.<sup>582</sup>

Problems affecting England during the war years were “giants on the road to reconstruction[:] (...) disease, ignorance, squalor and idleness.”<sup>583</sup> According to the committee, the only way to fight the “want”<sup>584</sup> was to put together a social security scheme. The insurance system was only a starting point for extending the inquiry to an evaluation of medical treatments, prevention of unemployment, and the provision of governmental help for large families.<sup>585</sup> Beveridge seriously undermined the initial intent to limit the review to hospital services and chose instead to reconstruct the social security system in its entirety. With regard to health care services, he called for a radical overhaul.<sup>586</sup>

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<sup>581</sup> Beveridge, William Henry Beveridge Baron & Social Insurance, *Social Insurance and Allied Services: Beveridge Report* (1942), p.1.

<sup>582</sup> Henry E. Sigerist, *From Bismarck to Beveridge: Developments and Trends in Social Security Legislation*, 8 Bull. Hist. Med. 365 (1943).

<sup>583</sup> Beveridge, William Henry Beveridge Baron & Insurance, *Social Insurance and Allied Services: Beveridge Report*, supra 581, p.1.

<sup>584</sup> *ibid.*

<sup>585</sup> Harris, *William Beveridge a Biography N/E*, supra 577, p.375.

<sup>586</sup> Webster, *The National Health Service: A Political History*, supra 23, p.7.

A mixture of old and new principles characterizes the report. The most striking feature remains Beveridge's commitment to national solidarity.<sup>587</sup> He proposed that a solidary system based on "needs" rather than "means"<sup>588</sup> be put in place, all of it pivoting around the fundamental principles of equity and universalism.<sup>589</sup> Committed to these resource egalitarian principles, he organized his demonstration around the notion of "subsistence," a concept he inherited from Richard Titmuss's work *Problems of Social Policy*. Beveridge embraced the idea of a system of social security that accounted for human needs and not a person's capacity to finance the services.<sup>590</sup>

He suggested that "medical treatment covering all [required care should] be provided for all citizens by a national health service" and proposed to finance the system through central taxation.<sup>591</sup> For the most part, his project seems to have been inspired by a Durkheimian notion of solidarity, in which the state imposes social obligations for the benefit of all its citizens. On this subject, he states,

After trial of a different principle, it has been found to accord best with the sentiments of the British people that an insurance organised by the community by use of compulsory

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<sup>587</sup> Harris, *William Beveridge a Biography N/E*, , supra 577, p.409-410.

<sup>588</sup> Beveridge, William Henry Beveridge Baron & Insurance, *Social Insurance and Allied Services: Beveridge Report*, supra 581.

<sup>589</sup> Harris, *William Beveridge a Biography N/E*, , supra 577, p.385.

<sup>590</sup> *ibid.*, p.386.

<sup>591</sup> Beveridge, William Henry Beveridge Baron & Insurance, *Social Insurance and Allied Services: Beveridge Report*, supra 581, p.7.

power, each individual should stand in on the same terms; none should claim to pay less because he is healthier or has more regular employment. In accord with that view, the proposals of the Report mark another step forward to the development of State insurance as a new type of human institution, differing both from the former methods of preventing or alleviating distress and from voluntary insurance. The term “social insurance” to describe this institution implies both that it is compulsory and that men stand together with their fellows. The term implies a pooling of risks except so far as separation of risks serves a social purpose.<sup>592</sup>

The new system would be universal and solidary but also fundamentally egalitarian. For Beveridge, it was the responsibility of “the State to offer security for service and contribution. [To] organiz[e] security (...) not [to] stifle incentive, opportunity, responsibility; in establishing a minimum.”<sup>593</sup> By meeting the needs of its citizens, the state was to provide sufficient health care entitlements to enable the pursuit of opportunities. With those words, Beveridge described a profoundly resource egalitarian policy. To him, health care, like police protection or the maintenance of the roads, had to be free at the point of use and available to all, to grant each individual the same opportunity to achieve life goals.<sup>594</sup>

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<sup>592</sup> *ibid.*, p.6-7.

<sup>593</sup> *ibid.*, p.1.

<sup>594</sup> Brian Edwards et al., *The National Health Service: A Manager's Tale 1946-1992* (1993), p.3.

Reading through the lines of the report reveals that Beveridge clearly conceived of health care as a primary good. Its distribution had to be operated by the state to ensure that everyone received equal access to health care based on needs. This implied that the most needy, and therefore least well off, should be favored by the system. This inequality in distribution was tolerable because it was necessary to provide all with the same opportunity to pursue life plans. Overall, the report establishes the terms of a quintessentially Rawlsian social contract.

The Beveridge plan was to provide protection, although minimal, against poverty and would enact the principle of aid based on needs.<sup>595</sup> It also forced wartime politicians to take a stance on what the “social minimum” should encompass.<sup>596</sup> Unfortunately, the results of the inquiry led interest groups to retreat in their positions and created bitter jealousies that stalled the reform and precluded the achievement of consensus over a new health service.<sup>597</sup>

*ii. The Creation: A Just and Egalitarian Consensus?*

The war had driven the country into an economic depression, which placed even greater emphasis on issues of social security. Ironically, the Luftwaffe

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<sup>595</sup> EK Den Bakker & GW De Wit, *Social Security in a European Perspective*, 8 The Geneva Papers on Risk and Insurance-Issues and Practice 248 (1983), p.410.

was successful in paving the way to a unified health care system by coordinating all hospitals under the civil defense regional association. It was a greater achievement than what British politicians and planners had accomplished over the past two decades.<sup>598</sup> Unfortunately, the Beveridge plan was no nearer realization in 1945 than it had been in 1942. Voluntary hospital lobbying groups along with the BMA had launched a virulent attack against the planners and had been successful in blocking the initiative.

As the war ended, the Labour Party came to power.<sup>599</sup> Selecting his cabinet, Prime Minister Clement Attlee made the audacious choice to appoint Aneurin Bevan to the Ministry of Health.<sup>600</sup> Attlee believed Bevan had sufficient strength to reinitiate negotiations on health services.<sup>601</sup> Bevan did not disappoint and showed an ability to take decisive and constructive actions.<sup>602</sup> He started by gaining the trust of the health service planning operation staff and then secured his position by diffusing the pessimistic atmosphere that years of quarrelling over the future of the health service had embedded. He initiated discussions with the perspective that a new health service would be a bold, “civilized,” and forward-thinking project for the

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<sup>596</sup> *ibid.*

<sup>597</sup> Webster, *The National Health Service: A Political History*, supra 23, p.8.

<sup>598</sup> *ibid.*, p.6.

<sup>599</sup> Webster, *The Health Services since the War. 1, 1, , supra 22, p.76.*

<sup>600</sup> *ibid.*

United Kingdom. With this newfound optimism, but to the discontent of senior officials and the medical profession, Bevan proceeded with policy-making.<sup>603</sup>

Cultivating a regime of continuous negotiations during wartime, the BMA had eroded the government's policy-making power in the realm of health care. Nonetheless, the independent-minded Bevan had decided to reestablish the Ministry's supremacy by taking little to no input from outside interests.<sup>604</sup> His plan constituted a dramatic break from the past.<sup>605</sup> His tripartite proposal was meant to reorganize the functioning of hospitals, GPs' teams, and health centers. The system was intended to function "subject to local influence" but would primarily be under central control.<sup>606</sup>

The Conservatives immediately objected and took the debate in a predictable direction. To them, a plan to nationalize voluntary hospitals was an attack on charitable institutions, and the idea of regulating doctors' salaries would result in a full-time salaried service. Bevan's fellow Labour-party comrades were also critical of the project, as it failed to propose a full-time salaried

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<sup>601</sup> *ibid.*, p.76.

<sup>602</sup> Webster, *The National Health Service: A Political History*, supra 23, p.13.

<sup>603</sup> *ibid.*, p.14.

<sup>604</sup> *ibid.*

<sup>605</sup> Ministry of Health, *Memorandum on the Future of the Hospital Services*, [1945].

<sup>606</sup> Webster, *The Health Services since the War. 1, 1*, supra 22, p.97-98.

service and permitted paid beds in state hospitals. Finally, critics from both ends came together to voice their concern about the detrimental effect of having less involvement from local governments in the allocation and provision of health care services.<sup>607</sup>

In the face of controversy, Bevan remained determined and brushed off the ineffective opposition in Parliament, and with few amendments, the NHS Act was enacted on November 6, 1946.<sup>608</sup> Lord Beveridge saluted Bevan's success, as for the first time a "true Ministry of Health" was given the authority and duties to finally stamp out ill health.<sup>609</sup>

Outside Parliament, the victory was not so swift. First to share their discontent were the voluntary hospitals' administrators. To them, free health care services and the suppression of access barriers would dampen public interest and significantly harm the system. The government quickly replied, as it believed it was unthinkable to rely on fear to stimulate charitable contributions. With this, the voluntary hospitals' and local authorities' opposition was discredited once and for all.<sup>610</sup>

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<sup>607</sup> *ibid.*

<sup>608</sup> Webster, *The National Health Service: A Political History*, supra 23, p.15.

<sup>609</sup> Webster, *The Health Services since the War. 1, 1*, supra 22, p.100.

<sup>610</sup> Delamothe, *NHS at 60: Founding Principles*, 1216 , supra 531.

The medical association made a better case for its members.<sup>611</sup> The patchwork quilt of services delivered before 1948 was based on private agreements between doctors and patients; thus, the BMA was to take a firm stand in negotiating the role of doctors under a new public system. To indicate protest, the medical profession had first refused to join the ranks of NHS.<sup>612</sup> Believing that the issues at stake were too diverse and too important, doctors would not settle for a secondary role in the health care system. Medical consultants and GPs expressed equally serious but different grievances to the government.

Medical consultants had been pushing for regionalized health care services but were not completely averse to the idea of a nationalized system. They were most concerned about the remuneration they would receive under the new system. The government came through and allowed the private practice of medicine in NHS hospitals and offered consultants full-time and part-time NHS contracts. Consultants also successfully negotiated distinctions in the form of capitation fees to reward excellence and to compensate any loss

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<sup>611</sup> Webster, *The National Health Service: A Political History*, supra 23, p.26.

<sup>612</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594.

of private earnings. For the government, these concessions were worth making as it had finally gained the full cooperation of medical consultants.<sup>613</sup>

GPs entered negotiations with distrust and unwillingness to compromise. They wanted the sale and purchase of goodwill associated with their medical practices to continue and to base their remuneration on a capitation fee free of government control,<sup>614</sup> but thanks to the medical consultants' reconciliation efforts, a reasonable compromise was reached.<sup>615</sup> GPs remained independent contractors on the condition that they would cooperate with the NHS enterprise.

These negotiations marked an extremely important turning point for the medical profession. From then on, consultants and GPs would be only partly independent but would be satisfied with the for-profit status they had secured for themselves. The medical profession had tacitly agreed to protect and safeguard the NHS's core egalitarian principles in exchange for its autonomy.<sup>616</sup> Ultimately, the British population and the medical profession had entered into a social contract that laid the foundations of the new health services.

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<sup>613</sup> Webster, *The National Health Service: A Political History*, supra 23, p.26.

<sup>614</sup> *ibid.*, p.27.

<sup>615</sup> *ibid.*, p.28.

<sup>616</sup> Eckstein, *Pressure Group Politics*, 1069, supra 33.

With the medical profession on board, the NHS was launched in July 1948. Aneurin Bevan was victorious in that he had “universalize[d] the best” health care services, divorced the ability to pay from the provision of quality treatments,<sup>617</sup> and “provide[d] the people of Great Britain, no matter where they [were], with the same level of service”<sup>618</sup> free of charge at any point of use.<sup>619</sup> His utilitarian ambitions to improve and maximize the British population’s good health had materialized through the advent of an egalitarian system. After all, the purpose of an egalitarian and universalized system of care was to exhaust ill health in the territory, to improve medical treatment to provide better care to workers and consolidate a more productive workforce, and ultimately to reduce health care costs across the entire British population.

Overall, Bevan’s success in achieving a central system reflected a long evolutionary process pushed by rationalists and medical technocrats. The for-profit sector’s strong activism had gained much during the negotiation process, securing its independence and a unique status under the new system.<sup>620</sup>

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<sup>617</sup> Edwards et al., *The National Health Service: A Manager’s Tale 1946-1992*, supra 594.

<sup>618</sup> *National Health Service Act*, Public Law Chapter 81, (1946): Part I.

<sup>619</sup> Edwards et al., *The National Health Service: A Manager’s Tale 1946-1992*, supra 594, p.4.

<sup>620</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.19.

*iii. The Foundations of the Act: Analysis of the Second Reading of the NHS Bill*

*Before the House of Commons*

Primary historical sources give a precise picture of the debates and discussions leading up to the creation of the NHS and, more particularly, to the enactment of the foundational Act. Analysis of the Second Reading of the Bill before the House of Commons reveals the egalitarian essence<sup>621</sup> of the project but also relays the utilitarian motivation behind the initiative.

Aneurin Bevan dominated most of the discussion and offered an introductory discourse in favor of equality and universality in the NHS. Fervent in his critique of the principle of subsidiarity, he affirmed, “it is repugnant to a civilized community for hospitals to have to rely upon charity (...).”<sup>622</sup> Bevan was supported by Labour MP Boardman, who also opposed the provision of health care through charity or based on the principle of subsidiarity, as he stated with great conviction that he knew that “working men and working women (...) do not want charity whether the source is good or bad. Charity at its best humiliates.”<sup>623</sup>

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<sup>621</sup> *Second Reading of the National Health Service Bill*. House of Commons. (1946).

<sup>622</sup> *ibid.*, p.2.

<sup>623</sup> *ibid.*, p.84.

There were many statements criticizing the idea of subsidiarity<sup>624</sup> and the libertarian distribution of health care resources that relies on charity to finance and provide care without significant input from a central form of power. This counter-discourse mainly relayed the Members' preference for an egalitarian allocation system. Indeed, participants called for solidarity within the community to share the risks, financial burdens, and benefits provided by a universal system of care, and thus were indirectly calling for more efficiency.<sup>625</sup> This justified Bevan's utilitarian motivation to help Britain reduce the accumulation of ill health. To him, helping individuals to obtain free health care in the entire territory would help to increase the aggregate "health utility" of the country as a whole.

More particularly, Labour representative Charles Key talked about "the interests of the community [that] demand [a] distribution of medical services (...) organised with the claims and needs of patients and not the whims and fancies of practitioners as the guiding factor (...)." He believed that resources could be pooled "as a community [to] pay doctors for general care, irrespective of individual needs."<sup>626</sup>

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<sup>624</sup> *ibid.*, p.2, 15, 69, 84, 108.

<sup>625</sup> *ibid.*, p.14, 53, 56, 97, 104.

<sup>626</sup> *ibid.*, p.53.

Egalitarian justice principles undoubtedly transcended all the discussions that took place during the Second Reading of the Bill. The importance of providing equal access to health care to enable the realization of life plans became a leitmotif.<sup>627</sup> Frederic Messer, Parliamentary Representative of the Labour Party, described the bill as

an attempt to bring within the reach of every working man the opportunity of treatment without having to put his hand in his pocket and pay for it at the time he was ill.<sup>628</sup>

The initiative would encourage mutual support among members of British society to foster a sense of responsibility and to provide more resources so that Britons could improve their opportunities to achieve life plans. Parliamentary Secretary to the Ministry of Health Charles Key evoked this idea when he addressed the importance of solidary health authorities:

Why should these local citizens, with greater means at their disposal, and greater opportunities for development, do less than their predecessors have done? I am convinced that they will do more. With the growing sense of social responsibility which is so evident in our people today, greater interest, greater initiative and greater participation in the development of our social service will become more potent than ever before.<sup>629</sup>

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<sup>627</sup> *ibid.*, p.20, 44, 81.

<sup>628</sup> *ibid.*, p.44.

<sup>629</sup> *ibid.*, p.50.

Absent from the debate, the BMA and its interests were critically underrepresented. Addressing the role that the medical profession should have in the new system, Aneurin Bevan used language criticizing a market approach in the realm of medicine. Indeed, he argued,

What they [(the opposition)] say, in effect, is that, unless doctors are allowed to buy and sell practices like hucksters in the market place, and unless they can retain their private enterprise, they are not going to be good public servants.<sup>630</sup>

Bevan believed that financial incentives would gangrene the system. He would not accept a libertarian approach to health care and would not allow the medical profession to merchandise health care services. Mr. Key supported Bevan and added,

The interests of the community demand that the distribution of medical services shall be organised with the claims and needs of patients and not the whims and fancies of practitioners as the guiding factor.<sup>631</sup>

This analysis of the Second Reading of the NHS Bill before the House of Commons relays the importance of egalitarian and utilitarian principles of justice at the origin of the NHS. Interestingly, the implicit concordat between the state and the medical profession is absent from the discussion.

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<sup>630</sup> *ibid.*, p.116.

<sup>631</sup> *ibid.*, p.53.

Excluded from the drafting process, the for-profit sector could only voice its unwillingness to negotiate outside the walls of Parliament.

Nonetheless, through the deal it struck with the government, the profession gained leverage that granted it a status that would remain unchanged throughout history.

### **B. The NHS and Community Care Act (1990): Libertarian Dynamics Installed Without the Intervention of the For-Profit Sector**

The 1979 elections marked the first step in an enterprise that would forever change the NHS. Margaret Thatcher and her government undertook a program of radical economic and social reforms. The Conservatives sought to reduce public expenditure and the government's involvement, which they believed were to blame for the difficult economic times the country was facing.<sup>632</sup>

As a result, a movement towards privatization, including health services, was promptly initiated. Ancillary services such as laundry, catering, and cleaning were contracted out to private providers in the hope of increasing efficiency.

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<sup>632</sup> Robinson & Dixon, *Health Care Systems in Transition: United Kingdom*, supra 510.

Therefore, it was only natural to conduct an inquiry on the NHS, as its management would also be affected by those reforms.<sup>633</sup>

In 1983, Sir Roy Griffiths, managing director of Sainsbury supermarkets was designated to lead the study. His private-sector experience made him the best candidate to investigate the inefficiency issues that were affecting the NHS.<sup>634</sup> He recommended a move towards a more managerial approach and away from the old-style consensus that had traditionally characterized NHS management. He believed that general managers had to be appointed at the unit, district, and regional levels.

Griffiths had been the first to imagine a more “businesslike” NHS.<sup>635</sup> Unfortunately, his innovative market approach was not well received by the workforce, which perceived it as an unstable and suspicious project.<sup>636</sup> The general managers he was proposing were bound to become powerless rulers who would ultimately defer all decisions to the medical profession, just as had occurred in the past. The report ended up diminishing the Conservative government’s popularity and produced no significant changes, but it was the

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<sup>633</sup> *ibid.*

<sup>634</sup> Webster, *The National Health Service: A Political History*, supra 23, p.167.

<sup>635</sup> Ham, *Management and Competition in the NHS*, supra 518.

<sup>636</sup> Webster, *The National Health Service: A Political History*, supra 23, p.174.

precursor to a dramatic change that would overtake the NHS seven years later.<sup>637</sup>

While campaigning was in full swing in the summer of 1987, a potential NHS reform became the focus of all electoral debates. The Labour Party had intensely targeted and antagonized Thatcherite policies in the realms of health, employment, and education; the Social Democratic Party/Liberal Alliance's manifesto had also heavily emphasized the NHS's "state of fundamental crisis and malaise."<sup>638</sup> Despite the attacks, the Conservatives were once again victorious, but this time they had come to power with a severely diminished majority.<sup>639</sup>

The general election had been a difficult experience for the Conservatives, and their victory did not make their task any easier. Every Tuesday and Thursday during the Prime Minister's Question Time at the House of Commons, Margaret Thatcher "had thrown at her case after case of ward closures, interminably postponed operations and allegedly avoidable infant deaths, all of them attributed to Government parsimony."<sup>640</sup>

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<sup>637</sup> Robinson & Dixon, *Health Care Systems in Transition: United Kingdom*, supra 510.

<sup>638</sup> Webster, *The National Health Service: A Political History*, supra 23, p.124.

<sup>639</sup> *ibid.*, p.125.

<sup>640</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100.

Indeed, it was during a financial and social crisis that the Thatcher Administration initiated its second mandate. Funding levels combined with mismanagement had put the NHS in serious difficulty.<sup>641</sup> During the course of the 1980s, expenditures had steadily grown, as technology was refined and the population aged; consequently, a greater number of people began to require more and costlier health care services.

Unfortunately, government funding had not sufficiently increased to fill the widening gap. Hospital services were affected the most, as the “efficiency trap” penalized productivity improvements, and expenses were on the rise while incomes were merely stable. Hospital managers were left with no other choice than to partially close beds, cancel non-emergency admissions, and freeze staff hires to reduce expenditures.<sup>642</sup>

Doctors and patients were also greatly disgruntled. The BMA was requesting additional resources to overcome the shortfall, and the Royal Colleges of Surgeons, Physicians, Obstetricians and Gynecologists issued a joint statement denouncing the critical state of the NHS.<sup>643</sup>

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<sup>641</sup> Webster, *The National Health Service: A Political History*, , p.133.

<sup>642</sup> Ham, *Management and Competition in the NHS*, supra 518, p.3.

<sup>643</sup> *ibid.*, p.3.

On January 31, 1989, with her back against the wall, Margaret Thatcher announced the launch of an inquiry that would lead to the White Paper *Working for Patients*. This document was the prelude to the most dramatic change ever in health care services: the NHS Community and Care Act.<sup>644</sup> With this piece of legislation, the government hoped to trigger more competition and introduced a managed health care market. Nonetheless, the goal was never to introduce a full-fledged free health care market.<sup>645</sup>

*i. Thatcher's Initiative: Working for Patients*

The 1980s value-for-money crusade did not bear the fruits that the Conservative government had anticipated. Unfortunately, the many doctors and nurses newly employed by the NHS and the growing number of treated patients could not eradicate the population's negative perception of the new health care policies. Most remained convinced that the Conservatives' parsimony was partly responsible for the increased inefficiency affecting the NHS.<sup>646</sup>

The medical profession, opposition parties, and the government had entered into a dialogue of the deaf, leading to no real agreement on how to close the

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<sup>644</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594, p.146.

<sup>645</sup> Ham, *Management and Competition in the NHS*, supra 518, p.13.

efficiency trap.<sup>647</sup> Thus, the Chancellor of the Exchequer, Nigel Lawson, proposed the idea of a review of health care services. He convinced Margaret Thatcher to look into the functioning of the NHS to guarantee that money spent on health care would yield real value and improve patient care.<sup>648</sup> Embarrassed by the situation, the Prime Minister accepted immediately and set up a complete review of the health care system (Review). Thus, on January 25, 1988, it was unexpectedly announced during the BBC television program *Panorama* that Margaret Thatcher and a small group of her Ministers would initiate a high-level inquiry into the NHS.<sup>649</sup>

The announcement triggered an immediate reaction from the medical association. Excluded from the Review the BMA was slighted and interpreted the government's lack of consultation as a deliberate snub to the profession.<sup>650</sup> Indeed, Thatcher had purposely set up a cabinet committee to challenge the medical profession and signal the new and lesser role she was willing to give it in the constellation of power. These feelings of exclusion and affront would shape the BMA's perspective of the entire project.<sup>651</sup>

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<sup>646</sup> Webster, *The National Health Service: A Political History*, supra 23, p.182-183.

<sup>647</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.144.

<sup>648</sup> *ibid.*, p.141.

<sup>649</sup> *ibid.*

<sup>650</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594, p.151.

<sup>651</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.147.

The inquiry explored the possibility of a radical reform. Talks about a new approach to financing health care services through private insurance and giving a lesser role to the state to increase patients' choice attracted significant attention. It was argued that to offer health care resources to everyone, patients had to become consumers and buy their services on a competitive market. American ideas certainly inspired this proposal.<sup>652</sup>

In the end, however, other discussions surrounding new means of financing through the adoption of a European model of social insurance or a voucher system<sup>653</sup> led to a dead end and pushed policy-makers to think of alternatives that would preserve financing through taxation.<sup>654</sup> Frightened, doctors adopted a coy attitude, suggesting that no major restructuring of the health care system was needed and that only a small percentage of increased funding would make a difference.<sup>655</sup>

Even though problems of rampant health care costs in the United States were not obviously relevant to the British underfunding debate, as the Review progressed the American influence became stronger.<sup>656</sup> An American

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<sup>652</sup> *ibid.*, p.148.

<sup>653</sup> *ibid.*, p.150.

<sup>654</sup> Alain C. Enthoven & Nuffield Provincial Hospitals Trust, *Reflections on the Management of the National Health Service: An American Looks at Incentives to Efficiency in Health Services Management in the UK* (1985).

<sup>655</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, *supra* 100, p.147.

<sup>656</sup> *ibid.*, p.148.

expert with significant experience in health care reforms, having participated in the HMO movement, created the internal market solution. Alain Enthoven assumed the task of analyzing the deeper and more central issues affecting the NHS. To him, the problem was simple: money was simply not following the patients.<sup>657</sup>

Enthoven was far from radical in his approach; he simply tried to refocus the debate and to bridge competing and diverging interests.<sup>658</sup> He called for more incentives to stimulate productivity in health care and thus proposed the development of an internal market for health care services. Nonetheless, he advocated a trial for the initiative before it was to be fully implemented.<sup>659</sup>

The strong opposition created by the Review fostered an unspoken alliance between the BMA and the Labour Party. In the eyes of both groups, the proposed changes would lead to “market medicine as practiced across the Atlantic.”<sup>660</sup> The attempt to introduce financial incentives into the NHS was a clear betrayal of its foundational principles.<sup>661</sup> According to the BMA, this dangerous cost-cutting exercise was likely to hurt the doctor-patient

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<sup>657</sup> *ibid.*, p.149.

<sup>658</sup> *ibid.*, p.150.

<sup>659</sup> Webster, *The National Health Service: A Political History*, supra 23, p.187-188.

<sup>660</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.153.

<sup>661</sup> *ibid.*, p.146.

relationship.<sup>662</sup> Yet, in many ways the beginning of these tough negotiations greatly resembled the 1946 showdown, and it was expected that “the leaders of the profession could summon their troops to battle but could not make them fight.”<sup>663</sup>

The Review proposition regarding primary care services only increased GPs’ discontent. The reform had been in the cards for the previous decade, as the government wanted to offer choice to patients.<sup>664</sup> Through new contracts and the purchaser-provider divide, the Conservative Administration hoped that GPs would become patients’ representatives and help them voice their preferences. The practitioners would also become fundholders and directly purchase care for their patients. Patient autonomy would significantly increase because if patients became dissatisfied with their GPs’ choices, it would then be possible to re-enroll in a new practice.

Evidently, the BMA did not see eye-to-eye with the Administration. It was convinced that the proposal would lead to the fragmentation of health care services and would eventually destroy the comprehensive nature of the NHS. Patients would not gain more choice, nor would doctors feel more

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<sup>662</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594, p.151.

<sup>663</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.159.

<sup>664</sup> *ibid.*, p.158.

incentivized.<sup>665</sup> It only added insult to injury to believe that the medical profession would be responsive to market incentives and to think that treatment would be selected based on financial considerations rather than on need.<sup>666</sup>

If GP practices were to stay within budgets or even generate any surplus, they would have to deny patients the most expensive treatments or limit enrollment to the healthiest applicants.<sup>667</sup> Although GPs had always thought of themselves as NHS “shopkeepers,” they still could not agree to a reform that would transgress the system’s fundamental principles. Never invited to discuss the terms of the new GP contract, they felt that the Administration was purposely antagonizing them.<sup>668</sup>

On January 31, 1989, the White Paper *Working for Patients* finally emerged from this tumultuous Review.<sup>669</sup> This document was clearly the child of the political forces that had conceived it. Although radical change had been promised, the founding principles of the NHS remained untouched;<sup>670</sup> and

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<sup>665</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594, p.147.

<sup>666</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.158.

<sup>667</sup> *ibid.*, p.156.

<sup>668</sup> *ibid.*, p.158.

<sup>669</sup> Webster, *The National Health Service: A Political History*, supra 23, p.190.

<sup>670</sup> Department of Health, *Working for Patients*, [1989].

although the concept was extensively discussed, the words “internal market” never appeared in the pages of the White Paper.

The document was promoting a culture of consciousness, the expansion of patient choice, and it called for an innovative split between the purchasers and the providers of health care services.<sup>671</sup> Efficiency was mentioned only discreetly,<sup>672</sup> and the government’s plan to increase competition by creating entities to run hospitals and services was also unveiled. These entities would take the form of self-governing NHS trusts. District authorities would also undergo a transformation and assume a new purchasing role.<sup>673</sup>

On February 22, 1989, *Working for Patients* was presented and debated in front of the House of Lords. Discussions obviously revolved around the internal market project, and the discourses included many elements of justice. Members of the House reacted mostly negatively to the proposal’s fundamentally libertarian flavor.<sup>674</sup> A parsimonious but strong advocacy for a subsidiary mode of organizing health care services emerged. According to Conservative Member Lord Trafford, a greater level of subsidiarity would help guarantee the equal provision of health care services. In his words,

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<sup>671</sup> Davies & Powell, *How to Ration Health Care-and be Re-Elected: The UK Experience*, 138 , supra 18, p.142.

<sup>672</sup> Webster, *The National Health Service: A Political History*, supra 23, p.190.

<sup>673</sup> Ham, *Management and Competition in the NHS*, supra 518, p.9.

<sup>674</sup> *Debates on Working for Patients*. House of Lords. (1989 ), p.15, 18, 24, 41, 43.

We are supposed to be equalising care throughout the country, so these are some of the things that desperately need to be addressed. (...)In my view the White Paper addresses some of these central problems. It devolves downwards so that we do not have a massive centralised bureaucracy. One of the most remarkable things on reading it is how much power the centre is prepared to surrender.<sup>675</sup>

Nevertheless, many Members did not share his enthusiasm. There were numerous critiques of the market approach, and even more frequent were appeals to respect the fundamental, egalitarian values that had characterized the NHS throughout its history.<sup>676</sup> The lively debate provided a prime example of the path of dependence these values had enshrined in NHS policy-making over its 40 years of existence. The most eloquent intervention was certainly the tirade of Labour Party Member Lord Ennals, in which he stated,

What most people see in the National Health Service—an embodiment of social justice—is anathema to her philosophy. (...) The public have tolerated a succession of Conservative reorganisations over the past 10 years and more. Frankly, those reorganisations have not achieved much in terms of an improvement of the National Health Service but I emphasise that none of them has challenged the basic principles on which the National Health Service was founded. However, throughout this period of Conservative reorganisation there has been the lurking fear that one day an over-confident Conservative Government would decide to introduce its free market, profit-orientated dogma into our National Health Service. That is why there

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<sup>675</sup> *ibid.*, p. 18.

<sup>676</sup> *ibid.*, p.7, 8, 22, 24, 25, 26.

has been a suspicion that the National Health Service is not safe in the hands of the Prime Minister. I must say that today it is no longer a suspicion, it is a certainty. (...) I believe that this would be the beginning of the end for a service based on patients' welfare. (...) In my view the proposals put producers before patients and profits before people.<sup>677</sup>

Fear of the market paradigm emerged through an anti-libertarian discourse throughout the debate. Most Members simply could not see the market as the most optimal tool for enacting a just allocation of health care resources.

Finally, discussions revolving around a new approach to community care in which authorities would supply services instead of providing individuals with income support<sup>678</sup> also exposed a strong communitarian inspiration for health care service provision in the community.<sup>679</sup> The Baroness Cox, a cross-bench Member, stated,

[The White Paper] is overwhelmingly oriented to a medical service and it virtually ignores the need for an integrated system of community care. (...) If a dichotomy between hospital and community care is allowed to develop there is a danger that we may revert to the unsatisfactory fragmentation that existed prior to 1974. (...) Nobody wants the care of the mentally ill or handicapped, the chronic sick or the elderly to become Cinderella services once again.<sup>680</sup>

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<sup>677</sup> *ibid.*, p.7.

<sup>678</sup> Ham, *Management and Competition in the NHS*, supra 518, p.40.

<sup>679</sup> *Debates on Working for Patients.*, supra 674, p.26, 27, 46, 55, 57.

<sup>680</sup> *ibid.*, p.26.

In the same vein, Lord Hesketh advocated having “trusts stand close to their local communities.”<sup>681</sup>

Nonetheless, it is worth mentioning that during most of these debates, conceptions of justice appeared only in watermark despite the fact that some Members believed that the NHS’s fundamental resource egalitarian principles were under threat, whereas others praised the proposal’s libertarian approach.

Overall, the Review and resulting White Paper signaled a defeat for the medical profession. It marked the end of the BMA-policy veto and highlighted the weakness of doctors in the local administration of health care. Despite the government’s dependence on the medical profession to implement its reform, doctors had been once and for all resigned to a backseat role in the NHS.<sup>682</sup>

Convinced of the significant stimulus these reforms would trigger, the government decided to have *Working for Patients* translated into legislation. The purchaser-provider split would potentially break down the hierarchy threatening the NHS and would provide a level of uncertainty that could

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<sup>681</sup> *ibid.*, p. 57.

<sup>682</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.161.

create enough competitiveness to tackle inefficiency problems.<sup>683</sup> Thus, *Working for Patients's* proposal was merged with plans for community care to form the NHS and Community Care Act.

*ii. New and More Just Means of Distribution? Rationing With an Internal Market for Health Care to Achieve Egalitarian Goals*

The health care reform attracted significant attention, perhaps more for its form than its content. The use of commercial language generated great anxiety. The population feared that the NHS would become a business venture.<sup>684</sup> Managers were urged to clean up their language and reiterate the Administration's commitment to the founding principles.<sup>685</sup> The NHS was not to become a business but would be managed like one, given that, according to Health Secretary Kenneth Clark, "medicine is more important than baked beans but most baked bean companies are run better than most hospitals."<sup>686</sup>

The internal market reform certainly provoked significant change, but it also built on the initial consensus.<sup>687</sup> The system remained financed through

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<sup>683</sup> Ham, *Management and Competition in the NHS*, supra 518, p.9.

<sup>684</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594, p.154.

<sup>685</sup> *ibid.*, p.155.

<sup>686</sup> *ibid.*, p.154

<sup>687</sup> Bevan & Robinson, *The Interplay between Economic and Political Logics: Path Dependency in Health Care in*

taxation, universally available, and free of charge at the point of use. Nonetheless, a transition from a fully integrated system to a contractual organization of services was to occur.<sup>688</sup>

On the purchaser side, health authorities had the duty to commission the best services available, irrespective of whether private or public providers dispensed these services. Their only goal had to be to cater to their population's health care needs. On the provider side, hospitals in the form of NHS trusts were to provide services commissioned by health authorities and GP fundholding practices.<sup>689</sup>

Doctors were fearful of the consequences that this libertarianism-infused Act would have on the profession. All the non-medical considerations they had to balance while deciding on a course of treatment certainly threatened their clinical independence.<sup>690</sup> The Act proposed to use utilitarian principles to allocate resources more equally by having health authorities rank and prioritize health care services.<sup>691</sup> Conceptions of justice in the NHS and Community Care Act certainly reflect the conflicted perspectives that informed its crafting.

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*England*, 53, supra 45, p.55.

<sup>688</sup> Ham, *Management and Competition in the NHS*, supra 518, p.13.

Libertarian precepts prescribing more freedom and market competition to achieve a more just allocation of resources dominated the redesign of the NHS. Patients were transformed into consumers, and a managed market for health care services was created. A conscious shift from efficiency to effectiveness was taking place. Nonetheless, the egalitarian conception of justice remained unchanged; only the means to obtain equality in health care were different. Policy-makers were hopeful that the market would fulfill its promises by providing a better distribution of resources and by allowing patients more and better choices.<sup>692</sup>

The Act still embraced Bevan's initial conception of a universal system. The NHS would provide the best health care to the greatest number and for the greater good of the community.<sup>693</sup> Medical professionals had to be involved in this utilitarian exercise to help rank the cost-effectiveness of treatments, and District Health Authorities were invested with the mission to provide the most beneficial services to the greatest numbers, when fulfilling their commissioning duties.<sup>694</sup>

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<sup>689</sup> Davies & Powell, *How to Ration Health Care-and be Re-Elected: The UK Experience*, 138 , supra 18, p.142.

<sup>690</sup> *ibid.*

<sup>691</sup> Sarah Barclay, '*A New Hip is Better Value than a Liver*', (1991).

<sup>692</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594, p.149-150.

<sup>693</sup> Barclay, '*A New Hip is Better Value than a Liver*'; supra 691.

<sup>694</sup> Edwards et al., *The National Health Service: A Manager's Tale 1946-1992*, supra 594, p.149-150.

Overall, the ideological core of the NHS Community and Care Act combined both libertarian and utilitarian means to achieve the NHS's authentic egalitarian goals.

*iii. The Foundations of the Act: Analysis of the Second Reading of the NHS*

*Community and Care Bill Before the House of Lords*

The Second Reading of the NHS Community and Care Bill before the House of Lords confirms the influence of different conceptions of justice on the drafting of this Act. Many of the Members' discourses put forward the pressing problems of efficiency affecting health care services. Several of them promoted the government's line of conduct and argued in favor of the proposal. Among them, Conservative Member Lord McColl of Dulwich made a strong case for increased competition as a means of improvement, stating that "the solution lies in the introduction of competition (...) [and] that it [would] help to solve that problem [by] provid[ing] the missing incentive for people." Coupled with this libertarian approach, utilitarian principles were also promoted, as they would help to initiate the internal market. As mentioned by Conservative Member Lord Henley, they would "provide a service that makes the most cost-effective use of resources"<sup>695</sup>

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<sup>695</sup> *Second Reading of the Community and Care Bill*. House of Lords. (1990 ), p.33.

and should be regarded as “a virtue, [and] not a vice.”<sup>696</sup> He insisted that it was now a “duty to make sure that money [was] used to bring the maximum benefit.”<sup>697</sup>

The consensus was unanimous; more than three statements attest to Members’ concern to place on the agenda priority-setting for the allocation of health care resources<sup>698</sup> in order to maximize benefits and health care. The discourse of the Labour Member Baroness Lockwood highlighted the ranking of needs promoted by the utilitarian health care system:

[n]obody [was] suggest[ing] that the National Health Service should have a bottomless purse. (...) [P]riorities and choices [must be set] but they should be properly evaluated and not just costed.<sup>699</sup>

A more communitarian discourse<sup>700</sup> also emerged in six important passages addressing the proposals made for community and primary care. Along with others, the Baroness Cox was hoping that the community and the needs of more vulnerable groups could be prioritized over the promotion of market incentives. She stated,

I have a nightmare— which I fear could become reality— of many very vulnerable people finding that community care is

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<sup>696</sup> *ibid.*

<sup>697</sup> *ibid.*

<sup>698</sup> *ibid.*, p.23, 32, 82.

<sup>699</sup> *ibid.*, p.32.

<sup>700</sup> *ibid.*, p.15, 16, 42, 44, 54, 65.

a Utopian myth. They find instead that the community does not or cannot care and that the services that should be caring for them are not available to help them in their time of need. (...) That is why I plead for systematic, vigorous evaluation and inspection not only of the National Health Service, but also of community care.<sup>701</sup>

Lord Bishop of Manchester agreed and found that the community's needs could only be addressed locally, and he called for a subsidiary organization of services assisted by health authorities that would provide a "link with the people and their communities."<sup>702</sup>

The Second Reading of the Bill confirms that fundamental principles and egalitarian values paved a rigid path of dependence from which no policy-maker was allowed to deviate. Members constantly discussed the pillars of the NHS, universality and equality, more than they denounced inappropriate market methods to achieve just health care.<sup>703</sup> More than eight instances reflect the Members' attachment to these values.<sup>704</sup> For example, the Baroness Cox again offered an eloquent plea in favor of the NHS:

I believe the National Health Service is one of the most humanitarian institutions the world has ever known. It has provided a popular and generally equitable health service, (...) Therefore, I will wholeheartedly support any policies which help to put the principles which the National Health Service enshrines into practice more effectively; but I, and

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<sup>701</sup> *ibid.*, p.44.

<sup>702</sup> *ibid.*, p.44.

<sup>703</sup> *ibid.*, p.6, 40, 73, 78, 81.

<sup>704</sup> *ibid.*, p.14, 24, 44, 45, 50, 65.

my professional colleagues, cannot and will not support proposals which appear to us to risk damaging this precious institution and thereby possibly harming those whom it serves.<sup>705</sup>

This led Lord Rea (Labour) to challenge the purpose of the Review, the results published in *Working for Patients*, and of course, the introduction of a new health care Bill. For him,

[T]he White Paper that introduced the Bill pays lip service to the National Health Service, it seems to have missed two fundamental advantages of the NHS as it now stands. The first, which has been mentioned by many speakers, is its truly comprehensive nature. Not only is it available to anyone, however poor, but high standards are available throughout the country. (...) I can only ask why, if the present system is popular with the public and professions alike and is comprehensive and economical, is it necessary to make such fundamental changes.<sup>706</sup>

Although revolutionary, the Act had to remain true to the original idea of justice behind the creation of the NHS. As Baroness Lockwood (Labour) summed it up,

The National Health Service is a different creature from what it was in 1948. The economics have inevitably changed as new technologies and techniques have become available. In her opening remarks the Minister said that we were concerned about change and continuity. That is quite right. We are certainly concerned about those but we do not want the change to be so drastic that the continuity is broken.<sup>707</sup>

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<sup>705</sup> *ibid.*, p.45.

<sup>706</sup> *ibid.*, p.50, 51.

<sup>707</sup> *ibid.*, p.32.

Absent from the debate, the for-profit medical profession still had allies among Labour Members who represented their interests and helped them to preserve the fundamental, egalitarian values of the NHS. Fiercely debated, the Act was nonetheless enacted, the managed market was implemented, and the egalitarian foundations were preserved.

### **C. The Health and Social Care Act (2012): A Consumerist Reform Preparing a Shift Towards a Hybrid System?**

The 2010 elections mark another interesting turning point in the history of Britain and a crucial crossroad for the NHS. Denied of an outright victory, the Conservative Party had to negotiate the first post-war coalition government with the Liberal Democrats.<sup>708</sup> Adding to this period of unique political change were economic difficulties looming on the country and on the NHS, as it faced its longest period in history of low funding growth.<sup>709</sup> In fact, political analysts believed that the next decade would be the most challenging financially for health care services. A rethinking of the organization was imminent to allow the NHS to be more efficient and to

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<sup>708</sup> Thomas Quinn, *From New Labour to New Politics: The British General Election of 2010*, 34 *West European Politics* 403 (2011).

<sup>709</sup> David Buck & Anna Dixon, *Improving the Allocation of Health Resources in England* | *the King's Fund*, p.2.

meet the financial challenges of a growing aging population and the cost of new drugs and treatments.<sup>710</sup>

During the course of the past decade, many lifestyle factors (obesity, alcohol-related illness, cancer, coronary diseases) and technological advances had contributed to health care costs rising at a much higher rate than inflation.<sup>711</sup> Unwarranted variations in access, utilization, and quality of care had also widened health inequalities since 1997.<sup>712</sup>

Nonetheless, a major reform of the health services was not initially in the cards for the new Coalition government. Yet, less than three months after the publication of a modest program for the NHS, the Department of Health, along with Secretary of State for Health Andrew Lansley, announced the publication of a ground-shaking White Paper proposing far-reaching changes for the provision of health care in Britain.<sup>713</sup>

*Equity and Excellence: Liberating the NHS (Equity and Excellence)* revealed the government's intentions to promote greater diversity in health care services

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<sup>710</sup> <http://www.bbc.co.uk/news/health-12177084>.

<sup>711</sup> <http://www.bbc.co.uk/news/health-12177084>.

<sup>712</sup> Ruth Thorlby & Jo Maybin, *A High Performing NHS?: A Review of Progress 1997-2010* (2010).

<sup>713</sup> Klein, *The Twenty-Year War Over England's National Health Service: A Report from the Battlefield*, supra 513, p.853.

and to have the for-profit sector play a greater role in the NHS.<sup>714</sup> The review promised to “stop the top-down reorganisation of the NHS that [had] got[ten] in the way of patient care”<sup>715</sup> and to preserve the NHS’s founding and core principles.<sup>716</sup> The goal was to set up an ambitious but speedy reform that put patients first while improving health care outcomes.<sup>717</sup>

Thus, a Bill was introduced to Parliament on January 19, 2011. The controversy and animosity it created halted the legislative process. The Coalition called for a pause to reflect and listen to the main stakeholders.<sup>718</sup> Opposition came from all sides: politicians, the public, and of course, the medical profession were outraged by the imminent crime against the core values of the NHS. They saw only problems and no solutions in the Bill.<sup>719</sup> The Labour Party, the Royal College of General Practitioners, the Royal College of Nursing, and the BMA joined forces to terminate the legislative process. Yet, despite the online petitions, street demonstrations, and open

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<sup>714</sup> David J. Hunter, *A Response to Rudolf Klein: A Battle may have been Won but perhaps Not the War*, J. Health Polit. Policy Law (2013), p.869.

<sup>715</sup> Klein, *The Twenty-Year War Over England's National Health Service: A Report from the Battlefield*, supra 513, p.852.

<sup>716</sup> *ibid.*

<sup>717</sup> A. Dixon & C. Ham, *Liberating the NHS: The Right Prescription in a Cold Climate*, The King's Fund Response to the 2010 Health White Paper (2010).

<sup>718</sup> Ewen Speed & Jonathan Gabe, *The Health and Social Care Act for England 2012: The Extension Of new Professionalism*, Critical Social Policy (2013).

<sup>719</sup> Klein, *The Twenty-Year War Over England's National Health Service: A Report from the Battlefield*, supra 513, p.847.

objections, the Bill went back to Parliament. Each clause was discussed and negotiated until a patched-up version incorporating more than 1,000 amendments finally received royal assent on March 27, 2012.<sup>720</sup>

The Health and Social Care Act has thus far been the biggest shake-up of the NHS.<sup>721</sup> The consumerist revolution it proposes changes the character of a patient's entitlement. Focusing on the individuals' ability to choose public or private providers to satisfy their health care needs, it provides patients with more freedom and a claim right against the state.

Although the fundamental egalitarian conception of justice remains virtually untouched, for the first time in history the founding principles have come into question, and a new, more direct role is envisaged for the for-profit sector. The Act introduced a radical reform of commissioning and promoted a market approach for organizing the NHS;<sup>722</sup> with this, a hybridized system is certainly on the horizon.<sup>723</sup>

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<sup>720</sup> *ibid.*

<sup>721</sup> Webster, *The National Health Service: A Political History*, supra 23.

<sup>722</sup> *ibid.*

<sup>723</sup> C. Webster, *Confronting Historical Myth*, 19 *Health Serv. J.* (1988).

*i. The Beginning of a Long Controversy: Equity and Efficiency*

*Equity and Efficiency* was published at breakneck speed. After only six weeks, the document emerged and included a broad plan for reform with no real details on implementation.<sup>724</sup> For the Coalition, avoidable deaths across the health care system justified yet another reorganization of the NHS.<sup>725</sup> Thus, the far-reaching White Paper offered to take a more libertarian approach to providing and commissioning health care services without betraying the system's egalitarian foundations.<sup>726</sup>

Within the first pages of the report, the government had presented itself as the protector and guardian of the NHS's core values, stating,

It is our privilege to be custodians of the NHS, its values and principles. We believe that the NHS is an integral part of a Big Society, reflecting the social solidarity of shared access to collective healthcare, and a shared responsibility to use resources effectively to deliver better health. /We are committed to an NHS that is available to all, free at the point of use, and based on need, not the ability to pay. We will increase health spending in real terms in each year of this Parliament. /The NHS is about fairness for everyone in our society. It is about this country doing the right thing for those who need help.<sup>727</sup>

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<sup>724</sup> Kieran Walshe, *Reorganisation of the NHS in England*, 341 *BMJ* (2010).

<sup>725</sup> Roger Jones, *The White Paper: A Framework for Survival?* 60 *The British Journal of General Practice* 635 (2010).

<sup>726</sup> Sheena Asthana, *Liberating the NHS? A Commentary on the Lansley White Paper, "Equity and Excellence"*, 72 *Soc. Sci. Med.* 815 (2011).

<sup>727</sup> Department of Health, *Equity and Excellence: Liberating the NHS*, (2010), p.7.

Along with this desire to preserve the system's foundations came a motivation to perfect health care services through a market approach, to promote efficiency, competition, and accountability. The Coalition was formulating an ambitious goal to

free up provision of healthcare, so that in most sectors of care, any willing [p]rovider can provide services, giving patients greater choice and ensuring competition stimulates innovation and improvements, and increases productivity within a social market.<sup>728</sup>

A slow but decisive turn from solidarity to subsidiarity was initiated. By devolving some of its power to local authorities,<sup>729</sup> the government hoped that “[g]reater autonomy [would] be matched by increased accountability to patients and democratic legitimacy.”<sup>730</sup> Instead of micromanaging health services, the Department of Health was to fulfill its duties from a distance. The medical profession would also be granted more managerial responsibilities and decision-making power in the allocation of health care resources.<sup>731</sup>

The White Paper also proposed to open the health care market further to the for-profit sector in the realms of commissioning and providing care, again to

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<sup>728</sup> *ibid.*, p.37.

<sup>729</sup> Dixon & Ham, *Liberating the NHS: The Right Prescription in a Cold Climate*, supra 717.

<sup>730</sup> Department of Health, *Equity and Excellence: Liberating the NHS*, supra 727, p.27.

<sup>731</sup> Kieran Walshe & Chris Ham, *Can the Government's Proposals for NHS Reform be made to Work?* 342 *BMJ* (2011).

make the NHS more patient-centered and to increase the quality of health care services.<sup>732</sup> The reform would enact change at the government level by creating a new Department of Public Health to work alongside the Department of Health and an NHS Commissioning Board to minimize top-down political interference. The Board would mostly oversee the work of GP commissioners working on behalf of the Secretary of State and would provide leadership on commissioning for quality, promoting patient and public involvement, and the commissioning of services not dispensed by CCGs.<sup>733</sup> In the new NHS, it would be up to “front-line” professionals, rather than the government, to structure, choose, and provide the services that were most adequate for their patients.<sup>734</sup> This reflected the Coalition government’s desire to reduce the state’s role in health care and to allow patients to “top-up” their public entitlements with the services offered by private providers.

In addition, with the goal of effectively reducing costs of provision, the Strategic Health Authorities and PCTs would be dissolved and regrouped into Foundation Trusts.<sup>735</sup> These new entities were expected to compete

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<sup>732</sup> *ibid.*

<sup>733</sup> Dixon & Ham, *Liberating the NHS: The Right Prescription in a Cold Climate*, *supra* 717.

<sup>734</sup> Asthana, *Liberating the NHS? A Commentary on the Lansley White Paper, “Equity and Excellence”*, 815, *supra* 726.

<sup>735</sup> *ibid.*

with private-sector providers. An increase in competition among providers evidently called for more regulation. Monitor<sup>736</sup> would act as the main economic regulator encouraging and promoting competition, setting prices, guaranteeing the continuity of essential services, preventing anti-competitive behavior, and even applying necessary sanctions.<sup>737</sup>

The underlying theme running as a form of subtext through the entire document was that achieving the twin goal of efficiency and cost-cutting did not necessarily require sacrificing quality or equity in health care.<sup>738</sup> All could be achieved by outsourcing to the for-profit sector the management and administration of commissioning duties and by providing certain services with the help of the private sector.<sup>739</sup>

Following its publication, *Equity and Efficiency* created an uproar. The general public found the lack of justification for this new reform hard to swallow.<sup>740</sup>

Of course, supporters of a market-based reform welcomed the proposal,<sup>741</sup>

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<sup>736</sup> *About Monitor* | *Monitor*, last accessed 4 January 2014, “Monitor is the sector regulator for health services in England. Our job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefits”.

<sup>737</sup> Webster, *The National Health Service: A Political History*, supra 23.

<sup>738</sup> Asthana, *Liberating the NHS? A Commentary on the Lansley White Paper, “Equity and Excellence”*, 815, supra 726.

<sup>739</sup> *ibid.*

<sup>740</sup> Nicholas Timmins, *Never again? the Story of the Health and Social Care Act 2012*, Kings Fund <[http://www.kingsfund.org.uk/publications/never\\_again.html](http://www.kingsfund.org.uk/publications/never_again.html)> (2012).

<sup>741</sup> Simon Stevens, president of global health at United Health Group, and a trustee of the King’s Fund stated: “More patient power; a greater role for GPs in planning and funding decisions; a stronger focus on clinical outcomes; NHS hospitals with operating freedoms similar to universities; an end to day to day

but they were quickly outnumbered by the discontented stakeholders. The medical community, local authorities, and NHS managers were, unsurprisingly, averse to more competition and greater private-provider interference in health care.<sup>742</sup>

Despite the for-profit features of GP practices and the work of consultants in the private sector, medical professionals voiced the same concerns they had raised regarding previous reforms. To them, this proposal would compromise the doctor-patient relationship and had the potential to contaminate the entire health care system.<sup>743</sup>

Tension grew as the White Paper was transformed into a full-fledged Bill. For a period of 20 months, the scale and speed of the reorganization and the potential “privatization” of the NHS became the focal points of all parliamentary debates on health care.<sup>744</sup> In April 2011, the government called for a time-out to conduct further consultation and launched the NHS Future Forum.<sup>745</sup> This quasi-royal commission proceeded to a broad consultation and speedily reported on the opposition formulated by GPs and other NHS

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politicisation thanks to arms’ length regulation and an expert national commissioning board what’s not to like about the new NHS White Paper?”, *BMJ* 2010 More brickbats than bouquets? *BMJ* 341:c3977.

<sup>742</sup> Walshe & Ham, *Can the Government’s Proposals for NHS Reform be made to Work?*, supra 731.

<sup>743</sup> Timmins, *Never again? the Story of the Health and Social Care Act 2012*, supra 740.

<sup>744</sup> *ibid.*

<sup>745</sup> Klein, *The Twenty-Year War Over England’s National Health Service: A Report from the Battlefield*, supra 513, p.855.

interest groups. The Department of Health adopted many recommendations; nevertheless, negotiations remained fierce as the legislative process resumed.<sup>746</sup>

Finally, after all too many changes and revisions, the Bill became law in March 2012. The NHS would begin its radical transformation,<sup>747</sup> although many critics still objected to the reform, stressing that it undermined the founding principles of free and universal provision of health care.<sup>748</sup>

*ii. Schizophrenic Justice or the Potential Privatization of a Universal Health Care System?*

The Health and Social Care Act was inspired by some libertarian principles inherited from the Thatcher era, and most important, it advanced a consumerist conception of health care services delivery, but it also honored the NHS egalitarian past. While retaining public funding to finance health care services, the privatization of the allocation and provision processes could potentially lead to a hybrid system of public health services delivery in England.

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<sup>746</sup> *ibid.*

<sup>747</sup> Peter Bailey, *Primary Care Duped: The Government's Bill Will Wreck the NHS*, 344 *BMJ* (2012); Allyson M. Pollock & David Price, *How the Secretary of State for Health Proposes to Abolish the NHS in England*, 342 *BMJ*

Heavy criticism targeted the unprecedented intensity with which market principles had to be employed in the realm of health care provisioning. According to Pollock et al., the “entitlement to equality of provision” could be greatly eroded and result in the death of the NHS.<sup>749</sup>

Echoing the reforms made in the education sector, the Coalition government wished to remove itself from the allocation process and have the market distribute this public good, like any other commodity.<sup>750</sup> Thus, the floodgates were opened to “any qualified provider.”<sup>751</sup> Bids for community care, sexual health services, and even prison health care services from large corporate companies such as Virgin Healthcare, Serco, or United Health were to become common practice.<sup>752</sup>

Certain areas of care would be at risk of fragmented service provision due to lack of coordination among the many actors present on the market.<sup>753</sup>

Furthermore, overseas corporations strictly accountable to their shareholders and out of the British regulators’ reach would be free to provide lower-

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(2011), p.800-803.

<sup>748</sup> Speed & Gabe, *The Health and Social Care Act for England 2012: The Extension Ofnew Professionalism*, supra 718.

<sup>749</sup> Allyson M. Pollock et al., *How the Health and Social Care Bill 2011 would End Entitlement to Comprehensive Health Care in England*, 379 *The Lancet* 387 (2012).

<sup>750</sup> Hunter, *A Response to Rudolf Klein: A Battle may have been Won but perhaps Not the War*, supra 714, p.870.

<sup>751</sup> Nick Black, “Liberating the NHS”—*Another Attempt to Implement Market Forces in English Health Care*, 363 *N. Engl. J. Med.* 1103 (2010).

<sup>752</sup> Speed & Gabe, *The Health and Social Care Act for England 2012: The Extension Ofnew Professionalism*, ;

quality services.<sup>754</sup> Although Monitor would guarantee that all providers compete on equal footing, it was not assigned the mission of safeguarding the collaboration or integration of health care providers.<sup>755</sup>

The Act foreshadows the advent of a hybridized system. Having been granted general powers, local authorities are expected to step into the shoes of the health secretary and assume public health functions, despite their extremely limited resources.<sup>756</sup> The Secretary of State's duty to promote a comprehensive service is maintained, but his or her duty to provide comprehensive health services is abolished<sup>757</sup> and substituted with a lesser duty to "act with a view to securing"<sup>758</sup> comprehensive services. Also striking is the milder duty of the Secretary of State to "reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service,"<sup>759</sup> which replaced the full-fledged duty to promote equal access.<sup>760</sup>

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Hunter, *A Response to Rudolf Klein: A Battle may have been Won but perhaps Not the War*, supra 714, p.871.

<sup>753</sup> Webster, *The National Health Service: A Political History*, supra 23.

<sup>754</sup> Hunter, *A Response to Rudolf Klein: A Battle may have been Won but perhaps Not the War*, supra 714, p.871.

<sup>755</sup> Webster, *The National Health Service: A Political History*, supra 23.

<sup>756</sup> *Health and Social Care Act*, (2012): .

<sup>757</sup> *ibid.*, part I, sec. 1.

<sup>758</sup> *ibid.*

<sup>759</sup> *ibid.*, part I, sec. 4, 1(c).

<sup>760</sup> Pollock & Price, *How the Secretary of State for Health Proposes to Abolish the NHS in England*, supra 747.

Neither the NHS Commissioning Board supervising CCGs nor the CCGs themselves were invested with the duty to ensure equal access to health care services based on need. CCGs are only mandated to meet “reasonable requirements”<sup>761</sup> by providing the “services or facilities [they] consider appropriate.”<sup>762</sup> Furthermore, CCGs only owe these duties to the enrolled population within their commissioning groups.

Risk-spreading is also critically endangered because CCG enrollees are to be drawn from a list of general members instead of from a pool of individuals residing in a specific geographical area. Practice boundaries are thereby abolished, and patients can be accepted irrespective of their place of residence, potentially leading GPs to cherry-pick enrollees and exclude sicker and poorer patients from their practices.<sup>763</sup>

Critics of the reform find it difficult to comprehend how public interests can still be preserved and strengthened now that the delivery of health care services is no longer in public hands.<sup>764</sup> Promises might be fulfilled, but the

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<sup>761</sup> *Health and Social Care Act*, supra 756, part I, sec. 13, 2(a).

<sup>762</sup> *ibid.*, part I, sec. 14, 3(a)(1).

<sup>763</sup> Pollock & Price, *How the Secretary of State for Health Proposes to Abolish the NHS in England*; Martin Powell & Robin Miller, *Privatizing the English National Health Service: An Irregular Verb?* J. Health Polit. Policy Law (2013).

<sup>764</sup> Pollock & Price, *How the Secretary of State for Health Proposes to Abolish the NHS in England*; Powell & Miller, *Privatizing the English National Health Service: An Irregular Verb?*, supra 763.

risk of costs rising and quality decreasing, ultimately creating more health inequalities, is also very much present.<sup>765</sup>

This lingering conflict between welfare and market ideologies inherited from the Thatcher era<sup>766</sup> has led the Coalition government to believe that problems in health care can be resolved through an increase in competition.<sup>767</sup> Nonetheless, in contrast to reforms led for public utilities, the government has never explicitly formulated a desire to privatize the NHS.<sup>768</sup> This reform certainly marks a new shift from licensure to regulation, whereby the state assumes the role of a buyer rather than a provider of care.<sup>769</sup> Nonetheless, in no way does it signal the active privatization of the system. The NHS continues to be funded by central taxation, available to all and for free at every point of use.<sup>770</sup>

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<sup>765</sup> Hunter, *A Response to Rudolf Klein: A Battle may have been Won but perhaps Not the War*, supra 714, p.873.

<sup>766</sup> Philip Bobbitt, *The Shield of Achilles: War, Peace, and the Course of History* (2007).

<sup>767</sup> Michael J. Sandel, *Justice: What's the Right Thing to do?* (2010).

<sup>768</sup> Timmins, *Never again? the Story of the Health and Social Care Act 2012*, supra 740.

<sup>769</sup> Speed & Gabe, *The Health and Social Care Act for England 2012: The Extension Of new Professionalism*, supra 718.

<sup>770</sup> Klein, *The Twenty-Year War Over England's National Health Service: A Report from the Battlefield*, supra 513, p.847.

iii. *The Foundations of the Act: Analysis of the Second Reading of the Health and Social Care Bill Before the House of Lords*

After the NHS Future Forum's listening exercise, the Parliament reconvened to discuss the reform for a second time. The House of Lords proceeded with the Second Reading of the Bill on January 31, 2012. Overall, this debate relayed the tension in the discourse of two distinct clans, each defending their own conception of justice through polarized discourses.

On the one hand, the reformers stressed the need to adopt a libertarian and more consumerist approach to create more competition in health care service provision to empower patients, and although advocating consumerist means, they were nevertheless unwilling to compromise the NHS's original goals.<sup>771</sup>

On the other hand, the advocates of the status quo focused on preserving an egalitarian idea of justice. Extremely critical of the market approach relayed in the drafting of the Bill they worried about the reform's potential impact on vulnerable groups.<sup>772</sup>

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<sup>771</sup> Many occurrences relay the libertarian spirit of the act, *see Second Reading of the Health and Social Care Bill*. House of Lords. (2011), p.4, 5, 18, 46, 63.

<sup>772</sup> More than 14 occurrences make a reference to egalitarian principles, *see ibid.*, p.9, 10,11, 22, 23,24, 25,

Among the many consumerist and some libertarian concepts mentioned throughout the debate, Conservative Member Earl Howe evoked the importance of a subsidiary approach to the organization of health care services, stating,

[The Act] allows power to be devolved from the centre so that innovation is unleashed from the bottom up, supported by clear lines of accountability. It is, in fact, the inverse of a top down reorganisation.<sup>773</sup>

One purpose of the reform was certainly to enact a consumerist approach with a decentralized administration and provision of health care services. No definite idea of justice was adamantly promoted in the discourses, but a libertarian approach emerges in Howe's argument to promote competitiveness<sup>774</sup> to achieve better care. According to him,

where competition can operate to improve the service on offer to patients, or to address a need that the NHS fails to meet, we should let the system facilitate it. However, competition only has a place when it is clearly and unequivocally in the interests of patients.<sup>775</sup>

The Baron Naseby, also a member of the Conservative Party, supported him. The Baron more particularly stated,

[C]ompetition is good for any industry. It makes it possible for new innovations, for better value for money and for solutions to be found. Competition gives people pride and

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28, 29, 30, 31, 32, 40, 44, 51, 60, 61, 64.

<sup>773</sup> *ibid.*, p.3.

<sup>774</sup> *ibid.*, p.5

<sup>775</sup> *ibid.*, p.4.

responsibility. Even within the NHS there are numerous examples. (...) The state does not have to undertake everything. It has to be a demanding purchaser, an experienced demanding purchaser, and vigorously assess outcomes.<sup>776</sup>

These consumerist and libertarian supporters, however, were also fiercely opposed and criticized in their approach.<sup>777</sup> Labour Member the Baroness of Thorton offered an eloquent plea, arguing,

[The reform] will change the NHS from a health system into a competitive market. It will turn patients into consumers and patient choice into shopping. Most crucially, it will turn our healthcare into a traded commodity. (...) We do not support making our NHS into a regulated market, as advocated by some.<sup>778</sup>

Summing up her camp's position, the Baroness Billingham said that it was senseless to initiate this reform in the first place. To her,

there is an underlying sinister motive to advance the market philosophy into the NHS, which will ultimately destroy it. The cherished principles of the NHS as a universal service will indeed be lost forever.<sup>779</sup>

Indeed, the defenders of the NHS's universal values believed that the market should not intervene in the distribution of a common good or in a service that is, according to the Socio-Democrat Lord Owen, "not a public

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<sup>776</sup> *ibid.*, p.28.

<sup>777</sup> *See more particularly*, *ibid.*, p.9, 32, 60.

<sup>778</sup> *ibid.*, p.9.

<sup>779</sup> *ibid.*, p.31.

utility,”<sup>780</sup> simply because “health is different.”<sup>781</sup> In the same vein, Lord Beecham emphasized that

The health service is of great utility to the people of this country. It is not a utility like gas, water or electricity - still less an insurance fund. It falls to this House to preserve the principles of the National Health Service and facilitate its continuous improvement in the service of the people.<sup>782</sup>

The debate pivoted around a tension between a new consumerist libertarian-inspired ideology and the importance of preserving the core values of the NHS. Here again, the path of dependence created by the 1946 universal and egalitarian principles permeated the Second Reading of the Act such as in the words of Baroness Bakewell:<sup>783</sup>

In 1946 the National Health Service was just such a bold and significant leap forward. As we consider how it might be improved, we need to bear in mind what we are changing: one of the finest, most highly regarded and valued institutions of British life, with a global reputation. The enduring essence of the NHS must not be yielded up to the transient imperatives of an external free market.<sup>784</sup>

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<sup>780</sup> *ibid.*, p.11.

<sup>781</sup> *ibid.*, p.11.

<sup>782</sup> *ibid.*, p.22.

<sup>783</sup> Among many these occurrences explicitly the importance of NHS fundamental value, *see ibid.*, p.23, 25, 31, 44.

<sup>784</sup> *ibid.*, p.28.

#### IV. Conclusion

After the war, Aneurin Bevan imagined a unified health care system whose only goal would be to provide the entire British population with health care based on needs and not on means. As a successful institution, the NHS would forever embrace and protect these values thanks to the help of the medical profession. The initial alliance between the state and the BMA did not divorce the medicine from the money but separated the practice of medicine from the doctors' income and thereby removed any perverse incentives.<sup>785</sup> This constraint has led the medical profession to be the most fervent defender of the NHS's fundamental principles. Despite Margaret Thatcher's dream of a beneficent internal market coming to the rescue of an inefficient health care service, the NHS remained universally available, free at the point of use, and funded through taxation.<sup>786</sup> Certainly money had to follow the patient, but mostly the system's core values had to be preserved.

This path of dependence has woven an egalitarian thread throughout the health care system's entire legislative history. Although often intertwined with other conceptions of justice, egalitarian justice principles have endured

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<sup>785</sup> Klein, *The New Politics of the NHS: From Creation to Reinvention*, supra 100, p.155.

<sup>786</sup> Bevan & Robinson, *The Interplay between Economic and Political Logics: Path Dependency in Health Care in England*, 53, supra 45, p.53.

all reforms of the NHS. This chapter demonstrates that justice is ontological to the NHS and, in particular, how certain trends have provided the means to achieve egalitarian ideals over the past 70 years.

## CONCLUSION:

### Finding Solutions to Health Care Issues

#### *Concluding Remarks on the Role of Profits and Justice in the Development of Allocation Laws*

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In this dissertation I have discussed the context and multiple historical events that have given rise to major health care reforms in the United States and England during the past 70 years. I laid out these historical foundations to analyze discourses of justice in legislative preparatory work for these two jurisdictions and to unveil the reasons leading to the enactment of crucial health care allocation laws.

In this chapter I present my findings and conclude regarding the influence of justice principles and the role of for-profit actors in the drafting of these reforms. I also present observations on the notion of profits in health care and on the convergence of health care policies in western welfare states, to finally suggest prospects for further research.

More generally, I highlight the contribution of this research to the field of health care law: revealing a link between different perspectives on health care allocation issues and offering a comparative and philosophical analysis of health care laws to elaborate more optimal distribution processes.

## **I. On the Allocation of Health Care Resources in Western Welfare States**

This dissertation builds on available literature and research in the fields of philosophy and health law to make an initial, pivotal argument about the special nature of health care. Indeed, to argue in favor of the just allocation of health care resources, I chose to begin my analysis by defining health care as a crucial element participating in the achievement of the Common Good. The goal of this philosophical demonstration was to later verify whether this assumption had been accepted in practice, in other words, whether laws drafted for the allocation of special resources such as health care had been inspired by principles of justice.

For this, I fleshed out the four philosophical archetypes, each embodying this assumption, to form a theoretical framework for the analysis of health care financing and provision laws. Thus, the libertarian, egalitarian, utilitarian, and communitarian conceptions of justice were given equal consideration in forming the analytical reading grid applied to laws enacting health care reforms in the United States and England from the post-World War II era to the present day. A conscious choice was made not to select or create a unique conception of justice for the analysis of the historical context

and primary sources attesting to the creation of these laws, because all four archetypes relay different but equally important principles for the just distribution of resources.

Furthermore, using the aforementioned literature on the history of western health care systems, I also described, explained, and sketched out the historical foundations giving rise to the privately run American health care system and the publicly funded NHS of England. Rather than offering a raw chronology recounting the development of these systems, I chose to analyze major health care policy trends and to expose the roles of influential stakeholders in the development of health care legislation in both countries.

This historical and thematic study has helped to confirm the existence of paths of dependence in health care policy-making as previously noted by American political scientists. In the following section, I also present findings regarding the for-profit sector's role in the development of health care reform, and I elaborate on the existence of these paths of dependence.

### **A. Just Laws for the Allocation of Health Care Resources**

The conclusions presented hereafter result from a descriptive and evaluative analysis that I conducted to determine the influence of accounts of justice on

the drafting of health care reforms in the United States and England. Perhaps additional work based on these conclusions could offer policymakers and lawmakers useful prescriptions to guide the process of future reforms and rectify these systems' shortcomings; nonetheless, the primary purpose of this research was not to generate such prescriptions, nor was it to provide an evaluative analysis of these systems' ability to fulfill principles of justice, even though subsequent sections touch upon these themes.

The findings of the discourse analysis of the health care legislative processes in the United States and the United Kingdom show that health care lawmaking in both these jurisdictions does not comprise simply poor arbitrages and pragmatic considerations, but it is in fact inspired by certain principles of justice that emerge in the negotiations and in the final version of health care acts. Applying the analytical framework developed in the first chapter of the dissertation, I evaluated, in turn, the influence of all four conceptions of justice on the drafting of each health care reform in both the American and British case studies and found that all of the Bills discussed included one or more conceptions of justice. It is therefore possible to qualify these as "just" laws inasmuch as the presence of justice principles in the discourses leading to their enactment confers on them a "just" character. Reverting to the primary definition of justice presented in the introductory

chapter, I also conclude that because all of these laws aim to promote an effective system for a fairer and more optimal allocation of health care resources, they should also, from that standpoint, be deemed “just.”<sup>787</sup>

Beginning my analysis with the United States, I noted a constant oscillation in policy-making, which was also present in legislative debates, between egalitarian principles of justice and a more libertarian approach to the distribution of health care resources. The history of this health care system accounts for the schizophrenic nature of its health care policy. The initial structure of the system was not based on a particular ideology but resulted from an accident of history.

The power struggle between unions and employers during World War II, coupled with their lack of commitment to any political party, formed the basis for a privately run system. The refusal to turn to the state for the coverage of American employees and the medical association’s determination to stand its ground to protect its autonomy have prevented the advent of a universal, egalitarian health care system. From the beginning, the for-profit sector created an immovable path of dependence for health care policy development.

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<sup>787</sup> Cf. definition of justice provided p.9.

Surprisingly, three different conceptions of justice have informed the drafting of laws creating some of the most important health care reforms in the United States. Starting with legislation enacted in the 1960s to finance health care services for the medically indigent aged, I noted clear indications of a resource egalitarian trend in the development of the Kerr-Mills Act. The aged required care and protection, but employers were unwilling and unable to extend coverage; thus, the government had to step in. The project of a universal health care system was again nipped in the bud. For the first and not the last time, the state would take on the health care needs of some of the most vulnerable Americans. Ulterior motives but also Rawlsian ideals guided the discourse of for-profit actors during the negotiation stages. Many statements in the final version of this Act attest the importance of resource egalitarian justice principles.

The amendments to the Social Security Act that followed the Kerr-Mills Act also embraced the egalitarian trend of the 1960s and created the most important public programs for health care in American history: Medicare and Medicaid. At this point, the health care needs of the poor and the elderly became a part of the state's duties. I found that the legislative intent behind both of these initiatives was essentially welfare egalitarian, given that both programs reflect the goal of providing all Americans with access to health

care services. The input of the for-profit sector led to Medicare's tripartite structure. Ultimately, insurers were delighted as they had weeded out most of the high-risk applicants.

The reading of the 1973 HMO Act revealed clear evidence of a communitarian conception of justice coupled with a libertarian philosophy, to implement a revolutionary project. HMOs were designed to satisfy rural communities' pressing health care needs and reflected the ambition to reduce health care costs by promoting primary care medicine. The concept was the Republicans' political answer to the Democrats' Health Security. Here again, another attempt at socializing medicine was defeated through the help of corporate America. HMOs were promoted as a pro-market and cost-effective initiative benefitting employers and local communities.

Fast-forwarding through history, the analysis of the ACA (2012) confirmed the importance of justice principles for the allocation of health care resources. The drafting clearly relays some principles of welfare egalitarian justice. Nonetheless, even though libertarian and egalitarian justice principles had been extensively debated in Committee, it was surprising to notice that, when deciding the fate of the health care reform, the Supreme Court avoided discussing distributive issues. This shows that the allocation, rationing, and

management of health care resources remain political and sensitive in the United States.

The analysis of the second case study demonstrates that the debate is set in different terms in the United Kingdom. Principles of justice are also very much present in the negotiations, the drafting, and the final versions of NHS Acts. Nonetheless, it is the “egalitarian seeds” planted at the system’s inception that have paved a path of dependence restricting health care policy in this system.

Indeed, stakeholders participating in the British health care system have helped to preserve an idea of justice that has, over time, transcended health care policy and lawmaking. Even though the means to achieve the egalitarian ideal are different from one reform to the next, the fundamental idea of justice remains unchanged.

Starting with the foundational NHS Act of 1946, my analysis highlighted the consensus surrounding the project of a solidary health care system and presented the lengthy negotiations leading to the enactment of this Act. This legislation was certainly the product of the post-war era, the groundbreaking work accomplished by the Beveridge report, and the ambition of Aneurin

Bevan. With this project, Bevan wanted to implement a system that could improve the general health status of the population and benefit the entire British nation.

The egalitarian principles in the final version of the Act result from utilitarian calculations. My analysis of subsequent acts demonstrates that the utilitarian and egalitarian conceptions of justice are ever-present in each major health care reform that occurred in England over the past 70 years.

In addition, the medical profession, initially vigorously opposed to the idea of a centralized system, finally entered into a tacit concordat with the state, which settled their role in the new system. All agreed with the basic egalitarian principles, but a deeper and less apparent debate began to surface. Discussions about the degree of health care equality the state had to provide finally emerged.

Should the government take the role of a minimalist insurer, providing a basic level of care to the population and guaranteeing equality in treatment to each individual, or should it provide equality in outcome, providing “bog” minimal health care services to the entire population and allowing the purchase of additional out-of-pocket benefits to supplement state benefits?

My analysis has shown that this collectivist versus individualistic vision of equality is also scattered throughout subsequent health care reforms.

The 1990 NHS Community Care Act perfectly illustrates this tension and attests a shift in the methods taken to achieve the egalitarian ideal. The Thatcherite health care reform aimed to introduce competition in health care services by using libertarian tools to achieve greater efficiency and to continue to guarantee equal access to health care service. The core values of the NHS were to survive, as the state remained the sole funder of the system.

Initially heavily criticized by a medical profession wary that the reform would erode the egalitarian principles of the NHS, GPs and consultants finally got on board with the reform and embraced the purchaser-provider divide. My analysis of this groundbreaking Act confirms the importance of egalitarian and utilitarian principles of justice in health care lawmaking in England, but it also attests a desire to shift towards more libertarian methods to achieve this equality.

Subsequent health care reforms followed a similar trend. In 2012, another shift occurred, this time from a patient-focused ideology towards a

consumerist approach to health care. Nonetheless, the NHS Health and Social Care Act still preserved the NHS's egalitarian ideals. The reform marked an ideological turning point for the management and provision of health services, but not for their financing.

The libertarian principles restricting state intervention in health care and giving more freedom to patients were ingrained during the Thatcher era; they have now been replaced by a consumerist ideology giving patients rights and entitlements against the state. The reform aimed to provide better access to health care by increasing patients' choice and enabling them to seek health care services from private providers.

This dissertation reveals that multiple conceptions of justice have influenced both the American Congress and the British Parliament in the crafting of their health care laws. This does not mean that other pragmatic reasons have not also influenced the elaboration of health care reforms, nor does it explain which conceptions of justice have had the most influence or should be preferred for the reform of these systems.

Certainly, social utility and the need to promote a healthy workforce were great motivators for employers to provide insurance to workers in the

United States and indirectly led the government to take charge of retirees. In the United Kingdom, social utility was also a prime concern of the founders of the NHS, but values such as respect for human dignity have also helped to advance the utilitarian and egalitarian justice principles in the negotiation process.

Overall, the analysis of legislative debates and preliminary legislative work has revealed that, along with other values, more than one conception of justice has guided distribution processes in both these welfare states. In the United States, justice has at times been used as a tool to enact health care reform; in the United Kingdom, justice has been the main inspiration behind health care laws. Thus, among the reasons influencing policy-makers, justice is always evoked either as an implied underlying theme or as an explicit motivation to legislate. This proves that health care policy in the United States and in the United Kingdom does not result merely from pragmatic considerations.

## **B. The Role of For-Profit Actors in the Drafting of Law for the Allocation of Health Care Resources**

Political scientists have made the argument that for-profit actors participating in private health care systems have led the debate and advanced their own incentives, thus imposing their pragmatic vision for the allocation of health care resources, whereas in publicly financed systems, the absence of these actors has led them to play a lesser role in the allocation process.

The path of dependence and stakeholder theory have helped me to show that reality does not verify this assumption and that health care policy-makers and major stakeholders have not been guided solely by their own interests but have also been inspired by some sense of justice when they negotiate health care allocation laws.

My analysis reveals that in the American private health care system, the for-profit sector has indeed played a crucial role in all major decisions leading to the distribution of health care resources and has been animated by principles of justice that emerged in its discourse during each of the analyzed Acts' negotiations.

Starting with the Kerr-Mills Act, the AMA's indirect but essential role in the advent of this health care financial law is remarkable. The employers' refusal to provide retirees with health care coverage pushed the government to take action and develop a program to provide for the vulnerable, medically indigent aged. Although the initiative did not have the anticipated success, employers and commercial insurers were triumphant in delegating the duties to the government.

The for-profit sector's passive attitude lingered throughout the 1960s and is particularly noticeable in the development of Medicare and Medicaid in 1965. Without a doubt, these programs were the consequence of the for-profit's status quo regarding the provision of health care to the poor and the aged and commercial insurers' desire to carve out a share of a more lucrative market, leaving high-risk applicants in the hands of the public sector.

The political science literature and an analysis of events leading to the election of Richard Nixon reveal that, in the 1970s, the HMO project depended on the for-profit sector's more active participation. Indeed, thanks to the support of corporate employers, the Republican Administration was able to develop and secure this project. Employers played a crucial role in

negotiating the Act and were to play an even greater role in its implementation.

Twenty-first century politics also provided a fertile playground for the already strong for-profit sector's lobbying. Insurers' and employers' interests were vigorously represented during the ACA's committee stages, and both interest groups clearly voiced their opposition to the Bill. Surprisingly, the analysis of legislative debates and the events surrounding the ACA's enactment show that physicians were not as mobilized as a group as they had been previously. Indeed, diverse opinions with regard to the new health care reform emerged during the negotiation stages. The patchwork that constitutes the final version of the Act can be explained partly by the vigorous push and pull that occurred between part of the for-profit sector and the government during the Committee stages.

Ultimately, the initial pattern of distribution triggered by the post-war struggles made a later restructuring of the system impracticable. Because of an accident of history, employers have taken center stage, becoming pooling institutions and, later on, insurance providers. The powerful lobbying of physicians has also throughout history blocked a universal system of care in the United States. The medical profession's desire to preserve its autonomy

and to shelter its profit has planted the seeds for rampant health care costs and a market-oriented allocation of resources.

Although throughout the 1960s the atmosphere of love, community support, and sharing that was present in American society transferred to the realm of health care through egalitarian legislative efforts, responses to the initial mismanagement led to inevitable cost-containment measures in the 1970s. In retrospect, it seems rather paradoxical to have taken the disease as a cure. The same profit-driven market philosophy that had created a crisis in the insurance and provision sectors was reapplied through cost-containment solutions. Now, the methods prescribed by the ACA come at a time when irreversible patterns will have to be addressed. Some flexibility is certainly required on the part of the for-profit sector and many healthy Americans.

Undoubtedly, the American for-profit sector is one of the most important participants in the allocation of health care resources. Motivated by incentives of their own, for-profit actors are also animated by ideas of egalitarian, libertarian, communitarian, and even utilitarian justice, and they shared these ideals during the negotiation and drafting stages of health care financing and provision laws.

This dissertation also reveals that in the United Kingdom, for-profit stakeholders, particularly health care professionals, have resisted rather than ignited health care reforms. Contrary to the American for-profit sector, they have always placed their own benefits after the promotion of egalitarian principles and have always been fierce promoters of universal care.

My research reveals that the BMA's benevolent attitude stems in part from the pact it made with the government at the system's inception. In 1946 the terms of this tacit concordat were set in the foundational Act. The medical professionals' fate was then tied to the enduring nature of the universal health care system, as it guaranteed their status as sole providers of care.

Thus, in the 1990s the Conservative government's project to run the NHS "like a business" evidently struck a chord with the medical profession. The BMA entered the negotiation arena, vigorously opposing the enactment of the NHS Community Care Act. The for-profit sector could never have supported a market initiative because it was constantly worrying that a more libertarian approach to health care would affect their interest and compromise the system.

In 2012, the path of dependence channeling health care policy in Britain was once again preserved despite the radical changes triggered by the Health and Social Care Act. The for-profit sector was to be involved in many aspects of the reform proposed by the new health care Bill. Medical professionals and particularly GPs were targeted. Unsurprisingly, they were also the first to actively voice their concerns, along with medical consultants. Participating in the consultative NHS Forum for the Future, they engaged in an aggressive campaign against the reform. Once again, fearing that this consumerist initiative would erode the doctor-patient relationship and threaten their status as sole sellers of medical services, medical professionals opposed the project put forward by the Coalition government. This reform was also particularly unique as it aimed to involve for-profit actors other than the medical professionals. With the goal of providing patients with more choice and more autonomy, private providers would be more present in the health care market.

In England, for the most part, the for-profit sector has been vested with the original and atypical role of safeguarding the essence of the national health care system. Although it has no presence within the walls of Parliament, the for-profit sector is in great part responsible for the path of dependence set by the egalitarian foundational principles of the NHS. It has also, throughout

history, provided extensive guidance on the crafting of health care allocation laws.

Thus, traditional explanations that justify the enactment of suboptimal health care laws by focusing on the medical profession's power to sway the debate in favor of its interests fall short in several respects. Physicians and other medical professionals play very different roles across welfare states; thus, incentives vary, and so does their ability to promote these interests.

In the United States, the for-profit sector has created a path of dependence that has at times interfered with ideals of justice, perhaps because the medical profession was seeking more autonomy, insurers were seeking more freedom of commerce, and the overall for-profit sector was seeking less constraints from the government.

Nevertheless, these actors have also helped to promote libertarian and communitarian principles to achieve a more subsidiary organization of health care services. The state took on the protection of vulnerable groups and promoted egalitarian justice ideals. The constant battle between the trifecta and the state over which justice archetype should prevail is a constant leitmotif in the American health care legislative history.

In the United Kingdom, the for-profit sector has helped the government to achieve its egalitarian goal by increasing competition and setting the standard for the delivery of health care services, and it has ultimately motivated the public sector to become more efficient. Thanks to the tacit concordat, it has also committed to safeguard the foundational egalitarian principles of the NHS.

In both systems the for-profit sector is very much present but takes very different approaches. The consensus surrounding the NHS policy-making sharply contrasts with the struggles characterizing the American system's legislative history.

Evidence provided by the analysis of primary sources demonstrates that conceptions of justice have shaped the for-profit sector's discourse in both western welfare states. Specifically, in the case of the United Kingdom, it is fair to conclude that principles of justice set the social discursive terms within which health care rationing policy debates and decisions occur.

For-profit actors, specifically the medical profession, seemed to be genuinely guided and inspired by egalitarian principles. Time and again, the BMA promoted equal access and provision of care for the entire territory.

These health care reforms and the actors participating in their elaboration seem to be guided and inspired by egalitarian justice principles. Furthermore, discourses of justice are not merely instrumental in the achievement of a more optimal health care system; they are a philosophy that inspires these reforms.

With regard to the American health care system, discourses of justice, irrespective of the conception relayed, appear to have been instrumental in the for-profit sector's pursuit of its autonomy and the consolidation of its independence from political powers. The medical profession, insurers, and employers have, in turn, used different conceptions of justice to advance their agendas, even though it could be argued that, at times, higher moral grounds were also considered as pivotal.

A small caveat should nevertheless be added regarding these observations. It may be presumptuous and approximate to conclude definitively on the motives that have led the for-profit actors to employ discourses of justice, given that no empirical work (i.e., interviews) or psychological study has proven these findings. Such an evaluation is beyond the scope of this dissertation, and the conclusions drawn above derive from the partial explanations resulting from archival work done on primary sources.

## **II. On Inferences Derived From the Primary Findings**

Although not the primary focus of the study, two important inferences can also be derived from the findings of this dissertation: one with regard to the importance of profits in the realm of health care and another relating to the recent convergence of health care policies in western welfare states. Both sets of remarks should be addressed, as they are crucial for the development of future research to improve the allocation of health care resources.

### **A. On the Notion of Profits in Health Care**

The central role played by the for-profit sector in the development of health care financing and provision laws in the United States and in the United Kingdom as well as the issues affecting both of these nations' health care services has led many to wonder whether profit-seeking stakeholders are solely responsible for the "gangrene" that is affecting western health care systems. Correlating these two elements may help to find a culprit, but most important, it is an essential step for developing more optimal and efficient health care allocation laws.

Health care costs in the United States are patently higher than in any other western welfare state.<sup>788</sup> A multitude of factors can explain this increase: the cost of defensive medicine, the lobbying of the pharmaceutical industry, the costs of insurance, and the lack of aggressive commissioning by the state for the purchase of health care services.<sup>789</sup> It is important to note that all of these activities generate great profits.

Indeed, the threat of malpractice has led to an increase in professional insurance and has given perverse incentives to physicians to order unnecessary tests for their patients. The pharmaceutical industry's destructive lobbying has led to unaffordable medicine. In addition, health care providers and insurers act as price fixers, minimizing their risk and increasing their profit margins.

In the American private health care system, the for-profit sector generates profits that are redistributed outside the confines of the system. The corporate structure of these entities leads managers to redistribute profits to shareholders that are external to the system. The lack of accountability to patients due to the fiduciary duty that corporations (private health care

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<sup>788</sup> D. A. Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*, 10 Issue Brief (Commonwealth Fund) 1 (2012).

<sup>789</sup> Aaron Carroll, *What Makes the US Health Care System so Expensive*, The Incidental Economist, ; ELISABETH ROSENTHAL, *Colonoscopies Explain Why U.S. Leads the World in Health Expenditures*

providers and insurers) owe to their shareholders harms the system and contributes to noxious health care costs.

In private systems, the right to run a business prevails over any health care entitlement. Indeed, the absence of a right to health care in the United States causes employers, insurers, and private health care providers to prioritize fiduciary duties to their shareholders over the needs of patients and the insured. The for-profit sector has a say in health care policy not because of the benefit it generates for the system but because it exclusively provides health care to the population.

In the United Kingdom, health care costs are also on the rise but account for a lesser share of the GDP.<sup>790</sup> The British government is the sole funder of the system and retains most of the commissioning power for the purchase of health care services. Competition on the health care market tends to successfully drive down costs. Thanks to the work of NICE, the state is able to privilege the most cost-effective treatments. In this universal health care system, the right of private providers to run their business is subordinate to patients' well-being. This dissertation finds that the Secretary of Health and

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New York Times, 2013

<sup>790</sup> Squires, *Explaining High Health Care Spending in the United States: An International Comparison of Supply, Utilization, Prices, and Quality*, 1 *supra* 788.

the NHS owe a duty to patients that exceeds the duty any corporate provider owes to its shareholders.

This can be explained by the fact that most of the profits that for-profit entities derive from health care service provision or the sale of insurance are reinjected into the corporate structure and thus remain within the health care system. Private health care companies such as Bupa operate in partnership or in parallel with the NHS and have no shareholders. Indeed, Bupa redistributes the generated profits within its structure, to improve the services it provides to patients and insured.<sup>791</sup>

Evidently, profits in tax-subsidized health care systems are treated differently. The for-profit sector is allowed to participate in the promotion and provision of health care services, not as part of a right to run business but as a privilege to participate in the just distribution of health care services.

Overall, in this dissertation I have elucidated the particular roles of for-profit entities in the creation and development of health care laws. I now offer preliminary and ancillary remarks about the potential impact of the redistribution of benefits produced by these entities on the good functioning of health care systems. Whether profits are distributed outside the health

care system or reinjected within its confines to improve health care services significantly impacts the allocation of health care resources. Distributing profits derived from health care services outside the system reduces efficiency, weakens risk pools, and significantly impacts health care costs.

Certainly, profits may drive the system to success or failure irrespective of the justice theory adopted. As long as some form of justice and profits remain inside the system, there will be more just health care: essential resources will be more accessible, and it may be possible to reach more optimal outcomes. The system may also be subject to less pressure coming from external for-profit actors, and these actors may have to be more accountable to patients.

## **B. On the Convergence of Health Care Policies**

Traditional literature classifies health care systems along a continuum, with private systems at one end of the spectrum and state-funded systems at the other.<sup>792</sup> This classification stems from the type of structure, organization, and health care policy governing the allocation of health care resources in different welfare states. Nonetheless, this dissertation has demonstrated that

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<sup>791</sup> Bupa, *Private Health Insurance, Individual, Group, Family Healthcare*, last accessed 10 January 2014.

<sup>792</sup> John G. Cullis & Peter A. West, *French Health Care: Viewpoint A-System X?* 5 *Health Policy* 143 (1985).

there are no “pure” health care systems.<sup>793</sup> In reality, health care systems are multifaceted and respond differently to social and economic contexts that adopt hybrid approaches.

The examination of the most recent health care reforms in the United States (ACA 2010) and in the United Kingdom (Health and Social Care Act, 2012) confirms this assumption. Both of these health care laws provide evidence that health care policies guiding the organization and the management of these systems are now converging. Even though the American and British health care systems are situated at opposite ends of the continuum, they now seem to be pursuing similar patterns for the allocation of their resources.

Indeed, despite their different modes of financing, organization, and management, a new paradigm has emerged that cuts across the original ideological divide. The ACA promotes the universalization of health care coverage to reform its private system, whereas the Health and Social Care Act mandates that private health care providers compete with the public sector in health care. Both systems are now converging towards a hybridized allocation of health care resources.

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<sup>793</sup> Chernichovsky, *Health System Reforms in Industrialized Democracies: An Emerging Paradigm*, 339 , supra 9.

With the exception of public programs, the majority of health care services in the United States remains privately funded, and risks are spread unevenly, as private insurers select their applicants according to their health status. Thus, with the advent of the individual mandate, the ACA might spread risk across the entire American population. In the United Kingdom, the funding of health care services remains in the hands of the state, but the presence of for-profit actors at the provision level significantly increases the share of private entities on the health care market.

This recent convergence in health care policy can be partially explained by the new realities affecting western welfare states' populations and a certain consensus on the role of health care.<sup>794</sup> Specifically, both of these reforms highlight the newfound importance of solidarity in access to health care.<sup>795</sup> Even though neither the United States nor the United Kingdom bases their health care policy entirely on solidarity, both reforms stress the importance of universal coverage.

In the United States, the implementation of the individual mandate is the most critical part of the reform, as it hopes to accomplish a healthier risk base for insurers and to provide all Americans with equal access to health

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<sup>794</sup> *ibid.*

care services. In the United Kingdom, the universality of care is preserved by reaffirming the public power's funding duty. The goal of the Health and Social Care Act is to make patients more equal in treatment rather than in access, giving them the opportunity to purchase additional health care services to satisfy their health care needs.

On the flip side, these reforms have reduced governments to the role of payers and have them delegate most of their duties to the private sector.<sup>796</sup> A more striking similarity also emerges in the diminished role given to health experts in the allocation of health care resources at a micro level. The American Congress and Westminster now believe that patient choice should rule the allocation process and grant less leeway to medical professionals.

### **III. On Prospects for Further Research**

The findings of this research provide invaluable information for policy-makers and legal philosophers to build on and to develop laws to palliate issues affecting health care systems around the world.

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<sup>795</sup> Protection, *Affordable Care Act of 2010*, 124 ; *Health and Social Care Act*, supra 756 .

<sup>796</sup> Pollock & Price, *How the Secretary of State for Health Proposes to Abolish the NHS in England*, supra 747.

## **A. Raising Awareness to Develop More Optimal Health Care**

### **Allocation Laws**

This dissertation demonstrates the ways in which justice is central to the drafting of allocation laws in western welfare states. It also explains how the for-profit sector participates in the legislative process to promote its interests but also to advance certain principles of justice.

Nonetheless, the principles of justice relayed in the drafting of health care financing and provision laws neither guarantee the just application of these norms, nor do they imply the just allocation of health care resources. The findings of this research are only a stepping-stone for determining which conception of justice leads to the optimal allocation of health care resources. Future research on allocation laws needs to be conducted to improve the allocation process, to create optimal laws for the distribution of health care resources, and finally, to tackle scarcity and access issues affecting western health care systems. Amendments and later versions of the laws presented in both case studies should be analyzed to determine which Act has created the most just allocation and to assess which conception of justice is most potent.

Awareness that particular paths of dependence influence health care policy-making and the enactment of allocation laws provides an important contribution to research in the field of public health law. Legislators might be able to use this research to circumvent or use these paths to create optimal health care financing and provision laws.

### **C. Confirming the Unique Status of Health Care**

Now more than ever, it is important to gauge whether health care is truly a unique common good, to understand whether it is the only common good that mandates the just allocation of its resources. Indeed, future research should aim to determine whether other common goods are, in theory and in practice, subject to similar allocation patterns that also call for the just allocation of their resources.

For this, another comparative study, this time between two domains of social goods, should be conducted. For example, an examination of laws for the allocation of educational resources during the post-Brown era to the present day should be compared to the analysis already accomplished for health care laws in the United States. This study could help to deduce similar distributive implications at the legislative level. Assessing the specialness of

health care in comparison to education is of crucial importance for future policy debates, particularly on the universality of care.

Similar public-private dynamics transcend the distribution of both these public goods, and even though the guarantee of a minimum level of education has already been accomplished, the guarantee of a basic level of care has never been successfully put forward in the United States. This may be because, in reality, health care is not any more and may be even less, special than education. In the light of this future research, allocation processes may have to be re-evaluated and policy choices made more consciously by acknowledging the importance of justice in the process.

#### **D. Using Law as a Tool for Social Change**

The allocation and rationing of health care resources should now be at the top of western welfare states' priority list given the scarcity, access, and cost issues affecting western health care systems. This dissertation certainly contributes to solving these imminent problems, as it reveals the importance of a philosophical understanding of the legislative process and provides a better understanding of the motives behind the drafting of laws leading to suboptimal outcomes. Perhaps now that this research has elucidated the

rationale that underlie the legislators' enactments of laws producing suboptimal outcomes for the distribution of health care resources, it will be possible to create more optimal laws for the allocation of these resources.

Through the use of discourse-analysis methods and a study of key historical events, this project has unmasked and delineated bias concerning the reasons leading to suboptimal outcomes in the realm of health care. I now hope that, thanks to these findings, this study contributes to public debates on health care allocation issues, to ignite more critical discussions about the distribution and rationing of health care resources. Legislative institutions should now use "law, first and foremost, [as] a tool for change,"<sup>797</sup> as they have the power to improve the health status of many people if they start to take health care seriously and to treat deficiencies in health care as a social issue, rather than allowing governments to use it as a stage for political theater.

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<sup>797</sup> Mary Robinson.

## APPENDIX

JUSTICE ARCHETYPE	KEY WORDS
Libertarian	Autonomy, charity, market, competitiveness, property
Egalitarian	Equity, equality, fairness, inequality, welfare, vulnerable group, right to health/health care, category, opportunity
Utilitarian	Utility, happiness, maximization, priority, ranking
Communitarian	Community, society, common good
All Archetypes	Solidarity/Subsidiarity

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