



# HEALTHCARE AS A RIGHT, NOT A PRIVILEGE

Reshaping America's Moral Lens

Thesis Project: GLST 5972

Dr. Inslee

**Author Note:**

Work found in this thesis includes excerpts from course writings in courses: GLST 5153, GLST 5673, GLST 5962, GLST 6343, & GLST 6423.

Karla J. Butts

March 1, 2016

## Table of Contents

<b>Introduction.....</b>	<b>2</b>
<b>Review of Literature.....</b>	<b>3</b>
<b>Historical Roots of Healthcare in the Unites States.....</b>	<b>4</b>
<b>Who and What Defines Health?.....</b>	<b>5</b>
<b>Capabilities.....</b>	<b>6</b>
<b>Healthcare Right vs Privilege.....</b>	<b>7</b>
<b>The Affordability of the Affordable Care Act.....</b>	<b>8</b>
<b>Healthcare Marketplaces/Co-ops: A Different Approach to Coverage in the Era of     The Affordable Care Act.....</b>	<b>9</b>
<b>The Business of Healthcare.....</b>	<b>10</b>
<b>Understanding the New Law.....</b>	<b>10</b>
<b>Structural Violence.....</b>	<b>11</b>
<b>Healthcare as a Right.....</b>	<b>12</b>
<b>Time for Change Now.....</b>	<b>13</b>
<b>Historical Significance in Health Care.....</b>	<b>14</b>
<b>Shift Forward.....</b>	<b>16</b>
<b>Paradox of Policy.....</b>	<b>17</b>
<b>Public Feedback.....</b>	<b>19</b>
<b>Shifting the Moral Lens: A Human Rights Approach.....</b>	<b>23</b>
<b>Brief History of the Sisters of Providence.....</b>	<b>26</b>
<b>A Different Template for Healthcare.....</b>	<b>27</b>
<b>Financial Perspective.....</b>	<b>32</b>
<b>Recommendations.....</b>	<b>33</b>
<b>Conclusion.....</b>	<b>35</b>
<b>Appendix A- Hippocratic Oath.....</b>	<b>37</b>
<b>Appendix B- Providence Core Values.....</b>	<b>38</b>
<b>Work Cited.....</b>	<b>39</b>

### **Introduction:**

Throughout American history, the general public's access to even basic health care has been an ongoing challenge. Contributing factors include the inability of many to gain coverage for preexisting conditions, the inability of working families to qualify for employee health benefits, and the fear of the cost because of poor socioeconomic situations. The question before us as a nation currently is this: "Are we a country that's defined by values that say access to health care is a commodity awarded to only the highest bidders?" (President Obama, 9 June 2015). Or are we a country that believes that health care is a right for all? According to the 2014 United States Census Bureau, the nation's poverty level was 14.8% which equates to roughly 46.7 million people living in poverty. The Census Bureau poverty line is based on a family of four with an annual income of \$27,230. The Census additionally noted, however, that 89.6% of citizens have health coverage in some capacity (United). That being said, why are we not at a 100% healthcare coverage for all, and why do we not focus more on the care and wellbeing of our citizens who live on the margins of society?

While The Affordable Care act and Catholic Health Organizations have begun to shift the healthcare moral compass, from privilege to right, many Americans do not agree and do not choose to help pay for healthcare for others; indeed, paying for others is the "objectionable" change implemented by the Affordable Care Act. The ideology of the Catholic Health Services, however, finds it morally objectionable not to care for the sick and the vulnerable, therefore, it focuses the moral compass on how to better serve those in need. A moral compass, for the purposes of this thesis, is one's personal ability to choose between right or wrong. I question why the decision to provide health care has been deemed wrong by a subset population and not strongly challenged by the other side? If the topic were providing public education to children

across the United States, the resulting depth of debate and challenge would be much less than that seen about the ACA. The future picture is not yet clear, and people still live on society's margins, but by implementing a moral compass shift, we can start to perceive what it will take for all people to have healthcare access. Health care is not a commodity or a measure of privilege; it is not only a human right, it is also a moral one. Today the Affordable Care Act and Catholic Health Organizations work to move the moral compass from one of a privilege to one of human rights. In this thesis, I will define this compass and explain first how the Affordable Care Act advanced a change in law that began the compass shift. My thesis will also show how Providence Regional Medical Center in Everett, WA, has answered the changes made in the law. By leading first with its mission, as it has for decades, Providence highlights how the law and also healthcare establishments push for justice in the American health care system. To show the progression of shifting this moral compass, this thesis will examine the history of health care in the United States, the moral arguments raised in healthcare, the economics of health care and the translation of faith based health healthcare models to secular ones. To provide background and specific situations, I will use qualitative information from personal interviews and blogs obtained to give firsthand accounts of the impact that the new law is having on citizens.

### **Review of Literature**

There have been discussions and debates examining the implementation of the ACA, spanning college campuses to Capitol Hill, even before the law went into effect. It is difficult to miss the subject on the daily news and it is front and center in the current presidential race. A long overdue result of these examinations around the country has highlighted questions on issues of morals and ethics related to health care, whether outright or in sub context. Many opinions range about the new law, but few condensed explanations help the public better understand its

purpose and its proposed outcomes. While the literature provided covers many opinions and themes, this review will focus on four main subjects: the history of healthcare in America, the business of healthcare, the definition of the new ACA law, and human rights in the context of healthcare access. Although endless amounts of literature pertain to the ACA and human rights, this paper primarily addresses the moral compass of American healthcare.

### **Historical Roots of Healthcare in the United States:**

The concept of Universal Health Care is not new in the United States. Tracing its historical roots defines where, as a country, we have been and our current position regarding availability and access to health care. In 1999, Karen Palmer created a summative outline in the article “A Brief History: Universal Health Care Efforts in the US,” and while many similar articles are partisan in nature, Palmer provides a bipartisan approach that highlights strengths and weaknesses from both sides, therefore allowing for a critical examination of wins and losses in program development. Historical timing has stunted the implementation of a successful system, and in the early 1900’s any attempt to introduce systems similar to ones in Europe, specifically in Germany, was “buried in an avalanche of anti-Communist rhetoric” (Palmer 3). Through the 1940’s, movements to implement a national health insurance were highly politicized by those in positions of power, but because the movements never won political ground, universal health was unavailable to the American citizens. However, in the path to a more just health system, we must understand that “the institutional representatives of society do not always represent those that they claim to represent” (Palmer 6). In contrast to the uneven political positions and policies, faith based organizations have taken a strong position in healthcare development. Models from the past, present, and future highlight a diverse approach to caring for all populations. Identifying

the need to care for the poor and the vulnerable shifts the focus from profit and insurance to that of an inclusive approach to care.

The case study of Mother Joseph and the Sisters of Providence, outlined in *The Bell and the River* by Sister McCrosson, reveals the comprehensiveness that comes from a collaborative approach of government and faith. Five Sisters set out to meet the demands to care for the poor, sick, and the orphaned, an act desperately needed because of the vast growth, development, and conflict over land in the West in the mid-1800's. Heading through the Northwest frontier, surrounded by the ongoing power struggles for land between the indigenous tribes and the white soldiers, the Sisters were thought to be in constant danger. However, Captain John Mullan who was charged to oversee the roads between Walla Walla and Fort Benton stated, "The only good...that I have ever seen effected among these people has been due to the exertion of these Catholic missionaries" (McCrosson 138). While the government fought to push the indigenous tribes farther and farther from their land, the Sisters grappled with how they could further extend their services to them. They saw their acts as their calling from God to help and heal the marginalized.

### **Who and What Defines Health?**

Defining both health and medical need is difficult, and the difference becomes the controversial crossroads when stating that healthcare is a right. There are multiple interpretations and definitions of "health" creating the push-pull reaction to the questions and requirements of what some deem as essential medical care. This definition of health drives not only the payment decisions of insurance companies, but public opinion as well. How broad should the term "health" be? Should it encompass "mental health, emotional health, and social well-being?" (Hill

450). Constitutional arguments abound about what should or shouldn't be covered under the new Affordable Care Act, and these studied arguments challenge the government, insurance agencies, and healthcare organizations. B. Jessie Hill argues that when we step back and evaluate all that the term healthcare can encompass, and the challenges of the new law, we can understand the charge before the government to determine the just rights of the people under the new mandated coverage. Additionally, because of the lack of definition of health, the subject becomes camouflaged in morality, in terms of cost vs value, and also in terms of what is defined as necessity and rights.

Those in positions of power must define what is evenhanded and what is not as they study any resource distribution of health services. First, they need a means to measure the social justice implications of inconsistent healthcare distribution before they can focus on the fact that all people in need, especially those in lower socioeconomic situations, do not have the same access as those in higher socioeconomic levels. Understanding that equity and equality are not the same thing is the premise that Braverman and Gruskin assert in their article "Defining Equity in Health." They argue that defining equity can help create criteria that can facilitate measurements, shedding light on inequitable distribution of benefits.

### **Capabilities:**

Healthcare as a right is not a new ideology. Conversations and writings dating back to early Western philosophers have indicated for centuries the need to protect physical and mental abilities, and they expressed that laws of nature exist to protect all citizens. Thomas Papadimos unpacks this concept in *Healthcare as a Right, not a Privilege: a Construct of Western Thought* published in 2007, before the Affordable Care Act was installed. He connects the dots between

those in lower socioeconomic situations and professional health care. He argues that these people have fewer opportunities and access to care which results in their higher risk to poor health. He believes a strong advocate to help move the pendulum for change is found within academic medical centers, the facilities that historically see the highest volumes of financially compromised patients. He also asks the larger question of what it means to say we will give access to everyone. Regardless, he recommends change and argues that we are capable of action to create change.

All lives matter, and everyone has the right to dignity. Dignity includes living our lives with the ability to develop our individual capabilities and potential. Martha Nussbaum outlines a comprehensive model which calls policy makers' attention to the importance of a list of Central Capabilities in the work of social justice. In *Creating Capabilities*, Nussbaum argues that if one capability is compromised, the overall wellbeing of the individual is compromised. The main goal of this approach is to teach the understanding that everyone has a right to equal dignity, and that includes healthcare.

### **Healthcare Right vs Privilege: What is the Moral Argument?**

Access to health care is a right not a privilege, and not acting on this belief presents the moral dilemma that stands in the way of progress. A collaborative approach between government and those not only providing, but most important, those receiving care, is imperative. Everyone is in a unique state with their personal health, similar to the uniqueness of their intelligence and capabilities, but regardless our unique differences, health care should be a right for all. Efrat Ram-Tiktin uses the Human Development Approach to question who determines a person's level of health and argues, "How should we prioritize between one worse



off patient” (Tiktin 343), and another when we distribute health benefits. The “healthcare” policing of individuals is an unjust and immoral approach to determining the level of health coverage one should have access to. When evaluating health care, caretakers should work under the mantra that “personal responsibility and effort extended to preserve a healthy lifestyle are not relevant criteria for people’s entitlements to health care” (Tiktin 350).

To promote the right of health care, we must adopt the concept of neighborly love. Humanizing current policy and perception comes when we can realize that “love’s relevance extends far beyond the interpersonal to the social structural” (Moe-Lobeda 177). As global citizens, we are all each other’s neighbors. The moral compass for change already exists in our society; however, society has yet to fully understand, accept, and work to change the reality of the current negative state of humanity. This requires all to remove moral blinders to begin sustainable change in our marginalized communities. Interruptions to success in this process comes when people in positions of power neglect to recognize that less inclusive social perspectives have a human cost.

### **The Affordability of the Affordable Care Act:**

The out of pocket expense of health insurance is out of reach for a large portion of Americans who do not have employer- provided insurance or who do not qualify for government subsidies and coverage. The expected cost for the nation is 1.76 trillion dollars (Stark) in the first ten years of the Affordable Care Act policy; however, the individual tax in 2015 for not obtaining coverage “begins at \$ 95/year and rises to \$700 per year after three years” per person, a small amount in comparison to an individual policy (Stark 2) . While the ACA in its current state helps many who can afford it, there are many who still simply cannot afford it, and it is those

who then must pay a fee/tax for being uninsured. Dr. Stark offers research proving such gross economic gaps for the poor and underserved stating that “as implementation continues, the ACA will continue to adversely impact and severely restrict choices for virtually everyone in Washington State” (Stark 11), though his findings go beyond the residents of Washington State.

The lack of health care coverage actually increases the amount of medical debt carried by uninsured individuals because they still have medical needs and must pay for them. In 2013, at least 61% of uninsured people claimed expense as the main reason for not carrying coverage (Kaiser). Additionally, the expansion of Medicaid does not apply to all United States residents, nor does it fully cover the gap of those eligible for it under the 138% poverty line. The result is that people delay seeking health care for fear of incurring more bills and can become statistics for Keiser’s research that finds that the “uninsured are less likely than those with insurance to receive preventative care and services for major health conditions and chronic diseases” (Keiser 2). The Keiser Foundation argues the cost of health care will increase if coverage does not close the gap to provide access to preventative, non-catastrophic coverage and care. Reduction in health expenditures will occur for individuals and hospitals alike when the U.S. achieves equitable distribution of care.

### **Healthcare Marketplaces/Co-ops: A Different Approach to Coverage in the Era of the Affordable Care Act:**

Creative approaches to coverage may step up to cover gaps and provide access that traditional insurance approaches cannot. For example, medical co-ops provide a model in which members contribute to a general fund that is then accessed, within the prescribed parameters, to cover the cost of care. These organizations provide a lower cost option to traditional medical

insurance. Another available one is a faith based option for those with like-minded belief systems. Medi-Share requires a strict profession of faith (Christian) for an applicant to qualify, which limits its access to populations of different faiths and beliefs and creates natural restrictions.

During this time of change and transition in health insurance requirements, medical co-ops have offered a viable option. Operating as non-profit organizations with the vision of “putting needs of people ahead of profits” (Herrick), they reach those in the gaps. Herrick’s case study shows, however, that these co-ops may not operate to potential and may fail because of their precarious financial structures and their tendency to over-enroll. Co-ops must revamp their models if they hope to create a viable market share and maintain their humanitarian vision.

### **The Business of Healthcare:**

To unpack the human and economic costs of health care, the government and healthcare systems must come together to understand the current status of those who are insured versus uninsured and question why are there so many left in the gap, from there they need to commit to how the system bridges that gap. It is a complicated, ever changing picture because everyone’s current health status “has the potential to be a source of a number of different traps” (Banerjee 43). Part of the business side of healthcare, then, is to determine what other factors impact individuals’ overall health, so the entire “health” consideration goes beyond the availability of coverage. The healthcare needs of all are important, and that also includes the economics of serving all, even those on society’s margins. Making major changes will influence the healthcare industry as a whole, but they are changes needed to improve the overall health care system.

Balancing the market demands and the role of Catholic values in health care can often appear even more of a tug of war. It is imperative to define the role of Catholic values because “Catholic health care, the largest not-for-profit provider of health care in the United States” (McDonough 34) is an institution that has great ability to examine how we, as a nation, use the market to influence care. However, while the market may determine how health care is funded, the role of the Catholic Church is to influence that health care access is available to all and that the distribution is equitable.

### **Understanding the New Law:**

At first, many questioned The Affordable Care Act and its personal impact on American citizens. With nearly 11,000 pages in the final document, it seemed unreadable, and Americans needed a short cut to the meaning of the new law and to its potential impact. What is important to note is “Obama Care was created first and foremost to help the uninsured. (Tate 45). In the *Obama Care Survival Guide*, Nick Tate covers sixteen of the new law’s largest subject titles to provide realistic, unbiased, hands-on advice to those purchasing new exchange plans. Tate asserts that it is crucial that those interested be informed so as to make the best decision for themselves, both economically and financially.

### **Structural Violence:**

Not having access to equitable resources is a form of structural violence; when official social structures in place and supported by law, policy, and government prevent citizens from reaching their potential, these are violent structures. Paul Farmer and a group of researchers in *Structural Violence and Clinical Medicine* suggest structural interventions so as to reduce poor patient health outcomes resulting from their lack of access to appropriate care. They further

suggest change in perception from one in which healthcare is a commodity to that of a universal health approach which will focus not primarily on finances and which also charges physicians with taking the lead in the movement for structural change.

The subject of human rights in healthcare here in the United States, as a field of research and advocacy, has been limited. Healthcare has been wrapped in the context closely aligned with law and therefore tied to power. What is needed is a shift of the healthcare discussion and agenda, bringing it back to the structure of human rights. Paul Farmer argues in *Pathologies of Power: Rethinking Health and Human Rights* that “claims that we live in an era of limited resources fail to mention that these resources happen to be less limited now than ever before in human history” (Farmer 1493). This fact validates that our current approach of focusing primarily on finances and not on protecting human rights will lead to further marginalizing of the poor and the vulnerable.

### **Healthcare as a Right:**

In the Lance Gable’s article, “Patient Protection and Affordable Care Act, Public Health, and the Elusive Target of Human Rights,” he states that “March 2010 represents a significant turning point in the evolution of health care law and policy in the United States” (340). Although the Affordable Care Act (ACA) does not commit or infer the language that healthcare is a right, its framework provides an opportunity to expand that conversation. Gable further believes it gives the opportunity to transition the concept of making insurance available to all citizens into the concept that all citizens have a right to healthcare. Gable also asserts that much of the work done by the ACA provides the first step in the right to health and to healthcare.

President Obama has declared in multiple speeches that healthcare should be available to all Americans. In contrast to Gable's assumptions, that our policy edges away from the term "right," Mahiben Maruthappu and his partners challenge his position in their work *Is Health Care a Right? Health Reforms in the USA and their Impact upon the Concept of Care*. They argue that the inception of the Affordable Care Act came directly from a rights' based approach. They highlight that U.S. health coverage in the US prior to the ACA lacked an ethical and rights' base. However, Gable and Maruthappu do agree that as a nation we are now positioned to make strides in furthering this discussion in a rights- based context.

**Time for Change is now:**

The cost of healthcare has reached historically high numbers, partly due to patients being sicker when they present for care. There are other contributing factors as well. The economics of healthcare is a key motivator for changing our approach, and in doing so for making healthcare more accessible and affordable. It is now reaching populations it has not in the past. Sister Carol Keehan assisted in creating a vision that not only fosters Catholic traditional values, but also addresses the economics of reform and explains how reform itself can have positive outcome. She enlisted the talents of Americans to help draft and implement the reform, and in her *Yes! The Time is Now*, Keehan rallies interfaith and secular participants to take part in the movement to change history and the direction of healthcare.

The purpose of this review is to provide the reader a baseline of information encapsulating policy, business, and human impact. It also presents a high level explanation of the new law and highlights the gap between the business of healthcare and the compassion for those it is meant to serve. It is a complex subject and will require much work to study the connection

between morals and finances that compete for healthcare monies. It will also require examining the structurally violent framework that our country's healthcare industry has operated under for decades.

### **Historical Significance in Health Care**

Looking back, we can see that healthcare had a long and curious history in the United States, and technological developments plus advanced scientific knowledge have completely changed the field from its early days. With advancement, however, questions arose. Who would pay for care as prices began to climb and as doctors expected fees with services; however, the question of access and rights had not yet been constant in the conversation. Between 1910 and 1920 the medical profession was becoming very prestigious as incomes continued to rise. In the 1930's, President Roosevelt pushed for health insurance on a national level but lost to internal political conflicts. However, on January 11, 1944 during WWII, President Roosevelt returned to the table to declare a Second Bill of Rights. He noted that growth was evident and that "economic truths have become accepted as self-evident" (Heritage 8). It was inclusive to all citizens no matter race or creed, and proclaimed for all "the right to adequate medical care and opportunity to achieve and enjoy good health; and their right to adequate protection from the economic fears of old age, sickness, accident, and unemployment" (Heritage 8). This amendment is the first glimpse at government's defining healthcare as a right. In 1948, the Universal Declaration of Human Rights (UDHR) was introduced, and its Article 25 states, "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" (Universal). And again in 1966, the

*International Covenant on Economic, Social and Cultural Rights*, Article 12, section 1 allows, “The states, Parties to the present Covenant, recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and it further states in section 2, part D, allowance of pre-existing illness or “the creation of conditions which would assure to all medical service and medical attention in the event of sickness” (International 3). Sadly, these documents show great purpose but are not legally binding. The reality is that “Constitutional law in the United states, unlike many other democracies, provides no general right to health care or health insurance” (Starr 131). The closest we get to a rights’ based system is with Medicare and Medicaid which appeared in 1966; however different presidents have pushed for change only to receive significant political pushback, which highlights a lack of attention to healthcare rights. There has, however, been a shift in focus on the political side to that of profitability and the market share occupancies of health care, ironically centering the health care conversation on politics and economics rather than on the human rights of our citizens to healthcare.

### **Shift Forward:**

As time has moved forward so has the momentum of change in the world and its inner workings. Technology has shortened the time- space gap, we are now able to deliver goods and services quickly to all corners of the world, so through globalization, one might also assume that the U.S. could deliver ready access to healthcare. However, globalization has not only increased corporate profits, but has also led to the question posed by Amartya Sen in the article *How to Judge Globalism*, “The question is not just whether the poor, too, gain something from globalization, but whether they get a fair share and a fair opportunity” (Lechner and Boli 24). Having that question put in front of me deepens my desire to unpack the human cost of



globalization, especially in medicine. The availability of technology and care practices should promote not only more access but more affordable access.

Globalization has many definitions and interpretations, but at its core it is “about increasingly interconnectedness character of the political, economic, and social life of the peoples of this planet” (Groody 13); it should be used as a tool for openness to change in perception and not used as a tool to stall development of socioeconomically compromised communities. In fact, it “could be used to represent the aspiration of a world community that respects universal standards of fundamental human rights and is characterized by a sensitivity to the need for global solidarity and a recognition and acceptance of sociocultural differences” (Hamelink 30). We have politicized and capitalized growth and development for profit, and in the process, both private and governmental agencies have prevented those most in need the opportunity to achieve good health. Growth and development and the process of globalization may promise more advanced medical techniques and practices; however, it is “the inequity in the overall balance of institutionalized arrangements which produces very unequal sharing of the benefits of globalization” (Sen 24). For the U.S., the most industrious nation on the globe, the human cost imposed by this imbalance is unacceptable.

### **Paradox of Policy**

Why the disinterest in our citizens’ health and healthcare access? Kevin Palmer presents in his article “A Brief History: Universal Health Care Efforts in the US,” that universal approaches have failed because of “interest group influence (code words for class), ideological differences, anti-communism, anti-socialism, fragmentation of public policy, the entrepreneurial character of American medicine” (Palmer 5). However, in 2010, the U.S. healthcare industry

made a dramatic shift. The Affordable Care Act was introduced as law, its goal to make insurance more accessible and affordable to all Americans, not just to a privileged percentage. This act finally begins the shift in conversation. Though not posed as a human rights initiative, it hinted at the concept. President Obama led simply by expanding access to coverage, making the nation and its citizens accountable for their care to reduce the pull on the emergency departments. He trusted that this approach would reduce overall health care costs, and that a reduction in mortality for all could be more achievable. He understood that for this equation to work, we Americans must make preventative care more accessible, which he hoped would occur through the process of enacting the ACA.

Robust arguments oppose the Affordable Care Act (ACA). In policy development and implementation, push and pull influence all. When the national discussion includes whether the government should or should not be involved in healthcare, people stand strong in their opinion on both sides. Anne-Marie Slaughter addresses the paradox of policy movement in her article “A New World Order,” in which she acknowledges the proverbial tug of war in governmental decision making. Instead, America could use a world ordered conceptual framework to help equitably distribute goods and services including that of basic healthcare, but of course, that is not yet in the conversation either. The paradox? We acknowledge that “we need more government on a global and a regions scale, but we don’t want the centralization of decision-making power and coercive authority so far from the people actual to be governed” (Slaughter 286). We want it on our terms; we want to be involved. Well and good, but as a collective whole, do we use justice and morality as foundations for our decisions, or do we use finance and individual privilege?

Many argue that the Affordable Care Act is unconstitutional. In the book *Why Obamacare is Wrong for America*, a team of authors, Grace-Marie Turner, James Capretta, Thomas Miller, and Robert Moffit state that “Obama Care imposes an unprecedented mandate on individuals to purchase government-approved health insurance” (Turner 163). I challenge these authors and ask them who then is responsible for American healthcare, especially if Americans cannot buy existing premiums on their own. This mandate argues that it builds an “accountability layer” in a system that has no system of universal care. The Supreme Court itself has many times seen the question of healthcare constitutionality. In 2012, the court struck down an effort to repeal the ACA law because of its particular language. In this argument, citizens would pay a penalty for not having insurance; however, the Supreme Court ruled that “Obamacare was declared a tax and not a mandate, and was therefore declared constitutional” (Obamafacts). The Supreme Court delivered its second ruling in June 25, 21015, when it declared subsidies legal. At the time of this thesis writing, the Supreme Court has deemed the Affordable Care Act constitutional. But the question still remains is how American citizens feel about the new law that impacts them.

### **Public Feedback**

To discern what American citizens really feel about the new ACA law, I researched and discovered three helpful blogs from diverse locations: The Wonkblog, The Matt Walsh Blog, and Vanity Fair featuring the Eichen-Blog. I searched blogs to capture objective opinions from a diverse population about how the Affordable Care Act either directly influenced the authors or about how they see it affecting the country as a whole. Blogs are an open forum, and one can remain anonymous, allowing for people to speak freely on their position. My first observation was the Wonkblog featured in the Washington Post by Jason Millman titled “Who is still

uninsured under Obamacare - and why.” The posting was November 12, 2014, with the purpose to identify the status of who is covered thus far, but more important, who still remains without coverage. He is direct and outlines his blog in condensed categories, which includes the younger population as well as coverage in different racial groups. He enlisted the help of the Gallop Polls from October 2014 to verify opinion. Observing the responses, he has found that they passionately react to cost and Medicare coverage. As they transition, one person in particular remains engaged in the blog throughout, user name sanjait, and his participation veered the conversation from the national cost of Medicaid to that of individual cost. He highlights that it is “quite arguable the \$5K+ deductibles for bronze plans under the ACA are impractically high for some people. Even those about the Medicaid threshold may not be able to pay up to that amount in a given year” (Sanjait). This concept was a sharp turn from trying to discover the purpose of the blog and who is still uninsured to a political forum and focus on the statistics rather than the people behind the numbers. Categories highlighted are Access, Confusion, Cost, and Politics.

Next came The Matt Walsh Blog entitled “The Definitive Guide to How Obamacare is Destroying American Lives,” created October 21, 2013, with 708 Comments/Respondents. Walsh posted a request from his readers asking him to explain how Obamacare influenced them, and bingo, he had over 700 comments. He responds honestly, saying he’s not a genius, but an average guy looking for comments from anyone who cares to respond to questions about the ACA. He offers his responders a platform for voicing concerns about the ACA, and he pledges to send his gleaned information to the White House. Included is a strong statement: “For every person thanking his lucky stars for this new healthcare entitlement, thousands of low and middle income families are suffering” (Walsh). The word entitlement sheds light on the general public’s

understanding of what and who is covered, pointing to the need for a social justice movement pushing healthcare as a right for all, not as privilege for a few.

Of his 708 responses, I used only the first nineteen, and those came from different people and surprisingly all from different states. There were some from states that expanded Medicaid and from some who had not; however, the Medicaid expansion did not appear to influence people's emotions. Beyond a first name and a state, the responses were virtually anonymous. Responders posted personal information about finances, salaries, and age, facts that are usually taboo to discuss openly. I did not see strong political references, not that there was an absence of politics, as with the Washington Post blog, but the fearful honesty from each of the nineteen starkly contrasted to the Washington Post blog responses that showed virtually no essence of distress. Categories developed were primarily cost and access.

The final blog observation was The Eichen-Blog by Kurt Eichenwald, "The Truth about Obamacare and How It Solves the Suffering of the Insured," which was created on October 4, 2013, and had 57 Comments/Respondents. The early responders issued strong political statements, focusing on a Tea Party member's sharing that "One Tea Party type I spoke with actually said the way to solve the health-care problem would be for the lazy uninsured just to take jobs that provide insurance benefits" (Eichenwald). Eichenwald looks to unpack how those who are not covered actually impact those who are, and he provided thorough explanations on his position. He develops his statements in an effort to remove the stigma attached to those without coverage. Equality wears an odd blanket here. It is most sobering when the postings address equality of treatment for those with different levels of coverage. Some responders veered more towards how people should be allotted coverage and the personal responsibility of one's health and the role that should play into the type of coverage available. The ACA requires

coverage, but it also makes individuals accountable regarding their care. At the same time, laws now prevent patients' penalization for preexisting conditions which would, in this conversation, mark patients who should have no coverage or different levels of coverage. In a rights based model, the focus is caring for all, the rich to the poor and the vulnerable, which supports the concept that no life is worth more than another. Eichenwald made the point that "Obamacare is an essential step toward healing the deeply sick American health-care system" (Eichenwald). This powerful statement is lost to those responders who focused on personal cost more than on providing healthcare for all. No one mentioned health care as a moral right.

These blog themes indicate the focus toward specifically defining American healthcare, its coverage rights, and the question of its equal access. However, though the blogs discuss cost, access, and needs, they do not directly speak to the question of morality and ethics of individual rights to American health care access. Some merely hint at the subject. Yet, to address this moral compass, we need only read the Hippocratic Oath, the oath that physicians have recited and pledged for centuries. It is "one of the oldest binding documents in history," (Tyson) and though it has evolved over time, it remains a prominent guiding document for the American Medical Association. Updated in "1964 by Louis Lasagna, Academic Dean of the School of Medicine at Tufts University, and used in many medical schools today" (Tyson), it states: "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick." Care, not payment, is the focus for the provider. Over time the popular soundbite when discussing universal care comes down to who is going to pay for it and people questioning why they need to pay for others. This leaves the Nation divided in answering the question "am I my brother's keeper" or not?

Today, are we our brothers' keepers? It seems to depend on the cost. But promoting rights to health care is a solid start to "keeping" our brothers and sisters. Humanizing current policy and perception comes when we realize that "love's relevance extends far beyond the interpersonal to the social structural," (Moe-Lobeda 177) and as global citizens, we are all each other's neighbors. America is unique in its moral compass for change, and it stands ready to discuss any upcoming law or existing one. For my thesis' sake, my position is healthcare for all. However, the journey for providing access and care to all stops when our legislators fail to use their power to benefit all. Moe-Lobeda emphasizes the importance of learning and focusing on our moral lens, using the concept of neighbor love, the mandate that we love and care for one another. Understanding how individual and agency actions "pertain to whomever one's life in some way impacts or whose life impacts one's own" (Moe-Lobeda 177) should become a driving force. She argues that with the grace of God, and powerful individuals as catalysts for change, every day results will eventually show long reaching outcomes. We can also apply the same theory to outcomes in the position of healthcare for all. Moe-Lobeda advises that if humans created it, humans can change it as well. She maintains that the moral compass for change already exists in society, but society must adopt it, value it for all, and change with it.

### **Shifting the Moral Lens: A Human Rights Approach**

In order to begin the groundwork for not only change, but sustainable change, the U.S. needs a complete root level evaluation of current state of rights to healthcare, and the structures in place for current allotment and access. The instillation of a new law does not guarantee that the system is not structurally violent. Structural violence, coined by Johan Galtung in the 1960's "describes social structures-economic, political, legal, religious, and cultural – that stops individuals, groups, and societies from reaching their full potential" (Farmer 1686). Not having

equitable resources available is clearly a form of structural violence. Paul Farmer and a group of researchers in the journal entry *Structural Violence and Clinical Medicine*, point to the need for structural interventions to help reduce poor patient outcomes due to their lack of access to healthcare. They state a change in the perception that healthcare is a commodity to that of a universal health as rights focused. It is not financial, and it charges physicians with taking the lead on the movement for structural change, and in the process connecting their oaths with their needed participation to eliminate harmful healthcare structures.

The subject of human rights as a field of research and advocacy in U.S. healthcare has been limited. Healthcare has been wrapped in the context closely aligned with law and therefore tied to power. What is needed is a shift of the healthcare discussion and agenda, bringing it back to the structure of human rights. Paul Farmer argues in *Pathologies of Power: Rethinking Health and Human Rights*, that our current financially focused approach does not align with ensuring that citizen's human rights are being protected, and it will lead to further marginalization of the poor and the vulnerable. We need to reframe the discussion by insisting that "public health and access to medical care are social and economic rights; they are every bit as critical as civil rights" (Farmer 1487). By failing to acknowledge this disparity, we turn a blind eye to the elephant in the room, the fact as a country we are failing to care for all.

Regarding this topic of economic rights, I interviewed Karen Hargreaves, a forty-four year old woman who worked full time as a nursing assistant for a small, private group home that cannot offer her insurance. The U.S. requires employers to offer insurance if their companies exceed a certain number of employees. Smaller companies' employees must purchase their own or pay a penalty. Karen's employer cannot provide her insurance, and insurance is too expensive



for her to afford, so not only does she pay the fine for being uninsured, she is left uncovered, vulnerable, and fearful. During my interview, I asked what her biggest personal fear was. She replied, “Getting a major illness or disease that I cannot afford to get care for” (Hargreaves). People in Karen’s position not only lack care, they also lack dignity. Restricting the capabilities of leading a healthy life, the lack of available healthcare harms those who most need assistance, those on society’s edges, who on the surface may appear to be managing. However, if we take a closer look, we can see the suffering people go through without access to care. As I argue that as a country we need to shift our moral compass to honor citizens like Karen, I agree with author Martha C. Nussbaum who in *Creating Capabilities* states that “a focus on dignity will dictate policy choices that protect and support agency, rather than choices that infantilize people and treat them as passive recipients of benefit” (Nussbaum 30). We need to humanize policy as it is real life, not profit that matters most.

Again we see the disparity of “a very high standard with excellent health outcomes for the wealthy and privilege and good health insurance and an inadequate standard with poor health outcomes for those with less resources” (Gable 342). The ACA has not had enough life yet to break through these barriers. However, the action required to break this separation and bring justice to those left in this disparaging situation is for the government and the health care industry to “be willing to part with ego-boosting self-deceit and power-maintaining ideologies, be ready to rewrite the story of our identities and reform our practices” (Volf 255) to erase inequities in healthcare. The vital point is that every citizen should have the same access and opportunities to adequate care. By providing equity in distribution of health we are creating healthier communities and increase personal capabilities. Additionally, the access to manage

one's health will reduce the burden of some forms of catastrophic care, the result of unmanaged care.

Even though the Affordable Care Act is a strong first step at making an attempt at equitable distribution and access to healthcare, the truth is that we have started only with insurance reform, but the end goal should be healthcare reform. Coverage and access are only the tip of the proverbial iceberg when engaging in this conversation. A strong economic argument holds that the Affordable Care act is not sustainable; however, "is it cheaper to provide basic level of healthcare than it is to allow people to die in the streets? (Donovan). Shocking perhaps in America, but if we fail to offer accessible, affordable care, those on the margins of society will die from lack of care in our streets or in shelters, and we should ask then if it is morally sustainable to ignore populations at risk? The Vice President of Mission at Providence Regional Medical Center, Dr. Donovan, questioned, "Is it morally abject to let the poor be left without care passively?" This is a "second aspect of structural violence: the complicity or silent acquiescence to it" (Moe-Lobeda 72). The answer should be a resounding NO. However, if we choose to address the issue of lack of access and passive care, we then are turning a national blind eye to this problem. The intention, whether conscious or not, is if not to do harm, then to prevent harm's being done, therefore perpetuating structural violence.

In order to move the general opinion that access to basic, life sustaining, essential healthcare that allows people to achieve their capabilities, the U.S. needs a transformational shift. As with projects launched in developing countries, in the most developed nation in the world shifting the moral compass of health care rights "requires a process that allows the community to clarify for itself what really matters and why it matters" (Myers 175). For too long the

government has itself determined the needs for the community as a whole with little recognition of the community's real needs. The time has come for the people also to have a voice. As a whole, the community and the government must understand that the necessary change "requires that we say no to some things in order to say yes to what really matters. Transformation implies changing our choices" (Meyers 3). Not only has the Affordable Care Act put that concept of change into motion, but for decades, Catholic Health Services has worked from a patient focused template which runs its day to day operations to care for all in need. It focuses on how it can deliver care more cost effectively in order to care for more.

In Catholic Health Services, Providence Health and Services is an institution that espouses as its main focus to care for the poor and the vulnerable in an inclusive, unbiased, and compassionate way. Providence, as a case study for this thesis, highlights specific ways that healthcare can succeed and thrive using basic, compassionate principles, realistic finances, and a healthy moral lens. Providence works from a strategic model of five pillars that not only frames its core values, but also provides financial sustainability. The practices of Providence, though faith based, easily translate into a secular model as well. This thesis will illustrate Providence's clear, initial mission to care for the sick, poor, and abandoned by implementing its current five pillar approach which details its financially sustainable healthcare methods to care for those on margins of society. The Providence system began in the early 1800's, and from its divine calling, it has succeeded as one of the largest healthcare organizations in the United States.

### **Brief History of the Sisters of Providence:**

In 1843 the Sisters of Providence was created in Montreal, Canada, birthed from the concept of caring for the poor and the vulnerable. The "young community was led by Emilie

Gamelin, who had devoted her life to easing the needs of the city's poorest residents" (Providence). In 1856, Emilie and five Sisters embarked on a journey to Washington territory where there were "few schools, and little in the way of charitable services for those suffering the misfortunes of life on the frontier" (Providence). Unaware of the dangers of traveling through the outback, they felt protected and carried by God. The sisters crossed language barriers while working with multiple indigenous tribes, incurred illness and endured inclement weather, but such did not derail their mission; instead it reinforced that the work they were called to do must be done. Everything they needed to carry their mission forward required simplicity, transparency, and a belief that the work that they were embarking on would benefit the communities they came in touch with even for a brief period. This approach sets the stage for the future vision and mission that still guides ministries today. The focus was never on the needs of these women, but the needs of the poor and vulnerable whom they were called to serve. The resourcefulness they used to educate and heal those who sought their help build the foundation that is still present today when evaluating growth development plans and delivery of care.



A composite portrait of the Sisters of Providence  
who established the community in the Pacific Northwest.  
Bottom, L-R: Sister Praxedes, Mother Joseph, Sister Mary of the Precious Blood.  
Top, L-R: Sister Vincent de Paul, Sister Blandine  
Courtesy of Providence Archives,

### **A Different Template for Healthcare:**

Fast forward 173 years from when the original Sisters of Providence set out to care for the poor and the vulnerable. In a case study conducted at Providence Regional Medical Center in Everett, WA. I compared the original mission framework with the work still being conducted today. With now over 32 healthcare Ministries and Affiliations and over 100,000 employees soon applicable to seven states, the missional core values stand strongly in place. Though this is just one example in a billion-dollar industry, Providence takes the stand that caring for those in need is not an option, it is a calling.

Similar to the principles outlined in the Affordable Care Act, the goal for Providence is to extend care to those in need, assure there is access. Providence's mission states "As People of Providence, we reveal God's love for all, especially the poor and the vulnerable, through our compassionate service" (Providence) To accomplish its mission, Providence follows five core values (Appendix B): Respect, Compassion, Justice, Excellence, and Stewardship. Each of these pillars align with meeting the expectations of the mission and vision; and as an organization, it commits to adhering to these principles. My thesis will show how each pillar works in harmony with the next to create a health model that focuses on the moral compass, yet still maintains profitable and innovative so as to meet the needs of the ever changing healthcare field.

To create a just and equitable arena to deliver care, caregivers must respect all who walk through the doors of any medical facility and realize that they are vulnerable and in need of

different levels of care. Sometimes the fear of the financial cost and embarrassment make this first step into a facility almost unbearable for some, which contributes to their delayed care and poor health outcomes. In the pillar of respect, Providence states that “we welcome the uniqueness and honor the dignity of every person, we communicate openly and we act with integrity, we develop the talents and abilities of one another” (Providence). Everyone is equal, and it provides care and services no matter the situation. Yes, facilities are bound by law to treat patients without refusal; however, they are not bound by law to be respectful and invested in the best care for all.

Medical doctors take the Hippocratic Oath and promise that “[they] will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug” (Appendix A). The foundation of providing this care lies within the ability to do so compassionately. The second core value is compassion, which reads that “we reach out to people in need and give comfort as Jesus did, we nurture the spiritual, physical and emotional well-being of one another and those we serve, we embrace those who are suffering” (Providence). From the Christian perspective, “Christianity sees each human life as profoundly interconnected with others in a series of overlapping relationships” (Groody 23), but I question if the secular mindset consistently embraces that same perspective. Our national moral reach should be inclusive, not exclusive, in the distribution of care and compassion.

When visitors walk through a Providence facility, they not only see these five core values posted throughout, but they get a sense of them in action when they watch how employees interact with patients, families, and anyone who walks through the hallways. I was recently at a

ministry leadership meeting at the Everett campus, and at the end of this particular meeting, the COO asked for examples of how we had seen the five core values in that hospital. One person recounted a story about compassion, saying that there was a patient who had frequented the emergency department, a homeless gentleman without resources. He had been referred to one of the local clinics, and when he first arrived, he desperately needed toiletries, a shower, and a set of fresh clothes. When he returned for his follow up appointment he found those items and services waiting for him plus a backpack and food collected by the staff. There is no policy, there is no directive hidden in a lengthy document that dictates the delivery of such care. Instead, this story shows the acts of leading with mission first. Unfortunately, this is the shift of the social moral lens when we generously help our brothers and sisters when they are in the most need. It easily translates to a secular model: simply put the patient/person first.

To focus the moral lens on delivering equitable care, the third core function, Justice, is essential. Providence stands by this pillar stating, “We believe everyone has a right to the basic goods of the earth, we strive to remove the causes of oppression, we join with others to work for the common good and to advocate for social justice” (Providence). One example justice occurs within the structure of ~~its~~ Providence’s financial counseling department. During an interview with Kelly Kikuchi, Manager of Financial Services I asked how the Affordable Care Act and new affiliations Providence has made with secular hospitals translate into the mission of caring for the poor and the vulnerable. Kelly responded as follows:

Financial counseling used to include a broad spectrum; then 1 Revenue Cycle changed so we could just focus on the poor and the vulnerable, and we have customer support so that anyone that needs help with their bills or has questions about their bills, they have a face

to face contact. That is our focus. I think the ACA was just another tool to help those patients in the model we already have. (Kikuchi)

According to Lloyd Dean, president and CEO of Catholic Healthcare, a just healthcare system means that “ideally, people should receive affordable, high quality and compassionate care when they need it” (Dean 20). Kikuchi and Dean both stress that focusing on the person’s needs, and removing poverty’s stigma in delivering care allows justice to play an active role in this care both for the patient and for the community.

To achieve the organization’s mission and vision, the pillar of Excellence charges its caregivers to serve at the highest level of quality. Providence describes its Excellence value by stating that “we set the highest standards for ourselves and for our ministry, we strive to transform conditions for a better tomorrow while serving the needs of today, we celebrate and encourage the contributions of one another” (Providence). For example, monthly local leaders at the Everett campus meet to evaluate practices and environments that could see waste reduction. Leaders consistently investigate a process and question if it can be improved upon to better serve the ministry. This is a collaborative approach, one that involves teams, and one that truly recognizes prior similar efforts to sustain the mission and vision. Because Providence employees regularly evaluate how they can improve processes that ultimately impact patient care, they all assume the role of care provider. This example amplifies the necessity of a care delivery system led by a patient focused lens that does not see one having more rights to care than others. Excellence as a value is arguably translatable to a secular model that seeks a patient focused culture.



The fifth and final pillar is Stewardship. Regarding it, Providence states that “we believe that everything entrusted to us is for the common good, we strive to care wisely for our people, our resources, and our earth, we seek simplicity in our lives and in our work” (Providence) This pillar raises the question of healthcare economics. However, under this pillar, Providence is evaluating how to manage its gifts to care for the poor and the vulnerable. Sheri Feeney, Chief Financial Officer for Providence Regional Medical Center, Everett, agrees that if the United States declares healthcare for all, we need a better healthcare definition and answers to the question of what makes a non-secular institution excel? When asked how Providence might align itself with a system that does not tend to put community first, Feeney responded, “It is very Catholic to say we will look at the community, and we will support everybody, but we only have this much” (Feeney). This comment highlights that no matter the position, secular or non-secular, available resources create a realistic picture of equitable distribution. Feeney added the following:

[If] we said everybody should have access to health care ..., our economy cannot support that. You would have to say everyone has access to this much health, care and you would have to draw a line because there is a bucket that you can afford. It’s either a bucket of this much healthcare for a small amount of people, or it’s health care for all, and we draw a line somewhere. (Feeney)

To support the bucket large enough to accommodate the ideology that basic, essential healthcare should be available to all, the U.S. needs a complete overhaul in healthcare reform, not insurance. The excellent financial planning at Providence allows it to excel in reaching the

community it serves. If we of the U.S. are unwilling to have that healthcare reform conversation, it truly speaks to the gap in the moral compass.

### **Financial Perspective:**

The financial implications of poor health are vast. The financial responsibility is a broad subject depending on the context for which it is being discussed. For medical facilities, the concept of bad debt is a concern. According to Sheri Feeney at PRMCE, “People who do not qualify for charity because the treatment of our policy says that they don’t qualify [do not pay] their balances, so we have an increase in bad debt but a reduction in charity care” (Feeney). These are essentially people in the gap; they do not qualify on either side, Medicaid and/or traditional charity care. Feeney explains yet another obstacle that health institutions face saying that “the pressure on cost is inflation, that every year inflation occurs, and we are battling against it, so when you look at the total spend, and you look at it as just a math equation, you are always battling against inflation” (Feeney). These examples highlight the extreme difficulty medical facilities face while trying to deliver care. The reality is “going without coverage can have serious health consequences for the uninsured because they receive less preventative care, and delayed care often results in more serious illness requiring advanced treatment” (Key 7), thus creating higher financial implications for medical facilities. Additionally, it is important to create a broader understanding within our communities, whether personal, political, or the medical community that “being uninsured also can have serious financial consequences. The ACA holds promise for many people who will gain access to health insurance coverage, but monitoring how coverage changes and who is left out of coverage” (Key 7), is also important to evaluate. What

will not change is the need for people to access care, and as a country we need to stop assuming someone else is going to pay for it.

### **Recommendations:**

The five pillars that form Providence's mission, while scripturally based, still easily translate to secular health care models, and they can also help change the moral compass of American health care. Frontline workers in healthcare, primarily nurses, see the many barriers patients face. I asked Carla Brennen, a nurse from the University of Washington, about how the Affordable Care Act was written and presented and if she felt its information was truthful? She responded "No, only because I think there are so many people who are pro or con against it that it is hard to tell what the truth is. There are so many people against it and so many people for it, it just gets confusing. I mean just go to Facebook" (Brennen). This sheds light on even the ACA's attempt to deliver opportunities for those without coverage; they are lost in the very process meant to assist them. No government- presented program automatically meets with public acceptance, or even understanding. The constant push and pull of human rights versus a highly discussed public service such as universal health care does not guarantee the people who need such assistance will understand the policy, which further marginalizes that sector. While the ACA creates options for healthcare, not providing adequate access/education to this assistance program can seem another layer of structural violence.

Educating the populace regarding healthcare options has fallen to the receiving facilities that seek to guide patients to register for qualified health plan or subsidies. Providence Regional Center in Everett provides excellent training for its staff on how to assist patients who present without insurance coverage. In my interview with her, Kelly Kikuchi highlighted that if a patient

presents outside of the qualifications for Medicaid in Washington or Oregon, “Providence actually funded the ability to pay for patients premiums, but it goes through foundation...they pay the premiums for a whole year” (Kikuchi) After the year has passed, staff will help patients register for a program they qualify for, so Providence stays with those who seek care to offer options that help them stay healthy. This consistent aide falls in alignment with the core values of the institution; however, I argue that this consistent care needs also to come from the government. If the goal is to reduce wasteful spending on healthcare, then as a nation, we need to communicate clearly any law, especially one that requires citizens to comply or be taxed, perceived as a fine. This communication is simply part of the whole: information should be clear and accessible to the people it affects most.

Another component that needs additional work in the next phases of the ACA is a realistic evaluation of the financial cost for individual plans. Though a consumer based approach, the ACA still has a cost disconnect: in reality, all are not able to afford the options currently available, so the expectation that they will acquire coverage is false. Medical COOPs provide a unique opportunity to access, and the ACA “created a type of nonprofit health insurance cooperative that would borrow funds from the government for startup costs and solvency reserves.” (Herrick 1) Though COOPs are thought to “put the needs of people ahead of profits” (Herrick 1), with the concept of people paying in at a rate that would cover the costs of the care has not come to fruition. There appears to be more work needed, but the participatory approach at reduced costs of traditional coverage is encouraging. What is clear is it that it is prohibitive that the tax is more affordable than coverage; that approach does not improve the health of our society, nor does it drive down costs of care. The most upsetting point to this approach is that it continues to marginalize those in lower socioeconomic conditions.

## Conclusion

In the argument of whether healthcare is a right or a privilege, I argue that healthcare is not a commodity or a measure of privilege, but that it is a human right, and a moral one. Today the Affordable Care Act and Catholic Health Organizations work to move the moral compass from that of privilege to that of a rights based model. This thesis has defined this compass, identified its components, and explained specifically how two significant agencies are pushing for change in the American healthcare system: the Affordable Care Act with its change in law, and Providence Regional Medical Center that leads first with its Mission, to push for change in the American healthcare system.

To prove my thesis point, I have examined the history of health care in the United States, the moral argument raised in healthcare, the economics of health care, and the translation of faith based health healthcare models to secular ones. Findings have provided hope that as a nation we are capable of resetting the moral compass and eliminating the structurally violent processes. Reframing the tasks of insurance reform to one of a healthcare reform that encompasses all people of our nation is a crucial next step beyond the establishment of the Affordable Care Act. In order to do so, those in positions of power who can impact and influence change must take this step to commit to both the medical and civilian communities and to clearly define what is basic healthcare. Those same law makers must also define a process toward financing this care.

The guiding principles that Providence Regional Medical Center enlists to deliver their care and drive their economic plans, includes at its center the five core pillars that as a whole create a just delivery system. Although the Providence system is just one example, its values and practices could be translated to a secular audience to show how to dismantle structurally violent policies and begin the conversation of how to make healthcare for everyone a reality and not a

hypothetical notion. By reshaping our moral lens, we have the ability to design a system that is just and equitable. At the end of the day, the economic argument fails to justify why we currently have a broken system. It fails because if we choose not to care for people now, we will end up caring for them later at a higher acuity level and cost, so from that important economical point, it would be more cost effective to provide basic, preventative care up front. Now is the time to challenge those in positions of authority, both corporate and governmental, and demand comprehensive healthcare reform that would reassure those citizens struggling with life challenging questions such as “What would I do or what would happen if I got sick?” We have the capacity to be a nation that chooses to put the overall well-being of our people first; let us make the right choice.

## Appendix A

### HIPPOCRATIC OATH: MODERN VERSION

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not," nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.

## Appendix B

# The Providence Commitment

## Mission

As People of Providence,  
we reveal God's love for all,  
especially the poor and vulnerable,  
through our compassionate service.

## Core Values

### Respect

*All people have been created in the image of God. Genesis 1:27*

We welcome the uniqueness and honor the dignity of every person  
We communicate openly and we act with integrity  
We develop the talents and abilities of one another

### Compassion

*Jesus taught and healed with compassion for all. Matthew 4:24*

We reach out to people in need and give comfort as Jesus did  
We nurture the spiritual, physical and emotional well-being of one another and those we serve  
We embrace those who are suffering

### Justice

*This is what the Lord requires of you: act with justice, love with kindness  
and walk humbly with your God. Micah 6:8*

We believe everyone has a right to the basic goods of the earth  
We strive to remove the causes of oppression  
We join with others to work for the common good and to advocate for social justice

### Excellence

*Much will be expected of those who are entrusted with much. Luke 12:48*

We set the highest standards for ourselves and for our ministry  
We strive to transform conditions for a better tomorrow while serving the needs of today  
We celebrate and encourage the contributions of one another

### Stewardship

*The earth is the Lord's and all that is in it. Psalm 24:1*

We believe that everything entrusted to us is for the common good  
We strive to care wisely for our people, our resources and our earth  
We seek simplicity in our lives and in our work



### Work Cited

Banerjee, Abhijit V, Duflo, Ester. *Poor Economics A Radical Rethinking of The Way To Fight*

*Poverty*. New York. Public Affairs, 2011. Print.

Brannen, Carla. Personal Interview. 17 November 2014.

Braverman,P and S. Gruskin. “Defining equity in health.” *Journal of Epidemiology &*

*Community Health* 53 (2003): 254-258. Print.

Christian Care Ministry. *Christian Care Ministry*. CCM. 2015. Web. 22Sept.2015.

Dean, Lloyd. “A New Day in Washington”. *Health Progress*. 90.1 2009: 20-23. Print

Donovan, D.W. Personal Interview. 12 August 2015.

Eichenwald,Kurt. *The Truth About Obamacare and How It Solves the Suffering of the Insured*.

Vanity Fair, 2013. Web. 7 December 2014.

Farmer, Paul. “Pathologies of Power: Rethinking Health and Human Rights”. *American Journal*

*Of Public Health* 89.10 (1999): 1486-1496. Print.

Farmer, Paul, Bruce Nizeye, Sara Stulac, and Sulmaan Keshavjee. “Structural Violence and

Clinical Medicine.” *PLoS Medicine* 3:10 (2006): 1686-1691. Web. 15 August 2015.

Feeny, Sheri. Personal Interview. 14 July 2015.

Gable, Lance. “The Patient Protection and Affordable Care Act, Public Health, and the Elusive

Target of Human Rights.” 39:3 (2011): 340-354. Web. 1 October 2015.

Groody, Daniel G. *Globalization, Spirituality, and Justice*. New York: Orbis Books, 2007. Print.

Hargreaves, Karen. Personal Interview. 9 November 2014.

Hamelink, Cees J. *The Globalization Reader*. Ed. Frank J. Lechner and John Boli. Hoboken, NJ: Wiley-Blackwell, 2014. Print.

Herrick, Devon M. "Obamacare Health Insurance COOPs Are Unraveling."

National Center for Policy Analysis 163 2015: n page. Web. 18 Oct. 2015.

Hill, B. Jessie. "What Is the Meaning of Health? Constitutional Implications of Defining

"Medical Necessity" and "Essential Health Benefits" Under the Affordable Care Act."

*American Journal of Law & Medicine* 38 (2012): 445-470. Print.

"International Covenant of Economic, Social, and Cultural Rights." *United Nations Human Rights* N.p. 2015. Web. 16 October 2015.

"Key Facts about the Uninsured Population". The Henry Keiser Family Foundation. n.d.

Web. 14 April 2015.

Kikuchi, Kelly. Personal Interview. 21 August 2015.

Keehan, Carol. "Yes! The Time is Now." *Health Progress* 90.1 (2009): 18-19. Print.

Matt Walsh. "The Definitive Guide to How Obamacare Is Destroying American Lives." *The Matt Walsh Blog*. 21 Oct. 2013. Web. 24 Nov. 2014.

Maruthappu, Mahiben, Rele Ologunde, and Ayinkeran Gunarajasingam. "Is Health Care

A Right? Health Reforms in the USA and their Impact Upon the Concept of Care."

- Annals of Medicine & Surgery* 2 (2013): 15-17. Online.
- McCrosson, Sister Catherine. *The Bell and the River*. Palo Alto. 2006. Print.
- McDonough, Mary J. "Catholic Values and the Market: Friends or Foes?" *Health Progress* 90.1 (2009): 34-37. Print.
- Myers, Bryant. *Walking with The Poor*. New York: Orbis Books, 2011. Print.
- Milliman, Jason. *Who is still uninsured under Obamacare-and why*. The Washington Post. 12 November 2014. Web. 24 November.
- Moe-Lobeda, Cynthia. *Resisting Structural Evil*. Minneapolis: Fortress Press, 2013. Print.
- Nussbaum, Martha C. *Creating Capabilities*. Cambridge: The Belknap Press of Harvard University Press, 2011. Print.
- Obama, Barak. "Health Care Reform." Catholic Health Association, Washington D.C. 9 June 2015. Lecture.
- OBAMACARE FACTS. Home page. 2014. Web. 1 November 2014.
- Palmer, Karen S. "A Brief History: Universal Health Care Efforts in the US." *Physicians For A National Health Program*. PNHP. n.d. Web. 2 Oct. 2015
- Papadimos, Thomas J. "Healthcare access as a right, not a privilege: a construct of Western Thought." *Philosophy, Ethics, and Humanities in Medicine*. 2 (2007): n.pag. Web. 16 October 2015.

Providence Health and Services. "Pioneer, Leader, Woman of Faith." *About Providence*.

Providence Health and Services, 2016. Web. 6 Feb. 2016.

Providence Health and Services. "Living Our Mission." *Mission and Core Values*. 2016. Web. 6 Feb. 2016.

Providence Health and Services. "Mission Integration and Spiritual Care." *Our Mission and Core Values*. 24 September 2015. Web. 29 February 2016.

Ram-Tiktin, Efrat. "The Right to Health Care as a Right to Basic Human Functional

Capabilities." *Ethic Theory Moral Practice* 15 2012: 337-351. Print.

Sen, Amartya. *The Globalization Reader*. Ed. Frank J. Lechner and John Boli. Hoboken, NJ:

Wiley-Blackwell, 2014. Print.

Slaughter, Anne-Marie. *The Globalization Reader*. Ed. Frank J. Lechner and John Boli,

Hoboken, NJ : Wiley-Blackwell, 2014. Print.

Stark, Roger." The Impact of the Affordable Care Act in Washington State." *Washington Policy*.

WashingtonPolicy. n.d. Web. 14April2015.

Tate, Nick J. *ObamaCare Survival Guide*. West Palm Beach: Humanix Books, 2012. Print.

The Heritage Foundation. *FDR's Second Bill of Rights*. 2015. Web. 16 October 2015.

Turner, Marie-Grace, James C. Capretta, Thomas P. Miller, and Robert Emmet Moffit.

*Why Obamacare Is Wrong for America*. 1<sup>st</sup> ed. New York: Broadside, 2011. Print.

Tyson, Peter. "The Hippocratic Oath Today". Nova. PBS, 27 March01.Web.30December 2015.

Volf, Miroslav. *Exclusion & Embrace*. Nashville: Abingdon Press. 1996. Print.