AIDS and Policymaking in the US and UK during the 1980s

Thomas Robert Harper

A thesis submitted in partial fulfilment of the requirements of
Sheffield Hallam University
for the degree of Doctor of Philosophy

March 2024

Candidate Declaration

I hereby declare that:

1. I have not been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree.

2. None of the material contained in the thesis has been used in any other submission for an academic award.

3. I am aware of and understand the University's policy on plagiarism and certify that this thesis is my own work. The use of all published or other sources of material consulted have been properly and fully acknowledged.

4. The work undertaken towards the thesis has been conducted in accordance with the SHU Principles of Integrity in Research and the SHU Research Ethics Policy.

5. The word count of the thesis is **79,989.**

Name	Thomas Rober Harper
Date	March 2024
Award	PhD
Research Institute	Culture and Creativity
Director (s) of Studies	Dr Ben Offiler

Abstract

The AIDS Crisis of the 1980s represented an unprecedented public health challenge that transcended the boundaries of disease response, capturing a multitude of policy issues and a plethora of interconnected and competing socio-cultural problems. This thesis employs a comparative framework to develop a fresh analysis of the British and American responses to AIDS during the 1980s. It demonstrates the importance of the period prior to the discovery of HIV and redresses scholarly focus on the mobilisation against it from the mid-decade onwards in the US. Furthermore, it challenges and builds upon the existing scholarship through a comparative lens, placing a spotlight on the emergence of new material and debates around inaction and mobilisation that would previously have been missed by a focus on individual nation states.

The main contention of this thesis is that a comparative framework enables a perspective to better articulate the nuances of AIDS policy development in the US and UK, and to reassess the existing scholarship within a broader contextual and circumstantial scope. It posits that 1981-1989 was a period of two distinct policy phases. The pre-discovery phase (1981-1984) was largely governed by similar levels of administrative inactivity on both sides of the Atlantic. However, this thesis asserts that we must contextualise these parallels and suggests the absence and avoidance framework to better explain them. The post-discovery phase (1985-1989) was primarily shaped by the contrasting mobilisation and stagnation of the British and American policy narratives in important policy areas such as public health education, screening and policy for intravenous drug use. These divergent policy trends cultivated unique policy discourse that reflected the individual context of the respective nations and, subsequently, delivered alternative responses to the disease.

Table of Contents

Abbreviations

ABRC	Advisory Board for the Research Councils
ACDP	Advisory Committee on Dangerous Pathogens
ACMD	Advisory Council on the Misuse of Drugs
ACT UP	AIDS Coalition To Unleash Power
AIDS	Acquired Immunodeficiency Syndrome
AMA	American Medical Association
ASA	Advertising Standards Agency
BBC	British Broadcasting Corporation
BTS	British Transfusion Service
CDC	Centres for Disease Control
CDSC	Communicable Disease Surveillance Centre
CEO	Chief Executive Officer
CIA	Central Intelligence Agency
CMO	Chief Medical Officer
CO	Cabinet Office
DEM	Democratic Party
DHHS	Department of Health and Human Services
DHSS	Department of Health and Social Services
DOJ	Department of Justice
EAGA	Expert Advisory Group on AIDS
GMC	General Medical Council
GRID	Gay Related Immune Deficiency
HAART	Highly Active Antiretroviral Therapies
HCFA	Health Care Financing Administration

HIV	Human Immunodeficiency Viruses
HSAC	Home and Social Affairs Committee Sub-Committee on AIDS
IVDU	Intravenous Drug Use
LD	Legionnaires Disease
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer
MP	Member of Parliament
MRC	Medical Research Council
NHS	National Health Service
NIAID	National Institute of Allergy and Infectious Disease
NIH	National Institute of Health
OCA	Official Committee on AIDS
OMB	Office of Management and Budget
OPA	Obscene Publications Act (1959)
OTA	Office of Technology Assessment
PHS	Public Health Service
PWAs	People with AIDS
RHAs	Regional Health Authorities
RMOs	Regional Medical Officers
RP	Republican Party
SSC	Social Service Committee
STD	Sexually Transmitted Disease
TSS	Toxic Shock Syndrome
UK	United Kingdom
US	United States
USSR	Union of Soviet Socialist Republics

Acknowledgement

There is an irony to writing a large proportion of a PhD thesis on a pandemic disease whilst living through one, but it has made me even more grateful for those who have supported me on this journey.

Throughout this process I have been lucky enough to be surrounded by supportive and honest people who have helped sustain, guide and support me and the delivery of this project. I am indebted to my supervisory team – Doug Hamilton, Laura Evans and Niels Petersson – whose expertise have played a vital role in the development of myself and this project. Your integrity and commitment have made this thesis a better product.

To my Director of Studies, Ben. Your part in this project long precedes the pages of this thesis. From the seminar rooms of American Politics and Society to the submission of this thesis, I have benefitted greatly from your kindness, honesty, and willingness to engage with my passion for academic history.

To my close friends, Elliott Holmes, Gian-Piero Meade and Thomas Wing. Your support has often picked me up from the low ebbs of this project and I have cherished your willingness to enthusiastically ask questions and listen to the corresponding lecture.

I am grateful to my pooch, Willow, whose fluffy tuft, desire for attention and excitement, and willingness to just *be* has provided much needed rest and rejuvenation.

To my family, whose support has been unconditional. To Grandma Jennifer and Grandad Jeffrey, you have supported my interests with passion and without question since the day I was born. This thesis is testament to what that support and love can do for someone.

To my parents, to whom I owe so much. From Dad's phone calls on his travels across Britain asking: 'Have you finished it yet?' to Mam's weekly coffee catch up to reassure a frustrated historian, your place in these pages might not be evident to most, but to me, you are both everywhere. I strive to make you proud of the man you raised.

To my future wife, Kimberley. Throughout this journey you have been my light, a constant beacon of hope and unconditional love that has often pulled me from the lonely lows of PhD

research. You have stuck with me and this process with an unparalleled enthusiasm for my ambition and I am grateful for every second you are by my side.

Introduction

In the post-pandemic world, perceptions of public health now habitually transcend the spatial boundaries of the nation state and have become increasingly interdisciplinary. This globally orientated perspective promotes the value of comparative and transnational analyses for their ability to facilitate policy learning and best practice for public health issues such as disease response in the future. In British and American politics, public health has long attracted substantial political capital, from the Affordable Care Act (2010) under Barack Obama to the subsequent attempts to reshape that legislation under Donald Trump to public health inquiry into infected blood and the COVID-19 response in Britain. The contribution of expert academic discourse to the often volatile and fast paced arenas of public health policy has demonstrated value and retained influence against changing circumstances. This thesis employs a comparative framework to develop a fresh analysis of the British and American responses to AIDS during the 1980s. It demonstrates the importance of the period prior to the discovery of HIV and redresses scholarly focus on the mobilisation against it from the mid-decade onwards in the US. Furthermore, it challenges and builds upon the existing scholarship through a comparative lens, placing a spotlight on the emergence of new material and debates that would previously have been missed by a focus on individual nation states. Ultimately, this thesis expands our knowledge of epidemic response and provides a better understanding of policy development and public health in a world increasingly aware of health as a global issue.

Literature Review

HIV/AIDS scholarship in the social sciences has embraced a diversity of methodologies, communities and perspectives that have advanced our understanding of the disease, those it has affected, and those responsible for policy relating to it. In the late 1980s and early 1990s, a variety of new material was published in response to the first decade of the disease coming to an end. Stand out collections such as the HIV/AIDS special issues *Living with AIDS (Parts One and Two)* published in *Daedalus* in 1989 explored the intersection between social and

natural sciences to help shape our understanding of this new disease.[1] The special issues featured contributions from Ronald Bayer, Norman E. Zinberg, Charles E. Rosenberg, Patricia Day, Rudolf Klein, Daniel Fox and former director of the National Institute of Allergies and Infectious Diseases (NIAID) Anthony Fauci.[2] In the UK, the most valuable contribution to British scholarship came with Virginia Berridge's *AIDS in the UK* which focused on the multiple stages of policy development between 1981-1994, beginning with 'policy from below' through to militaristic mobilisation and towards a chronic disease model in the early 1990s.[3] Berridge, alongside collaborator Phillip Strong and other scholars such as John Street, Patricia Day and Rudolf Klein, have made valuable contributions to our early understanding of the AIDS Crisis.[4]

As a potential consequence of the chronic disease response shaping HIV/AIDS policy in the UK detailed by Virginia Berridge, recent scholarship on British AIDS policy has been more disparate and pursued with less vigour compared to the 1990s.[5] In 2017 Matt Cook explored the emotions of AIDS discourse in 1987 Britain, and Adam Burgess examined the 'remarkable' public education campaign 'Don't Die of Ignorance'.[6] In 2019, Jon Agar explored the role of Margaret Thatcher in AIDS policy against the backdrop of Norman Fowler's AIDS policy commentary *AIDS: Don't Die of Prejudice,* which provided a new insider perspective on the decade and the Prime Minister's role in policy development.[7] In the US, scholars have advanced a variety of issues including Brooke McKeever's much-needed interjection on the value of good leadership through analysis of Surgeon General Everett Koop's role in the publication of public health education materials such as *Understanding AIDS.*[8] Alongside his

[1] S. R. Gross et al, 'Special Issue: Living with AIDS', *Daedalus,* 118:2 (Spring, 1989), pp. 1-201. S. R. Gross et al, 'Special Issue: Living with AIDS Part Two', *Daedalus,* 118:3 (Summer, 1989), pp. 1-254.
[2] Ibid.
[3] V. Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford 1996).
[4] V. Berridge and P. Strong, 'AIDS and the Relevance of History', *Social History of Medicine,* 4:1 (April 1991), pp. 129-138. V. Berridge and P. Strong, 'AIDS in the UK: Contemporary History and the Study of Policy', *Twentieth Century British History,* 2:2 (January 1991), pp. 150-174. P. Day and R. Klein, 'Interpreting the Unexpected: The Case of AIDS Policy Making in Britain', *Journal of Public Policy,* 9:3 (July-September 1989), pp. 337-353. J. Street, 'British Government Policy on AIDS: Learning Not To Die of Ignorance', *Parliamentary Affairs,* 41:1 (October 1988), pp. 490-507.
[5] Berridge, *AIDS in the UK*.
[6] M. Cook, 'Archives of Feeling": the AIDS Crisis in Britain 1987', *History Workshop Journal,* 83 (March 2017), pp. 51-78. A. Burgess, 'The Development of Risk Politics in the UK: Thatcher's "Remarkable" but forgotten "Don't Die of Ignorance" AIDS Campaign', *Health, Risk and Society,* 19:5-6 (2017), pp. 227-245.
[7] J. Agar, *Science Policy under Thatcher* (London 2019), pp. 122-138. N. Fowler, AIDS: *Don't Die of Prejudice* (London 2014).
[8] B. W. McKeever, 'Public Relations and Public Health: The Importance of Leadership and Other Lessons Learnt from "Understanding AIDS" in the 1980s', *Public Relations Review,* 47 (December 2021), pp. 1-9.

recent edited collection, *Beyond The Politics of the Closet*, Jonathan Bell's discussion of the intersection between welfare accessibility and People with AIDS (PWAs) has emphasised the need to see AIDS policy as part of a broader exchange between the state and PWAs and not an isolated public health issue.[9] Tasleem Padamsee has advanced our understanding of the politics of infection prevention in the US that has helped this thesis better contextualise British and American attitudes to drug policy in the 1980s, encouraging a vital discussion around the role of expertise and scientific consensus in the cultivation of AIDS policy.[10]

Through the development of AIDS policy discourse, scholars have increasingly explored the intersection of the disease and the broader spectrum of policy spheres it encapsulated. Although areas beyond the remit of policy – such as the study of activism and demographic studies focused on race, sexuality and gender – have received growing attention, this thesis remains primarily concerned with policy and in this regard drug policy has attracted substantial and consistent attention. The nature of these debates, however, has been closely tied to contextual factors such as domestic policy, or structural and socio-cultural issues. In the US, scholars have explored the relationship between AIDS and the penal system, triangulating a relationship between race, incarceration and HIV/AIDS infection. Laurie Shrage has more recently explored race, HIV and mass incarceration, recommending scholars and policymakers revisit the adverse effect of US drug policy on public health objectives such as rates of HIV infection.[11] Likewise, Janet Weston has collaborated with Virginia Berridge to discuss the interplay between liberal consensus in England and Wales and social conservatism in Ireland in response to AIDS in the penal system during 1980s and 1990s.[12] In the UK, drug policy has also received thoughtful consideration from scholars who have more acutely examined policies of harm reduction for infection control. Early scholars such as Gerry Stimson

[9] J. Bell, *Beyond The Politics of the Closet: Gay Rights and the American State Since the 1970s* (Philadelphia 2021). J. Bell, 'Rethinking the "Straight State": Welfare Politics, Health Care, and Public Policy in the Shadow of AIDS', *The Journal of American History,* 104:4 (March 2018), pp. 931-952.
[10] T. Padamsee, 'The Politics of Prevention: Lessons from the Neglected History of US HIV/AIDS Policy', *Journal of Health Politics, Policy and Law,* 42:1 (February 2017), pp. 73-122.
[11] L. Shrage, 'African Americans, HIV, and mass incarceration', *Lancet,* 388 (14 July 2016), pp. E2-E3. K. McLean, 'The Biopolitics of Needle Exchange in the United States', *Crit Public Health,* 21:1 (March 2011), pp. 71-79. B. Lichtenstein, 'Drugs, Incarceration, and HIV/AIDS Among African American Men: A Critical Literature Review and Call to Action', *American Journal of Men's Health,* 3:3 (September 2009), pp. 252-264. K. M. Blankenship et al, 'Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System', *Journal of Health Care for the Poor and Underserved,* 16:4 (November 2005), pp. 140-146.
[12] J. Weston and V. Berridge, 'AIDS Inside and Out: HIV/AIDS and Penal Policy in Ireland and England & Wales in the 1980s and 1990s', *Social History of Medicine,* 33:1 (February 2020), pp. 247-267.

and John Strang have provided vital contributions with the latter drawing attention to the overlap between public health and the penal system explored by American scholars.[13] More recently, Alex Mold has explored the development of drug policy in Britain and featured AIDS as a prime mover of harm reduction strategies.[14]

In September 2017, the *Journal of American History* published an *Interchange* roundtable discussion with contributions from leading scholars in the field of HIV/AIDS with the goal of identifying new and valuable areas for academic inquiry. Although the roundtable highlighted a plethora of potential areas for the advancement of knowledge it is the intersection between Daniel Fox and Jonathan Bell's call for a more comprehensive study of AIDS politics and policy that this thesis is inspired to respond to.[15] The contention of this thesis is that a comparative framework enables a perspective to better articulate the nuances of AIDS policy development in the US and UK, and to reassess the existing scholarship within a broader contextual and circumstantial scope. Whereas Fox, Day and Klein have suggested that political leaders in the US, UK and Sweden largely favoured expert advice, a combination of new material and fresh analysis points to a disparity between the British and American responses to the role of expert advice.[16] In the first instance, the comparative method highlights the importance of individual and administrative agency in the development of early AIDS policy, drawing out the intricacies of the American response by contrasting the perception of inactivity captured by accounts such as Randy Shilts's *And the Band Played On* with the different circumstances surrounding British inaction.[17] Whereas early account have emphasised perceptions of inaction, this thesis utilises archival material in the US and UK unavailable at the time to detail the importance of knowledge and agency in the differentiation of AIDS policy in Washington and Whitehall during the initial period of policymaking. Consequently, this discussion posits the conceptual framework 'absence and avoidance' to better explain the period of policymaking in the US

[13] G. Stimson, 'AIDS and Injecting Drug Use in the United Kingdom, 1987-1993: The Policy Response and the Prevention of the Epidemic', *Social Science & Medicine,* 41:5 (September 1995), pp. 699-716.
[14] A. Mold, 'Framing Drug and Alcohol Use as a Public Health Problem in Britain: Past and Present', *Nordic Studies on Alcohol and Drugs,* 35:2 (April 2018), pp. 93-99. John Strang, 'AIDS and Drug Misuse in the UK – 10 Years on: Achievements, failings and new harm reduction opportunities', *Drugs: Education, Prevention and Policy,* 5:3 (1998), pp. 293-304.
[15] J. Brier et al, 'Interchange: HIV/AIDS and U.S. History', *The Journal of American History,* 104:2 (September 2017), pp. 434-444.
[16] P. Day, D. Fox and R. Klein, 'The Power of Professionalism: Policies for AIDS in Britain, Sweden, and the United States', *Daedalus,* 118:2 Living with AIDS (Spring 1989), p. 109.
[17] R. Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (1987).

and UK before the discovery of HIV as a causative agent – henceforth referred to as 'pre-discovery' – as underpinned by a different levels of policy agency. In the UK, the absence of British policymakers was largely underpinned by a broader lack of engagement in Whitehall, Parliament and in the media. By contrast, White House policymakers articulated an understanding of AIDS policy that rendered the administration's inactivity more calculated, akin to Michael Schaller's suggestion that Reagan was unwilling to engage with the disease and was uneasy about the prospect of a federal response.[18]

Secondly, the comparative analysis posits that the period following the discovery of HIV as a causative agent – henceforth referred to as 'post-discovery' – to be one of divergence between the US and UK. Central to this divergence was the disparate adherence of policymakers in the US and UK to the advice and expertise of the medico-scientific community and the authority of the individual upholding that consensus. The commitment of British policymakers to the advice of experts and public health officials distinguished those in Whitehall from their White House counterparts who demonstrated an increasingly acute suspicion of those promoting safe sex and harm reduction strategies such as condom use and needle exchange. Lastly, the comparative framework adopted in this work aims to shed new light on the unique and sporadic transnational exchanges between the US and UK during the decade. Primarily an expression of interest from British policymakers, those in Whitehall and Parliament looked across the Atlantic for learning at important junctures of policy development. Reflecting on policy leadership, delayed intervention and service provision British policymakers sporadically utilised a case study approach to the American experience in pursuit of developing a more effective response themselves that cultivated a unique transnational relationship between the two policy responses.

In addition to the Anglo-American comparison this thesis offers specific contributions to the British and American scholarship on AIDS policy. In relation to the British discussion of AIDS policy developments during the 1980s, it expands on the valuable foundation laid by Virginia Berridge and her collaborators such as Phillip Strong by utilising the archival material unavailable to them in the early 1990s. Through these newly available materials – including declassified Cabinet Office papers, extensive digitised parliamentary records (Hansard),

[18] M. Schaller, *Reckoning with Reagan: America and Its President in the 1980s* (New York 1992), pp. 93-94.

Official Committee on AIDS and Home and Social Affairs Sub-Committee on AIDS papers – this thesis provides greater clarity on the internal dialogue shaping AIDS policy development, shedding light on policy discourse in Whitehall and the Department of Health and Social Services. Although Jon Agar has engaged with AIDS policy through the lens of science policy, this discussion will greatly improve our understanding of the British response and add much needed depth to our understanding of Margaret Thatcher's role in the development of AIDS policy.[19] By extension, this insight provides a vital layer of new analysis that better equalises the US and UK when constructing the comparative methodology.

In the American context, the thesis aims to achieve two goals. Firstly, it addresses the 1980s as a decade of two parts – pre and post discovery of HIV – to better understand the development of AIDS policy in the US. Attributing a greater responsibility to the government's wilful inability to articulate a coherent AIDS agenda, the pre-discovery period (1981-1984) was a period largely shaped by the Reagan administration's avoidance of AIDS. Moreover, this discussion aims to go beyond the existing scholarship which often fails to properly capture the intricacies of this early period and provide both new material and analysis on what shaped this often-neglected period of policymaking. Secondly, it explores the post-discovery period (1984-1989) as one informed by continued policy malaise, the fostering of legislative opposition and the eventual mobilisation of White House resources towards a policy strategy that actively challenged aspects of the medico-scientific consensus on epidemic response.

Methodology

Underpinning this thesis is a comparative framework that seeks to incorporate and test aspects of a transnational methodology in the sphere of AIDS policymaking. Informed by comparative theory constructed by Mandelbaum, Bloch and Skocpol and Somers, this thesis adopts a comparative framework that is grounded in the provision of equal shares to the British and American responses.[20] Where Padamsee has analysed the US response by

[19] J. Agar, *Science Policy Under Thatcher*, p. 126.
[20] M. Mandelbaum, 'Some Forms and Uses of Comparative History', *American Studies International,* 18:2 (1980), pp. 19-34. M. Bloch in A. O. Hill and B. H. Hill Jr, 'Marc Bloch and Comparative History', *The American*

integrating examples of British AIDS policy, this thesis consciously constructs an equally weighted British and American comparison to better respond to the current gaps in AIDS historiography on both sides of the Atlantic.[21] Moreover, the adoption of what Stefan Berger has labelled a 'symmetrical' or 'universalizing' approach to comparative study was done to explore what shaped AIDS policy under different socio-political contexts and not to demonstrate the uniqueness of a particular regional or national narrative that Berger attributes to an 'asymmetrical' approach.[22] It is possible to question the decision to select two cases and not several, to choose two English speaking nations and not a diverse range of languages and cultures. Whereas these challenges present vital and potentially fruitful additions to the conceptual framing of this thesis, the following discussion explores how this project has reconciled these questions into a comparative framework that seeks to fully engage the British and American policy responses to AIDS.

Stefan Berger has signposted comparativists to familiarising themselves with the social contexts of all selected cases and reflect on the spatial and time constraints that frame a comparative study, this thesis has considered these challenges with a particular focus on developing a conceptual framework that included cases that ask the right questions.[23] Whereas the selection of Britain and America during the 1980s might appear guided by superficial ideas of a 'special relationship' between the two nation states or by 'political marriage' between President Ronald Reagan and Prime Minister Margeret Thatcher – which have been redressed and challenged by scholars – this assumption would poorly reflect the intimate details that reinforce the uniqueness and importance of an Anglo-American comparison during this specific period.[24] Scholars such as Desmond King have reflected on the ideological kinship between Thatcherism and Reaganism and have noted the inherent benefits

Historical Review, 85:4 (October 1980), pp. 828-846. T. Skocpol and M. Somers, 'The Use of Comparative History in Macrosocial Inquiry', *Comparative Studies in Society and History,* 22:4 (October 1980), pp. 174-197.

[21] Padamsee, 'Fighting an Epidemic in Political Context', p. 1004.

[22] S. Berger, 'Comparative and Transnational History' in S. Berger, H. Feldner, and K. Passmore (eds), *Writing History: Theory and Practice* (Third Edition) (London 2020), pp. 295-296.

[23] Ibid, p. 297.

[24] B. J. Brickman, D. Jermyn and T. L. Trost, 'Still Crazy After All These Years? The 'Special Relationship' in Popular Culture', in B. J. Brickman, D. Jermyn and T. L. Trost (eds), *Love Across the Atlantic: US-UK Romance in Popular Culture* (Edinburgh 2020), pp. 1-16. W. Wallace and C. Phillips, 'Reassessing the Special Relationship', *International Affairs,* 85:2 (March 2009), pp. 263-284. L. Quam and R. Smith, 'US and UK Health Care: A Special Relationship? What Can the UK and US Health Systems Learn From Each Other? *British Medical Journal,* 330:7490 (April 2005), pp. 530-533.

of drawing the two ideologically similar governments together for analytical purposes.[25] In addition, the adoption of an Anglo-American comparative scope for AIDS scholarship is not entirely new; scholars such as Fox, Day, and Klein have explored the British, American and Swedish responses in 1989[26] and more recently, Tasleem Padamsee has surveyed AIDS policy in the US between 1981-2015 and incorporated British examples into her work.[27] Although a methodological approach built around Britain and America benefits from a shared language, a cultural affinity, a pre-existing diplomatic alignment and specific ideological kinship present between Thatcherism and Reaganism, it is the underlying dissimilarity between the two that ensures a useful framework for policy comparison. Against this backdrop of socio-cultural and political likeness, the British and American political and health care systems and the values that uphold those traditions are distinct and contribute a vital dynamic to this thesis which will be outlined later in this discussion. Furthermore, the selection of two case studies was deliberate having reflected on Norman Fowler's *Don't Die of Prejudice* which considered some nine case studies and the special issue of *Daedalus* 'Living with AIDS' which required two issues to explore the global scope of AIDS globe in 1989.[28] Narrowing to two case studies became a pragmatic and logical step towards delivering an equitable and focused exploration of the British and American responses. Moreover, the feasibility of a study spanning several case studies with an associated level of travel and expenditure made multiple research sites undesirable and would have detracted from the framework set out by the initial project scope.

Additionally, this thesis seeks to explore the potential for a transnational discourse on AIDS policy, offering insight into historical developments that transcend the spatial borders of the nation states' response to disease. Whereas scholars of transnationalism have similarly extended little interest to AIDS policy and often emphasised the physical aspects of transnational exchange that transcend national boundaries – goods, people, money – this thesis explores the reflective practices of British policymakers that underpinned this subtle and unique historical narrative.[29] As described by Sven Beckert a transnational approach is a

[25] D. King, *The New Right: Politics, Markets and Citizenship* (Basingstoke 1987), p. 1.
[26] Fox, Day and Klein, 'The Power of Professionalism', pp. 93-112.
[27] T. Padamsee, 'Fighting an Epidemic in Political Context: Thirty-Five Years of HIV/AIDS Policy Making in the United States', *Social History of Medicine,* 33:3 (December 2018), pp. 1001-1028.
[28] Fowler, *Don't Die of Prejudice*, Contents. Gross et al, 'Living with AIDS', pp. 1-201. Gross et al, 'Living with AIDS Part Two', pp. 1-254.
[29] Transnationalism Scholarship: C. Z. Enns, L. C. Diaz, and T. Bryant-Davis, 'Transnational Feminist Theory and Practice: An Introduction', *Women and Therapy,* 44:1 (July 2020), pp. 11-26. A. Curthoys and M. Lake,

'way of seeing … transnational history focuses on uncovering connections across particular political units.'[30] It is through this pursuit of connection – born from the adoption of a comparative approach – that we might see a unique relationship between the US and UK that manifested as complex political interactions. The adoption of a transnational lens for the study of AIDS policy presented an opportunity to understand policy in a global context, not as individual units of isolated government activity but a contribution to a broader policy narrative. Therefore, we might consider Ann Curthoys and Marilyn Lake's definition of transnational history as 'the study of the ways in which past lives and events have been shaped by processes and relationships that have transcended the borders of nation states.'[31] Whilst this thesis remains primarily a comparative study, understanding the interaction between the White House and Whitehall through a transnational lens has provided new analysis and future opportunities for scholar to explore AIDS through a connected and not an isolated historical lens.

The source material for this thesis has spanned archival collections across Britain and American and has included a vast array of source types and formats. Nevertheless, the primary source material for this top-down approach to AIDS policymaking has been official documents largely collected from two sites, The National Archives at Kew, London and the Reagan Presidential Library and Museum in Simi Valley, California. In addition, this thesis has utilised Congressional Records, the Hansard Parliamentary Records, the London School of Hygiene and Tropical Medicine's AIDS Social History Programme, the Office of the Historian (US) and more. In constructing this source base, it was vital to reflect on what McKee and Porter have labelled the 'motive' for using sources and the implications of such material.[32] The 'motive' for using such a large collection of official material was to engage with the policymakers themselves in a way that historians have been unable to do since AIDS scholar first began – a limitation largely created by document protections. A consequence of this process was the need to pursue additional perspectives to contextualise the internal discussion of cabinet members

Connected Worlds: History in Transnational Perspective (2005), pp. 5-20. A. Korner, 'Transnational History: Identities, Structures, States', in B. Haider-Wilson, W. D. Godsey, and W. Mueller (eds), *International History in Theory and Practice* (Vienna 2017), pp. 266-290.

[30] C. A. Bayly et al, 'AHR Conversation: On Transnational History', *American Historical Review*, 5 (December 2006), p. 1454.

[31] Curthoys and Lake, *Connected Worlds*, p. 5.

[32] H. A. McKee and J. E. Porter, 'The Ethics of Archival Research', *College Composition and Communication,* 64:1 (September 2012), pp. 64-65.

and civil servants with parliamentarians, journalists, and policy advocates to mitigate the potential echo chamber of official narrative that an approach from below mitigates. Reflecting on Ziemann and Dobson's 'plurality of possible readings' this thesis has actively engaged in a recursive research process that has continually examined and re-examined the complex meanings embedded in the official texts used to construct the AIDS policymaking process, adopting a broad spectrum of supplementary official and unofficial materials to fully comprehend the policy climate that produced AIDS policy under Thatcher and Reagan.[33]

A notable exclusion from this source base has been materials dedicated to the activist story and the associated charities and non-governmental organisations working towards AIDS policy in the 1980s such as the AIDS Coalition To Unleash Power (ACT UP), Gay Men's Health Crisis, the Terrence Higgins Trust, and the London Lesbian and Gay Switchboard. In the pursuit of AIDS activism, recent contributions have diversified our understanding of activist engagement with AIDS. Collaborating with Jonathan Bell in *Beyond the Politics of the Closet*, Timothy Stewart-Winter, Dan Royles, and Kevin Mumford have drawn attention to the interplay between identity – in particular race and sexuality – and AIDS advocacy in Chicago, Philadelphia, and Britain.[34] Beyond Bell's recent edited collection Steven Epstein has established a long catalogue of literature on AIDS activism and politics which includes his book *Impure Science.*[35] It is true that activism played a vital role in shaping the climate in which policymakers engaged with AIDS. For example, consider the important role of protest captured in the documentary film *How to Survive a Plague* by David France, however, the internal workings of government AIDS policy remained the primary contribution of this thesis and therefore, the detailing of activism remains limited throughout.[36]

Two important structural differences between the US and the UK emerge with varying degrees of significance throughout the decade: the political and health care systems. Whilst the differences between the British and American political and health care systems are well

[33] B. Ziemann and M. Dobson, 'Introduction' in B. Ziemann and M. Dobson (eds), *Reading Primary Sources: The Interpretation of Texts from Nineteenth and Twentieth Century History* (Second Edition) (Oxon/New York 2020), pp. 1-20.
[34] T. Stewart-Winter in Bell, (eds) *Beyond the Politics of the Closet,* pp. 83-99. D. Royles in Bell (eds), *Beyond the Politics of the Closet,* pp. 100-117. K. Mumford in Bell (eds), *Beyond the Politics of the Closet,* pp. 118-138.
[35] S. Epstein*, Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkely 1996). S. Epstein, 'The Construction of Lay Expertise: AIDS Activism and the Forging of Credibility in the Reform of Clinical Trials', *Science, Technology and Human Values,* 20:4 (October 1995), pp. 408-437.
[36] *How To Survive a Plague*, (2012), David France, accessed 29 March 2021.

documented, what we must consider more specifically is the relationship between these two structural factors and how they might shape fundamentally different policy narratives. Fundamentally, the British constitutional monarchy was operationally and structurally different from the American federal republic. In 1980s Britain, government power was increasingly centralised as part of a pre-devolution system that placed Westminster firmly at the heart of policymaking across the UK.[37] Under this system AIDS policy was driven from Westminster and contributed to the diversity of contexts discussed in the Houses of Parliament where, in particular, Scottish MPs voiced concern for the rising caseloads in Edinburgh, Glasgow and Dundee whereas today we might expect such discussion to take place regionally at Holyrood.[38] By contrast, the American federal republic vested significant powers in state and local legislatures, providing control over major domestic policy issues such as public health and more specific issues such as marriage. Stephen Colbrook has suggested that in response to public health challenges in the US, 'states remained at the forefront of responding to public health crises.'[39] Whereas this thesis is primarily concerned with a comparison between Thatcher and Reagan's governments, these structural differences present unique challenges to AIDS policy development and application that intersect with partisan calls for action amongst policymakers on Capitol Hill and in Westminster. Furthermore, they draw attention to the broader implications of the political systems in which AIDS policy was developed, contextualising the criticism of Democrat's from California and New York and MPs from Scotland as reflections of the challenges presented by their respective systems.

Politically, the relationship between the executive and legislative branches had a significant impact on the development of policy in the US. The Democratic Party held a majority in the House of Representatives for the duration of Reagan's presidential term and in the Senate

[37] Devolution was a process in which started in the late 1990s in the UK government and gave power to Scotland, Wales, and Northern Ireland and the Republic of Ireland for the purpose of limited self-rule. This has since been extended to include some metropolitan mayors in England. Danny McKinnon has suggested that devolution 'altered the institutional landscape of public policy in the UK, generating some high-profile examples of policy divergence, whilst also providing evidence of policy convergence.' D. McKinnon, 'Devolution, state restricting and policy divergence in the UK', *The Geographical Journal,* 181:1 (March 2015), p. 47.

[38] Lord Campbell of Croy was a prominent advocate of the Scottish epidemic in Westminster voicing concern for the 'disturbingly high' rate of HIV/AIDS amongst intravenous drug users in Scottish cities. Hansard, House of Lords, 10 March 1986, c. 393.

[39] S. Colbrook, 'Why Pandemics Matter to the History of U.S. State Development', *Modern American History,* 4 (2021), pp. 329-332.

during the 96th (1979-1981) and 100th (1987-1989) congressional terms.[40] Over time this cultivated a growing sense of partisanship that regularly pitted the White House against the House of Representatives and was particularly acute prior to the mobilisation of Surgeon General Koop in late 1986 and the White House more generally in 1987. Democrats in the House of Representatives provided vital impetus to policy developments at odds with the White House response – or lack thereof. By contrast, the activity demonstrated by the Department of Health and Social Services (DHSS) in Britain after 1985 cultivated an increasingly cooperative discussion in Parliament shaped by a healthy Conservative majority in the House of Commons for the duration of the disease's first decade. The disparity between Thatcher and Reagan's control of the political system – whilst having consequences beyond AIDS policy – contributed to different challenges for each government and can be seen in President Reagan's loose grip on AIDS spending in Congress and the comparative ease with which Norman Fowler's AIDS agenda achieve consensus in Parliament in 1985-1986.[41]

Intersecting with the political cultures of the US and UK during the 1980s were the health care systems and the values that underpinned them. In the US, the delivery of health care had been a mixed enterprise composed of private health insurance markets augmented around publicly funded programmes governed by federal and state legislation and legislatures since the Great Society reforms of the 1960s. In the UK, the National Health Service (NHS) had provided health care provision in Britain under the banner of universal accessibility and the welfare state since the late 1940s.[42] Scholars of Anglo-American health care have increasingly drawn attention to the systemic and structural differences between the US and UK as grounded in opposed value systems that have long governed the development of the two systems. Recently, Carolyn Tuohy has argued along similar lines to Chris Ham that the hybrid American and centralised British systems are emblematic of broader political and cultural traditions that reinforce societal perceptions of the role of government and variances in institutional trust.[43]

---

[40] 'Party Divisions in the House of Representatives', [Party Divisions https://history.house.gov/Institution/Party-Divisions/Party-Divisions/| US House of Representatives: History, Art & Archives], accessed 26 January 2024. 'US Senate Party Division', [https://www.senate.gov/history/partydiv.htm], accessed 26 January 2024.

[41] For chapter specific discussion of these themes see: chapter two for Reagan's control of spending and chapter's two and three for Fowler's AIDS agenda between 1985-1986.

[42] R. Baggott, *Public Health: Policy and Politics* (Basingstoke 2010). C. Ham, *Health Policy in Britain: Public Policy and Politics* (Basingstoke 1999).

[43] C. Tuohy, *Remaking Policy: Scale, Pace and Political Strategy in Health Care Reform,* (Toronto 2018), p. 104. C. Ham, 'US and UK Health care: A Special Relationship? Money Can't Buy Satisfaction', *British Medical Journal,* 330 (March 2005), pp. 597-599.

Consequently, these systems and the values that underpinned them cultivated different political challenges throughout the 1980s as the AIDS Crisis escalated. Whereas the early part of the decade in America produced debates around service provision for people with AIDS (PWAs) whose access to health care had become threatened by ambiguity around insurance policy, loss of employment and the difficulty of treating a new deadly and poorly understood disease, the safety net of service provision provided by the NHS combined with a comparatively small caseload proved a different prospect for British policymakers. Furthermore, Ham has suggested that these disparate values and subsequently the structures and systems they have cultivated in the US since the 1960s have made the possibility of a traditional transnational exchange on health care unlikely.[44] Ham has argued that the centralised British system was better positioned to learn from their American counterparts and this thesis has demonstrated that this form of transnational policy learning did take place. Under Norman Fowler the DHSS actively considered the perceived failures of the US response as part of an effort to inform and develop effective responses to AIDS in the UK.[45]

Furthermore, the contemporary politics of the 1980s provides a vital connection between the US and UK case studies and underpin a valuable comparative element in the pursuit of understanding epidemic policymaking. The Reagan and Thatcher administrations of the 1980s adopted a similar political ethos, broadly labelled as neoconservative or 'New Right', that Desmond King has argued brought together the social orientation of modern conservatism with ideals of liberalism that championed individualism, free market economics and limited government.[46] A moniker constructed by British commentators, the 'New Right' became a political movement that achieved success across a variety of platforms across Europe and the US during the 1980s.[47] In the US, scholars have grappled with the intricacies of conservatism with great success since Alan Brinkley labelled twentieth century American conservatism an 'orphan in historical scholarship.'[48] There has since been an upturn in conservatism scholarship in the new millennium to the extent that Brinkley has suggested it now plays an

[44] Ham, 'US and UK Health care: A Special Relationship?', pp. 597-599.
[45] Ibid.
[46] King, *The New Right*, pp. 2-13.
[47] Ibid, p. 1.
[48] A. Brinkley, 'The Problem of American Conservatism' *The American Historical Review,* 99:2 (April 1994), p. 409.

important role in American life and academia.[49] Other influential scholars such as Kim Phillips-Fein have asserted that the Reagan presidency was the realisation of a grassroots movement emerged from the distaste of New Deal reform which would learn from the failure of Barry Goldwater in the 1964 presidential election and go on to cultivate popular sentiment under Ronald Reagan in the late 1970s and 1980s.[50]

Comparatively, Margaret Thatcher's position in British history has been increasingly shaped by Thatcher the politician and less by narratives of conservative ascendency like those documented in America. John Lyon has described conservatism under Thatcher as interwoven with economic ideals developed by Milton Friedman and the Chicago School of Economics with a comparatively reduced role for social engineering and values-based messaging captured by close advisor Keith Jospeh's speech at the Grand Hotel in 1974 entitled, 'Our Human Stock is Threatened.'[51] Nevertheless, the interplay between these two overarching principles of neoconservatism – economic liberalism and social conservatism – informed policy development and rationale across the British and American contexts. In the US, the economic and social tenets of neoconservatism were more intimately connected than in the UK where Margaret Thatcher demonstrated a less clear view of social issues than she did fiscal and monetary issues. Although Reagan's endorsement of social issues – such as school prayer and the Equal Rights Amendment – was less substantive than religious groups such as Jerry Falwell's Moral Majority might have wanted, the Reagan administration made public a clearer vision for social issues than Thatcher. As John Lyons has suggested, where Reagan pronounced ideas on society, faith and values, Prime Minister Thatcher demonstrated substantial restraint on those same issues in addition to a record of supporting legislative reform on abortion and homosexuality.[52] Nevertheless, the intersection between these 'New Right' principles and AIDS policy was increasingly important as government intervention on both sides of the Atlantic heated up.

[49] A. Brinkley, 'Conservatism as a Growing Field of Scholarship', *The Journal of American History,* 98:3 (December 2011), p. 748.
[50] K. Phillips-Fein, 'Conservatism: A State of the Field', *The Journal of American History,* 98:3 (December 2011), pp. 724-726.
[51] J. F. Lyon, *America in the British Imagination: 1945 to the Present* (New York 2013), p. 101. K. Joseph, 'Speech at Edgbaston: Our Human Stock is Threatened', *Margaret Thatcher Foundation,* 19 October 1974, [https://www.margaretthatcher.org/document/101830], accessed 27 March 2024.
[52] Lyon, *America in the British Imagination*, p. 105.

In the British context, Virginia Berridge has suggested that the AIDS Crisis of the 1980s pitted New Right conservatism against a liberal consensus, a conflict which in the sphere of public health increasingly tested ideals of individual and collective responsibility.[53] Whereas New Right political thought prioritised individual responsibility more generally, in Britain the public health manifestation embraced the medico-liberal consensus that cooperated to reaffirm the collectivist orientation of the British health care system and the existing tradition of shared responsibility that had cultivated popular sentiment for the NHS to this point. The Reagan White House consistently positioned health, welfare and social policy broadly within an economic framework that pursued fiscal responsibility and budgetary restraint but achieved greater levels of change through impactful legislation such as the Budget and Reconciliation Act 1981 which recouped 35.2 billion dollars from 200 federal programmes.[54] As such, AIDS policy – particularly prior to mobilisation in 1987 – faced an uphill battle that was primarily pitched between the legislative and executive branches of the federal government. Embodied in President Reagan's famous adage on the role of government – 'Government is not the solution to the problem. Government is the problem' – the interplay between AIDS and the White House was habitually cast as a turbulent exchange between a growing sense of urgency and appreciation surrounding the disease and the capacity for devastation it presented and the broader political and governance objectives set out by the Reagan administration.[55] Therefore, this thesis explores the interplay between AIDS and New Right political thought and the subsequent importance and volatility of contextual factors in elevating and suppressing ideology in the facilitation of epidemic response.

Chapter Structure

The chronological structure of this thesis is intended to demonstrate that AIDS policy during the 1980s in the US and UK was not monolithic and that existing scholarship has left much of the early decade untouched in pursuit of the mid-decade mobilisation of policy on both sides of the Atlantic. Whereas important contributions like Jennifer Brier's chapter 'What Should

[53] Berridge, *AIDS in the UK*, p. 14.
[54] I. Morgan, *Reagan: American Icon* (London 2016), p. 180.
[55] 'Inaugural Address 1981', *Reagan Presidential Library & Museum,* 20 January 1981, [https://www.reaganlibrary.gov/archives/speech/inaugural-address-1981], accessed 14 February 2024.

the Federal Government Do to Deal with the Problem of AIDS?' and John Street's article 'British Government Policy on AIDS' have facilitated fruitful discourse on AIDS policy they have spent little time exploring the policy dynamics prior to the discovery of HIV.[56] In the UK, Virginia Berridge has emphasised the importance of this early period in her discussion of 'policy from below' which has identified a self-help responses from 'AIDS Missionaries' constituted of clinicians and the British homosexual community through organisation such as the Terrence Higgins Trust who largely operated without support from Whitehall and Parliament.[57] This thesis builds on Berridge's contribution by utilising new archival material and a comparative framework to develop an understanding of 'policy from above' in the UK, examining the factors facilitating policy discourse and development throughout the 1980s in comparison with the US response. Beginning with the period 1981-1984, this thesis situates the dynamic ebbs and flows of AIDS policy in the 1980s within a broader chronological structure that presents a comprehensive appreciation of policy development during the decade.

Building on the existing US scholarship that has centred around perceptions of administrative inaction, chapter one expands our current understanding of the period June 1981 – May 1984 through a comparative analysis of the British and American responses to the disease. Set in a policymaking climate hampered by ignorance, unknowns, and misinformation, the perception of administrative inaction that has shaped existing historiographical narratives has rightly emphasised the inability of the Reagan administration to respond in a timely fashion to the earliest challenges posed by the disease. Central to this chapter's discussion, however, is the need to move beyond inaction as the core component of historical critique and towards a conceptualisation of early AIDS policymaking that attributes a more prominent role to the awareness and agency governing the administrative response to AIDS prior to the discovery of HIV in May 1984. By comparing the circumstances shaping the similar US and UK responses, this chapter asserts that the British experience can be better understood as administrative absence and the American experience as administrative avoidance. The conceptual

[56] J. Brier, *Infectious Ideas: US Political Responses to the AIDS Crisis* (Chapel Hill, 2009), pp. 78-121. J. Street, 'British Government Policy on AIDS: Learning Not to Die of Ignorance', *Parliamentary Affairs*, 41:1 (October 1988), pp. 490-507. Other examples include D. M. Fox and E. H. Thomas, 'AIDS Cost Analysis and Social Policy', *Law, Medicine, and Health Care*, 15:4 (Winter 1987/88), pp. 186-211. Fox, Day, and Klein, 'The Power of Professionalism', pp. 93-112.
[57] Berridge, *AIDS in the UK*, pp. 13-80.

framework 'absence and avoidance' reassesses the notion of inaction by emphasising the disparate responses adopted by the Thatcher and Reagan administrations in cultivating that inactivity. Whereas the British government – in Parliament and Whitehall – afforded AIDS little attention, a White House discourse – albeit limited – demonstrated a more calculated ignorance. In addition, this chapter begins a thesis-wide discussion about the importance of who the disease affected and how this shaped contemporary policy narratives. Intertwined with budgetary warfare between the executive and legislative branches of government in the US, this chapter highlights the fundamental differences between inaction and inadequacy in the US and UK to better explain the broader political context shaping early AIDS policy on both sides of the Atlantic.

Chapter two examines the aftermath following the discovery of HIV (May 1984 – December 1985) as a transition period between the 'absence and avoidance' of 1981-1984 and the mobilisation of 1986. Central to this chapter's contribution is a detailing of the relationship between rhetoric and action in the facilitation of AIDS policy in the US and UK between 1984 and 1985. In the US, a growing disparity between the urgency of the public health polity and the laboured commitments of the White House towards policy progress compromised American AIDS policy despite the nationwide escalation of the disease.[58] Challenged by the inherent paradox between expanding epidemic response and social spending retreat, US AIDS policy became increasingly defined by the stark contrast between the aims of AIDS policy advocates across the political sphere and the administrations popular mandate of federal retrenchment. By contrast, British AIDS policy advocates slowly established a network for policy deliberation that stemmed from the participation and cooperation between the Department of Health and Social Service – led by Chief Medical Officer Donald Acheson – and advocacy from health care professionals and biomedical researchers. Moreover, the prominence of scientific and public health advocacy in the UK cultivated a fundamental distinction between the British and American responses that grew more intense as the decade

[58] 'Public health polity' is a phrase adopted by Daniel Fox in his paper *AIDS and the American Health Polity* which he uses to 'describe the ways a community … conceives of and organises its response to health and illness.' I have applied the term here in a similar fashion to refer to the broader community engaged in AIDS policy advocacy broadly defined – health care professionals, policymakers from a variety of levels (national, state, local), insurance providers, patients and activists. (D. Fox, 'AIDS and the American Health Polity: The History and Prospect of a Crisis of Authority', *The Milbank Quarterly,* 83:4 (November 2005), p. 1. (Reprinted from the *Milbank Quarterly*, 64:1 (1986), pp. 7-33.)

progressed. In addition to the growing disparity in policymaking infrastructure, another vital vehicle through which this sense of difference was communicated was Reagan's AIDS funding which attracted significant opposition from Democrats in Congress. Although Norman Fowler's expanding AIDS agenda in Britain attracted criticism for a tight purse on occasion, the intensity of opposition critique in the US became symbolic of the Reagan administrations inability to articulate a coherent AIDS policy that adequately reconciled the tenets of neoconservative governance and epidemic response. Subsequently, chapter two cites the intersection between AIDS funding, policy priority and opposition critique as prime drivers in the development of AIDS policy in the period following the discovery of HIV.

Chapter three represents a turning point in the comparative analysis. It argues that 1986 – a common point of origin for scholars of AIDS policy – occupies a unique place in the policymaking narrative as a point of divergence between the US and UK. Moreover, this divergence places an increasingly intense spotlight on the factors shaping policy development on either side of the Atlantic. A proponent of an alternative perspective on AIDS policy, Margaret Thatcher became increasingly concerned with the impact of public health messaging about sex and recreational drug use. Unsuccessful and disruptive in nature, Margaret Thatcher's attentive challenges to Norman Fowler brought into focus President Reagan's absence on AIDS policy despite an overlapping distaste for safe sex and harm reduction messaging.

In addition to executive leadership, the second and third parts of chapter three emphasises the importance of public discourse in distinguishing the previously aligned policy responses. Part two demonstrates how intravenous drug use and screening policy in Britain were adopted as important focal points in the response to AIDS. It shows that a degree of consensus was achieved in the parliamentary sphere, which contributed to a willingness to adopt the policy in decision-making circles. By contrast, the legislative-executive battle in the US that hindered policy development and posited little change in fortune for epidemic response. Part three chronicles the emergence of Surgeon General Dr Everett Koop as a publicly praised but administratively disruptive player in the American response to AIDS. It discusses the broader context of his impact on the US AIDS narrative, exploring the response to his material and how it positioned the Reagan administration's record of AIDS. Furthermore, it will chart the importance of the November Debate in the House of Commons. Whereas the Commons was

no stranger to AIDS discourse by late 1986, the November Debate was the largest, most substantive discussion of the British response thus far and encouraged commendation, critique and recommendation for government officials who attended throughout the lengthy discussion.

Alongside the broader development of AIDS policy discourse in 1987, the emergence of education and screening heavily influenced the British and American policy narrative. In the first instance chapter four will situate a growing concern for screening alongside a wider discussion of public policymaking in the US and UK during 1987, detailing the disparate policy stances of the Reagan and Thatcher administrations. Whereas British policymakers steadfastly rejected calls for mandated testing in the UK in favour of the voluntary approach championed by medical science, Reagan's officials pressed hard for a more sympathetic dialogue on mandated testing. Moreover, the Thatcher government's dismissal of special case testing further demonstrated the British distaste for widespread testing which was seen to be expensive and ineffective. By contrast, White House officials maintained an approach to mandated testing that produced the failed adoption of pre-marital screening and the successful visa ruling change aimed at keeping AIDS out of the US. Moreover, this detailing of screening policy will demonstrate further the important role played by an adherence to medical consensus in determining screening policy and upholding the divergent trends in AIDS policy generally. Likewise, public health education proved another policy issue that hinged on differing responses to the established medical consensus. Informed by President Reagan's notion that 'medicine and morality teach the same lessons', the second part of this chapter explores the construction of public health education in America in comparison to the already expanding British campaign.[59] Focusing on the interplay between moralism and medicine, this section posits that the White House attempted to reconcile science and moralism in an unequal public health partnership that deeply contrasted the deliberate separation adopted by British policymakers. Moreover, the emphasis on values and moralism by White House officials encouraged a more prominent role for social conservatism which had received little attention because of the administrations limited intervention.

[59] Reagan Presidential Library and Museum (RPLM), R. Reagan, 'Remarks at the American Foundation for AIDS Research Awards Dinner', 31 May 1987, [https://www.reaganlibrary.gov/archives/speech/remarks-american-foundation-aids-research-awards-dinner] accessed 2 May 2023.

Coinciding with Reagan's departure from the Oval Office, chapter five examines the period 1988-89 through the most prominent policy issues that permeated AIDS policy during the short first decade (1981-1989). Structured thematically, this chapter will firstly revisit funding as a quantitative manifestation of priority with increasing significance in a climate of neoconservative ascendency. Through research spending and service provision chapter one explores the priority afforded AIDS policy generally towards the end of the 1980s and how funding highlighted the priority areas of disease response under Reagan and Thatcher. Secondly, this chapter investigates the status of moralism during the period 1988-89 before shifting focus to a discussion of the interplay between education and moralism. Understood as a vehicle for social conservative ideas in the US, education attracted a more potent dose of moralism both publicly and privately than many other areas of policy and draws out the discussion on moralism that has permeated this thesis. Thirdly, this chapter examines policy related to intravenous drug use (IVDU) and the development of disparate policy responses and their coalescence with existing traditions on harm reduction and the politics of drug policy more generally in the US and UK. Lastly, this chapter details the closing developments of the screening debate that proliferated in the second half of the decade. It details the ideological implication of the respective governments' screening mandates and explores the usefulness of ideology in the sphere of testing where the principles of neoconservatism are less evident in policy development. Fundamentally, this chapter draws together the major policy issues that shaped AIDS policy in the US and UK since 1981, expanding our understanding of the interplay between political philosophy and practical politics in the pursuit of epidemic response.

On 5 June 1981, the Centres for Disease Control's *Morbidity and Mortality Weekly Report* shared Dr Michael Gottlieb report of rare and deadly disease in five previously healthy homosexual men in Los Angeles, California.[60] In May 1984, the causative agent of that disease was discovered by French and American scientists and by the end of 1987 over 50,000 American and 1,800 British people were known to have that very syndrome reported by Dr

[60] M.S. Gottlieb et al, 'Pneumocystis Pneumonia – 1996 Editorial', *Morbidity and Mortality Weekly Report,* 45 (30 August 1996), pp. 729-733.

Gottlieb – the vast majority succumbing to the disease before the decade's end.[61] It is at the inception of that policymaking story that this thesis begins, with chapter one's discussion of the conceptual framework 'absence and avoidance' and the examination of the period from June 1981 to May 1984.

[61] National Centre for HIV, STD, and TB Prevention, 'HIV and AIDS --- United States, 1981 – 2000', *Morbidity and Mortality Weekly Report,* 50:21 (June 2001), pp. 430-434. D. Acheson, *Chief Medical Officer Annual Report 1987* (1987), pp. 115-126. These numbers are 'AIDS cases' and not the number of seropositive HIV cases.

Chapter One

Absence and Avoidance: 1981-1984

Introduction

Novel and perplexing, the pattern of disease and death that emerged in June 1981 represented the start of a policymaking response that stimulated new scientific discovery and ignited a series of interconnected socio-cultural threads that reshaped the lived experience of thousands of people on both sides of the Atlantic. Accompanied by the ascendency of conservatism in the White House and Whitehall, the policy response to the early AIDS Crisis was fraught with political challenges and socio-cultural tension from the beginning. Operating in the darkness fostered by scientific ignorance, the problematic inactivity that accompanied the unfamiliarity of the disease laid the foundation for a complex policy response that entangled ideology and epidemic response in a tussle for political dominance. As this chapter chronicles the earliest years of the disease and the associated policymaking response, the complexity of responding to AIDS in the 1980s becomes increasingly apparent.

In the US, the work of journalist Randy Shilts was central to the early AIDS narrative.[62] His emphasis on the detrimental intersection between Reagan's social conservatism and homosexuality informed a growing perception of federal inadequacy.[63] Likewise, Cindy Patton has discussed the relationship between sexuality and AIDS in her work *Sex and Germs* and detailed a fear of sexuality that coincided with a fear of germs.[64] Patton has suggested that the neoconservative family values model espoused by the Reagan administration was merely one dimension of a discriminatory platform constructed around the disease and the 'others' it primarily affected.[65] Science correspondent Robin McKie contributed a journalistic account of the British epidemic that was similarly critical of the government, emphasising the initial

[62] R. Shilts, *And the Band Played On: Politics, People, and the AIDS Epidemic* (1987), p. xxii.
[63] Ibid.
[64] C. Patton, *Sex and Germs: The Politics of AIDS* (Boston 1985), pp. 12-16.
[65] Ibid.

period (1981-1984) as fundamentally defined by 'misinformation, misunderstanding and prejudice.'[66] Importantly, these journalist accounts had limited access to the policymaking network determining AIDS policy unlike scholars today. More recently, Jennifer Brier has provided valuable insight into the first Reagan administration (1981- 1984), however, her emphasis on the second Reagan administration (1985-1989) has left the door open for further discussion of policy development during the critical early years of the epidemic in the US.[67] In his book, *Don't Die of Prejudice,* former Secretary of State for Health and Social Services Norman Fowler was similarly engrossed in the policy mobilisation of the mid-decade in Britain, neglecting to provide the clarity on AIDS policy between 1981-1984 that – given his proximity to AIDS policy – few other could do with such authority.[68] Similarly, British scholarship of this initial period is less developed, with Virginia Berridge's *AIDS in the UK* the standout work describing the earliest part of the decade as 'a period of incoherence, of absence of knowledge, of groping in the dark.'[69] Moreover, Berridge has incorporated the first half of the decade into her analysis as a 'preliminary phase' of policymaking that preceded Norman Fowler's 'wartime response' between 1986-87.[70]

In response to the historiographical opportunities presented by the existing scholarship, this chapter examines the acceptability of inaction as the cornerstone of existing historical enquiry into the initial period. Whereas inactivity certainly pervaded the administrative responses of Ronald Reagan and Margaret Thatcher, this chapter utilises the comparative framework at the heart of this thesis to showcase the variance in circumstance and attitude that demand a more measured appraisal of administrative inaction. Adopting the 'initial period of policymaking' from the first reporting of AIDS in June 1981 to the discovery of HIV in May 1984, this discussion demonstrates the circumstantial disparity between the US and UK epidemics. The White House faced a greater challenge in terms of both scale (aggregate number of cases and rates of infection) and visibility (public and internal disease dialogue) compared to those in Whitehall. In addition, this chapter explores the implications of ignorance and information in shaping this period of AIDS policymaking. It embraces the work of Greenaway, Smith and

[66] R. McKie, *PANIC: The Story of AIDS* (Wellingborough, 1986), p. 7.
[67] J. Brier, *Infectious Ideas: US Political Responses to the AIDS Crisis* (Chapel Hill, 2009), pp. 79-80.
[68] N. Fowler, *AIDS: Don't Die of Prejudice* (London, 2014), p. 1.
[69] V. Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford, 1996), p. 13.
[70] Ibid.

Street who have suggested that an apparent lack of information made AIDS decision-making a difficult task, situating this broader notion of inadequate information against the contextual difference in the US and UK experience of the disease to better understand the role of information in the perception of 'absence and avoidance'.[71] Moreover, this discussion emphasises the presence of an informed AIDS narrative in the White House that demonstrated a growing appreciation of the disease's capacity for devastation. Demonstrating the importance of agency in the pursuit of inactivity – the decision to do nothing remains a decision – the lack of policy intervention in the US was a form of 'administrative avoidance' that contrasted the 'administrative absence' in the UK under Margaret Thatcher, clarifying the underlying disparity that differentiated the response of Whitehall and the White House during this early period of AIDS policymaking.

Early Engagement, 1981-1982

The response to accounts of a new deadly disease was unsurprisingly complicated. Operating in a climate of uncertainty created by a stark lack of understanding and clear absence of information, formulating policy was a substantial challenge for those faced with the responsibility for early disease response. In the first instance, this discussion highlights the early disparity between the US and UK experiences of AIDS and how these differing characteristics cultivated unique circumstances for British and American policymakers.[72] In his book *Reagan: American Icon*, Iwan Morgan has suggested that AIDS was 'one of the blind spots in Reagan's optimistic vision of America.'[73] Although Morgan writes more generally on President Reagan's attitude to AIDS policy throughout his tenure, this discussion will begin dissecting the broader implications of a policy 'blind spot' or administrative inactivity by establishing the 'absence and avoidance' framework that underpins this chapter's contribution.

[71] J. Greenaway et al, *Deciding Factors in British Politics: A Case Studies Approach* (London, 1992), p. 91.
[72] The term experience has been adopted to better reflect the language of policymakers faced with an emergent disease. Until the end of this period, the prospect of an epidemic was not as acute as hindsight or existing account of crisis might suggest.
[73] I. Morgan, *Reagan: American Icon* (London 2016), p. 241.

Following the *Morbidity and Mortality Weekly Report* on 5 June 1981, the Public Health Service (PHS) began sporadically articulating a stance on the disease as research progressed under the supervision of a task force led by Centres for Disease Control (CDC) Director, Dr James Curran.[74] Although the Public Health Service possessed a plethora of expertise and resources, the multiplicity of unknowns surrounding the sudden presentation of rare infections and cancers in previously healthy individuals shaped a policy environment informed by very little scientific evidence or consensus. By July 1982, the CDC had reported cases of Pneumocystis Carinii Pneumonia (PCP) amongst three previously healthy heterosexual males with pre-existing haemophilia – two deceased at the time of reporting – with one individual exhibiting symptoms as early as October 1980.[75] In November 1982, the CDC published basic safety guidelines for health care professionals and laboratory employees working with the disease or infected individuals, setting out a basic hypothesis that casual contact was unlikely to cause infection and that an unknown causative agent appeared to be involved in direct transmission such as sexual contact or intravenous drug use (IVDU).[76] Reflecting the low political status of the disease, the White House produced no public position during the early stages of development. Moreover, the absence of information – as Street et al have suggested – likely contributed to an unwillingness amongst policymakers and concerned advocates to position themselves on issues which they did not fully understand, the absence of firm positions on transmission and casual contact in the PHS and CDC an impactful indicator of this inability to advise with confidence.[77] As this discussion will outline, ignorance and uncertainty formed a formidable part of the AIDS policymaking process throughout the initial period and the inability of policy advocates in the US to articulate a confident position on certain aspects of the disease reinforced Berridge's notion of 'groping in the dark.'[78]

---

[74] M.S. Gottlieb et al, 'Pneumocystis Pneumonia– Los Angeles', *Morbidity and Mortality Weekly Report,* 30 (June 1981), pp. 250-252. A case definition for AIDS was not published until September 1982 making the disease presentation as PCP or Kasposi Sarcoma the main characterisation of what would become AIDS during the initial phase.

[75] N. J. Ehrenkranz et al, 'Epidemiological Notes and Reports: Pneumocystis Carinii Pneumonia Amongst Persons with Haemophilia A', *Morbidity and Mortality Weekly Report,* 31:27 (July 1982), pp. 365-367.

[76] Hospital Infections Program (CDC-NIH), 'Current Trends Acquired Immune Deficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staff', *Morbidity and Mortality Weekly Report,* 31:43 (November 1982), pp. 577-580.

[77] Greenway et al*, Deciding Factors in British Politics*, p. 91.

[78] Berridge, *AIDS in the UK*, p. 13.

The first wave of public AIDS dialogue in the US was heavily connected to medical and media speculation about a new killer disease affecting predominately gay men. *The New York Times* published an article entitled, 'New Homosexual Disorder Worries Health Officials' in May 1982, which discussed the perceived risk factors associated with homosexuality from the perception of widespread promiscuity to recreational drug use.[79] In July 1982, the CDC published a report reaffirming the relationship between sexual orientation and transmission observed by media speculation as 75% of known cases were recorded in homosexual and bisexual males.[80] Although the PHS and CDC had demonstrated an appreciation for the emergent disease, the reality for many Americans was a reliance on the infrequent updates published in the middle pages of the nation's preferred broadsheets such as the *New York Times* and the *Washington Post* or even more sporadic, television specials like 'AIDS' aired by *Nightline* on ABC News in December 1982.[81] Some likely came across the disease in more niche publications such as *The Advocate* or even first hand as the deadly disease gradually spread geographically and demographically in hotspots like New York City, Los Angeles and San Francisco. What was certain, however, was that the American public received no guidance from the Oval Office. The disparity between the visibility of the President and individuals such as Larry Speakes and Nightline anchor Ted Koppell was a problem with growing political capital by early 1983 as public critique of federal inaction slowly emerged in Congress. Although the role of Deputy Press Secretary brought Larry Speakes and the public together in the White House Press Room with predictable frequency, Reagan's unwillingness to adopt a public position on the disease became the basis of his administration's initial response and a symbol of federal inaction.

Across the Atlantic, British policymakers had a markedly different AIDS experience. As the lack of archival material suggests, policymakers in the Houses of Parliament and Whitehall failed to discuss the disease in any capacity throughout the period June 1981 – July 1983. Central to this disparity in early engagement was the difference between the US and UK caseloads, a disparity that would fundamentally shape the UK's ability to scrutinise and learn from the US

[79] 'New Homosexual Disorder Worries Health Officials', *The New York Times*, 11 May 1982.
[80] Centres for Disease Control, 'Kaposi's Sarcoma (KS), Pneumocystis Carinii Pneumonia (PCP), And Other Opportunistic Infections (OI): Cases Reported to CDC as of July 8, 1982', (July 1982), pp. 1-2.
[81] 'A Disease's Spread Provokes Anxiety', *New York Times,* 8 August 1982. 'Insensitive', *Washington Post,* 11 December 1982. 'AIDS', Nightline: ABC News, 17 December 1982.

experience. Whilst it is important to observe the inherent complications of comparing AIDS data prior to the introduction of effective testing and a worldwide case definition, the available data does provide some perspective on the clear disparity in circumstances. By the end of 1983, the CDC had recorded 3064 AIDS cases in the US, of whom 42.2% had died.[82] At the same time, the UK had recorded only 31 'clinical AIDS cases', a vastly different 0.05 cases per 100,000 people compared to 1.3 cases per 100,000 in the US.[83] Responding to a more subdued presentation of the disease than their US counterparts, the absence of UK policymakers prior to July 1983 was symptomatic of a disease largely unknown to the majority of the British public. Although British and American policymakers were presented with the same disease and accompanying lack of understanding, the difference in caseload that distinguished the two experiences of the disease between 1981 and 1982 fostered little disparity in attentiveness as both administrations pursued a policy characterised by inactivity.

In the US, this perception of federal inactivity was publicly scrutinised in the White House Press Room by reporter Lester Konsolving whose questioning of Deputy Press Secretary Larry Speakes has become a vital and infamous indicator of the relegated position of AIDS policy during the earliest years of the Reagan administration. When asked about the President's knowledge of the 600 AIDS deaths reported by the CDC in October 1982, Deputy Press Secretary Larry Speakes told journalist Lester Konsolving, 'No, I don't have anything about that, Lester.'[84] Provoking laughter at Konsolving's expense, the reporter's scrambling for an answer ended frustratingly with: 'in other words, the White House looks at this like a great joke.'[85] Although Konsolving was no ally to the gay rights movement or the male homosexuals represented in early AIDS data, the reporter's persistence clarified the status of AIDS in the Reagan White House during a period in the policy's infancy. Adopting no firm position on the disease or the administration's stance on it, Speakes' press conference likely achieved the sense of vagueness intended for the public sphere. Although Speakes' dismissive responses to Konsolving's advances reflected an absence of material in the Deputy Press Secretary's notes, the administration was more informed about the disease than Speakes had implied.

[82] CDC, 'Acquired Immune Deficiency Syndrome (AIDS) Weekly Surveillance Report', (22 December 1983), p. 1.
[83] D. Acheson, *Chief Medical Officer Annual Report: 1985* (1985), p. 41.
[84] *When AIDS Was Funny,* (2015), Scott Calonico, [http://www.scottcalonico.com/#/when-aids-was-funny/], accessed 29 March 2021.
[85] Ibid.

Fiscally, the Reagan administration had demonstrated an awareness of what the disease required, allocating a limited but nonetheless tangible $5.6 million to the CDC and NIH in the financial year 1982 for AIDS activity.[86] However, these numbers pale in comparison to the $322 billion ($185 billion in private and $136.8 billion in public expenditure) spent on 'national health expenditure' in 1982 which amounted to 10.5% of Gross National Product (GNP).[87] Moreover, in September 1982 LGBT magazine *The Advocate* reported that the Senate had approved an additional $500,000 for the CDC before President Reagan vetoed the bill (H.R. 6863) containing the extra AIDS funding, with Congress overturning the veto in October pushing through over $14 billion of appropriations.[88] In a letter to Congress justifying his veto, President Reagan cited the need to 'press forward in an all-out attack on wasteful and unnecessary spending.'[89] In this pursuit of the 'wasteful and unnecessary', the Reagan administration's drive to reduce federal expenditure restricted early AIDS policy initiatives. With limited political capital to expend, early AIDS policy was likely discussed as a constituent part of a broader discourse on reducing federal health spending. Moreover, the President's challenging of H.R. 6863 – however unsuccessful it was – represented a characteristically principled rejection of domestic spending increases. More specifically, this bill placed AIDS resourcing more directly in the public sphere of policymaking and the support of congressional members – whether specifically advocating for AIDS or social policy generally – mobilised a legislative challenge to the blanket social spending retreat practiced by the Reagan administration. Importantly, the unsuccessful veto combined with the $5.6 million allocated to the PHS for 1982 demonstrated an awareness of the disease that destabilised the image of presidential ignorance painted by Speakes in October 1982. Moreover, Speakes' dismissal of Konsolving served as a limited but seemingly effective method of suppressing public interest in the disease. Combined with the President's rejection of fresh money for the CDC, the

[86] Sue Daoulas Files (AIDS 2:1), Reagan Presidential Library and Museum (RPLM), William Winkenwerder, 'Preliminary Results of the HCFA Survey of Total Federal AIDS Expenditure', 11 August 1988, p. 12 (Table 1).
[87] R. M. Gibson, D. R. Waldo and K. R. Levit, 'National Health Expenditures, 1982', *Health Care Financing review,* 5:1 (Fall, 1983), p. 3.
[88] 'Senate Panel OKs Gay Health Funding', *The Advocate,* 16 September 1982. 'Congress Overrides Veto: Bill with AIDS Funding is Approved', *The Advocate,* 14 October 1982.
[89] 'Veto of H.R. 6863', R. Reagan, 28 August 1982, [https://www.senate.gov/legislative/vetoes/messages/ReaganR/HR6863-Hdoc-97-231.pdf], accessed 15 March 2024.

Speakes-Konsolving exchange further exacerbates perceptions of administrative avoidance in the White House and demonstrated a willingness to perpetuate inactivity.

Furthermore, the administration's knowledge of the disease far exceeded the level portrayed by Deputy Press Secretary Speakes during his exchange with Lester Konsolving. The dispatch of a telegram from the State Department to the US embassy in Haiti – reports of new cases amongst Haitian immigrants in July 1982 contributed to their inclusion in the CDC's 'four Hs' (homosexuals, haemophiliacs, heroin users and Haitian immigrants)[90] – entitled 'AIDS Among Haitian Populations' on 21 September 1982 demonstrated the presence of an AIDS dialogue within the federal government that suggested the State Department was an authority on the disease.[91] Whilst the telegram was somewhat dismissive – suggesting 'only' 600 cases had been recorded in the US – the telegram's sponsor, Secretary of State George Shultz, offered authoritative stances on the current transmission hypothesis (via blood and blood products) and the risk associated with 'promiscuous sexual behaviour' and 'illegal IV drug use.'[92] Demonstrating an acute appreciation of the newest science on the disease, the State Department's communication with the Haitian embassy served as an early indication of the complicated relationship between the domestic and foreign policy response to the disease. It highlighted the State Department's unique perspective on AIDS and placed a spotlight on the diversity of response cultivated by the various levels of government and the contexts in which they operated.

Given the Secretary of State's proximity to the President, the likelihood that Speakes' impression of presidential ignorance was wholly accurate remained increasingly dubious. Moreover, the timing of Shultz' telegram – less than a month before the Konsolving-Speakes exchange – undermined Speakes' cavalier dismissal of AIDS in favour of a calculated avoidance of the issue in the public sphere. Therefore, Shultz's understanding of the disease combined with his status as an influential cabinet member complicated the dismissive tone adopted by Speakes during his press conference. Whilst his notes might have been light on AIDS content, the State Department's informed position on the deadly disease affirmed the need to displace

[90] G. T. Hensley et al, 'Opportunistic Infections and Kaposi's Sarcoma Among Haitians in the United States', *Annals of Internal Medicine,* 31:26 (July 1982), pp. 353-354.
[91] Document 2 in S. Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', *Office of the Historian*, (Bureau of Public Affairs, November 2017), p. 2.
[92] Ibid.

views of inactivity with more representative notions of avoidance that assign agency to the Reagan administration's inability or unwillingness to address the disease publicly.

Demonstrated by the lack of material available for the pre-discovery period compared to the post-discovery, the British and American policy dialogues were inherently limited between 1981-1982. Likewise, policymakers experienced a similar deficiency in scientific understanding that perpetuated this lack of material whilst undermining the very foundation of policymaking – information. Nevertheless, the perception of ignorance and inaction discussed in the earliest accounts of the disease response – particularly in the US – fail to account for policy agency, placing an inequitable emphasis on outcome over circumstance. Whereas outcome is fundamentally important and frequently the most appropriate aspect of policy to measure, this comparative discussion has highlighted the need to incorporate outcome and context more closely, cultivating a more representative discourse on AIDS policy that allows for the disparity in attentiveness to shape our understanding of administrative inactivity.

Although the US and UK achieved similar levels of inattentiveness in terms of policy output, a vital distinction in awareness existed between the two administrations that reinforces the 'absence and avoidance' framework set out in this chapter. Whereas Margaret Thatcher and her Conservative government appeared uninterested in the comparatively low number of AIDS cases in the UK, the wider parliamentary discourse on the issue was similarly mute. The Thatcher government's position on AIDS policy reflected a widespread indifference on the disease in the British polity – albeit a chorus of activist groups was gathering momentum such as the London Lesbian and Gay Switchboard (established 1974) and the Terrence Higgins Trust which was formally established following a short informal existence in August 1983. However, the Reagan administration's AIDS experience operated in a substantially different political economy.

Likely facilitated by the rising infection rate, the American polity demonstrated a multitude of tangible engagements with AIDS that, by contrast, failed to materialise in Britain. In the legislative sphere, congressional support for H.R. 8683 and the successful overturning of President Reagan's veto demonstrated a politically visible discourse on AIDS as a health issue despite AIDS funding being constituent part of a much large appropriations bill. Moreover, the federal budget for the financial year 1982 provided specific funding for AIDS activity at the CDC and whilst it was comparatively small – military spending, for example, averaged 6% of

GDP between 1982-1989 and the Reagan administration would spend some $2.7 trillion on military outlays during his two terms in office – it nonetheless acknowledged to the presence of an AIDS dialogue.[93] The complicated intersection between Reagan's rejection of 'wasteful' and 'unnecessary' spending under H.R. 8683 and the budgeting of resources for AIDS spending clarified the contradiction between the administration's public and private discussions on the disease. Moreover, this distinction between public and private materialised most acutely in the State Departments growing concern with AIDS in the global context as evidenced by Schultz's telegrams on the disease to Haiti and later Africa.

Therefore, the perception of inactivity in the US is not wholly accurate, the existence of a developed policy narrative that demonstrated both the allocation of funding and a discourse on the potential for further spread at the executive level (Schultz being a senior cabinet member and thus, an executive level position in government) undermines the perception of inactivity and inaction. Whereas inactivity and inaction provide a limited appreciation of the agency inherent in the federal government's inability to articulate a position on AIDS in terms of policy output and publicity, this discussion proposes to better explain the Reagan administration's approach as administrative avoidance. Informed by the disparity between the circumstances shaping the similarly inattentive response of the Thatcher and Reagan administrations, this discussion has showcased the need to push our understanding of the earliest iterations of AIDS policy beyond the confines of inactivity and inaction and towards more nuanced concepts of absence and avoidance that better reflect the differences highlighted by a comparative methodology. The following discussion focuses on the period 1983-84, carrying forward the absence and avoidance framework to explore the British and American responses in a political climate increasingly aware of the new deadly disease.

Developing Policy Narratives, 1983-1984

Whilst still 'groping in the dark', as Virginia Berridge has suggested, policymakers in 1983-1984 were steadily benefiting from the increasingly intense glow of scientific enquiry into the

[93] Morgan, *Reagan*, p. 181.

disease that would produce the discovery of HIV as the causative agent for AIDS in May 1984.[94] Nevertheless, AIDS policymaking remained deeply intertwined with the dynamic politics of the time and the socio-cultural tapestry that steadily fostered a dangerous public impression of the disease and those it affected. Furthermore, this phase of policymaking showcases the increasing importance of 'who' the disease affected and 'what' AIDS policy represented to policymaking in the White House and Whitehall, situating the continued absence and avoidance of the Reagan and Thatcher administrations alongside a broader appreciation of public health financing and the socio-cultural status of PWA's in the US and UK. Revisiting Morgan's notion of a 'blind spot', this discussion emphasises the continued importance of agency and circumstance as distinguishing factors in our understanding of AIDS policy.[95]

In the UK, 1983-1984 was a period of increased – albeit still limited – awareness across the British political sphere, when AIDS discourse steadily attracted political actors such as MPs and commentators at leading broadsheets like *The Guardian* and *The Observer*. When MP Gwyneth Dunwoody raised the first parliamentary question on AIDS in the UK on 11 July 1983, the UK was still somewhat of a spectator when it came to the disease.[96] Between July 1983 and May 1984, Parliament recorded only seven AIDS specific discussions and a formal House of Commons debate on the government's response would not occur until November 1986.[97] Although this increased awareness brought Britain much closer to the American experience of the disease, political engagement remained limited in the Parliamentary sphere and a subsequent lack of DHSS material suggests that the same was true of Norman Fowler's department. Nevertheless, this parliamentary engagement demonstrated the establishment of a British AIDS discourse and alluded to the centrality of blood and blood products to this upward trend and the problematic absence of the male homosexual experience during the earliest attempts to account for the disease in the policymaking sphere. Moreover, the focus on blood and blood products amongst parliamentarians coincided with media speculation on the very same issue, however, the public and parliamentary narratives never truly coalesced.

[94] Berridge, *AIDS in the UK*, p. 13.
[95] Morgan, *Reagan*, p. 241.
[96] Hansard, Written Answer (WA), 11 July 1983, v. 45 c. 275.
[97] Hansard, WA, 11 July 1983, v. 45 c. 275. Hansard, House of Lords (HL), 14 July 1983, v. 443 c. 895-896. Hansard, WA, 14 November 1983, v. 48 c. 328, Hansard, WA, 17 November 1983, v.48. Hansard, WA, 17 January 1984, v. 71 c. 222. Hansard, WA, 8 May 1984, v. 59. Hansard, WA, 14 May 1984, v. 60. Hansard, House of Commons, 21 November 1986, v. 105. c. 800-864.

Whereas those few engaged with AIDS in the Houses of Parliament maintained a narrow focus on blood safety, media speculation showcased a diversity that – whilst detrimental and sensational at times – explored AIDS beyond the confines of blood safety, Factor VIII, and haemophilia.

Although AIDS data was limited in the UK, the American experience had identified a high prevalence of the disease in bisexual and homosexual males as early as the first recording of the disease – 5 June 1981 – and subsequently in the first full epidemiological report published by the CDC in July 1982 that indicated over 70% of total AIDS cases were attributable to bisexual and homosexual males.[98] In the UK, *The Observer* reported – albeit detrimental to the perception of those affected by the disease – a 'handful' of 'Gay Disease' cases in the UK in November 1982.[99] As public discourse on AIDS became more visible, British media outlets maintained an awareness of the homosexual experience in a fashion not documented in the political sphere. In April 1983, a Daily Mail review of *A Killer in the Village* – a documentary looking at AIDS in Greenwich Village, New York City – adopted the title 'A New Plague Hits the World', documenting the programme's 'sobering … mounting sense of shock and incomprehension.'[100] *The Observer's* Robin McKie detailed the centrality of homosexuality in the article 'London Gay Plague Alert' which emphasised the damaging effect of the stigmatised rhetoric associated with the disease.[101] Article titles such as, 'Gay Plague Sets Off Panic' and 'Thousands of British Gays Have Symptoms of AIDS' were symbolic of McKie's notion of stigma whilst demonstrating an awareness of homosexuality in the public sphere that underscored the problematic sense of visibility that pervaded perceptions of AIDS in the parliamentary sphere.[102]

Following the discovery of HIV in 1984 and a universally accepted case definition, the Chief Medical Officer's annual reporting on AIDS demonstrated a high prevalence of AIDS amongst bisexual and homosexual males in the UK between 1982-1985 at 92% of total cases.[103]

---

[98] Gottlieb et al, 'Pneumocystis Pneumonia', pp. 250-252. CDC, 'Kaposi's Sarcoma, Pneumocystis Carinii Pneumonia, And Other Opportunistic Infections', p. 2.
[99] 'No Defence Against Gay Disease', *The Observer*, 6 November 1982.
[100] 'A New Plague Hits the World', *The Daily Mail,* 26 April 1983.
[101] 'London Gay Plague Alert', *The Observer,* 6 June 1983.
[102] 'Gay Plague Sets Off Panic', *The Observer*, 26 June 1983. 'Thousands of British Gays Have Symptoms of AIDS', *The Observer*, 7 August 1983.
[103] GB0809 AIDS Social History Programme/1/2, D. Acheson, *Chief Medical Officer's Annual Report: 1985* (1985), p. 41.

Although this data was constructed after the period in question, the likelihood that researchers and later policymakers had some awareness of this high prevalence was strong. Whereas parliamentarians failed to engage with the prevalence of the disease in bisexual and homosexual males, the presence of a media narrative that reinforced – and periodically challenged in the case of McKie – the negative stigma associated with the disease placed a spotlight on the importance of sexuality to the social construction of AIDS. Therefore, this discussion contextualises the development of a blood safety narrative alongside the omission of the male bisexual and homosexual experience to better understand this vital policymaking juncture and what facilitated this conceptualisation of AIDS policy in the UK.

A request for more information on the number of haemophiliac cases in the UK, Dunwoody's written answer represented the first instalment in the limited and narrowly focused parliamentary discourse on AIDS between 1983-1984.[104] In response to Dunwoody, Parliamentary Under-Secretary of State for Health and Social Services, John Patten highlighted the limited availability of data but noted that the deaths of five males had been reported, none of whom were haemophiliacs.[105] Additionally, of the seven Hansard entries related to AIDS between July 1983 and May 1984, three examined blood safety as the primary issue and another integrated blood products into a broader discussion of AIDS in the UK. These records fail to observe the male homosexual dimension of the disease to the extent that Lord Glenarthur's mention of 'promiscuous male homosexual activity' on the 14 July 1983 is the only reference available in Hansard.[106] Moreover, the absence of a Whitehall discourse during this period places greater emphasis on the available parliamentary debates as the primary – and most visible – facilitator of AIDS policy discourse in British politics. Equally, Patten's ability to articulate a response bound by – limited – data was a subtle declaration of administrative awareness. Although a comparatively low-ranking government official, Patten demonstrated an understanding of AIDS that Whitehall – or more specifically Richmond House, the departmental headquarters of the DHSS – had not yet declared, further complicating the sense of detachment accompanying the UK's unrepresentative disease discourse and absenteeism.

[104] Hansard, WA, 11 July 1983, v. 45 c. 275.
[105] Ibid.
[106] Hansard, House of Lords (HL), 14 July 1983, v. 443 c. 895.

Interest in blood safety and blood products was not isolated to politicians in Westminster. Science editors such as Andrew Veitch for *The Guardian* reported steadily on contaminated blood products throughout 1983-1984. Articles such as 'US Blood Products Face Ban in AIDS Scare'[107] and 'Body and Soul: Fowler's Blood Money' criticised the government's failure to be self-sufficient in blood products like Factor VIII, drawing a link to AIDS and the importing of contaminated blood products from the US.[108] Veitch also demonstrated a transnational awareness of AIDS in his articles, 'AIDS Takes US Path'[109] and 'US Blood Caused AIDS' that imported the US AIDS experience and the UK's problematic dependence on Factor VIII manufactured in the US.[110] Furthermore, Veitch's reporting of a Bristol man's death from AIDS[111] – believed to be from a contaminated US blood product – only two days before Edwina Currie queried the status of the blood clotting agent Factor VIII in Parliament reinforced the pre-occupation with blood products in Parliament and the issue's resonance in the public sphere.[112]

Importantly, media speculation in Britain shed light on the bisexual and homosexual male experience of the disease, emphasising a link with the disease that frequently embellished negative rhetoric such as 'Gay Plague' and sensationalising the centrality of sexuality as a method of transmission. Contextually, the harmful reporting of the relationship between homosexual males and AIDS reinforced an undercurrent of socio-cultural tension about alternative sexuality that still pervaded British society despite the liberalisation of civil rights laws in the late 1960s. A British Social Attitudes survey conducted in 1983 found that 50% of those asked believed that sexual relations between two adults of the same sex was 'always wrong' with another 12% believing it was 'mostly wrong.'[113] Only 17% thought homosexuality was 'not wrong at all.'[114] In a socio-political climate still coming to terms with homosexuality as an 'alternative lifestyle', the notion that a conservative government might appear ignorant of a disease primarily affecting Gay men was unsurprising. Likewise, the socio-cultural

[107] 'US Blood Products Face Ban in AIDS Scare', *The Guardian*, 2 May 1983.
[108] 'Body and Soul: Fowler's Blood Money', *The Guardian*, 11 May 1983.
[109] 'AIDS Takes US Path', *The Guardian*, 21 February 1984.
[110] 'US Blood Caused AIDS', *The Guardian*, 8 November 1983.
[111] Ibid.
[112] Hansard, WA, 14 November 1983, v. 48 c. 328.
[113] A. Park and R. Rhead, 'Personal Relationships' in A. Park et al (eds), *British Social Attitudes 30* (London, 2013), pp. 14-19.
[114] Ibid.

structures shaping the status of homosexuality in the US cultivated a similar fringe status that disadvantaged policy advocates, from PWAs living with the disease to those in Washington writing and supporting legislation. Whereas this coverage was problematic, Jeffrey Weeks has suggested that a paradoxical process of increased stigmatisation resulted in a 'much louder voice in society' for policy advocates.[115] Moreover, the emphasis on sexuality cultivated a detrimental sense of visibility for PWAs in the first instance, however, this visibility contributed to a more open discussion of sexual health more generally and LGBT civil rights more specifically throughout the late twentieth century despite legislation such as Section 28 threatening to regulate sexuality and civil rights.

By January 1984, Health Minister Kenneth Clarke shared data that stated only three of the 108 AIDS cases in the UK were haemophiliacs and therefore intimately linked to blood or blood products.[116] Shaped by the interplay between the parliamentary pre-occupation with blood safety and the glaring absence of homosexuality, the UK's first steps into AIDS policy proved to be problematic but seemingly dissimilar to their American counterparts. Furthermore, media coverage of the disease cultivated a problematic but nonetheless public discourse on AIDS, highlighting the centrality of the male homosexual experience alongside blood safety. The work of journalists such as Andrew Veitch contributed to the perception of misrepresentation in the parliamentary sphere, underpinning the focus on blood safety as important but disproportionally represented comparative to the epidemiological data that emphasised the impact on bisexual and homosexual males. Therefore, the establishment of a policymaking dialogue in July 1983 – albeit infrequent and limited – served as a vital step in moving Britain out of the spectator seats on AIDS policy, however, this was accompanied by the continuation of the 'business as usual' attitude that proliferated the absenteeism of the period 1981-1982. Despite scarce contributions from DHSS officials such as John Patten and Kenneth Clarke, the absence of Margaret Thatcher and her cabinet continued to accompany the comparatively low UK caseload, reinforcing a subdued – if not deficient – sense of urgency at cabinet level in the UK.

[115] J. Weeks, 'AIDS and the Regulation of Sexuality' in V. Berridge and P. Strong (eds), *AIDS and Contemporary History* (Cambridge, 1993), p. 31.
[116] Hansard, WA, 17 January 1984, v. 71 c. 222.

In the US, the period 1983-84 was primarily defined by the increasing visibility of AIDS, publicly and politically. Although the Reagan administration had faced some setbacks – notably, the failed veto of H.R. 8683 – the administrations avoidance of AIDS remained largely uncontested throughout 1981-1982, however, this dynamic changed between 1983 and 1984. Whereas some commentators anchored their criticism to perceptions of delay, a growing chorus of influential Democrats began publicly emphasising who the disease was affecting, highlighting the detrimental social construction that they believed was hindering AIDS policy advocacy. In his 1987 book, *And The Band Played On,* journalist Randy Shilts levelled similar accusations of homophobia at the Reagan administration, citing his belief that the administration's distaste for homosexuality cultivated a climate of AIDS policy neglect.[117] Therefore, this discussion examines the perception of administrative homophobia in 1980s America and the Reagan response in light of this criticism. Moreover, it will situate AIDS policy against responses to other high profile infectious diseases such as Toxic Shock Syndrome (TSS) and Legionnaires Disease (LD).

In the first instance, it is useful to explore the social construction of AIDS (or a social constructionist approach) and how this provides a vital framework for our understanding of AIDS policy during the 1980s. Detailed by Conrad and Barker in a 2010 article reviewing social constructionism, the authors articulated Berger and Luckman's 1966 definition that, 'social constructionism examines how individuals and groups contribute to producing perceived social reality and knowledge.'[118] Moreover, a 'social constructionist approach to illness is rooted in the widely recognized conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition).'[119] A concept central to Susan Sontag's acclaimed exploration of AIDS and the accompanying rhetoric of plague, it is vital to highlight the cultural and social systems that influenced policymaking and clarify the broader impact these constructs had on AIDS policy in both the US and UK.[120] Furthermore, early AIDS policymaking (defined as pre-discovery) intersected with a significant degree of uncertainty which undoubtably amplified the undercurrent of fear that proliferated the ostracization and

[117] Shilts, *And the Band Played On,* pp. xvii-xxiii.
[118] P. Berger and T. Luckman in P. Conrad and K. K. Barker, 'The Social Construction of Illness: Key Insights and Policy Implications', *Journal of Health and Social Behaviour,* 51 (S) (October 2010), p. 67.
[119] L. Eisenberg in P. Conrad and K. K. Barker, 'The Social Construction of Illness: Key Insights and Policy Implications', *Journal of Health and Social Behaviour*, 51 (S) (October 2010), p. 67.
[120] S. Sontag, *AIDS and its Metaphors* (New York 1989).

stigmatisation of People with AIDS (PWAs). Revisiting the Speakes-Konsolving exchange and the subsequent ridicule of homosexuality in the White House Press Room in October 1982, the likelihood that the social construction of AIDS influenced the socio-cultural status of the disease and associated policy was well-defined.

The growing availability of epidemiological data in 1983-1984 pointed towards the devastating prevalence of the disease amongst bisexual and homosexual males, the disease heavily prevalent in cities such as New York City and San Francisco. The BBC Horizon documentary *Killer in the Village* shed light on the impact of the new deadly disease on Greenwich Village in New York City, suggesting the disease had 'taken its greatest toll of death and of fear among vast community of gay men who walk in its shadow.'[121] By July 1982, the CDC had recorded 339 (74.4% of total cases) cases of AIDS amongst bisexual and homosexual men,[122] eighteen months later that number would rise to 2187 (76.5% of total cases).[123] Embodied in the short-lived acronym, GRID (Gay Related Immune Deficiency), the high prevalence of the disease amongst bisexual and homosexual males placed a spotlight on the intersection between the politics of sexuality in the US and the early presentation of disease. Incorporating a wider appreciation of sexual politics in America, Ted Weiss linked AIDS inactivity to the status of homosexuality in the US generally, suggesting a 'resistance to basic civil rights protection for homosexuals' pervaded US political culture and therefore, limited progress on AIDS.[124] Furthermore, a Gallup opinion poll conducted in June 1982 found that of those asked, 'Do you feel homosexuality should be considered an acceptable alternative lifestyle or not?', only 34% expressed the belief that it was an acceptable lifestyle.[125] By contrast, the Californian public rejected 'Proposition 6' which sought to ban homosexuals from teaching positions at the ballot box in 1978.[126] Much like the regional nature of disease prevalence, the disparity between Californian attitudes and the Gallup poll demonstrated the vast political and cultural network that constituted the American republic in the 1980s. Not simply a centralised system

[121] BBC Horizon, *Killer in the Village* (April 1983), [https://www.bbc.co.uk/iplayer/episode/p01z2lbp/horizon-19821983-killer-in-the-village], accessed 25 March 2024.
[122] CDC, 'Kaposi Sarcoma, Pneumocystis Carinii Pneumonia, And Other Opportunistic Infections', pp. 1-2.
[123] CDC, 'AIDS Weekly Surveillance Report', p. 1.
[124] T. Weiss, 'Acquired Immune Deficiency Syndrome', Congressional Record 129 (1983), p. 10804. (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023.
[125] 'Homosexuality', *Gallup*, 11 September 2002, [https://news.gallup.com/poll/9916/homosexuality.aspx], accessed 22 February 2024.
[126] 'Proposition 6 (The Briggs Initiative): Annotated', *JSTOR Daily,* 28 October 2022, [https://daily.jstor.org/proposition-6-the-briggs-initiative-annotated/], accessed 21 February 2024.

of governance like Thatcher's Britain, the pursuit of a national AIDS policy in America was underpinned by a complicated tapestry of diverse state and local political and socio-cultural narratives.

As detailed previously, a similar attitude towards homosexuality was documented in Britain despite a different – albeit newly established – legislative convention, reaffirming the slow pace of change associated with socio-cultural norms and their ongoing impact on new policy challenges such as AIDS. Conversely, prominent congressional representatives like Jesse Helms (REP-NC) frequently opposed AIDS-related legislation proposed on the grounds of anti-gay critique, becoming a leading member of AIDS opposition throughout the decade. Moreover, Helms' opposition was frequently accompanied by the ascendency of the religious right as a political force led by figure heads such as Jerry Falwell whose anti-gay sentiment produced literature such as the *Moral Majority Review* in July 1983 that published the headline, 'AIDS: Homosexual Disease Threatens American Families' alongside a picture of a family wearing face masks.[127] Nonetheless, *Hardwick vs. Bowers* (1986) ensured no legal changes to the status of homosexuality at the state level until *Lawrence vs. Texas* (2003) resulted in a Supreme Court verdict that made same-sex relations legal, upholding the seemingly contentious status quo around sexuality for the duration of the 1980s. Therefore, in the void between the administration's avoidance of AIDS and the need for policy developed a critique that centred on the relationship between who the disease affected and the White House's lack of intervention.

In the congressional sphere, this was increasingly acute and articulated publicly by Democrat opposition. Adopting a more inclusive and tolerant moralism than that espoused by Jerry Falwell and his Moral Majority, George Crockett (DEM-MI) spoke of a 'moral challenge' that required Americans to move towards a greater understanding of gay people.[128] Publicly critical of the federal response, Gerry Studds (DEM-MAS) asserted to the House of Representatives that 'the principal reason [for inaction] is that most AIDS victims – at least so far – have been homosexuals.'[129] Studds continued: 'it is difficult not to speculate whether Federal health

[127] "Moral Majority report", *HIV and AIDS 30 Years Ago*, [https://hivaids.omeka.net/items/show/9], accessed 16 January 2023.
[128] G. Crockett, 'Acquired Immune Deficiency Syndrome', Congressional Record 129 (1983), p. 10811. (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023.
[129] Ibid, p. 10804.

authorities might be paying greater attention if AIDS were taking a particularly heavy toll on other, more innocent, segments of our population.'[130] Likewise, Henry Waxman commented, 'had this disease afflicted children or the Chamber of Commerce [,] I'm sure the Reagan administration would have been breaking down all doors in order to push the government on all fronts to deal with it.'[131] Virginia Apuzzo told the Sub-Committee on Government Operations investigating the federal response to AIDS that she believed 'the government's slow response on AIDS is directly related to who is affected by this disease as much as what the disease is.'[132] Articulated as a belief that the Reagan administration was reluctant to address AIDS because of 'who' it affected, Apuzzo, Waxman, and Studds alluded to the importance of social construction to the Reagan response to AIDS. Moreover, the inclusion of innocence by Studds and children by Waxman underscored the notion of agency attached to infection throughout this period. Whereas these hypothetical 'victims' were evoked to demonstrate an imbalance of compassion, they acutely exhibited the perception of agency attached to the disease's social construct.[133] Likewise, Jonathan Bell has explored similar ideas of imbalance in his work on the US welfare system where the 'deserving' welfare recipient forms an integral part of our growing understanding of the intersection between participation and identity in the 'Straight State.'[134] The extension of Waxman's critique into the prioritisation of economic policy over epidemic response embedded the lack of policy response compared to the mobilisation experienced by economic policy and deregulation during the same period. The unwillingness to articulate a challenge to this problematic narrative was subsequently an expression – albeit grounded in idleness and maintained by speculation – of support for the proliferation of a misinformed social construct that negatively impacted PWAs and the communities in which they resided.

[130] Ibid, p. 10805.
[131] H. Waxman, 'Federal Response to AIDS: Hearings before a Sub-Committee of the Governments Operations', *House of Representatives*, 98:1 (1-2 August 1983), p. 81.
[132] V. Apuzzo, 'Federal Response to AIDS: Hearings before a Sub-Committee of the Governments Operations', *House of Representatives*, 98:1 (1-2 August 1983), p. 25. Original emphasis on 'who'.
[133] During the early 1980s a very limited number of cases existed in children and many 'innocent victim' narratives were directed at haemophiliacs infected through contaminated blood, however, by the middle of the decade infant cases were sadly growing which resulted in children and their 'innocence' receiving more and more attention.
[134] J. Bell, 'Rethinking the "Straight State": Welfare Politics, Health Care, and Public Policy in the Shadow of AIDS', *The Journal of American History,* 104:4 (March 2018), p. 932.

Whereas understanding the implications of the social construct is inherently valuable, this discussion now shifts towards identifying specific examples, adding more weight to the Reagan administration's avoidance of AIDS policy. On 5 July 1983, Dr Mathilde Krim, Chair of the American Foundation for AIDS Research, forwarded an anonymous, handwritten letter from a PWA to the President in the hope he might engage with the issue and sympathise with the despair amongst those affected by the disease. The response Krim received – and the accompanying drafting process – provides a vital insight into the intersection between the disease and the perception of those it affected in the White House. Moreover, the documentation of the drafting process reaffirms this discussion's pursuit of circumstance and agency in the appraisal of the Reagan response. In the letter, a young man explained that he had served in the military with distinction before describing his own experience of living with the disease.[135] He wrote, 'I get up every morning and get the newspaper, ravage through it hoping there will be mention of a cure. But there isn't … I hope you will open up your heart and overlook the prejudice in life and give those men a chance to live.'[136] Reflecting on the author's request for his letter to reach the President, Krim noted, 'I would not have paid attention to an anonymous letter if it did not concern a subject as serious as this one. It rings too true to be ignored.'[137] During the process of drafting of a reply to Dr Krim, White House staff replaced a whole paragraph from the original draft thanking the anonymous individual for their military service – referring to him as a patriot – with an opening line that adopted the term 'young American' instead of 'patriot' and ignored his military service completely.[138] Given that the only identifiable material provided by the author was his military service and that he is male, the decision to remove a paragraph recognising his military service in favour of no acknowledgement resulted in a somewhat flippant response. The removal of the author's military service – given the President's position as Commander in Chief and Reagan's favourable outlook on a strong military and foreign policy – suggested the removal of military recognition was purposeful, maintaining a sense of separation that distinguished the author's desirability as a veteran from his contentious status as a PWA. Moreover, the letter's focus on

[135] HE001 0793473, RPLM, Anonymous, 'Handwritten Letter to President Reagan', 5 April 1982, p. 1. (The document is marked April 1982, however, the accompanying documents are all marked 1983 suggesting a cataloguing error may have occurred or the letter was ignored or misplaced)
[136] Ibid.
[137] HE001 0793473, M. Krim, 'Forwarded Letter to President Reagan', 5 July 1983, p. 1.
[138] HE001 0793473, R. Woodworth, 'Revised Draft of President Reagan's Response to Dr Krim', 11 July 1983, pp. 1-2.

Dr Krim and not the author resonated with a characteristic detachment from the overarching theme of despair that accompanied the author's in-depth discussions about living with the disease.

The drafting of Krim's letter captured the administration's continued indifference to AIDS policy and the accompanying ambiguity surrounding the administration's AIDS agenda. Addressing Krim and her research commitments directly, the original draft welcomed 'counsel or criticism', the final draft welcomed the more subtle, 'comments and contributions.'[139] The defensive use of 'comments and contributions' framed a dialogue with the White House as contributory not stimulating, limiting the scope of outsiders to contest government inactivity on an issue they had little interest in discussing. In addition, the more assertive 'number one public health priority' was replaced with 'top priority' and administration changed to DHHS.[140] The deferral of policy agency to the DHHS exemplified the administration's defensiveness, attempting to reshape responsibility for AIDS by removing the White House as the agent of AIDS policy intervention. Hampered by the onward charge of the 'Reagan Revolution', the devolution of responsibility from the administration to the DHHS in the final draft indicated a desire to move AIDS away from the Oval Office. Whereas Claudine Schneider (REP-RI) suggested that 'our government has a responsibility to assist fellow Americans who face a life-and-death situation due to AIDS', no meaningful contributions emerged from the Oval Office during this period.[141] Culminating in statements such as: 'unfortunately, there is no dramatic public way to demonstrate the intensity and scope of the study and research effort which is being devoted to AIDS', the administration's lack of interest in addressing the disease was increasingly acute and imbued with a lack of urgency.[142] Overall, the exchange between Dr Matilda Krim and the White House was emblematic of the Reagan response to this point. The drafting process emphasised the importance of the disease's social construct, removing references to military service and patriotism whilst demonstrating little sympathy for the author's condition. Furthermore, the administration's suggestion that little could be done publicly to demonstrate the intensity of research resonated with the attempt to defer

[139] Ibid.
[140] Ibid.
[141] C. Schneider, 'Acquired Immune-Deficiency Syndrome', *Congressional Record 129* (1983), p. 14159. (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023.
[142] HE001 0793473, R. Reagan, 'President Reagan's Reply to Dr Krim', 5 August 1983, pp. 1-2.

responsibility to the DHHS, the White House maintaining the distance that had become synonymous with the Reagan response throughout this early period.

Maintaining his silence, the President's continued inattentiveness did little to redeem his administration's policy inactivity and the congressional opposition it attracted, however, the disease surfaced at a time of social spending retreat that significantly undermine the prospect of epidemic response. In the developing political climate of the 1980s, the status of the disease as a social policy issue made it susceptible to wider attacks on domestic spending. Where this discussion has highlighted the need to understand the circumstances and agency associated with the avoidance of AIDS policy under President Reagan and placed significant emphasis on who the disease affected, it is vital to supplement this narrative with an appreciation of what AIDS policy represented. Therefore, the intersection between resourcing and AIDS policy in a way that exacerbated the underlying issues of representation and social construction outlined throughout this chapter.

As medical science attempted to keep pace with the rising incidence rate in the US, opposition calls for more funding increased considerably in Congress. Unsurprisingly, the Reagan administration was a reluctant actor in the financing of the federal response to AIDS. In the same year the Omnibus and Reconciliation Act recouped $35.2 billion from over 200 domestic programmes, AIDS received only $12 million for research, surveillance, treatment, and care.[143] Between 1982 and 1984, the federal government spent $154.9 million on tackling AIDS through research spending, surveillance, and care (via Medicaid and Medicare).[144] Comparatively, the Reagan administration increased defence spending by an enormous 34% between 1981 and 1985, from $171 billion to $229 billion.[145] Whereas the vast discrepancy between AIDS and military spending has a clear underlying scale disparity, this difference demonstrated the Reagan's fluid use of fiscal responsibility in determining fiscal policy. Consequently, this variance in the application of fiscal responsibility sheds light on the importance of the 'what' AIDS policy represented to the Reagan administration and what it represented was a resource hungry issue with a long-term scope that would fundamentally undermine the process of retrenchment championed by his administration. Reflecting on the

[143] Morgan, *Reagan*, p. 180. Winkenwerder, 'Preliminary Results of AIDS Expenditure' p. 12 (Table 1).
[144] Ibid.
[145] This increase is measured in real 1982 dollars. J. Patterson, *Restless Giant: The United States from Watergate To Bush V. Gore* (New York 2005), p. 200.

growing seriousness of AIDS in the US and the perceived inadequacy of the government's approach to AIDS funding in May 1983, Henry Waxman noted, 'it is a disgrace that business as usual should be perpetuated by the administration's budget while the epidemic doubles in caseload every 6 months.'[146] Echoing Waxman's sentiment, the Office of Technology Assessment's (OTA) review of the initial federal response concluded that the inability to provide sustainable funding significantly hampered the federal AIDS response, cementing the perception of inadequacy in both opposition critique and federal review.[147] Although federal appropriations represented a formidable part of Reagan's social spending retreat, the administration's strategy for decreasing the federal footprint also included the enforcement of personnel ceilings. The limiting of personnel handicapped the ability of health institutions to respond to the growing crisis through research projects and large-scale epidemiological studies as no framework for AIDS currently existed. As a result, institutions were required to amend existing funding structures to make space for new AIDS projects. Furthermore, AIDS attracted a substantial amount of new funding to the extent that it might reshape entire funding plans for institutions such as the NIH and CDC. Whilst President Reagan was distant on AIDS policy, his vision of reducing federal reach permeated through his administration, manifesting in the failure to provide sustainable funding in the early fight against AIDS.

Moreover, the diverting of congressional appropriations into research and not education or care might be suggestive of a 'magic bullet optimism', however, it was likely a symptom of the intersection between circumstance and a solution. The prominence of research in the congressional appropriations alluded to a need for basic research into the disease, but the corresponding lack of education and prevention were symptoms of inadequate information and the administration's unwillingness to get ahead of the growing epidemic. In the financial years (FY) 1982-1984, the PHS spent $12.9 million on 'education and prevention' compared to the substantially higher $84.4 million on AIDS research.[148] The reduction in funding for education and prevention by $2.6 million in FY1984 presented another example of budgetary restriction in the US, however, the continued rise in aggregate spending associated with

[146] H. Waxman, 'Amendment Offered by Mr Natcher', *Congressional Record* 129 (1983), p. 13960. (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023.
[147] Office of Technology Assessment, *Review of the Public Health Service Response to AIDS*, (February 1985), p. 6-8.
[148] Winkenwerder, 'Preliminary Results of AIDS Expenditure', p. 12 (Table 1).

spiralling research costs maintained the sense of momentum desired by policy advocates in Congress. Nevertheless, the absence of a federal dialogue on infection prevention placed greater emphasis on the pursuit of research as grounded in an optimistic belief a forthcoming solution could resolve the epidemic.

Importantly, the unsustainability of federal resourcing reinforced the approach Reagan had adopted to social spending. However, exploring the issue of disease funding more broadly sheds light on the important intersection between the 'who' and the 'what' of AIDS policymaking. Although the absence of knowledge fundamentally undermined any attempt to develop a nationwide education or prevention campaign prior to the advent of large-scale testing, the lack of available funds to promote awareness of a disease primarily killing a sexual minority was problematic, nonetheless. By April 1983, Democrats such as Patrick Moynihan (DEM-NY), Ted Weiss (DEM-NY) and Henry Waxman (DEM-CAL) had all voiced their growing concern about the disease and the inactivity of government. Ted Weiss criticised the 'alarmingly slow' response of government, highlighting the disease's high mortality rates when compared to other recent health crises such as Legionnaire's Disease (LD) and Toxic Shock Syndrome (TSS).[149] Likewise, Mike Lowry (DEM-CAL) and Gary Ackerman (DEM-NY) raised LD and TSS in a similarly comparative light, the responses to both diseases being thrust into the AIDS spotlight as evidence of the federal government's capacity to respond to new health issues. In their 1989 article, *AIDS in the US: Patient Care and Politics,* Ron and Rogers documented that during the years 1981-1982, the National Institute of Health (NIH) spent $36,100 for each death from TSS and $34,841 for each death from LD; in comparison, each AIDS death in 1982 received a meagre $8,991.[150] Although a wider context influences these numbers – disease timelines, existing disease knowledge, expenditure on policy intervention and much more – the aggregate spending per case grounded the frustrations of Weiss, Ackerman and Lowry in some semblance of reality. Moreover, Hajjeh et al noted in a 1999

[149] T. Weiss (NY), 'The AIDS Epidemic', *Congressional Record* 129 (1983), p. 9372. (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023. Legionnaires Disease is a serious pneumonia that first surfaced at the Philadelphia Convention of the American Legion in 1976 and is caused by the development of the waterborne bacteria Legionella. 'Legionella (Legionnaires Disease and Pontiac Fever)', Centres for Disease Control and Prevention, [https://www.cdc.gov/legionella/about/history.html], accessed 12 January 2023. First categorised between 1979-1980, Toxic Shock Syndrome primarily affected menstruating women and has since been linked to inadequate tampon manufacturing. A. A. Reingold et al, 'Toxic Shock Syndrome – United States', *Morbidity and Mortality Weekly Report,* 46 (June 1997), pp. 492-496.
[150] A. Ron and D. E. Rogers, "AIDS in the United States: Patient Care and Politics", *Daedalus* 118, No 2 Living With AIDS, (Spring 1989), p. 47.

study that TSS had infected 2,835 Americans (92% women) with a fatality rate of 3.5% between 1981-1986.[151] By December 1983, only eighteen months since the first recorded case of AIDS in the US, the CDC had reported 3064 cases of AIDS with a mortality rate of 42%.[152] Despite a higher caseload and mortality rate, AIDS failed to achieve the sense of urgency other recent health crises had, further substantiating opposition critiques of federal inactivity and the centrality of who the disease affected. A recurrent manifestation in the opposition critique, the comparison of LD and TSS with AIDS showcased more than a tangible disparity in aggregate indicators such as spending and caseload, it clarified the centrality of what Virginia Apuzzo, Executive Director of the National Gay Task Force called the 'who' of the AIDS Crisis.[153]

As demonstrated by the visible interplay between the disease's social construction and the preconceived ideals of fiscally responsible governance, the period 1983-1984 served to better explain the motivations and circumstances informing the administrative absence and avoidance that had characterised the period 1981-1984. In both the US and UK, the inattentiveness of government leadership ensured that AIDS remained an issue outside the popular mandate of tax cuts, deregulation and privatisation, the circumstances that shaped Reagan and Thatcher's inattentiveness differed, both remained firmly outside the policy spotlight for the duration of the initial phase. Illuminated by a growing awareness of the disease's social construction, congressional opposition attributed the lack of policy development to the Reagan administration's unwillingness to engage with communities whose socio-cultural status was contentious. Likewise, the absence of bisexual and homosexual males from the policymaking narrative contrasted the engagement of the media in Britain who against a backdrop of concern for blood products in Parliament raised questions about the nature of this poor visibility and the associated linkage with the social construction of the disease. Although the UK and US narratives showcased the importance of caseload in cultivating a sense of urgency amongst policymakers, the centrality of sexuality in both nations highlighted the extent to which the 'who' of the AIDS Crisis played a vital role in shaping the lack of policy intervention. Moreover, the culmination of sexuality and fiscal responsibility in

[151] R. A. Hajjeh et al, 'Toxic Shock Syndrome in the United States: Surveillance Update, 1979-1996', *Emerging Infectious Disease*, 5:6 (December 1999), p. 808.
[152] CDC, 'AIDS: Weekly Surveillance Report', p. 1.
[153] Apuzzo, 'Federal Responses to AIDS', p. 25.

the US showcased the paradoxical relationship between New Right principles and epidemic response to a disease primarily affecting minority communities.

Conclusion

In a May 1983 press release, Assistant Secretary of Health, Dr Edward Brandt told the American public 'I want to stress that I feel a sense of great urgency about AIDS … the American people [need] to be given timely, accurate information so they will be neither unduly frightened or overly complacent.'[154] By April 1984, on the eve of HIV's discovery, Brandt's call for action, education and awareness remained a distant policy prospect. Whereas this chapter has primarily advanced the importance of policy agency and circumstance, what underpinned the importance of these issues was the continuation of inactivity in both the US and UK. Characterised by the continuation of budgetary warfare between the White House and Congress, the incompatibility of epidemic response and Reagan's relentless drive for fiscal responsibility in federal government laid the foundation for a decade of paradoxical interplay between AIDS and Reaganism. Moreover, the underlying complications attached to the social construction of AIDS made policymaking a tempestuous prospect for many apprehensive about the fringe status of PWAs, underpinning an opposition commentary on the dynamics shaping the desirability of those the disease affected most intimately.

In the UK, the comparatively low caseload ensured that British parliamentarians lagged substantially behind their US counterparts in both urgency and awareness. Establishing a parliamentary discourse in July 1983, the absenteeism that characterised the British response reflected a wider indifference in the UK generally. Importantly, British AIDS discourse communicated a similar importance around who AIDS affected and the need to incorporate the social construction of the disease into the examination of the policymaking process and those participating in policy development. The failure to observe the centrality of the homosexual experience to AIDS in the UK was a problematic undercurrent that highlighted

[154] HE001 133599, RPLM, E. N. Brandt Jr, 'Statement by Edward N Brandt Jr, MD. Assistant Secretary of Health', 24 May 1983, p. 5.

the contentious status of alternative sexuality in Britain, seemingly aligning the US and UK on the perception of alternative lifestyles in an age of conservative ascendency. Moreover, this discussion has grounded the increasingly public opposition critique in comparisons with Legionnaires Disease and Toxic Shock Syndrome, highlighting the importance of 'who' the disease affected to AIDS policymaking. Furthermore, it has examined notions of inactivity in early literature and pursued a critique that has emphasised the agency afforded government actors whose decisions – or indecision – shaped varying degrees of neglect and inactivity in the US and UK.

When the Secretary of Health and Human Services, Margaret Heckler, stepped up to the lectern in the early afternoon of Monday 23 April 1984 accompanied by Research Scientist Dr Robert Gallo and informed reporters that Gallo had identified HIV as the cause of the AIDS virus, the magic bullet optimism of the Reagan administration appeared justified.[155] Likely a symptom of Gallo's discovery and an unwavering belief in the power of science, Heckler publicly endorsed a two-year timeline for an AIDS vaccine.[156] As the initial phase of policymaking ended with the discovery of HIV in May 1984, the prospect of a rapid response to the new deadly disease had materialised. Although the disparity in caseload was substantial, the comparable levels of inattentiveness placed the Reagan and Thatcher administrations on a similar footing as the next phase of policymaking approached. The absence and avoidance of the previous three and a half years had laid the foundations of opposition critique in the US and a complicated ambivalence in the UK. Transitioning into a post-discovery phase of policymaking, the ability of the Reagan and Thatcher administrations to tackle the paradoxical relationship between ideology and epidemic response and move beyond the legacy of absence and avoidance played a vital role in defining the first decade of AIDS.

[155] 'Press Conference: Margaret Heckler', *John Cohen AIDS Research Collection,* 23 April 1983*,* [https://quod.lib.umich.edu/c/cohenaids/5571095.0256.002/?view=toc], accessed 27 March 2024.
[156] Ibid.

Chapter Two

The Post-Discovery Period:

May 1984 – December 1985

Introduction

In May 1984, optimism about the future of AIDS policy reached a height to which it would not return for some time. Buoyed by the potential for new scientific enquiry following the discovery of HIV by French virologist Dr Luc Montagnier and American biomedical researcher Dr Robert Gallo, the prospect of a 'solution' seemed closer than ever.[157] Although this optimism proved to be misplaced, it still encouraged a groundswell around the science of epidemic response. Whereas the preceding period of policymaking was shaped by the administrative absence and avoidance of the Thatcher and Reagan administrations, the period May 1984 to December 1985 entailed varying degrees of policy mobilisation and intervention. Where Virginia Berridge and Jennifer Brier have provided analysis, scholarship of AIDS policy during this period has been limited on both sides of the Atlantic compared to scholarship dedicated to 1986 onwards.[158] This chapter posits that the period immediately following the discovery of HIV was transitional and that we must conceptualise it as occupying a unique space between the 'groping in the dark' that preceded it and the apparent mobilisation of 1986 onwards.

In the first instance this chapter explores the priority afforded AIDS policy on both sides of the Atlantic. As the escalating health crisis attracted growing political attention in the public sphere – such as media engagement, congressional discussion, and Parliamentary debate – the intersection between rhetoric and action in determining policy status became more acute. In the US, arms of the Public Health Service (PHS) like the Centres for Disease Control (CDC)

[157] 'Press Conference: Margaret Heckler', *John Cohen AIDS Research Collection,* 23 April 1983.
[158] V. Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford, 1996), pp. 13-78. J. Brier, *Infectious Ideas: U.S. Political Responses to the AIDS Crisis* (Chapel Hill, 2009), pp. 78-88.

continued messaging that emphasised the importance of AIDS, however, the Reagan administration failed to match such rhetoric with action. Responding to this intersection between action and rhetoric, this chapter explores the role of social spending retreat and neoconservative governance generally in the depreciation of AIDS policy status under President Reagan during a time of growing visibility. By contrast, the willingness of UK policymakers to cultivate a specific AIDS policy network demonstrated a response to the disease grounded in a need for action. Whereas US policy actors from the PHS appeared disassociated from the federal mandate of White House officials, British policymakers from the Department of Health and Social Services (DHSS) appeared to act on a shared vision of interdepartmental cooperation. Moreover, the centralised British system favourably addressed the need for cooperation on a national level by encouraging a nationwide perspective that likely suppressed regional issue but upheld a pursuit of a British AIDS policy. By contrast, American federalism attributed responsibility for the delivery of public health to state and local governments which complicated expressions of 'national priority' exercised by public health officials concerned with federal jurisdiction and not the politics of a state with few AIDS cases. Primarily exploring executive leadership and policy priority in the post-discovery period, this chapter outlines the development of alternative policymaking networks for AIDS policy in the US and UK and the growing importance of internal and external opposition to the cultivation of effective – and often ineffective – epidemic response.

Furthermore, a central theme in this chapter's contribution is funding and the growing significance resourcing had in the developing discourse surrounding AIDS in the US and UK following the discovery of HIV. As described by Greenaway et al, the most influential resource in the development of AIDS policy was money and whilst the role of government was not 'purely financial' the allocation of public funds significantly impacted the prevailing wind of policy development.[159] In addition, Desmond King has emphasised the growing significance of funds centrally appropriated by a 'New Right' government whose tight fisted control of the government spending attributes greater weight to the pounds and dollars spent.[160] Furthermore, this was increasingly true of the retrenchment of social spending in Washington and the pursuit of budget balancing in Whitehall. This discussion will explore the importance

[159] Greenaway et al, *Deciding Factors in British Politics: A Case-Studies Approach* (1992), p. 72.
[160] D. King, *The New Right: Politics, Markets and Citizenship* (Basingstoke 1987), p. 120.

of funding to the development of AIDS policy during the earliest stages of policy mobilisation, chronicling the similarities and differences between the two administrative attitudes towards funding. Moreover, it will explore opposition critiques of inadequacy and shed light on the willingness of key policymakers to reconcile the ideological contradictions inherent in attempting to construct a fiscally responsible epidemic response.

Therefore, this chapter cites the intersection between funding, priority, and opposition as prime drivers in the development of AIDS policy in the period immediately following the discovery of HIV. Where Virginia Berridge has stressed the victory of a liberal consensus in the UK, this chapter asserts that we benefit from situating this victory alongside the developing executive-legislative battle on Capitol Hill to contextualise the cultivation of AIDS policy in a climate of neoconservative ascendency.[161] Whereas scholarship specifically concerned with this brief period is limited in both the US and UK, this chapter highlights the unique historiographical position of this period, a stage foregrounding the debates around mobilisation, response and agency that have defined the more actively discussed aspects of AIDS in the US and UK.

Public Health, Priority, and Policy

Operating in a climate shaped by rising infection rates and newly acquired scientific knowledge, the question of priority and executive action shifted into the policy spotlight with greater acuity. Whereas previous iterations of AIDS policy had been heavily informed by the climate of absence and avoidance in the UK and US, the post-discovery period provided a valuable shift in information and visibility that altered the fundamental dynamic of AIDS policymaking. In the first instance, this discussion will construct an awareness of the British and American AIDS policymaking climates following the discovery of HIV, highlighting the importance of opposition critique to the growing visibility of AIDS in both Westminster and Washington. In addition, it will highlight the emergence of divergent policymaking trends in the UK where the policymaking discourse sought to reflect on the perceived failing of the American response since 1981. Developing an infrastructure and network specifically

[161] Berridge, *AIDS in the UK*, p. 55.

designated for AIDS policy, the British response demonstrated an appreciation for effective decision-making and policy leadership that was innovative in the context of the US-UK narrative. Expressed through an interconnected hybrid system built on expert input through the Expert Advisory Group on AIDS (EAGA), led by Chief Medical Officer Donald Acheson combined with policy units such as H-Committee led by Secretary of Health and Social Services Norman Fowler, the British response became increasingly formalised when compared to the American response which appeared to stagnate despite growing critique from state representatives in California and New York and officials in the PHS.

Although issues of priority and policy status had plagued policymakers throughout the initial period (June 1981 to May 1984), those intimately associated with AIDS policy in the post-discovery period appeared more proactive in their renewal of priority. In June 1984, Dr Richard Krause, Director of the National Institute of Allergy and Infectious Diseases (NIAID) sent a letter to the Ambassador of Zaire highlighting the potential for new AIDS research with a particular focus on the different risk factors that characterised the Zaire AIDS experience such as widespread heterosexual transmission and equal gender distribution. Reporting on the importance of AIDS policy in the US Krause outlined that 'AIDS is currently the nation's most urgent public health problem and the USPHS reports regularly to the Executive Branch and Congress on research activities and advances.'[162] Intersecting with his pursuit of international cooperation and cosmopolitan research, the endorsement Krause offered AIDS policy had more urgency than those offered by White House spokesman Larry Speakes months earlier.[163] An early indication of the often fragmented relationship between politics and medicine, Krause's appraisal of policy status demonstrated an acutely medical perspective on the infection's potential for devastation and contrasted the precedent of inactivity set by the administration. The issuing of high priority by authoritative public health officials such as Krause resonated deeply with the growing mobilisation of frustrated opposition in Congress.

Despite enthusiastic endorsement from administrators like Krause who operated within the federal government's health and medicine apparatus, the contradiction between the Reagan

[162] Document 6 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', *Office of the Historian*, (Bureau of Public Affairs, November 2017), p. 14.
[163] Although Krause coupled his expression of policy importance with a desire for international cooperation, the perception that the US merely wanted to use Zaire as an 'AIDS Laboratory' presented a substantial barrier to Krause's cosmopolitan research aims.

administration's goals for federal retrenchment and the scaling of an epidemic response were increasingly apparent. A valuable example of this problematic intersection came in President Reagan's 1985 State of the Union Address. Reagan's 1985 address highlighted the broader implications of AIDS policy and the administration's top priorities. In stark contrast to the political traditions of the New Deal and the Great Society, the social spending retreat of Reagan's first term situated health, social and welfare policy – and consequently AIDS policy – firmly outside of Reagan's vision for America. Reviewing a period in which 3,665 people had died of AIDS, the President failed to mention the disease and primarily tackled issues of economic recovery and Cold War politics.[164] Emblematic of an agenda built on tax reform, military expenditure, and domestic spending retreat, Reagan's 1985 State of the Union Address emphasised the detachment of the President's vision for America and the messaging on AIDS espoused by public health officials like Krause. Furthermore, Secretary of State for Health and Human Services Margaret Heckler told a *Frontline* interview in 2006 that her priorities for her department and AIDS conflicted and that both the disease and fiscal integrity were both high priorities for the nation during her stewardship of the DHHS between 1983 and 1985.[165] In a climate of social spending retreat, the disconnect between the broader White House agenda and public health administrators such as Krause – and to an extent Heckler – undercut promises of status delivered by both sides throughout this transitional period.

By contrast, the State Department's concern for the health and safety of employees deployed overseas in countries with high rates of HIV/AIDS demonstrated a proactiveness distinct from those operating within the confines of domestic politics. Albeit in a foreign policy setting largely shaped by the specific circumstances facing State Department employees, the Department facilitated overseas AIDS research projects and disseminated education material to federal employees in a similar fashion to the distribution of safety guidelines to health care

[164] CDC, 'Acquired Autoimmune Deficiency (AIDS) Weekly Surveillance Report United States', 31 December 1984, p. 1. R. Reagan, 'Address for a Joint Session of Congress on the State of the Union', 25 January 1985, *The American Presidency Project,* [https://www.presidency.ucsb.edu/documents/address-before-joint-session-the-congress-the-state-the-union-4], accessed 14 July 2021.
[165] 'Interview with Margaret Heckler', *PBS: Frontline,* 11 January 2006, [https://www.pbs.org/wgbh/pages/frontline/aids/interviews/heckler.html], accessed 5 October 2023.

professionals in the medical sector.[166] Central to this internal dialogue was the growing concern about the progression of heterosexual transmission in Africa. A letter recorded by the State Department from Dr Richard Krause on 14 June 1984 referenced a 1983 research project that studied 38 Zairian AIDS cases that showed a ratio of 1:1 male to female gender representation. The project's findings published in *The Lancet* in July 1984 – identified 'frequent heterosexual contact further [implicating] heterosexual transmission.'[167] The State Department's concern with the pace of change in Africa was unsurprising, not only did the disease behave differently – in an epidemiological sense – but many employees operated in the African region making the spread of disease an understandable source of anxiety.

In February 1985 a *Los Angeles Times* article documented Dr Jonathan Mann's concerns that the Zairian epidemic was behaving differently to the US epidemic, citing comparatively low numbers of homosexual cases and high numbers of cases amongst women.[168] Prompted by an increasing concern for the health and safety of overseas employees operating in areas with high rates of HIV/AIDS the State Department distributed the document, *AIDS: The Facts* to 'all Department of State health beneficiaries in their regions. Administrative notices and post newsletters should be used to disseminate this information as quickly as possible.'[169] The education leaflet engaged with the disease as a heterosexual issue, expressing an underlying concern regarding the sexual activity of federal employees deployed in areas with high infection rates. The document continued, 'There is increasing evidence that heterosexual transmission is an important means of spread with obvious implications concerning prostitution.'[170] Motivated by the increasing visibility of heterosexual transmission and operating in an environment seemingly detached from the constraints of the domestic AIDS agenda, the State Department emerged as a voice of concern that attempted to cultivate

[166] A similar approach was adopted in early 1985 by the Expert Advisory Group on AIDS (EAGA) who sent letters and information pamphlets to doctors, nurses and other health care practitioners emphasising diagnosis and infection control.
[167] P. Piot et al, 'acquired immunodeficiency syndrome in a Heterosexual Population in Zaire', *The Lancet,* 324:8394 (July 1984), p. 65.
[168] Dr Mann was an American Doctor who was working on a joint research project in Zaire. The US-Zaire-Belgian SIDA project was an AIDS research project that aimed to study the disease in Africa and was headquartered in Kinshasa, Zaire (Now Democratic Republic of Congo). 'Sharp Difference Between Victims There and in the US. Study Hopes to Uncover Why Zaire Leads Africa in AIDS Cases', *The Los Angeles Times,* 22 February 1985.
[169] Document 7 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI Global Issues II', *Office of the Historian*, (Bureau of Public Affairs, November 2017), p. 18.
[170] Ibid, p. 21.

awareness and knowledge amongst those carrying out the Department's remit. Instructed by the State Department to discuss the disease with all new arrivals, the linkage between sex work and heterosexual transmission clarified the department's unique pursuit of awareness and education in a foreign policy context. Though sex work carried greater risk of transmission due to the probability and frequency of multiple sexual partners, the expressed concern about the relationship between heterosexual transmission and the danger posed by prostitution cemented AIDS as a heterosexual issue for the State Department. Moreover, the heterosexual and gender-balanced nature of the Zaire epidemic undermined any notion of a framework that reflected the US experience of the disease. However, the focus on prostitution – and the associated behaviour of employees – somewhat centred the State Department's interaction with the disease around fringe or contentious groups, like the risk group framework adopted domestically.

Largely shielded from the scrutiny of the US media and distanced from the tensions of domestic politics the organisation could exercise greater political and administrative freedom than most when attending to AIDS. Moreover, the Department promoted education and awareness in terms of risk assessment. Informed to a lesser degree by political allegiance, the Regional Medical Officers (RMOs) charged with the dissemination of AIDS information acted as part of a commitment to the health of federal employees serving the employees' interest more acutely. Although firmly situated within the Reagan administration, the State Department's AIDS policy demonstrated a disassociation with the Reagan agenda that aligned RMOs much closer to the PHS and the CDC than with the politics of the Oval Office. Whilst the State Department's pursuit of AIDS was distinct from the domestic response, we might ask why the State Department's application of knowledge failed to assimilate with the domestic response. Whereas the epidemiological presentation of AIDS in certain contexts varied – as demonstrated in Zaire – the development and application of knowledge by the State Department was largely independent of context. The specific discussion of prostitution by the Department was an anomaly – compared to the homosexual orientated discourse observed in the US and UK – in an otherwise well-informed and widely accepted discussion on transmission and individual safety that centred around risk-taking behaviours like unprotected sex, multiple sexual partners and intravenous drug use. Attributing this disparity to the Department's foreign policy remit alone, however, might be tenuous. Whilst Schultz had

greater control over what his department disseminated, the absence of this material – informed by the medico-scientific consensus – from the domestic approach was likely a casualty of the Reagan administration's inattentiveness on the issue. Whereas employees of the State Department placed in areas with high rates of infection likely benefited from a risk assessment framework that identified AIDS as cause for concern, a similar unease for the general population or risk groups failed to materialise domestically. Consequently, the Department's mandated dissemination of information through RMOs demonstrated a different approach to those concerned with AIDS in the US, all the while showcasing the ability to realise AIDS policy through education and awareness. Moreover, this response emphasised the disparity between the Reagan administration's articulation of priority and status and the actual policy response.

In the UK, the policymaking sphere continued to foster the limited AIDS discourse that had developed during the initial years of the epidemic, steadily cultivating a newfound visibility for the disease. Between July 1984 and December 1985, Parliament recorded fifteen written answers, and three House of Commons and four House of Lords debates related to AIDS. Like the preceding period, the driving force behind this parliamentary engagement was blood products and blood safety.[171] Although brief discussions engaged with funding for AIDS research and a search for a cure or vaccine, between May and December 1984, five of the eight written answers submitted queried blood-related issues. Moreover, speculative newspaper commentary underpinned a continued preoccupation with blood safety in the general population; for example, articles like 'Gays Run Blood Risk' from *The Guardian* in November 1984 were symptomatic of the UK's problematic blood focused narrative.[172] Responding to a question on blood safety through a written answer in December 1984, Minister of Health Kenneth Clarke outlined the government's emphasis on 'strengthening our

[171] Hansard, WA, 23 November 1984, v. 68. Hansard, WA, 26 November 1984, v. 68. Hansard, WA, 28 November 1984, v. 68. (AIDS: Blood Donors). Hansard, WA, 28 November 1984, v. 68. (AIDS: Scotland). Hansard, WA, 28 November 1984, v. 68. c. 486. (AIDS: Wales). Hansard, WA, 4 December 1984, v. 69. c. 161. Hansard, WA, 11 December 1984, v. 69. c. 471. (AIDS). Hansard, WA, 11 December 1984, v. 69. (AIDS: Research). Hansard, WA, 8 February 1985, v. 72. c. 708. Hansard, House of Commons (HC), 11 February 1985, v. 73 c. 14. Hansard, HL, 13 February 1985, v. 460 c. 181-184. Hansard, WA, 14 February 1985, v. 73. Hansard, WA, 15 February 1985, v. 73. Hansard, WA, 18 February 1985, v. 73. Hansard, HC, 12 March 1985, v. 75 c. 141. Hansard, HL, 18 March 1985, v. 461 c. 359-387. Hansard, HC, 16 April 1985, v. 77 c. 121. Hansard, HL, 24 July 1985, v. 466 c. 1200-1202. Hansard, HL, 23 October 1985, v. 467 c. 1085-1088. Hansard, WA, 24 October 1985, v. 84. Hansard, WA, 9 December 1985, v. 88. Hansard, WA, 16 December 1985, v. 89.

[172] 'Four Infected by AIDS Blood', *The Guardian,* 20 November 1984.

efforts to dissuade people from donating blood if they are at high risk of transmitting [the] AIDS virus.'[173] Although Clarke was not directly responsible for blood products during this period – in a 2021 statement to the Infected Blood Enquiry, Lord Glenarthur (Parliamentary Under-Secretary of State for Health in the House of Lords between June 1983 and March 1985) confirmed his responsibility for blood products – his statement and the associated steps to protect the blood supply represented an important, albeit limited, break from the inactivity of the preceding years.[174] The US response to blood related issues appeared more professional and grounded in a more technical debate about blood safety that engaged private organisations which collected blood and plasma for the manufacture of blood products and the arms of the federal government responsible for regulation. Leveton et al have suggested that whilst 'government and private agencies identified, considered, and in some cases adopted strategies' for risk mitigation, these safety measures were limited in scope and reflected a lack of consensus about the nature and magnitude of the problem.[175]

Despite the apparent rising tide of engagement in Parliament, critique of the government response was ever-present. Speaking to the House of Commons in February, Conservative MP Sir Raymond Gower placed the spotlight on the spread of AIDS in the US and Australia before asking if the government had shown 'far too much complacency about the matter in this country.'[176] Informed by a perception of escalation and inadequacy in the US, Gower's assertion that the British government had been complacent appeared grounded in the potential similarity of the British, American and Australian experiences of the disease. Conversely, Gower's critique foreshadowed a transnational awareness of the US response that fundamentally shaped the British relationship with the disease and the response it produced. Although critical of the government response, Gower's comments embraced both the delays in government action and the potential for 'complacency' to cause widespread devastation in the UK. In response to Gower, Parliamentary Under-Secretary for Wales Wyn Roberts rejected the allegations of complacency, articulating a concern for both the gravity of the situation and

[173] Hansard, House of Commons (HC), 4 December 1984, v. 69 c. 161.
[174] 'Written Statement of Lord Glenarthur', *Infected Blood Inquiry*, 9 July 2021, [https://www.infectedbloodinquiry.org.uk/evidence/written-statement-lord-simon-glenarthur], accessed 1 March 2024.
[175] L. B. Leveton et al, *HIV and the Blood Supply: An Analysis of Crisis Decisionmaking* (Washington 1995), pp. 73-74.
[176] Hansard, HC, 11 February 1985, v.73 c. 14.

the need to avoid 'unnecessary panic.'[177] Underpinning the complacency central to Gower's critique, the incompatibility of a heightened concern about AIDS and a corresponding agenda of inactivity grounded in anxiety management appeared problematic.

Whereas previous iterations of AIDS discourse had achieved little of substance, the trajectory of disease response in the UK appeared to change. In February 1985, the Blood Transfusion Service (BTS) distributed a new pamphlet, *AIDS: Important New Advice for Blood Donors* which highlighted risk-taking behaviours such as using contaminated needles and unprotected sex with multiple partners, advising individuals engaging in those behaviours to refrain from donating blood.[178] An important contribution to the growing discourse on AIDS in the UK, the BTS pamphlet represented an early effort to disseminate information to the general public on the behaviours that – at the time of publication – were understood as core components of the British experience of the disease. Moreover, the intersection between blood safety, the general population and the 'innocent victim' constructed a justifiable policy stance that allowed for a measured engagement with the more contentious dimensions of the disease dialogue, such as intravenous drug use and transmission amongst male homosexuals. Nevertheless, the pamphlet highlighted the absence of policy aimed at those most intimately affected by the disease: male homosexuals and intravenous drug users. Whereas the need to protect the blood supply was fundamentally important, the need to adequately address the centrality of male homosexuals and IVDUs as well as the broad spectrum of issues associated with the disease came into focus. Speaking to the House of Commons on 20th February, Clarke outlined the continued expansion of the government's fledgling disease response. Alongside the BTS pamphlet that was now in distribution, the Health Minister spoke of expert input from the Advisory Committee on Dangerous Pathogens (ACDP) to develop guidelines to protect health care professionals, the production of information leaflets to promote awareness amongst risk groups such as male homosexuals and intravenous drug users, and the testing of screening kits for individual use and blood products that included heat treatment trials.[179] Clarke's activity in the House of Commons between December 1984 and February 1985 demonstrated the mobilisation of key policymakers in the British government, the prospect of an expanding government response reinforced an emerging sense of priority and status.

[177] Ibid.
[178] The National Archive (TNA), PREM19-1863, 'AIDS: Important New Advice for Blood Donors', (1985).
[179] Hansard, HC, 20 February 1985, v. 73 c. 499-500.

Although Clarke's authority as a senior minister was important, his early prominence emphasised the ongoing absence of cabinet ministers such as Norman Fowler.[180] Whereas British policymakers had upheld their narrow focus on blood-related AIDS issues and subsequent policy provided a poor prospect for those most intimately affected by the disease, Clarke's Commons appearances in early 1985 demonstrated a policy mobilisation more representative of who the disease primarily affected.

In February 1985, the establishment of the Expert Advisory Group on AIDS (EAGA) by the Chief Medical Officer Donald Acheson was a vital turning point for British AIDS policy. Constituted of 'experts on all aspects of the disease', the group produced and sponsored several important publications such as the Chief Medical Officer's *General Information for Doctors* which was distributed across the UK in May 1985.[181] The letter raised awareness of the risk groups, clinical presentation, and diagnosis of the disease, providing guidance on controlling the spread of AIDS to health care practitioners operating throughout the NHS and private sector. Acheson highlighted the relevant sections of the Public Health (Control of Disease) Act 1984 for practitioners in 'rare and very exceptional cases' that legal or police intervention was necessary to prevent harmful behaviour.[182] Although the catalyst for the EAGA's creation was less clear, Acheson's role in pushing for the group's establishment was noticeable, building on the Medical Research Council's (MRC) existing AIDS Working Group which at the time was the 'main source of information concerning European and World Health Organisation AIDS research initiatives.'[183] Through the advisory support provided by the EAGA, British AIDS discourse appeared more focused and driven towards policy development, prioritising the distribution of information via outputs such as the Chief Nursing Officer's letter to nurses sent in July 1985 discussing infection control and care for HIV patients based on EAGA member Elizabeth Jenner's work on the disease at St Mary's Hospital, London.[184] Moreover, the EAGA

[180] Ibid.
[181] Hansard, HC, 20 February 1985, v. 73 c. 498.
[182] GB0809 AIDS Social History Programme/1, London School of Hygiene and Tropical Medicine (LSHTM) AIDS Social History Programmes Collection, Department of Health and Social Services, 'General Information for Doctors', 15 May 1985, p. 11.
[183] 'INQY0000362 – Presentation Note: Infected Blood Inquiry: Role of the Chief Medical Officer', *Infected Blood Inquiry,* 1 July 2022, [https://www.infectedbloodinquiry.org.uk/evidence/inqy0000362-presentation-note-infected-blood-inquiry-role-chief-medical-officer-01-jul], accessed 27 March 2024, p. 9.
[184] 'DHSC0002323 - Draft Submission to PS (H) AIDS: Health Education and Prevention', *Infected Blood Inquiry,* 15 May 1985, [https://www.infectedbloodinquiry.org.uk/evidence/dhsc0002323113-draft-submission-aids-health-education-and-prevention-15-may-1985], accessed 27 March 2024, p. 2.

and DHSS supported the publication of *Some Facts About AIDS* (1985) and the revision of the Blood Transfusion Service information leaflet *AIDS: Important New Advice for Blood Donors* (1985), which targeted basic information and awareness at the general population.[185] The publications emphasised individual risk factors such as sexual behaviour, drug use and blood donation and what people should do if they suspect they might be infected. Minister for Health Barney Hayhoe lauded the success of the EAGA later that year stating, 'the introduction of all of these measures in such a short time has been made possible by the setting up of an advisory group on AIDS (EAGA).'[186] Importantly, however, the EAGA was not a parliamentary body and the ongoing absence of any major legislative or political leadership to tackle the growing epidemic remained a prominent similarity between the US and UK.

In August 1985, the protracted absence of British Prime Minister Margaret Thatcher was subtly ended as she was formally included in AIDS policy discussions for the first time. A two-page letter sent from the Parliamentary Under Secretary of State for Health summarised the UK response to date, offering the Prime Minister some brief details about the status of the epidemic in Britain and the US. The briefing-style letter received by Thatcher was symptomatic of her approach to AIDS thus far, simplified and comparatively late it affirmed the consequences of her distance and inattentiveness during the preceding period. Writing to the PM in September 1985, Norman Fowler outlined that 'the AIDS infection represents one of the most serious public health hazards faced by this country for many decades. With the help of our Expert Advisory Group on AIDS a range of measures has been taken to control the spread of infection … Further action is in the pipeline.'[187] Fowler's account to the PM balanced the increasing severity of the disease with endorsements of future policy activity and praise for the EAGA.[188] Nevertheless, Fowler's opening line: 'in view of the renewed interest in the media recently, you may wish to be aware of the current state of play on AIDS' highlighted the PM's distance from AIDS policy and subsequent policy ignorance. [189] Covered with the underlining of Private Secretary Mark Addison, the attached 'Measures Taken' in 'Annex A' indicated Thatcher's limited engagement, the Prime Minister's need for basic briefing papers

[185] TNA, PREM19-1863, 'Some Facts About AIDS', (1985).
[186] TNA, PREM19-1863, 'The Fight Against AIDS – More Government Money', 25 September 1985.
[187] TNA, PREM19-1863, 'Acquired Immune Deficiency Syndrome (AIDS)', 25 September 1985.
[188] Ibid.
[189] TNA, PREM19-1863, 'Letter from Lord Patten to the Office of the Prime Minister', 28 August 1985.

were a symptom of her protracted distance despite the accelerated rate of policy mobilisation that had occurred in the seven months prior.[190]

Nevertheless, the prospect of Thatcher becoming involved with AIDS – in an increasingly visible capacity – stimulated significant internal debate. In September 1985, Policy Advisor David Willetts suggested to the PM that she might open the new £30 million Blood Products Laboratory at Elstree noting 'it combines attractive themes – high-quality British science, action to protect innocent victims of AIDS, and spending on health infrastructure.'[191] The Elstree lab had been a focal point for the discussion of blood products and blood safety in the UK. Norman Fowler had received a range of bad press in the early 1980s as science correspondents attributed the delay in self-sufficiency and contamination from US sources to budget cuts sponsored by Fowler. *The Guardian* published headlines like, 'Body and Soul: Fowler's Blood Money' and 'Extra £30m could have kept out AIDS' highlighting Fowler's role in the failure to protect the British blood supply from infectious diseases like AIDS and Hepatitis B.[192] Whether for parliamentary or electoral gain, Willetts positioned AIDS as a multidimensional issue that offered potential benefits for Thatcher as a means to encourage her involvement. Willetts's recommendation, however, provoked outrage from Private Secretary Mark Addison who proclaimed, 'My own feeling on this is that the Prime Minister should stay clear of AIDS (!), even when it is a question of opening laboratories to help innocent victims.'[193] Addison's remarks echoed the perceived distinction between the disease (biological condition) and the illness (the social diagnosis) that shaped problematic notions of innocence. Moreover, Willetts and Addison both adopted innocence to evoke an emotional response to AIDS, Willetts to reinforce the positive and Addison the negative. The use of innocence in policy deliberation reinforced the importance of 'social diagnoses' to the

[190] The annotation of documents by Private Secretary's is common practice in Whitehall and is documented *passim* in Caroline Slocock's, *People Like Us: Margaret Thatcher and Me* which chronicles her time as a private secretary in Margaret Thatcher's Downing Street. C. Slocock, *People Like Us: Margaret Thatcher and Me* (London 2019).

[191] Willetts had worked in a variety of advisory roles under Thatcher, from the roles in the Treasury to the Downing Street Policy Unit. He would later work for the Centre for Policy Studies. TNA, PREM19-1863, 'AIDS', 25 September 1985.

[192] 'Body and Soul: Fowler's Blood Money', *The Guardian,* 11 May 1983. 'Extra £30m could have kept out AIDS', *The Guardian*, 3 May 1983.

[193] TNA, PREM19-1863, 'Diary Meeting – AIDS', 26 September 1985.

construction of the disease in Whitehall, especially to those concerned with the Prime Minister's relationship with AIDS policy.

Observing the unpredictability the disease attracted as a new and contentious political issue, Cabinet Secretary and close advisor to Thatcher Robert Armstrong suggested the Prime Minister use the Cabinet Committee network to 'keep an eye on' what he labelled a 'highly sensitive political subject.'[194] Thatcher rejected Armstrong's suggestion of a potential Cabinet Committee as 'unnecessary' but maintained that she must be updated on any new developments.[195] Against the backdrop of rising unemployment and rioting across the UK, Thatcher's rejection of a Cabinet Committee for AIDS could have been a symptom of the already testing period between September-October 1985 and a need to avoid 'distraction'. What constituted Thatcher's understanding of 'unnecessary' is less clear, however, the Prime Minister's perception of policy status likely contrasted with those advocating for AIDS policy in Whitehall. Nevertheless, the Prime Minister remained hands-off for a multitude of possible reasons, delaying the formalisation of the British response at the Prime Ministerial level. Whereas Thatcher remained hands-off on AIDS policy, the work of Donald Acheson, Norman Fowler, and the DHSS gradually shifted AIDS policy towards greater visibility, both politically and publicly. Although Thatcher rejected Armstrong's proposed Cabinet Committee, the prospect of a committee alone demonstrated the presence of effective policy advocacy in Westminster and Whitehall. Having entered the policymaking discourse in a limited sense in 1985, the absence of Prime Ministerial engagement remained a barrier to higher priority on both sides of the Atlantic.

On 17 September 1985 President Reagan finally broke his silence and spoke publicly about AIDS. In a press conference held in the East Room of the White House the President responded openly to questions about AIDS on a live television broadcast. Situated around in-depth discussions about economic growth and the Strategic Defence Initiative, the President offered his first public thoughts on what AIDS meant to his administration. When asked about a scientist's suggestion that his administration's research spending was 'not nearly enough' Reagan assured the nation that, 'it'll be 126 million [dollars] next year. So, this is a top priority

[194] TNA, PREM19-1863, 'Acquired Immune Deficiency Syndrome (AIDS)', 1 October 1985.
[195] TNA, PREM19-1863, 'Cabinet Office: AIDS', 3 October 1985.

with us.'[196] Resonating with Dr Krause's earlier notion of priority, Reagan's emphasis on his administration's contributions were expected and tangible. Undermining the Reagan administration's expansion of funding, however, was the battle between the legislative and executive spheres of government, a battle Congress was winning. Although the President indicated AIDS was a top priority, the reality that his office had actively tried to depreciate AIDS spending every year since 1983 complicated any perception of financial support.[197] Furthermore, the President's use of 'budgetary constraints' to justify his administration's contributions demonstrated the entanglement of AIDS policy and fiscal responsibility. Although the proposed $126 million was undoubtedly a tangible display of 'support', it was achieved through partisan dispute and spoke volumes about the administration's commitment to social spending retreat and the leadership of congressional opposition in pushing through those appropriations.[198] In response to the President's comments, House Democrat Ted Weiss (NY) suggested Reagan was 'inappropriately self-satisfied' with his administration's response to the disease and added that, 'this is not the time for self-satisfaction. Now is the time for Presidential leadership.'[199]

Moreover, the President's first public encounter with AIDS was not exclusively about fiscal responsibility. When asked about his position on children with AIDS returning to school Reagan stated, 'I can understand both sides' before pointing towards the inability of medical science to 'come forth unequivocally and [state], "This we know for a fact, that it is safe." And until they do, I think we just have to do the best we can with this problem.'[200] The President's inability to articulate a stance on children with AIDS attending school had subtle but damaging consequences for those attempting to educate the general population about the behaviours that shape the spread of the disease in the US. Responding to concerned Texas resident Charlotte Dearien a month after the President's press conference, Director of the Centre for Infectious Disease Walter Dowdle highlighted that 'there is no scientific evidence that AIDS is

[196] American Presidency Project (APP), 'The President's News Conference', 17 September 1985, [https://www.presidency.ucsb.edu/documents/the-presidents-news-conference-951], accessed 12 January 2022.
[197] Ibid.
[198] The following section, 'Avoiding Inadequacy', explores the paradoxical nature of funding a 'New Right' response to an epidemic disease in more detail.
[199] Weiss (NY), 'President's Self-Satisfaction in AIDS Epidemic Termed as Inappropriate', *Congressional Record: Bound Edition* 131:17 (1985), p. 24123, (Text from Congressional Record Permanent Digital Collection) [accessed 16 November 2022].
[200] APP, 'The President's News Conference', 17 September 1985.

spread through casual contact.'[201] Rebutting requests for a nationally mandated quarantine for homosexuals and PWA's, Dowdle's written exchange with Dearien suggested a consensus existed in the administration that reflected the accepted science on casual contact and AIDS transmission.[202] Similarly to Thatcher's position on a new Cabinet Committee, however, Reagan's inarticulate position on children with AIDS attending school was likely bound to the interwoven political tapestry that made up the President's support base and public image. Outwardly conservative on issues such as abortion and the importance of the family unit (defined as the heteronormative nuclear family), the President had attracted substantial support from the right generally but increasingly from the religious right and others active on social design such as Jesse Helms who was a prominent spokesman for socially conservative values in Congress. Whereas the President utilised 'medical science' to paper over the cracks in his administration's unrealised public education campaign, his press conference underlined the disconnect between the White House and vital advocates and policymakers, such as congressional opposition, the scientific community, and the Public Health Service.

The emergence of Reagan and Thatcher as participants in AIDS policy was varied in scope and the two leaders adopted different paths that resulted in similarly disconnected responses to the disease. In Whitehall, the Prime Minister assumed a passive and private function in AIDS policy development, entrusting responsibility to the existing DHSS power dynamic that had facilitated policy mobilisation since early 1985. By contrast, President Reagan's adoption of a public stance on AIDS – albeit limited in scope and direction – reflected the mounting friction in Congress where Democrat opposition remained successfully critical of his administration's response to the near 15,000 AIDS cases in the US.[203] Despite their inclusion in AIDS policy discourse both Reagan and Thatcher remained politically disconnected from the disease response; the President's inability to articulate the medical consensus on casual contact and the rudimentary nature of Thatcher's AIDS briefing papers upholding an ever present sense of ineffectual leadership.

[201] HE001 345231, RPLM, W. Dowdle, 'Reply to Charlotte Dearien', October 1985, pp. 1-2.
[202] Dearien's letter was received on 13 August 1985, the internal referral note was signed the same day Reagan spoke on AIDS, 17 September 1985 and a reply mailed back on 3 October 1985.
[203] On 30th December 1985 the CDC reported over 15,000 AIDS cases in the US. Centres Disease Control, 'Acquired Immunodeficiency Syndrome (AIDS) Weekly Surveillance Report', *Centre for Infectious Diseases*, 30 December 1985, p. 1.

Moreover, those informing Thatcher's perception of AIDS used the Reagan response to demonstrate the impact of ineffectual leadership and inaction, situating the Prime Minister's first engagement with the disease in August 1985 around the cautionary tale of the US epidemic.[204] Comparatively, US policymakers documented little concern for the UK experience. Likely influenced by the international research projects in countries like Zaire, the State Department maintained a keen interest in the African AIDS experience but showed few signs of policy engagement with Europe beyond research disputes with the *Institut Pasteur* in France. Despite the PHS-sponsored International AIDS Conference in Atlanta attracting some 2,000 people from twenty-six countries, the Reagan administration's lack of interest in the disease generally maintained a predominantly US-centric view of AIDS.[205] Nevertheless, underpinned by the consequences of their delayed involvement, the disparity between public and private engagement distinguished the two leaders, their differing approaches produced the same detached outcome and maintained the foundational importance of the wider policymaking community in progressing AIDS policy on both sides of the Atlantic.

Although the Prime Minister remained a private partner and Reagan failed to follow up his first public engagement with any meaningful contributions, the prospect of an increasingly active government response in the UK was growing. Moreover, the integration of the American epidemic into the British policy narrative as a case study of an advanced public health crisis highlighted a transnational policy awareness amongst those in Westminster that failed to materialise in Washington. In September 1985, the DHSS took the government's AIDS platform public in a press release shared by Minister of Health, Barney Hayhoe. Although earlier discussions had outlined a desire to make a low-key statement on AIDS, Norman Fowler favoured a more active stance suggesting 'the Government should be seen to be taking action to cope not only with the public health problems involved, on which we are well advanced, but also with these wider implications.'[206] The DHSS proceeded with a full press release that outlined the government's position on AIDS to the British public, including significant reference to the US response to the deadly disease. Hayhoe's announcement demonstrated a keen awareness of the troubling situation in the US before shifting focus towards the specific

[204] TNA, PREM19-1863, 'Acquired Immune Deficiency Syndrome', 28 August 1985.
[205] HE001 310235, RPLM, Unknown, 'Comments Concerning the Outcome of the International Conference on AIDS', 26 April 1985, p. 1.
[206] TNA, PREM19-1863, 'Prime Minister: Acquired Immune Deficiency Syndrome', 25 September 1985.

details of the next phase of the UK response.[207] Adopting a cautionary tone, Hayhoe's discussion of the US experience emphasised the inactivity of the Reagan government and the relationship between the administration's absence and the acceleration of the AIDS epidemic in America, a trend that was well-established in government publications, such as *Some Facts About AIDS* and the Chief Medical Officer's Report on AIDS (1985) which actively compared the UK experience to the US.[208] The British interest in the US experience exhibited a transnational or global perception of the disease that explored the implications of AIDS across a multitude of policy contexts. Citing documents such as *AIDS: How To Keep Yourself Safe* (1985) from New Zealand, UK policymakers demonstrated a willingness to look elsewhere for strategy.[209] From the disconnect between the White House and policy advocates in the Public Health Service to the building opposition in congress, Fowler's pursuit of visible intervention highlighted the need to avoid the administrative inactivity that had beset the US government. Fully aware of the 'difficult tightrope between being accused of bureaucratic inertia and being so active as to whip up public hysteria', the government concluded that Hayhoe's announcement had achieved a political balance and that a foundational awareness of future AIDS activity had been achieved.[210]

In October 1985 Norman Fowler continued the expansion of his policymaking network by establishing a Ministerial Steering Group on AIDS and an interdepartmental team of senior officials, taking the discussion of the disease more formally beyond the walls of the DHSS. Fowler's expanding network attracted support and endorsement from others in the government, namely Secretary of State for Wales, Nicholas Edwards who suggested, 'Following talks I had during my recent visit to the USA. I regard the work of the [proposed] Steering Group as being of the first importance.'[211] Fully aware of the hastening US epidemic faced by those in Washington, Edwards reaffirmed Fowler's request for an interdepartmental group on AIDS. Ultimately, Norman Fowler's aspiration to depart from the 'ad-hoc basis' of AIDS policy in favour of a 'more formal arrangement for the resolution of problems' informed

[207] TNA, PREM19-1863, 'Acquired Immune Deficiency Syndrome', 28 August 1985.
[208] TNA, PREM19-1863, 'Some Facts About AIDS', (1985). TNA, PREM19-1863, 'HTLV3 infection, the AIDS epidemic and the control of its spread in the UK', June 1985.
[209] TNA, PREM19-1863, 'AIDS: How To Keep Yourself Safe', August 1985.
[210] TNA, PREM19-1863, 'Prime Minister: AIDS', 25 September 1985.
[211] TNA, PREM19-1863, 'Acquired Immune Deficiency Syndrome (AIDS)', 8 October 1985.

his desire to develop an AIDS-specific policymaking network.[212] Starting in the DHSS with the establishment of the EAGA, the British AIDS policy network slowly expanded throughout 1985 to encapsulate a more diverse group of British policymakers that promoted a more active and informed policymaking climate.

Throughout 1985 both Reagan and Thatcher maintained a distanced approach to their respective AIDS experiences. Although Thatcher's inclusion in August 1985 certainly made her involvement more tangible, the Prime Minister operated from a safe distance. Norman Fowler and Donald Acheson took responsibility for developing a UK response and slowly built a policymaking network that better equipped UK policymakers to attend to the issue of growing infection rates in the UK. Starting with the establishment of the EAGA in February 1985 and culminating with the proposal of the Ministerial Steering Group on AIDS later that year, Fowler and Acheson had progressed the AIDS policymaking dialogue beyond the internal workings of the department immediately responsible for the disease and towards a more inclusive discussion about epidemic response. Comparatively, the Reagan administration struggled to overcome the climate of inactivity that had constrained AIDS policy in the initial phase of policymaking. Although high ranking individuals such as Dr Krause endorsed AIDS as a high priority issue in the US, the disease's entanglement with Reagan's wider political endeavours undermined any notion of political significance. Despite the President taking a public – albeit limited – stance on AIDS in late 1985, his presence offered little in the way of policy mobilisation beyond the confirmation of his administration's vague action plan for tackling the disease in the second half of the decade.

Avoiding Inadequacy: AIDS Policy and Funding

One of the foremost expressions of 'New Right' policy status was funding as the scale of resources allocated to a specific issue afforded it a political standing. In a climate that emphasised fiscal responsibility and budgetary restraint, AIDS policy funding derived significance from the paradoxical intersection between escalating spending on epidemic

[212] TNA, PREM19-1863, 'Acquired Immune Deficiency Syndrome (AIDS)', 25 September 1985.

response and the pursuit of government retrenchment. Whether it be a Congressional review investigating the Public Health Service's (PHS) response to AIDS or parliamentarians questioning the attentiveness of the British response, the notion of inadequacy had harassed AIDS policy since its inception on both sides of the Atlantic. Whilst embracing the usefulness of dollars and pounds spent this discussion utilises policymaking dialogue to demonstrate that whilst principles such as fiscal responsibility infiltrated AIDS funding discourse, this approach achieved limited traction in the face of growing opposition both internally and externally.

Important to the discussion that follows are the circumstantial and structural differences between the US and UK response to AIDS between 1984-1985. Structurally, the British response benefitted from a universal healthcare system that absorbed much of the acute service provisions such as in-patient care. In the US, private health insurance companies were increasingly concerned with the growing cost of AIDS care and the impact this might have on risk pools and payment premiums.[213] Furthermore, these structural variances manifested differently on the balance sheet. In the US, AIDS spending reviews for federal programmes such as Medicare and Medicaid were recorded annually from 1983. However, the accounting for the provision of AIDS care in the National Health Service (NHS) remained elusive with the most available data being funding allocations for specific AIDS programmes, such as education, testing and research, or extra resourcing for hotspots, such as the Thames region. To remedy this disparity, this discussion integrates policy discourse more directly into a data-driven framework of AIDS funding to better inform our comparative understanding of funding across contexts and circumstances. Through the lens of budget spending and discourse analysis, this discussion will highlight the growing disparity between US and UK attitudes to spending. Furthermore, this discussion sets out to explore the contradiction of 'expansion and retreat' under neoconservatism.

In the brief period prior to the discovery of HIV as the causative viral agent and during the process of federal retrenchment often conceptualised as the 'Reagan Revolution', the administration reduced the Centres for Disease Control (CDC) budget by 2.7% as part of the wider retrenchment of social and welfare spending.[214] Despite rising infection rates and

[213] D. Fox, 'D. Fox, 'AIDS and the American Health Polity: The History and Prospect of a Crisis of Authority', *The Milbank Quarterly,* 83:4 (December 2005), pp. 15-23. (Reprinted from the *Milbank Quarterly*, 64:1 (1986).
[214] Office of Technology Assessment (OTA), *Review of the Public Health Service Response to AIDS*, (February 1985), p. 39.

caseloads, the pursuit of social spending retreat that had depreciated CDC funding some years earlier continued to impact disease response. Although some policymakers hailed the progression of research under Reagan as 'nothing short of spectacular', the role of the White House in cultivating an environment for AIDS research to flourish was complicated.[215] In 1984, the Reagan administration requested $20 million less from Congress for AIDS funding than the Public Health Service (PHS) had indicated it would need for that financial year, a request Senator Ted Kennedy described as 'totally inadequate.'[216] Similarly in 1985, the Reagan administration requested $30 million less than the PHS had requested – slightly less than the 1984 congressional allocation of $60 million.[217] In both 1984 and 1985 Congress overruled the Reagan administration's budget and appropriated more than the PHS had originally requested.[218] By 1985, the CDC received 35% more funding than it did in 1979 and AIDS funding specifically had increased from $5.6 million in FY1982 to $97.4 million in FY1985.[219] Central to tackling the inadequacy of the Reagan AIDS budgets of 1984 and 1985 was the effective policy advocacy of congressional opposition, such as Californian Representative Henry Waxman. In a statement to the House of Representatives Waxman noted that 'despite the administration's reticence, AIDS funding has been substantially increased each year, largely because of the strong leadership that the Congress … has exerted in this area.'[220] Whereas President Reagan's avoidance of AIDS had contributed to a substantial lack of policy direction, this inattentiveness provided ample opportunity for a successful legislative challenge to the executive's inability to articulate a coherent AIDS agenda and subsequently, overturn the hollow sense of urgency demonstrated in the 1984 and 1985 AIDS budgets.

Nevertheless, the successful advocacy of congressional opposition placed greater emphasis on the disconnect between Krause's 'public health priority number one' and the broader 'Reagan Revolution.'[221] Congress played a vital role in the determining of federal expenditure

[215] 'Statement of Dr James Mason, Acting Assistant Secretary for Health, Department of Health and Human Service', Office of Technology Assessment Findings on the Public Health Service Response to AIDS, 21 February 1985, p. 21.
[216] Ibid, p. 32. Kennedy (CAL), 'Amendment No. 4389', *Congressional Record: Bound Edition* 130:19 (1984), p. 26681, (Text from Congressional Record Permanent Digital Collection), accessed 14 September 2021.
[217] OTA Assessment of Findings, p. 39.
[218] Ibid, p. 32.
[219] Ibid, p. 36. Ibid, p. 32.
[220] 'Statement of Chairman Henry Waxman', Office of Technology Assessment Findings on the Public Health Service Response to AIDS, 21 February 1985, p. 2.
[221] Document 6 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', *Office of the Historian*, (Bureau of Public Affairs, November 2017), p. 14.

on AIDS through federal appropriations, approval of White House budgets and participating in budgetary discourse. When responding to the challenge of AIDS policy appropriations, it was congressional opposition that shed light on the perceived inadequacies of the Reagan response and advocated for change in response to those shortfalls. A consistent mouthpiece for congressional opposition, Waxman placed a spotlight on the problematic relationship between AIDS resourcing and the administration's funding priorities stating that 'clearly the administration's original request of a freeze and a cut was artificially constructed … the President's budget policy speaks loudly for itself in addressing competing needs and priorities.'[222] Likely at the heart of Waxman's perception of competing needs was the rapid advancement of defence spending in the context of social spending retreat during a growing health crisis. Reflecting on this 'Spend Up' in defence policy under Reagan in July 1986, *The Atlantic* reported that the average military aircraft cost around $27 million dollars to buy new in 1986 and therefore the entire AIDS budget for 1985 could afford only three aircraft maximum – an estimate not including the B1 Bomber or the C5 Transport, the Air Force's biggest items at the time.[223] This comparison highlighted – as Waxman suggested – the problematic interplay between AIDS and the broader Reagan agenda. The administration's expansion of defence spending – and the comparative enormity of those increases – complicated notions of fiscal responsibility used to justify resistance to the funding increases requested by Democrats in Congress. Whereas this spending disparity confirmed Reagan's high priority policy areas – such as, military spending, tax cuts, fiscal restraint, and deregulation – it also contextualised the messaging of public health officials such as Krause. Although Krause was a high-ranking public health official, his broader influence on the direction of policy in the Reagan White House was vastly different to other high-ranking officials such as economist and director of the Office of Management and Budget David Stockman who guided Reagan's economic policy between 1981-1985. Therefore, the pursuit of budgetary constraint and fiscal responsibility on AIDS policy was largely constructed to reflect the Reagan administration's pursuit of higher priority projects such as Cold War military upscaling and economic revitalisation. Consequently, the affirmations of priority espoused by public health officials such as Krause were increasingly reliant on support from congressional

[222] H. Waxman, 'AIDS Epidemic', *Congressional Record: Bound Edition* 131:14 (1985), p. 19268, (Text from Congressional Record Permanent Digital Collection), [accessed 14 September 2021].
[223] 'The Spend-Up', *The Atlantic,* July 1986.

Democrats such as Henry Waxman who applied pressure to the administration's periphery treatment of AIDS resourcing.

By early 1985 the pressure exerted in Congress spilled over into a review of the Federal response to AIDS, providing a valuable opportunity to cross examine witnesses on the administrative avoidance that had permeated the initial phase of policymaking. Manifesting in the Office of Technology Assessment's (OTA) *Review of the Public Health Service Response to AIDS*, the pursuit of information and testimony from White House officials shone an increasingly bright light on the role of ideology in the cultivation of the Reagan administration's response to AIDS – or lack thereof. Testifying to the OTA in February 1985, Dr James Mason, Acting Assistant Secretary of Health, stressed the need for responsibility and redistribution as vital to the Reagan response. Firstly, Mason outlined that the administration believed it was 'inherently responsible to shift resources to high priority projects such as AIDS.'[224] Although it is not uncommon for governments to redistribute funds to tackle specific issues such as emergent health challenges like AIDS, reallocation in the pursuit of effective epidemic response appeared fraught with a disjointed appreciation of the epidemic's gravity and an uneven emphasis on fiscal responsibility. During the early crisis, the OTA reported that redistribution played a vital role in shaping AIDS funding accounting for an estimated $26.7 million of the total $28.7 million provided for AIDS in FY1983.[225] Furthermore, the redistribution of existing funds required other policy areas to relinquish vital resourcing to make space for AIDS. For example, in 1985 the National Cancer Institute (NCI) budgeted for the redistribution of nearly $6 million worth of existing project funding to be allocated to AIDS projects.[226] Between the efforts of Congress and the redistribution of existing resources, the Reagan administration's approach to AIDS policy was increasing shaped by fiscal restraint and opposition resistance.

Mason continued to pursue an explanation grounded in fiscal restraint when he added, 'I think, philosophically, the department has felt that we should reallocate until we know specifically what our needs are.'[227] Although Mason had emphasised the importance of

[224] 'Statement of Dr James Mason', OTA Assessment of Findings, p. 23.
[225] 'History of AIDS Funding, Fiscal Years 1982 to 1985', Office of Technology Assessment Findings on the Public Health Service Response to AIDS, 21 February 1985, p. 45.
[226] 'National Cancer Institute Budget Estimate', Office of Technology Assessment Findings on the Public Health Service Response to AIDS, 21 February 1985, p. 45.
[227] 'Statement of Dr James Mason', OTA Assessment of Findings, p. 25.

information – or lack thereof – to the administration's redistribution approach, it is unclear exactly what information was deficient. With nearly 8,000 known AIDS cases recorded by the end of 1984, the suggestion that White House policymakers lacked the necessary information to upscale AIDS policy with fresh investment was problematic.[228] Moreover, the availability of epidemiological data and scientific material on the vectors of transmission attracted growing consensus amongst scientists, making messaging and education on safe behaviour – like those communicated by the State Department's RMOs – easier to articulate with authority and confidence even prior to the landmark discovery of HIV in May 1984.[229] We might also consider that Mason's testimony took place at the start of Reagan's second term which could create some uncertainty about the future of AIDS policy, however, his inclusion of 'philosophically' alluded to an undercurrent of fiscal responsibility that was uncharacteristic of a public health official, his proximity – compared to Krause – to the White House a potential reason for his allegiance to language endorsed by the Oval Office. Contextualised by the significant expansion of the defence budget, the inability to provide additional, rather than diverted, funds for AIDS perpetuated an AIDS budget suppressed by the politics of federal retrenchment and an administration grappling with congressional demands for more resources.

Reporting a conclusion that resonated with Ted Kennedy's criticism of the administration's inadequate funding, the OTA suggested 'the statement that AIDS is the DHHS's number one priority has not always been supported by financial and personnel resources.'[230] In addition, Chairman of the OTA Hearings and AIDS policy advocate Ted Weiss added in a damning closing statement, 'ultimately it catches up. You can't hide epidemics, no matter what the budgetary people say.'[231] Captured in his emphasis on the 'budgetary people', Weiss placed a spotlight on the intersection between fiscal responsibility and epidemic response, highlighting the unsustainability of the White House approach to AIDS resourcing and subsequently, the important role of Congress in challenging the administration's avoidance of AIDS. Whereas the inactivity of the White House had encouraged questions of 'who' the epidemic was

[228] 'Acquired Autoimmune Deficiency (AIDS) Weekly Surveillance Report', *Centre for Infectious Diseases: Centres for Disease Control*, 31 December 1984, p. 1.
[229] CDC, 'Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations', *Morbidity and Mortality Weekly Report,* 4:32 (March 1983), pp. 101-103.
[230] 'Statement of Dr James Mason', OTA Assessment of Findings, Ibid, p. 46.
[231] Ibid. p. 47.

affecting, funding and federal spending generally emerged as a powerful tool in the arsenal of administrative avoidance, directing priority away from and inhibiting progress towards AIDS policy at several vital junctures. In Congress, policy advocates successfully acquired AIDS appropriations in 1984 and 1985 that better reflected the urgency of the escalating American epidemic. Culminating in the OTA report on the federal response in 1985, this growing chorus of organised opposition maintained a legislative-executive battle over AIDS funding that upset the culture of retreat established by the 'Reagan Revolution'.

Across the Atlantic, the funding discourse was increasingly inward looking and achieved significant success in the reorientation of government attitudes towards AIDS spending. The prospect, however, of an imminent and vast expansion of AIDS spending was unlikely in the UK for several reasons beyond the significant disparity in AIDS cases. Underpinned by the National Health Service (NHS) and the accompanying ease of access to 'front of house' acute services, the initial caseload in Britain was absorbed by the universal health care system.[232] Moreover, the ability of the NHS to absorb these initial cases in principle – free at the point of use – deeply contrasted with the questions raised by American insurance providers concerned by spiralling healthcare costs. In addition, charitable organisations such as the Terrence Higgins Trust, London Gay Switchboard, and Gay Medical Association had begun developing an AIDS discourse and support services by 1983-1984 which encouraged learning and awareness amongst the British homosexual community specifically that constituted most of Britain's AIDS cases.[233] A consequence of the functionality of the NHS, the low political engagement and small caseload, the documentation of UK AIDS funding before 1985 is somewhat elusive compared to the US which recorded Medicare and Medicaid spending on the disease from 1983. Moreover, the relationship between military spending and AIDS funding was less dramatic than in America, Thatcher presiding over the first stages in a steep

[232] The acute services of a hospital setting in the UK are often divided into 'Front' and 'Back' of 'House'. The 'House' is the hospital. The 'Front' is primarily constituted of Accident and Emergency (A&E) and Urgent Care Services in the UK. These are described as responding to issues most acute or in the first instance before moving patients as required to the 'Back of House' services which are often ward settings or specialist units. In the context of AIDS diagnosis, a General Practitioner (GP) Surgery or sexual health clinic might also be considered somewhat like the 'Front' services, however, they are not acute but diagnostic in nature.
[233] 'Our History: 1980s', *The Terrence Higgins Trust,* [https://www.tht.org.uk/our-work/about-our-charity/our-history/1980s], accessed 13 November 2023.

decline in defence spending from 5% of national income in 1985 to less than 4% by the end of the decade.[234]

Nevertheless, Norman Fowler indicated in a letter to the Prime Minister that the government had contributed nearly £1 million to AIDS activity by September 1985.[235] However, the £900,000 spent of trialling blood screening and testing kits shows that the bulk of this spending likely occurred after May 1984 following the discovery of HIV.[236] Importantly, Fowler earmarked a further £912,000 for 1985 which committed the government to another substantial expansion of AIDS funding between 1984-1985.[237] Moving beyond a funding portfolio that primarily targeted testing and screening, the UK government expanded resource allocation in key fields such as outpatient care, counselling, and regional hotspots. Nearly £700,000 of this new resource was channelled into the worst affected parts of the UK, the Regional Health Authorities (RHAs) for Thames North East, Thames North West, and Thames South East which reported 216 of the 275 known cases recorded in the UK by the end of 1985.[238] Although expanding, the paradox of funding a fiscally responsible epidemic response was never far away provoking criticism of Fowler and his DHSS colleagues in late 1985.

On 6 November 1985, the Secretary of the Medical Research Council (MRC) Dr James Gowan suggested that the UK establish a National Epidemiological Centre for the study of AIDS to coordinate a centralised AIDS surveillance system in the UK.[239] Gowan's recommendation was prompted by his belief that 'the situation in the UK is extremely unstable … We need to match our response to the potential scale, urgency, and uniqueness of the problem. I am not clear that collectively we have yet recognised the gravity of the situation and the potential costs of an inadequate response.'[240] Following support for the initiative, discussions commenced on how to fund the project, however, the idea of further expanding AIDS funding hit an obstacle. Given that the Department for Science and Education had already committed over £400,000 to AIDS projects from the department's research budget, the desired sponsor for the project

[234] 'Defence Spending', *Institute for Fiscal Studies,* [https://ifs.org.uk/defence-spending], accessed 29 February 2024.
[235] TNA, PREM19-1863, '', 25 September 1985.
[236] Ibid.
[237] TNA, PREM19-1863, 'AIDS', 6 November 1985.
[238] TNA, PREM19-1863, 'AIDS', 6 November 1985. GB0809 AIDS Social History Programme/1/2, D. Acheson, Chief Medical Officer's Annual Report, (1985), p. 42.
[239] TNA, PREM19-1863, 'AIDS', 6 November 1985.
[240] Ibid.

was Norman Fowler and the DHSS. In response, Fowler offered to fund 10% (£50,000) of the project's cost in the first year, an amount the Advisory Board for the Research Councils (ABRC) described as 'inadequate.'[241] It is unclear exactly why Fowler offered such a low amount – in relation to his department's proximity to the project's goals of infection surveillance and therefore, his responsibility for the outcome – but it is clear his proposal fell short of his responsibility in the eyes of his peers. Whereas Fowler had expanded AIDS funding substantially in the period immediately following the discovery of HIV, the ABRC's criticism likely reflected a desire for sustainable resourcing of epidemic response. In addition, the ABRC observed 'that the total costs of the epidemiological research programmes are dwarfed by the potential costs of caring for AIDS victims within the health service.'[242] In a climate shaped by the awareness of policymakers, the media and advocacy groups, the demand for more resources perpetuated the political paradox between fiscal responsibility and epidemic response. With the recent discovery of HIV prompting a wave of investment in screening and testing kits, the ever-present anxieties of the fiscally responsible in Parliament seemed somewhat justified. By contrast, the prospect of inactivity and inadequacy cultivating a catastrophic long-term human cost placed greater strain on the need to reconcile this increasingly imbalanced equation between the resourcing and response highlighted by the ABRC and Dr Gowan.

In early December 1985, Secretary of State for Science and Education Keith Joseph maintained pressure on Fowler and 'the very modest financial contribution which you [Fowler] had so far been able to offer failed to reflect the primary responsibility of you and your fellow ministers … on what is essentially a national public health emergency.'[243] In his condemnation Joseph channelled the inadequacy communicated by the ABRC whilst placing a spotlight on the wider implications of this ministerial 'squabbling' on the government's AIDS response.[244] Joseph confessed 'it could be acutely embarrassing for the Government if Sir James [Gowan] were able to claim on that occasion [Parliamentary and Scientific Committee on AIDS meeting] that inter-departmental wrangling was holding up vital work.'[245] Days later, Fowler agreed to fund

[241] TNA, PREM19-1863, 'ABRC Advice on Distribution of Science Budget', 29 November 1985.
[242] Ibid.
[243] TNA, PREM19-1863, 'AIDS', 2 December 1985.
[244] Ibid.
[245] Ibid.

up to 50% (£250,000) of the project with Joseph contributing 40% (£200,000) from his budget, the remaining funds contributed by the Scottish and Welsh offices.[246] In a move that demonstrated the importance of inter-departmental cooperation, the necessity of Joseph's injection of funds highlighted the potential for fiscal responsibility to undermine British AIDS policy, but the ability of policymakers to reconcile this funding issue placed it on firmer ground. The extent to which this funding was 'new money' or redistributed capital is unclear, however, the shifting of resources to account for the increase in demand was probable and featured in future critiques of AIDS funding in the Houses of Parliament.

Although criticism of Fowler's funding proposal was short-lived it was fruitful and produced the necessary gains to fulfil the cautionary demands for a disease surveillance centre. Whereas British policymakers such as Keith Joseph and Dr James Gowan had negotiated a positive outcome for AIDS funding, this funding dispute highlighted some continuity between funding discourse in the US and UK. Echoing the critique of inadequacy and unsustainability raised by the OTA, Ted Weiss and Henry Waxman in the US, Joseph and Gowan highlighted a dissatisfaction with government AIDS funding and a willingness to advocate for increases that better reflected the sense of urgency felt in the DHSS. A vital distinction between the US and UK, however, was the origin of this critique. Whereas Joseph and Gowan raised issues with funding behind closed doors in Whitehall, President Reagan attracted public criticism from congressional opposition. Informed by a disparity in circumstances, the increasing publicity surrounding the inadequacies of the Reagan response distinguished the British and American experiences as those in Whitehall remained comparatively sheltered from public critique. Whether an attempt to avoid perceptions of political 'squabbling' or an effort to take responsibility for AIDS, Fowler's departure from budgetary restraint maintained the sense of momentum that had characterised the UK response throughout 1985, overcoming an apparent bump in the policymaking road.

Although British and American AIDS policymakers demonstrated a willingness to control the funding to AIDS policy throughout the period 1984-1985, AIDS funding captured the variance in the application of such fundamental political principles in the sphere of epidemic response. In the US, the Reagan administration attended to AIDS funding as a constituent part of social

[246] TNA, PREM19-1863, 'AIDS', 5 December 1985.

and welfare spending, articulating philosophical ideals of fiscal responsibility and the redistribution of resources as a means of respecting the budgetary restraints of the 'Reagan Revolution'. By contrast, in Britain the DHSS – in cooperation with departments such as Education and Science – developed a resourcing platform previously concerned with testing and screening to include early service provisions for epidemic hotspots in the Thames region. Despite Fowler's expansion of funding policy advocacy from cabinet colleagues was required to maintain the sense of momentum achieved in early 1985. While in Britain vital policymakers such as Fowler succumbed to internal pressure for resource expansion, the Reagan White House encountered greater opposition that successfully undermined attempts to control AIDS expenditure. Fundamentally, this early AIDS funding discourse demonstrated the paradox of financing an adequate epidemic response in a climate of fiscal responsibility and highlighting the vital role of policy advocacy – both internally and externally – in overcoming the threat of inadequacy.

Conclusion

By the end of 1985 the AIDS policy landscape had changed dramatically. Following the discovery of HIV in May 1984 the prospect of informed policymaking rapidly increased and scientific enquiry grew bolder and more optimistic. In the US and UK, the policymaking narrative had developed substantially, discourse now criticised government AIDS policy publicly and privately with a growing recognition of the danger posed by AIDS. In the UK, British policymakers slowly coalesced around a new network of decision-making units from the medically led Expert Advisory Group on AIDS (EAGA) to the fostering of a potential Committee and Sub-Committee on AIDS. By contrast, the network of policymakers primarily associated with the progress of AIDS policy in America were found in Congress and not the White House. Although advocacy in the Centres for Disease Control (CDC) and Public Health Service (PHS) maintained a sense of urgency about the disease in the US, it was Democrat opposition in Congress that achieved traction in terms of discourse and intervention. Supplementing the growing nexus of policymaking was the advancement of executive leadership. Speaking publicly on AIDS in a press conference in late 1985 Reagan alluded

vaguely to the prevailing scientific consensus on casual contact in a move symbolic of his prolonged disassociation with the disease. Similarly, Prime Minister Thatcher was brought into the AIDS fold in 1985 but continued a silent role in AIDS policy, merely monitoring the activities of Fowler and Acheson.

Furthermore, the resourcing of AIDS policy proved to be a vital battleground between the legislative and executive sphere in the US. When the White House habitually attempted to depreciate AIDS funding congressional opposition displaced ideas of fiscal responsibility in favour of a rapidly growing foundation of research spending. Although Norman Fowler in the UK attempted to deviate from the growing consensus in the DHSS regarding funding, those advocating for sustainable AIDS funding achieved success in maintaining an expanded agenda for epidemic response into late 1985. As demonstrated by the British and American approaches to AIDS resourcing, the pursuit of ideological or principled policy development was not unopposed. In the context of AIDS policy, the paradoxical interplay between principles of fiscal responsibility and epidemic response manifested in legislative challenges to the Reagan executive and the transient departure of key policymakers from principles of fiscal control. The tide of AIDS policymaking had changed and the US and UK responses to the disease were becoming increasingly divergent.

Chapter Three

A Turning Point:

Divergent Trends in AIDS Policymaking in the US and UK in 1986

Introduction

Although much of the scholarship has primarily looked at 1986 as 'the beginning' of the AIDS Crisis, this chapter builds on the preceding two chapters' contributions to demonstrate that 1986 occupies a unique space in the Anglo-American AIDS experience as the origin of the divergence of policy narratives. This thesis has posited that the tendency to view 1985-1986 as the start of AIDS policy has poorly positioned our understanding of the decade as a whole and this chapter reaffirms the importance of realigning analysis of AIDS in the 1980s to better incorporate the years 1981-1986. Nevertheless, as Norman Fowler, Virginia Berridge, and Jennifer Brier have all outlined, 1986 was an important year for AIDS policy on both sides of the Atlantic.[247] In the UK, policymakers continued to build on the momentum of late 1985 and progress AIDS policy into the Houses of Parliament and Whitehall with greater intensity, placing the issues of education, intravenous drug use (IVDU) and screening on the table for public and private debate. In the US, the executive-legislature battle that had gripped Congress and the White House continued to burn through the energy of policymakers in the House and Senate. Moreover, policy leadership in the US and UK became increasingly uncomfortable with the development of AIDS policy. Where Margaret Thatcher became a vocal spokesperson for a minority view that emphasised the need to preserve public innocence in response to Norman Fowler's public education campaign, President Reagan articulated a lukewarm position that fuelled a growing chorus of congressional opposition that maintained charges of inattentiveness and inadequacy.

[247] N. Fowler, *Don't Die of Ignorance* (London 2014), p. 1. V. Berridge, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford 1996), pp. 81-123. J. Brier, *Infectious Ideas: U.S. Political Responses to the AIDS Crisis* (Chapel Hill 2009), pp. 88-91.

To demonstrate the divergence in the US-UK AIDS policy narrative this chapter will first consider the changing role of Margaret Thatcher and how it intimately reshaped the relationship between AIDS and policy development in the UK. Adopting a more hands-on approach to AIDS policy throughout 1986, Margaret Thatcher met significant resistance from the now well-established Fowler-Acheson policy dynamic that had governed AIDS policy since early 1985. Thatcher's unsuccessful challenge of Fowler's AIDS agenda has provided a vital perspective to readdress the importance of President Reagan's inattentiveness in the US. Moreover, the Prime Minister's AIDS policy interjections highlighted the importance of the policy ownership provided by Fowler and the Department of Health and Social Services (DHSS) during the preceding period of Thatcher's inattentiveness.

Next, this chapter will review the first half of 1986 as the emergence of a formidable public discourse in the US and UK. During this period, both Congress and Parliament debated publicly on AIDS generally whilst conducting specific discussions on vital policy areas such as intravenous drug use (IVDU) and screening. Although these debates were still somewhat detached from the internal workings of the White House and Whitehall, they nonetheless played a vital role in shaping the existing AIDS discourse in both nations.

Lastly, this chapter will detail the important events shaping the second half of 1986. In the UK, the November Commons debate provided a fresh opportunity to bring together the public facing sphere of policymaking to debate the course of the British response to AIDS. Although unsurprising issues such as funding and screening provided a useful base for the British discussion, emerging topics such as drug policy permeated the most heated exchanges and encouraged new directions for policy discourse and intervention. In the US, this period corresponded with public critique and the rise of Surgeon General Koop into the leadership vacuum left by the Reagan White House. Against the backdrop of the Institute of Medicine's critical report *Confronting AIDS,* the Surgeon General communicated to the American people a report that offered guidance, advice and information in a fashion that surpassed anything the federal government had offered thus far.

The purpose of this chapter is to position 1986 as a pivotal year in the first decade of AIDS in the US and UK. Departing from a focus on 1986 as the beginning of AIDS policymaking, this chapter will outline 1986 as a year of divergence in the Anglo-American narrative. As policymakers in Whitehall and the White House attended to the contradiction and

complications cultivated by the interplay between neoconservatism and epidemic response in increasingly disparate ways these previously aligned administrative responses drifted apart. As this chapter will highlight, the changing role of Margaret Thatcher and the corresponding lack of change in the Reagan White House were catalytic in deepening this narrative divergence.

Margaret Thatcher and AIDS Policy:

The Changing Dynamics of Policy Ownership and the Necessity of Public Health Education

The relationship between the Prime Minister and AIDS had long been shaped by her detachment from the disease and those it affected most intimately. Contributing little during the pre-discovery phase of policymaking between 1981-1984, Margaret Thatcher's role in the slow progression of AIDS policy reflected her prolonged disassociation from the disease. In 1986, the role and involvement of the Prime Minister took on a new form, primarily shaped by a willingness to push back – albeit in a limited fashion – against Norman Fowler's expanding AIDS agenda and the direct sexual health messaging at the heart of the government's public education campaign. Thatcher found herself engaged with the intimate details of AIDS policy unlike before.

Whereas Jon Agar has suggested that Thatcher was motivated by 'moral revulsions, public perceptions of the role of government and her understanding of concerns about family and privacy', this discussion frames the Prime Minister's interventions as regulatory and disruptive.[248] Moreover, it will detail how the Prime Minister constructed a critique grounded in the separation of sex and society that conceptualised AIDS education efforts – primarily the developing discussion on sexual health – as problematic. The widespread public health concern for individual sexual behaviour clashed with Thatcher's traditional attitudes that understood sex to be a private matter. Pursuing a variety of avenues to achieves these goals,

[248] J. Agar, *Science Policy Under Thatcher* (London 2019), p. 126.

the Prime Minster presented herself as a custodian of public innocence in response to public health messaging on AIDS the blurred the lines between existing attitudes towards sexual health and public health education. Becoming increasingly vocal in her dealings with AIDS policy, the Prime Minister's apprehensions were frequently at odds with those closely involved with policy development. Aware of the potential for reputational damage, Thatcher encouraged a public health response constrained by a sympathetic separation of messaging on sexual health and the general population. Preoccupied with the risk of causing offence and encroaching on individual privacy, Thatcher attempted to cultivate a response that was less direct and more conscious of traditional attitudes towards public discourse about sex. At odds with the Prime Minister's perspective, Norman Fowler stood firm on his vision for AIDS policy, pushing forward an agenda that prioritised educating the public on the behaviours that increased an individual's risk of infection, promoting language and messaging that provided clarity and relatability to those who required the information the most. Backed by the medical expertise of Chief Medical Officer (CMO) Donald Acheson, Fowler resisted several of the Prime Minister's interventions, maintaining the firm grip on AIDS policy he had nurtured since 1985.

In February 1986 following the distribution of a draft health education leaflet sponsored by Norman Fowler and the Department of Health and Social Services (DHSS), Margaret Thatcher entered the AIDS policymaking fold in a fashion previously unseen. Apprehensive about the benefits of her government facilitating a public dialogue on sexual practices and recreational drug use, the Prime Minister articulated a distaste for the direct and sexually explicit messaging proposed by the DHSS leaflet on AIDS. Focused primarily on the language adopted in the leaflet, Thatcher's suggested that the language used by the DHSS would negatively affect young teenagers.[249] Moreover, the Prime Minister conflated the leaflet's aim of harm reduction with the potential for government overreach that blurred the traditional boundaries of sexual health as a private matter.[250] Likewise, Sir Ian Percival spoke in the House of Commons about the corrupting and destabilising affect that exposure to sex and drugs would have on young people, emphasising a view of British politics that fused the perceived social mores of the 'permissive society' of the 1960s and 1970s with contemporary issues like AIDS,

[249] The National Archive (TNA), PREM19-1863, 'AIDS', 25 February 1986.
[250] Ibid.

other sexually transmitted infections such as Hepatitis B, and rising drug misuse statistics.[251] Exemplified by her request to rethink the inclusion of a section on 'risky sex', Thatcher's critique placed a spotlight on the incompatibility of public health and private behaviour that a public discourse on sexual practice and recreational drug use would likely invite.[252]

In response the Prime Minister's Private Secretary reported that 'the Lord President voiced your concerns, but H [H-Committee] appear unanimously to have felt the material simply had to be included.'[253] On the specific request made by the Prime Minister, the Private Secretary indicated, 'The Chief Medical Officer explained to me that … in his professional judgement their inclusion in the publicity was vital.'[254] For Chief Medical Officer (CMO) Donald Acheson, the direct and explicit sexual health messaging that resonated with the British public was vital. Favouring the medical expertise of the CMO, H-Committee asserted that the style and language chosen for the education campaign was to break down the potential barriers that inhibited the campaign's potential effectiveness amongst specific audiences such as young, sexually active people in the general population. Although the rejection of Thatcher's general position on the AIDS leaflets messaging reaffirmed the prevailing AIDS policy power dynamic operated by Fowler and Acheson, it placed an important spotlight on the Prime Minister's strength of feeling regarding the social dimension of her government's platform. In 1988, Thatcher would briefly emphasise the importance of the family unit as the source of 'moral energy in society' during the Conservative Party Conference at the Winter Gardens in Blackpool, however, her response to the steadfastness of Fowler, Acheson and H-Committee underpinned an unwillingness to grapple with these social issues with the same enthusiasm as economic policy.[255] Nevertheless, Thatcher's initial reaction to the prospective AIDS education leaflet demonstrated the watershed such messaging represented. Adopting direct and sexually explicit language the public health education leaflet on AIDS attempted to

[251] Hansard, House of Commons (HC), 21 November 1986, v. 105 c. 834. For further material on the socio-cultural significance of the period 1955-1975 see M. Donnelly, *Sixties Britain: Culture, Society, and Politics* (Oxon 2013). Donnelly's notion of overlapping contexts is a useful framework for situating permissiveness in twentieth century Britain.

[252] TNA, PREM19-1863, 'AIDS', 25 February 1986.

[253] Prior to the establishment of the Official Committee on AIDS and the Sub-Committee on AIDS in October-November 1986, H-Committee was the main group responsible for AIDS policy and was largely constituted of members of the DHSS. Original emphasis on 'had'. TNA, PREM19-1863, 'Controlling the Spread of Acquired Immune Deficiency Syndrome (AIDS)', 26 February 1986.

[254] Ibid.

[255] 'Speech to Conservative Party Conference', *Margaret Thatcher Foundation*, 9 October 1987, [https://www.margaretthatcher.org/document/104431], accessed 27 March 2024.

reshape the frontier between sexual health as a taboo topic driven by concepts of individual responsibility and shame towards an issue requiring a collective public health response grounded in education and awareness.

On 3 March the Prime Minister adopted a more institutionalised approach to her attempted reshaping of Norman Fowler's public education campaign. Focusing once again on the language and style of the publications, Thatcher questioned the education material's acceptability in the eyes of the Advertising Standards Authority (ASA) and the Obscene Publications Act 1959 (OPA).[256] In response, Norman Fowler assured the Prime Minister that he had already consulted with the appropriate people regarding his campaign's acceptability, confirming the relevant parties believed no problems would arise given the 'overwhelming public interest requirement to provide factual information to the public to prevent the spread of AIDS provided a full "public good" defence.'[257] Thatcher's use of the ASA and OPA was an important deferral of responsibility that highlighted Thatcher's unwillingness to engage more intimately with AIDS policy and similarly, to articulate a social conservative message on society and sex aligned with her distaste for the existing messaging. A developing theme in AIDS policy, Thatcher continued to demonstrate little conviction when cultivating a more socially conservative message that aligned more closely with her own views of society and sex. The defensibility of the campaign's material and messaging as in the public interest positioned the Prime Minister somewhat at odds with the 'public good'. Moreover, the campaign's foundation rested on a scientific consensus that promoted the very material and messaging Thatcher opposed.

Nevertheless, these exchanges clarify the disassociation of Thatcher and the broader policymaking community at the heart of AIDS policy development and the Prime Minister's use of the ASA and OPA highlighted a fundamentally different perception of public health education. Responding to Fowler's foresight a Private Secretary reported back to the DHSS that 'the Prime Minister has emphasised that she still remains against certain parts of the advertisement. She thinks that the anxiety on the part of parents and teenagers, who would never be in danger from AIDS, would exceed the good which the advertisement might do.'[258]

[256] TNA, PREM19-1863, 'AIDS', 3 March 1986.
[257] TNA, PREM19-1863, 'AIDS', 5 March 1986.
[258] TNA, PREM19-1863, 'AIDS', 6 March 1986.

Primarily concerned with those 'who would never be in danger', Thatcher conceptualised the relationship between public health education and AIDS differently to Fowler and Acheson, emphasising the need to direct messaging towards at risk populations in contrast to the DHSS leadership who championed a much broader engagement with the general population. Importantly, these exchanges have shown what underpinned the Prime Minister's opposition to Fowler's education plan. The emphasis on parents and teenagers demonstrated a careful consideration for the transition of sex as a private issue controlled by parents and the family unit towards an issue of the public sphere, increasingly governed by the state through the National Health Service and by actors such as the CMO. Moreover, the inclusion of parents and teenagers alluded to a forward-looking public health strategy and demonstrated that Fowler and Acheson's perception of AIDS transcended a risk group framework. Although homosexual males and IVDUs were central to H-Committee's understanding of AIDS, it was the expanding horizon of Fowler and Acheson's messaging that created problems for Thatcher. Opposed to the consensus achieved by Fowler and H-Committee, Thatcher's belief that AIDS education was unnecessary outside the established risk groups perpetuated an image of those 'who would never be in danger' as innocent victims of Fowler's sexually explicit education material. Whereas the prospect of this changing power dynamic was chiefly underpinned by a concern for public health, Thatcher's conceptualisation of harm and innocence resonated beyond the confines of a socially conservative critique of sexually explicit messaging even if such ideals were the prime movers in her argumentation.

In a closing remark the Prime Minister's Private Secretary noted, 'Your Secretary of State [Fowler] will now wish to consider how to proceed in the light of the Prime Minister's firmly held views', however, Fowler and H-Committee resisted.[259] On 11 March, the Prime Minister accepted the minor amendments proposed by Fowler and approved the publication of the advertisements.[260] Despite Thatcher's intervention, H-Committee achieved an almost unchanged set of advertisements, thereby reinforcing the Prime Minister's position as a policy outsider. Whereas Thatcher's opposition engaged socially conservative themes concerned about the declining status of the family and the innocence of young people, her appeals for an institutional response shed light on the prospect of public health education breaking down

[259] Ibid.
[260] TNA, PREM19-1863, 'AIDS', 11 March 1986.

the existing status quo on society and sex, of public and private and they would receive further pressure as 1986 progressed.

Faced with a continued increase in AIDS cases Fowler suggested to Lord President of the Council (and *de facto* Deputy Prime Minister) Willie Whitelaw that the Government must considerably increase the education campaign to have any hope of slowing the spread of the disease.[261] Fowler's proposed method of increasing public awareness was a nationwide leaflet drop that he hoped would 'achieve a breakthrough in public recognition of the seriousness of the problem.'[262] Unsurprisingly, Fowler's desire to expand the UK's AIDS agenda into British homes sparked resistance from the Prime Minister and other conservative critics who cited the various risks associated with a national leaflet drop.

Lord Hailsham, a conservative critic of Fowler's AIDS policy argued that a leaflet drop represented the distribution of an unsolicited document and 'unsolicited correspondence is not universally popular, and not always effective as a means of communicating information or advice.'[263] Focused on the issue of consent, Hailsham's perception of AIDS was less about the disease and more about the impact of Government encroachment into the private sphere on public opinion. Like Thatcher's notion of necessary and unnecessary education, Hailsham's positioning of AIDS contrasted the need to establish awareness in the general population with government overreach.

Similarly to Lord Hailsham, the Prime Minister was opposed to the idea of a nationwide leaflet drop and sought 'professional advice on the likely impact' the proposed messaging might have on public opinion.[264] Like her use of the ASA and the OPA in March 1986 Thatcher's desire to seek 'professional advice' was in part a means of checking such a campaign was needed whilst putting pressure on the perceived necessity of the direct and explicit messaging put forth by Fowler and Acheson. The distribution of a nationwide leaflet that promoted openness about sexual health – such as condom use and safe sex with multiple partners – placed a bright spotlight on the Prime Minister's earlier assertions of public innocence and the perceived consequences of widespread public health messaging on AIDS. A nationwide leaflet drop

[261] TNA, PREM19-1863, 'AIDS – Public Education', 21 August 1986.
[262] Ibid.
[263] TNA, PREM19-1863, 'AIDS – Education', 3 September 1986.
[264] TNA, PREM19-1863, 'AIDS – Public Education', 10 September 1986.

would cross the boundary between public and private and place the messaging at the heart of Thatcher's critique in the homes of every British family without exception. Consequently, this discomfort encouraged a sense of scepticism from the Prime Minister that manifested a need to – once again – regulate AIDS policy in a way that seemed inoffensive and politically risk-averse. Thatcher's opposition, however, remained distanced and limited in scope as she sought to use institutional mechanisms in the form of private sector consultancy to place pressure on the Fowler messaging platform in a fashion not dissimilar to her use of the APA and OPA.

Reflecting on Fowler's proposal, David Willetts – a member of the Policy Unit – offered his support to the leaflet drop and suggested the Prime Minister receive an AIDS briefing to bring her up to date with the disease and the current UK strategy.[265] Likewise, Advisor Andy Bearpark supported the leaflet drop but placed greater emphasis on the disease's growing presence in the media and hinted that the government needed to keep pace with public opinion.[266] Describing the prospective leaflet's content as 'not offensive', Bearpark sought to allay the Prime Minister's fear of offending her constituents in the general population and her apprehension about the added value of Fowler's expanded education campaign.[267] Bearpark continued: 'it is now clear that the spread of the disease is going to affect the community generally, and not just sub-groups such as drug addicts and gays.'[268] Foregrounding the importance of attending to AIDS within the context of the general population, Bearpark's engagement with Thatcher stressed the importance of moving the Prime Minister's viewpoint away from 'those who would never be in danger' and towards a broader scope that accepted the capacity for widespread devastation. Bearpark and Willetts proved persuasive as the Prime Minister scheduled an AIDS briefing after her November trip to the US to meet with President Reagan where it appeared she was unlikely to discuss the disease at great length.

Accompanying calls for the Prime Minister to receive an AIDS briefing from Fowler and Acheson was a growing understanding that Thatcher required a more involved role in the development of AIDS policy, a position supported by Andy Bearpark, Bernard Ingham, and

[265] TNA, PREM19-1863, 'AIDS – Willetts', 7 November 1986.
[266] TNA, PREM19-1863, 'AIDS – Bearpark', 7 November 1986.
[267] Ibid.
[268] Ibid.

David Willetts.[269] Although Thatcher had proven largely peripheral in discussions about AIDS in 1986, the benefits of her involvement were three-fold: to better equip Thatcher to respond to AIDS as a political issue, to bring greater validity to AIDS in response to the mounting concern for transmission into the general population, and to closely supervise the development of policy to regulate and minimise the political risk associated with AIDS policy. An AIDS briefing was arranged and Fowler and Acheson personally updated the Prime Minister on AIDS in the UK for the first time on 28 November.[270] Focusing on basic information and the reality that no cure or vaccine existed, the Prime Minister offered little inspiration, reiterating the importance of maintaining the balance between 'preventing the spread of disease, and causing panic.'[271] Thatcher's most valuable contribution came from the request to distribute the briefing as widely as possible and recommending a special briefing be prepared for the European Council.[272] A symptom of her long-term discomfort and the rejection of her advances throughout 1986, the November briefing merely confirmed Thatcher's outsider status and strengthened the Fowler-Acheson policy dynamic. When situated against an expanding AIDS agenda, the commitment of millions of pounds in extra funding and the establishment of two decision-making units (Official Committee on AIDS and HSAC Sub-Committee on AIDS), the need to clarify rudimentary information demonstrated the consequences of the Prime Minister's protracted absence and the policy ignorance it fostered.

Thatcher's final and most impactful intervention of 1986 came on 30th December. In response to a request from Norman Fowler to issue a Prime Ministerial broadcast on AIDS Thatcher refused citing her belief that such an action was unnecessary.[273] During her time in Whitehall Thatcher had not used a broadcast, even during the Falklands conflict which she referenced as a precedent for her retort of Fowler's request. Unmoved in her stance, Thatcher firmly set the bar for Fowler's campaign against AIDS. A subtly important exchange between the Prime Minister and Fowler, the rejection of a broadcast – good or bad – provided a ceiling for the British AIDS response. Whereas 1986 had been largely shaped by those at the heart of policy mobilisation in the DHSS, the Prime Minister provided no ambiguity when contextualising the

[269] Ibid.
[270] TNA, PREM19-1863, 'AIDS', 10 November 1986.
[271] TNA, PREM19-1863, 'AIDS', 28 November 1986.
[272] Ibid.
[273] TNA, PREM19-1863, 'AIDS – Ministerial Broadcast', 30 December 1986.

priority and policy status of AIDS within the broader context of her government's activity. Furthermore, the rejection of a broadcast firmly removed the possibility of the Prime Minister assuming pole position on epidemic response. Despite her interventions in early 1986, by the end of the year the Prime Minister was very much at the periphery of AIDS policy, philosophically and practically.

For AIDS policy and Margaret Thatcher, 1986 proved a pivotal year. Although the Prime Minister's authority over policy development changed very little, her activity and associated consequences of those interjections altered the composition of her relationship with the disease. Thatcher's rejection of Fowler's messaging asserted a socially conservative critique that had found little space in Whitehall to date. The attempted utilisation of the ASA and OPA to uproot aspects of Fowler's education campaign firmly positioned her as a policy outsider. Whereas Thatcher had previously maintained a sense of distance from AIDS policy – perpetuated by Fowler and Acheson's ongoing control of policy development – the Prime Minister had now brought herself closer to AIDS policy albeit in a fashion opposed to the policy consensus.

Divergent Policymaking Responses: Policymaking Infrastructure and Legislature Critique in the US and UK

Opening a more substantial discourse on AIDS, policymakers and policy advocates in the US and UK engaged in a growing discussion of the disease in 1986. 1986 was a vital period that saw a transition from the similarities of absence and avoidance (1981-1984) towards increasingly dissimilar policy responses that began in the post-discovery phase (May 1984 onwards). To demonstrate this divergent narrative this discussion will explore the US and UK policymaking dialogue by utilising parliamentary and congressional discourse on AIDS. It will explore the development of an AIDS specific policymaking infrastructure in the UK and the comparative lack of a similar structure in the US as a vital indicator of policy development and evidence of the growing disparity between the two administrations.

Although AIDS policy advocates were establishing a firmer presence on Capitol Hill, the incompatibility of the disease and the prevailing political ethos became increasingly evident.

A reflection of the Reagan administration's unwavering scrutiny of domestic spending, AIDS became a health crisis shaped by designs on limited federal expenditure. Despite public declarations of 'national interest' and 'high priority', the President maintained his push for social spending retreat in early 1986 which prompted criticism from Congress of his responses inadequacy and lack of policy ownership.[274] Speaking to the House of Representatives in February, Ted Weiss (DEM-NY) suggested that 'yesterday President Reagan went up to the Department of Health and Human Services and told the staff there that he considered AIDS to be the No. 1 health priority concern of his administration. At the same time, he sent to us a budget proposal which would gut the funding for programs which address the AIDS epidemic.'[275] Emphasising the contradictory interplay between Reagan's supportive public persona and his private efforts to curtail federal expenditure on the disease, Weiss shone a spotlight on the administration's habitual inadequacy by condemning the President's lip service proclaiming to the House of Representatives in a discourse entitled, *The President's Handling of the AIDS Crisis*: 'Some top health priority - come on, Mr. President, have a heart. People are dying out there.'[276] Articulated alongside an assortment of fleeting commitments to developing AIDS policy, the President emphasised that he had requested a 'major report' from Surgeon General Everett Koop amongst broader appeals to tackle prevention and awareness in the US.[277] Although federal spending had dominated AIDS discourse in the White House thus far, the prospect that the President's contradictory public and private stances on AIDS were underpinned by a 'magic bullet optimism' built on a faith in science delivering a solution was not unsurprising.[278]

The introduction of the *AIDS Counselling, Education and Service Act 1986* (S.2345) by New York Senator Daniel Patrick Moynihan became emblematic of the challenge posed to the

[274] American Presidency Project (APP), 'Remarks to Employees of the Department of Health and Human Services', [https://www.presidency.ucsb.edu/documents/remarks-employees-the-department-health-and-human-services], accessed 11 March 2024. APP, 'Message to the Congress on America's Agenda for the Future', [https://www.presidency.ucsb.edu/documents/message-the-congress-americas-agenda-for-the-future], accessed 11 March 2024.
[275] T. Weiss (NY), 'The President's Handling of the AIDS Crisis', *Congressional Record* 132 (1986), p. 1944. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.
[276] Ibid.
[277] APP, R. Reagan, 'Remarks to Employees'.
[278] Magic Bullet Optimism - a belief that huge research spending would eventually produce a cure or solution for AIDS, avoiding the need to development long term policy. Interestingly, in the UK, Labour MP Leo Abse was highly critical of the government for the delay in responding to AIDS, a delay he attributed to the Conservative government's subscription to 'American optimism.' (Hansard, HC, 21 November 1986, v. 105 c.821.)

Reagan White House by an expanding federal AIDS agenda driven by service provision.[279] Highlighting the legislature-executive battle over AIDS resourcing, Weiss told his colleagues in the House of Representatives that 'in each year of the epidemic, the Congress has overcome the unwillingness of the administration to fund AIDS.'[280] Allocating substantially larger amounts year on year than the Reagan budget intended, Congress continued to uphold a challenge to the lack of priority provided by the White House. Moynihan's legislation was symbolic of the gaps created by the Reagan administration's drive to reduce federal AIDS expenditure, targeting the expansion of services for the growing number of people with AIDS (PWAs) that the existing system was not built to support and providing a more tangible, long term federal commitment to AIDS resourcing. Furthermore, the legislation shed light on the struggle to establish a sense of ownership for AIDS policy in the White House and how – despite Congressional intervention – the continued desire to depreciate AIDS resourcing became symptomatic of a broader lack of attentiveness in terms of policy intervention.

Reflecting on the American approach to AIDS resourcing, Labour MP Leo Abse passionately appealed to the House of Commons to dissuade the government from falling into the trap of 'American optimism' that had stifled the US response.[281] Abse – the individual responsible for the piloting of reforms to homosexuality lawin Britain – emphasised the overreliance of US AIDS policy on a solution grounded in scientific discovery and not service provision and education, a dependency that became symbolic of the growing divergence in the US and UK policy narrative. Although Abse was not a decision-maker, his critique aligned closely with the prevailing policy initiatives in Whitehall and the DHSS. By contrast, the interplay between efforts to push back the expansion of service provision and maintaining public and private support for research endeavours, the Reagan White House appeared optimistic about the ability of research and science to remove the contradictions between epidemic response and neoconservative governance by providing a solution grounded in medical innovation and not public health.

[279] D. P. Moynihan (NY), 'AIDS Counselling, Education, and Service Act', *Congressional Record* 132 (1986), p. 8125. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.
[280] T. Weiss (NY), 'Twenty Thousand AIDS Cases, 10,800 Dead', *Congressional Record* 132 (1986), p. 8852. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.
[281] Hansard, HC, 21 November 1986, v. 105 c.821.

More specifically, policymakers adopted an increasingly ideology free perspective in their pursuit of AIDS policy that manifested in a fresh and engaged discussion about the rising infection rate amongst intravenous drug users (IVDUs). Uneasy about the prospect of infection amongst IVDUs, Sir Bernard Braine MP took to the House of Commons to articulate his concern for the growing equality between rates of HIV/AIDS reported amongst male and female IVDUs.[282] Although Braine failed to substantiate the origins of his concern with regards to AIDS and IVDUs, his concern for IVDUs more generally was a well-founded political issue familiar to many policymakers in Westminster. In 1981, the number of people using heroin was estimated to be between 10,000 and 25,000 in the UK, however, by the middle of the decade this estimate had increased dramatically to between 60,000 and 80,000.[283] In addition, the price of heroin was decreasing rapidly making the drug more accessible and by the end of the decade the price of heroin was half the 1978 value.[284] As heroin became increasingly accessible and the number of heroin users swelled so did the risk of widespread needle sharing and subsequently, the mass transmission of HIV amongst injecting users.[285] Although IVDU was certainly a nationwide issue, the rise in HIV infection rates amongst recreational drug users was more acute in Scotland and thus, major cities such as Edinburgh, Glasgow and Dundee became focal points in the growing AIDS and IVDU discourse.[286] Failing to adequately reflect the disparity between the English and Scottish experience of HIV/AIDS, Barney Hayhoe suggested to Braine that individuals ceasing 'casual and promiscuous relationships' was the best way to stop the spread of disease in the UK.[287]

Nevertheless, the Scottish experience achieved growing traction in Westminster following the advocacy of individuals such as Lord Campbell of Croy who voiced his concern for the 'disturbingly high' rates of infection amongst IVDUs in Edinburgh.'[288] Likewise, Sir Bernard Braine observed a transnational comparison between the escalating situations in Edinburgh and New York City concluding that such a comparison was 'a dreadful statement to have to

[282] Hansard, HC, 6 March 1986, v. 93 c.560.
[283] N. Morgan, 'The Heroin Epidemic of the 1980s and 1990s and its effect on crime trends – then and now', *Home Office Research Report*, 79 (July 2014), p. 25.
[284] G. V. Stimson, 'British Drug Policies in the 1980s: A Preliminary Analysis and Suggestions for Research', *British Journal of Addiction*, 82:6 (May 1987), pp. 480-481.
[285] Ibid.
[286] Hansard, HC, 6 March 1986, v. 93 c. 561.
[287] Ibid.
[288] Hansard, House of Lords (HL), 10 March 1986, v. 472 c. 393.

make.'[289] The disparity between the Scottish and English experience reflected that of many American states such as Wyoming and North Dakota which had a combined total of 9 AIDS cases (< 0.1% of total cases) or even North Carolina and Michigan with a total of 418 AIDS cases (combined 1.4% of total cases) whose experience of AIDS was substantially different to hard hit states like California and New York which combined for a total of 15,577 cases (53.7% of total cases).[290] Where Braine drew on the Edinburgh-New York City comparison to demonstrate the rapidly climbing rates of infection, the catalytic effect of IVDU was another underlying similarity between the two cities' climbing rates of infection. These regional and even local disparities between total AIDS cases highlighted the complexity of developing a federal mandate for epidemic response as the challenges posed across the nation – US or UK – existed on a complicated epidemiological spectrum that varied in caseload and by demographic and lifestyle characteristics.[291]

Citing a concern for the sexual partners of infected IVDUs and babies born to infected mothers, Braine perceived the relationship between IVDUs and the general population as a concerning avenue through which the disease could spread on a large scale.[292] Clarifying his position he added: 'If it is not checked, it will become endemic among injecting drug users and it is likely that it will infect others who have never injected drugs and have never had any reason to suppose themselves to be at risk.'[293] Like Margaret Thatcher's notion of those 'who would never be in danger', Braine's concern for the infectious potential of IVDUs indicated the importance of protecting the general population to his perception of AIDS policy.[294] Seemingly unconcerned with the welfare of IVDUs, Braine represented a new wave of policymakers formally entering the AIDS policy fold for the first time enlightened by the realisation that the general population was at risk of the deadly disease.

Amid the rising tide of concern about IVDU politicians looked to policy that could stem the flow of infection and the most noteworthy and contentious of these was needle exchange. A scheme based on the exchange of used injecting equipment like needles and syringes for clean

[289] Hansard, HC, 6 March 1986, v. 93 c. 561.
[290] Centres for Disease Control, 'AIDS Weekly Surveillance Report', (December 1986), p. 2.
[291] Although not the focus here, adopting a similarly comparative structure to this study to examine the diversity of experiences in state, city or local would be a fruitful pursuit for future scholarly work.
[292] Hansard, HC, 6 March 1986, v. 93 c.560.
[293] Ibid.
[294] TNA, PREM19-1863, 'AIDS', 6 March 1986.

alternatives, the policy attracted significant opposition in both Houses of Parliament from the moment it was introduced. Braine described the policy as 'the equivalent of trying to control an epidemic of smallpox by issuing vials of smallpox.'[295] Continuing his opposition to needle exchange by suggesting it was 'tantamount to inciting, assisting, aiding or abetting the commitment of offence', Braine viewed needle exchange in terms of drug use and not infection control, perceiving any attempt to supply injecting equipment as condoning recreational drug use.[296] Likewise, Parliamentary Under-Secretary for Health Baroness Trumpington told the House of Lords that she feared a needle exchange scheme might encourage experimentation with injectable drugs amongst young people and perpetuate the already problematic issue of recreational drug use in Britain.[297]

Fundamentally, both Braine and Trumpington's apprehensions about needle distribution highlighted the complicated interplay between needle exchange as a usage issue and an infectious disease issue.[298] Whereas needle exchange attracted advocacy that emphasised the need to consider the potential effects a nationwide scheme would have on lowering infection rates amongst IVDUs, detailed discussion was largely confined to Whitehall where the nuances of the scheme could be discussed without public attention. The apprehensiveness of politicians on needle exchange was largely captured by a HSAC Sub-Committee minute in late 1986 which suggested that following the potential introduction of a nationwide needle exchange scheme, there would 'no going back.'[299] Anxieties about a rise in recreational drug use following the potential introduction of a needle exchange scheme were widespread, however, the contentious nature of the subject clouded much of the discussion about the policy and undermined the scheme's value as a barrier to infection. Intended to remove contaminated needles from circulation, the schemes were primarily geared around harm reduction whilst also opening avenues for IVDUs to access services and support.[300]

[295] Hansard, HC, 6 March 1986, v. 93 c.560.
[296] Ibid.
[297] Hansard, HL, 10 March 1986, v. 472 c. 393.
[298] Hansard, HC, 6 March 1986, v. 93 c. 560.
[299] CAB/134/5005, TNA, Home and Social Affairs Committee Sub-Committee Meeting (HSAC), 3 December 1986, p. 7.
[300] The use of circulation here denotes the sharing of needles in shooting galleries. The use of communal or shared injecting equipment in shooting galleries was common and represented an important location for disease transmission.

Seemingly unreserved in their dismissal of a needle exchange scheme, the small chorus of Conservative policymakers cited showed little enthusiasm for the potential benefits a potential needle exchange might provide IVDUs. The concern amongst some policymakers that needle exchange would merely perpetuate recreational drug use endorsed a usage approach towards needle exchange that dismissed IVDUs as necessary recipients of policy intervention and demonstrated a failure to fully grasp the primary benefit of introducing an exchange scheme – stopping the spread of HIV/AIDS. Importantly, during these initial stages of discussion, needle exchange schemes had very little field evidence. Although Baroness Masham of Ilton correctly cited the effectiveness of schemes in Holland and Switzerland, the apprehensive approach adopted by UK policymakers reflected the experimental nature of the proposed policy intervention.[301] Overall, the initial response to needle exchange was underwhelming and the prospect of the scheme's adoption in the parliamentary sphere was unlikely despite heated debate. The discussion in Whitehall and the DHSS was increasingly focused on the potential for infection prevention which helped maintain a buoyancy for needle exchange as a potential policy intervention, however, opposition from those fixated on needle exchange as a usage issue lingered in Parliament.

In the US a similarly cautious approach had been adopted in hard-hit cities like New York City. By 1987, it was estimated that nearly half of the city's 200,000 heroin users could be carrying HIV and in response, organisations such as ADAPT had established private – and illegal – needle exchange schemes before the first city-sponsored scheme was set up with limited success years later.[302] Writing in 1993, Warwick Anderson concluded in his study on needle exchange in New York City that the 'explicit moral and political aspects of the problem' were paramount in shaping policymaker unease despite the spiralling number of infections amongst IVDUs.[303] In summary Anderson suggested that needle exchange faced significant social resistance which ultimately limited the ability of expert groups and specialists to deliver policy intervention that dealt with HIV infection amongst IVDUs.[304] Likewise, many British policymakers looked to the broader implications of needle exchange and expressed an unease

[301] Hansard, HL, 10 March 1986, v. 472 c. 394.
[302] W. Anderson, 'The New York Needle Trial: The Politics of Public Health in the Age of AIDS', in V. Berridge and P. Strong (eds), *AIDS and Contemporary History* (1993), p. 162. Ibid p. 163.
[303] Ibid, p. 174.
[304] Ibid.

about the potential intervention that misrepresented the policy's fundamental goal of infection prevention – the technical issue to use Anderson's terminology – in favour of the controversial political issue of recreational drug use. Reflecting Anderson's hypothesis in the UK context, the scheme's boundary-pushing concept provoked a response from those concerned with the moral dilemma attached to the distribution of injecting equipment. Although initial critics of needle exchange demonstrated a heightened focus on the social implication of needle distribution, this perspective was grounded in a fear of rising recreational drug use that was appropriate for the period's drug policy discourse.

Unconvinced by needle exchange, Minister of Health Barney Hayhoe suggested that IVDUs might 'realise the gravity of the threat to their health from the HTLV infection, I hope that they will cease sharing their equipment.'[305] Hayhoe's desire to see IVDUs simply 'realise' and 'cease' their usage demonstrated a misunderstanding of the challenges posed by IVDU. Likewise, Scottish MP Barry Henderson suggested that 'the best way to control drugs and the spread of AIDS would be to encourage more self-discipline and higher moral standards among the population at large.'[306] Similarly, Parliamentary Under-Secretary for Scotland John MacKay proclaimed to the House of Commons that 'AIDS is a totally self-inflicted disease … it is a moral question, which comes down to people reviewing their living habits.'[307] Those evoking notions of immorality and corruption increasingly individualised the issue of AIDS in a way comparative to the style of discourse associated with recreational drug use and the sexual revolution of the 1960s and 1970s. Capturing the essence of what Alan Brinkley has called 'a relatively short phenomenon born of the frustrations of … perhaps above all the political and cultural upheaval of the 1960s and 1970s,' the pursuit of a moralist and individualistic critique emphasised the perceived linkage between the social mores of the preceding decades and AIDS epidemic of the 1980s.[308] Moreover, this narrative represented the culmination of a socially conservative critique that was increasingly concerned with the decline of traditional values and the relegation of the family unit, a narrative Lesley Hoggart has described as at 'the forefront of attempts to reverse the liberalism of the 1960s and 1970s.'[309] Furthermore, these

[305] Hansard, HC, 6 March 1986, v. 93 c. 560.
[306] Hansard, HC, 30 April 1986, v. 96 c. 918.
[307] Ibid.
[308] A. Brinkley, 'The Problem of American Conservatism', *American Historical Review,* 99:2 (April 1994), p. 415.
[309] L. Hoggart, 'Neoliberalism, the New Right and Sexual Politics' in A. Saad-Filho and D. Johnston (eds), *Neoliberalism* (London 2005), p. 149.

ideals were seemingly opposed to the public health response being fashioned by the DHSS whose emphasis on collective responsibility was firmly in-keeping with the attitude towards public health that had shaped post-war reforms of British healthcare.

In a heated exchange, Scottish Labour MP John Maxton responded by underlining MacKay's finger pointing moralism as 'a most remarkable statement and a major condemnation of large numbers of people who just happen to have lifestyles different to that of the Parliamentary Under-Secretary of State.'[310] Observing MacKay's interjections on IVDUs and HIV infection, Maxton illustrated the contentious intersection between usage and infection prevention that underpinned the difficult discussion of needle exchange and transmission via IVDU generally. Whereas those critical of needle exchange and IVDU policy generally had placed a spotlight on a more cautious approach to transmission via IVDU, they represented a minority in the growing discourse around AIDS policy and amongst key policymakers such as Norman Fowler and Donald Acheson. Similarly, the moralism espoused by the likes of Braine, Henderson, and MacKay reflected the disruptive interjections of Margaret Thatcher although the Prime Minister demonstrated a more acute concern for children and the family. A valuable factor distinguishing policymakers such as Fowler and Acheson from those championing a moralistic critique was the requirement for policy intervention. Ultimately, H-Committee's steadfast focus on education embodied a drive towards delivering tangible policy interventions that endeavoured to tackle AIDS in the UK. Although a heightened sense of moralism pervaded the parliamentary sphere during this period it achieved little traction. Despite fleeting endorsements from the Prime Minister and verbal backing amongst some parliamentarian's moralism failed to permeate the British response in 1986.

As the summer of 1986 arrived in the US AIDS discourse remained focused on federal funding, notably with Representative Robert Mrazek (DEM-NY) highlighting the glaring gaps in AIDS funding and Senator Al D'Amato (REP-NY) calling for immediate federal action to attend to the 'costly disease.'[311] In July, the discussion of funding moved towards federal and private sector responsibility for AIDS-related workplace disability claims under Section 504 of the

[310] Hansard, HC, 30 April 1986, v. 96 c. 918.
[311] R. Mrazek (NY), 'AIDS Treatment', *Congressional Record* 132 (1986), p. 18602. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024. A. D'Amato (NY), 'AIDS Demonstration Projects', *Congressional Record* 132 (1986), p. 19602. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

Rehabilitation Act. Signed into law in 1973, Section 504 of the Rehabilitation Act 'forbids organizations and employers from excluding or denying individuals with disabilities an equal opportunity to receive program benefits and services.'[312] Although Senator Jesse Helms (REP-NC) emphasised the need to allow insurance companies to assess an individual's 'possibility of developing AIDS', Section 504 blurred the lines between health care and civil rights.[313] A conservative advocate known for his outspoken views on Gay rights and AIDS, Helms lobbied for the right for private healthcare providers to assess AIDS risk factors when calculating customer premiums citing the inequity of a risk pool filled with unknown PWAs driving up the overall cost of healthcare for American consumers.[314] In contrast, Massachusetts Representative Barney Frank suggested that 'there are people who have sunk to the point of [demagoguing] against people with AIDS, a classic case of blaming the victim and inflicting pain and hardship on people who are already suffering and on their families and on their friends.'[315] Unlike Helms, Frank focused on uncoupling PWAs from concepts of collective responsibility and consequence. This, however, this raised broader questions about the relationship between Reagan's remodelling of the US welfare system and AIDS policy.

Framed by Fox, Day, and Klein as a 'heavy burden that was made worse by the absence of federal subsidies', the impact of the Reagan administration's pursuit of federal retrenchment on social and welfare expenditure contributed to a climate of neglect that undermined and deeply contrasted the collectivist welfare politics associated with the New Deal and the Great Society.[316] As the conditions for participation in the US welfare system narrowed during the 1980s the difficulties associated with diagnosing, treating, and researching AIDS placed greater strain on the relationship between the consumer and private health insurance, threatening to undermine the overall goal of healthcare provision. More recently, Jonathan Bell has discussed PWAs as prospective recipients of federal benefits in the age of Reagan,

[312] 'Your Rights Under Section 504 of the Rehabilitation Act (1973)', *Department of Health and Human Service: Office of Civil Rights,* June 2006, p. 1. [https://www.hhs.gov/civil-rights/for-individuals/disability/section-504-rehabilitation-act-of-1973/index.html], accessed 11 March 2024.
[313] J. Helms (NC), 'Disapproving an Act of the District of Colombia District', *Congressional Record* 132 (1986), p. 14617. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.
[314] Ibid.
[315] B. Frank (MAS), 'Section 505 of the Rehabilitation Act and Discrimination Against People with Disease in the Workplace', *Congressional Record* 132 (1986), p. 17036. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.
[316] D. Fox et al, 'The Power of Professionalism: Policies for AIDS in Britain, Sweden, and the United States', *Daedalus,* 118:2 Living with AIDS (Spring 1989), p. 105.

observing the 'peculiar dynamic of welfare politics' that challenged the politics of poverty, social exclusion, and bureaucratic inertia to build a more visible presence for individuals with AIDS in the US welfare system.[317] Although the provision of healthcare has been a fundamental part of welfare discourse for much of the post-war period in the US, the AIDS Crisis highlighted the importance of the private-public dynamic to the provision of healthcare in the US. As suggested by the dialogue between Helms and Frank, the interplay between private insurance and the federal purse was a point of difference that has little resonance in the UK. Unlike British policymakers who benefitted from the comforting safety net provided by the National Health Service (NHS), US policymakers were required to state the terms of engagement for AIDS healthcare provision and these discussions often boiled down to the fundamental question of who was responsible for funding AIDS care during a period of spiralling costs.

Similarly in July, following a Department of Justice (DOJ) ruling that stated 'AIDS victims may be fired or excluded from Federal programs if public health officials and employers believe such acts will prevent spreading the fatal disease' the issue of civil rights and AIDS collided publicly.[318] The ruling largely threatened the future employment status of those employed by the federal government or by government contracts who might test positive for AIDS. The *New York Times* reported that the ruling had caused 'dismay' and 'anger' amongst scientists and health officials and identified the DHHS as the author of the poorly received new ruling.[319] Moreover, the American Medical Association state that the ruling permitted discrimination against people with AIDS and was 'incorrect and unjustified.'[320] An internal handwritten note – with no author or recipient's name attached – observed a sense of tension in the Reagan administration following the release of the new ruling: 'there is a serious inter-agency dispute brewing here; Justice and HHS [Health and Human Services].'[321] Moreover, a conflicting sense of ownership pervaded the administration's public response to the ruling's negative reception. An unnamed health official called it 'a surprise' whilst DOJ spokesman John V. Wilson stated

[317] J. Bell, 'Rethinking the "Straight State": Welfare Politics, Health Care, and Public Policy in the Shadow of AIDS', *Journal of American History,* 104:4 (March 2018), p. 932.
[318] HE001 430274, Reagan Presidential Library and Museum (RPLM), Unknown, 'Memo – Department of Justice Ruling on AIDS Federal Employment', 23 June 1986.
[319] 'Ruling on AIDS Provoking Dismay', *The New York Times*, 27 June 1986.
[320] 'A.M.A. Assails Decision of Justice Dept. on AIDS', *The New York Times,* 12 July 1986.
[321] HE001 430274, RPLM, Unknown, 'Memo - AIDS Federal Employment', 23 June 1986.

'If people have a quarrel, it's with Congress. Congress legislates and we interpret what's been given to us.'[322] Speaking to *the New York Times*, Assistant Attorney General Charles J. Cooper clarified that current civil rights law did not offer any protection to those with AIDS working for the federal government.[323] Citing the wide ranging impact the new ruling would have on her constituents, Californian Councilwoman Helen Albert wrote to the President calling the ruling 'the most profound denial of basic human rights … this decision is not only an atrocity, but it ignores <u>all</u> [original emphasis] scientific data.'[324] Symptomatic of the administration's unclear AIDS agenda, the DHHS's new ruling contradicted the administration's existing stance on casual contact that had reflected the scientific consensus on the issue. Therefore, the new ruling appeared to be a pursuit of PWAs in the workplace, communicating a sense of discrimination the administration could little afford.

Somewhat conspiratorially Senior Policy Analyst James Warner noted in a memorandum to Assistant to the President on Policy Development, John Svahn, that the 'members of the high-risk groups … are also becoming emotional in response to what they see as a campaign against them, thinly disguised as a fear of infection.'[325] Warner also noted a newspaper poll in New York City that found that 37% of respondents believed that AIDS was created by the CIA as a means to eliminate homosexuals and that graffiti in the District of Columbia had equated AIDS to genocide.[326] Whereas Warner's notion of conspiracy and 'emotion' provided an alternative to the waves of critique the DHHS ruling attracted, the ruling on federal workers with AIDS represented a brief and incoherent intervention entangled in a public health response to infectious disease. Furthermore, the ruling demonstrated the growing disassociation between the Reagan White House and the scientific establishment on core messaging such as casual contact. The inability of the Reagan administration to articulate messaging aligned with the scientific consensus on the disease provided little validation for those delivering the White House AIDS stance on Section 504 and the disability ruling. Consequently, the perception of discrimination against PWAs intensified, culminating in a heightened sense of disillusionment

[322] 'Ruling Provoking Dismay', *The New York Times*, 27 June 1986.
[323] Ibid.
[324] HE001 408924, RPLM, H. F. Albert, 'Letter to the President on the Department of Justice ruling on firing employees with AIDS', 3 July 1986, p. 1.
[325] HE001 438058, RPLM, J. Warner, 'Letter to John A. Svahn', 1 August 1986, p. 4.
[326] Ibid.

amongst AIDS policy advocates that remained frustrated and distraught with the Reagan response to the still escalating epidemic.

As the year progressed and the frequency of AIDS-related debates began to decline, Californian Representative Henry Waxman (DEM-CAL) delivered a damning critique of Reagan's response to the House of Representatives in August. Reflecting a frustration with the inadequate federal response, Waxman stated that 'We will remember and regret saving a few million dollars and losing hundreds of thousands of lives.'[327] Comparing Reagan's administrative avoidance to the failure of Neville Chamberlain's policy of appeasement and Herbert Hoover's Great Depression presidency, Waxman emphasised the incompatibility of Reaganomics and the AIDS Crisis proclaiming 'We have a Nation under the reign of a budget-slashing administration and under siege by a budget-busting epidemic.'[328] Waxman's war and tyranny metaphors communicated a sense of discontent amongst opposition policymakers that was symbolic of the legislature-executive battle that had gripped AIDS policy since 1983. Citing the 'politics of sexuality in this country', Waxman accentuated the relationship between the social and economic pillars of Reaganism when criticising 'the Reagan Administration-pennywise and pound-foolish and afraid to be seen helping gay men and drug abusers has consistently short-changed all efforts. We will pay for that neglect.'[329] Moreover, Waxman's condemnation underlined the centrality of funding inadequacy as a cornerstone of opposition critiques. Shaped by the inability to articulate a strategy that reconciled the administration's ideological commitments to fiscal responsibility and social conservatism, the US government response continued to attract criticism. Although Sir Bernard Braine amongst others had vocalised a moralist socially conservative critique, key British policymakers appeared less shackled by the interplay between ideology and the politics of sexuality and AIDS than their US counterparts whose commitment to fiscal responsibility, social conservatism and executive disassociation continued to undermine AIDS policy in the US.

Following an extended period of limited engagement that undermined the sense of urgency demonstrated in the UK, between March and May 1986, Baroness Trumpington opened a debate in the House of Lords in October that ignited a diverse discussion on issues ranging

[327] H. Waxman (CA), 'Disapproving an Act of the District of Colombia District', *Congressional Record* 132 (1986), p. 14617. (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.
[328] Ibid.
[329] Ibid.

from screening mandates to AIDS in prisons. In a short opening speech that emphasised individual responsibility, the importance of education, and the seriousness of AIDS in the UK, Trumpington assured her colleagues that the government was taking action to tackle the spreading disease.[330] Although Trumpington's derived her notions of action from Norman Fowler's expanding AIDS agenda, the issue of screening had yet to receive significant attention until now. An issue raised by Baroness Sharples, the screening of entrants from countries with comparably high rates of infection was an idea floated with increasing frequency as advocates promoted the perceived benefits of keeping the disease 'out of the UK' through border regulations and testing.[331] Confirming that the government had discussed the possibility of screening, Trumpington reiterated that no decision had been made.[332] She cited the advice of medical experts who questioned the effectiveness of testing entrants before outlining the immense practical implications of such an undertaking.[333] Moreover, introducing the screening of foreign entrants on a selective basis carried complicated diplomatic baggage. Simon Glenarthur – returning from the Commonwealth Health Conference – privately notified senior officials including the Prime Minister that 'both Tanzania and Uganda were prepared to take strong and immediate retaliatory action should we implement screening.'[334] Described by Glenarthur as a considerable 'strength of feeling', the Commonwealth nations opposition to the screening of their citizens entering the UK demonstrated the political and practical implications of screening specific groups of entrants. Summarising the issue during an exchange with Foreign Minister Geoffrey Howe weeks later, Norman Fowler suggested that 'if the aim is to prevent anyone with AIDS virus from entering the United Kingdom, then the only logical position is to require the screening of all visitors and the screening of returning residents. But the practical implications of this are daunting.'[335] Faced with several substantial barriers, the prospect of screening becoming a cornerstone of the UK's response was increasingly unlikely; however, interest at the parliamentary and government level did not dissipate despite the disinterest from leading policymakers like Fowler and Acheson. Likely a consequence of growing confidence in and availability of testing protocols, the perception of

[330] Hansard, HL, 14 October 1986, v. 480 c.680.
[331] Ibid, c.681.
[332] Ibid, c.683.
[333] Ibid.
[334] TNA, PREM19-1863, 'Screening for AIDS', 17 October 1986.
[335] TNA, PREM19-1863, 'AIDS', 7 November 1986.

screening as an effective response was largely grounded in a superficial appreciation of what mandated testing could provide the UK response. As Fowler and Acheson had outlined, the thin veil of protection provided by screening was generally targeted at the wrong people, was incredibly time sensitive both in terms of frequency of testing and length of perceived protection, extremely difficult to enforce and vastly expensive.

In the US, screening was similarly challenging and attracted a more complicated response. Margot Canaday has described immigration law as 'the arena where the state had the greatest administrative discretion to act against a subject population … There, the state created and articulated some of its most far-reaching rules defining homosexuality.'[336] In addition, Amy Fairchild and Eileen Tynan have note that whilst 'the AIDS epidemic did not represent the first instance in which epidemiology used the language of risk groups, nationality, or race to define parameters of a disease. Yet for the first time, epidemiology became prominent in the attempt to contain the blood of particular nationalities.'[337] For example, Haitian migrants were subjects of early AIDS policy and their classification as a risk group by the CDC in 1982 contributed to a recommendation to avoid donating blood that developed into a Food and Drug Administration ban on donating in 1984 for all Hatain migrants who had entered the US after 1977.[338] Despite AIDS policy facing a wide variety of political and economic barriers, the pursuit of medical testing for visas and foreign entrants faced less opposition as the Reagan administration exercised the federal responsibility for immigration law.

Minutes from a February meeting between the State Department and DHHS suggested that the DHHS remained 'unswayed by the difficulties and expense imposed by making ELISA tests … a part of the medical exam for visas' and intended to pursue a rule change that would make AIDS a grounds for visa denial.[339] The pursuit of screening contradicted the sentiment of

[336] M. Canaday, *The Straight State: Sexuality and Citizenship in Twentieth Century America* (Princeton/London 2009), p. 214.
[337] A. L. Fairchild and E. A. Tynan, 'Policies of Containment: Immigration in the Era of AIDS', *American Journal of Public Health,* 84:12 (December 1994), p. 2013.
[338] G. T. Hensley, 'Opportunistic Infections and Kaposi's Sarcoma among Haitians in the United States', *Morbidity and Mortality Weekly Report,* 31:26 (July 1982), pp. 353-361. Fairchild and Tynan, 'Policies of Containment', p. 2013.
[339] The British Society of Immunology describes the ELISA test – Enzyme-Linked Immunosorbent Assay (ELISA) – is an immunological assay (a procedure used to measure the presence of something) commonly used to measure antibodies, antigens, proteins, and glycoproteins in biological samples. (C. Horlock, 'Enzyme-linked immunosorbent assay (ELISA), *British Society of Immunology,* [https://www.immunology.org/public-information/bitesized-immunology/experimental-techniques/enzyme-linked-immunosorbent-assay], accessed

budgetary restraint that had governed AIDS policy and Reagan's presidency generally since 1981 and the suggestion that a large-scale screening programme for AIDS might attract special attention appeared problematic. Unlike the UK discussion of screening that adopted a cautious approach, the State Department and DHHS held different opinions on screening foreign entrants and visa applicants. The State Department noted: 'They [DHHS] are also insensitive to the near certain retaliatory (reciprocal, if you wish) actions other governments will take, and the expense and difficulties that will impose on U.S. citizens.'[340] In a letter addressed to the Director of the Office of Management and Budget James Miller, Assistant Secretary of Legislative and Intergovernmental Affairs William L. Ball suggested that the DHHS had given 'insufficient consideration' to the 'difficulties inherent in implementing their proposal.'[341] Likewise, Deputy Secretary of State, John C. Whitehead contacted James Miller to remind him that the US was seen as a 'principal exporter of the disease' and that the proposed rule change carried with it significant 'political risk.'[342] Both Whitehead and Ball affirm the State Department's opposition to the proposed rule change taking great care to outline their belief that the proposal was expensive, ineffective and unnecessary.

By definition, a strong and successful health screening policy would keep a disease out of the US only if implemented before the escalation of the disease within the country. Given the nearly 16,000 known cases of AIDS recorded domestically by the end of 1985, and the perception amongst many nations that the US was 'patient zero' for AIDS globally, any suggestion that AIDS could be 'kept out' was problematic.[343] Government-sponsored literature in the UK such as *Some Facts About AIDS* looked to the US as the most affected country in the world which reaffirmed the illusionary prospect of keeping 'out' a disease that was already 'in'.[344] Moreover, the cost of this prospective testing raised questions about the application of fiscal responsibility and the broader practicality of such as screening protocol. For example, the State Department estimated that providing ELISA testing for refugees entering the US would cost the federal government $2.2 million a year, a significant figure

22 December 2023. Document 14 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI Global Issues II', *Office of the Historian*, (Bureau of Public Affairs, November 2017), p. 40.
[340] Ibid.
[341] HE001 382833, RPLM, W. L. Ball, 'Letter to OMB – James Miller', 6 February 1986, p. 1.
[342] HE001 383452, RPLM, J. C. Whitehead, 'Letter to OMB – James Miller', 21 March 1986, p. 2.
[343] Centres for Infectious Disease, 'Acquired Immune-Deficiency Syndrome (AIDS) Weekly Surveillance Report', *Centres for Disease Control,* 30 December 1985, p. 1.
[344] TNA, PREM19-1863, 'Some Facts About AIDS', (1985).

when compared to the tens of millions the Reagan administration had tried to avoid allocating to the AIDS budget each year since 1983.[345] Moreover, the Reagan administration's commitment to recycling budgetary restraint and fiscal responsibility as barriers to policy intervention were not aroused in response to the DHHS's approach to screening policy, leaving this early exploration of the US screening debate as something of a unique exchange. Demonstrating an uncharacteristic ambivalence to expenditure and diplomatic fallout, the style and vigour of the DHHS's pursuit of screening was an AIDS policy anomaly. Although a single-minded, US-centric approach would somewhat explain the health department's actions, the glaring flaws, huge expense, and unrealistic expectations of keeping AIDS 'out' made the preoccupation with a screening mandate increasingly at odds with the administration's broader appeals for limited engagement with AIDS policy. Whilst the screening policy was unrealised in 1986 it would establish strong support in 1987 and 1988.

In October in the UK, policymakers raised questions about the timing of the government's campaign, Crossbencher Lord Kilmarnock asked 'are they [the government] satisfied that their advertising campaign is adequate? Are the Government aware that it has been widely criticised as being too feeble, possibly because of fear of public disapproval, and has failed to provide enough information to help prevent the spread of the virus.'[346] Shaped by the complicated political status of AIDS, Kilmarnock's appraisal of the relationship between inaction and fear resonated with the apprehensiveness of many policymakers who remained concerned about a plethora of AIDS related topics from IVDU to explicit educational material. In late 1985, the Prime Minister's aides and secretaries had already voiced concern about her involvement with AIDS policy and by early 1986, Thatcher herself had noted her fear of public disapproval. Kilmarnock's actions adding substance to the absence and avoidance framework, he highlighted the fear of public disapproval as a potentially central factor in both the failure to adopt policy earlier and the inability to adequately push the boundaries of epidemic response. Although Kilmarnock's critique somewhat dismissed the significance of Fowler's education package and the associated funding increases – particularly when compared to the Reagan administration's continued efforts to limit AIDS expenditure – the suggestion that some policymakers feared the expansion of AIDS policy reflected the anxious sentiment in

[345] HE001 382833, RPLM, W. L. Ball, 'Letter to OMB – James Miller', 6 February 1986, p. 2.
[346] Hansard, HL, 14 October 1986, v. 480 c.682.

more conservative or cautious circles. In response to Kilmarnock's assessment, Trumpington outlined the government's commitment to funding AIDS policy, citing the allocation of £5 million worth of funding for education, more resources for the three hardest hit Regional Health Authorities and a range of research and training activities.[347] Representing both an endorsement of and a challenge to Kilmarnock's notion of inadequacy, the expansion of funding and policy activity between 1985 and 1986 represented progress in terms of tangible policy output, however, these investments did not overshadow the absenteeism that had pervaded the government's early response to the disease.

By late 1986, the discussion of the disease had become more frequent and diverse to the extent that senior officials in the Thatcher administration pushed for a more structured approach to AIDS policymaking. Encouraged by Cabinet Secretary Robert Armstrong's belief that 'these matters [AIDS] need to be addressed by Ministers urgently; and the existing machinery is not proving to be adequate for the purpose', the Prime Minister swiftly approved a request for the creation of AIDS specific policymaking units.[348] Thatcher authorised the establishment of an Official Committee on AIDS (OCA) and a corresponding Home and Social Affairs (HSAC) Sub-Committee on AIDS. The development of appropriate 'machinery' signalled an endorsement of AIDS policy in the public sphere that coupled policymaking priority with a sense of accountability that had been absent thus far.[349] Acknowledging the need for a government AIDS agenda Armstrong noted 'the issues are now so difficult, urgent and politically sensitive that they need to be driven from the centre.'[350] Moreover, Armstrong observed the absence of the British executive – 'the centre' – from AIDS policymaking which largely captured the absence of the Prime Minister whose contributions to executive action amounted to little in comparison to the work of Fowler who had driven AIDS policy forward. The interplay between Thatcher and Fowler's contributions, however, emphasised the perceived importance of the Prime Minister's involvement to progressing AIDS policy to the next stage. The need to articulate a coherent vision for AIDS policy throughout government had become increasingly important and the establishment of specific policymaking

[347] Ibid.
[348] TNA, PREM19-1863, 'AIDS', 21 October 1986.
[349] 'The threat of AIDS requires a determined and co-ordinated response by Government. We have, of course, ensured that the appropriate machinery is available within Government to enable this effort to be fully co-ordinated among the Department's.' TNA, PREM19-1863, 'AIDS', 21 October 1986.
[350] Ibid.

mechanisms further demonstrated a commitment to and urgency around disease response in the UK.

Setting the tone for future meetings, the first OCA meeting immediately tackled what the disease represented in Britain by highlighting issues of political risk, moralism, and practicality as cornerstones of the government's approach to the disease.[351] The committee – chaired by William Whitelaw – outlined the advisory nature of the group's existence before transitioning to a discussion about AIDS in the UK guided by Donald Acheson's summary document *AIDS – The Current Situation in the United Kingdom* that had been published in July[352]. Reflecting on AIDS education the OCA noted that 'ministers might see advantages in distancing the Government from its [Public Education Campaign] dissemination.'[353] The idea that ministers would want to distance themselves from Fowler's campaign once again highlighted the fear of public disapproval amongst government ministers. Despite the College of Health's critique that the education campaign was still 'too little, too late', the production of government-sponsored sexually explicit material cultivated an awareness from many policymakers that embodied much of the moralistic apprehensions that had shaped Margaret Thatcher's interventions throughout 1986.[354]

Following the first OCA meeting, the HSAC Sub-Committee on AIDS (HSAC) met for the first time. Primarily driven by the likes of Norman Fowler and Donald Acheson, the HSAC Sub-Committee represented the more active arm of the government's two new AIDS policymaking units. Identifying the UK's education campaign, IVDUs and screening as the group's primary focus areas the committee outlined a course of action that better reflected the sense of urgency in Robert Armstrong's letter than the OCA's cautious discussion of political risk.[355] Dealing with the issue of screening, the Sub-Committee took a firmer stance on general testing, rejecting it as a policy 'based on ill-considered premises', however, the issue of screening specific groups required more discussion.[356] The Sub-Committee's rejection of general screening due to impracticality was unsurprising but the issue of screening specific groups – particularly certain foreign entrants from particular countries, such as international

[351] CAB/134/5005, TNA, Official Committee on AIDS (OCA), 7 November 1986, pp. 1-4.
[352] Ibid, Annex A, p. 1.
[353] Ibid, p. 4.
[354] Ibid, Annex D.
[355] CAB/134/5005, TNA, HSAC, 11 November 1986, p. 2.
[356] Ibid, p. 3.

students – remained a policy challenge for Fowler and his colleagues. Despite the warnings of Simon Glenarthur on his return from the Commonwealth Health Conference, the idea that the government might screen specific groups entering the UK remained on the table despite Fowler himself appearing firmly against the idea.

Although the issue of IVDU was not discussed at length, AIDS education proved to be a fruitful topic that highlighted the disparate viewpoints of the OCA and HSAC Sub-Committee. Describing the four rounds of advertising that distributed 140 million copies of Fowler's AIDS advert between March and October 1986 as 'factual, sober and authoritative', the Sub-Committee concluded that 'there should be no reservation on that score' as they looked to maintain the momentum of the UK's education campaign.[357] Conscious of the need for striking and informative messaging to maintain the sense of urgency cultivated by the education campaign, the Sub-Committee prepared to deliver demographic-specific educational content starting with young people.[358] A stark contrast to the OCA's messaging on ministers distancing themselves from the education campaign, the Sub-Committee pushed for television content as 'a matter of urgency.'[359] Seemingly unshackled from a fear of public disapproval, the Sub-Committee's pursuit of television content indicated a clear disparity in the appraisal of political risk compared to the OCA. Convening for a second meeting a week after the first, the issue of education remained a priority for the HSAC Sub-Committee as Norman Fowler confirmed the allocation of a further £10m to the UK's education campaign.[360] Although an issue with a broader scope than just AIDS education, the reorganisation of the Health Education Council (HEC) into the Health Education Authority (HEA) attracted the committee's attention. Concerned that the HEC's reorganisation might undermine the AIDS education effort the Sub-Committee offered Norman Fowler their support for a swift transition to the new HEA structure.[361]

In 1986, AIDS policymaking became more formal and public facing in both the US and UK. Nevertheless, the British and American responses to AIDS diverged throughout 1986 as important policy decisions pushed the Thatcher and Reagan administrations further from the

[357] Ibid.
[358] Ibid.
[359] Ibid.
[360] CAB/134/5005, TNA, HSAC, 18 November 1986, p. 1.
[361] Ibid, p. 2.

previously similar inattentiveness that had now shift from the British response. In the US, the continuation of an executive-legislature struggle maintained an acute focus on the importance of federal AIDS funding despite brief and unsuccessful interjections into welfare benefits and civil rights issues for PWAs. By contrast, British policymakers carried forward the momentum of the previous year through nationwide public education campaigns and increasingly visible parliamentary debates around IVDUs and screening. Capitalising on the centralised nature of the British political system, British policymakers constructed AIDS-specific decision-making apparatus that developed and disseminated policy across the UK from Whitehall, distinguishing the US and UK responses to a degree unseen since the disease was first reported.

Whereas the American epidemic had progressed at a substantial pace incomparable to the British experience, the rate of mobilisation observed in the UK outperformed the executive-legislature stagnation that had beset Washington. As the end of 1986 approached the divergence between the two neoconservative responses placed a spotlight on the reconciliation of political ideology and epidemic response. Moreover, the willingness of policymakers in Whitehall and the White House to depart from the political contradictions of fiscal responsibility and socially conservative constructions of sex and society in pursuit of epidemic response and public education increasingly correlated with the ability to reconcile politics and public health effectively and efficiently.

Cultivating Critique and AIDS Discourse: The Koop Report, *Confronting AIDS,* and the November Debate

As 1986 progressed October and November became months of increasing importance for AIDS policymakers on both sides of the Atlantic. In the US in October, the Surgeon General Dr C. Everett Koop thrust the Reagan administration into the spotlight, breaking the long streak of absenteeism that had characterised the Reagan response throughout the decade. Coupled with the Institute of Medicine's report *Confronting AIDS* which highlighted the flawed federal response, a departure from a sense of administrative avoidance was tangible on Capitol Hill. In the UK, policymakers continued to build momentum, culminating in a House of Commons

debate on AIDS that engaged with the disease at a breadth and depth unseen in the UK thus far. As 1986 concluded the UK and US continued their divergent trends, setting policymaking markers that spoke to the continued development of divergent narratives.

On 22 October, Koop released a report on AIDS that formally positioned the federal government on a multitude of issues related to the disease.[362] A recognised conservative – known for his opposition to abortion – Koop provided a balanced, scientific account of AIDS that was warmly received by news outlets and policy advocates.[363] The thirty-six-page report was distributed across the nation, promoting – amongst other things – safe sex, condom use and education, incorporating illustrations and information about support groups such as the Minority Task Force on AIDS, Gay Men's Health Crisis, and the Public Health Service AIDS Hotline.[364] Although the report was met with enthusiasm by many, the issue of government-sponsored material on sexual health and recreational drug use proved to be a characteristically contentious issue for many administrators.[365] In a memo to the President before its public release, Cabinet Secretary Alfred H. Kingon described the report as 'hard-hitting, and it does get into areas normally thought of as on the seamy side.'[366] Kingon's language – 'seamy' and 'hard-hitting' – alluded to Koop's desire to engage in a direct and informative discussion on AIDS that filled the void left by the administration's vague AIDS agenda. Moreover, this approach attracted unwanted internal attention from those concerned with Reagan's broader public appeal, Koop later recalled opposing the 'political meddlers in the White House [who] tried to bottle up the report' encouraging him to 'update' – likely an implicit request for change or omission – his discussion on condoms and sex education.[367] Grounded in a socially conservative perception of sex and society, the desire to regulate Koop's content mirrored the advances of Margaret Thatcher in the UK whose approach to Norman Fowler's education campaign only months earlier was reminiscent of what Koop compared to

[362] Sue Daoulas Files (AIDS 3:1), RPLM, C. E. Koop, 'The Surgeon General's Report on Acquired Immunodeficiency Syndrome', October 1986.
[363] Ibid.
[364] Ibid, pp. 35-36.
[365] Despite emphasising the need for humanity in response to AIDS, Koop was intensely aware of the negativity directed at PWAs by some in government, recalling those at the extreme who believed in killing or locking up huge swathes of infected people. C. E. Koop, 'The Early Days of AIDS, As I Remember Them', Annals of the Forum for Collaborative HIV Research, 13:2 (March 2011), p. 9.
[366] HE001 408924, RPLM, A. H. Kingon, 'Memo to the President – Koop Report', 1 October 1986, p. 1.
[367] Koop, 'The Early Days of AIDS', p. 8.

'walking a tightrope.'[368] Likeminded, Fowler and Acheson and Koop encountered a climate of apprehension from politicians concerned with compromising the innocence of the public, a position that conflicted with the higher goal of epidemic response.

Despite Koop's intention to remain somewhat independent his report brought the notion of federal responsibility into the spotlight, offering a sense of ownership that the Reagan administration had thus far shown an unwillingness to provide. Reflecting on the report's timing and significance *The New York Times* stated: 'Americans tend to whisper when they talk about AIDS. Welcome, therefore, the loud voice of Surgeon General C. Everett Koop.'[369] Although the Koop Report might have stimulated a sense of departure from the malaise of the previous half decade, the absence of federal leadership arrested any sense of enthusiasm drummed up by the Surgeon General's report. Reflecting on the tardiness of this renewed sense of direction and ownership, the Institute of Medicine's (IM) own report, *Confronting AIDS,* acutely tackled the failure of leadership and the absence of direction in the federal response to AIDS. Also published in October 1986, *Confronting AIDS* commended the Koop Report but placed greater emphasis on the 'woefully inadequate' federal efforts on education and communication.[370] Identifying a 'lack of cohesiveness and strategic planning', the IM recommended the establishment of a National AIDS Commission to monitor and inform federal activity on the disease.[371] The report also stressed that the appropriate resources – financial, human, and otherwise – be made available, revealing an awareness amongst *Confronting AIDS* committee members that the administration's desire to tackle domestic spending represented a barrier to epidemic response.[372]

When cultivating their review of the Reagan administration's response to AIDS the IM placed a very clear responsibility on the President himself, recommending that 'the President take a strong leadership role in the effort against AIDS and HIV, designating the control of AIDS as a major national goal.'[373] *Confronting AIDS* placed an increasingly bright spotlight on the White House and the question of policy ownership that had plagued policymakers in Washington

[368] Ibid, p. 7.
[369] 'Dr. Koop's Decent AIDS Report', *The New York Times,* 25 October 1986.
[370] Institute of Medicine: National Academy of Science, *Confronting AIDS: Directions for Public Health, Health Care and Research,* (October 1986), p. 10.
[371] Ibid, p. 32.
[372] Ibid, p. 33.
[373] Ibid.

since the earliest public discussion of federal response. Similarly, Surgeon General Koop later noted: 'The major problem was that the President was not out in front offering the leadership that only he could provide … for months I had tried to cover for the embarrassing silence of the Oval Office on the scourge of AIDS. I kept telling myself the President had to speak out soon.'[374] Furthermore, during his contemplation in 2011 Dr Koop suggested that he had very little contact with the President and believed – based on secondary accounts – that Reagan had not bothered to read his report and likely relied on pre-prepared press releases to guide his public engagements on AIDS.[375] Although *Confronting AIDS* and the Koop Report emphasised the Reagan administration's inadequate resourcing, communication and education on AIDS it demonstrated the crucial impact of the President's ineffectual stance on the disease. Whereas *Confronting AIDS* openly criticised the leadership vacuum encouraged by the President's absence, the positive socio-cultural response to the Koop Report and the Surgeon General's efforts to construct a public dialogue on important issues such as safe sex, casual contact and IVDU further demonstrated the AIDS policy neglect the White House had cultivated.

In the UK, the momentum generated by the growing AIDS policy infrastructure now spilled over into the parliamentary sphere. In late November, Norman Fowler led a landmark debate in the House of Commons that was the first of its kind dedicated exclusively to the discussion of AIDS. Fowler opened the debate by emphasising the growing severity of AIDS in the UK and the interplay between government response and individual responsibility.[376] Likewise, Scottish Conservative MP Anne McCurley noted the government's change from 'a rather gracious walk to a fast trot.'[377] Warning of the 'great hold' the disease had on the US and the need to learn from the mistakes of those across the Atlantic, Fowler cited the Institute of Medicine's *Confronting AIDS* alluding to a sense of transnational awareness that would become a supplementary part of the November debate's identity.[378] Appreciating the global nature of AIDS, the need to consult and reflect on the experiences of America, Continental Europe and Africa demonstrated an outward looking tendency in Parliament that

[374] Koop, 'The Early Days of AIDS', p. 9.
[375] Ibid.
[376] Hansard, HC, 21 November 1986, v. 105 c. 800.
[377] Ibid, c. 842.
[378] Ibid, c. 799.

distinguished the UK dialogue from the US. In response to Fowler's seriousness, Labour MP and Shadow Cabinet member Michael Meacher reflected on the pace of change in AIDS policy throughout 1986 suggesting 'as a nation we have gone from hardly talking about AIDS at all to scarcely talking about anything else.'[379] Although many policymakers at the November debate were reflective in their contributions, the maturation of British AIDS discourse underpinned a growing consensus that viewed these positive developments as the groundwork of a much bigger public health project. Whilst an undercurrent of transnationalism captured the attention of some policymakers whose watchful commentary of the American epidemic foregrounded a broader concern for a worsening British experience, the substance of the November debate tackled several key areas pertaining to funding, screening, and needle exchange under Thatcher.

Despite transitioning to a position of greater understanding that communicated a sense of bipartisanship and progress, the resulting dialogue demonstrated the complicated status of the disease and those it affected most intimately – primarily male homosexuals and IVDUs. Although Norman Fowler set out a platform that reflected the scientific consensus on IVDU and safe sex, the intersection between individual behaviour and ideals of moral decline continued to harass AIDS policy in a fashion that many deemed 'unhelpful.'[380] Ushered in by the necessity for a public health discourse on individual behaviour, government responsibility and the safety of the population at large, the propensity for AIDS policy discourse to disturb the political landscape and undermine the status quo on public innocence and acceptability was far-reaching and uncomfortable for many. Recognising this potential for discomfort Fowler affirmed: 'it may be that some will be offended by it. I regret that – but I have to say I believe the greater danger is that the message does not go over.'[381] In the context of AIDS policy in the US and UK during the 1980s, this statement to the House of Commons by the Secretary of Health and Social Services put a line in the sand for British AIDS policy and policymakers. Fowler's statement provided policy ownership, validating the growing sense of urgency around the disease and the need to mobilise the general population to the severity

[379] Ibid, c. 808.
[380] Ibid, c. 800. In response to Anne McCurley's suggestion that Labour Councillors had promoted promiscuity and retained a sense of accountability for AIDS because of it, Michael Meacher responded to McCurley, 'that is not a very helpful intervention.' (Hansard, HC, 21 November 1986, c. 810.)
[381] Hansard, HC, 21 November 1986, v. 105 c. 800.

of the situation. Furthermore, Fowler and his DHSS colleagues embraced the need for bipartisanship, pushing forward AIDS and associated issues such as education, IVDU and screening into parliamentary discourse. This willingness to open a public and bi-partisan discourse on AIDS was an important signal of the government's growing seriousness, a stark contrast to the isolation and resistance of the Reagan White House.

Perhaps unsurprisingly, the first issue discussed at length was funding. Opening the opposition account Michael Meacher described Fowler's AIDS agenda as 'too little, too late' before shifting his focus towards what he called the 'dribs and drabs' approach used to fund the British AIDS response.[382] A proponent of new AIDS money, Meacher suggested that a figure comparable to the recommendation made by the College of Health of between £50 million and £100 million might still be inadequate.[383] Likewise, Liberal MP Archy Kirkwood remained convinced 'not enough was being done and not enough was being spent.'[384] Emphasising the interplay between funding and priority Meacher suggested that 'in the end, it [funding] is the measure of the Government's seriousness in facing the problem.'[385] Meacher's suggestion that AIDS funding was under threat or inadequate was somewhat undermined by the rapid expansion of funding during 1986.[386] For example, the allocation of an extra £20 million towards public education alone represented a substantial financial commitment compared to the extra £900,000 provided for all AIDS activity in 1985.[387] Reflecting on policy priority, MP for Central Fife Willie Hamilton suggested anything less than that the seriousness offered the Falklands' conflict would be inadequate and proposed the Thatcher government's attentiveness to law and order be used as a barometer for AIDS spending.[388] Unlike the US debate which focused on the tension between resource depreciation and expansion, the UK debate focused primarily on expanding the funding already provided by Fowler's department.

[382] Ibid, c. 812.
[383] Ibid, c. 831. Ibid, c 811.
[384] Ibid, c. 829.
[385] Ibid, c. 812.
[386] The Medical Research Council had been providing funding for AIDS projects for some time by this point and the DHSS – likely accompanied by other departments – had promised a further £300,000 a year in 1986 which made over £500,000 in annual contributions. (Hansard, HC, 21 November 1986, v. 105 c. 827.) Throughout 1985 and 1986, the Public Health Laboratory (PHL) was seen to be under threat from cost cutting, however, the government had denied any intention of slashing funding on several occasions. During the November debate, Michael Meacher speculated that Fowler intended to cut £4 million from the PHL but little was said about the issue afterwards. (Hansard, HC, 21 November 1986, v. 105 c. 812.)
[387] Hansard, HC, 21 November 1986, v. 105 c. 802.
[388] Ibid, c. 837.

Shaped by the continued expansion of the Fowler agenda and the political visibility that accompanied it, the November debate's discussion of funding laid the groundwork for policymakers to move beyond a 'pounds spent' mentality and towards tackling the intricate issues that shaped the spread of AIDS in the UK. AIDS funding constituted another part of the US-UK narrative that – despite similar foundations – found itself drifting further apart as the decade progressed.

The place of screening in the UK's AIDS policy discourse took a more definitive position during the November debate, MP Anne McCurley described screening as never being 'fool proof.'[389] Despite MP David Crouch suggesting that screening visitors would attract significant support from constituents, the Commons consensus on screening was to the contrary.[390] Described as providing 'illusionary protection' and a 'huge waste of public money', Michael Meacher prompted Fowler to suppress any 'alarmist' notion of mass compulsory screening.[391] Aware of the difficulties posed by any form of screening policy, Fowler stated that 'a decision to take any such measure – even the more limited measure – could not be taken lightly', a position he upheld in meetings of the HSAC Sub-Committee on AIDS weeks earlier.[392] Looking to the US again, Fowler cited the Institute of Medicine's opposition to general screening in favour of voluntary testing as an effective method of stopping the spread of AIDS.[393] Moreover, Fowler included the defeat of the LaRouche Movement's proposition 64 – which proposed far reaching testing and restrictions on PWAs – by two votes to one during a public referendum in California.[394] Fowler's inclusion of Proposition 64 demonstrated his awareness of the American epidemic and the associated state level developments that shaped AIDS policy beyond the federal remit. Furthermore, the failure of LaRouche by ballot proposition reaffirmed Fowler's vision for an AIDS response that would infringe upon the civil rights of PWAs in the way proposed by LaRouche and the Prevent AIDS No Initiative Committee (PANIC) had proposed in California. The disinclination of parliamentarians and government ministers to pursue screening generally reflected the State Department's concerns about cost,

[389] Ibid, c. 841.
[390] Ibid, c. 807.
[391] Ibid, c. 814
[392] Ibid, c. 806. Ibid.
[393] Ibid, c. 807.
[394] Ibid.

impracticality and consequence, sharing a like-mindedness with UK policymakers but not with their colleagues in Washington.

Acutely aware of the escalating situation in Scotland, the issue of AIDS-related drug policy took centre stage as the most divisive issue discussed during the November debate. Reiterating the need for action, Scottish MP Gavin Strang suggested that the government must be swifter in responding to the epidemic amongst IVDUs.[395] Likewise, MP Archy Kirkwood indicated that 'the Scottish situation is different … the situation in Scotland is now unique … I make an earnest plea to the Minister to look at the special circumstances in Glasgow.'[396] Accompanying calls to action from Scottish MPs concerned with the escalating epidemics in major Scottish cities like Edinburgh – a situation frequently compared to New York City – and Glasgow was the contentious status of drug policy which centred around the potential for government-sponsored needle exchanges. Thus far, the government had maintained an ambiguous stance on needle exchange, offering neither support nor rejection. Unsurprisingly, this stance prompted members of the House to push Fowler and his colleagues on a more definitive position like screening, however, the complicated intersection between infection control and drug usage prompted a heated evaluation of needle exchange schemes as a viable policy intervention.

For many policymakers opposed to a needle exchange scheme, the distribution of clean needles and syringes promoted the use of injectable drugs and therefore implied that the government condoned recreational drug use. Several of those opposing needle exchange cited the interplay between recreational drug use and moral decline. MP Roger Sims alleged that 'there are moral objections to both suggestions [needle exchange and free condoms] … There are moral implications in what we are discussing.'[397] Likewise, Anne McCurley noted: 'I believe deep in my heart that issuing sharps encourages drug taking'[398] and Sir Ian Percival spoke to the corrupting of youth and the destabilisation of society.[399] Ultimately, the November discussion of needle exchange served to air the concerns of those preoccupied with AIDS and recreational drug use as a symptom of moral decay. In the absence of a clear

[395] Ibid, c. 803.
[396] Ibid, c. 831.
[397] Ibid, c. 856.
[398] Ibid, c. 842.
[399] Ibid, c. 834.

government stance on needle exchange, those apprehensive about the distribution of needles and syringes were met with little guidance on the potential importance of a needle exchange scheme for infection control. Seemingly bogged down in the quagmire of moralism that often-pervaded discussions of alternative or illegal behaviour, the discussion of needle exchange and IVDU generally proved fruitless and likely prompted the promotion of the issue at the Official and Sub-Committee levels in 1987. Previously defined by the disparity between public and private discussion of the disease, the November debate served as a waypoint for British AIDS discourse. Guided by the expansion of Norman Fowler's AIDS agenda, the November debate demonstrated the prioritisation of education and awareness to cultivate a public health response and break down the barriers between sex and society to inform a collective responsibility for infection control. Although a consensus developed on issues of screening, the discussion of needle exchange and messaging remained divisive issues, evoking moralistic critique of fringe communities and alternative lifestyles. The most significant unanswered question of the debate proved to be needle exchange. Providing little guidance on the issue, the potential for a needle exchange scheme polarised the Commons, leaving the HSAC Sub-Committee and Official Committee much to consider as the seriousness of AIDS amongst IVDUs in Scotland came into focus.

Distinguished by bipartisanship and action, the November debate further exaggerated the gulf in dialogue and action between the UK and US. The gathering momentum of the Fowler AIDS agenda informed a policymaking sphere somewhat unified in response to the deadly disease, shedding light on the impact of internal and ideological conflict in Washington. Whereas congressional opposition critiqued Reagan's AIDS policy it was the Koop Report that brought the administration's inadequacies into the spotlight. Surgeon General Koop's report and his subsequent work in the public sphere emphasised the absence of ownership and leadership of AIDS policy had received under Reagan. Highlighted by both the British response and *Confronting AIDS*, the importance of organised and visible leadership in response to AIDS was invaluable and helped establish disparate policy experiences in the US and UK. As this chapter has suggested, 1986 was a year of divergent AIDS policy development that culminated in the policy infrastructure and policy mobilisation in the UK and a recurrent sense of stagnation in the US.

Conclusion

As the impact of AIDS became increasingly visible the nuances of AIDS policymaking intensified and diversified in equal measure, prompting responses that fundamentally reshaped the existing narrative between the two neoconservative administrations. In the US, AIDS policymakers continued to clash with the Reagan White House on core issues such as resourcing and policy status, upholding the executive-legislature battle that had shaped American AIDS discourse since 1983. Moreover, the Reagan administration's inability to articulate a coherent AIDS policy contributed to internal disputes with the State and Justice Departments and external conflict with policy advocates on disability benefit and resourcing. In the UK, the DHSS maintained the momentum of 1985 with the establishment of the Official Committee on AIDS and the Home and Social Affairs Committee Sub-Committee on AIDS. Supplementing this internal decision-making was an increasingly active parliamentary sphere whose critique contributed to a sense of urgency and activity in Westminster. The development of policy infrastructure in Whitehall and cooperative discourse in Westminster distinguished the British response from the political conflict that defined the Reagan response.

Moreover, 1986 reshaped the relationship between policy ownership and epidemic response to varying degrees. Employing an approach which focused on remodelling Fowler's education campaign, Thatcher frequently voiced her apprehensions about the material's public acceptability and reception amongst young people. Grounded in a belief that education and awareness carried little weight outside the established risk groups, the Prime Minister championed a moralistic alternative that opposed Fowler's AIDS agenda. Unsuccessful in her pursuit of fundamental change, Thatcher maintained her unwillingness to grapple with the disease that reinforced her earlier admissions of discomfort and disinterest. By contrast, President Reagan remained elusive throughout 1986, appearing sporadically to make brief public remarks that offered little in terms of direction or ownership. Receiving significant criticism in reports such as *Confronting AIDS* and in Congress from prominent Democrats, the lack of policy ownership in the US continued to restrict progress and the positive reception of the Surgeon General's report further demonstrated the need for leadership at the highest

levels of government to engage popular sentiment on disease prevention that moved towards a federal response.

This chapter posited 1986 as a vital year in the development of AIDS policy in Britain and America and central to this importance was the divergence of the two nations' policy responses to AIDS. Building on the framework laid out by the preceding chapters, 1986 represented a vital shift in momentum in the UK that contributed to the divergence of two previously aligned policy discourses. Looking forward to the remainder of the 'first decade of AIDS', this chapter serves as a crossroads in the US-UK narrative being constructed throughout this thesis. Whereas Fox, Day and Klein have emphasised a likeness between the British and American responses, the remainder of this thesis explores the continued divergence of the two policy narratives and the uniqueness of the resulting policy interventions.[400]

[400] P. Day, D. Fox and R. Klein, 'The Power of Professionalism: Policies for AIDS in Britain, Sweden, and the United States', *Daedalus*, 118:2 Living with AIDS (Spring 1989), p. 109.

Chapter Four

Divergence Continued:

The Role of a Medico-Scientific Consensus and Moralism in Shaping AIDS Policy in the US and UK in 1987

Introduction

Although policymakers in both the US and UK had – to varying degrees – developed AIDS policy, the disease maintained an upward trajectory into 1987 as its true scale slowly began to unfold. In the US, the Centres for Disease Control (CDC) had recorded 29,003 cases by the end of 1986, which equated to a near doubling of American AIDS cases from the data point the previous year.[401] Accompanying this rise in cases was the continuation of several epidemiological trends. New York, California, and Florida remained the hardest hit states, disease prevalence amongst White (60%), Black (24%) and Hispanic (14%) Americans remained similar and only a slight increase in cases amongst females was recorded (up from 6.5% to 7%).[402] In the UK, AIDS cases continued to rise but at a much slower rate.[403] By the end of 1986 the Chief Medical Officer (CMO) Donald Acheson had estimated around 2,158 AIDS cases in Britain with noticeable increases amongst intravenous drug users (IVDUs) who now dominated infection rates in Scotland where they represented 64.5% of total cases compared to England where the IVDUs constituted 7% of the cumulative total of AIDS cases.[404] Whilst British and American policymakers both encountered escalating infection rates, the looming possibility of AIDS entering the population at large, and epidemiological shifts that

[401] Centres for Disease Control (CDC), 'AIDS Weekly Surveillance Report – United States AIDS Program, Centre for Infectious Diseases Centre for Disease Control', 29 December 1986, pp. 1-5. CDC, 'Acquired Immunodeficiency Syndrome (AIDS) Weekly Surveillance Report – United States AIDS Activity', 30 December 1985, pp. 1-3.
[402] CDC, 'AIDS Weekly Surveillance Report', 1986, pp. 1-5.
[403] GB0809 AIDS Social History Programme/1/2, D. Acheson, *Chief Medical Officer's Annual Report, 1987* (December 1987), p. 115.
[404] CAB/134/5005, The National Archive (TNA), Home and Social Affairs Committee Sub-Committee on AIDS (HSAC), 7 November 1986, Annex A p. 2.

reshaped existing perception of people with AIDS (PWAs), the White House and Whitehall carried into 1987 a momentum that maintained the divergent trajectory between the two neoconservative administrations.

Whereas the previous chapter discussed the initial divergence of the British and American responses to AIDS, this chapter details the process of divergence and the different policy responses in notable areas such as screening and public health education. In the first instance, this chapter details the policymaking dialogue in the US and UK and the emergence of screening as a prominent AIDS policy issue. Where Padamsee has noted that 'based on a combination of scientific evidence and ethical argument' a liberal – or voluntary – approach to HIV/AIDS testing had a legacy in the US, this chapter explores the tension between the US 'health polity' and the Reagan administration whose conflicting impressions on AIDS testing manifested differently in each context such as ports of entry.[405] In the domestic context, the liberal approach discussed by Padamsee was championed by contemporary public health professionals in the PHS and CDC alongside congressional advocacy from Democrat Henry Waxman and Republican Orrin Hatch who coalesced around the voluntary testing approach favoured in the medico-scientific community achieving the successful rebuttal of widespread pre-marital testing at the state level.[406] Importantly, the state level responsibility for marriage licenses shaped the administration's ability to influence pre-marital testing policy. Able to simply advocate and not legislate for state level change, the Reagan administration found much greater success with border testing where it possessed greater powers to implement change.

In the UK, a voluntary testing protocol achieved a wide consensus amongst policymakers in Whitehall and Parliament. Described by Patricia Day and Rudolf Klein as being guided by the value system of the medical profession, a 'liberal' approach that emphasised a voluntary testing, confidentiality, and anonymity was popular amongst British policymakers throughout the decade and subsequently, cultivated a hostility to approaches for compulsory testing or

[405] D. Fox, 'AIDS and the American Health Polity: The History and Prospect of a Crisis of Authority', *The Milbank Quarterly,* 83:4 (December 2005), pp. 15-23. (Reprinted from the *Milbank Quarterly*, 64:1 (1986). T. Padamsee, 'Lessons from the Neglected History of US HIV/AIDS Policy', *Journal of Health, Politics and Law,* 42:1 (February 2017), p. 91.
[406] Ibid.

calls for quarantine for infected individuals.[407] Although Day and Klein have highlighted the 'first responsibility of doctors … towards their patients' as a facilitating factor in the development of a liberal approach, this discussion highlights the autonomy of British policymakers in articulating a coherent and comprehensive appraisal of the evidence provided by public health professionals in the face of multiple 'special case' challenges. As the US shifted towards a – self titled – 'common sense' approach that contrasted the ethos of British policymakers, the adherence of policymakers to the medico-scientific consensus and the advice it yielded became a central aspect of the continued divergence between the US and UK narratives across a variety of policy issues.

Similarly, the disparate adherence of British and American policymakers to the language and principles of the medico-scientific consensus heavily influenced a divergent trend in public health education. This discussion explores the different approach to the role of moralism – often conceptualised by policymakers in the 1980s as 'right' and 'wrong' – in the determining of AIDS education in the US and UK.[408] Positioned around a socially conservative emphasis on family values, chastity, and faithfulness, the Reagan administration attempted to reconcile the medico-scientific consensus on sexual health with broader religious and social teachings on sex and marriage. In stark contrast once again, British policymakers deliberately separated moralism and public health education as messaging with fundamentally different goals. Where Whitehall attributed responsibility for moralism to the Church – likely the Church of England, however, policymakers often refer to 'the church' inclusive of Christianity and Judaism – the role of government was to disseminate data and knowledge backed by the medico-scientific community and remain outside moralistic preaching. Although educational materials were distributed by the White House in a similar fashion to Fowler's nationwide leaflet drops, the American pursuit of values-based education diametrically opposed the separation of science and moralism adopted by British policymakers. The contrasting interplay between social conservatism and the medico-scientific community in the sphere of public

[407] P. Day and R. Klein, 'Interpreting the Unexpected: The Case of AIDS Policy Making in Britain', *Journal of Public Policy,* 9:3 (July - Septmeber1989), p. 346.
[408] Reagan Presidential Library and Museum (RPLM), R. Reagan, 'Remarks at a Luncheon for Members of the College of Physicians in Philadelphia, Pennsylvania', 1 April 1987, [https://www.presidency.ucsb.edu/documents/remarks-luncheon-for-members-the-college-physicians-philadelphia-pennsylvania], accessed 15 March 2024.

health education played a pivotal role in shaping the divergent responses to AIDS education in Britain and America in 1987.

Consequently, this chapter will explore the centrality of policymaker adherence to the medico-scientific consensus on AIDS in the development of AIDS policy in 1987. It will detail the disparate approaches to the role of moralism in the cultivation of AIDS education and the subsequent tension this provoked between key figures such as President Reagan and Surgeon General Koop. Furthermore, it will reaffirm the importance of the British policymaking infrastructure to the continued divergence of the British and American responses to AIDS and the associated value of a shared vision for AIDS policy in the British AIDS discourse that sustained policy development through personnel changes in late 1987.

Debating Mandated Testing:
Disparate Responses to the Medico-Scientific Consensus on AIDS Testing

In 1987, British and American policymakers shifted their focus towards the issue of screening. A topic with a still-unclear agenda, the prospect of mandated testing across a variety of circumstances, and the associated implications such a policy might invite, had yet to be fully understood or explored. This discussion explores the British and American debates that facilitated different responses to mandated testing. Moreover, it demonstrates that a similar liberal approach was favoured by public health professionals in the US and UK, the adoption of this expert advice by policymakers varied.

Accompanying the developing screening discourse were fundamental changes to the policymaking sphere. In the US, the establishment of the Presidential Commission on AIDS chaired by Eugene Mayberry provided an opportunity for American policy advocates to engage with the Reagan administration and deliberate on a more comprehensive and coherent policy response. In the UK in late 1987, a Cabinet reshuffle resulted in Norman Fowler leaving the DHSS – replaced by John Moore – threatening to derail the progress made by Fowler and his colleagues. Whereas the Commission's establishment was accompanied by optimism, these changes resulted in no substantial shifts in policy trajectory. Although British

policymakers debated the intricacies of screening policy with greater intensity following Fowler's departure from the DHSS, the policymaking infrastructure erected in Whitehall maintained a reliance on expert advice. This reliance stabilised British policymaking and maintained an adherence to the medico-scientific consensus that had governed much of the preceding period's policy development. By contrast, the Presidential Commission failed to inspire widespread policy development and a Commission reshuffle in October reaffirmed the broader frustrations of AIDS policy advocates in the US whose struggle to build momentum continued.

Screening quickly became a fast-moving focal point for British policymakers in 1987. Addressed by the Official Committee on AIDS at their first meeting of 1987, those present set about clarifying the government's position on a variety of screening proposals that spanned far reaching proposals for compulsory screening to immigration screening for sponsored students coming to the UK to study.[409] AIDS was still a poorly monitored disease in Britain, and the advent of a more intense screening debate likely placed a spotlight on weakness of the UK's public health data collection infrastructure. The perception that an aggregate increase in testing – compulsory and directed at large demographics – would deliver better data and traceability was on the surface a plausible alternative to the voluntary approach. Moreover, this increase in data was seen as an important aspect of calls for testing in a variety of vocations such as health care professionals to those handling food in the supply chain.

Nevertheless, concerns about the potential fallout associated with widespread screening remained for policymakers in both the Official Committee (OCA) and HSAC Sub-Committee (HSAC). Attendees at the OCA meeting on 9 January revisited the undesirability of compulsory testing and the perceived 'problems of practical and principle' that had ensured the groups' stance remained firmly against it.[410] Anonymised testing was also discussed, with those present agreeing that the potential ethical and legal liability, combined with the data provided being devoid of usable behavioural and demographic indicators because of confidentiality and anonymity protocols, resulted in the protocol lacking scientific validity and justification.[411]

[409] CAB/134/5137, TNA, Official Committee on AIDS (OCA), 9 January 1987, pp. 1-9.
[410] Ibid. p. 6.
[411] In this context, 'Anonymised testing' referred to a testing protocol where samples are collected from sources not originally intended for HIV/AIDS testing, however, these tests have no identifiable data meaning they are unable to be traced back regardless of the outcome. Ibid, p. 6.

Domestically, the ethical, legal, and practical hurdles to effective screening firmly situated the government against widespread testing of the general population, a position that had maintained strength since 1986 when screening was first tabled.

Despite different circumstances – international fallout and retaliation, perceptions of racially motivated testing raised by African nations, and the complications provided by the movement of tourists – the testing of foreign entrants received a similar response at the OCA. Rejecting immigration screening on the grounds of 'impracticality, disruption, cost and possible retaliation by other governments while, on the other hand, the marginal impact on the AIDS problem would be very low indeed', mandated testing in the UK was an increasingly undesirable prospect that provided limited protection and data either domestically or at ports of entry.[412] Moreover, the suggestion that sponsored students could be tested was deemed 'a highly emotive issue' carrying significant political risk and policymakers subsequently favoured no further intervention.[413] Although the OCA briefly revisited the screening of foreign entrants in March – reaching the conclusion that it was inviable on several counts – the government had established a consensus on screening that embraced the foundational principles of voluntary testing and confidentiality set out some months prior by the same committees, rejecting the limited scope of expensive mass screening.[414]

In America, the discussion of screening emerged slightly later in 1987. Shaped by the Reagan administration's embrace of a more comprehensive testing protocol, the US engaged in a divisive debate over testing protocol that pitched pro-testing factions in the White House against leading public health officials. Whilst earlier efforts to engage with AIDS had publicly emphasised federal spending and the need for values-based education, screening was initially an issue reserved for inter-departmental discourse. The desirability of a screening protocol appeared to be rooted in a growing public anxiety about the disease in the general population: a *Washington Post* poll in March 1987 suggested that 85% of those asked thought pre-marital testing should be introduced.[415] In April, Surgeon General Everett Koop formally wrote to New Hampshire Governor John Sununu following his proposal for pre-marital AIDS testing in the

[412] CAB/134/5137, TNA, OCA, 14 January 1987, p. 3.
[413] Ibid.
[414] CAB/134/5137, TNA, OCA, 16 March 1987, p. 2.
[415] Document 27 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', Office of the Historian, (Bureau of Public Affairs, November 2017), pp. 74-77.

state suggesting 'while well intentioned, such laws would spend a lot of money testing a group for AIDS at low risk and finding few cases.'[416] The Surgeon General stated his support for voluntary testing as a better and more cost effective use of limited AIDS resources whilst reaffirming his belief in 'strong laws' that enhanced the US response.[417] Koop later revisited this sentiment in a September Roundtable with *USA Today* journalists for C-SPAN, reiterating that those most at risk were increasingly unlikely to get married and therefore pre-marital testing targeted the wrong demographics – for male homosexuals it was illegal to marry and Koop described IVDUs as a 'fragmented and disorganised' group driven foremost by addiction not by interpersonal behaviours such as marriage and family building.[418]

Nevertheless, Koop's rejection of Sununu's testing proposal attracted an internal backlash. Writing to Chief of Staff Howard Baker Jr about an irate phone call he had received from Governor Sununu about regional opposition to his pre-marital testing bill from federal agencies (CDC and DHHS), Under Secretary for Education and future assistant to the President on Policy Development Gary Bauer noted that he had reiterated that the CDC does not represent the White House on the issue which had 'not had full airing .. yet.'[419] Although Bauer's appeasement of Governor Sununu reaffirmed the White House position on pre-marital testing it positioned the administration at odds with public health officials and the medico-scientific consensus on screening. Whereas Koop embraced the perception of wasted federal dollars frequently ascribed by the Reagan White House as a shorthand for low priority, the underlying belief that the aggregate increases in testing achieved by pre-marital testing would provide poor data at high cost demonstrated a core difference in viewpoint between White House politicians and public health officials. Furthermore, the ability to see past the wasted expenditure put forward by Koop complicated the administration's habitual rejection of funding for service provision. Importantly, the interplay between Koop, Bauer, and Governor Sununu captured the jurisdictional limitations of the administration's influence over marriage licencing which was controlled by state legislatures. Although Koop and Bauer could

[416] HE001 475117, RPLM, C. E. Koop, 'Letter to Governor Sununu on AIDS Testing for Marriage Licenses', 13 April 1987, p. 1.
[417] Ibid.
[418] 'Surgeon General Dr. Everett Koop Roundtable', *USA TODAY via C-SPAN*, 17 September 1987, [https://www.c-span.org/video/?151150-1/surgeon-general-roundtable], accessed 27 April 2023.
[419] HE001 466266, RPLM, G. Bauer, 'Memorandum to Howard H. Baker Jr', 13 May 1987, p. 1.

provide their views, the power to implement change for marriage licensing rested at the state level and was subsequently state-specific.

In May the President took his views for mandated testing public with mixed results. Although an aggregate increase in testing had attracted significant support in the White House and from a caucus of conservative supporters – the La Rouche Movement's Proposition 64 in California a prime example – Reagan now received criticism from leading public health officials. Maintaining a firm stance on widespread voluntary testing, Director of the Centres for Disease Control (CDC) James Mason told the *New York Times* that the administration's drive for mandated pre-marital testing was 'unlikely to be very effective even in a community with a high general prevalence.'[420] Moreover, the President's appearance at the American AIDS Foundation Research Awards Dinner upheld the rejection of mandated testing as a problematic cornerstone of the Reagan response, supporting both Mason and Koop's consensus on targeted volunteer testing and counselling. Emphasising that the federal role was 'to provide scientific, factual information', Reagan reconciled ideals of 'medicine and morality' when highlighting the need to establish 'a moral base' for preventatives and other scientific measures.[421] After contextualising his AIDS policy, Reagan confirmed his desire to list HIV/AIDS as a contagious disease as a means for dismissing entry for those seeking permanent residence in the US.[422] Moreover, Reagan confirmed his support for pre-marital testing and routine testing for those visiting drug abuse clinics and in prisons.[423] In response, the audience – primarily constituted of public health officials and health care professionals – booed the President's proposed testing protocol.[424] Navigating the middle ground between the administration and medical science, Koop offered an approach to testing that emphasised the need to target testing for at-risk populations on a voluntary basis, however, the Surgeon General's advice was seemingly ignored and the push for mandate testing continued.

Accompanying the discussion of pre-marital testing was the potential for new immigration law to prohibit individuals with HIV/AIDS entering the US. Speaking at a Domestic Policy Council

[420] 'Experts On AIDS Urge More Testing On Optional Basis', New York Times, 11 May 1987.
[421] RPLM, R. Reagan, 'Remarks at the American Foundation for AIDS Research Awards Dinner', 31 May 1987, [https://www.reaganlibrary.gov/archives/speech/remarks-american-foundation-aids-research-awards-dinner] accessed 2 May 2023.
[422] Ibid.
[423] Ibid.
[424] Ibid.

meeting, Gary Bauer asserted that the 'practical problems' confronting border screening 'could be worked out' and that any resulting cost saving for AIDS treatment for immigrants would outweigh the expense of a border testing protocol.[425] Similarly, Secretary of Education William Bennett suggested that 'it was inconsistent to test domestically and not abroad' and supported listing a HIV test as a criterion for visa approval.[426] For Bauer and Bennett, these impracticalities – cost, delivery, data collection to name a few – appeared somewhat trivial compared to the importance of aggregate increases in testing, notwithstanding most of that testing was likely to be on low-risk populations. By contrast, the rejection of screening in the UK hinged on the impracticality of mandated testing as both a prevention method and a data collection protocol. Moreover, the focus of British policymakers on confidentiality, the threat of pushing the disease underground and the actual added value of conducting the data collection showcased a more comprehensive appreciation of screening as a policy issue. The Reagan administration's pursuit of mandated testing opposed the public stances of Surgeon General Koop and organisations such as the American Medical Association (AMA), highlighting the disassociation of the White House and the existing medico-scientific consensus in favour of a politically motivated strategy built on aggregate data capture that threatened to undermine the very principles that guided medical science and public health administrators.[427]

In State Department documents from the beginning of 1987, Secretary of State, George Shultz demonstrated that he was primarily concerned with AIDS in foreign territories where the US operated or with the disinformation campaign being communicated by the USSR, however, immigration testing did feature fleetingly.[428] A primary concern of Bauer's, the issue of an immigration ruling was explored at Cabinet level through Secretary of Defense Weinberger detailing the military's approach to HIV testing.[429] The meeting produced a consensus that favoured an immigration rule change for HIV/AIDS that would place the disease on the dangerous contagious diseases list. In a markedly different response to testing from the UK,

[425] Document 27 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988', pp. 74-77.
[426] Ibid.
[427] HE001 474611, RPLM, N. Risque, 'Memorandum on the American Medical Association's position on AIDS Testing', 1 July 1987, p. 1.
[428] Document 33 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', Office of the Historian, (Bureau of Public Affairs, November 2017), pp. 85-87.
[429] Document 28 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', Office of the Historian, (Bureau of Public Affairs, November 2017), pp. 77-78.

the White House set out formalising an immigration rule change as part of a strategy to keep more AIDS cases out of the US. Whereas countries such as the UK looked to the US as an example of a developed epidemic and the epicentre of the global AIDS narrative, the prospect of keeping the disease out through immigration law appeared problematic.[430] For example, 97% of AIDS cases (27,519 out of 28,274) in North America (US and Canada) were in the US compared to a total of 3,732 cases in Europe and 610 in the UK (as per January 1987) – but it firmly maintained the administration's opposition to the medical consensus on the issue.[431] Consequently, in May 1987 following a White House directive the Public Health Service added HIV to the list of dangerous contagious diseases and by August the same year the ruling became effective. In 2010 it was repealed by the Obama administration, but the rule change set the tone for HIV/AIDS-related immigration law for over two decades and further distanced the US response from the UK approach.[432]

From Reagan to Bauer and Bennett, the discussion of a mandated testing protocol had emerged in 1987 as a pivotal battleground for AIDS policymakers. Whereas British policymakers favoured the medical consensus that emphasised the ethical and legal complications that underpinned the impracticality and limited benefits provided by testing mandates, White House policymakers achieved varying success through an approach that targeted aggregate increases in AIDS testing. Despite senior public health officials pushing back on demands for mandated testing, a mixed approach succeeded. Although pre-marital testing was not widely adopted it did achieve some engagement at the state level.[433] Writing in 1988, Colby and Baker noted that whilst most state legislatures had discussed pre-marital testing, the only states to adopt and legislate for pre-marital testing by 1988 were Illinois and

[430] Hansard, House of Commons, 21 November 1986, v. 105 c. 807.
[431] TNA, PREM19-2775, 'Acquired Immunodeficiency Syndrome: Background Information', 14 January 1987, p. 6-7.
[432] R. Morrow, 'AIDS and Immigration: The United States Attempts to Deport a Disease', *The University of Miami Inter-American Law Review,* 20:1 (Autumn 1988), p. 132.
[433] In addition, marriage law and the associated regulation of marriage law had become increasingly contested throughout the late nineteenth and twentieth centuries as outlined by Shanley. Where the concern for the collapse of the marriage as an institution was well documented by conservatives in 1980s America – President Reagan a prime example – broader discussion about the role of the State and the states control over marriage had been debated to the extent that some advocated for marriage to be a private contract devoid of State participation. (M. L. Shanley, 'Review: Public Values and Private Lives: Cott, Davis, and Hartog on the History of Marriage Law in the United States', *Law and Social Inquiry*, 27:4 (Autumn 2002), pp. 923-925.)

Louisiana.[434] Importantly, this failure to achieve widespread pre-marital testing reinforced the medical consensus on the testing of low-risk groups, a position publicly defended by Surgeon General Koop and CDC Director James Mason.

Although UK policymakers kept certain aspects of immigration rulings under review – such as testing students sponsored to study in the UK and ensuring insurances existed for those travelling with a positive diagnosis – the US joined a small group of countries prohibiting entry due to HIV positivity, a dramatic departure from the medical – and global political – consensus on testing. Domestically, this rule change represented a notable victory for the doctrine of 'common sense' testing espoused by the Reagan administration. The absence of widespread opposition to an immigration rule change in the White House produced the desired policy outcome that failed to muster with pre-marital testing in at the State level. The rule change demonstrated the Reagan administration's divergence from the medico-scientific consensus in favour of an approach that mandated testing to relieve widespread ignorance of infection status which was largely at odds with the prevailing ethos of public health officials responsible for the delivery of AIDS intervention.

Following the earlier pre-occupation with screening policy, policymakers in the US and UK transitioned into a period shaped by personnel changes and dynamic shifts in policymaking structure. In June in the US, Executive Order 12601 established the Presidential Commission on AIDS which provided a potential avenue through which AIDS policymakers might realise a structure of AIDS policy like that created in the UK. The Commission's future, however, was underwhelming and the journey towards the reporting date in June 1988 was problematic and at times turbulent. Considered against the backdrop a growing screening debate – and later public health education as detailed in Part Two – the opportunity for positive change following the establishment of the Presidential Commission contrasted the potential for derailment in Britain following the departure of Fowler as the figurehead of AIDS policy. Nevertheless, the following discussion will explore how the existing personnel and structures responded to these challenges and how they impacted their respective policy discourses.

[434] D. Colby and D. Baker, 'State Policy Response to the AIDS Epidemic', *Publius: The Journal of Federalism,* 18:3 (Summer, 1988), p. 117.

In the US, the Presidential Commission on AIDS brought together a diverse group of individuals that demonstrated the complex and interconnected problem AIDS presented to Reagan's America. Made up of 12 official panel members and supported by a Commission staff of over 40 people, the group attracted expertise from the worlds of medicine and business to politics and education.[435] Led by accomplished Mayo Clinic physician Eugene Mayberry, the panel was commissioned with a variety of goals that spanned the evaluation of the federal response and exploring potential education efforts and prevention strategies to understanding the international dimension of the disease from the American perspective.[436] Moreover, the selection of the panel and their diverse backgrounds offered some insight into the group's potential approach to the disease. Unsurprisingly, the discipline with the greatest representation was medicine: Dr Colleen Conway-Welch, Dr Theresa L. Crenshaw, Dr Burton James Lee III, Dr Frank Lilly, Dr Woodrow A Myers and Dr William B Walsh all hailed from prominent medical institutions.[437] Even panel member Dr Cory SerVaas who brought a journalistic viewpoint to the Commission as editor and publisher of the *Saturday Evening Standard,* received an M.D from Indiana University School of Medicine.[438] In addition to the expected inclusion of medical personnel, several of the panel members' backgrounds aligned with important AIDS-related issues that required federal attention. Representing the interests of the Church, Cardinal John O'Connor's appointment was unsurprising. A Catholic priest with a track record for public health efforts in New York City, he embodied the message of 'medicine and morality' espoused by the Reagan administration. Retired Admiral James Watkin provided a military perspective and Representative Penny Pullen from Illinois brought to the table a state-orientated viewpoint that aligned with the administration's general approach, her legislature part of a minority of states which had enacted a pre-marital testing mandate in 1987. John J Creedon's inclusion alluded to the growing importance of the

[435] 'Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic: Submitted to the President of the United States', 24 June 1988, [https://archive.org/details/reportofpresiden00pres/page/n1/mode/2up], accessed 15 March 2024.
[436] American Presidency Project (APP), 'Executive Order 12601 – Presidential Commission on the Human Immunodeficiency Virus Epidemic', 24 June 1987, [https://www.presidency.ucsb.edu/documents/executive-order-12601-presidential-commission-the-human-immunodeficiency-virus-epidemic], accessed 15 March 2024.
[437] RPLM, R. Reagan, 'Appointment of 12 Members of the Presidential Commission on the Human Immunodeficiency Virus Epidemic', 23 July 1987, [https://www.reaganlibrary.gov/archives/speech/appointment-12-members-presidential-commission-human-immunodeficiency-virus], accessed 15 March 2024.
[438] Ibid.

relationship between AIDS and private medical insurance. The CEO of Metropolitan Life Insurance Co – one of America's largest insurance and personal coverage providers – Creedon's inclusion held the potential to shape a vital debate central to the long-term success of the US response, and his private sector experiences a were contrast to the majority medicine perspective of the panel. Likewise, the appointment of Amway Co-Founder and President Richard DeVos was likely the most interesting of the President's selections. With no relevant philanthropic commitments or public health related experience listed on the President's announcement, DeVos appeared to be a panel member whose potential value rested on his status as a lay person with business acumen. Nevertheless, DeVos and his colleagues were appointed on 23 July 1987 and expected to report back to the President on AIDS in the US by June the following year.

Whereas the Presidential Commission's existence encouraged a perception of policy activity, it was the resulting inaction that was most significant. What accompanied the seemingly far-reaching goals of the Commission was an extended period that elapsed with very limited policy interjection from the White House. George Shultz worked with the CDC to implement the new immigration ruling for HIV/AIDS that now prevented individuals with a positive diagnosis from entering the US.[439] The State Department continued to pursue the USSR on the disinformation campaign that had labelled AIDS a biomedical weapon created by the US government.[440] The administration promoted AIDS Awareness and Prevention Month in October and rejected advances for AIDS legislation in Congress by Senator Ted Kennedy (S. 1220 – AIDS Research and Information Act, 1987).[441] Outside this, the administration attempted to negotiate the relationship between 'medicine and morality' as part of an education push during the early summer of 1987 but these efforts also dissipated following the Commission's establishment. Whilst the Commission's assembled a new collective of policy advocates, the resulting stagnation in federal intervention undermined the benefits inherent in the groups existence and provided the Reagan White House with a policymaking unit to take shade behind.

[439] Document 31 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', Office of the Historian, (Bureau of Public Affairs, November 2017), pp. 81-82.
[440] Document 33 in Stephen Randolph (eds), 'Foreign Relations of the United States, 1981-1988, pp. 85-87.
[441] APP, 'Statement of Administration Policy: S. 1220 – AIDS Research and Information Act of 1987', 1 October 1987, [https://www.presidency.ucsb.edu/documents/statement-administration-policy-s-1220-aids-research-and-information-act-1987-0], accessed 15 March 2024.

In October, Chairman Eugene Mayberry was the most significant of several resignations from the Presidential Commission indicated a sense of dissatisfaction amongst those sitting on the panel. Asked by a reporter about the 'dissention and disarray' on the panel and the prospect that the group might not report on time the President responded hopefully, however, his diversion to the need for diversity on the panel communicated an unease about the remaining vacancies left unfilled following the October reshuffle. Depicted as the moral compass of the Commission, the potential departure of the Archbishop of New York, Cardinal John O'Connor, was a particular focus for Journalists.[442] Mayberry was replaced by Admiral James Watkins who would carry the Commission through to the June 1988 deadline accompanied by O'Connor. However, the sense of stagnation accompanying the Commission's research period (June 1987 – June 1988) remained problematic and suggestive of an administration biding time on the substantial expansion of federal AIDS resources for care, treatment and research that the Commission would likely recommend. Similarly to the Office of Technology Assessments report in 1985 or the Institute of Medicine's *Confronting AIDS* in 1986, the potential recommendation likely represented another challenge to the Reagan administration's AIDS policy inadequacies and the subsequent failure to build momentum highlighted the wider inattentiveness at the heart of the US response. In the Presidential Commission the White House had a valuable vehicle to communicate with the American public, however, the establishment of the Commission itself proved to be the administration's policy intervention. Moreover, the Commission's experience of 1987 represented another missed opportunity for the Reagan White House which failed to mobilise behind the announcement of June 1987 further validating criticism of the administration's inability to articulate an AIDS policy that addressed the seriousness of the American epidemic.

In the UK, Norman Fowler's departure as Secretary of State for Health and Social Services was the most significant personnel change since the government initially mounted a response to the disease. The first test faced by Fowler's successors was a proposed screening mandate for the British military from Secretary of State for Defence, George Younger. Citing the special

[442] Cardinal O'Connor was a religious leader in New York City who received substantial criticism from organisations such as AIDS Coalition To Unleash Power (ACT UP), reaching protest levels in December 1989. Overall, O'Connor had a complicated relationship with AIDS, opposing homosexuality publicly but working to support HIV/AIDS efforts in New York City during his time as Archbishop. His complicated relationship with PWAs features prominently in David France's documentary film, *How To Survive A Plague* (2014).

circumstances of the British military, Younger proposed that a comprehensive screening protocol be put in place for all serving personnel from new recruits to those already active, suggesting that those who test positive should be discharged.[443] Apprehensive about the prospect of introducing mandatory screening for the military, the HSAC Sub-Committee noted that Younger's proposal 'ran entirely counter to the Government's existing policy on screening.'[444] Dismissing the notion that the Armed Forces represented a special case, the Sub-Committee suggested that Younger's proposal would open up large-scale issues regarding testing other government employees and the difficulties associated with those employees carrying the disease, concluding that they had 'serious misgivings about the Defence Secretary's proposal.'[445] Despite the potential to adopt a special case approach to George Younger's proposal for military testing, the Sub-Committee's rejection of an Armed Forces testing mandate continued the apprehension that had shaped screening policy generally under Fowler. Moreover, the Sub-Committee's unmoving commitment to volunteer testing reaffirmed the government's firm adherence to the scientific and medical consensus on the role of testing in the British response as one increasingly informed by awareness, accessibility, and confidentiality.

By autumn the issue of compensation for haemophiliacs had surfaced, attracting attention in the Houses of Parliament and from advocates in the public sphere such as the Haemophiliac Society. In a letter to the Prime Minister's Office in September the new Secretary of State for Health and Social Services, John Moore noted that 'we will be under considerable parliamentary and public pressure.'[446] Taking a firm stance on the estimated £3 million in compensation, Moore alleged that it would be difficult to distinguish the claim of haemophiliacs from many other groups and that a compensation scheme would set a bad precedent and encourage pressure from other quarters.[447] Facing an uphill battle to justify a no compensation stance amidst increased interest from the media, Health Minister Tony Newton admitted to the Prime Minister in early November that such an approach was 'unlikely to prove politically sustainable' and that the cost was likely closer to £5-£10 million.[448]

[443] CAB/134/5135, TNA, HSAC, 22 July 1987, p. 3.
[444] Ibid, p. 4.
[445] Ibid, p. 5.
[446] TNA, PREM19-2775, J. Moore, 'Compensation for Haemophiliacs', 24 September 1987, p. 1.
[447] Ibid, p. 2.
[448] TNA, PREM19-2775, T. Newton, 'Compensation for Haemophiliacs', 2 November 1987, p. 1.

Likewise, Speechwriter and Policy Unit member John O'Sullivan agreed with Tony Newton and stressed the need to attract public support during spending cuts.[449] Moreover, O'Sullivan suggested a public support base existed for compensation and that 'a refusal to compensate would be hard to sustain, so we would risk the worst of both worlds. And the sums involved are small.'[450] In response, Moore proposed to provide the Haemophiliac Society with £10 million in compensation that the organisation could distribute.[451] Adding a sense of validity to Moore's proposal, Willie Whitelaw relayed the Solicitor General's belief that 'provided it was done as an ex-gratia payment with a specific disclaimer of liability, this was most unlikely to jeopardise the Government's position in denying legal liability.'[452]

Although the internal discussion of compensation drifted into obscurity following the Solicitor General's inquiry into the legal ramification of such a compensation scheme, Labour MP Robin Cook approached the issue in the House of Commons. Responding to Health Minister Tony Newton's announcement on the proposed £10 million compensation scheme for haemophiliacs, Cook raised a variety of issues but focused on the inadequacy of the government's remuneration.[453] Cook asserted that the £10 million compensation was 'less than half the capital sum that is paid by his department in cases of vaccine damage' and amounted to a little over £8,000 per case.[454] Speaking directly to Newton, Cook asked how his department arrived at £10 million and whether he felt the 'modest sum' of £8000 per case was enough 'when the pressing need for families of the victims is to keep a roof over their heads by clearing a mortgage?'[455] In response, Newton was quick to clarify that the scheme was not at heart a 'compensation scheme' that denoted fault, it was 'recognition of a special and unique combination of circumstances.'[456] Despite the internal dialogue consistently labelling the sum 'compensation', the need to publicly highlight the circumstantial nature of the funds reflected the Solicitor General's emphasis on 'ex gratia', a gesture of goodwill that accepted no fault on behalf of the government.[457] This notion of goodwill attracted significant

[449] TNA, PREM19-2775, J. O'Sullivan, 'Compensation for Haemophiliacs', 2 November 1987, p. 1.
[450] Ibid.
[451] CAB/134/5135, TNA, HSAC, 10 November 1987, p. 10.
[452] TNA, PREM19-2775, W. Whitelaw, 'Compensation for Haemophiliacs', 11 November 1987, p. 1.
[453] Hansard, House of Commons (HC), 16 November 1987, v. 122 c. 768.
[454] Ibid.
[455] Ibid.
[456] Ibid.
[457] The question of fault would be the central issue of the Infected Blood Inquiry between 2017-2023.

attention in the House of Commons, many of those present questioning the extent to which the recipients of funds could still pursue legal action for negligence in the future. Newton assured Dafydd Wigley (MP for Caernarfon) that he had no intention of limiting an individual's ability to seek compensation on the grounds of negligence.[458]

Newton stressed the need for flexibility in the compensation and the role of the Haemophiliac Society in distributing the funds independently of the government to those who needed it on an case by case basis.[459] Whilst many supported Cook's notion of inadequacy, the sense that the scheme expressed the government sympathy for those affected was noted, albeit with a murky appreciation of the government's role in the management of blood and blood products prior to 1987. Importantly, the compensation scheme highlighted more of the power dynamics shaping the post-Fowler period. In responding to the issue of compensation, Moore cited his fear that any form of compensation would set a precedent and place pressure on the government to compensate other affected groups. Newton's ability to negotiate a more sympathetic response from the HSAC – with sporadic support from O'Sullivan and Whitelaw – demonstrated a detachment between the Secretary of State for Health and Social Service and the intricate issues at the heart of AIDS policy under Fowler. The DHSS dismissal of screening for the military upheld the consensus on testing generally, however, the issue of compensation encouraged policy engagement and deliberation from new players in the post-Fowler DHSS.

November proved to be an important month for AIDS policymakers, the issue of mandated testing returned, with medical staff – particularly doctors – the focus of the newest wave of testing hysteria. Favouring the voluntary approach to testing that had won out on almost every screening debate that had taken place in the UK, internal discussion about testing medical practitioners appeared to stimulate a more complex discussion about the validity of a volunteer approach for doctors and nurses. Recalling Wille Whitelaw's 'misgivings' about the DHSS line on 'testing medical practitioners to the Prime Minister, Principal Private Secretary to the Prime Minister, Nigel Wick documented the start of a policy deliberation that emphasised the shifting dynamics of AIDS policy that threatened to undermine the preceding

[458] Hansard, HC, 16 November 1987, v. 122 c. 769.
[459] Ibid, c. 768.

period's doctrine on testing.[460] What followed was nearly a month of negotiation between Thatcher, Whitelaw, Newton, and various other policymakers in Whitehall. Health Minister Tony Newton reinforced the importance of volunteer testing in a letter to the Prime Minister's Office, encouraging healthcare practitioners to seek advice, testing and counselling where appropriate.[461] Although in agreement with the broader sentiment of Newton's paper, John O'Sullivan suggested 'it [Newton's proposal] only begins to be applicable when the doctor knows he is infected. This negates much of the advice in Mr Newton's paper.'[462] Moreover, O'Sullivan was critical of Newton for relying on confidential counselling as the government's defence, stating: 'I would not like to be the Minister of Health, nor indeed the President of the General Medical Council, when the first patient died of AIDS contracted from a doctor who had concealed his infection.'[463] Somewhat similar to the discussion of compensation, the issue of responsibility for infection was central to the government's response to testing doctors, however, reconciling the desirability of both patient protection and employee – and personal – confidentiality presented a complicated task.

Following a meeting between the Prime Minister, Willie Whitelaw, John Moore, Tony Newton, and John O'Sullivan the more intricate details of a testing policy for doctors were explored. In the meeting minutes – recorded by Nigel Wicks – the issue of risk and responsibility alluded to a fear of 'legal damages' and the belief that the public would not accept doctors not being obligated to test deeming it 'politically impossible to argue otherwise.'[464] Conversely, the fear that mandated testing might push the disease and those affected by it further from care and counselling provided a defence of the government's existing volunteer approach.[465] The limited and time-sensitive protection afforded by mandatory testing and the practical implications of carrying out such a protocol also supported the volunteer approach adopted in other quarters of public work like the military. Nevertheless, the Prime Minister affirmed that 'the present approach to the screening of doctors for HIV was not tenable.'[466] The resulting government stance was a hyper vigilant variation on the previous volunteer

[460] TNA, PREM19-2775, N. Wicks, 'Doctors and AIDS', 17 November 1987, p. 1.
[461] TNA, PREM19-2775, T. Newton, 'Doctors Infected by HIV', 19 November 1987, Annex 2 p. 1.
[462] TNA, PREM19-2775, J. O'Sullivan, 'Doctors Infected with HIV', 23 November 1987, p. 2.
[463] Ibid, p. 3.
[464] TNA, PREM19-2775, N. Wicks, 'Minutes from Meeting about Doctors with AIDS', 24 November 1987, p. 1.
[465] Ibid, p. 2.
[466] Ibid.

approach championed by Tony Newton, the government now requesting that the General Medical Council (GMC) 'place a strict duty on doctors to take all necessary steps to check whether they were carriers of HIV virus; and if they were, to inform the necessary authorities of that fact.'[467] In the event that the GMC refused, the government would consider pursuing legislation to bring about a more defensible position.[468] The willingness to consider legislation in this context illustrated the perceived importance of screening doctors and contrasted with the government's general lack of interest in pursuing AIDS legislation during the decade.[469]

This approach was immediately successful. On 9 December the GMC had demonstrated a strong degree of support for the adoption of the government's stance on testing doctors.[470] Whitelaw also noted that the corresponding dental and nursing organisations had indicated the adoption of a similar policy for their members and that the policy had received a positive reception in the media.[471] Seemingly opposed to Newton, Whitelaw and the GMC, John O'Sullivan maintained in a letter to the Prime Minister that those doctors already infected still posed a threat to the general population.[472] Proposing mandatory testing at six-weekly intervals for medical practitioners in high risk areas such as surgery, O'Sullivan aligned more with the Reagan administration's approach to testing than his British colleagues.[473] O'Sullivan's pursuit of a tougher testing protocol for doctors was a prime example of the complicated and likely unresolvable issue screening medical practitioners presented. The belief that a volunteer approach overtly relied on the honesty of medical practitioners was understandable, given the potential for stigma, discrimination, and dismissal, the personal fallout from a positive diagnosis was hugely significant for the individual in question. Moreover, the potential for a testing protocol to identify any existing cases amongst practitioners attended to the issue central to O'Sullivan's dissatisfaction with the current policy stance. Nevertheless, O'Sullivan's notion of fallibility failed to observe the limited – and somewhat false – sense of security provided by a routine testing protocol. Frequently referenced by those favouring a widespread volunteer approach such as Surgeon General

[467] Ibid.
[468] Ibid.
[469] Ibid.
[470] TNA, PREM19-2775, W. Whitelaw, 'Doctors with HIV Infection and AIDS', 9 December 1987, p. 1.
[471] Wicks, 'Minutes about Doctors with AIDS', p. 2.
[472] TNA, PREM19-2775, J. O'Sullivan, 'Doctors with HIV Infection and AIDS', 15 December 1987, p. 1.
[473] Ibid.

Koop and Chief Medical Officer Donald Acheson, the testing of doctors would not only screen a low-risk group but a negative test would only offer assurance for that given period, providing a potentially false sense of security for future patient interactions.[474] Despite these objections, Thatcher accepted the progress made by Whitelaw and Newton, noting that she would like the DHSS to explore the possibility of routine testing for future discussion.[475]

Superficially, the issue of screening medical practitioners was resolved in a characteristically British way, by prioritising awareness, voluntary testing, and confidentiality. Whilst this was certainly true of the November-December exchanges in Whitehall, the decision to pursue a stricter variation of voluntary testing that evoked a practitioner's duty represented a shift in policy dynamic that brought into question the validity of volunteer testing. George Younger's proposal for military testing on a special case basis had attracted only limited support and thus, voluntary testing prevailed as the core mantra of the British approach to testing. Conversely, the screening of doctors provoked a more acute appreciation of the need for testing amongst policymakers, making the prospect of mandated testing a more realistic intervention. What distinguished the case for screening medical practitioners was their proximity to the general population and the prospect of government liability. Unlike military personnel whose circumstances were unique – field transfusions and critical wound management for a comparatively small population of traceable individuals – domestic medical practitioners had the potential to infect the general population, undermining their duty of care and leaving the government – as stewards of the NHS – legally liable. Likely influenced by the contaminated blood issue and the escalation of compensation for haemophiliacs, the threat of liability and a failure of care prompted a willingness to question the principled adoption of voluntary testing and whilst the principle remained intact, the scepticism surroundings its long-term viability was mounting in Whitehall.

[474] A common example: an individual might get tested and provide a negative result. Upon receiving their results, they leave the doctor's office and within hours of a negative test contract the disease from an infected needle, contaminated blood, or sexual intercourse with an infected individual. Given the long incubation period and the resulting lack of symptoms this individual might assume for the next six weeks between routine tests that they are 'negative' and behave as such, engaging in unprotected sex and needle sharing. Although a routine test weeks later would likely catch this new infection, the idea that it has protected people from initial infection is flawed given the potential for transmission during the six-week interval. Moreover, this also assumes that the individual returns for routine testing, not missing further testing based on the knowledge that they tested negative 'recently'.

[475] TNA, PREM19-2775, N. Wicks, 'Doctors with HIV Infection and AIDS', 18 December 1987, p. 1.

By the end of 1987, the impact of the Presidential Commission and Fowler's departure came into focus. In the UK, policy momentum remained steady and requests for military screening and compensation for haemophiliacs upheld the policy consensus. However, screening doctors and John Moore's apprehension regarding compensation alluded to a shift – albeit slowly – in the perception of AIDS in the UK. In the US, the advancement of AIDS policy stuttered under the guise of the Presidential Commission's activity and the faltering commitment of those appointed to report for it. Ultimately, the second half of 1987 proved to be a transitional period defined by changes in the AIDS policy power dynamic.

1987 cemented the emergence of divergent trends in the US and UK policymaking narratives. In key areas of AIDS policy such as screening, British and American policymakers negotiated the intricate details of immigration, pre-marital testing and the screening of medical practitioners to produce distinctly different policy interventions and justifications that achieved varying degrees of success. Guided by an adherence to the prevailing medical consensus on testing, the British response continued to champion voluntary testing and achieved a sense of coherence that reaffirmed the ethical and legal issues that underpinned the limited usefulness of any data collected from the screening of low-risk groups. Comparatively, US policymakers demonstrated a greater willingness to depart from voluntary testing, adopting what policy advocates labelled a 'common sense' approach to testing that utilised mandated testing to increase the aggregate number of tests done, dispelling ignorance about individual infection status. A beacon of scientific authority, the advocacy of Surgeon General Koop in 1987 showcased the White House's transient commitment to the principles of medical science and the administration's inability to marry 'medicine and morality' into a coherent AIDS ethos, which the following discussion on education will explore in greater depth.

'Don't Medicine and Morality Teach the Same Lessons':
The Role of Moralism in the Development of Public Health Education[476]

[476] APP, R. Reagan, 'Remarks at a Luncheon for Members of the College of Physicians in Philadelphia, Pennsylvania', 1 April 1987, [https://www.presidency.ucsb.edu/documents/remarks-luncheon-for-membersthe-college-physicians-philadelphia-pennsylvania], accessed 15 March 2024.

Driven by the absence of a cure, a vaccine and effective treatments, education remained the most viable prospect for large-scale infection prevention on both sides of the Atlantic. This discussion will explore AIDS education and the accompanying volatility that beset public health education throughout 1987 through the interplay between medicine and moralism. Whereas President Reagan attempted to marry the contrasting protocols of medicine and moralism, policy advocates in the UK maintained a clear distinction between government and the church. As a cornerstone of their campaign, the Church – again, likely the Church of England but often broadly defined by the HSAC and OCA as inclusive of Christianity and Judaism – remained in touch with the prevailing winds of AIDS policymaking with a remit to respond to the need for moral guidance explicitly deemed outside the role of government. As British policymakers entered January with a national leaflet drop, nationwide education was advancing compared to the situation in the United States where the White House was exploring the idea of government-sponsored AIDS messaging. Consequently, this discussion will navigate the disparity between the US and UK responses to AIDS education through the framework of medicine and moralism. It investigates the Reagan and Thatcher administrations' attempts to reconcile – or distinguish – the two approaches, the former through a complicated and seemingly contradictory notion of parallel teaching between moralism and science and the latter through a directly contrasting distinction between the state and religion.

The existing literature has discussed social conservatism in the US and UK as guided by similar principles but distinct in practice. Allan Lichtman has pointed to Reagan's endorsement of school prayer, anti-abortion law, and family values as examples of his social conservatism in a political platform that stressed the need to reverse the decline of the traditional family unit in modern America.[477] Speaking to the nation via radio in December 1986, Reagan himself suggested the family was the 'nucleus of civilisation' and had 'come under virtual attack' having lost sway in the spheres of education and governance.[478] Similarly, Thatcher stressed the importance of family life during her speech at the 1987 Conservative party conference in

[477] A. J. Lichtman, *White Protestant Nation: The Rise of the American Conservative Movement* (New York 2008), p. 376.
[478] RPLM, R. Reagan, 'President Reagan's Radio Address on Family Values', 20 December 1986, [https://www.reaganlibrary.gov/archives/speech/radio-address-nation-family-values], accessed 15 March 2024.

Blackpool, asserting that 'the family is the first place where we learn those habits of mutual love, tolerance and service on which every healthy nation depends for its survival.'[479] Nonetheless, Desmond King has highlighted the US interpretation of conservatism as one that placed greater emphasis on the social aspects of the philosophy than did their British counterparts, stressing Thatcher's preference for economic revitalisation and not social engineering.[480] Jeffrey Weeks, writing on AIDS and the regulation of sexuality in the UK concluded that despite holding socially conservative views akin to Reagan, Thatcher pursued them erratically and with little enthusiasm and presided over a period of growing awareness for the homosexual community in Britain.[481] In AIDS policy, the application of socially conservative teachings of family and marriage – discussed hereafter as moralism – achieved a similar distinction between the US and UK. Where the British government championed the separation of state and moralism, the Reagan White House pursued a contrasting agenda that complicated public health messaging on safe sex and harm reduction.

Encouraged by the success of the public education campaign in 1986, the Home and Social Affairs Committee Sub-Committee on AIDS (HSAC) set about a more substantive plan for the remainder of the decade. In a memorandum received by the Prime Minister from Norman Fowler on 14 January 1987, the Secretary for Health and Social Services outlined his department's goal for the nation's public education campaign on AIDS: 'to stop the spread of the virus now so that in the 1990s the number of deaths from AIDS does not continue to rise.'[482] Incorporating the disease's long incubation and the often subtle presentation of symptoms into the policy timeline, those sitting on the HSAC demonstrated an acute awareness that AIDS would be a part of public health in the long term and therefore required more policy foresight and planning. Although Fowler's earlier prioritisation of education embraced a more realistic approach to epidemic response than the magic bullet optimism of the Reagan administration, his combination of public health education with new slogans like 'Today's Carriers: Tomorrow's Cases' emphasised Fowler's forward looking AIDS policy

[479] 'Speech to Conservative Party Conference', *Margeret Thatcher Foundation,* 9 October 1987, [https://www.margaretthatcher.org/document/106941], accessed 15 March 2024.
[480] D. King, *The New Right: Politics, Markets and Citizenship* (Basingstoke 1987), pp. 1-7.
[481] J. Weeks, 'AIDS and the Regulation of Sexuality' in V. Berridge and P. Strong (eds), *AIDS and Contemporary History* (1993), pp. 23-31.
[482] TNA, PREM19-2775, N. Fowler, 'Background Information', p. 1.

ethos.[483] For the Sub-Committee, the future success of the public education campaign rested on the government's ability to communicate with at-risk groups whose characteristics and behaviours represented the greatest threat to the general population and in this regard, their focus was firmly fixed on two demographics: intravenous drug users (IVDUs) and young people.

In January, the HSAC set the parameters of future education efforts stating that 'injecting drug misusers represented the greater threat for the spread of AIDS into the general population than did the homosexual community.'[484] In determining IVDUs as a priority group for the next phase of public education, the HSAC placed significant emphasis on their potential to transmit HIV beyond the confines of the established risk groups and into the general population with devastating effect due to their majority heterosexuality. Although male homosexuals still constituted most AIDS cases in the UK (87% in England by December 1987), the rapidly rising rate of infection amongst IVDUs – particularly in Scottish cities such as Edinburgh, Glasgow, and Dundee – focused the attention of AIDS policymakers on the bridging capacity of those using injectable drugs.[485] Described by the HSAC Sub-Committee as a group 'as heterosexual as the rest of the population', IVDUs were characterised as a sexually viable avenue through which the transmission of HIV into the general population was easiest and most direct.[486] Moreover, IVDUs were a community primarily made up of young, sexually active people 'who regarded their sex lives involving more than one partner as perfectly normal and within social convention.'[487] Mindful that conventional public health education techniques would likely be less effective when attempting to communicate with IVDUs due to the circumstances surrounding their usage, the Sub-Committee noted 'some very specific means would have to be found for reaching drug misusers effectively.'[488] Faced with a high priority audience with a well-documented record of poor receptiveness to public health education, the Sub-

[483] Ibid, p. 5.
[484] CAB/134/5135, TNA, HSAC, 14 January 1987, p, 3.
[485] GB0809 AIDS Social History Programme/1/2, D. Acheson, *Chief Medical Officer's Annual Report: 1987* (December 1987), p. 118.
[486] TNA, HSAC, 14 January 1987, p, 3.
[487] Ibid, p, 4.
[488] Ibid.

Committee shifted its focus onto public education for young people as a means of targeting risk-taking behaviour such as unprotected sex with multiple partners and IVDUs.[489]

Likewise, US policymakers shifted their focus towards educating young people with President Reagan notifying Congress in late January that his administration intended to build on the foundation made by the Surgeon General's October 1986 report and expand the nation's AIDS education effort.[490] In his message to Congress Reagan stressed the need for education 'grounded in the moral and cultural values of parents and communities.'[491] Although somewhat vague, the interweaving of parents and community with moral and cultural values embraced the family-orientated undercurrent that permeated throughout Reagan's political base. Emphasising their capacity as a sexually active demographic, the educating of young people about AIDS shed light on the interplay between science and moralism as force with different messaging. In a February briefing paper the administration clarified this sentiment, notifying the President that the Surgeon General and Secretary for Education, William Bennett had made the joint statement that 'young people must be told the truth - - that the best way to avoid AIDS is to refrain from sexual activity until as adults they are ready to establish a mutually faithful monogamous relationship.'[492] Although this message appeared somewhat misaligned with Koop's widely praised – and widely criticised – 1986 report on AIDS that promoted safe sex, condom use, and awareness alongside broader appeals for behaviour change and education, the joint statement was likely an ideal scenario for the Surgeon General whose broader appeals were open to safer sex practices and harm reduction strategies. Nevertheless, the administration's emphasis on family and community as the bedrock of the nation's AIDS education effort somewhat muddied the public health message on the disease, placing greater strain on the relationship between medicine and moralism.

The interplay between medicine and moralism was not a uniquely American issue, however, although the British manifestation of the relationship was somewhat different. On 9 January,

---

[489] Importantly, policymakers did not forget about IVDUs as a priority group during this period, turning to experimental Needle Exchange trials as an infection control intervention in April 1987. In terms of public education, however, it appeared that the HSAC perceived the combination of Needle Exchange and education, and awareness aimed at young people as the best 'value for money' approach.
[490] RPLM, R. Reagan, 'Message to Congress on "A Quest for Excellence", 27 January 1987, [https://www.reaganlibrary.gov/archives/speech/message-congress-quest-excellence], accessed 15 March 2024.
[491] Ibid.
[492] HE001 470299, RPLM, R. M. Kruger, 'AIDS Briefing Paper for the President', 4 February 1987, p. 2.

the Official Committee on AIDS framed the issue of moralism in markedly different terms suggesting a distinction be made between the practical role of the Government and the churches need to provide 'guidance on the moral implications' of the disease.[493] In the first instance, the Official Committee established the churches as the custodian of moralism and in doing so, alleviated some of the entrapments inherent in a values-based approach to public health education.[494] Consequently, the Official Committee encouraged the disassociation of the government and moralism, favouring practicality and a scientific approach to epidemic response.[495] Unlike their US counterparts, the Official Committee demonstrated a willingness to separate medicine and moralism at a fundamental level and provided a necessary barrier between scientific consensus and moral conjecture. During a February appraisal of the public education campaign the Official Committee documented that the public education campaign had succeeded in 'avoiding the more contentious moral issues raised by the disease' as part of a self-proclaimed validation of the committee's approach.[496] Nevertheless, the interaction between moralism and public education was seemingly inevitable across the political arena. In the Prime Minister's sphere, advisor Hartley Booth spoke of 'the recurring theme in the responses we have received and are coming into this office, namely that we are not stressing the importance of abstinence and faithfulness sufficiently.'[497] Concluding his note to the Prime Minister with: 'we have a long way to go with this one. First of all, our message of the practical need for faithfulness need to be stronger.'[498] Booth's values-based commentary on AIDS education resonated with the socially conservative precedent set by President Reagan's 'medicine and morality' construct and Margaret Thatcher's separation of innocence and sexual health in 1986.

Retreating in early 1987 following her unsuccessful campaign against Norman Fowler's AIDS messaging in 1986, Margaret Thatcher herself documented similar ideals of moral guidance and faithfulness in drafted material to Chief Rabbi Immanuel Jakobovits between March and April. In a memorandum to the Prime Minister that similarly criticised the tone and messaging of the government's education campaign, Jakobovits proclaimed: 'In short, the campaign

[493] CAB/134/5137, TNA, OCA, 9 January 1987, p. 1.
[494] Ibid.
[495] Ibid.
[496] CAB/134/5135, TNA, OCA, 4 February 1987, p. 2.
[497] TNA, PREM19-2775, H. Booth, 'AIDS', 16 January 1987, p. 1.
[498] Ibid, p. 2.

should say plainly: AIDS is the consequence of pre-marital sex, marital infidelity, sexual deviation and social irresponsibility – sacrificing enduring happiness for momentary pleasures, and putting selfish indulgence before duty and discipline.'[499] In a drafted reply that was never dispatched, Thatcher alluded to her preference for a values-based approach to AIDS education, writing 'I sympathise with your views and there is no doubt that if such messages, emphasising the moral dimension, were accepted and acted upon, a campaign on these lines would be successful in preventing the spread of the disease by intimate sexual contact.'[500] Supportive of Jakobovits' critique of society's permissiveness towards indulgence and pleasure, Thatcher's 'moral dimension' reinforced her previous interventions on risky sex and public innocence and in turn distinguished her from the prevailing policy philosophy shaping contemporary AIDS policy. Moreover, the Chief Rabbi's interjection on moralism embraced the exact role the Fowler-Acheson policymaking axis envisaged for the Church: custodians of morality. By 'defending society against dangers far transcending the awesome ravages of AIDS', Jakobovits occupied the turbulent moral ground that threatened to undermine government AIDS messaging.[501] Whilst messages of abstinence and faithfulness certainly appealed to a substantial stratum of British society, the moralising of public health threatened the prospect of behaviour change and thus, we might conceive that the government permitted the churches to promote a moral message in their stead. An arrangement that likely benefitted both parties greatly, the government able to maintain a defensible position on safe sex and condom use, the churches equipped to contextualise public health messaging with their own positions on the very same issues. Furthermore, the government's ability to separate itself from such messaging served to strengthen its commitment to epidemic response. Although Thatcher and Booth's values-based messaging was indicative of moralism in Whitehall, this approach was seemingly at odds with the dominant policy philosophy that separated public health and moral conjecture and reaffirmed the status of Thatcher, Booth and moralism as policy outsiders.

In the parliamentary sphere, the intersection between public education and moralism was more acute. Diversifying the discussion of values-based education beyond the ideals of faithfulness and abstinence, a more targeted debate about sex education and public health

[499] TNA, PREM19-2775, I. Jakobovits, 'Memorandum to the Prime Minister on AIDS', 11 March 1987, p. 2.
[500] TNA, PREM19-2775, M. Thatcher, 'Drafted Reply to Chief Rabbi Jakobovits', 9 April 1987, p. 1.
[501] TNA, PREM19-2775, Jakobovits, 'Memorandum on AIDS', p. 2.

evolved. In the House of Commons, Roger Sims (MP Chislehurst) praised the education campaign's ability to 'trod carefully the difficult line between giving explicit information and not causing offence' before pointing to a 'moral code' when discussing AIDS amongst homosexuals.[502] On 17 February, Michael Hirst (MP Strathkelvin and Bearsden) asked the Minister of State for Education and Science, Angela Rumbold, for assurance that the booklet, *Children at School and Problems Related to AIDS* (1986) 'will be given in a sensitive way that reinforces the moral guidance that children receive at home' before accusing Labour-controlled districts of using the educational material to promote homosexuality.[503] Responding in a measured fashion, Rumbold highlighted the broader public health scope of the booklet when attending to Hirst's issue of moral sensitivity.[504] She surmised that 'it is important that all instructions appertaining to AIDS is taught within the context of a proper social structure and the proper social apparatus of married family life.'[505] Rumbold's embrace of the nuclear family and apparatus of the traditional domestic environment navigated the overtly moralising tone of monogamy and faithfulness in a way that likely embodied Fowler's desired approach to AIDS education.

During this period Fowler himself entered the parliamentary sphere, responding to Andrew MacKay's (MP East Berkshire) request to push public health adverts back from 5pm to 7pm 'to avoid young children seeing them and their parents being embarrassed.'[506] Fowler sympathised with MacKay whose concern echoed Thatcher's 1986 interjection but offered no compromise on his public health adverts.[507] Likewise, Tony Marlow (MP Northampton North) noted his distaste for the question "gay or straight?" in education adverts on television, suggesting it invites 'equality of choice' for adolescents watching.[508] Once again, Fowler offered his apologies for any offence caused but noted that 'the greater need and demand is to get the message over to the public.'[509] Indicative of his public health stance, Fowler's rebuttals reinforced the hard-line stance he had adopted throughout 1986 in the face of mounting pressure from Margaret Thatcher and her apprehensions about the public

[502] Hansard, HC, 23 January 1987, v.108 c. 1187.
[503] Hansard, HC, 17 February 1987, v. 110 c. 751.
[504] Ibid, c. 753.
[505] Ibid.
[506] Hansard, HC, 25 February 1987, v. 111 c. 281.
[507] Ibid.
[508] Ibid, c. 282.
[509] Ibid.

education campaigns. On 10 March, John Townsend (MP Bridlington) posited a question about AIDS education and homosexuality in schools, suggesting that 'the time has come to ban homosexual propaganda in schools, on television, in newspapers and in other forms of the media.'[510] Offering Townsend some vague agreement about the place of homosexuality in schools, Fowler speculated that 'we must take account of the cases among drug users sharing needles and heterosexuals … and therefore it is right that we should be prudent about the information that we give to the public.'[511] Whilst the homophobic sentiment inherent in Townsend's question preceded Section 28's passing by a year, Patrick Duffy (MP Sheffield, Attercliffe) brought the question of morality more acutely to Fowler's attention suggesting the next stage of his campaign 'should point out, without preaching, that there are moral choices available to the public.'[512] In response, Fowler clarified the inherent safety in faithful monogamy before shifting focus towards the role of the Church in providing a 'complementary' campaign.[513] Fowler's responses emphasised the limited role of moralism in his education campaign, articulating a vision of public health education that corresponded with the Official Committee's previous statements on the distinct roles of the government and church, the former defined by evidence-based practicality and the latter moral guidance.

Similarly, March proved to be a vital month for AIDS education in the US with the prospect of a public education effort shining a light on the Reagan administration's ability to juggle medicine and moralism and articulate a coherent and informative education campaign. Moreover, the period March-April demonstrated the importance of a values-based approach to AIDS education in the US, detailing the contrasting role of moralism in the US and UK education responses to AIDS. The prospect of a public awareness campaign in the US represented the culmination of a public health consensus that embraced education as the primary form of infection prevention – akin to the UK's earlier adoption of education that acknowledged the elusiveness of a vaccine or cure – and the controversial but widely accepted precedent set by the Koop Report in October 1986. Echoing Koop's sentiment in his department's report on AIDS in March, Secretary for Health and Human Services Dr Otis

[510] Hansard, HC, 10 March 1987, v. 112 c. 140.
[511] Ibid.
[512] Section 28 was an addition to the Local Government Act passed in 1988 which prohibited the promotion of homosexuality by local governments. The legislations impact on AIDS policy is explored in greater depth as part of chapter Five. Hansard, HC, 10 March 1987, v. 112 c. 140.
[513] Ibid.

Bowen commented that 'our best hope today for controlling the AIDS epidemic lies in educating the public … a massive, effective campaign to educate them is in order.'[514] The sense of urgency imbued within Bowen's embrace of public education certainly reflected the necessity of a federal campaign that filled the sizable vacuum left by years of administrative inactivity.

Describing the principles proposed by the Domestic Policy Council and approved by the President, Bowen firmly situated moralism within his department's scope for AIDS education emphasising that 'any health information developed by the Federal Government that will be used for education should encourage responsible sexual behaviour based on fidelity, commitment, and maturity, placing sexuality within the context of marriage.'[515] Conceptually, Bowen's principles proposed that the protection of the family unit be the primary output of the education campaign, upholding the government's continued ostracization of communities at the epicentre of the US epidemic during a vital stage of policy mobilisation. Failing to observe the two major risk groups – homosexual and bisexual males and IVDUs – in the first instance, the values-based framework the administration erected to guide AIDS education was fundamentally incompatible with the socio-cultural status of those most at risk. The placing of 'sexuality in the context of marriage' reinforced the heteronormative nuclear family unit as the primary recipient of AIDS education and translated poorly into discourse with homosexuals – whose rights to privacy and marriage were not ratified until *Lawrence vs. Texas* (2003) and *Obergefell vs. Hodges* (2015), respectively – and IVDUs whose usage often resulted in disconnection and disassociation from the family unit. Moreover, Bowen's ideals of fidelity and commitment embraced the family as a reproductive unit, a sentiment that resonated titles like *Homosexual Diseases Threaten American Families* published by the Moral Majority in July 1983, which pictured the archetype nuclear family wearing face masks to 'protect' them from AIDS infection.[516] Although Bowen offered more comprehensive statements that engaged with the need for 'accurate health information', the frequent reiteration of the need for parental values and consent and not scientific or medical guidance reaffirmed the

[514] HE001 464630, RPLM, O. Bowen, 'HHS Report on AIDS', 18 March 1987, p. 2.
[515] In this context, Bowen is using sexuality to describe sexual content or activity in the context of sexual health and sexual activity unlike contemporary definitions of sexuality which refer to sexual identity. Bowen, 'HHS Report on AIDS', p. 2.
[516] "Moral Majority report," *HIV and AIDS 30 Years Ago*, accessed 28 March 2023, [https://hivaids.omeka.net/items/show/9.], accessed 15 March 2024.

conditionality of AIDS education efforts and the inequitable – and often contradictory – merging of moralism and medicine as a framework for a public health messaging.[517] Similarly, British and American policymakers demonstrated differing adherences to the role of moralism in the cultivation of AIDS education and subsequently, the US-UK policy narrative diverged further.

In the public sphere, medicine and moralism debates continued to play out with increasing intensity, particularly for President Reagan whose previously distanced or scripted AIDS exchanges had ensured he remained dissociated from the more contentious elements of disease response. In April 1987, however, this changed as journalists placed greater emphasis on the President's message on AIDS education and the perceived contrast between himself and the Surgeon General's efforts to create awareness amongst the general population. During a speech to the College of Physicians in Philadelphia in April, Reagan celebrated his administration's AIDS spending – playing down the role of Congress in releasing those funds – and talked up his government's deregulation of the Food and Drug Administration (FDA) that had helped push experimental AIDS drugs into testing stages.[518] He failed to note the work of the AIDS Coalition To Unleash Power (ACT UP) protests that had shed light on the need for such deregulation.[519] Publicly positioning himself on the issue of values-based AIDS education during his speech, Reagan asserted that 'AIDS information cannot be what some call "value-neutral." After all, when it comes to preventing AIDS, don't medicine and morality teach the same lessons?'[520] Much like Bowen's 'accurate health information', the President's conceptualisation of medicine and moralism was conditional and contradictory from the outset. During an informal exchange with reporters following his speech to the College of Physicians, the President was questioned about William Bennett's disagreement with Surgeon General Koop's support of sex education for children, in particular the inclusion of messaging about condoms as a preventative method.[521] Although the President diverted attention from

[517] Bowen, 'HHS Report on AIDS', p. 2.
[518] APP, R. Reagan, 'Remarks at a Luncheon for Members of the College of Physicians in Philadelphia, Pennsylvania', 1 April 1987, [https://www.presidency.ucsb.edu/documents/remarks-luncheon-for-members-the-college-physicians-philadelphia-pennsylvania], accessed 15 March 2024.
[519] Ibid.
[520] Ibid.
[521] RPLM, R. Reagan, 'Informal Exchange with Reporters in Philadelphia, Pennsylvania', 1 April 1987, [https://www.reaganlibrary.gov/archives/speech/informal-exchange-reporters-philadelphia-pennsylvania], accessed 15 March 2024.

the White House disagreement by discussing the need for values, Bennett and Koop's conflicting stances were the very embodiment of the friction between medicine and moralism and demonstrated the incompatibility of medical science and moralism in the sphere of AIDS education.

As Brooke McKever has explored, Koop reconciled many of his conservative beliefs in the name of a coherent and evidence-based approach to AIDS, developing vital education material and a public presence that focussed on science (the *what)* and not concepts of immorality and judgement (the *whom)*.[522] Bennett – like Reagan and Bowen – demonstrated a much firmer commitment to moralism as an infection prevention and control protocol. For example, a *Los Angeles Times* article reporting on the Bennett-Koop dispute noted that Bennett had proposed teaching heterosexual sex as the appropriate behaviour to stop transmission amongst homosexuals.[523] Likewise, Reagan responded to questions about the best preventative method by borrowing First Lady Nancy Reagan's 'Just Say No' rhetoric which reinforced abstinence as 'a pretty good answer' to infection control.[524] Reagan suggested that condom use and preventative methods generally should be 'taught in connection with values, not simply taught as a physical mechanical process.'[525] Reagan's exchange with reporters in Philadelphia highlighted the administration's attempt to integrate medicine and moralism as 'equal' partners in AIDS education, aligning socially conservative principles of abstinence with impressions on evidence-based practice. Nevertheless, the interplay between the two was profoundly inequitable. The suppression of condom use as a prevention method and the promotion of abstinence were prime examples of the administration's selective adherence to the education message produced by advocates of medical science such as Surgeon General Koop. The relegation of the 'physical mechanical process' in favour of the intangibility of a values-based approach exemplified the conditionality of Reagan's approach to AIDS messaging and his avoidance of the contentious elements of transmission. Alluding to a wider socially conservative edict, Reagan's apathy for the mechanical process was illustrative of a

[522] B. McKever, 'Public Relations and Public Health: The Importance of Leadership and Other Lessons Learned from "Understanding AIDS" in the 1980s', *Public Relations Review*, 47 (2021), pp. 5-6.
[523] 'Bennett, Koop Settle Dispute: Education Chief Insisted Moral Values Were Being Ignored', *Los Angeles Times,* 31 January 1987.
[524] Just Say No was the slogan for First Lady Nancy Reagan's anti-drug campaign that also pushed similar rhetoric of self-control and abstinence. Reagan, 'Informal Exchange with Reporters', 1 April 1987.
[525] Ibid.

rejection of science that endorsed the inequitable interplay of moralism over medicine. Pushing further, Reagan suggested sex education required the accompaniment of values such as abstinence to help teach 'right and wrong' to young people.[526] This perception of 'right and wrong' spoke to the communities whose 'physical mechanical processes' the administration endeavoured to avoid discussing, such as IVDUs using injectable drugs and bisexual and homosexual males engaging in anal intercourse. The preoccupation with a values-based approach also situated the administration's core message at odds with medical science and the approach adopted by Norman Fowler and his colleagues in Whitehall, whose deliberate distinction between the role of the church and government enhanced the credibility and coherence of AIDS messaging.

In April-May the President continued his pursuit of medicine and moralism during private exchanges with Dr John A Howard, President of Rockford College (1960-1977) and founding member of the conservative think-tank the Rockford Institute, whom Reagan had received letters from about a response to AIDS that intimately integrated Christianity.[527] Entitled 'A Sounder Anti-AIDS Option', Howard's written commentary firmly situated a critique of Koop's education messaging around the idea of a 'Christian response to AIDS.'[528] Underpinned by a criticism of the 'non-judgemental permissiveness' that he believed had caused AIDS in the first place, Howard communicated his stance on the disease as one shaped by prejudice and separated those on the moral high ground who had 'steadfastly held to a strict moral in his own life' and those who had 'rejected standards of right behaviour … forced to pay a price for rejection.'[529] Howard's scrutiny reinforced the sense of right and wrong inherent in Reagan's previous support for values-based education, constructing a similar image of moralism as a bastion of disease education and infection control. Moreover, Howard attacked Koop's claim that 'we are not at war with a lifestyle' positing that 'it is at this point, it seems to me, that Christians are called upon to intervene and say, "Dr Koop, we respectfully disagree. We believe our nation must forcefully, albeit compassionately, reject the lifestyle that endorses

[526] Ibid.
[527] Dr John A Howard was an active advocate of conservatism in the US from the 1960s onwards establishing the Rockford Institute in 1976 – one year before his dismissal as President of Rockford following student protesting his policies – and founding the socially conservative think-tank, the Howard Centre for Family, Religion and Society in 1997 to study abortion, homosexuality, and divorce in the US.
[528] HE001 477640, RPLM, J. A. Howard, 'A Sounder Anti-AIDS Option', 8 April 1987, p. 2.
[529] Ibid.

homosexual intercourse, sexual promiscuity, and the intravenous use of recreational drugs.''[530] Shedding light on the perception of AIDS education amongst American conservatives, Howard's unapologetic rejection of the 'mechanical processes' and those associated with them shaped a belief in moralism as a tool for public health intervention embedded in the heteronormative ideals of marriage and family. Sympathising with Howard, Reagan pointed to his speech to the College of Physicians in Philadelphia which emphasised his belief in the similarity between the teachings of medicine and moralism suggesting his administration's education efforts will do 'a better job in the months ahead.'[531] Although Reagan's pursuit of a socially conservative AIDS education agenda was less flagrant than Howard's demonising of homosexuality and IVDUs, Howard's critique merely embellished the core values of the President's approach to education and AIDS generally. When Reagan publicly emphasised 'chastity before marriage and fidelity after it', Howard proclaimed joy.[532] Conversely, when Koop mentioned condoms and sex education, Howard recoiled in dismay.[533] Where Reagan spoke of the need to 'swing [the pendulum] back towards a moral code that once prevailed in this country', Howard recounted the 'non-judgemental permissiveness' that had 'given impetus to the breakdown in the family, the mass production of children by unwed mothers, the increase in crime and other grave social pathologies.'[534]

Reminiscent of Hofstadter's *Paranoid Style in American Politics,* the linkage between social pathology – the idea of 'societal' disease and injury – and AIDS advanced intolerance as a component of values-based education and endorsed the conditional nature of moralism and medicine as a framework for AIDS education.[535] Intolerant of those alternative lifestyles that conflicted with Christian family values, the Reagan administration's broader appeal to morality shared the undertones of prejudice that ostracised those who were attributed a double stigma – stigmatisation predicated on both a positive AIDS status and fringe societal status – that excluded homosexuals and IVDUs from constructs such as medicine and moralism and the education effort it championed.[536]

---

[530] Ibid, p. 4.
[531] HE001 477640, RPLM, R. Reagan, 'Letter to Dr John A Howard About AIDS', 6 May 1987, p. 1.
[532] Ibid.
[533] HE001 477640, RPLM, J. A. Howard, 'Letter to the President about AIDS', 23 April 1987, p. 1.
[534] Reagan, 'Letter to Howard About AIDS', p. 1. Howard, 'A Sounder Anti-AIDS Option', p. 4.
[535] R. Hofstadter, 'The Paranoid Style in American Politics', *Harper's Magazine,* (November 1964), pp. 77-86.
[536] G. Herek, 'AIDS and Stigma', *American Behavioural Scientist,* 42:7 (April 1999), p. 1110.

Whilst education remained a principal role in AIDS policy, the ability of policymakers on both sides of the Atlantic to negotiate the message of 'medicine and morality' continued to shape AIDS education and epidemic response generally well into the middle of 1987. By July, British policymakers had established a firm foundation of educational material, from newspaper adverts to television campaigns the government's position on AIDS was well positioned and seemingly engaging – a feedback poll presented to the HSAC in February 1987 suggested that 95% of those polled had seen some form of AIDS education material and 98% knew the disease was transmitted by IVDU and sexual intercourse.[537] Capitalising on this sense of awareness, the HSAC pushed forward on plans to deliver specific material to children and young people as part of Fowler's foresighted vision for epidemic response embodied in the slogan *Today Carriers: Tomorrow's Cases.*[538] The next manifestation of this push was an AIDS video that aimed at 13-16 year old children which set out to cultivate a basic awareness of the disease and how it was transmitted. Although the HSAC noted that 'the danger that some people might be offended by some of the explicit material in the film was … unavoidable', individuals in Whitehall quickly jumped at the opportunity to sponsor a values-based approach to AIDS education for young people.[539] In a letter sent immediately after the above-mentioned HSAC meeting, Advisor Hartley Booth notified the Prime Minister that 'we seem to have been a little misled' about the proposed AIDS video for children.[540] Booth critiqued the HSAC's statement that 'fidelity to one partner is safest', indicating a sense of dissatisfaction with the Sub-Committees preference for 'prudence and practicality.'[541] Outlining a framework that emphasised family, marriage, and morals, Booth saw the educational video as an opportunity to engage with young people on the effectiveness of 'be prudent' with 'some reference to higher standards of conduct.'[542] Booth's engagement with moralism misaligned him with Fowler and much of the HSAC whose endorsement of practicality had continued to prevail. Reaffirming his outsider status, Booth's pursuit of a stronger values-based message demonstrated the importance of practicality to the British approach and the successful separation of medicine and moralism at key junctures in the public health education campaign

[537] CAB/134/5135, TNA, HSAC, 4 February 1987, p. 2.
[538] TNA, PREM19-2775, Fowler, 'Background Information', p. 5.
[539] CAB/134/5135, TNA, HSAC, 2 July 1987, p. 1.
[540] TNA, PREM19-2775, H. Booth, 'AIDS Film for 13–16-Year-Old Schoolchildren H (A) Today', 2 July 1987, p. 1.
[541] Ibid.
[542] Ibid.

thus far. Moreover, Booth's critique of the 'flimsy line of defence presented by "careful contact" was a rejection of Fowler's faith in practicality and Acheson's scientific approach, his opportunistic request for higher standards resonated with the belief in moral decline that characterised the Reagan-Howard exchanges in the US.[543]

Interjecting his own designs on moral conduct and higher social standards, Booth set about attributing his underlying belief in moral decline to the alternative lifestyles that remained at the epicentre of AIDS in the UK. In the first instance, Booth cited George Younger's comment that 'there was no reference stating the innate undesirability of homosexuality and no reference to [the desirability of] loving or married relationships.'[544] Engaging with Younger's explicit rejection of homosexuality – which resonated with John Howard's opinions on the role of homosexuality, IVDUs and sexual promiscuity in moral decline – Booth claimed 'the fact is simple – prudence is unlikely to be a strong enough barrier against sexual activity unless it is strengthened by a moral prohibition.'[545] Booth's attempt to reconcile the perceived vagueness of the HSAC's notion of prudence by incorporating ideals of 'moral prohibition' akin to Reagan's 'moral code' demonstrated a side of AIDS policy that featured sparingly in key policy exchanges of the HSAC Sub-Committee and Official Committee. A result of the intention to separate government and church messaging – that of practicality and moral guidance – Booth's ideals of moralism achieved little traction with those intimately responsible for policy direction like Norman Fowler and Donald Acheson. Moreover, this lack of traction served to distinguish the US and UK relationship with moralism as a tool for AIDS education. Whilst Booth's moralism shared common ground with the Prime Minister and authoritative personnel such as Lord Hailsham, these principles existed on the fringes of the Fowler-Acheson vision for AIDS policy and subsequently failed to realise a level of success comparable to that of the Reagan administration whose prioritisation of a 'moral code' set a precedent of abstinence-oriented education for the remainder of the decade.

Nevertheless, the development of an AIDS education video for schoolchildren continued throughout 1987 and by September the material was ready for stakeholder testing and approval for distribution. Underpinned by the campaign's 'generally favourable and …

[543] Ibid.
[544] Ibid.
[545] Ibid.

widespread support for the Government's AIDS education initiative',[546] Private Secretary Mark Addison notified the Prime Minister in July that the video would soon be tested in schools but might feature the omission of 'a controversial sequence' – later suggested to be a sequence on condom use.[547] Following the initial stage of stakeholder testing, the AIDS educational video produced by the government had received 'no adverse reaction from school governors and the video had been generally welcomed.'[548] This positive note on the video's reception was primarily directed at English and Welsh schools and a later note alluded to a more contentious reception in Scotland. In Scotland, the educational video had provoked 'strong reactions from the Roman Catholic schools and to a lesser extent from the non-denominational churches.'[549] A crossroad between education and religion, the likelihood that an AIDS education video – featuring an animated sequence on condom use – might have attracted adverse reactions from school representatives was high. Interestingly, religious schools in England and Wales were not specifically mentioned in the discussion of Roman Catholic schools suggesting they adopted the material more willingly or that they simply featured to a lesser extent in the initial testing phase. Consequently, the HSAC Sub-Committee noted the need for 'very careful thought' when approaching schools in Scotland.[550]

The next in-depth discussion of the educational video was early November. The HSAC remained optimistic about the education video and continuing to reflect on the 'generally … positive and supportive' feedback they had received in England and Wales despite continued apprehension in Scotland.[551] Although members of HSAC had previously commented on the 'moral content' and raised questions about the condom animation sequence, the video was received well by school governors, teachers, and pupils whose feedback reinforced the view that educational content was presented 'in a suitably matter of fact manner.'[552] Importantly, the pilot scheme's success was coupled with a varying but positive level of endorsement from religious leaders in the UK. Writing to the Archbishop of Canterbury, the Cardinal of Westminster and the Chief Rabbi, the Secretary for Education and Science Kenneth Baker

[546] CAB/134/5135, TNA, HSAC, 22 July 1987, p. 7.
[547] TNA, PREM19-2775, M. Addison, 'Prime Minister – H (A) Meeting Update', 24 July 1987, p. 1.
[548] CAB/134/5135, TNA, HSAC, 30 September 1987, p. 4.
[549] Ibid.
[550] Ibid.
[551] CAB/134/5135, TNA, HSAC, 10 November 1987, p. 1.
[552] Ibid.

relayed that in England and Wales 'all three churches had responded favourably to the video, although they all proposed to produce their own notes for teachers in church schools.'[553] Although the support of the church in the delivery of educational material in English and Welsh schools – that also included material on condom use – was somewhat conditional, it represented a significant step towards achieving substantial public awareness in a population vital to the government's long term goals for the disease.

Supportive and engaged to varying degrees, the provision of specific notes by the churches represented an expected and willingly incorporated compromise on delivery that ensured the video's widespread dissemination in religious schools. Interestingly, the three churches Baker contacted raised different issues in their feedback that focused on a variety of AIDS-related issues and not exclusively on moral guidance as one might have expected. The observers for the Roman Catholic Church in England and Wales noted that 'the condom animation sequence would be appropriate for use in Catholic schools only in exceptional circumstances.'[554] The Catholic Church's avoidance of the condom animation was unsurprising but, importantly, not dismissive of the video's broader messaging on infection control and safer sexual practices. The Anglican observer's feedback was outwardly positive deeming 'that the video was a useful and practical exercise in sex and anti-AIDS education' whilst the Archbishop of Canterbury had expressed some concern about the use of AIDS victims in the film, however, many agreed this was a vital and telling part of the videos message.[555] Seemingly reconciling the potentially problematic interplay between practicality and moralism, the AIDS education video proved to be a fruitful integration of church and society. Whereas non-denominational schools would likely embrace sex education more willingly, the potential for religious schools to derail the governments education efforts on the grounds of conflicting values was high but largely reconciled by compromises on how the video would be delivered.

Although the government and church had navigated this barrier in England and Wales, the issue of Scottish schools remained an obstacle to the HSAC's push for the video to be used across the whole of the UK. Scottish observers emphasised the Scottish AIDS experience as one shaped by IVDUs – unlike England and Wales where the disease primarily affected

[553] Ibid.
[554] Ibid, p. 2.
[555] Ibid.

bisexual and homosexual males – and a broader concern was raised about the need to clearly communicate a message on moral conduct.[556] Articulating a more evident sense of moralism than the English and Welsh observers and their associated churches, Scottish observers 'expressed a concern that the video failed to provide clear moral and ethical guidance, in particular that it fostered the impression that sexual relations between children under the age of consent was acceptable.'[557] In the first instance, the discussion of 'moral and ethical guidance' highlighted the dynamic interplay between the disease (biological) and the illness (social and cultural). Falling short of affirming a form of moral or ethical code, the call for clear guidance resonated with a socially conservative critique that targeted immorality and indulgence over an appraisal of transmission as a mechanical process. Furthermore, the interjection of the age of consent and the acceptability of underage sex positioned AIDS education as a tool for epidemic response against a belief in safeguarding the innocence of young people and the public generally. This grey area between public innocence and epidemic education presented an important battleground for those who desired for a broader values-based response. Vulnerable populations such as children presented an understandably more complicated ethical prospect for AIDS education than sexually active adults or IVDUs.

Reaffirming the need for caution discussed at the September HSAC meeting, the Scottish stance on the educational message remained focused on the absence of moralism than those in England and Wales, a critique that had support from the British Prime Minister and her advisor Hartley Booth. Moreover, these affirmations on morality placed the ideals of Scottish observers much closer to the Howard-Reagan exchange than England and Wales. Secretary of Scotland Malcolm Rifkind recommended that the Sub-Committee push to distribute the video across Scotland to local education authorities for them to negotiate the video's use.[558] Rifkind believed that devolving power to Scottish schools might improve the possibility of the material achieving approval in the face of opposed at the national level because of regional variance in denominational schools across Scotland.[559] Furthermore, the potential for voluntary adoption amongst those opposed to core aspects of the material – or the principle generally – represented a compromise on delivery that likely appeased the fringe and at times

[556] Ibid.
[557] Ibid.
[558] CAB/134/5135, TNA, HSAC, 10 November 1987, p. 2.
[559] Ibid.

inflammatory commentary on AIDS that inhibited acceptance in the first place. Although the fringe but nonetheless present undercurrent of moralism provided some threat of derailment, the distribution of the government's AIDS video for school children was scheduled for January 1988 by the HSAC Sub-Committee at the 30 November meeting. Moreover, this meeting proved to be the last substantive discussion of AIDS education for the remainder of 1987 as the focus for AIDS policy generally shifted towards what 1988 held for policymakers.

In the US, the second half of 1987 was significantly less productive than the first. As education discussions slowly dissipated following the establishment of the Presidential Commission on AIDS in May, October 1987 was labelled 'AIDS Awareness and Prevention Month' and provided some much-needed impetus to the administration's stance on the disease as the end of the year approached. Highlighting the lack of progress made by the Reagan administration on education, Proclamation 5709 provided President Reagan with an opportunity to maintain his rhetoric of 'medicine and morality' whilst reinvigorating the seemingly stagnant US AIDS education policy.[560] Championing marriage and sexual abstinence, Reagan reaffirmed his belief in monogamy and faithfulness as both morally and scientifically sound prevention strategies and emphasised once again the socially conservative principles at the heart of the administration's messaging on AIDS. Painting the administration's values-based approach as one underpinned by concerns about moral decline and guided by a socially conservative doctrine of abstinence and marriage, the President advised Americans to follow 'this wise and timeless counsel' suggesting 'our nation is poorer for the lost contributions of those who, in rejecting it, have suffered great pain, sorrow and even death.'[561]

Nevertheless, the President's characteristically public announcement of AIDS Awareness and Prevention Month also endorsed a stance on education that supported parental autonomy and the anti-federalism associated with Reagan's wider political ethos. Inherent in Reagan's belief that 'parents have the primary responsibility to help children see the beauty, goodness and fulfilment of chastity before marriage and fidelity within it', the President engaged with the sense of mistrust of government that he celebrated in his inaugural speech in 1981.[562] This

[560] RPLM, R. Reagan, 'Proclamation 5709 – AIDS Awareness and Prevention Month, 1987', 29 September 1987, [https://www.reaganlibrary.gov/archives/speech/proclamation-5709-aids-awareness-and-prevention-month-1987], accessed 15 March 2024.
[561] Ibid.
[562] RPLM, R. Reagan, 'Inaugural Address 1981', 20 January 1981, [https://www.reaganlibrary.gov/archives/speech/inaugural-address-1981', accessed 15 March 2024.

devolution of responsibility from the government to the family emphasised the individual not the collective response. The promotion of a values-based 'moral code of conduct' over a structured and programmable public health response further embraced Reagan's principled rejection of federal intervention. Moreover, Reagan affirmed that 'educational efforts should be locally determined and consistent with parental values', maintaining the devolution of ownership from the federal level to the local level, or even further to the home.[563] Although the announcement of an AIDS Awareness and Prevention Month publicly signified a step towards greater visibility and dialogue on AIDS, the President's affirmations on abstinence and fidelity served to advance the inequitable interplay between medicine and morality manufactured by the administration's methodology for infection prevention. Furthermore, the underlying endorsement of individual ownership and parental autonomy communicated a more acute awareness of the complicated intersectionality between AIDS and the broader tenets of Reaganism. The President's public messaging on medicine and moralism emphasised ideologically aligned concepts that worked to devolve responsibility for disease prevention – and education as a central tool for public health education – from the federal government to the individual in a way characteristic of the administration's approach to US politics and society since January 1981.

Although President Reagan's framework of medicine and moralism reflected his own belief in the shared message of medical science and moral teaching when discussing AIDS, his construct has provided a valuable framework that illustrated both the disparity between the US and UK approaches to AIDS education and the ranging importance of conservatism to those responses. Distinguishing medicine and moralism as core principles, the British response adopted a fundamentally different approach to AIDS messaging which prioritised the need for direct communication over moralistic preaching that policymakers in Whitehall feared might alienate communities at the epicentre of the epidemic. Conversely, White House policymakers attempted to navigate the ambiguity between science and moralism, firmly situating public health material around family values, marriage, and monogamy. Despite the emergence of a more tangible education effort from the Reagan administration, the inability of the President and Surgeon General Koop to articulate a coherent message on condom use was just one

[563] RPLM, Reagan, 'Proclamation 5709', 29 September 1987.

example of the administration's struggle to negotiate the relationship between philosophical and practical politics.

Conclusion

In 1987, screening and public health education dictated AIDS discourse at the highest levels of politics in the US and UK. Whereas impracticality and ethical conundrums dissuaded British policymakers from pursuing any form of screening protocol, the White House conceptualised AIDS as a disease that could be kept out at ports of entry by testing protocols. Enthusiasm in the White House maintained pressure on mandated testing domestically but achieved significantly less success than the introduction of an immigration rule change. A symptom of the distribution of power between the state and federal government under American federalism, the ability of the Reagan administration to directly impact immigration rulings but only advocate for state level reform to marriage licenses limited the progression of the pre-marital testing protocols the administration favoured. Whereas arguments of impracticality and ineffectiveness proved potent in the UK, they appeared ineffectual to Reagan policymakers whose pursuit of immigration rule changes despite the cost, extending federal reach and impracticality highlighted the differences between ideology in theory and practice.

Similarly, the challenge of public health education encouraged a divergence between the British and American responses that hinged on the value afforded moralism in the dissemination of public health messaging. Where the White House attempted to reconcile the grey area between medicine and moralism, British policymakers provided a stark contrast, cultivating distinct roles for science and moralism in the pursuit of infection prevention and disease education. The promotion of safe sex, condom use and IVDU intervention (needle exchange and methadone prescription) in the UK starkly contrasted the faithfulness and monogamy teaching emphasised by the President and his advisors whose values-based platform left little space for the scientific consensus on contraception or harm reduction in at-risk populations.

Alongside these divergent trends, 1987 cemented the significance of entrepreneurial and structural factors in determining AIDS policy in the US and UK as the departure of Norman Fowler and the establishment of Reagan's Presidential Commission achieved limited impact – positive and negative – in altering the course of action in their respective countries. As the end of the 1980s approached, the dawn of a new decade and a new administration brought about the culmination of a variety of vital AIDS policy issues on both sides of the Atlantic, the threads of neoconservative AIDS policy shifting ever closer to the final chapter of the first decade of AIDS.

Chapter Five

The End of the Beginning, 1988-1989

Introduction

1988-89 represented the end of the beginning for AIDS policy. At the decade's conclusion, British and American AIDS policy had truly diverged and continued to do so into the final months of President Reagan's tenure in the White House. This chapter explores the most prominent AIDS issues that faced policymakers on both sides of the Atlantic and will utilise them to demonstrate the continuity of AIDS policymaking in each nation and the continuing policy divergence between British and American in 1988 and 1989.

Although much of the literature on AIDS in the US and UK spans the end of the 1980s, our understanding of this period as a 'changing of the guard' or transition period is limited. In the UK, Virginia Berridge and Philip Strong have identified a shift in the policy response from 1987 onwards that they have described as the normalisation of AIDS as a 'non epidemic chronic disease' that informed AIDS policy into the early 1990s.[564] In the US, Tasleem Padamsee has contextualised the end of the 1980s as setting the stage for a more active federal response to the disease, framing the late 1980s and early 1990s as a 'turning point' in AIDS discourse.[565] This distinction between the 1980s and 1990s was largely a consequence of a growing ability to 'treat' HIV/AIDS. As medical innovation delivered new drug therapies such as AZT (introduced in 1987 but increasingly accessible by the early 1990s) and highly active antiretroviral therapies (HAART) which were introduced in 1996-97 and became standardised treatments that prolonged life.[566] This chapter reinforces those arguments by showing 1988-89 as the end of an era – the short first decade of AIDS, 1981-1989 – that culminated with the

[564] V. Berridge and P. Strong, 'AIDS in the UK: Contemporary History and the Study of Policy', *Twentieth Century British History,* 2:2 (January 1991), pp. 167-168.
[565] T. Padamsee, 'Fighting an Epidemic in Political Context: Thirty-Five Years of HIV/AIDS Policy Making in the United States', *Social History of Medicine,* 33:3 (December 2018), p. 9.
[566] A. Tseng, J. Seet and E. J. Phillips, 'The Evolution of Three Decades of Antiretroviral Therapy: Challenges, Triumphs and the Promise of the Future', *British Journal of Clinical Pharmacology,* 79:2 (February 2015), pp. 182-184.

end of Ronald Reagan's presidency in the US and the closing of the British AIDS policymaking network in Whitehall. It will explore the role of ideology in shaping policy development at the end of the 1980s, highlighting thematic elements such as inadequacy and moralism in the pursuit of a better understanding of this transitional period of AIDS policymaking. Furthermore, it will assess the status and character of the policy issues. That assessment underscores the argument of this thesis that AIDS policy was not monolithic but complicated and intersectional by nature. Therefore, this chapter analyses the impactful nature of this period as the end of the existing policy dynamic, building on Berridge and Strong's 'normalisation' and exploring the stage setting potential of the late 1980s in the context of AIDS policy of the late twentieth century.

Firstly, this chapter addresses AIDS funding and use the disparity between research spending and service provision to explore both government and AIDS policy priority. In the US, the pursuit of research represented an ideologically defensible response that contrasted with the British focus on education, treatment, and care. This sheds light on the importance of structural health care differences in the development of conflicting funding responses. Secondly, the chapter will explore education as a vessel for socially conservative rhetoric and details the role of moralism in shaping attitudes towards AIDS education policy. Thirdly, it will assess both the ideological and socio-cultural barriers that encouraged the growing disparity in the US and UK responses to AIDS policy for IVDU. Primarily discussed through the comparative success and failure to adopt harm reduction strategies in the UK and US respectively, it will evaluate the importance of a pre-existing aversion to the rejection of harm reduction schemes, such as needle exchange, in the US in favour of abstinence-focused strategies that aligned with the administration's 'War on Drugs'. Finally, this discussion will address mandated testing as a unique example of the UK demonstrating an approach more typically neoconservative, preserving the rights of the individual and halting the march of widespread testing from ports of entry to medical professionals. In the US, screening protocol continued to uphold the immigration rule changes made in 1987, demonstrating the difference between political philosophy in theory and practice whilst drawing attention to the unique conceptualisation of border testing as a defence of the nation issue akin to military spending or the 'War on Drugs' rather than a public health or social policy issue.

Ultimately, this chapter will continue to develop our understanding of the role of ideology in the determining of AIDS policy, examining the interplay between political philosophy and practical politics in the pursuit of epidemic response. It will position the continuity of AIDS policy in the US and UK alongside the protracted divergence that had characterised the Anglo-American narrative since the mid-decade. This chapter concludes the analysis of the most prominent issues that shaped AIDS policy between 1981-1989 and emphasises the importance of structural factors, the medico-scientific consensus and ideology to AIDS policy in the 1980s.

AIDS Funding, 1988-89:
Service Provision, Research Spending and Structural Differences

Funding is a potent indicator of policy priority and political conviction. This thesis has frequently revisited the inherent value of funding (and more broadly resourcing, inclusive of total staff, new recruitment, and long-term funding strategy) as a policymaking yard stick, by which we can quantify and contextualise epidemic policymaking. The period 1988-89 was a period of growth for AIDS funding, as the White House and Whitehall allocated greater levels of resources to AIDS policy in aggregate terms. However, the channels through which this increase was guided differed significantly. Funding allocations demonstrated the fundamental difference in the US and UK responses to AIDS and maintained the sense of divergence established in 1986. Although approaches to research funding aligned the US and UK more closely following substantial commitments to the Medical Research Council (MRC) in the UK, the continuing difference between research spending represented a single example that distinguished the administrative responses on either side of the Atlantic.

In the UK, previous engagements with funding had acknowledged the government's growing funding platform but a firm the belief – particularly on opposition benches – that more could be spent on a national emergency like AIDS. In February, crossbencher Lord Kilmarnock – a vocal critic of the Thatcher government's AIDS policy – highlighted the disparity between the government's pledge of £50 million and the figure advocated by the Office of Health

Economics, £80 million, describing Whitehall's proposal as 'well short.'[567] By November, these calls for additional funding had been answered; Minister for Health David Mellor published answers to parliamentary questions which noted sums in excess of £76 million for health authorities in 1988 and an extra £68 million in 1989 for AIDS-related services.[568] By early 1989, Mellor had promised some £130 million for AIDS-related services in the House of Commons in the first full debate on AIDS since the Fowler debate in November 1986.[569] Despite Mellor's expansion of funding, opponents continued to exert pressure on Mellor and his colleagues, and sustained their criticism of governmental inadequacy and delay. Moreover, the apprehension central to opposition critique of resource distribution and the pursuit of 'new money' reflected a broader apprehension about 'fiscal responsibility' that transcended AIDS policy. This suspicion cultivated an ideological baggage associated with funding from a government who sought to restrict government spending through privatisation and spending cuts since 1979. These apprehensions had also existed in the US and were expressed in response to the crippling retrenchment of welfare, social and domestic spending generally under President Reagan. Importantly, criticism of AIDS funding policy in Britain and America was contextualised by the specifics of health care accessibility. In the US, it moulded a debate in Washington that expressed a necessity for service provision inclusive of programmes such as Medicare and Medicaid. By contrast, British policymakers prioritised funding for education campaigns, specific support for hard-hit localities and harm reduction strategies, such as needle exchange. Therefore, the criticism of government AIDS funding in the UK reaffirmed a similarity between opposition calls for 'new money' in Washington and Westminster but provided more evidence for the impact of structural issues such as health care access that underpinned debates about service provision and AIDS funding.

Labour MP for Peckham Harriet Harman expressed her concern regarding government AIDS policy suggesting 'preventative and community services remain inadequate in most areas and non-existent in some.'[570] Harman warned of the impact poor community provisions would have in the UK, citing a transnational perspective on 'the United States where AIDS sufferers

[567] Hansard, House of Commons (HC), 3 February 1988, v. 492 c. 1081.
[568] Hansard, Written Answer (WA), 15 November 1988, v. 140 c. 557.
[569] Hansard, HC, 13 January 1989, v. 144 c. 1106.
[570] Ibid, c. 1108.

are dying on the streets.'[571] Harman believed that the government should do more, her critique echoing Conservative MP Charles Irving who asserted that Mellor's expansions might be 'nothing like enough.'[572] What these exchanges produced in the House of Commons in early 1989 was the '£7 million question', a manifestation of the heated exchange on funding that charged notions of inadequacy against the government's expanding funding agenda. Described by Harman as 'a pittance' and by Labour backbencher Alan Williams as 'pitiful', the '£7 million' referred to funds outlined by Mellor that were made available to local authorities to facilitate AIDS-related services. Harman and William's criticisms were directed at AIDS funding specifically and endorsed an ideological challenge to the spending ethos adopted by the Thatcher government and its potential to shape the British response to AIDS. Harman herself drew direct attention to the centrality of this frustration when citing the funds 'taken from my local authority' that blurred perceptions of inadequacy with broader dissatisfaction with government spending under Thatcher.[573] The re-emergence of accusations of inadequacy in response to the expansion of AIDS funding in the UK intersected with a discontent amongst those opposed to the spending cuts and decentralisation fostered by the Thatcher government. Moreover, opposition criticism articulated a need for more money, which in turn reinforced a perception that the Thatcher government had achieved a baseline for AIDS funding. Although the necessity for 'new money' was likely derived from the establishment of a funding base that provided for the basic needs of British AIDS policy, it combined with an underlying suspicion of Conservative attitudes to social and welfare spending captured by Harman and Williams. Nonetheless, in the context of a public health crisis the provision of 'enough' by government ministers contrasted poorly with external estimates from the College of Health and Office of Health Economics estimates which facilitated a debate that demanded more than subsistence.

In the US, the scale of the federal funding effort was unparalleled, even compared to the efforts of the World Health Organisation to which the US and UK were major contributors. The archival material on federal AIDS funding is incredibly detailed making the destination and intended purpose of specific funding traceable, thereby increasing the usefulness of the archival data comparative to similar materials in the UK. Importantly, this material allows us

[571] Ibid.
[572] Ibid, c. 1115.
[573] Ibid, c. 1113.

to align the public claims of the Reagan administration with interdepartmental recording of spending collected by the Office of Management and Budget during the 1980s. In his 1988 address to Congress entitled, *A Union of Individuals,* President Reagan noted that 'Federal funding is not the only solution' before outlining a proposal for $1.5 billion in fiscal year 1989 for 'research, treatment, testing, counselling, and education, up ten-fold since 1985.'[574] In February, Reagan once again endorsed plans for federal funding that outlined a further $2 billion for 'additional research, education, and treatment in 1989', however, this included the $1.3 billion already allocated to the Public Health Service (PHS).[575] In comparison, Reagan proposed a 6% increase in law enforcement spending and a further 13% increase in drug law enforcement bringing the total spend on each to $4.5 billion and $3.9 billion respectively.[576] Observing 1989 as an end and high point of Reagan's AIDS spending, the accumulation of resources into the low billions still situated the disease below policy flashpoints like the 'War on Drugs' and spending on the disease paled in comparison to the $2.7 trillion spent on nuclear weaponry, weapons procurement, and research and development during Reagan's presidency.[577] In addition, a survey conducted on federal AIDS expenditure continued to highlight the enormity of the US effort and the areas facilitating this meteoric rise in expenditure towards the end of the decade. Unsurprisingly, the Department of Health and Human Services (DHHS) received 90% of the total spend on AIDS with 60% of that being spent by the PHS whose 1989 budget allocation stood at $1.3 billion alone and was estimated to require some 1900 employees to fulfil.[578] Moving beyond these aggregate categories and into departmental spending the pivotal role of the surveillance at the Centres for Disease Control (CDC) and research at the National Institute of Health (NIH) in the inflation of federal AIDS spending becomes clear.

During the same period the CDC and NIH received nearly $1 billion, while the Health Care Financing Administration (HCFA) – the organisation responsible for Medicaid and Medicare –

[574] Reagan Presidential Library and Museum (RPLM), R. Reagan, '1988 Legislature and Administrative Message: A Union of Individuals', [https://www.reaganlibrary.gov/archives/speech/1988-legislative-and-administrative-message-union-individuals], accessed 22 March 2024.
[575] American Presidency Project (APP), R. Reagan, 'Message to Congress Transmitting the Fiscal Year 1989 Budget', [https://www.presidency.ucsb.edu/documents/message-the-congress-transmitting-the-fiscal-year-1989-budget], accessed 22 March 2024.
[576] APP, Reagan, 'Message to Congress'.
[577] I. Morgan, *Reagan: American Icon* (London 2016), p. 181.
[578] Sue Daoulas Files (AIDS 2:1), RPLM, William Winkenwerder, 'Preliminary Results of the HCFA Survey on Total Federal AIDS Expenditures', 11 August 1988, p. 1.

received $520 million for care services. [579] Furthermore, CDC and NIH research and surveillance activities accounted for over half of the CDC and NIH expenditure with 'education and information' accounting for $260 million of the remaining total.[580] Importantly, research alone was estimated to total $632 million in 1988 and a further $840 million in 1989.[581] These numbers showcased the importance placed on research and the willingness to fund what is likely the most dollar-intensive aspect of the federal AIDS strategy. Fundamentally important throughout the decade – inspiring the term 'magic bullet optimism' – was the intense pursuit of basic research which ensured the US remained a world leader in HIV/AIDS knowledge acquisition. Furthermore, the combination of high research and surveillance spending alluded to a potential magic bullet optimism in the White House that contrasted a long-term strategy built around awareness and education.

Adopting a narrower focus on research specific funding allows for a clearer understanding of the role played by research in shaping AIDS funding and the associated implications such an approach had on AIDS policy more generally in the US and UK. Although the Social Service Committee (SSC) in the UK report critiqued the neglect of AIDS research policy and the underutilisation of the vast wealth of medical research talent in the UK by the British government, it served to highlight a disparity in the prioritisation of research as a primary function of AIDS policy. Responding in detail to a written answer in November 1988, Health Minister, David Mellor outlined the expansion of research funding to £13 million in 1989 alone (£13.5 million was spent on AIDS in 1984-85 and 1987-88 combined) including £5 million for an MRC vaccine and drug programmes with a further £23.5 million committed to the MRC for 1989-1992.[582] Importantly, the policy status of research in the UK changed very little during the period 1988-89; research remained an issue of measurable importance that attracted significantly less public and political debate than other areas such as education, screening, and AIDS policy for IVDU. Moreover, as research funding increased a corresponding rise in AIDS funding more generally nullified any sense of intensity building towards research specifically.

[579] Ibid, p. 3.
[580] Ibid, p. 1.
[581] Ibid, p. 13.
[582] Hansard, WA, 15 November 1988, v. 140 c. 557.

In comparison, the expansion of research funding documented above constituted the latest endorsement of research as a policy priority in the US. By 1988, all sixteen of the centres and institutes of the NIH – encompassing nearly 1,000 full-time workers – were involved in HIV-related activities ranging from basic research to prevention and education measures.[583] In the FY1989, AIDS research spending in the US reached approximately $10,317 (or £6,448) per AIDS case compared to £6,559 per case in the UK.[584] Although the American per capita spend was slightly less than the British, the vast disparity in caseload – 350 AIDS cases per million in the US compared to 35 per million in the UK – made aggregate spending in the US much higher than the UK by a considerable margin.[585] Consequently, the scale of the US research programmes likely influenced British policymakers – and AIDS policymakers globally – who observed the NIH efforts and responded by allocating funding to areas such as education as a means of maximising pounds or dollars spent. When situated against rising infection rates and growing AIDS activism in the US, the perceived benefits of a large-scale research programme – beyond the early returns of basic knowledge acquisition – might have swayed British policymakers closer to education campaigns and infection prevention as policies with a better initial return on investment.

This discussion opened with an emphasis on the quantitative benefits of funding as a tool for the appraisal of policymaking, allowing space for an exploration of policy priority that can be explicitly measured unlike speeches and parliamentary exchanges between the representatives of government and those sitting on opposition benches. In the first instance, this discussion has alluded to the underlying differences that shaped the resourcing of AIDS policy between 1988-89. Moreover, it has examined the importance of structural factors such as health care accessibility in the shaping of resourcing strategies and how that informs our perception of government AIDS spending. Whereas the Reagan administration's pursuit of research funding and the British focus on service provision as part of a long-term prevention strategy demonstrated alternative approaches to AIDS resourcing, this difference upheld the divergence of the two responses as increasingly guided by alternative policy perspectives.

[583] Winkenwerder, 'HCFA Survey of AIDS Expenditures', p. 5.
[584] Ibid, p. 13.
[585] GB0809 AIDS Social History Programme/1/2, D. Acheson, *Chief Medical Officer's Annual Report, 1988*, (December 1988), p. 119.

Education, Moralism, and AIDS Policy

Moralism most frequently criticised those at the margins between society and lifestyles that differ fundamentally from the lived experience of the general population. Where the emergence of HIV/AIDS in British and American politics coincided with the ascendency of conservatism in the US under Ronald Reagan – and previously Barry Goldwater – and in the UK with Margaret Thatcher, the potential for moralism to pervade government policy became greater. Furthermore, the Reagan administration had championed a socially conservative message to a degree unseen under Thatcher, the vocal support of organisations like Jerry Falwell's Moral Majority evidenced a groundswell around moralism in the US that failed to develop in the UK. Although Thatcher had privately supported advocates of moralism such as Rabbi Immanuel Jakobovits and discussed the importance of family more publicly towards the end of the decade, the pursuit of moralism under Thatcher was limited compared to in Reagan's America.[586] During 1988-89, the British and American experience of moralism continued to shape a disparate policy narrative that ultimately afforded the components of moralism differing levels of importance and authority in the development of AIDS policy. This discussion explores the role and status of moralism during the period 1988-89, identifying how impactful moralism was in the determining of AIDS policy. In addition, it will identify and showcase the potential for external influence on policy development. Furthermore, it will explore education as a vessel for moralism and maintain a critique of President Reagan's 'medicine and morality' framework as neither equitable nor accurate. Lastly, this discussion will situate moralism as an expression of ideology that attracted disparate levels of engagement in the US and UK, which ultimately contributed to the divergence of the British and American experiences of moralism as a component in policy development.

In the UK in 1988, Section 28 of the Local Government Act came into effect prohibiting local authorities from intentionally promoting homosexuality or publishing material with the

[586] TNA, PREM19-2775, I. Jakobovits, 'Memorandum to the Prime Minister on AIDS', 11 March 1987, p. 2. 'Speech to Conservative Party Conference', Margaret Thatcher Foundation, 9 October 1987, [https://www.margaretthatcher.org/document/104431], accessed 27 March 2024.

intention of promoting homosexuality.[587] On the surface, Section 28 represented a stark contrast to the precedent-setting educational material that promoted more open-mindedness towards the relationship between society and sex in response to HIV infection. Moreover, Section 28 addressed the publishing and promotion of material that promoted homosexuality which intimately intertwined the legislation with AIDS education and advertising in a regulatory fashion like Margaret Thatcher's use of the Advertising Standards Authority and Obscene Publication Act in 1986. In the House of Commons, MP Harriet Harman criticised the climate created by Section 28 asserting that it had made the 'task of reaching school children with such information more difficult.'[588] Responding to Harman, Health Minister David Mellor noted that an amendment had been made to ensure that AIDS related material was not stopped and emphasised the importance of AIDS education in schools.[589] The likelihood that Section 28 could be used to regulate AIDS education was strong, however, the ring-fencing outlined by Mellor alluded to a privileging of AIDS policy. Whereas this privilege emphasised the significance of AIDS education, it highlighted Section 28's application to AIDS policy as far-reaching in scope but limited in practice. Viewed specifically through the lens of AIDS policy, Section 28 represented the legislative advance that had remained absent from the British approach to moralism throughout the 1980s, however, the legislation's impact on AIDS policy was limited in scope given the prevailing centrality of education as a tool for infection prevention and the willingness of policymakers to ring-fence AIDS messaging as a result.

Although Section 28 represented a legislative challenge to the sexually progressive social climate cultivated in the UK following the legalisation of homosexuality in the late 1960s, the intersection between society and sex continued to draw out expressions of moralism. The attempts to balance open dialogue and moralising continued to stress the boundaries of those who favoured the separation of discourse on sexual health and the general population. Labour MP Chris Smith emphasised the importance of individual behaviour and advocated for an end to vagueness suggesting 'this problem can be controlled not by Government but by the behaviour of individuals.'[590] Importantly, Smith's emphasis on the individual was not

[587] The National Archive (TNA), 'Local Government Act (1988)', accessed 8 August 1988, [https://www.legislation.gov.uk/ukpga/1988/9/section/28/enacted].
[588] Hansard, HC, 13 January 1989, v. 144 c. 1111.
[589] Ibid, c. 1160.
[590] Ibid.

condemnation of a person's identity, lifestyle, or sexuality but a message of empowerment that highlighted an individual's agency in preventing transmission of the disease.

In his 1988 article *AIDS and Traditions of Homophobia*, Richard Poirier discussed the idea of 'moral contagion' – described by Brady, Crockett and Van Bavel as 'the spread of moralized content' – as a concept that embedded the rejection of homosexuality prevalent in aspects of modern Christianity with the growing presence of alternative sexualities in an increasingly cosmopolitan and globalised social dialogue.[591] Utilising Poirier's terminology, the presence of a 'moral contagion' in the communication of individual responsibility denoted a rejection of the individual as well as their associated behaviour; one example being Reagan's previous Director of Communications (February 1985 – March 1987) and future Republican Presidential candidate (1992 and 1996), Pat Buchanan who in a 1983 broadcast asserted: 'the poor homosexuals. They have declared war on nature and now nature is exacting an awful retribution.'[592] In response to Buchanan's platform of homophobia, Poirier emphasised the social construction of the disease in Buchanan's depiction of AIDS, suggesting 'Buchanan really does not want a cure for AIDS, he wants a cure for anal intercourse.'[593] By contrast, the emphasis on individual responsibility adopted by Chris Smith reflected the medico-scientific consensus on safe sex messaging and harm reduction, an emphasis that had been at the forefront of Norman Fowler and Donald Acheson's vision for AIDS education during the period of mobilisation that produced the direct and frank adverts like 'Don't Die of Ignorance'.

Furthermore, the case of haemophiliac compensation highlighted the intersection between moralism and AIDS policy: the idea of the innocent victim permeated throughout the discussion of contaminated blood in a way unlike that of homosexuality or IVDU. Conservative MP Patrick Cormack told the House of Commons that the government had a 'real moral responsibility' towards those affected by contaminated blood.[594] Although the circumstances surrounding the contamination of blood supplies were inherently different to other routes of transmission, such as sexual contact or recreational drug use, the application of moral

[591] R. Poirier, 'AIDS and Traditions of Homophobia', *Social Research,* 55:3 (Autumn 1988) In Time of Plague, p. 462.
[592] 'AIDS Disease: It's Nature Striking Back', *The New York Post*, 23 May 1983. W. Brady, M. J. Crockett and J. J. Van Bavel, 'The MAD Model of Moral Contagion: The Role of Motivation, Attention, and Design in the Spread of Moralized Content Online', *Perspectives on Psychological Science,* 15:4 (July 2020), p. 978.
[593] Poirier, 'Traditions of Homophobia', p. 474.
[594] Hansard, HC, 13 November 1989, v. 160 c. 153.

obligation in the case of contaminated blood posited an individual's social status against their ability to attract sympathy and support and by contrast, prejudice. Media outlets such as *The Times* published headlines like 'Walking Through A Moral Minefield' that explored similar concepts to 'moral contagion' and the intersection between those the disease affected, risk-taking behaviours, and the social construction of the disease in public discourse.[595] Nevertheless, 'moral contagion' appeared largely absent from government messaging on the disease, a potential consequence of earlier efforts in 1986 and 1987 to ground the material produced by Whitehall in medico-scientific consensus and not moralism.

By contrast, this moralising achieved little traction in the UK's education material. Although education had now adopted a less prominent government position since the public education campaign was formally handed to the newly formed Health Education Authority (HEA), the production of material targeted at both the general population and established risk groups continued to occupy the public and policymaking consciousness. Whereas moralism rarely featured in parliamentary discourse on AIDS education and awareness, the British government's education strategy between 1988-89 adhered to the scientific consensus, promoting safer sex and condom use in a fashion akin to previous efforts. Addressing the potential for members of the House to moralise those affected by AIDS, Lord Kilmarnock proclaimed that 'the danger of focusing disapproval on particular groups is that it distracts attention from the real risk of spread among the "normal" population … one cannot simply put a ring fence or a *cordon sanitaire* round supposedly "normal" morally and physically healthy population.'[596] Kilmarnock's notion of distraction alluded to a need for policymakers to see the bigger picture on AIDS and see through the risk-groups and view the disease as a societal issue. Nevertheless, Kilmarnock's notion of normality in the general population alluded to a sense of abnormal that – when placed against Patrick Cormack's earlier expression of 'real moral responsibility' – might devalue the experience of groups at the fringes of societal definitions of normal.

In January, a similarly anti-moralistic sentiment was adopted in a discussion of education. Conservative MP Charles Irving asserted that 'we must resist the persuasive siren calls of the well-meaning moral brigade, which maintains that we must pretend that extra-marital sex

[595] 'Walking Through a Moral Minefield', *The Times,* 9 July 1989.
[596] Hansard, House of Lords (HL), 3 February 1988, v. 492 c. 1082.

does not happen.'[597] Lord Winstanley spoke on the need to dissuade people of Victorian teachings on sex and the Lord Bishop of Worcester promoted 'combatting those demons of ignorance, prejudice and fear' in the pursuit of education and awareness.[598] Irving's comments resonated with the 'focusing of disapproval' in Lord Kilmarnock's previous discussion on AIDS education and reflected a consensus in Parliament on the need for direct and honest AIDS education. Nevertheless, a concern remained regarding the proliferation of fear and ignorance. Conservative MP Tim Rathbone highlighted the associated reality behind Lord Kilmarnock's 'focusing of disapproval' that he believed uniquely threatened minority and fringe communities at the intersections between AIDS and socio-cultural discrimination.[599] Therefore, British politicians demonstrated a clear awareness of the potential for moralising and the associated damage such an approach could cause for groups who would attract such disapproval. An apparent rejection of 'moral contagion', those in Parliament showcased a willingness to embrace the government's science-first stance on AIDS education in a fashion dissimilar to the American values-based approach established in 1987 and continued into 1988-89.

A sense of 'moral contagion' had been felt throughout the decade in the sphere of AIDS education. In the US, the dissemination of educational material had achieved some momentum by 1988-89 compared to the relative scarcity of the preceding period. Throughout 1988 President Reagan maintained a vocal stance on a values-based approach to education that afforded AIDS and the associated discussion of behaviour a more prominent role in presidential press and media coverage. In May, the CDC distributed the pamphlet, *Understanding AIDS* to all households and Post Office box holders at a cost of $26.6 million.[600] Whereas the pamphlet represented a substantial contribution to public discourse and carried with it the support of Surgeon General Dr C. E. Koop, it was ordered by Congress and demonstrated the ongoing absence of federal leadership in the sphere of AIDS policy. [601] Despite Henry Waxman's statement on 'the strong leadership that the Congress … has exerted' was some three years prior, the Californian's commentary on federal and presidential

[597] Hansard, HC, 13 January 1989, v. 144 c. 1117.
[598] Hansard, HL, 3 February 1988, v. 126 c. 1082.
[599] Hansard, HC, 13 January 1989, v. 144 c. 1132.
[600] Sue Daoulas Files (AIDS 1:1), RPLM, 'AIDS Household Mailout – Timetable', 14 September 1988, pp. 1-2.
[601] Ibid.

leadership continued to resonate with AIDS policy in 1988.[602] Likewise, the Department of Education also published a pamphlet entitled *AIDS and the Education of Our Children: A Guide to Parents and Teachers* which had distributed 1.7 million of the 2.5 million copies printed to schools, parent-teacher organisations, physicians, and parents by June 1988.[603] Importantly, these federal education efforts continued to emphasise a values-based approach to information and awareness that centred on themes of abstinence (sexually and more generally regarding risky behaviours such as drug use), faithfulness and monogamy.

In January 1988, President Reagan highlighted abstinence before marriage and faithfulness within marriage before suggesting that 'if the American people follow this wise and timeless counsel, if our schools and families and media communicate it effectively, the spread of AIDS can be greatly diminished.'[604] Where the President's message shed light on the importance of individual behaviour, his 'wise and timeless counsel' conceptualised AIDS as a disease affecting the heterosexual population. Reagan's emphasis on the family and omission of bisexual and homosexual males and IVDUs further demonstrated the President's inability to articulate a coherent message on AIDS that reconciled the medico-scientific consensus on the disease and his vision for the American family unit. Likewise, the Department of Health and Human Services educational pamphlet, *Understanding AIDS* quoted Surgeon General Koop who reinforced the need for 'responsible behaviour based on understanding and strong personal values.'[605] Although Koop promoted values akin to the President, his emphasis on behaviour and not the family unit communicated a more inclusive public health message on AIDS that better walked the tightrope between medicine and moralism. Furthermore, condom use was also framed as a preventative measure that fell short of abstinence and faithfulness. Whilst this was an accurate depiction of relative risk, condom use received a characteristically less favourable push than the values-based initiatives at the heart of the federal education effort. As described in chapter four, the intersection between education and moralism was stronger in the US when considered against the British attitude to education which emphasised the medical consensus on safer sex and condom use more clearly. Moreover, a

[602] 'Statement of Chairman Henry Waxman', Office of Technology Assessment Findings on the Public Health Service Response to AIDS, 21 February 1985, p. 2.
[603] Winkenwerder, 'HCFA Survey of AIDS Expenditures', p. 11.
[604] RPLM, Reagan, 'A Union of Individuals', [https://www.reaganlibrary.gov/archives/speech/1988-legislative-and-administrative-message-union-individuals], accessed 22 March 2024.
[605] C. E. Koop, 'Understanding AIDS', *Department of Health and Human Services,* May 1988, p. 2.

similar discourse can be observed in the pursuit of harm reduction as an infection prevention strategy where British policymakers demonstrated a similar open-mindedness to harm reduction and condom use, a perspective that failed to penetrate the ethos of 'medicine and morality' proposed by President Reagan. Increasingly intertwined, the expression of safe behaviour in the US became dependent on the socially conservative construct of moralism espoused by the federal government throughout the second half of the decade.

Between 1988 and 1989, moralism achieved a similar policy status and impact as it had throughout the second half of the 1980s in both the US and UK. Whereas British policymakers frequently relinquish ties to moralism as a framework for prejudice and focussed disapproval, the American approach championed a values-based approach to education. Furthermore, President Reagan's medicine and morality concept embraced many aspects of moral contagion but attributed to the concept a vagueness that afforded greater political manoeuvrability. Whereas President Reagan and British policymakers in Whitehall demonstrated an awareness of medicine and moralism when developing AIDS education policy, they cultivated vastly different interpretations of that relationship and the role it should play in the determining of public health messaging.

Disenfranchised and Alienated:
Harm Reduction Strategies and AIDS Policy for IVDU

The re-emergence of intravenous drug use (IVDU) as an important AIDS issue in early 1988 was an unsurprising policy development. A continuation of the relationship fostered between AIDS and IVDU earlier in the decade, IVDUs and their potential to shape the future characteristics of the AIDS epidemic on both sides of the Atlantic encouraged policymakers to tackle the complicated and seemingly intensifying threat presented by drug users. The following discussion explores IVDU in the political consciousness of British and American policymakers in 1988-89, examining the factors that facilitated the renewed sense of urgency surrounding AIDS policy for IVDU in the UK and the comparative lack of interest in alternative or innovative interventions in the US. The potential for IVDUs to bridge the gap between at risk groups and the general population as a sexually active and majority heterosexual

demographic potentially engaging in the sharing of contaminated needles and unprotected sex with an infected partner, and the growing foundation of scientific evidence endorsing – to varying extents – the expansion of interventions such as needle exchanges, were prime movers in the renewal of IVDU policy.

This section will also examine the rejection of contentious IVDU strategies in the US in favour of abstinence-orientated interventions akin to Nancy Reagan's 'Just Say No' campaign for a drug free America. Furthermore, this discourse explores the interplay between science and ideology evident throughout this thesis. Attitudes towards IVDU policy once again demonstrated a variance from the medico-scientific consensus and particularly, the willingness amongst American policymakers to try and negotiate the grey areas between moralism and medical science as part of a broader commitment to values-based policymaking. Whereas a preoccupation with the threat posed to the general population was the driving force behind the re-emergence of IVDU policy in 1988-89 in the UK, the willingness to adhere to or dissent from medical consensus proved the determining factors in the divergence of the US and UK narratives.

The discourse dedicated to AIDS policy for IVDU has – unsurprisingly – developed a close relationship with drug policy more generally, particularly in the US where the spectre of the 'War on Drugs' continues to shape historical enquiries into drug policies of the late twentieth century. Central to this discussion is the growing distinction between the US and UK responses to AIDS policy for IVDU and how the socio-cultural attitudes to drug policy generally contributed to the cultivation of distinctly different policymaking environments that produced contrasting responses to the prospect of harm reduction. In the US context, Christina Johns has alluded to 'the creation of the enemy class' and Norman Zinberg to the mobilisation of the 'franchised and employed' against the 'disenfranchised and deeply alienated.'[606] Both Johns and Zinberg explored the construction of a socio-cultural framework that positioned drug use primarily as criminal or contentious. Comparatively, Gerry Stimson has identified a cultural distinction between US and UK drug policy that had long informed a fundamentally different approach to harm reduction. Labelled the 'British System' by E. W. Adams in the

[606] C. Johns, 'The War on Drugs: Why the Administration Continues to Pursue a Policy of Criminalization and Enforcement', *Social Justice,* 18:4 (Winter 1991), p. 155. N. E. Zinberg, 'Social Policy: AIDS and Intravenous Drug Use', *Daedalus,* 118:3 Living With AIDS: Part 2 (Summer 1989), p. 33.

1930s to describe the medical prescribing of opiates to addicts (viewed as patients) as a "system of legalized purveying", a culture of harm reduction pre-dated AIDS policy for IVDU by several decades; British medical practitioners, unlike their American counterparts, had practiced substitute prescribing for heroin addiction since the Inter-War period.[607] Moreover, John Strang has suggested that pursuit of harm reduction for infection prevention in the 1980s in the UK was a calculated effort and 'public health physicians recognised that, whilst aware that moral positions may be taken with regard to the behaviour, their task was to concentrate on achieving reductions in the harms identified.'[608]

A prominent theme throughout this thesis, the interplay between medicine and moralism provided a compelling backdrop for the complicated interactions the state had with drug policy and the primary recipients of those efforts. Katherine McLean has explored US needle exchange as 'a politics of life and death', chronicling the complicated intersections between the prospect of state-sanctioned harm reduction as both 'sanctioned massacres' and empowering 'disqualified bodies, only of interest to state power in the infectious threat they pose.'[609] Adopting the concept of 'disqualified bodies' this discussion examines the role of the general population in shaping AIDS policy for IVDU and therefore, qualifying the extent to which we might attribute the increasing interest in IVDUs as policy subjects towards the end of the decade to the perception of threat posed to the general population.

The sense of urgency attributed to IVDUs was primarily derived from a combination of rising cases amongst IVDUs in the US and UK and the potential for those using injectable drugs to bridge the gap between the established risk groups and the general population. In the US, the Centres for Disease Control (CDC) had attributed some 17% of US cases to IVDU by the end of 1987.[610] President Reagan pointed to the 'direct relationship between drug abuse and the spread of HIV' in his response to the report of the Presidential Commission on AIDS in June 1988. The British Communicable Disease Surveillance Centre (CDSC) believed 7% of English AIDS cases were IVDU, an increase of 63% from the levels recorded some twelve months

[607] G. Stimson, 'British Drug Policies in the 1980s: A Preliminary Analysis and Suggestions for Research', *British Journal of Addiction*, 82 (1987), p. 478.
[608] J. Strang, 'AIDS and Drug Misuse in the UK – 10 Years On: Achievements, Failings and New Harm Reduction Opportunities', *Drugs: Education, Prevention and Policy,* 5:3 (1998), p. 294.
[609] K. McLean, 'The Biopolitics of Needle Exchange in the United States', *Critical Public Health*, 21:1 (March 2011), pp. 71-79.
[610] Centres for Disease Control (CDC), 'AIDS Weekly Surveillance Report', 28 December 1987, p. 1.

prior.[611] Reviewing the government's response to AIDS in the UK, the Social Services Committee Report on AIDS described the challenge of rising rates of infection amongst IVDUs as 'the most difficult feature of the AIDS problem.'[612] In addition, IVDU was an increasingly regionalised phenomenon, in which infection rates in cities such as New York and Edinburgh reached heights not seen in other hard-hit areas, such as London or San Francisco, where the epidemic primarily afflicted male homosexuals. Whereas Chief Medical Officer Donald Acheson vaguely stated in his annual report of 1987 that the impact of IVDU infection would be most profoundly felt by Scotland – the absence of firm statistics being an example of the comparatively poor reporting of the disease in the UK.[613] Frightening estimates for New York City suggested that 50%-60% of the city's 200,000 heroin users were thought to be infected by 1987.[614] Subsequently, these rising rates of infection amongst a predominantly heterosexual population fuelled the revisiting of IVDU by policymakers following previous interventions in 1986 as noted in chapter three.[615] This time, however, the policy responses were markedly different.

Although policymakers in the early decade struggled to come to terms with the need for both innovative and well-established infection prevention strategies that balanced effective infection control with concerns about accessibility and criminality, the need for public health-styled service provisions for injecting drug users surfaced with greater appeal than in previous years. It encouraged a more comprehensive debate about infection prevention and drug usage. Informed by a perception of IVDUs as a 'transient' demographic, often consumed by addiction and the consequences associated with it, interventions such as needle exchange schemes presented a controversial approach to infection prevention that provided a barrier to transmission and the potential to bring IVDUs closer to support services.[616] Although officials in both the US and UK remained firm on their belief that 'not shooting drugs' was undoubtedly the first line of defence against infection via IVDU, the likelihood of AIDS

[611] GB0809 AIDS Social History Programme/1/2, D. Acheson, 'Annual Report of the Chief Medical Officer: 1987', December 1987, p. 118.
[612] TNA, PREM19-2775, John Moore, 'Government Response to the Social Service Committee Report on AIDS', 18 January 1988.
[613] Acheson, 'Annual Report 1987', p. 118.
[614] Ibid. W. Anderson, 'The New York Needle Trial: The Politics of Public Health in the Age of AIDS' in V. Berridge and P. Strong (eds), *AIDS and Contemporary History* (1993), p. 162.
[615] Chapter three, pp. 14-20.
[616] MP Gavin Strang summed up this rhetoric in his Commons statement, 'drug takers [IVDUs] are a transient group: they are not a fixed population.' (Hansard, HC, 31 March 1988, v. 130 c. 1294)

policymakers embracing other treatment or prevention strategies became an increasingly real prospect throughout 1988 as new evidence and argumentation emerged in favour of expanding drug treatment and support services.[617]

Despite attracting the lion's share of attention for infection prevention amongst IVDUs, needle exchange was not the only preventative method proposed to control infection via contaminated needles. Tried and tested approaches such as substitute prescribing were already in use across the UK. The volume of methadone – a drug substitute prescribed for heroin addiction – supplied to British pharmacies between 1988 and 1992 increased nearly four-fold.[618] However, Stimson has suggested that no 'structured methadone maintenance programmes' like those in the UK existed in the US during this period.[619] Substitute prescribing attended to the issue of infection control by removing the initial problem of injecting, replacing it with an alternative ingestible form of drug that serviced an individual's addiction. Whilst fundamentally safer than needle exchange – in that it removed the physical risk of injection – substitute prescribing faced a similarly uphill climb to needle exchange albeit for contrasting reasons. Whereas methadone, for example, removed the physical mechanism of infection in the first instance it did little to remove the wider risk of infection via needle or syringe later. A debate akin to the sense of protection provided by mandatory screening, the initial mitigation of risk – and the sense of protection provided by it – lasted only as long as the safer practices – such as methadone use in the case of drug use or abstinence and condom use in the case of safe sex – continued thereafter. Much like sexual abstinence, methadone failed to provide a barrier to infection if users subsequently returned to injections.[620] Moreover, the fundamental issue underpinning the success of any intervention aimed at IVDUs, whether it be methadone use or needle exchange, was engagement and service adoption. Previously identified as a transient group with a fractured and often unpredictable relationship with service provisions and public health support, the initial contact required for intervention was frequently the most difficult barrier to overcome and had previously shaped earlier education attempts that resolved to target young people about the risks of injecting drugs to deter future risky behaviour.

[617] Koop, 'Understanding AIDS', p. 3.
[618] Stimson, 'AIDS and Injecting Drug Use', p. 704.
[619] Ibid.
[620] Ibid.

In the UK, IVDU increasingly became the focus for policymakers concerned with heterosexual transmission and the general population. The HSAC Sub-Committee, chaired by Secretary of State for Health and Social Services, John Moore, considered IVDUs to be a 'major route' of transmission and emphasised that the 'experience of foreign countries could leave no doubt that this should be regarded as a very grave threat.'[621] Likewise, Scottish Labour MP Gavin Strang and Parliamentary Under-Secretary for Scotland Michael Forsyth both emphasised the bridging capacity of IVDUs as a threat to the heterosexual community in the House of Commons.[622] By January 1989, the significance afforded IVDUs as a bridging population was still entertained in the House of Commons and the intersection between IVDUs as a sexual active demographic using contaminated injecting equipment helped maintain a sense of urgency about policy development.[623] Moreover, a May 1989 Gallup poll reported by *The Guardian* reaffirmed the presence of drug use and AIDS in the public consciousness, 'drug abuse' (64%) and AIDS (42%) being perceived as the biggest threats to young people of the 13 potential answers provided to the 934 people questioned.[624] Therefore, the threat posed by AIDS and IVDUs had captured the imagination of the public and policymakers alike; what emerged was a slow shift away from the idea of AIDS as a homosexual epidemic and towards a disease increasingly shaped by risk-taking behaviour of a particular kind more broadly.

In early 1988 the government's response to the Advisory Council on the Misuse of Drugs (ACMD) report on drug misuse and AIDS encouraged further discussion of British policy for IVDUs. Summarising the ACMD report to the HSAC Sub-Committee, Health Minister Tony Newton outlined the report's focus on bringing IVDUs closer to support services, sharing the report's belief that needle exchange presented yet another opportunity to achieve this goal.[625] Furthermore, Newton highlighted that the pilot schemes had achieved some success in bringing IVDUs closer to support services, recording cases of individuals ceasing injecting and others ceasing sharing needles.[626] These positive outcomes – albeit limited – resulted in the ACMD report recommending the expansion of needle exchange across the UK 'without

[621] CAB/134/5253, TNA, Home and Social Affairs Committee (HSAC) Sub-Committee on AIDS, 17 February 1988, p. 3.
[622] Hansard, HC, 31 March 1988, v. 130 c. 1294-98.
[623] Hansard, HC, 13 January 1989, v. 144c. 1102.
[624] 'Drugs and AIDS top risks facing young people', *The Guardian,* 18 May 1989.
[625] CAB/134/5253, TNA, HSAC, 22 June 1988, p. 4.
[626] Ibid.

waiting for a full evaluation of the initial pilot schemes.'[627] In addition, the Chief Medical Officer's Expert Advisory Group on AIDS (EAGA) strongly supported the expansion of needle exchange, reaffirming the close relationship between medical consensus and British policymakers that had been nurtured throughout the decade.[628] A *Times* article entitled, 'Needle exchanges "needed to contain the spread of AIDS", reported on Merseyside Drug and AIDS Co-ordinator, Allan Parry, whose call for an expansion of needle exchange echoed the EAGA and ACMD's pursuit of harm reduction strategies for IVDUs.[629] The Merseyside schemes operated by Parry had managed to collect 54,000 used syringes and handed out over 60,000 clean alternatives.[630] Furthermore, researchers tested 2,000 IVDUs using the schemes in Merseyside and returned zero positive cases compared to rates in Edinburgh where the article suggests some 1,000 IVDUs were infected with HIV.[631] Parry stated the success of his schemes rested on a commitment to harm reduction instead of pursuing an individual's drug usage.[632] Parry had previously welcomed US officials to Merseyside to showcase needle exchange as a policy intervention and was set to visit the US to continue the dialogue on harm reduction he had established months earlier.[633] A tangible transnational exchange of ideas, Parry highlighted the often-overlooked sense of shared experience that frequently pervaded other more traditional areas of US and UK relations such as economics, diplomacy, and defence.[634] The advocacy of the ACMD, EAGA and Parry all communicated an increasingly favourable climate for harm reduction interventions such as needle exchange. This level of advocacy – politically or publicly – for the expansion of needle exchange and harm reduction strategies more generally was not present during the initial 1986 dialogue on needle exchange that produced a cautious endorsement of experimental pilot schemes following months of debate.

Nevertheless, those working to promote harm reduction still needed to overcome the pre-existing fear of increased drug use presented to policymakers like John Moore. Documenting his apprehensions about the potential expansion of needle exchange schemes in the UK, Moore requested a more definitive evaluation of the scheme's ability to prevent transmission.

[627] Ibid.
[628] Ibid.
[629] 'Needle Exchanges "needed to contain the spread of AIDS", *The Times,* 20 February 1988.
[630] Ibid.
[631] Ibid.
[632] Ibid.
[633] Ibid.
[634] Ibid.

The interplay between usage and infection control had shaped earlier anxieties about needle exchange and calls for an expansion of the short-term experimental pilot schemes posited the formalisation of needle exchange as a central part of the government's AIDS agenda. In Parliament, Gavin Strang warned the House of Commons about the Scottish epidemic and labelled the government's response to the ACMD report 'profoundly disappointing.'[635] Strang's suggestion that the Government must 'bite the bullet' on needle exchange centres and the provision of clean syringes resonated with the advocacy of the ACMD, EAGA and Parry.[636] His urgency also aligned with media narratives like the *Guardian* article, 'AIDS lifeline for addicts who risk death for a fix', which focused on the epidemic experience of Scottish cities, drawing comparisons with New York City and shedding light on the valuable prospect of widespread harm reduction strategies.[637] Journalist Aileen Ballantyne suggested that 'the Government appear unwilling to be associated with actively promoting a clean needle campaign' upon visiting a needle exchange scheme in Edinburgh that serviced local IVDUs, of whom 60% were estimated to be infected with HIV.[638] Ballantyne's article on the struggles faced by IVDUs in Edinburgh attracted growing significance in a climate growing increasingly frustrated by Moore's untimely response to the ACMD report and the associated impact government inaction might have on IVDU and AIDS.[639]

A symptom of apprehension and the deliberation that followed it, the initial silence that accompanied the publication of the ACMD report in 1988 cultivated a public critique that focused less on its potentially controversial recommendation and more on the untimeliness of the government's response – welcome or unwelcome – to the report's findings. Shouldering the responsibility for AIDS policy in the wake of Norman Fowler's departure from the DHSS, John Moore faced the prospect of unproven policy intervention in needle exchange. Although Fowler had supervised the establishment of the pilot schemes, it was Moore who would need to appraise the potential expansion of the contentious policy intervention. Nevertheless, Moore's untimely apprehension served only to demonstrate the changing

[635] Hansard, HC, 31 March 1988, v. 130 c. 1294.
[636] Ibid.
[637] 'AIDS lifeline for addicts who risk death for a fix', *The Guardian,* 13 September 1988.
[638] Ibid.
[639] Hansard, HL, 4 March 1988, v. 494 c. 359.

attitudes towards harm reduction embodied in the diversifying advocacy of the EAGA, ACMD and regional backers such as Allan Parry.

Although harm reduction remained a contentious issue for many, the ACDM report on Drug Misuse and AIDS and the advocacy that supplemented it had produced tangible policy gains by the middle of 1988. The silence that accompanied the report's publication eventually dissipated, replaced by widespread departmental engagement, government funding, and a policymaking dialogue that prioritised the ACMD recommendations for the expansion of harm reduction strategies like needle exchange and substitute prescribing. In his response to the findings, Moore emphasised that UK cities must not become like New York and Milan where IVDU had become a driving force in the spread of HIV infection and thus, harm reduction would help achieve this goal.[640]

By January 1989, the government had expanded the number of needle exchange schemes in England from 14 to 60.[641] However, doubts remained about the high dropout rates of 30% to 50% that many schemes suffered.[642] Consequently, the inclusion of harm reduction also required the prioritisation of improvements to monitoring and evaluation to assess the efficacy of the new strategies for future policy appraisal.[643] The government's adoption of harm reduction included an expansion of resourcing that fundamentally reshaped drug-related AIDS policy and drug services generally. For example, 'drug misuse' and 'HIV/AIDS and drug misuse' received a total of £5.235 million and £1.132 million respectively for the financial year 1987-88.[644] By 1989-90, 'HIV/AIDS and drug misuse' alone was allocated some £9 million, increasing to over £16 million by 1993-94.[645] As suggested by Stimson, this surge in drug service funding for AIDS combined with the introduction of harm reduction strategies evidenced 'major changes in working philosophy and practices in drug services' and confirmed the transition from apprehension to advocacy then adoption by policymakers across the UK.[646] In addition, Stimson has pointed to three major 'facilitating' factors in the response to AIDS and drug use: the commonality of harm reduction in the British response to drug problems;

[640] CAB/134/5253, TNA, HSAC, 22 June 1988, p. 6.
[641] Hansard, HC, 13 January 1989, v. 144 c. 1107.
[642] Ibid, c. 1132.
[643] CAB/134/5253, TNA, HSAC, 22 June 1988, p. 5.
[644] Stimson, 'AIDS and Injecting Drug Use', p. 703.
[645] Ibid.
[646] Ibid.

new service provisions for drug issues; and the establishment of new drug agencies to facilitate a response.[647] This thesis posits a fourth factor in the pursuit of harm reduction: the prioritisation of infection prevention over usage.

Described by Health Minister David Mellor as 'a bridgehead into the wider community', policymakers determining the future of harm reduction and drug policy generally demonstrated a more acute appreciation of the bridging capacity of IVDUs.[648] Likewise, John Moore addressed the potential 'rapidity' of transmission between recreational drugs users and the 'heterosexual community.'[649] The language adopted by both Moore and Mellor cited transmission not usage as the primary concern regarding IVDUs, echoing the ACMD's statement that 'HIV is a greater threat to public and individual health than drug misuse.'[650] As suggested by Alex Mold, the dangers posed to the community by AIDS 'outstripped' those of drug use, constituting a vital fourth pillar to Stimson's earlier framework of facilitating factors.[651] Symbolic of the dynamic shifts in discourse between 1986 and 1988, the broader emphasis on transmission that now pervaded the policy advocacy of the ACMD and EAGA served to incorporate infection prevention as a primary objective – if not *the* primary objective – of AIDS-related drug policy. Moreover, the pursuit of harm reduction constituted a narrowing of focus amongst policymakers that leveraged the anxiety surrounding transmission outside the established risk groups. Whereas bisexual and homosexual males remained the most affected group reported in the Public Health Laboratory Service statistics, the formulation of British AIDS policy increasingly prioritised the heterosexual aspects of the disease as evidenced by the adoption of harm reduction in 1988-89 and the associated increases in funding that accompanied this change in policy priority.

In the US, the policymaking response to IVDU and AIDS between 1988-89 was different to the British response, favouring values-based initiatives that aligned with the broader 'War on Drugs' platform espoused by the administration throughout the decade.[652] Consequently, the

[647] Ibid, p. 705.
[648] Hansard, HC, 13 January 1989, v. 144 c. 1102.
[649] CAB/134/5253, TNA, HSAC, 22 June 1988, p. 6.
[650] Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse* (1988), p. 17.
[651] A. Mold, 'Framing Drug and Alcohol Use as a Public Health Problem in Britain: Past and Present', *Medical Humanities,* 35:2 (2018), p. 97.
[652] RPLM, R. Reagan, 'Address to the Nation on the Campaign Against Drug Abuse', [https://www.reaganlibrary.gov/archives/speech/address-nation-campaign-against-drug-abuse], accessed 22 March 2024.

integration of AIDS policy for IVDUs with the nationwide 'crackdown' on recreational drug use hindered the progress of harm reduction strategies that now shaped the British response. Whereas earlier scholarship, such as Norman Zinberg's *Social Policy: AIDS and Intravenous Drug Use,* emphasised the technical and social dimensions of IVDU in the proliferation of HIV infection, more recent research has increasingly focused on the relationship between AIDS policy for IVDU, the US 'War on Drugs' and incarceration. A large body of work now exists that explores the linkages between disproportionately high rates of drug-related incarcerations among Black males and the growing prevalence of HIV among Black Americans.[653] This discussion highlights the contrasting focus of US policymakers on AIDS policy for IVDU as a drug use issue and thus one driven by concepts of criminality that rejected harm reduction because of the associated law and order baggage that pervaded the potential distribution of clean injecting equipment or substitute prescribing. Building on the work of Katherine McLean and her notion of 'disqualified bodies', this section expands our understanding of the factors shaping the apparent abandonment of harm reduction and, subsequently, IVDUs.[654]

A well-documented dimension of the AIDS epidemic, the Koop Report published in October 1986, had already drawn attention to needle sharing and represented just one example of the pre-existing awareness of IVDU as a means of transmission.[655] By May 1988 in the US, the Department for Health and Human Services understandably continued to include 'sharing drug needles and syringes' on the list of risky behaviours in the nationally distributed leaflet 'Understanding AIDS', reaffirming that very sense of awareness that had prompted earlier engagements with AIDS policy for IVDU.[656] Alongside the distribution of *Understanding AIDS*, Ian MacDonald – Special Advisor to the President on Drug Policy – submitted a summary report on needle exchange and bleach distribution – the use of bleach to disinfect injecting apparatus – that shed light on the potential adoption of harm reduction in the US.[657] Engaging

[653] L. Shrage, 'African Americans, HIV, and Mass Incarceration', *Comment: The Lancet*, 388:10049 (14 July 2016), pp. E2-E3. K. McLean, 'The Biopolitics of Needle Exchange in the United States', *Critical Public Health*, 21:1 (March 2011), pp. 71-79. B. Lichtenstein, 'Drugs, Incarceration, and HIV/AIDS Among African American Men: A Critical Literature Review and Call to Action', *Journal of Men's Health*, 3:3 (September 2009), pp. 252-264. K. Blankenship et al, 'Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System', *Journal of Health Care for the Poor and Underserved*, 16:4 (November 2005), pp. 140-156.
[654] McLean, 'The Biopolitics of Needle Exchange', p. 78.
[655] G. E. Koop, *Surgeon General's Report on Acquired Immunodeficiency Syndrome* (1986), pp. 4-5.
[656] Koop, 'Understanding AIDS', p. 3.
[657] Sue Daoulas Files (AIDS 3:1), RPLM, P. J. Fischinger, 'Meetings on Needle Exchange and Bleach Distribution Programs', 11 May 1988, p. 2.

with a variety of international examples of needle exchange and bleach distribution, MacDonald and his colleagues heard a mostly positive account of needle exchange schemes in the UK and across Europe that had documented early successes in service use.[658] Importantly, many schemes included in the report had identified early – albeit small – increases in IVDUs entering drug treatment, results tentatively attributed to adoption of harm reduction schemes.[659] Nevertheless, MacDonald and his colleagues remained apprehensive, alluding to a more acute socio-cultural contrast in attitudes to harm reduction and drug policy generally. Most apparent was the problematic intersection between law enforcement and harm reduction. The 'cultural barriers' outlined by MacDonald and his colleague referred to the opposition of American law enforcement in both a practical and philosophical sense to the prospect of clean needle or bleach distribution to disinfect injecting equipment and prevent infection.[660] Although solutions such as marking the equipment distributed by exchange schemes appeared to resolve the impracticality of stop and search by police, it is apparent that an underlying aversion to harm reduction existed. The centrality of law enforcement to these early barriers also indicated the presence of criminality and drug usage as core components of the US approach to harm reduction. Therefore, the prospect of needle and bleach distribution was fundamentally opposed to the established culture of policing drug use in modern America.

In July 1988, MacDonald published his response to the recommendations made by the Presidential Commission on AIDS in which he noted a contrast with the British approach that increasingly viewed AIDS policy for IVDUs through the lens of drug policy and drug usage.[661] He advised the President to 'continue to communicate publicly [his] concern about drug abuse and its relation to HIV infection and continue to call for bi-partisan effort to enact your anti-drug proposals.'[662] Alluding to his perception of the relationship between HIV infection and IVDU as one primarily defined by drug usage, MacDonald's recommendation promoted the Reagan administration's pursuit of tougher anti-drug policies and the climate of crackdown that accompanied it. Moreover, MacDonald's framing of IVDU and HIV infection reflected the

[658] Ibid.
[659] Ibid.
[660] Ibid.
[661] Sue Daoulas Files (AIDS 1:1), RPLM, I. D. MacDonald, 'Memorandum to the President: Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic', 28 July 1988, p. 3.
[662] Ibid.

public sentiment established by the President only a day earlier in a press release – although no reference to this being planned is recorded – that emphasised the need for 'additional anti-drug abuse measures.'[663] Importantly, this bipartisan 'War on Drugs' sentiment has been drawn out in the existing literature.[664] Matthew Lassiter has noted the vital role of Democratic leadership throughout the second half of the twentieth century in driving through the drug policy reform primarily associated with Richard Nixon and Ronald Reagan.[665] MacDonald's call for unity underpinned an appeal to the anti-drug sentiment that suggested the 'cultural' barriers identified earlier could reflect a broader rejection of harm minimisation as a response to HIV infection among IVDUs.

Whereas British policymakers frequently highlighted the potential for needle exchange and substitute prescribing to bring IVDUs closer to treatment services, their American counterparts spent little time negotiating this important issue. The fleeting engagement with this vital juncture reaffirmed the centrality of usage to the US discourse on IVDU policy, alluding to both ideas of criminality and the associated cultural aversion that still permeated perceptions of harm reduction. Although MacDonald was reporting to the President on HIV infection, his emphasis on 'treatment' heavily endorsed the drug-use framework he had constructed around HIV infection and IVDU whilst serving the broader values-based approach.[666]

Furthermore, the framework constructed around AIDS policy for IVDUs also reinforced the cultural differences inherent in the American and British approaches to drug policy, highlighting the successful encroachment of drug policy on AIDS policy for IVDUs in the US and UK. The now decades long 'War on Drugs' embraced abstinence and tougher policing and sentencing, remodelling US drug policy into a rigid 'law and order' framework that perceived drug use as firstly, criminal activity and secondly, as a complex and multi-dimensional social issue. Moreover, Nancy Reagan's slogan, 'Just Say No', pressed abstinence as a politically safe and ideologically sound administrative response to the myriad problems associated with drug

[663] RPLM, R. Reagan, 'Statement on the Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic', [https://www.reaganlibrary.gov/archives/speech/statement-report-presidential-commission-human-immunodeficiency-virus-epidemic], accessed 22 March 2024.
[664] M. Lassiter, 'Impossible Criminals: The Suburban Imperative of America's War on Drugs', *Journal of American History*, 102:1 (June 2015), p. 127.
[665] Ibid.
[666] MacDonald, 'Memorandum to the President', 28 July 1988, p. 3.

use that demonstrated the lack of understanding and education on addiction that preoccupied policy advisors present at Ian MacDonald's meetings on AIDS policy for IVDUs. Comparatively, the 'British system' showcased an increasing willingness to attend to the nuances of addiction.[667] Evidenced by the development of the 'British system' throughout the twentieth century, harm reduction for infection control achieved traction in the UK to the extent that the government advocated for police awareness of harm reduction and promoted service entry at every available juncture as part of a wider endorsement of infection prevention. Such an approach was also adopted to encourage sex workers to use condoms, where previously the possession of condoms was used by law enforcement to evidence sex working this was now discouraged by the government as a means of promoting infection prevention and safer sex practices.[668] Championing an approach grounded in a growing perception of criminality – established in the late 1960s and 1970s in response to the perceived permissiveness of the preceding decade, most notably espoused by Richard Nixon and Ronald Reagan – the cultural intersection between the US 'War on Drugs' and AIDS policy for IVDUs favoured the prioritisation of drug use over infection prevention. Therefore, the cultural disparity between the British and American approaches to drug policy generally throughout the twentieth century informed AIDS policy for IVDUs.

Unlike their counterparts in Whitehall – and the UK generally – policymakers in the Reagan administration increasingly framed AIDS policy for IVDU around concepts of criminality, adopting a contrasting perspective on the harm reduction and drug usage debate that had informed discussions of IVDU throughout the decade. Acutely aware of the contradictory relationship between tougher drug policy and harm reduction, the Reagan administration cultivated a response that prioritised the broader edicts of the 'War on Drugs' and 'Just Say No' that embraced IVDU through the lens of drug use, rather than disease prevention. Although present, these ideals of criminality achieved significantly less traction in the UK as policy advocates coalesced around the growing body of evidence that supported harm reduction and the intersection between treatment and infection prevention it provided. As Katherine McLean has argued in her work, *Biopolitics of Needle Exchange in the United States,* the culture of arrest and 'don't waste your time educating drug addicts' that accompanied the

[667] G. Stimson, 'British Drug Policies in the 1980s: A Preliminary Analysis and Suggestions for Research', *British Journal of Addiction,* 82 (1987), p. 478.
[668] CAB/134/5253, TNA, HSAC, 17 February 1988, p. 10.

earliest (unofficial and illegal) harm reduction activities carried out by individuals such as needle exchange advocates like Jon Stuen-Parker was symptomatic of a broader socio-cultural rejection of harm reduction that had informed US drug policy for decades and ultimately contributed to a similar attitude towards AIDS policy for IVDUs.[669] Therefore, the discourse shaping AIDS policy for IVDU in the US and UK during the period 1988-89 was increasingly shaped by pre-existing cultural attitudes towards drug policy more generally. However, the prevailing political ethos on drug policy in the US served to drive home a cultural aversion to harm reduction in a fashion unseen in the UK. Moreover, the successful pursuit of and advocacy for needle exchange in the UK indicated a continued faith in the medical consensus and the 'British system' that had shaped drug treatment in Britain throughout the twentieth century. Consequently, AIDS policy for IVDU showcased the broader intersectionality of the Reagan 'War on Drugs' with attitudes towards AIDS-related drug policy, reinforcing the sense of divergence that had defined US and UK AIDS policy throughout the latter part of the 1980s.

Mandated Testing:
Screening Discourse and the New Right

As detailed throughout this thesis, the concept of mandated testing had occupied the consciousness of policymakers concerned with the spread of disease since the first documentation of AIDS. In Virginia Berridge and Phillip Strong's, *AIDS and Contemporary History,* Illana Lowry has documented the complicated baggage attached to widespread testing of sexually transmitted diseases (STDs) as part of a discussion on screening that surveyed seven decades of the twentieth century.[670] Lowry cited the damage caused by false positives, debates around the perceived necessity of mandated testing, and reliability issues.[671] This was a prominent issue in 1987, and British policymakers entered a complicated dialogue about screening which included the testing of medical professionals as well as further discourse on special case testing of military personnel. In the US, the intensity of

[669] McLean, 'The Biopolitics of Needle Exchange', p. 72.
[670] I. Lowry, 'Testing for a Sexually Transmitted Disease, 1907-1970: The History of the Wasserman Reaction', in V. Berridge and P. Strong (eds), *AIDS and Contemporary History* (1993), p. 87.
[671] Ibid.

screening discourse in 1987 dissipated as policymakers shifted focus towards delivering the new immigration ruling and political engagement with pre-marital testing faded more broadly at the state level despite enthusiasm from the White House. The purpose of this section is to survey the screening debate in 1988-89 in the US and UK, comparing the screening discourse in both nations with the preceding engagements with mandated testing in addition to the transnational perspective adopted; to identify changes in the discourse; to provide clarity on why these changes occurred; and to improve our understanding of the divergent trends in the US and UK approach to AIDS testing.

For British policymakers, the government's stance on screening had remained firm in the belief that mandated testing was fundamentally problematic. The Social Service Committee Report on AIDS advanced the importance of confidentiality and rejected the need for disease notification and the routine testing of international travellers as part of a package of comments that appeared generally supportive of the government's approach to screening policy thus far. In addition, the EAGA report on HIV-Infected healthcare professionals served to validate the calculated approach adopted by John Moore and his colleagues in late 1987. Donald Acheson's committee of experts determined that the risk to patients from infected healthcare workers was very low and that those who were infected 'should normally be required not to continue undertaking surgically invasive procedures', therefore requiring no further intervention on the government's behalf.[672] Moore documented his belief that the report's 'clear and authoritative statements … should go a long way to alleviating public concern over HIV-infected doctors.'[673] In late 1988, the HSAC Sub-Committee revisited the issue of screening health care professionals in response to the Joe Smith Report. The report, compiled by Dr Joe Smith, Director of the Public Health Laboratory Service, advocated for the introduction of involuntary anonymised testing. However, his recommendations received a mixed reception from the Royal College of Nurses who opposed the proposal and the General Medical Council (GMC) whose response suggested further investigation of the recommendations was required.[674] Observing the poor reception amongst health care workers, the Sub-Committee pivoted away from the prospect of mandated testing and the

[672] TNA, PREM19-2775, J. Moore, 'EAGA Report on HIV-Infected Health Care Workers', 25 March 1988, pp. 1-2.
[673] Ibid.
[674] CAB/134/5253, TNA, HSAC, 23 November 1988, p. 8.

proposal subsequently drifted out of the policymaking discussion for the remainder of 1988-89.

In May 1988, the government utilised the positive reception from the EAGA and the Social Service Committee Report by rejecting – again – the prospect of mass testing in the HSAC Sub-Committee. This support validated the Government's existing position on screening, the consensus that pervaded the British discourse served to reinforce the unattractiveness of mandated testing. This continuity in screening policy was likely a product of the voluntary ethos that had permeated the British approach to screening throughout the decade, maintaining a suspicion of mandated testing and the complications attached to the potential benefits it might provide. When questioned about adding an HIV test to the scope of tests conducted on expecting mothers, the 'obvious limitations' – likely appropriateness, confidentiality, and usefulness of the data collected – produced an unconvincing case for policy intervention.[675] This seemingly reliable framework for appraising testing also encouraged policymakers to be highly suspicious of 'self-test kits' introduced in early 1988, with some pushing for them to be heavily supervised and initially restricted to avoid issues of false positives and incorrect recording through improper use.[676] Therefore, early 1988 was a period of continuity for British screening policy. Upholding the existing consensus and distancing further the UK from those in the US and the lobbying for a firmer quarantine style response from Whitehall, the sustained alignment of the government and representatives from medical science and health care remained of paramount importance to the British approach to AIDS testing.

Although a consensus on screening had been achieved in Britain that produced little engagement in the Houses of Parliament or in Whitehall during the summer of 1988, the HSAC Sub-Committee revisited mandated testing in November with greater intent than previous discussions. Reviewing the existing stance on screening, Health Minister David Mellor emphasised that the Government had held a firm line against 'coercive testing' for some time and that they may wish to review this given the advent of new circumstances.[677] In short, the Government believed it should continue to support voluntary testing, citing the problematic

[675] CAB/134/5253, TNA, HSAC, 19 May 1988, p. 3.
[676] CAB/134/5253, TNA, HSAC, 19 July 1988, p. 1.
[677] CAB/134/5253, TNA, HSAC, 23 November 1988, p. 1.

legal and ethical issues presented by any form of 'coercive testing' as well as the requirement for regular re-testing to ensure proper coverage making any prospective protection time sensitive, limited in scope and expensive to maintain.[678] In addition, Mellor's inclusion of the term 'coercive' to describe mandated testing captured the sense of opposition among key policymakers in Britain. Whereas 'mandated' testing had previously been rejected, the transition towards 'coercive' testing carried a greater sense of hostility that illustrated a belief in voluntary testing as a tool that circumvented the complicated legal and ethical problems that threatened to push important groups such as IVDUs underground and away from the end goal of support services entry.

Furthermore, Secretary of State for the Foreign and Commonwealth Office, Geoffrey Howe, believed that Britain should continue to oppose the testing of travellers that had been adopted in other countries.[679] Contrasting the approach of the US, which pursued border protection more intensely, Howe's faith in the 'British approach' echoed the same argumentation put forth more generally against mandated testing – impracticality, cost, legality, and ethical barriers – and sustained agreement like other areas of AIDS testing. Although Howe and Mellor's views reflected the policy consensus, the framing of mandated testing as a coercive technique shed light on the extent to which British policymakers were opposed to widespread screening and how engrained in the British approach the voluntary ethos remained. In stark contrast to the American pursuit of border testing, pre-marital testing and prison inmate testing, the British response turned against mandated testing in the middle of the decade and this approach continued to mature as the end of the 1980s approached.

Although the Sub-Committee spent little time debating the question of anti-discrimination legislation – believing it unnecessary given the protection already provided by existing laws – the conduct of the Metropolitan Police caused concern.[680] Following a brief discussion about screening prison inmates, which resulted in the continued opposition to the testing of prisoners by the Home Office, Under-Parliamentary Secretary of State for the Home Office Douglas Hogg noted that 'the Metropolitan Police had recently began to ask potential recruits whether they had been tested for HIV and, if so, with what results.'[681] Conflicting with the

[678] Ibid.
[679] Ibid, p. 2.
[680] Ibid, p. 1.
[681] Ibid, p. 2.

prevailing consensus that emphasised voluntary testing and confidentiality, the indirect approach adopted by the Metropolitan Police undermined the foundational principles of the British attitude to testing and notification that had guided screening policy throughout the decade. Moreover, the Metropolitan Police's status as Britain's foremost police force and the organisation responsible for the city with the highest number of AIDS cases in the UK, carried with it a greater concern for the organisation's recruitment practices. Increasingly worried, Hogg had noted that the Home Secretary 'was inclined not to raise objections to that practice, but would welcome the Sub-Committee's views before reaching a final decision.'[682] Immediately, the HSAC Sub-Committee labelled the Metropolitan Police's actions 'unwelcome', suggesting 'there seemed no good reason' for such a practice to be carried out and that 'there was bound to be suspicion that the practice was simply fuelled by prejudice against homosexuals.'[683] 'Troubled' by these developments in London, the Sub-Committee concluded that such a practice was undesirable and undermined the government's broader approach to screening by encouraging other public services to follow suit and cultivating an objectionable precedent that might designate large groups unemployable and discourage voluntary testing generally.[684] Although the exact motivation for the Metropolitan Police's challenging of the government's policy is not listed and no further investigation was conducted by the HSAC Sub-Committee, the circumventing of testing protocol highlighted a desire for notification in the workplace that reflected the 'special case' attitude adopted by the Secretary for Defence in 1987 when advocating for the testing of military personnel. Moreover, these developments contrasted with the government's belief that anti-discrimination legislation was unnecessary. The willingness of public services like the Metropolitan Police to subvert government protocol and covertly pursue people with AIDS (PWAs) alluded to an undercurrent of prejudice and discrimination that maintained the complicated dynamics that ensured the continuing relevance of screening as a political issue late into the 1980s.

Importantly, the attempted circumvention of testing protocol reinforced the sense of socio-cultural baggage that Lowry had identified and the circumstances surrounding the Metropolitan Police's actions highlighted the existence of a dialogue regarding the place of

[682] Ibid, p. 2.
[683] Ibid, p. 3.
[684] Ibid, p. 4.

testing in the British response to AIDS. Moreover, this episode in screening discourse served as a rare flashpoint in the pursuit of mandated testing that demonstrated the government's commitment to a voluntary protocol whilst highlighting an awareness of the very same baggage Lowry's analysis alluded to some years later. Despite this unwelcome development in late 1988, the British screening discourse remained firmly attached to the ideals of voluntary testing until the end of the decade, demonstrating an uncompromising commitment to the medical consensus that had guided policymaking towards continuity on AIDS testing.

Unlike the dialogue observed in the UK, the screening discourse in the US was somewhat mute in 1988-89 despite substantial engagement throughout 1987. American policymakers – particularly those in the White House – appeared to have settled several important debates on screening in 1987 to the extent that the issue attracted very little interest for the remainder of Reagan's tenure as President. The successful pursuit of rule changes for border screening that made HIV infection grounds for exclusion was the central achievement of Reagan's screening policy. On pre-marital testing at the state level, the Reagan administration failed to inspire testing for marriage licenses amongst most state legislatures by the end of Reagan's tenure. The White House's success at the border reflected an important jurisdictional difference between immigration and pre-marital testing that highlighted Reagan's inability to shape broader engagements with screening policy in the US that policymakers operating in the centralised British system were unhampered by. Importantly, the advocacy of 1987 and the absence of dialogue in 1988-89 served to contextualise the administration's attitude towards testing and AIDS policy generally.

The likelihood that the Reagan administration was willing to pursue the expansion of mandated testing for the general population appeared to be declining. The administration's now fast approaching expiration date – January 1989 – likely factored into a discussion about policy priority that balanced existing gains made on mandated testing in 1987 with the expected political capital expenditure needed to achieve the further expansion of widespread testing envisaged by the administration. Moreover, the administration's abrupt departure from pursuing mandated testing coalesced with Reagan's vision for a drug free America and the more acute sense of fear surrounding a heterosexual epidemic that had stemmed in part from the threat posed by IVDUs bridging the gap between the established risk groups and the general population. Although calls for widespread data collection during the initial phase

(1981-1984) might have resonated with policymakers deeply aware of the need for an epidemiological understanding of the disease and the unsophisticated understanding of medical science at that time, the circumstances had certainly changed. The successful advocacy of the White House in 1987 had seemingly removed any semblance of urgency regarding screening.

Overall, the US and UK cemented their opposing approaches in 1988-89. Despite the appearance of aligned ideological principles, British and American policymakers produced disparate policy responses under the given circumstances. When President Reagan cited routine testing as 'essential' in protecting the public and assisting the federal, state, and local policymaking response, Minister of Health David Mellor adopted a negative tone when labelling the same testing protocol 'coercive'.[685] Likewise, the style of immigration policy adopted by the Reagan administration in 1987 was discussed and rejected by Secretary of State for the Foreign and Commonwealth, Geoffrey Howe.[686] Therefore, screening polarised the Reagan and Thatcher administration's, the British response revealing an appreciation of the ethical and legal complications inherent in a government-mandated testing protocol, frequently indulging a suspicion of testing that contrasted the White House perspective on the same issue. In the White House, the apparent cost – fiscally, ethically, and politically – of mandated testing appeared surmountable and justifiable as policymakers pushed intensely for routine testing in the military, in prisons, at borders and for marriage licenses as the means through which the federal government could achieve an essential sense of protection for the citizenry. Although the scope of a testing protocol in the military or prison was clearer, pre-marital testing provided what Closen, Gamrath and Hopkins have described as an 'ineffective and counterproductive' response even before the consideration of legal complications.[687] As such, the proliferation of a 'protection mindset' distinguished those advocating for mandated testing in the US from the consensus on 'coercive testing' in Whitehall.

In addition, the prospect of screening raised several vital questions about the place of political philosophy in the development of AIDS policy and the propensity for disciples of

[685] RPLM, Reagan, 'A Union of Individuals', [https://www.reaganlibrary.gov/archives/speech/1988-legislative-and-administrative-message-union-individuals], accessed 22 March 2024. TNA, HSAC, 23 November 1988, p. 1.
[686] TNA, PREM19-1863, 'AIDS', 7 November 1986.
[687] M. Closen, R. Gamrath and D. Hopkins, 'Mandatory Premarital HIV Testing: Political Exploitation of the AIDS Epidemic', *Tulane Law Review,* 69:1 (1994), pp. 71-74.

neoconservatism to negotiate the boundaries of ideological commitment in favour of a broader engagement with political consensus and the demands of epidemic response. In this regard, mandated testing proved a battleground for the complicated and often contradictory interplay between ideology and practical policy. Whereas the Reagan administration's adherence to neoconservative economic principles had permeated the conceptualisation of AIDS policy, the pursuit of mandated testing shed light on the difficult task of reconciling socially and economically conservative goals in the development of AIDS policy. Expensive and logistically frightening, a testing mandate that was even remotely large scale would require government activity typically unjustified under Reagan's philosophy of retrenchment. Moreover, forcibly testing large swathes of the citizenry represented an expansion of government influence and responsibilities that, once again, contradicted the broader Reagan platform on federal governance. Nevertheless, we might cite a special case scenario in which epidemic response required policymakers to negotiate the parameters of their own ideological commitments to achieve a common public health goal. However, even if we adopt such a sympathetic framework, we still find contradictions engrained.

Embodied by legislation such as the Omnibus Budget and Reconciliation Act 1981 that recouped billions in welfare dollars from the federal purse, these principles extended to the annualised attempts to retrench AIDS funding throughout the 1980s and the imposing of personnel ceilings which hindered research by restricting the recruitment of scientists in the Public Health Service. Although the British defence of voluntary testing – a protocol more fundamentally aligned with the libertarian and fiscally responsible arms of neoconservatism – infrequently cited these values directly, the language used embraced these very principles in their rejection of mandated testing.[688] For policymakers in Whitehall, widespread screening was considered expensive and impractical, it encouraged complicated legal and ethical issues that constituted government overreach that hindered confidentiality and deterred an individual from 'choosing' to come forward for testing. Whilst the Reagan administration had shown a willingness to endorse neoconservatism in the face of epidemic response more generally throughout the decade, it was Whitehall that adopted the principles of the 'New

[688] Embodied in President Reagan's notion of reducing the role of big government in people lives, the pursuit of individual liberty by removing the federal burden was an increasingly important theme throughout the 1980s and embodied in the decades tax cuts, deregulation, and spending retreat.

Right' in the face of demands for mandated testing. The pivotal role of medical science in shaping this distinction was vital.

The prevailing medical and scientific consensus on testing for HIV/AIDS demonstrated to both the Reagan and Thatcher administrations during 1988-89 was that voluntary testing was the most viable prospect for monitoring HIV infection. Director of the CDC James Mason had spoken publicly in 1987 about his opposition to mandated testing and he was supported by Surgeon General Dr Everett Koop who suggested that widespread testing was an ineffective use of already scarce AIDS resources. In the UK, Chief Medical Officer Donald Acheson, and his group of experts on the EAGA, continually rejected mandated testing throughout the decade and offered no compromise as 1990 approached. Nevertheless, the Reagan administration pursued a testing agenda that opposed the consensus in the medical community unlike his British counterparts who championed that very medical consensus. Importantly, the distinctly different levels of adherence to the medical consensus on screening was typical of the policymaking responses of the US and UK throughout the decade. Whereas British policymakers had relied heavily on medical science for policy insight since mobilisation began in 1985, the White House had frequently disengaged from organisations such as the CDC and American Medical Association on key issues such as funding and education. Therefore, the question remains, why did the Reagan administration oppose the medical consensus willingly adopted by the Thatcher administration in favour of mandated testing which proposed to undermine a variety of neoconservative principles that had shaped America in the decade of Reagan?

Essentially, the circumstances shaping the Reagan response had changed substantially by 1988-89 and the prospect of a heterosexual epidemic had stimulated a new wave of anxiety that incentivised policymakers to attend to AIDS as a general population issue. Importantly, we can identify the relationship between the adoption of mandated testing and the anxiety surrounding a heterosexual epidemic because of the increasingly prominent role of the general population in the discussion of screening. Whereas the administration's previous ambivalence had afforded AIDS an undesirable niche status informed by the failure to prioritise the struggle of bisexual and homosexual males and IVDUs earlier in the 1980s, the magic bullet optimism celebrated by Margaret Heckler in 1984 following the discovery of HIV had now faded and HIV/AIDS had developed into a profound public health challenge. The

Reagan administration's push for mandated testing protocols across a variety of circumstances therefore served to target the heterosexual general population and not the established risk groups identified and prioritised by those advocating for a voluntary approach to testing. Furthermore, the apparent absence of urgency when attending to the prevalence of the disease amongst bisexual and homosexual males cemented heterosexuality and the general population as prime motivators in the cultivation of Reagan's approach to screening. Ultimately, the gradual realisation of a platform of support in Washington for mandated testing – albeit not widespread or nationwide – indicated that the neoconservatism that aligned the Thatcher and Reagan administrations was a fluid concept, a set of guiding principles that policymakers might indulge with varying degrees of consistency and in response to the varying parameters. In the case of screening, the Reagan response was ideologically atypical as defined by previous engagements with AIDS policy but characteristically resistant to external pressure from the medical establishment, a stance which became symbolic of the administration's response to AIDS.

Screening discourse in the US and UK throughout the 1980s was ultimately defined by a sense of continuity for both administrations. Whereas the British response demonstrated a firm commitment to a voluntary approach to testing, policymakers in the White House tried with varying success to establish a system of mandated testing that slowly included sections of the general population. Although the growing anxiety surrounding the prospect of a heterosexual epidemic reframed screening as a general population issue in the US, British policymakers remained resolute in their adherence to the medical consensus despite the growing adoption of various screening policies – namely border testing – in the US and across the globe. Moreover, the relationship between the US and UK response became increasingly divergent as those in Whitehall held firm to a voluntary approach. Subsequently, screening provided greater clarity on the dynamic nature of ideology as a tool for AIDS policy development.

Although the Reagan administration's pursuit of mandated testing was likely deemed probable, this discussion has shed light on the apparent contradiction in the administration's adoption of mandated testing beyond the problematic ambivalence to the struggles of the initial phase. Therefore, the US and UK screening narrative was divergent and seemingly polarised, yet the Reagan administration's apparent departure from the neoconservative bastion that had shaped the federal response throughout the decade constituted a vital

flashpoint in the dynamic and often contradictory policy response to the AIDS Crisis of the 1980s.

Conclusion

Shaped by a sense of continuity, the policymaking discourse between 1988 and 1989 showcased a divergence that had been cultivated throughout the 1980s and maintained the disparate trends that had informed the transnational policymaking narrative thus far. From the outset, this chapter – and thesis generally – have sought to identify and understand the complex interplay between the most prominent issues shaping AIDS policy – moralism, funding, screening, AIDS policy for IVDU – as the first decade of the disease drew to a close. The realisation of screening, funding, and education goals throughout 1987 and early 1988 ensured that the subsequent period was not defined by heated exchange and volatility but by a sense of policy management that coalesced with the end of the Reagan years in the US. In addition, this chapter has presented the divergent trends that have gripped this transnational narrative since 1986 and demonstrated the continued disparity between British and American responses to issues such as AIDS policy for IVDU, funding for research, screening protocols and values-based education.

A pivotal dimension of this investigation, the role of ideology in the determining of AIDS policy remained complicated and circumstantial throughout the late decade. However, ideology maintained a more tangible presence in the US and contributed significantly to the sense of dissimilarity between the two nations. Whereas the American response to screening appeared to contradict the President's aspiration for government retreat, the contrasting investment in research and federally funded care initiatives upheld the administration's wider goals for a reduced welfare and social care system and large-scale research and development. Moreover, the socially conservative ethos of abstinence that permeated AIDS policy for IVDU and AIDS education further demonstrated the encroachment of ideology into specific policy areas and the subsequent variance in the degree of impact between the US and UK. In contrast, the British response continued to endorse the medico-scientific consensus that failed to achieve a similar level of support in America. Harm reduction, substitute prescribing,

safe sex, and condom use all evidenced a different philosophy on AIDS policy that engaged more generally with the socio-cultural issues associated with the disease and the population it affected. Although Whitehall deliberated on issues of screening and needle exchange more cautiously, the pursuit of these interventions ultimately distanced the British response from the US philosophically and practically. Fundamentally, this chapter has shed more light on the role of ideology in the development of AIDS policy and the importance of ideological adherence in the production of policy for epidemic response. Whereas the White House maintained socially conservative messaging on education and a fiscally responsible attitude to service provision for AIDS towards the end of the decade, those in Whitehall demonstrated a foundational belief in medical science that undermined ideology as a prime mover in British AIDS policy.

Conclusion

The AIDS Crisis of the 1980s was an unprecedented public health challenge in the US and UK. This thesis has utilised a comparative methodology and newly available archival material – such as cabinet papers, the Official Committee on AIDS and Sub-Committee on AIDS papers from the Thatcher government – to examine the British and American policymaking response to AIDS and explore the avenues of inquiry previously missed by a focus on individual nations. Building on the different bodies of literature in the US and UK, the contention of this thesis is that a comparative framework elicits new perspectives on existing scholarly debates. It provides new opportunities to explore the nuances of AIDS policy and better situate them within a broader contextual scope to embrace the complexities of policy development that had previously remained hidden.

1981-1989 was a short decade shaped by two distinct policymaking journeys in the US and UK. The pre-discovery period (1981-1984) of AIDS policymaking was largely shaped by the inactivity of the Thatcher and Reagan administrations and this thesis has utilised the absence and avoidance framework to better explain that inactivity. In the UK, British policymakers from Whitehall to Westminster demonstrated limited interest in the disease. Accompanied by a low caseload compared to the US and a sporadic – albeit developing – media narrative, policymakers in Whitehall were largely absent on AIDS during the pre-discovery period. By contrast, criticism of the Reagan administration's inactivity was more public and indicative of a White House ignorant to the spread of a new deadly disease. Whereas criticism of inaction captured the inattentiveness of the Reagan White House, this thesis has placed a spotlight on the presence of early policy discourse and cabinet level engagement. It has asserted that the Reagan administration's inactivity was carried out knowingly and whilst we can acknowledge the difficult circumstances faced by early policymakers the responsibility for inaction rests with the White House's decision to not construct an effective response to the AIDS crisis.

The post-discovery period (1985-1989) was a phase of policymaking increasingly shaped by different levels of mobilisation, producing a divergent policy narrative that cultivated alternative disease responses. Whereas scholars have often looked to 1985 and 1986 as starting points in AIDS policy discourse, this thesis has argued that 1986 was a *turning point*

in AIDS policymaking. Equipped with an AIDS-specific policymaking infrastructure, British policymakers pulled ahead of their American counterparts by crafting a response guided by education and awareness. Beset by the Reagan administration AIDS policy inertia, the American response stagnated throughout the middle of the decade whilst congressional opposition and the number of cases of AIDS increased. Furthermore, the relationship between the President and Prime Minister and AIDS policy became more visible to varying degrees. Attempting to negotiate the details of the UK's education strategy, the Prime Minister unsuccessfully adopted a more interventionist approach that contrasted the limited public engagement President Reagan fostered in the US that set the tone for the remainder of the decade. Nevertheless, the post-discovery period (1985-1989) captured significant leaps forward in AIDS policymaking in the US and UK, but it was the divergence of the two policy narratives that shaped these years the most. Throughout the post-discovery period policymakers negotiated important AIDS policy issues such as public health education, policy for intravenous drug use (IVDU), and screening that intersected with a variety of prominent political issues such as federal expenditure, the 'War on Drugs', and the politics around the family unit.

Although structural factors, such as health care accessibility, underpinned much of the comparative analysis in this thesis, moralism, existing socio-cultural attitudes and the status of the medico-scientific consensus emerged in the late decade as determining factors in AIDS policy on both sides of the Atlantic. The development of public health education became an important intersection between moralism and science. The Reagan administration's attempt to reconcile public health education with a moral message sharply contrasted with the British approach which carved out separate roles and responsibilities for AIDS messaging disseminated by the state and by churches in Britain. Screening discourse elicited a similar challenge to the medico-scientific consensus on AIDS policy. Whereas the 'liberal' public health approach championing voluntary testing and confidentiality achieved significant traction in the UK, the Reagan administration advocated mandated testing with varying success. Likewise, the pursuit of harm reduction for IVDUs in America was different compared to the piloting of needle exchange in Britain. Combined with the political baggage of the 'War on Drugs', the pre-existing socio-cultural aversion to harm reduction appeared insurmountable in the US.

In all these policy arenas, the adherence of policymakers to expert medico-scientific advice and guidance was vital in shaping the disparate policy trends of the mid-decade onwards. Where expert advice failed to gain traction ideology often prevailed. Nevertheless, this interplay between the medico-scientific consensus and ideology reaffirmed ideology as a fluid concept for policymakers. Where Reagan had frequently engaged in socially conservative messaging, Thatcher failed to muster a similar conviction for moralism and AIDS. Likewise, the Reagan government's habitual reductions to AIDS spending demonstrated a commitment to fiscal responsibility that failed to materialise into real opposition challenges to British AIDS policy, despite a brief disagreement in Whitehall in 1986. By contrast, the White House's introduction of immigration testing – against advice from leading public health officials – and the sponsoring of pre-marital testing endorsed a position that was firmly rejected by Whitehall. Although the Thatcher and Reagan administrations were influenced by similar neoconservative teachings, the application of these ideas was largely contextual.

This thesis has conceptualised AIDS policymaking in the 1980s as a non-monolithic process and that the existing notions of inaction governing much of our understanding have poorly captured the complexities of policy development. It has argued that the pre-discovery period of AIDS policymaking produced similar levels of inattentiveness in the US and UK but for different reasons. Building on the existing scholarship, the absence and avoidance framework placed a spotlight on the role of government agency in the determining of inaction. Where the British and American responses diverged in the post-discovery period, this thesis has asserted that these trends can be attributed to contextual differences and the fluctuating interplay between ideology and politics on the one hand, and an adherence to medico-scientific expertise on the other. In seeking to capture the complicated and often contradictory currents of AIDS policymaking in the 1980s, this thesis has derived lessons not just for historians wanting to understand and evaluate the past, but also for policymakers tasked with implementing public health policies today.

Bibliography

Primary Sources

AIDS Social History Programme (The National Archive and London School of Hygiene and Tropical Medicine)

GB0809 AIDS Social History Programme/1/2, Acheson. D, *Chief Medical Officer Annual Report: 1985* (1985).

GB0809 AIDS Social History Programme/1/2, Acheson. D, *Chief Medical Officer Annual Report 1986* (1986).

GB0809 AIDS Social History Programme/1/2, Acheson. D, *Chief Medical Officer Annual Report 1987* (1987).

GB0809 AIDS Social History Programme/1/2, Acheson. D, *Chief Medical Officer Annual Report 1988* (1988).

GB0809 AIDS Social History Programme/1, London School of Hygiene and Tropical Medicine AIDS Social History Programmes Collection, Department of Health and Social Services, 'General Information for Doctors', 15 May 1985.

American Presidency Project

American Presidency Project, 'Executive Order 12601 – Presidential Commission on the Human Immunodeficiency Virus Epidemic', 24 June 1987, [https://www.presidency.ucsb.edu/documents/executive-order-12601-presidential-commission-the-human-immunodeficiency-virus-epidemic], accessed 15 March 2024.

American Presidency Project, 'Message to the Congress on America's Agenda for the Future', [https://www.presidency.ucsb.edu/documents/message-the-congress-americas-agenda-for-the-future], accessed 11 March 2024.

American Presidency Project, 'Message to Congress Transmitting the Fiscal Year 1989 Budget', [https://www.presidency.ucsb.edu/documents/message-the-congress-transmitting-the-fiscal-year-1989-budget], accessed 22 March 2024.

American Presidency Project, 'Remarks at a Luncheon for Members of the College of Physicians in Philadelphia, Pennsylvania', 1 April 1987, [https://www.presidency.ucsb.edu/documents/remarks-luncheon-for-members-the-college-physicians-philadelphia-pennsylvania], accessed 15 March 2024.

American Presidency Project, 'Remarks to Employees of the Department of Health and Human Services', [https://www.presidency.ucsb.edu/documents/remarks-employees-the-department-health-and-human-services], accessed 11 March 2024.

American Presidency Project, 'Statement of Administration Policy: S. 1220 – AIDS Research and Information Act of 1987', 1 October 1987, [https://www.presidency.ucsb.edu/documents/statement-administration-policy-s-1220-aids-research-and-information-act-1987-0] accessed 15 March 2024.

American Presidency Project, 'The President's News Conference', 17 September 1985, [https://www.presidency.ucsb.edu/documents/the-presidents-news-conference-951], accessed 12 January 2022.

Audiovisual Sources

'AIDS', Nightline: ABC News, 17 December 1982, [https://www.youtube.com/watch?v=5FREjnYV_aM], accessed 11 January 2023.

BBC Horizon, *Killer in the Village* (April 1983), [https://www.bbc.co.uk/iplayer/episode/p01z2lbp/horizon-19821983-killer-in-the-village], accessed 25 March 2024.

How To Survive a Plague, (2012), David France, accessed 29 March 2021.

"Moral Majority report", *HIV and AIDS 30 Years Ago*, [https://hivaids.omeka.net/items/show/9], accessed 16 January 2023.

'Surgeon General Dr. Everett Koop Roundtable', *USA TODAY via C-SPAN*, 17 September 1987, [https://www.c-span.org/video/?151150-1/surgeon-general-roundtable], accessed 27 April 2023.

When AIDS Was Funny, (2015), Scott Calonico, [http://www.scottcalonico.com/#/when-aids-was-funny/], accessed 29 March 2021.

Congressional Record (Bound Edition)

'Acquired Immune Deficiency Syndrome', Congressional Record 129 (1983), (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023.

'AIDS Counselling, Education, and Service Act', *Congressional Record* 132 (1986), (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

'AIDS Demonstration Projects', *Congressional Record* 132 (1986), (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

'AIDS Epidemic', *Congressional Record: Bound Edition* 131:14 (1985), (Text from Congressional Record Permanent Digital Collection), accessed 14 September 2021.

'AIDS Treatment', *Congressional Record* 132 (1986), (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

'Amendment Offered by Mr Natcher', *Congressional Record* 129 (1983), (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023.

'Amendment No. 4389', *Congressional Record: Bound Edition* 130:19 (1984), (Text from Congressional Record Permanent Digital Collection), accessed 14 September 2021.

'Disapproving an Act of the District of Colombia District', *Congressional Record* 132 (1986), (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

‘President’s Self-Satisfaction in AIDS Epidemic Termed as Inappropriate’, *Congressional Record: Bound Edition* 131:17 (1985), (Text from Congressional Record Permanent Digital Collection), accessed 16 November 2022.

‘Section 505 of the Rehabilitation Act and Discrimination Against People with Disease in the Workplace’, *Congressional Record* 132 (1986), (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

‘The AIDS Epidemic’, *Congressional Record* 129 (1983), (Text from Congressional Record Permanent Digital Collection), accessed 11 January 2023.

‘The President’s Handling of the AIDS Crisis’, *Congressional Record* 132 (1986), (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

‘Twenty Thousand AIDS Cases, 10,800 Dead’, *Congressional Record* 132 (1986), (Text from Congressional Record Permanent Digital Collection), accessed 11 March 2024.

Government Reports (US and UK)

‘DHSC0002323 - Draft Submission to PS (H) AIDS: Health Education and Prevention’, *Infected Blood Inquiry,* 15 May 1985, [https://www.infectedbloodinquiry.org.uk/evidence/dhsc0002323113-draft-submission-aids-health-education-and-prevention-15-may-1985], accessed 27 March 2024.

‘Federal Response to AIDS: Hearings before a Sub-Committee of the Governments Operations’, *House of Representatives*, 98:1 (1-2 August 1983), [https://archive.org/details/federalresponset00unit/page/n7/mode/2up], accessed 24 June 2024.

Institute of Medicine: National Academy of Science, *Confronting AIDS: Directions for Public Health, Health Care and Research,* (October 1986), [https://archive.org/details/confrontingaidsd0002unse], accessed 24 June 2024.

Office of Technology Assessment, *Review of the Public Health Service Response to AIDS*, (February 1985), [https://repository.library.georgetown.edu/bitstream/handle/10822/708547/8523.PDF?sequence=1], accessed 24 June 2024.

‘Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic: Submitted to the President of the United States’, 24 June 1988, [https://archive.org/details/reportofpresiden00pres/page/n1/mode/2up], accessed 15 March 2024.

Hansard (British Parliamentary Records)

Hansard, House of Commons, 4 December 1984, v. 69. c. 160-161.

Hansard, House of Commons, 11 February 1985, v. 73. c. 14.

Hansard, House of Commons, 20 February 1985, v. 73. c. 498-500.

Hansard, House of Commons, 6 March 1986, v. 93. c.559-566.

Hansard, House of Commons, 12 March 1985, v. 75 c. 141.

Hansard, House of Commons, 16 April 1985, v. 77 c. 121.

Hansard, House of Commons, 30 April 1986, v. 96. c. 918.

Hansard, House of Commons, 21 November 1986, v. 105. c. 800-864.

Hansard, House of Commons, 23 January 1987, v. 108. c. 1168-1195.

Hansard, House of Commons, 17 February 1987, v. 110. c. 751-753.

Hansard, House of Commons, 25 February 1987, v. 111. c. 271-282.

Hansard, House of Commons, 10 March 1987, v. 112. c. 139-141.

Hansard, House of Commons, 16 November 1987, v. 122. c. 767-775.

Hansard, House of Commons, 3 February 1988, v. 126. c. 1081.

Hansard, House of Commons, 31 March 1988, v. 130. c. 1294-1300.

Hansard, House of Commons, 13 January 1989, v. 144. c. 1099-1161.

Hansard, House of Commons, 13 November 1989, v. 160. c. 153-160.

Hansard, House of Lords, 14 July 1983, v. 443. c. 895-896.

Hansard, House of Lords, 13 February 1985, v. 460 c. 181-184.

Hansard, House of Lords, 18 March 1985, v. 461 c. 359-387.

Hansard, House of Lords, 24 July 1985, v. 466 c. 1200-1202.

Hansard, House of Lords, 23 October 1985, v. 467 c. 1085-1088.

Hansard, House of Lords, 10 March 1986, v. 472. c. 393-395.

Hansard, House of Lords, 14 October 1986, v. 480. c.680-684.

Hansard, House of Lords, 3 February 1988, v. 492. c. 1077-1114.

Hansard, House of Lords, 4 March 1988, v. 494. c. 359.

Hansard, Written Answer, 11 July 1983, v. 45. c. 275.

Hansard, Written Answer, 14 November 1983, v. 48. c. 328.

Hansard, Written Answer, 17 November 1983, v. 48.

Hansard, Written Answer, 17 January 1984, v. 71. c. 222.

Hansard, Written Answer, 8 May 1984, v. 59.

Hansard, Written Answer, 14 May 1984, v. 60.

Hansard, Written Answer, 23 November 1984, v. 68.

Hansard, Written Answer, 26 November 1984, v. 68.

Hansard, Written Answer, 28 November 1984, v. 68. (AIDS: Blood Donors)

Hansard, Written Answer, 28 November 1984, v. 68. (AIDS: Scotland)

Hansard, Written Answer, 28 November 1984, v. 68. c. 486. (AIDS: Wales)

Hansard, Written Answer, 4 December 1984, v. 69. c. 161.

Hansard, Written Answer, 11 December 1984, v. 69. c. 471. (AIDS)

Hansard, Written Answer, 11 December 1984, v. 69. (AIDS: Research)

Hansard, Written Answer, 8 February 1985, v. 72. c. 708.

Hansard, Written Answer, 14 February 1985, v. 73.

Hansard, Written Answer, 15 February 1985, v. 73.

Hansard, Written Answer, 18 February 1985, v. 73.

Hansard, Written Answer, 24 October 1985, v. 84.

Hansard, Written Answer, 9 December 1985, v. 88.

Hansard, Written Answer, 16 December 1985, v. 89.

Hansard, Written Answer, 15 November 1988, v. 140. c. 555-557.

Miscellaneous

'INQY0000362 – Presentation Note: Infected Blood Inquiry: Role of the Chief Medical Officer', *Infected Blood Inquiry,* 1 July 2022, [https://www.infectedbloodinquiry.org.uk/evidence/inqy0000362-presentation-note-infected-blood-inquiry-role-chief-medical-officer-01-jul], accessed 27 March 2024.

Joseph. K, 'Speech at Edgbaston: Our Human Stock is Threatened', *Margaret Thatcher Foundation,* 19 October 1974, [https://www.margaretthatcher.org/document/101830], accessed 27 March 2024.

'Press Conference: Margaret Heckler', *John Cohen AIDS Research Collection,* 23 April 1983*,* [https://quod.lib.umich.edu/c/cohenaids/5571095.0256.002/?view=toc], accessed 27 March 2024.

'Speech to Conservative Party Conference', *Margaret Thatcher Foundation*, 9 October 1987, [https://www.margaretthatcher.org/document/104431], accessed 27 March 2024.

The National Archive, 'Local Government Act (1988)', accessed 8 August 1988, [https://www.legislation.gov.uk/ukpga/1988/9/section/28/enacted].

'Veto of H.R. 6863', R. Reagan, 28 August 1982, [https://www.senate.gov/legislative/vetoes/messages/ReaganR/HR6863-Hdoc-97-231.pdf], accessed 15 March 2024.

Newspapers (US and UK)

'A Disease's Spread Provokes Anxiety', *New York Times,* 8 August 1982.

'AIDS Disease: It's Nature Striking Back', *The New York Post*, 23 May 1983.

'AIDS lifeline for addicts who risk death for a fix', *The Guardian,* 13 September 1988.

'AIDS Takes US Path', *The Guardian*, 21 February 1984.

'A.M.A. Assails Decision of Justice Dept. on AIDS', *The New York Times,* 12 July 1986.

'A New Plague Hits the World', *The Daily Mail,* 26 April 1983.

'Bennett, Koop Settle Dispute: Education Chief Insisted Moral Values Were Being Ignored', *Los Angeles Times,* 31 January 1987.

'Body and Soul: Fowler's Blood Money', *The Guardian*, 11 May 1983.

'Congress Overrides Veto: Bill with AIDS Funding is Approved', *The Advocate,* 14 October 1982.

'Dr. Koop's Decent AIDS Report', *The New York Times,* 25 October 1986.

'Drugs and AIDS top risks facing young people', *The Guardian,* 18 May 1989.

'Experts On AIDS Urge More Testing On Optional Basis', *New York Times*, 11 May 1987.

'Extra £30m could have kept out AIDS', *The Guardian*, 3 May 1983.

'Four Infected by AIDS Blood', *The Guardian,* 20 November 1984.

'Gay Plague Sets Off Panic', *The Observer*, 26 June 1983.

'Insensitive', *Washington Post,* 11 December 1982.

'London Gay Plague Alert', *The Observer,* 6 June 1983.

'Needle Exchanges "needed to contain the spread of AIDS", *The Times,* 20 February 1988.

'New Homosexual Disorder Worries Health Officials', *The New York Times*, 11 May 1982.

'No Defence Against Gay Disease', *The Observer*, 6 November 1982.

'Ruling on AIDS Provoking Dismay', *The New York Times*, 27 June 1986.

'Senate Panel OKs Gay Health Funding', *The Advocate,* 16 September 1982.

'Sharp Difference Between Victims Their and in the US. Study Hopes to Uncover Why Zaire Leads Africa in AIDS Cases', *The Los Angeles Times,* 22 February 1985.

'Thousands of British Gays Have Symptoms of AIDS', *The Observer*, 7 August 1983.

'The Spend-Up', *The Atlantic,* July 1986.

'US Blood Caused AIDS', *The Guardian*, 8 November 1983.

'US Blood Products Face Ban in AIDS Scare', *The Guardian*, 2 May 1983.

'Walking Through a Moral Minefield', *The Times,* 9 July 1989.

Reagan Presidential Library and Museum

Digital Archive

Reagan Presidential Library and Museum, R. Reagan, 'Address to the Nation on the Campaign Against Drug Abuse', [https://www.reaganlibrary.gov/archives/speech/address-nation-campaign-against-drug-abuse], accessed 22 March 2024.

Reagan Presidential Library and Museum, Reagan, 'A Union of Individuals', [https://www.reaganlibrary.gov/archives/speech/1988-legislative-and-administrative-message-union-individuals], accessed 22 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'Inaugural Address 1981', 20 January 1981, [https://www.reaganlibrary.gov/archives/speech/inaugural-address-1981], accessed 15 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'Informal Exchange with Reporters in Philadelphia, Pennsylvania', 1 April 1987, [https://www.reaganlibrary.gov/archives/speech/informal-exchange-reporters-philadelphia-pennsylvania], accessed 15 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'Message to Congress on "A Quest for Excellence", 27 January 1987, [https://www.reaganlibrary.gov/archives/speech/message-congress-quest-excellence], accessed 15 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'Message to the House of Representatives Returning Without Approval a Fiscal Year 1982 Supplemental Appropriations Bill", 28 August 1982, [https://www.reaganlibrary.gov/archives/speech/message-house-representatives-returning-without-approval-fiscal-year-1982], accessed 15 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'President Reagan's Radio Address on Family Values', 20 December 1986, [https://www.reaganlibrary.gov/archives/speech/radio-address-nation-family-values], accessed 15 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'Proclamation 5709 – AIDS Awareness and Prevention Month, 1987', 29 September 1987, [https://www.reaganlibrary.gov/archives/speech/proclamation-5709-aids-awareness-and-prevention-month-1987], accessed 15 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'Remarks at a Luncheon for Members of the College of Physicians in Philadelphia, Pennsylvania', 1 April 1987, [https://www.presidency.ucsb.edu/documents/remarks-luncheon-for-members-the-college-physicians-philadelphia-pennsylvania], accessed 15 March 2024.

Reagan Presidential Library and Museum, R. Reagan, 'Remarks at the American Foundation for AIDS Research Awards Dinner', 31 May 1987, [https://www.reaganlibrary.gov/archives/speech/remarks-american-foundation-aids-research-awards-dinner], accessed 2 May 2023.

Reagan Presidential Library and Museum, R. Reagan, 'Statement on the Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic', [https://www.reaganlibrary.gov/archives/speech/statement-report-presidential-commission-human-immunodeficiency-virus-epidemic], accessed 22 March 2024.

Reagan Presidential Library and Museum, R. Reagan, '1988 Legislature and Administrative Message: A Union of Individuals', [https://www.reaganlibrary.gov/archives/speech/1988-legislative-and-administrative-message-union-individuals], accessed 22 March 2024.

Reagan Presidential Library and Museum

Physical Archive

HE001 073473, Reagan Presidential Library and Museum, Anonymous, 'Handwritten Letter to President Reagan', 5 April 1982.

HE001 073473, Reagan Presidential Library and Museum, M. Krim, 'Forwarded Letter to President Reagan', 5 July 1983.

HE001 073473, Reagan Presidential Library and Museum, R. Reagan, 'President Reagan's Reply to Dr Krim', 5 August 1983.

HE001 073473, Reagan Presidential Library and Museum, R. Woodworth, 'Revised Draft of President Reagan's Response to Dr Krim', 11 July 1983.

HE001 133599, Reagan Presidential Library and Museum, E. N. Brandt Jr, 'Statement by Edward N Brandt Jr, MD. Assistant Secretary of Health', 24 May 1983.

HE001 310235, Reagan Presidential Library and Museum, Unknown, 'Comments Concerning the Outcome of the International Conference on AIDS', 26 April 1985.

HE001 345231, Reagan Presidential Library and Museum, W. Dowdle, 'Reply to Charlotte Dearien', October 1985.

HE001 382833, Reagan Presidential Library and Museum, W. L. Ball, 'Letter to OMB – James Miller', 6 February 1986.

HE001 383452, Reagan Presidential Library and Museum, J. C. Whitehead, 'Letter to OMB – James Miller', 21 March 1986.

HE001 406504, Reagan Presidential Library and Museum, A. H. Kingon, 'Memo to the President – Koop Report', 1 October 1986.

HE001 408924, Reagan Presidential Library and Museum, H. F. Albert, 'Letter to the President on the Department of Justice ruling on firing employees with AIDS', 3 July 1986.

HE001 438058, Reagan Presidential Library and Museum, J. Warner, 'Letter to John A. Svahn', 1 August 1986.

HE001 464630, Reagan Presidential Library and Museum, O. Bowen, 'HHS Report on AIDS', 18 March 1987.

HE001 466266, Reagan Presidential Library and Museum, G. Bauer, 'Memorandum to Howard H. Baker Jr', 13 May 1987.

HE001 470299, Reagan Presidential Library and Museum, R. M. Kruger, 'AIDS Briefing Paper for the President', 4 February 1987.

HE001 474611, Reagan Presidential Library and Museum, N. Risque, 'Memorandum on the American Medical Association's position on AIDS Testing', 1 July 1987.

HE001 475117, Reagan Presidential Library and Museum, C. E. Koop, 'Letter to Governor Sununu on AIDS Testing for Marriage Licenses', 13 April 1987.

HE001 477640, Reagan Presidential Library and Museum, J. A. Howard, 'A Sounder Anti-AIDS Option', 8 April 1987.

HE001 477640, Reagan Presidential Library and Museum, J. A. Howard, 'Letter to the President about AIDS', 23 April 1987.

HE001 477640, Reagan Presidential Library and Museum, R. Reagan, 'Letter to Dr John A Howard About AIDS', 6 May 1987.

HE001 430274, Reagan Presidential Library and Museum, Unknown, 'Memo – Department of Justice Ruling on AIDS Federal Employment', 23 June 1986.

Sue Daoulas Files (AIDS 1:1), Reagan Presidential Library and Museum, 'AIDS Household Mailout – Timetable', 14 September 1988.

Sue Daoulas Files (AIDS 1:1), Reagan Presidential Library and Museum, I. D. MacDonald, 'Memorandum to the President: Report of the Presidential Commission on the Human Immunodeficiency Virus (HIV) Epidemic', 28 July 1988.

Sue Daoulas Files (AIDS 2:1), Reagan Presidential Library and Museum. W. Winkenwerder, 'Preliminary Results of the HCFA Survey of Total Federal AIDS Expenditure', 11 August 1988.

Sue Daoulas Files (AIDS 3:1), Reagan Presidential Library and Museum, C. E. Koop, 'The Surgeon General's Report on Acquired Immunodeficiency Syndrome', October 1986.

Sue Daoulas Files (AIDS 3:1), Reagan Presidential Library and Museum, P. J. Fischinger, 'Meetings on Needle Exchange and Bleach Distribution Programs', 11 May 1988.

Sue Daoulas Files (AIDS II 1:1), Reagan Presidential Library and Museum, 'Understanding AIDS', May 1988.

Scientific Papers (US and UK)

Advisory Council on the Misuse of Drugs, *AIDS and Drug Misuse* (1988).

Centres for Disease Control, 'Acquired Immune Deficiency Syndrome (AIDS) Weekly Surveillance Report', (December 1983), pp. 1-5.

Centres for Disease Control, 'Acquired Autoimmune Deficiency (AIDS) Weekly Surveillance Report', (December 1984), pp. 1-3.

Centres Disease Control, 'Acquired Immunodeficiency Syndrome (AIDS) Weekly Surveillance Report', (December 1985), pp. 1-3.

Centres for Disease Control, 'AIDS Weekly Surveillance Report', (December 1986), pp. 1-5.

Centres for Disease Control, 'AIDS Weekly Surveillance Report', (December 1987), pp. 1-6.

Centres for Disease Control, ‘Kaposi’s Sarcoma (KS), Pneumocystis Carinii Pneumonia (PCP), And Other Opportunistic Infections (OI): Cases Reported to CDC as of July 8, 1982’, (July 1982), pp. 1-2.

Centres for Disease Control, ‘Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations’, *Morbidity and Mortality Weekly Report,* 4:32 (March 1983), pp. 101-103.

Ehrenkranz. N. J. et al, ‘Epidemiological Notes and Reports: Pneumocystis Carinii Pneumonia Amongst Persons with Haemophilia A’, *Morbidity and Mortality Weekly Report,* 31:27 (July 1982), pp. 365-367.

Gottlieb. M. S, et al, ‘Pneumocystis Pneumonia– Los Angeles’, *Morbidity and Mortality Weekly Report,* 30 (June 1981), pp. 250-252.

Hensley. G. T. et al, ‘Opportunistic Infections and Kaposi’s Sarcoma Among Haitians in the United States’, *Morbidity and Mortality Weekly Report,* 31:26 (July 1982), pp. 353-354.

Hospital Infections Program (CDC-NIH), ‘Current Trends Acquired Immune Deficiency Syndrome (AIDS): Precautions for Clinical and Laboratory Staff’, *Morbidity and Mortality Weekly Report,* 31:43 (November 1982), pp. 577-580.

Piot. P, et al, ‘acquired immunodeficiency syndrome in a Heterosexual Population in Zaire’, *The Lancet,* 324:8394 (July 1984), pp. 65-69.

The National Archives

Home and Social Affairs Committee Sub-Committee on AIDS

CAB/134/5005, The National Archive, Home and Social Affairs Committee Sub-Committee on AIDS Meeting, 7 November 1986.

CAB/134/5005, The National Archive, Home and Social Affairs Committee Sub-Committee on AIDS Meeting, 11 November 1986.

CAB/134/5005, The National Archive, Home and Social Affairs Committee Sub-Committee on AIDS Meeting, 18 November 1986.

CAB/134/5005, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 3 December 1986.

CAB/134/5135, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 14 January 1987.

CAB/134/5135, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 4 February 1987.

CAB/134/5135, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 2 July 1987.

CAB/134/5135, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 22 July 1987.

CAB/134/5135, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 30 September 1987.

CAB/134/5135, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 10 November 1987.

CAB/134/5253, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 17 February 1988.

CAB/134/5253, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 19 May 1988.

CAB/134/5253, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 22 June 1988.

CAB/134/5253, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 19 July 1988.

CAB/134/5253, The National Archive, Home and Social Affairs Committee Sub-Committee Meeting, 23 November 1988.

The National Archive

Official Committee on AIDS

CAB/134/5006, The National Archive, Official Committee on AIDS, 7 November 1986.

CAB/134/5137, The National Archive, Official Committee on AIDS, 9 January 1987.

CAB/134/5137, The National Archive, Official Committee on AIDS, 14 January 1987.

CAB/134/5137, The National Archive, Official Committee on AIDS, 3 February 1987

CAB/134/5137, The National Archive, Official Committee on AIDS, 16 March 1987.

The National Archive

PREM19 – Thatcher Cabinet Papers (AIDS)

PREM19-1863, The National Archive, ‘ABRC Advice on Distribution of Science Budget’, 29 November 1985.

PREM19-1863, The National Archive, ‘Acquired Immune Deficiency Syndrome’, 28 August 1985.

PREM19-1863, The National Archive, ‘Acquired Immune Deficiency Syndrome (AIDS)’, 25 September 1985.

PREM19-1863, The National Archive, ‘Acquired Immune Deficiency Syndrome (AIDS)’, 1 October 1985.

PREM19-1863, The National Archive, ‘Acquired Immune Deficiency Syndrome (AIDS)’, 8 October 1985.

PREM19-1863, The National Archive, ‘AIDS’, 6 November 1985.

PREM19-1863, The National Archive, ‘AIDS’, 2 December 1985.

PREM19-1863, The National Archive, ‘AIDS’, 5 December 1985.

PREM19-1863, The National Archive, ‘AIDS’, 25 February 1986.

PREM19-1863, The National Archive, ‘AIDS’, 3 March 1986.

PREM19-1863, The National Archive, ‘AIDS’, 5 March 1986.

PREM19-1863, The National Archive, ‘AIDS’, 6 March 1986.

PREM19-1863, The National Archive, ‘AIDS’, 11 March 1986.

PREM19-1863, The National Archive, ‘AIDS’, 21 October 1986.

PREM19-1863, The National Archive, ‘AIDS’, 7 November 1986.

PREM19-1863, The National Archive, ‘AIDS’, 10 November 1986.

PREM19-1863, The National Archive, ‘AIDS’, 28 November 1986.

PREM19-1863, The National Archive, ‘AIDS – Bearpark’, 7 November 1986.

PREM19-1863, The National Archive, ‘AIDS – Education’, 3 September 1986.

PREM19-1863, The National Archive, ‘AIDS: How To Keep Yourself Safe’, August 1985.

PREM19-1863, The National Archive, ‘AIDS: Important New Advice for Blood Donors’, (1985).

PREM19-1863, The National Archive, ‘AIDS – Ministerial Broadcast’, 30 December 1986.

PREM19-1863, The National Archive, ‘AIDS – Public Education’, 21 August 1986.

PREM19-1863, The National Archive, ‘AIDS – Public Education’, 10 September 1986.

PREM19-1863, The National Archive, ‘AIDS – Willetts’, 7 November 1986.

PREM19-1863, The National Archive, ‘Cabinet Office: AIDS’, 3 October 1985.

PREM19-1863, The National Archive, ‘Controlling the Spread of Acquired Immune Deficiency Syndrome (AIDS)’, 26 February 1986.

PREM19-1863, The National Archive, ‘Diary Meeting – AIDS’, 26 September 1985.

PREM19-1863, The National Archive, ‘HTLV3 infection, the AIDS epidemic and the control of its spread in the UK’, June 1985.

PREM19-1863, The National Archive, ‘Letter from Lord Patten to the Office of the Prime Minister’, 28 August 1985.

PREM19-1863, The National Archive, ‘Prime Minister: Acquired Immune Deficiency Syndrome’, 25 September 1985.

PREM19-1863, The National Archive, ‘Prime Minister: AIDS’, 25 September 1985.

PREM19-1863, The National Archive, ‘Screening for AIDS’, 17 October 1986.

PREM19-1863, The National Archive, ‘Some Facts About AIDS’, (1985).

PREM19-1863, The National Archive, ‘The Fight Against AIDS – More Government Money’, 25 September 1985.

PREM19-2775, The National Archive, ‘Acquired Immunodeficiency Syndrome: Background Information’, 14 January 1987.

PREM19-2775, The National Archive, H. Booth, ‘AIDS’, 16 January 1987.

PREM19-2775, The National Archive, H. Booth, ‘AIDS Film for 13–16-Year-Old Schoolchildren H (A) Today’, 2 July 1987.

PREM19-2775, The National Archive, I. Jakobovits, ‘Memorandum to the Prime Minister on AIDS’, 11 March 1987.

PREM19-2775, The National Archive, J. Moore, ‘Compensation for Haemophiliacs’, 24 September 1987.

PREM19-2775, The National Archive, J. Moore, ‘EAGA Report on HIV-Infected Health Care Workers’, 25 March 1988.

PREM19-2775, The National Archive, J. Moore, ‘Government Response to the Social Service Committee Report on AIDS’, 18 January 1988.

PREM19-2775, The National Archive, J. O’Sullivan, ‘Doctors Infected with HIV’, 23 November 1987.

PREM19-2775, The National Archive, J. O’Sullivan, ‘Doctors with HIV Infection and AIDS’, 15 December 1987.

PREM19-2775, The National Archive, J. O’Sullivan, ‘Compensation for Haemophiliacs’, 2 November 1987.

PREM19-2775, The National Archive, M. Addison, ‘Prime Minister – H (A) Meeting Update’, 24 July 1987.

PREM19-2775, The National Archive, M. Thatcher, ‘Drafted Reply to Chief Rabbi Jakobovits’, 9 April 1987.

PREM19-2775, The National Archive, N. Wicks, ‘Doctors and AIDS’, 17 November 1987.

PREM19-2775, The National Archive, N. Wicks, ‘Minutes from Meeting about Doctors with AIDS’, 24 November 1987.

PREM19-2775, The National Archive, N. Wicks, ‘Doctors with HIV Infection and AIDS’, 18 December 1987.

PREM19-2775, The National Archive, T. Newton, ‘Compensation for Haemophiliacs’, 2 November 1987.

PREM19-2775, The National Archive, T. Newton, ‘Doctors Infected by HIV’, 19 November 1987.

PREM19-2775, The National Archive, W. Whitelaw, ‘Compensation for Haemophiliacs’, 11 November 1987.

PREM19-2775, The National Archive, W. Whitelaw, ‘Doctors with HIV Infection and AIDS’, 9 December 1987.

Secondary Sources

Article

Bayly. C. A et al, 'AHR Conversation: On Transnational History', *American Historical Review,* 5 (December 2006), pp. 1441-1464.

Bell. J, 'Rethinking the "Straight State": Welfare Politics, Health Care, and Public Policy in the Shadow of AIDS', *The Journal of American History,* 104:4 (March 2018), pp. 931-952.

Berridge, V. 'AIDS and the Rise of the Patient? Activist Organisation and HIV/AIDS in the UK in the 1980s and 1990s', *Medizin, Gesselschaft, und Geschichte*, 21 (2002), pp. 109-123.

Berridge. V and Strong. P, 'AIDS and the Relevance of History', *Social History of Medicine,* 4:1 (April 1991), pp. 129-138.

Berridge. V and Strong. P, 'AIDS in the UK: Contemporary History and the Study of Policy', *Twentieth Century British History,* 2:2 (1991), pp. 150-174.

Blankenship. K. M. et al, 'Black-White Disparities in HIV/AIDS: The Role of Drug Policy and the Corrections System', *Journal of Health Care for the Poor and Underserved,* 16:4 (November 2005), pp. 140-146.

Brady. W, Crockett. M. J and Van Bavel. J. J, 'The MAD Model of Moral Contagion: The Role of Motivation, Attention, and Design in the Spread of Moralized Content Online', *Perspectives on Psychological Science,* 15:4 (July 2020), pp. 978-1010.

Brier. J et al, 'Interchange: HIV/AIDS and U.S. History', *The Journal of American History,* 104:2 (September 2017), pp. 434-444.

Brinkley. A, 'Conservatism as a Growing Field of Scholarship', *The Journal of American History,* 98:3 (December 2011), pp. 748-751.

Brinkley. A, 'The Problem of American Conservatism', *The American Historical Review,* 99:2 (April 1994), pp. 409-429.

Burgess. A, 'The Development of Risk Politics in the UK: Thatcher's "Remarkable" but forgotten "Don't Die of Ignorance" AIDS Campaign', *Health, Risk and Society,* 19:5-6 (September 2017), pp. 227-245.

Closen. M, Gamrath. R and Hopkins. D, 'Mandatory Premarital HIV Testing: Political Exploitation of the AIDS Epidemic', *Tulane Law Review,* 69:1 (1994), pp. 71-115.

Colbrook. S, 'Why Pandemics Matter to the History of U.S. State Development', *Modern American History,* 4 (2021), pp. 315-333.

Colby. D and Baker. D, 'State Policy Response to the AIDS Epidemic', *Publius: The Journal of Federalism,* 18:3 (Summer, 1988), pp. 113-30.

Cook. M, 'Archives of Feeling": the AIDS Crisis in Britain 1987', *History Workshop Journal,* 83 (March 2017), pp. 51-78.

Conrad and K. K. Barker, 'The Social Construction of Illness: Key Insights and Policy Implications', *Journal of Health and Social Behaviour,* 51 (S) (October 2010), pp, 67-79.

Day. P and Klein. R, 'Interpreting the Unexpected: The Case of AIDS Policy Making in Britain', *Journal of Public Policy,* 9:3 (July-September 1989), pp. 337-353.

Enns. C. Z, Diaz. L. C, and Bryant-Davis. T, 'Transnational Feminist Theory and Practice: An Introduction', *Women and Therapy,* 44:1 (July 2020), pp. 11-26.

Epstein. S, 'The Construction of Lay Expertise: AIDS Activism and the Forging of Credibility in the Reform of Clinical Trials', *Science, Technology and Human Values*, 20:4 (October 1995), pp. 408-437.

Fairchild. A. L and Tynan. E. A, 'Policies of Containment: Immigration in the Era of AIDS', *American Journal of Public Health*, 84:12 (December 1994), p. 2013.

Fox. D, 'AIDS and the American Health Polity: The History and Prospect of a Crisis of Authority', *The Milbank Quarterly,* 83:4 (November 2005), pp. 1-26. (Reprinted from the *Milbank Quarterly*, 64:1 (1986), pp. 7-33.)

Fox. D et al, 'The Power of Professionalism: Policies for AIDS in Britain, Sweden, and the United States', *Daedalus,* 118:2 Living with AIDS (Spring 1989), pp. 93-112.

Fox. D and Thomas. E. H, 'AIDS Cost Analysis and Social Policy', *Law, Medicine and Health Care*, 15:4 (Winter 1987/88), pp. 186-211.

Gibson. R. M, Waldo. D. R. and Levit. K. R, 'National Health Expenditures, 1982', *Health Care Financing Review,* 5:1 (Fall, 1983), pp. 1-31.

Gross. S. R. et al, 'Special Issue: Living with AIDS', *Daedalus,* 118:2 (Spring, 1989), pp. 1-201.

Gross. S. R. et al, 'Special Issue: Living with AIDS Part Two', *Daedalus,* 118:3 (Summer, 1989), pp. 1-254.

Gottlieb. M. S. et al, 'Pneumocystis Pneumonia – 1996 Editorial', *Morbidity and Mortality Weekly Report,* 45 (30 August 1996), pp. 729-733.

Hajjeh. R. A. et al, 'Toxic Shock Syndrome in the United States: Surveillance Update, 1979-1996', *Emerging Infectious Disease*, 5:6 (December 1999), pp. 808-810.

Ham. C, 'US and UK Health care: A Special Relationship? Money Can't Buy Satisfaction', *British Medical Journal,* 330 (March 2005), pp. 597-599.

Herek. G, 'AIDS and Stigma', *American Behavioural Scientist,* 42:7 (April 1999), pp. 1106-1116.

Hill. A. O, and Hill Jr. B. H, 'Marc Bloch and Comparative History', *The American Historical Review,* 85:4 (October 1980), pp. 828-846.

Hofstadter. R, 'The Paranoid Style in American Politics', *Harper's Magazine,* (November 1964), pp. 77-86.

Johns. C, 'The War on Drugs: Why the Administration Continues to Pursue a Policy of Criminalization and Enforcement', *Social Justice,* 18:4 (Winter 1991), pp. 147-165.

Koop. C. E, 'The Early Days of AIDS, As I Remember Them', *Annals of the Forum for Collaborative HIV Research,* 13:2 (March 2011), pp. 1-26.

Lassiter. M, 'Impossible Criminals: The Suburban Imperative of America's War on Drugs', *Journal of American History*, 102:1 (June 2015), pp. 126-140.

Lichtenstein. B, 'Drugs, Incarceration, and HIV/AIDS Among African American Men: A Critical Literature Review and Call to Action', *American Journal of Men's Health,* 3:3 (September 2009), pp. 252-264.

Mandelbaum. M, 'Some Forms and Uses of Comparative History', *American Studies International,* 18:2 (1980), pp. 19-34.

McKee. H. A and Porter. J. E, 'The Ethics of Archival Research', *College Composition and Communication*, 64:1 (September 2012), pp. 64-65.

McKeever. B. W, 'Public Relations and Public Health: The Importance of Leadership and Other Lessons Learnt from "Understanding AIDS" in the 1980s', *Public Relations Review,* 47 (December 2021), pp. 1-9.

McKinnon. D, 'Devolution, State Restructuring and Policy Divergence in the UK', *The Geographical Journal,* 181:1 (March 2015), pp. 47-56.

McLean. K, 'The Biopolitics of Needle Exchange in the United States', *Crit Public Health,* 21:1 (March 2011), pp. 71-79.

Mold. A, 'Framing Drug and Alcohol Use as a Public Health Problem in Britain: Past and Present', *Nordic Studies on Alcohol and Drugs,* 35:2 (April 2018), pp. 93-99.

Morrow. R, 'AIDS and Immigration: The United States Attempts to Deport a Disease', *The University of Miami Inter-American Law Review,* 20:1 (Autumn 1988), pp. 132-171.

National Centre for HIV, STD, and TB Prevention, 'HIV and AIDS --- United States, 1981 – 2000', *Morbidity and Mortality Weekly Report,* 50:21 (June 2001), pp. 430-434.

Padamsee. T, 'Fighting an Epidemic in Political Context: Thirty-Five Years of HIV/AIDS Policy Making in the United States', *Social History of Medicine,* 33:3 (December 2018), pp. 1001-1028.

Padamsee. T, 'The Politics of Prevention: Lessons from the Neglected History of US HIV/AIDS Policy', *Journal of Health Politics, Policy and Law,* 42:1 (February 2017), pp. 73-122.

Phillips-Fein. K, 'Conservatism: A State of the Field', *The Journal of American History,* 98:3 (December 2011), pp. 723-743.

Poirier. R, 'AIDS and Traditions of Homophobia', *Social Research,* 55:3 (Autumn 1988) In Time of Plague, pp. 461-475.

Quam. L and Smith. R, 'US and UK Health Care: A Special Relationship? What Can the UK and US Health Systems Learn From Each Other? *British Medical Journal,* 330:7490 (April 2005), pp. 530-533.

Reingold. A. A. et al, 'Toxic Shock Syndrome – United States', *Morbidity and Mortality Weekly Report,* 46 (June 1997), pp. 492-496.

Ron. A and Rogers. D. E, "AIDS in the United States: Patient Care and Politics", *Daedalus* 118, No 2 Living With AIDS, (Spring 1989), pp. 41-58.

Shanley. M. L, 'Review: Public Values and Private Lives: Cott, Davis, and Hartog on the History of Marriage Law in the United States', *Law and Social Inquiry,* 27:4 (Autumn 2002), pp. 923-940.

Shrage. L, 'African Americans, HIV, and mass incarceration', *Lancet,* 388 (14 July 2016), pp. E2-E3.

Skocpol. T and Somers. M, 'The Use of Comparative History in Macrosocial Inquiry', *Comparative Studies in Society and History,* 22:4 (October 1980), pp. 174-197.

Stimson. G. V, 'AIDS and Injecting Drug Use in the United Kingdom, 1987-1993: The Policy Response and the Prevention of the Epidemic', *Social Science & Medicine,* 41:5 (September 1995), pp. 699-716.

Stimson. G. V, 'British Drug Policies in the 1980s: A Preliminary Analysis and Suggestions for Research', *British Journal of Addiction*¸82:6 (May 1987), pp. 477-488.

Strang. J, 'AIDS and Drug Misuse in the UK – 10 Years on: Achievements, failings and new harm reduction opportunities', *Drugs: Education, Prevention and Policy,* 5:3 (1998), pp. 293-304.

Street. J, 'British Government Policy on AIDS: Learning Not To Die of Ignorance', *Parliamentary Affairs,* 41:1 (October 1988), pp. 490-507.

Tseng. A, Seet. J and Phillips. E. J, 'The Evolution of Three Decades of Antiretroviral Therapy: Challenges, Triumphs and the Promise of the Future', *British Journal of Clinical Pharmacology,* 79:2 (February 2015), pp. 182-194.

Wallace. W and Phillips. C, 'Reassessing the Special Relationship', *International Affairs,* 85:2 (March 2009), pp. 263-284.

Weston. J and Berridge. V, 'AIDS Inside and Out: HIV/AIDS and Penal Policy in Ireland and England & Wales in the 1980s and 1990s', *Social History of Medicine,* 33:1 (February 2020), pp. 247-267.

Zinberg. N. E, 'Social Policy: AIDS and Intravenous Drug Use', *Daedalus,* 118:3 Living With AIDS: Part 2 (Summer 1989), pp, 23-46.

Books

Agar. J, *Science Policy under Thatcher* (London 2019)

Baggott. R, *Public Health: Policy and Politics* (Basingstoke 2010).

Bell. J, *Beyond the Politics of the Closet: Gay Rights and the American State Since the 1970s* (Philadelphia 2021).

Berridge. V, *AIDS in the UK: The Making of Policy, 1981-1994* (Oxford 1996).

Brier. J, *Infectious Ideas: US Political Responses to the AIDS Crisis* (Chapel Hill, 2009).

Canaday. M, *The Straight State: Sexuality and Citizenship in Twentieth Century America* (Princeton/London 2009).

Curthoys. A, and Lake. M, *Connected Worlds: History in Transnational Perspective* (Canberra 2005).

Donnelly. M, *Sixties Britain: Culture, Society, and Politics* (Oxon 2013).

Epstein. S, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (Berkeley 1996)

Fowler. N, *AIDS: Don't Die of Prejudice* (London 2014).

Greenaway. J, et al, *Deciding Factors in British Politics: A Case Studies Approach* (London, 1992).

Ham. C, *Health Policy in Britain: Public Policy and Politics* (Basingstoke 1999).

King. D, *The New Right: Politics, Markets and Citizenship* (Basingstoke 1987).

Leveton. L. B et al, *HIV and the Blood Supply: An Analysis of Crisis Decisionmaking* (Washington 1995).

Lichtman. A. J, *White Protestant Nation: The Rise of the American Conservative Movement* (New York 2008).

Lyon. J. F, *America in the British Imagination: 1945 to the Present* (New York 2013)

McKie. R, *PANIC: The Story of AIDS* (Wellingborough, 1986).

Morgan. I, *Reagan: American Icon* (London 2016).

Patterson. J, *Restless Giant: The United States from Watergate to Bush V. Gore* (New York 2005).

Patton. C, *Sex and Germs: The Politics of AIDS* (Boston 1985).

Schaller. M, *Reckoning with Reagan: America and Its President in the 1980s* (New York 1992).

Shilts. R, *And the Band Played On: Politics, People, and the AIDS Epidemic* (1987),

Slocock. C, *People Like Us: Margaret Thatcher and Me* (London 2019).

Sontag. S, *AIDS and its Metaphors* (New York 1989).

Tuohy. C, *Remaking Policy: Scale, Pace and Political Strategy in Health Care Reform,* (Toronto 2018).

Edited Collections

Berger. S, Feldner. H, and Passmore. K (eds), *Writing History: Theory and Practice* (Third Edition) (London 2020)

Berridge. V and Strong. P (eds), *AIDS and Contemporary History* (Cambridge, 1993).

Brickman. B. J, Jermyn. D, and Trost. T. L (eds), *Love Across the Atlantic: US-UK Romance in Popular Culture* (Edinburgh 2020).

Haider-Wilson. B, Godsey. W. D, and Mueller. W (eds), *International History in Theory and Practice* (Vienna 2017).

Saad-Filho. A and Johnston. D, (eds), *Neoliberalism* (London 2005).

Park. A et al (eds), *British Social Attitudes 30* (London, 2013).

Randolph. S (eds), 'Foreign Relations of the United States, 1981-1988, Volume XLI, Global Issues II', *Office of the Historian*, (Bureau of Public Affairs, November 2017).

Ziemann. B and Dobson. M (eds), *Reading Primary Sources: The Interpretation of Texts from Nineteenth and Twentieth Century History* (Second Edition) (Oxon/New York 2020).

Internet Sources

'Defence Spending', *Institute for Fiscal Studies,* [https://ifs.org.uk/defence-spending], accessed 29 February 2024.

'Homosexuality', *Gallup*, 11 September 2002, [https://news.gallup.com/poll/9916/homosexuality.aspx], accessed 22 February 2024.

Horlock. C, 'Enzyme-linked immunosorbent assay (ELISA), *British Society of Immunology,* [https://www.immunology.org/public-information/bitesized-immunology/experimental-techniques/enzyme-linked-immunosorbent-assay], accessed 22 December 2023.

'Interview with Margaret Heckler', *PBS: Frontline,* 11 January 2006, [https://www.pbs.org/wgbh/pages/frontline/aids/interviews/heckler.html], accessed 5 October 2023.

'Legionella (Legionnaires Disease and Pontiac Fever)', Centres for Disease Control and Prevention, [https://www.cdc.gov/legionella/about/history.html], accessed 12 January 2023.

Morgan. N, 'The Heroin Epidemic of the 1980s and 1990s and its effect on crime trends – then and now', *Home Office Research Report*, 79 (July 2014).

'Our History: 1980s', *The Terrence Higgins Trust,* [https://www.tht.org.uk/our-work/about-our-charity/our-history/1980s], accessed 13 November 2023.

'Party Divisions in the House of Representatives', [https://history.house.gov/Institution/Party-Divisions/Party-Divisions/| US House of Representatives: History, Art & Archives], accessed 26 January 2024.

'Proposition 6 (The Briggs Initiative): Annotated', *JSTOR Daily,* 28 October 2022, [https://daily.jstor.org/proposition-6-the-briggs-initiative-annotated/], accessed 21 February 2024.

'US Senate Party Division', [https://www.senate.gov/history/partydiv.htm], accessed 26 January 2024.

'Written Statement of Lord Glenarthur', *Infected Blood Inquiry*, 9 July 2021, [https://www.infectedbloodinquiry.org.uk/evidence/written-statement-lord-simon-glenarthur], accessed 1 March 2024.

'Your Rights Under Section 504 of the Rehabilitation Act (1973)', *Department of Health and Human Service: Office of Civil Rights,* June 2006, p. 1. [https://www.hhs.gov/civil-rights/for-

individuals/disability/section-504-rehabilitation-act-of-1973/index.html], accessed 11 March 2024.