
ARTICLE

OF STARS AND PROPER ALIGNMENT: SCANNING THE HEAVENS FOR THE FUTURE OF HEALTH CARE REFORM

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INTRODUCTION

On March 23, 2010, the United States took a giant step toward achieving universal health care, an elusive goal it has pursued for almost a century. The legislative fight was bitter and divisive, pitting Republicans against Democrats. It revealed, as effectively as any issue in recent years has, how difficult it is to achieve bipartisan cooperation when tackling America’s biggest problems. Nonetheless, the product of that contest, the Patient Protection and Affordable Care Act¹—

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¹ Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.).

referred to herein as the Affordable Care Act, the Act, or, as its detractors call it, “Obamacare”—fed the hopes of many Americans that we could finally come to recognize an adequate level of health care as a right of all our citizens and thus shake the dubious distinction the United States has long held of being the only major, industrialized nation on earth that has not committed to this noble goal.²

But as this is written, in March 2011, the Affordable Care Act’s future, and the future of health care reform more broadly, is far from certain. Two federal district courts have ruled that what many regard as the Act’s keystone provision, the individual mandate to purchase health insurance,³ is unconstitutional.⁴ The first court concluded that the offending provision can be excised from the law and the remainder left intact,⁵ the second held that the provision is so integral to the overall legislative scheme that the entire law must fail.⁶ Since three other district courts have already rejected challenges to the Act’s constitutionality,⁷ it is virtually certain that the Supreme Court will ultimately review the Act. If the case takes the traditional route through the courts of appeals, then it should reach the Supreme Court around the time of the national elections in November 2012.⁸ On a parallel

² See Bruce Vladeck, *Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future*, 93 AM. J. PUB. HEALTH 16, 16 (2003) (“We used to say that the United States shared with South Africa the distinction of being the only industrialized nation without universal health insurance. Now we don’t even have South Africa to point to.”).

³ See § 1501, 42 U.S.C.A. § 18091 (West Supp. 1B 2010) (imposing tax penalties for nonexempt individuals who do not obtain health insurance).

⁴ *Florida ex rel. Bondi v. U.S. Dep’t of Health & Human Servs.*, No. 10-0091, 2011 WL 285683, at *33 (N.D. Fla. Jan. 31, 2011); *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 782 (E.D. Va. 2010).

⁵ See *Cuccinelli*, 728 F. Supp. 2d at 789-90 (severing section 1501 and its related provisions from the statute, but declining to go further given the lack of evidence on record as to which sections of the statute could not survive independently of section 1501).

⁶ See *Bondi*, 2011 WL 285683, at *39 (finding it “evident” that Congress neither intended nor believed that the other provisions of the Affordable Care Act would stand independently from section 1501).

⁷ *Mead v. Holder*, No. 10-0950, 2011 WL 61139 (D.D.C. Feb. 22, 2011); *Liberty Univ. v. Geithner*, No. 10-0015, 2010 WL 4860299, at *11 (W.D. Va. Nov. 30, 2010); *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 891-95 (E.D. Mich. 2010).

⁸ For an analysis of the how the Supreme Court may decide the case, see *infra* note 105 and accompanying text. Virginia Attorney General Kenneth Cuccinelli petitioned the Supreme Court for expedited review, which would have bypassed review by the Court of Appeals for the Fourth Circuit. See Brief for Petitioner at 13 *Virginia ex rel. Cuccinelli v. Sebelius*, No. 10-1014 (U.S. Feb. 8, 2011), 2011 WL 465746, at *13; see also Press Release, Attorney General of Virginia, Attorney General Cuccinelli Announces He Will Seek Expedited Review of Virginia Health Care Lawsuit in the Supreme

track, the newly installed 112th Congress has begun to consider a repeal of the law.⁹ Despite the formidable obstacles that a repeal attempt would have to overcome—unlikely passage in the Senate¹⁰ and a likely presidential veto—the winds of opposition are blowing so strongly that a repeal is at least within the realm of possibility. Setting aside these challenges and assuming the Affordable Care Act survives, it is an open question whether the Act can deliver on its very ambitious promise to secure basic health care coverage for almost our entire population¹¹ without bankrupting the nation's health care financing system or reducing the quality of care those who are now covered enjoy. Clearly the road to universal health care is a difficult one for the United States. Like previous trips, this one may again prove to be a road to nowhere.¹²

What is it that makes the United States so different in regard to universal health care? Why have other nations been able to make the commitment while we, despite our impressive wealth and high social

Court (Feb. 3, 2011), *available at* http://www.oag.state.va.us/PRESS_RELEASES/Cuccinelli/020311_Healthcare_Expedited.html. On April 25, 2011 the Supreme Court denied certiorari. *Virginia ex rel. Cuccinelli v. Sebelius*, No 10-1014 (U.S. Apr. 25, 2011), 2011 WL 477048 at *1.

⁹ On January 19, 2011 the House passed, by a vote of 245–189, H.R. 2, 112th Cong. (2011), “[a]n act to repeal the job-killing health care law and health care-related provisions in the Health Care and Education Reconciliation Act of 2010.” See Final Vote Results for Roll Call 14, U.S. HOUSE OF REPRESENTATIVES (Jan. 19, 2011), <http://clerk.house.gov/evs/2011/roll014.xml>. For a discussion of the results of the repeal effort in the House, see Catalina Camia, *House Passes Repeal of Health Care Law*, USA TODAY ON POLITICS BLOG (Jan. 19, 2011, 6:49 PM), <http://www.usatoday.com/communities/onpolitics/post/2011/01/house-health-care-repeal-1/1>.

¹⁰ The Senate rejected the House bill on February 2, 2011 by a vote of 51–47. See U.S. Senate Roll Call Votes 112th Congress—1st Session, U.S. SENATE (Feb. 2, 2011), http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=112&session=1&vote=00009. See also Donna Smith & Thomas Ferraro, *Senate Rejects Bid to Repeal Healthcare Law*, REUTERS, Feb. 2, 2011, *available at* <http://www.reuters.com/article/2011/02/02/us-usa-healthcare-congress-idUSTRE70O62D20110202> (documenting the state of the political and legal battles being fought over the Affordable Care Act).

¹¹ The Congressional Budget Office (CBO) estimated in March 2010 that the Affordable Care Act would “reduce the number of nonelderly people who are uninsured by about 32 million, leaving about 23 million nonelderly residents uninsured (about one-third of whom would be unauthorized immigrants)” by 2019. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives, 9 (Mar. 20, 2011), *available at* <http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf>. The CBO also estimated that the Act “would produce a net reduction in federal deficits of \$138 billion over the 2010–2019 period as result of changes in direct spending and revenues.” *Id.* at 2.

¹² See JACOB S. HACKER, *THE ROAD TO NOWHERE: THE GENESIS OF PRESIDENT CLINTON’S PLAN FOR HEALTH SECURITY* (1997) (examining the complex of reasons why the Clintons’ attempt to pass their Health Security Act in the early 1990s failed).

ideals, have not been able to get there? Some five years ago, before the current health care reform contest got underway, I undertook a study of five other nations around the world—Argentina, France, Italy, Singapore, and Japan—to understand how each came to commit to universal health care. For reasons both obvious and not, this is a commitment of the greatest magnitude and seriousness, one from which retreat is close to impossible; thus it is a commitment not to be made lightly. It is a commitment the United States has not been able—or at least not willing—to make despite numerous attempts.¹³ Some—including President Obama as he campaigned for health care reform—have said that the stars have to be in proper alignment for a nation to commit to universal health care.¹⁴ So I set out in 2005 to discover what the “stars” are and what “proper alignment” would look like—in other words, what are the factors and elements that have to be in place in a nation for it to undertake the monumental commitment to assure that all its citizens have an adequate level of health care? My starry-eyed goal was to help the United States figure out how to get its stars aligned and finally take the plunge. I hoped that my insights might feed into the policy process and help the proponents of health care reform devise an approach and strategy that would make their campaign more effective and, ultimately, successful.

My work has taken place through an interesting and eventful period in U.S. history, one that health policy commentators, and historians generally, will be dissecting for years, perhaps decades, to come. It has seen Hillary Clinton, whom many regarded as the front-runner to secure the Democratic nomination in the 2008 presidential race, pass the baton to Barack Obama. In that shift, many liberals gradually

¹³ See Karen S. Palmer, Remarks at the Meeting of the Physicians for a National Health Program: A Brief History: Universal Health Care Efforts in the US (Spring 1999), available at http://www.pnhp.org/facts/a_brief_history_universal_health_care_efforts_in_the_us.php?page=all (describing the history of attempts to reform the U.S. health care system, from the late nineteenth century to the Medicare/Medicaid reforms of the 1960s).

¹⁴ See President Barack Obama, News Conference by the President (July 22, 2009), available at http://www.whitehouse.gov/the_press_office/News-Conference-by-the-President-July-22-2009 (“And the fact that we have made so much progress where we’ve got doctors, nurses, hospitals, even the pharmaceutical industry, AARP, saying that this makes sense to do, I think means that the stars are aligned and we need to take advantage of that.”); see also President Barack Obama, Statement by the President after Meeting with House Democratic Leadership (May 13, 2009) [hereinafter Obama, Statement], available at http://www.whitehouse.gov/the_press_office/Statement-by-the-President-after-meeting-with-House-Democratic-leadership (“That’s why we’ve got to get this done. We’ve got to get it done this year. We’ve got to get it done this year—both in the House and in the Senate. And we don’t have any excuses; the stars are aligned.”).

reset their dreams, sometimes with great difficulty, from wanting to see history made by electing the first female President of the United States to instead electing the first black President. It has seen Ted Kennedy, “the lion of the Senate,” who carried the torch of universal health care for decades, pass from the scene with a final, impassioned, noble push for his dream.¹⁵ And at the end of the contentious debates discussed above, this period has seen the most significant and far-reaching health care reforms since the passage of Medicare and Medicaid almost half a century ago. But to use the language of the so-called “Chinese curse,”¹⁶ the “interesting times” are far from over. Obamacare is squarely in the Republicans’ crosshairs, and Congress has joined the battle. The game is still on!

The primary objective of this Article remains basically the same as when I started my research: to set out my observations about what the “stars” and their “proper alignment” are, to provide a framework for understanding the factors that go into a nation’s decision to commit to universal health care and ultimately, to better understand America’s prospects for finally achieving universal health care. The context for my work, however, has changed, and changed again. I originally hoped my work might help lead to the passage of health care reform. When the Affordable Care Act was enacted, I reset my objective to offering an analysis of how we achieved this historic social goal. Now, with the Act under intense fire, my objective has shifted again, to offering a perspective that can be used to defend the tenuous gains made in 2010 and help our nation sustain the commitment it has made to the lofty goal of health care for all Americans.

What are the “stars”—the key factors that set the context for a nation’s movement toward providing universal health care? In my view, there are six factors, not mutually exclusive; they overlap and interact substantially. They are: economics, politics, history, infrastructure, demographics, and national character. A brief overview of each follows.

¹⁵ See Liza Berger, *Healthcare to Miss Kennedy*, MCKNIGHT’S LONG TERM CARE NEWS (Aug. 26, 2009), <http://www.mcknights.com/healthcare-to-miss-kennedy/article/150173> (describing Senator Kennedy’s involvement with the CLASS Act, a long-term disability program that he promoted until his death).

¹⁶ The curse, “May you live in interesting times,” has never been conclusively attributed to any Chinese source. See Gary Martin, *The Meaning and Origin of the Expression: May You Live in Interesting Times*, PHRASE FINDER, <http://www.phrases.org.uk/meanings/may-you-live-in-interesting-times.html> (last visited Mar. 15, 2011).

I. ECONOMICS

What is required of a nation's economic situation in order to seriously contemplate the commitment to universal health care? Health care for all can be an expensive proposition and it is a commitment that, once made, must be maintained in both good times and bad. One might expect, then, that a nation would choose to shoulder this burden only when its economic situation is sound and the nation has been in that enviable position long enough to feel that prosperity is a steady state—a sustainable future reality. Looking at the United States' own history supports such a theory.

Medicare and Medicaid were passed in 1965¹⁷ after almost two decades of relatively unbroken post-World War II prosperity. When President Lyndon Johnson called on the nation to commit to providing mainstream health care for the elderly (Medicare) and the poor (Medicaid), he was not asking Americans to reach into their pockets and give up some of their limited funds to help support the less fortunate. Rather, he was saying, in effect, "If history holds, next year will be better than this year. I'm asking you to commit a portion of next year's *incremental gain* so that the most vulnerable of our citizens are assured a decent standard of health care services. It is the least a nation as wealthy as ours can do."¹⁸ If one draws from this statement that Americans will commit to social equity programs only when they are feeling prosperous—and when they have felt that way for long enough that their memory of less fortunate times is dim—then it is unlikely the United States will make a sustainable commitment to universal health care in the foreseeable future. Indeed, one could infer that the peril in which the Affordable Care Act currently finds itself is largely attributable to Americans' fears about their economic future.¹⁹

¹⁷ The Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286.

¹⁸ The language quoted in the text is a paraphrase. For the President's exact statements, see President Lyndon B. Johnson, Remarks at the University of Michigan (May 22, 1964), in 1 PUBLIC PAPERS OF THE PRESIDENTS OF THE UNITED STATES: LYNDON B. JOHNSON 704 (1965). "The challenge of the next half century is whether we have the wisdom to use that wealth to enrich and elevate our national life, and to advance the quality of our American civilization." *Id.*

¹⁹ As with so many things, the validity of this statement turns on *which* Americans one is referencing; it is the age-old dichotomy between the haves and the have-nots. Those who have jobs and insurance, and are reasonably confident they will keep them, are more concerned about jeopardizing their own position than with extending coverage to the less fortunate. But for those whose access to health insurance and health services is less secure, the bad economy would likely increase their desire to see the Affordable Care Act survive current challenges and provide the enhanced safety net they need. See, e.g., John Holahan, *The 2007–09 Recession and Health Insurance Coverage*, 30

But prosperity is not historically a *sine qua non* for commitment to social advances; many nations around the world made their commitment to universal health care in times of economic distress. Perhaps most notably, the British launched their National Health Service (NHS) shortly after the end of World War II.²⁰ Their economy was weak and British cities were in dire need of rebuilding after years of wartime bombing. Sir William Beveridge, lead author of the famed “Beveridge Report” on social services in Britain,²¹ was asked how the country could possibly afford to provide health care for all when its financial situation was so shaky and so much work needed to be done to reduce the wartime debt. His answer essentially was, “how can we possibly afford not to?”²² The work of rebuilding a devastated nation and economy takes strong citizens. Beveridge argued that the productivity gains that would flow from having a system of national health care would more than offset the costs of establishing and maintaining that system.²³ It was a leap of faith argument, one that could not be tested until it was tried; in fact, it is not clear that Beveridge’s argument was ever empirically proven to be correct. But no matter; once the British had their NHS, their loyalty to its core concept—a governmental guarantee of an adequate level of care for all citizens—became unshakable.²⁴ Similarly, France and Italy, two of the nations I

HEALTH AFF. 145 (2011) (discussing the recent recession’s impact on the health care coverage by demographic group, and describing government programs as a “safety net”).

²⁰ See *The NHS: One of the Greatest Achievements in History*, BBC NEWS (July 1, 1998), http://news.bbc.co.uk/2/hi/events/nhs_at_50/special_report/123511.stm (“The UK’s National Health Service (NHS) came into operation at midnight on the fourth of July 1948.”).

²¹ See WILLIAM BEVERIDGE, *SOCIAL INSURANCE AND ALLIED SERVICES* (1942).

²² This is a paraphrase. For an exact quotation, see *id.* at 6: “But Want is one only of five giants on the road of reconstruction and in some ways the easiest to attack. The others are Disease, Ignorance, Squalor and Idleness.”

²³ In his report, Beveridge stated that

It is a logical corollary to the payment of high benefits in disability that determined efforts should be made by the State to reduce the number of cases for which benefit is needed. . . . Disease and accidents must be paid for in any case, in lessened power of production and idleness, if not directly by insurance benefits. One of the reasons why it is preferable to pay for disease and accident openly and directly in the form of insurance benefits, rather than indirectly, is that this emphasises the cost and should give a stimulus to prevention.

Id. at 158.

²⁴ See Denis Campbell & Toby Helm, *Poll Reveals Widespread Suspicion of NHS Reforms*, GUARDIAN.CO.UK (Jan. 29, 2011), <http://www.guardian.co.uk/politics/2011/jan/29/nhs-private-companies-yougov-poll> (“The YouGov survey found that only 27% of people back moves to allow profit-making companies to increase their role in the NHS.”); see also DEP’T OF HEALTH, *PUBLIC PERCEPTIONS OF THE NHS: DECEMBER 2007*

studied in greater detail, made their essential commitment to universal health care in the aftermath of World War II, when their economies were struggling. Although they did not fully implement universal health care at the end of the war, they did make a national commitment to the goal and pushed to realize it as rapidly as possible in the postwar years.²⁵

The relevance of this history to the current situation in the United States should be clear. Many have questioned, both before and after the passage of the Affordable Care Act, whether universal health care was something the United States could undertake in the midst of the most serious economic downturn since the Great Depression.²⁶ President Obama, employing Beveridge-like reasoning, had argued that our nation's failure to adopt meaningful health care reform stands in the way of achieving sustainable economic health.²⁷ The right re-

TRACKING STUDY 2 (2007), available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_095533.pdf ("Half of people agree that Britain's National Health Service is one of the best in the world and another half believe that overall the NHS provides good value for money to taxpayers." (emphasis omitted)); Rodney Lowe, *Financing Health Care in Britain Since 1939*, HIST. & POL. (May 2002), <http://www.historyandpolicy.org/papers/policy-paper-08.html> (chronicling how, at the time of its creation, Britain's single-payer system enjoyed "popular support and, equally important, met with little resistance from vested interests" and that this support has been unabating, with a 2001 opinion poll recording that "80% of those polled regarded the NHS to [be] critical to British society and that 75% opposed the creation of a two-tier system."); *The NHS: One of the Greatest Achievements in History*, *supra* note 20 ("The [NHS] has been beset with problems throughout its lifetime, not least a continuing shortage of cash. But having cared for the nation for half a century, most Britons consider the NHS to have been an outstanding success.").

²⁵ See ALESSANDRA LO SCALZO ET AL., 11 HEALTH SYSTEMS IN TRANSITION: ITALY 19-20 (2009), available at http://www.euro.who.int/__data/assets/pdf_file/0006/87225/E93666.pdf (describing the process in Italy as beginning with the 1923 guarantee of "hospital care for the needy, indigent population" and culminating with "[t]he 1978 reform . . . that created the SSN [which] introduced universal coverage to Italian citizens and established human dignity, health needs and solidarity as the guiding principles of the system"); SIMONE SANDIER ET AL., 6 HEALTH CARE SYSTEMS IN TRANSITION: FRANCE 7 (Sarah Thomson & Elias Mossialos eds., 2004), available at http://www.euro.who.int/__data/assets/pdf_file/0009/80694/E83126.pdf (describing the development of France's national social security system from its creation in 1945 through its gradual expansion and inclusion of additional segments of the population and finally the 1974 establishment of "a system of personal insurance for those who did not fall into any of the categories already covered").

²⁶ See, e.g., *Five Questions for John Holahan on Health Care Reform*, URBAN INST. (Mar. 5, 2009), <http://www.urban.org/toolkit/fivequestions/JHolahan2.cfm> (noting that, because of the recession, there is an increased need for health care reform but less funding available to support the effort).

²⁷ In Obama's own words,

forms, he contends, will help to stem the rising cost of health care that threatens the economic stability and the global competitiveness of American industry. But just as Beveridge's assertion that universal health care would help Britain get back on its feet after World War II remains unproven, Obama's claim that the Affordable Care Act's reforms will ultimately save the nation more money than they will cost calls for another leap of faith. How many are willing to take that leap remains to be seen²⁸ and as this issue plays out, the changes that are made to the health care system will be interesting indeed.

II. POLITICS

It is beyond question that politics plays a crucial role in the quest for universal health care. In fact, it seems that in recent times *politics* has largely replaced *policy* as the controlling factor. But what exactly does "politics" mean in the context of our star chart for the adoption of universal health care?

In the present taxonomy, politics refers not just to the political wrangling around health care reform, but also to the structure and procedures of the political institutions within which such wrangling takes place. For good or ill, the United States has a very complex and vigorous political system. As every schoolchild knows, a bill must make its way through a maze of committee processes and floor debates in a bicameral legislature replete with procedural obstacles before it can reach the President's desk, where it usually is either signed into law or vetoed, the latter action subject to an override by a congressional supermajority. All of this takes place in the harsh and often distorting glare of the media, the fourth branch of government,

the most significant driver by far of our long-term debt and our long-term deficits is ever-escalating health care costs. And if we don't reform how health care is delivered in this country, then we are not going to be able to get a handle on that Businesses are using money to pay their rising health care costs that could be going to innovation and growth and new hiring.

Obama, Statement, *supra* note 14.

²⁸ Newly installed Republican House Speaker John Boehner is one of many Republicans unwilling to accept the CBO's suggestion that repeal of the Affordable Care Act would "probably increase federal budget deficits over the 2012–2019 period by a total of roughly \$145 billion." Byron York, *Boehner Challenges New CBO Estimate that Repealing Obamacare Will Raise Deficit*, WASH. EXAMINER (Jan. 6, 2011), <http://washingtonexaminer.com/blogs/beltway-confidential/2011/01/boehner-challenges-new-cbo-estimate-repealing-obamacare-will-rais>.

which, except for the First Amendment's guarantee of a free press, is unaddressed by the Constitution and, thus, less constrained.²⁹

Moreover, like the power of the media, other elements of the political process not expressly provided for in the Constitution play a huge role. A prime example is the Senate's filibuster, which dramatically affected the run-up to the Affordable Care Act's passage. The contorted steps Congress took to get around the virulent opposition of the Senate Republican minority laid the foundation for the Republican claim that the Administration foisted Obamacare on an unwilling American public.³⁰ A measure as monumental as universal health care should be the product of bipartisan cooperation, the kind of cooperation that candidate Obama promised to seek if elected,³¹ but bipartisan cooperation is surely not something that the present health care reform debate reflects. To use a colorful metaphor, passing a major piece of legislation such as health care reform in the U.S. Congress is like trying to inflate a large hot-air balloon. It takes many people working closely together to inflate it but just a few pricks to cause its collapse.

Politics in this context also means the presence and influence of a champion for the cause. President Franklin D. Roosevelt was the

²⁹ An example of this unconstrained distortion is the much-publicized discussion of "death panels," which were the subject of a media frenzy with little connection to underlying facts. See, e.g., *infra* note 63 and accompanying text.

³⁰ See Julie Rovner, *Democrats Weigh Obscure Tactic to Pass Health Care*, NPR (Mar. 16, 2010), <http://www.npr.org/templates/story/story.php?storyId=124742346> (describing Republican anger over the possible use of a procedural vote to pass health care reform, which would block the chance for a filibuster).

³¹ See Senator Barack Obama, Remarks Introducing Senator Joe Biden in Springfield, Ill. (Aug. 23, 2008), available at <http://www.washingtonpost.com/wp-yn/content/article/2008/08/28/AR2008082803216.html> ("[A]fter decades of steady work across the aisle, I know [Joe Biden will] be able to help me turn the page on the ugly partisanship in Washington so we can bring Democrats and Republicans together to pass an agenda that works for the American people."); Interview by Steve Inskeep with Senator Barack Obama (Jan. 9, 2008), available at <http://www.npr.org/templates/transcript/transcript.php?storyId=17953420> ("[W]e can't get that change unless we have a working majority that can attract independents, attract some Republicans. And that is something that I think I can do most effectively as the nominee and, ultimately, as the president."); see also Senator Barack Obama, Presidential Election Victory Speech (Nov. 5, 2008), available at <http://elections.nytimes.com/2008/results/president/speeches/obama-victory-speech.html> (calling upon the nation to reject "the same partisanship and pettiness and immaturity that has poisoned our politics for so long," noting a powerful drive on the part of the Democratic Party to "heal the divides that have held back our progress," and declaring an intent to consider the interests of and represent all Americans).

champion of Social Security³² and President Lyndon B. Johnson fought for Medicare and Medicaid.³³ The quest for universal health care has had several national champions over the years—Ted Kennedy, Bill and Hillary Clinton, and Barack Obama stand out as the most visible. It seems fair to say that without a sustained commitment by a key national figure, health care reform in the United States could not be possible. But here is a place where our system arguably differs substantially from that of other countries. An American President, no matter how strongly committed to the cause, cannot succeed without the cooperation and support of countless others. In France, by contrast, the President has been able to progress much further on his own. The French President has the constitutional power to promulgate a law, *l'ordonnance*, much as our President can issue an executive order.³⁴ The difference is that, by political tradition, the French President's declaration could deal with matters more substantial than the lesser stuff that is generally the subject of American Presidents' executive orders.³⁵ Thus, important steps toward the establishment of the

³² See, e.g., President Franklin D. Roosevelt, Message to Congress Reviewing the Broad Objectives and Accomplishments of the Administration (June 8, 1934), available at <http://www.ssa.gov/history/fdrstmts.html#message1> (asserting that the uncertainty stemming from lack of social insurance “contribute[s] to social unrest and economic demoralization” and further that the government has an obligation to provide, and also every individual has the right to receive, “that security upon which welfare depends”).

³³ See President Lyndon B. Johnson, Remarks with President Truman at the Signing in Independence of the Medicare Bill (July 30, 1965), available at <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp> (celebrating the passage of the Act while observing that it had been two decades since President Truman first called on the nation to afford ill Americans the “opportunity to achieve and to enjoy good health” and that “the need for this action is plain; and it is so clear indeed that we marvel not simply at the passage of this bill, but . . . that it took so many years to pass it”).

³⁴ Article 34 of the French Constitution identifies areas of law and social policy that can only be addressed with an act of the legislature. These areas include “civic rights” and “fundamental guarantees granted to citizens,” “the base, rates, and methods of collections of all types of taxes,” “the setting up of categories of public legal entities,” and, specifically, “Social Security.” 1958 CONST. 34 (Fr.). Article 38 gives the executive branch the authority, with parliamentary permission, “to take measures by Ordinance that are normally [reserved to] statute law.” 1958 CONST. 38 (Fr.).

³⁵ See HAROLD C. RELYEA, CONG. RESEARCH SERV., R98-611, PRESIDENTIAL DIRECTIVES: BACKGROUND AND OVERVIEW 5 (2008), available at http://assets.opencrs.com/rpts/98-611_20081126.pdf (briefly describing the history of executive orders and explaining that the use of these directives is generally limited to “executive officials and agencies,” except in rare “emergency situations”). Commenting on the President's executive order powers, Todd Gaziano explains,

[T]he President's authority to issue written directives is not limited to express language in the Constitution that grants him power to issue such directives.

French universal health care system were taken through the mechanism of *l'ordonnance*.³⁶ The French Parliament can override the President's declarations by refusing to ratify them, but once the President makes and announces the declaration, it is a tough political feat to rescind the order. To take back an important benefit that has been given to the public is much harder than not giving it in the first place—or so one could argue. Perhaps the current movement in America to repeal Obamacare will offer an opportunity to test this dynamic in our own system. President Obama has the constitutional authority to veto a repeal of the Affordable Care Act, subject only to override by a congressional supermajority. But perhaps more importantly, opponents of the Act may find that, even though the Act has been in place only a short time, it has already gained enough staunch adherents to make building the political traction necessary to undo it impossible.

III. HISTORY

It is impossible, of course, to separate history from economics and politics; they are three musketeers who travel close together and whose fortunes are tightly intertwined. Sometimes, however, the lens of history can reveal insights that are less visible from the perspectives of economics and politics. For example, after World War II, the French had to decide what to do for their citizens whose health had suffered because of the war. There were the soldiers, of course, who had risked their lives for their country and surely were entitled to the fullest measure of health care. Their families also had a solid claim to the nation's gratitude and support, as did other civilians, some of them members of the resistance, who had been injured in the conflict or had had to defer needed health care because of wartime scarcity. Ultimately, says Professor Gérard de Pouvourville, it just did not make sense to exclude any French citizens from the national health care sys-

The President possesses additional authority to issue directives where that is the reasonable implication of the power granted (implied authority) or if it is inherent in the nature of the power conferred (inherent authority). . . . If the President's authority is implied or inherent in a statutory grant of power, Congress remains free to negate or modify the underlying authority.

Todd F. Gaziano, *The Use and Abuse of Executive Orders and Other Presidential Directives*, LEGAL MEMORANDUM (Heritage Found., Washington, D.C.), Feb. 21, 2001, at 4. In sum, the ability to issue executive orders is limited to the President's enumerated *executive* branch powers, granted either from the Constitution directly or from Congressional statutory authority.

³⁶ See SANDIER ET AL., *supra* note 25, at 7 ("The social security system officially came into being with the Ordinance of 4 October 1945.").

tem; consequently France committed to universal health care.³⁷ The war reminded the French that all of its citizens were in the struggle of life together, comrades in arms. Historical events, such as World War II, reinforced the underlying French ethos of *fraternité* (brotherhood) and *solidarité* (unity). Here again, the six “stars” overlapped, as the later discussion of national character will further reveal.

That war played a key role in moving European nations toward universal health care is not surprising given what a defining force war has been in the lives of generations of Europeans. The historical influence of World War II played out differently on other continents. In Argentina, another of the nations I studied, World War II contributed to universal health care in a different way. Wartime hostilities disrupted agricultural production in Europe and the Europeans looked to Argentina, among other non-European countries, to satisfy a substantial portion of their food needs.³⁸ Since the private market in Argentina was not sufficiently developed at the time to deal directly with the foreign demand, much of the commerce in agricultural commodities went through the Argentine government.³⁹ Consequently, the government ended the war with its coffers full, quite the opposite of the situation in Europe.

Juan Perón, the head of the government coming out of the War, and his equally famous and socially conscious wife, Eva, committed to bringing their nation into the modern age, using the government surplus to embark on ambitious projects of rural electrification, development of a national system of schools and public health care facilities, and the like.⁴⁰ Seeking to solidify his position with the powerful

³⁷ Interview with Gérard de Pouvourville, Professor and Health Econ. Chair, Healthcare Mgmt. Dep’t, ESSEC Int’l Bus. Sch., in Paris, Fr. (Apr. 14, 2006).

³⁸ See Hiroshi Matsushita, *A Historical View of Argentine Neutrality During World War II*, 11 DEVELOPING ECONOMIES 272, 284 (1973) (“Great Britain . . . needed Argentina more than ever to maintain its food supply during the war and welcomed Argentina’s neutrality because it was safer to maintain Argentine imports without provoking reprisals from the Axis.”).

³⁹ See *id.* at 289 (describing the close integration between Argentina’s foreign policy and its centralized economic efforts, specifically in terms of negotiating meat and egg contracts with the Allies); see also Otto T. Solbrig & Ernesto Viglizzo, *Sustainable Farming in the Argentine Pampas: History, Society, Economy, and Ecology* 27-28, (Harvard Univ., Working Papers on Latin Am., Working Paper No. 99/00-1, 1999), available at http://www.drclas.harvard.edu/uploads/images/28/solbrig_viglizzo.pdf (“The [Perónist] government with alacrity pursued import-substitution industrialization. The rural sector was to be the source of capital through a scheme by which the government bought the [local Argentine] harvest at a fixed price and exported it at higher world prices.”).

⁴⁰ See Koichi Usami, *Transformation and Continuity of the Argentine Welfare State: Evaluating Social Security Reform in the 1990s*, 42 DEVELOPING ECONOMIES 219-23 (2004)

trade unions, Perón struck a deal whereby health insurance would be mandatory and would be provided through union health plans, known as *Obras Sociales* (“social works”).⁴¹ Although it has undergone major changes over the years, the current Argentine health care financing system still has the same underlying structure.

Under Argentine law, a portion of workers’ wages (generally 3%) is withheld through payroll deduction for health care benefits and is matched with a contribution (generally 6%) from the employer. A portion of the combined amount is paid to the government to support its related regulatory activities and a portion is paid to the ANSSAL (*Administración Nacional del Seguro de la Salud*), the union-based national administrative body for health insurance,⁴² which, among other functions, administers a cross-subsidization scheme (“redistribution fund”) whereby—in principle, at least⁴³—the financially stronger *Obras* assist the poorer *Obras* in providing the mandatory minimum health benefits package (the PMO, or *Plan Médico Obligatorio*) to their members.⁴⁴ Not surprisingly, some *Obras* have done substantially worse than others in delivering quality health care benefits, and the government regulatory mechanisms have struggled for years to ensure that workers receive fair value for their contributions to the system.⁴⁵ The story of that struggle and of the market reforms undertaken to

(listing the various social programs initiated by the Perónist regime, such as the expansion of public hospital systems, the creation of financial social assistance, low income housing, and the similar public works undertaken by the Eva Perón Foundation, headed by Eva Perón herself).

⁴¹ See WORLD BANK, ARGENTINA: FROM INSOLVENCY TO GROWTH 74 (1993) (describing the history of Argentine health care provided by the unions).

⁴² *Id.* at 75.

⁴³ For a variety of reasons, the cross-subsidization scheme has not worked well. See *id.* at 76 (describing the system as “plagued with problems”).

⁴⁴ See PAN AM. HEALTH ORG., PROFILE OF THE HEALTH SERVICES SYSTEM: ARGENTINA 19 (2d ed. 2002) (discussing the redistribution of funds to the poorer *Obras*); Juan Pablo Uribe & Nicole Schwab, *The Argentine Health Sector in the Context of the Crisis* 7-8 (World Bank, Background Paper No. 6, Nov. 2002) (discussing the revenues of the “Solidarity Redistribution Fund”).

⁴⁵ See WORLD BANK, ARGENTINA: FACING THE CHALLENGE OF HEALTH INSURANCE REFORM 8 (1997) (discussing the problems faced by the Argentine health system, including financial instability and consumer dissatisfaction with “the extent of the coverage, quality of health care they receive, and limited choice for those required to contribute to health insurance through wage taxes”); ARGENTINA: FROM INSOLVENCY TO GROWTH, *supra* note 41, at 76-77 (discussing the numerous problems faced by the ANSSAL system).

foster greater competition among the *Obras* is fascinating and worth studying but is beyond the scope of this Article.⁴⁶

Like Argentina's, the U.S. health care system is largely built upon employment-based private health insurance. However, in the United States, labor unions play a lesser role. Employers may be influenced by union pressures—such as collective bargaining agreements—when choosing health benefits and plans, but their health care contributions, generally speaking, do not flow through the unions.⁴⁷ The broader point is that we have an employment-based health insurance system in this country as the cumulative result of a number of interlinked historical events. The labor strife of the Great Depression led to the passage of the National Labor Relations Act (Wagner Act) in 1935, guaranteeing U.S. workers the right to form unions and bargain collectively with employers regarding wages and other terms and conditions of employment.⁴⁸ From the mid-1930s into the 1940s, unions recruited a sizable portion of American workers, who saw collective bargaining as a way to enhance job security and increase their wages as the nation's economy recovered from the Depression.⁴⁹ When anti-inflationary

⁴⁶ See, e.g., Armando Barrientos & Peter Lloyd-Sherlock, *Reforming Health Insurance in Argentina and Chile*, 15 HEALTH POL'Y & PLAN. 417, 418-19 (2000) (discussing the history of health care reform in Argentina).

⁴⁷ An exception is found in arrangements like those the United Auto Workers (UAW) and General Motors (GM) negotiated in 2007. Companies such as GM that have a large "legacy" obligation to provide health care benefits to their retired workers have agreed to turn their retiree health care funds over to the union, transferring responsibility for providing the promised benefits. See Press Release, United Auto Workers, UAW Union Retirees File Proposed Settlement Establishing VEBA Trust (Feb. 22, 2008), available at <http://www.uaw.org/articles/uaw-union-retirees-file-proposed-settlement-establishing-veba-trust> (noting that by the terms of a settlement agreement, GM will transfer billions of dollars of legacy obligations to a "Voluntary Employees Beneficiary Association" trust fund controlled by the union, making the union responsible for administering the health care benefits of its retiree members). For further commentary on this issue, see, for example, Micheline Maynard, *Retirees' Health Costs Loom over U.A.W. Talks*, N.Y. TIMES, July 19, 2007, at A1, which notes that transferring control over health plans to the unions would be an "unusual solution" to the problem of retiree benefits; Ralph R. Reiland, Opinion, *UAW's 'Legacy' at GM*, PITTSBURGH TRIB., Jan. 12, 2009, available at http://www.pittsburghlive.com/x/pittsburghtrib/opinion/s_606661.html, which suggests that the UAW's stance on union benefits has caused serious financial damage to GM); and David Welsh et al., *Why GM's Plan Won't Work . . . and the Ugly Road Ahead*, BUS. WK., May 9, 2005, at 84, which discusses the difficulty GM faced in cutting costs because of its agreement with the UAW.

⁴⁸ See National Labor Relations Act, Pub. L. No. 74-198, 49 Stat. 449 (1935) (codified as amended at 29 U.S.C. §§ 151-169 (2006)) (granting and safeguarding employees' collective bargaining rights).

⁴⁹ See Ian Welsh, *The Glorious Future That American Unions Walked Away From*, AGONIST (Jan. 18, 2008, 4:10 PM), http://agonist.org/ian_welsh/20080118/decisions_like

legislation during World War II froze wages,⁵⁰ the unions sought other benefits for their members.⁵¹ Since the wartime legislation did not bar increases in “fringe benefits,” the unions used their bargaining clout to extract health benefits concessions from employers.⁵² As a result, the United States emerged from World War II with a system heavily oriented toward employment-based private health insurance. Postwar attempts by President Harry Truman and his Administration to establish a national health insurance program faced strong opposition from those who had obtained secure employment-based health plans and were protective of the status quo.⁵³ In the 1950s, changes to the

these have made the union movement what it is today (charting the rapid growth in the mid-1930s in union membership and subsequent decline as well as speculating on reasons for both).

⁵⁰ Congress enacted a variety of price-fixing and anti-inflationary legislation during World War II. *E.g.*, Emergency Price Control Act of 1942, Pub. L. No. 77-421, 56 Stat. 23, 50; Inflation Control Act of 1942, Pub. L. No. 77-729, 56 Stat. 765. The day after signing the Emergency Price Control Act, President Roosevelt issued an executive order that established the Office of Economic Stabilization and gave the National War Labor Board the authority to freeze wages. Exec. Order No. 9250, 7 Fed. Reg. 7871 (Oct. 6, 1942).

⁵¹ See Avik Roy, *Health Care and the Profit Motive*, 3 NAT’L AFF. 35, 38 (2010) (discussing the “ever more generous health insurance” benefits offered to employees during World War II in lieu of prohibited wage increases).

⁵² Discussing the National War Labor Board’s decision in the “‘little steel’ wage increase case,” Frank Dobbin noted that the decision was

a compromise that tied wage increases to inflation, thereby freezing real wages, and the decision served as a precedent for firms throughout the economy. . . . In 1943, the board ruled that pension and insurance benefits were not subject to the freeze. It is widely believed that this exemption spurred firms to increase benefits in lieu of increasing wages to attract and retain workers.

Frank R. Dobbin, *The Origins of Private Social Insurance: Public Policy and Fringe Benefits in America, 1920–1950*, 97 AM. J. SOC. 1416, 1436–37 (1992) (internal citations omitted).

⁵³ In her remarks on the history of universal health care, Karen Palmer explained, After FDR died, Truman became president (1945–1953), and his tenure is characterized by the Cold War and Communism. The health care issue finally moved into the center arena of national politics and received the unreserved support of an American president. Though he served during some of the most virulent anti-Communist attacks and the early years of the Cold War, Truman fully supported national health insurance. But the opposition had acquired new strength. Compulsory health insurance became entangled in the Cold War and its opponents were able to make “socialized medicine” a symbolic issue in the growing crusade against Communist influence in America.

Palmer, *supra* note 13, at 5.

In an interesting counterpoint to the United States’ failed attempt to provide national health insurance, Japan’s Constitution requires its government to ensure the provision of an adequate level of health care to all citizens. That obligation was included in Japan’s new constitution when members of the Truman Administration

tax code helped to solidify private health care by giving a substantial tax incentive to further expansion of the employment-based private system. Under the Internal Revenue Code of 1954, employers were allowed to deduct expenditures for employee health care benefits as an “ordinary and necessary” business expense, and employees did not have to recognize these contributions as taxable income.⁵⁴ The exemption for health care contributions by employers on behalf of employees provides, in effect, a tax shelter for employee health benefits. This incentivizes employees to demand that employers directly provide such benefits in lieu of taking the same dollar amount of compensation in the form of higher wages and then purchasing health insurance on their own with after-tax dollars. The above history—unionization during the Depression, the growth of employment-based insurance as a result of the War, and postwar tax incentives to continue that trend—goes a long way toward explaining the current U.S. health care financing system.

In a broader sense, there is another historical dynamic involved. Coming out of World War II, the United States soon entered the Cold War—in which the political spectrum was divided between the communist Soviet Union on the far left, and the United States, as the world’s other superpower, on the right. In this political climate, any inclination the United States might have otherwise had toward establishing a government-based health care system was overcome by our commitment to exemplifying free enterprise capitalism. This commitment contributed in some measure to the evolution of our current private health insurance system.⁵⁵ Arguably, since the end of the Cold War, the United States has become more free to experiment with government-based solutions to our health care problems. Or has it?

worked alongside their Japanese counterparts during the post–World War II occupation to craft a foundational document that would position Japan for a peacetime future of domestic tranquility, stability, and progress. Ironically, the victorious Americans were able to help enshrine in the constitution of their former enemies a social commitment that America could not manage to include in its own portfolio of governmental responsibilities. See Interview with John C. Campbell, Emeritus Professor of Political Sci., Univ. of Mich., in Tokyo, Japan (May 16, 2006) (discussing the history of Japan’s movement toward universal health care).

⁵⁴ See I.R.C. § 106 (Supp. III 1956) (“Gross income does not include contributions by the employer to . . . health plans . . .”); *Id.* § 162(a) (allowing a deduction for “other compensation,” which included health expenditures furnished by employers).

⁵⁵ See *supra* note 53 and accompanying text.

IV. INFRASTRUCTURE

Generally speaking, infrastructure is the foundation that undergirds our world. In the physical sense, our infrastructure is our roads, bridges, gas pipelines, the electrical power grid, and so forth. But as the term is used in this analysis of our health care system, “infrastructure” is the complex of health care professionals, hospitals, other health care facilities, drug and medical device manufacturers, health insurers, managed care organizations, medical schools, other institutions preparing people for roles in the health profession, and so on. Infrastructure is the ground on which we stand, the terrain on which we must build. Wherever we want to go, we have to start from where we are.

The present state of health care in America is very complicated. We can imagine and argue for all types of health care system models and configurations—single-payer governmental systems, mixed public-private systems, employment-based private systems, managed competition, and so on—but any debate must begin with what we presently have. Every health care delivery and financing element now in place is a stakeholder in the game called “reform.” And to make matters even more complicated, the main stakeholders all have extended networks of constituents that radiate outward from them. Private, for-profit Health Maintenance Organizations (HMOs), for example, can be expected to defend their turf when systemic reforms threaten to undercut them or limit their future potential. These HMOs in turn have contracted to insure legions of employers whose employees (and their families) are the HMOs’ subscribers. Any change that threatens the HMOs’ future existence, market share, operating methods, or cost and premium levels potentially threatens all of these secondary and tertiary stakeholders as well. Parties who have a vested interest in perpetuating the status quo, or at least *think* they do, resist change not only when they are sure that change will be bad for them, but also when they are merely uncertain. In other words, the more established the infrastructure—the more evolved and involved the current system—the more resistance to change there is likely to be.⁵⁶

When Britain, France, Italy, and Argentina were emerging from World War II and moving toward adopting new health care systems,

⁵⁶ See Humphrey Taylor, *Why Is Health Care Reform So Difficult in the United States*, HEALTH CARE BLOG (Dec. 22, 2009), http://www.thehealthcareblog.com/the_health_care_blog/2009/12/why-health-care-reform-is-so-difficult-in-the-united-states.html (comparing the ease of reform of American and foreign health care system structures and concluding that the difficulties in America are in part based on the complexity of the American system and the more pronounced influence of special interest groups).

their existing systems were much less evolved than the American system is today.⁵⁷ They were writing on a cleaner slate. Consequently, whatever forces may have worked against committing to universal health care and to the corresponding changes in government structure and involvement, those forces were far less developed and entrenched than the forces currently at work in the United States. Simply put, by waiting more than half a century to make our move toward universal health care, we have unwittingly and inadvertently made the task of health care reform substantially more difficult. The field has many more players, all of whom have a vested interest and a constituency with related vested interests. It is no surprise, then, that there is so much resistance to sweeping reform in the United States and that accomplishing even incremental change is difficult.⁵⁸

The infrastructure of America's health care system is not merely comprised of institutions with professional and financial interests at stake; it is also comprised of individuals' belief structures about the health care system. As the term is used here, public opinion is an important part of infrastructure. When reform is proposed, every person with "skin in the game" tries to calculate whether a particular change will be personally beneficial or hurtful. Some approach these calculations with an open mind: show them a better way and they will support it. But many are not so receptive; they are not sure how to weigh the pros and cons of change, so they make a choice, either ex-

⁵⁷ See *The NHS: One of the Greatest Achievements in History*, *supra* note 20 (describing the unstructured and unsophisticated nature of early British health care); *supra* notes 41-45 (discussing Argentine social services from the 1930s onward).

⁵⁸ Canada experienced similar resistance when it undertook health care reform. See, e.g., Palmer, *supra* note 13, at 7 (discussing the nearly fifty years it took for universal health care to spread throughout Canada and the intense challenges the reform movement faced throughout). In the United States, hurdles include the complexity of our current system, high administrative costs, and special interest groups. See Barbara L. Wolfe, *Changing the U.S. Health Care System: How Difficult Will It Be?*, 14 FOCUS 16, 18-19 (1992) (identifying "entrenched interest groups" as a primary roadblock to change); Uwe E. Reinhardt, *Why Does U.S. Health Care Cost So Much? (Part I)*, N.Y. TIMES ECONOMIX BLOG (Nov. 14, 2008, 7:30 AM), <http://economix.blogs.nytimes.com/2008/11/14/why-does-us-health-care-cost-so-much-part-i> (explaining that the cost differential between health care in the United States and Canada is in part due to "significantly higher administrative overhead costs than are incurred in other countries with simpler health-insurance systems," and "more widespread use of high-cost, high-tech equipment and procedures than are used in other countries," among other factors); Taylor, *supra* note 56 (opining that it is easier for other countries to change their health care systems because, among other reasons, "[o]urs is much more complicated with our 'thousand points of payment,' Medicare, Medicaid, Kaiser, the VA, the Mayo Clinic, HMOs, PPOs, and millions of employers and their different health plans").

plicity or implicitly, to just sit tight. “Better the devil I know than the devil I don’t know” is a good summary of their mindset.

It was this kind of suspicion about change that made the “Harry and Louise” commercials of 1993 to 1994 such an effective campaign against the Clintons’ Health Security Act proposal.⁵⁹ In them, a likeable couple was shown in home and work situations pondering the possibility of health care reform. In some of the ads, they started with a disposition toward change, acknowledging the current system’s problems and wanting to see it improved; but then one or the other of them raised a nagging question: Will our co-payments and deductibles go up? Would we be able to choose among providers? Might the quality of care go down? Will we have to wait for services? Their exchange ended with the conclusion that we should not rush forward too quickly. With clever subtlety these ads made a persuasive case for maintaining the status quo.

One should acknowledge, however, that infrastructure constantly changes as circumstances change. Many factors impact the public’s outlook on the need for change and the likelihood that such a change will benefit them, including the ups and downs of the economy, the public’s confidence in the security of their jobs and their health benefits, and media coverage of ongoing changes in the quality and cost of health services. And, of course, there’s also the “spin” put on devel-

⁵⁹ The “Harry and Louise” ads were the artful and highly successful creation of the Health Insurance Association of America (HIAA), and targeted the TV markets where they would have the greatest impact on congressional policymakers. They were arguably the single most effective opposition to the Clintons’ reform campaign. See Raymond L. Goldstein et al., *Harry and Louise and Health Care Reform: Romancing Public Opinion*, 26 J. HEALTH POL. POL’Y & L. 1325, 1326-33 (2001) (arguing that the ads caused members of Congress to believe health care reform was unpopular with the public).

All of these ads can now be found online. See Goddard Clausen Public Affairs, “*Bureaucrats*” *Featuring Harry and Louise*, YOUTUBE (June 5, 2010), <http://www.youtube.com/watch?v=rn4mEVke1RI>; Goddard Clausen Public Affairs, “*Changes*” *Featuring Harry and Louise*, YOUTUBE (June 5, 2010), <http://www.youtube.com/watch?v=wOPsAVd3f-Y>; Goddard Clausen Public Affairs, “*Choose*” *Featuring Harry and Louise*, YOUTUBE (June 5, 2010), <http://www.youtube.com/watch?v=9sJ5Ujysg5s>; Goddard Clausen Public Affairs, “*New Taxes*” *Featuring Harry and Louise*, YOUTUBE (June 5, 2010), http://www.youtube.com/watch?v=u1vw_Pxmoo; Goddard Clausen Public Affairs, “*Partners*” *Featuring Harry and Louise*, YOUTUBE (June 5, 2010), <http://www.youtube.com/watch?v=ebFfp5RFViU>; Goddard Clausen Public Affairs, “*Quality*” *featuring Harry and Louise*, YOUTUBE (June 5, 2010), <http://www.youtube.com/watch?v=nT0Pknif-i0>; Goddard Clausen Public Affairs, “*Yes But*” *Featuring Harry and Louise*, YOUTUBE (June 5, 2010), <http://www.youtube.com/watch?v=afLrm2awL3s>. Interestingly, “Harry and Louise” switched sides in 2008 and came out in favor of health care reform. See FamiliesUSA07, *The Making of Harry and Louise Return*, YOUTUBE (Aug. 19, 2008), <http://www.youtube.com/watch?v=ZhJQ5Viya7U&feature=related>.

opments by the various interested parties. Throughout the 2008 to 2010 health care reform debates, conservative news commentators and politicians routinely propagated the notion that the Obama Administration's proposed reforms were alternatively "European-style socialized medicine,"⁶⁰ "a government takeover" of health care,⁶¹ or an attempt to "put a government bureaucracy between you and your doctor."⁶² A perfectly reasonable proposal to compensate physicians for periodically informing Medicare patients of their end-of-life treatment options and offering assistance in making and documenting their choices was demonized as a sinister attempt to set up government "death panels."⁶³ Finally, a bewildering array of polls painted conflict-

⁶⁰ See Richard Wolf, *Clinton Health Plan Calls for Mandatory Coverage*, USA TODAY, Sept. 18, 2007, at A4 (quoting Mitt Romney's criticism of then-presidential candidate Hillary Clinton's proposal for universal health care).

⁶¹ See FRANK I. LUNTZ, *THE LANGUAGE OF HEALTHCARE 2009*, at 1 (2009), available at <http://wonkroom.thinkprogress.org/wp-content/uploads/2009/05/frank-luntz-the-language-of-healthcare-20091.pdf> (advising opponents of health care reform to use the phrase "government takeover" for maximum impact).

⁶² See Press Release, Hoeven for Senate, Hoeven Statement on the Passage of the Healthcare Bill (Mar. 21, 2010), available at <http://www.hoevenforsenate.com/news/detail.asp?newsID=36> (announcing then-Governor of North Dakota John Hoeven's "disappoint[ment] in the House's action today to pass the massive healthcare bill that puts government bureaucracy between you and your doctor"). Non-profit group MediaMatters for America has conducted extensive research on conservative media figures and the rhetoric they have used in their opposition to health care reform. See *Updated Report: Conservative Media Push 75-Year-Old "Socialized Medicine" Smear Against Health Care Reform*, MEDIA MATTERS FOR AM. (Aug. 19, 2009, 4:00 PM), <http://mediamatters.org/research/200908190039>. The group has compiled an enormous list of the use of the phrase "socialized medicine" to attack government-run health care, ranging from a Wall Street Journal op-ed ("Kimberley A. Strassel trotted out the falsehood that Obama is on a 'drive to socialize health care.'" to statements made by Fox News' Glenn Beck ("Beck claimed that health care reform is 'good old socialism . . . raping the pocket-books of the rich to give to the poor.'"). *Id.* The article goes on to state that conservative commentators have used this rhetoric since the 1930s. *Id.*; see also *Media Infected with Conservatives' "Socialized Medicine" Myth*, MEDIA MATTERS FOR AM. (Apr. 30, 2009, 9:17 PM), <http://mediamatters.org/research/200904300041> (compiling similar statements such as, "In an April 29 post to The Fox Forum, FoxNews.com financial columnist Liz Peek wrote: 'Team Obama wants to set up government-managed health insurance programs which will, in theory, compete with private insurers . . . Many people fear that it is but a short hop from nationalized health insurance to nationalized health care—a truly horrifying prospect for anyone who has studied the disaster of English socialized medicine. Do you want bureaucrats deciding whether you should get that MRI?'""); *Report: Limbaugh Conservatives Continue 75-Year-Old "Socialized Medicine" Smear*, MEDIA MATTERS FOR AM. (Mar. 5, 2009, 12:11 PM), <http://mediamatters.org/reports/200903050012> (providing additional historical analysis and examples).

⁶³ See Jim Rutenberg & Jackie Calmes, *Getting to the Source of the 'Death Panel' Rumor*, N.Y. TIMES, Aug. 14, 2009, at A1 (observing that the conservative news media perpetuated "the stubborn yet false rumor" that the health care plan featured "death

ing pictures of the “average American’s” ideas and attitudes toward health care reform.⁶⁴ People who do not know what to think about a particular subject, especially one as complex and difficult to analyze as health care reform, may be especially susceptible to being influenced by polling data. Their reaction might well be: “If the majority of Americans are against Obamacare, then I guess I should be too.”

An important part of the dynamic by which infrastructure impedes reform is nicely captured in Bob Dylan’s immortal words, “When you ain’t got nothin’, you got nothin’ to lose,”⁶⁵—or, more accurately, in their mirror image. In other words, if you have something—satisfactory health care in this case—you will be fearful of losing it. The substantial majority of Americans have health benefits and, while they may complain about the cost, coverage, or quality of those benefits, and may feel sorry for those who are not covered—some forty-seven million Americans, or nearly sixteen percent of the population⁶⁶—they won’t likely support change that may place their existing benefits at risk. This dynamic helps explain the effectiveness of the Harry and Louise advertising campaign discussed earlier. It was designed to fuel fear among the “haves,” that in attempting to insure the “have-nots,” they might lose something important. Americans may

panels”). For a humorous and informative view, see *The Daily Show with Jon Stewart: Interview of Betsy McCaughey* (Comedy Central television broadcast Aug. 20, 2009), available at <http://www.thedailyshow.com/watch/thu-august-20-2009/betsy-mccaughey-pt-1> (discussing how the Affordable Care Act mandates end-of-life counseling for the aged, which may have been the impetus for the “death panel” rumors). For a purely humorous take on the disinformation campaign, see *Death Panel Advisors, FUNNY OR DIE*, <http://www.funnyordie.com/videos/e357e52d41/death-panel-advisors> (last visited Mar. 15, 2011) (mocking the death panels rumor by insinuating that death panels, like Bigfoot, unicorns, and cyborgs, are real).

⁶⁴ See, e.g., Frank Newport, *Dueling Pollsters*, GALLUP POLLING MATTERS (Mar. 15, 2010), <http://pollingmatters.gallup.com/2010/03/dueling-pollsters.html> (juxtaposing polls concluding, on one hand, that a “solid majority of Americans oppose” the health care reform proposal before Congress and, on the other hand, the “American public is divided”); see also Steve Hallock, Editorial, *Polls vs. Polls: Dueling Opinion Surveys in the Health Debate Reflect Their Limited Value*, PITTSBURGH POST-GAZETTE, Mar. 2, 2010, at B7, available at 2010 WLNR 4332707 (“The latest poll numbers may or may not show decreasing American support for health care reform legislation depending on which survey is referenced, when it was taken, who was questioned and how it was conducted.”).

⁶⁵ BOB DYLAN, *Like a Rolling Stone, on HIGHWAY 61 REVISITED* (Sony Music Entertainment 1965).

⁶⁶ See U.S. DEP’T OF HEALTH & HUMAN SERVS., OVERVIEW OF THE UNINSURED IN THE UNITED STATES: AN ANALYSIS OF THE 2007 CURRENT POPULATION SURVEY 1 (2007), available at <http://aspe.hhs.gov/health/reports/07/uninsured/index.htm> (“In 2006, the percentage of people without health insurance for the entire year was 15.8%, an increase from 15.3% in 2005. During 2006, 47.0 million people were without health insurance for the entire year, a 2.2 million increase from 44.8 million people in 2005.”).

be capable of altruism, but if the earlier discussion about the national mood that contributed to the passage of Medicare and Medicaid⁶⁷ gives true insight into Americans' inclinations, then it would seem that our dominant instinct is to first look out for ourselves and our close family and friends, and to share only when doing so does not involve substantial sacrifice by this inner circle.⁶⁸ But, giving contemporary Americans the benefit of the doubt when comparing them to, for example, the British coming out of World War II, one need not conclude that Americans are inherently less altruistic or more selfish but rather, with regard to health care, Americans have more to lose than the British did in 1945.⁶⁹

V. DEMOGRAPHICS

Because universal health care is, by definition, provided to *all* the people in a society, it matters greatly who those people are. The composition of a society plays a powerful role in determining how benefits and burdens will be shared. Perhaps the most obvious effect of demographics is that the more diverse a society is, the harder it is to build consensus and achieve meaningful cooperation. The Scandinavian countries⁷⁰ are often cited for their comprehensive social safety-net programs, including income maintenance, health care, pensions, and childcare support systems.⁷¹ Given the demographics of these countries, their provision of these programs is not surprising. Fin-

⁶⁷ See *supra* note 18 and accompanying text.

⁶⁸ Obviously, it is not possible to make sweeping yet accurate generalizations about the personal inclinations of a large and diverse population, especially when the underlying observations are not confined to particular time periods or situational contexts. There have, however, been some very interesting attempts at developing and applying the science needed to do this analysis. An excellent example is TOM W. SMITH, ALTRUISM IN CONTEMPORARY AMERICA: A REPORT FROM THE NATIONAL ALTRUISM STUDY (2003), available at <http://www-news.uchicago.edu/releases/03/altruism.pdf>. Such studies can inform not only the current discussion, but also the later discussion herein of America's "national character." See *infra* Part VI.

⁶⁹ For more on Americans' communitarian ethic and willingness to share, see *infra* Part VI.

⁷⁰ I use the term "Scandinavian" in this Article in its broader sense, including not just Denmark, Norway and Sweden, but also Iceland and Finland.

⁷¹ See INT'L SOC. SEC. ADMIN., SOCIAL SECURITY PROGRAMS THROUGHOUT THE WORLD: EUROPE, 2010, at 77-83, 228-35, 296-302 (2010), available at <http://www.ssa.gov/policy/docs/progdsc/ssptw/2010-2011/europe/index.html> (summarizing Denmark's, Norway's, and Sweden's social security programs and their contribution rates, mandatory systems for retirement income, and other statistics related to social security, and illustrating the comparative depth of Scandinavian social security programs).

land, Norway, Sweden, and Iceland have homogeneous populations: they share DNA to a higher degree than most other populations;⁷² but more importantly, they have pronounced homogeneity in more noticeable characteristics, including language, educational background, and religion.⁷³ Accordingly, when a family down the block finds itself in financial distress or has health care issues, their neighbors can more easily identify with them and can imagine themselves in similar straits.⁷⁴ In such a sociopolitical climate, the average citizen may well think that if his neighbors, with whom he can easily identify, need a safety net to make it through a rough patch, then maybe he too will someday need such help. He will be more likely to support social security measures at the ballot box, not just to be a good neighbor but also for his own protection and peace of mind. By contrast, when an urban East Coast American hears about the plight of migrant farm workers in Southern California, she may feel *sympathy* for them but,

⁷² See A. Helgason et al., *A Reassessment of Genetic Diversity in Icelanders: Strong Evidence from Multiple Loci for Relative Homogeneity Caused by Genetic Drift*, 67 ANNALS HUM. GENETICS 281, 281-83 (2003) (finding that Iceland's "gene pool is less heterogeneous than those of most other European populations"); Thomas Hansen et al., *Brain Expressed MicroRNAs Implicated in Schizophrenia Etiology*, 9 PLOS ONE e873, at 5 (2007), <http://www.plosone.org/article/info:doi/10.1371/journal.pone.0000873> (describing Scandinavian countries as "ethnically homogeneous populations that only recently have been subject to non-Caucasian immigration").

⁷³ See, e.g., Ingvar Lundberg, *Zeitgeist, Ortgeist, and Personalities in the Development of Scandinavian Psychology*, 36 INT'L J. PSYCHOL. 356, 356 (2009) (noting that Scandinavian countries are "often perceived as a homogeneous group of nations, unified not only by their geographical neighbourhood in the northern periphery of Europe but also by similar languages . . . common historical and cultural traditions, similar political patterns, high priorities of social welfare systems, and high egalitarian ambitions"); see also Ulf Hedetoft, *Denmark: Integrating Immigrants into a Homogeneous Welfare State*, MIGRATION INFO. SOURCE (Nov. 2006), <http://www.migrationinformation.org/Profiles/display.cfm?id=485> ("Like the other Scandinavian countries, Denmark is a small, highly developed nation based on cultural homogeneity and social trust."); Peter J. Katzenstein, *Regionalism in Comparative Perspective*, ASRUDIAN CENTER (Jan. 7, 2008, 8:35 AM), <http://asrudiancenter.wordpress.com/2008/07/01/regionalism-in-comparative-perspective> (describing the historical process whereby the Scandinavian nations achieved and maintained a high degree of homogeneity, including "the Scandinavian currency union of 1873 . . . language reforms to create more similarity . . . and the beginnings of region-wide economic consultation and cooperation in the 1930s").

⁷⁴ Welfare laws called "Poor Laws," common in Scandinavia in the nineteenth and twentieth centuries, illustrate this concept. Through a combination of local and state action, the local poor community received relief and support. See Pirjo Markkola, *Welfare Provision in Finland in the 19th and Early 20th Centuries*, INST. OF HIST. RES. (Oct. 2008), <http://www.history.ac.uk/ihr/Focus/welfare/articles/markkolap.html> (drawing similarities between Finnish, Danish, Swedish, and Norwegian "Poor Laws," and noting that restrictions on migration, a shared Scandinavian legal and political system, and religious homogeneity partially enabled these provisions).

with so many demographic differences between them, she is less likely to feel *empathy*. It is harder to identify with people who look, sound, and act differently and who live three thousand miles away. Geography is a demographic factor too. It is more difficult to imagine that what happens to a distant people could also happen to you. To vote your federal tax dollars to help those people your sense of altruism must outweigh your instinct for self-protection.

During my travels in 2006, I spent a couple of weeks in Singapore, a nation with a highly developed and well-functioning health care system, seemingly one of the most successful in the world. The entire population has health coverage, and their health status statistics (including longevity, infant mortality, and morbidity rates) are among the best in the world,⁷⁵ a notable achievement given that their level of national health expenditures is well below the global average for developed nations.⁷⁶ My visit to Singapore was just before a general election and, despite the high level of satisfaction with the system reported by the Singaporeans with whom I spoke,⁷⁷ several nonetheless voiced concern about the rising cost of health care,⁷⁸ even though it

⁷⁵ See WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 154 annex tbl.1 (2000), available at http://www.who.int/whr/2000/en/whr00_en.pdf (ranking Singapore sixth in the world for “overall health system performance”).

⁷⁶ Worldwide health spending accounted for approximately 7.9% of the global gross domestic product (GDP) in 1998. See JEAN-PIERRE POUILLIER ET AL., WORLD HEALTH ORG., PATTERNS OF GLOBAL HEALTH EXPENDITURES: RESULTS FOR 191 COUNTRIES 5 (2002), available at <http://www.who.int/healthinfo/paper51.pdf> (“In 1998, the world spent an estimated [I]\$3.1 trillion on health goods and services out of an estimated total world income of [I]\$38.7 trillion. Thus, health spending represented some 7.9% of global GDP.”). As of 2006, in Singapore, the percentage of GDP spent on health care was 3.3%, while in the United States it was 15.3%. See WORLD HEALTH ORG., WORLD HEALTH STATISTICS 2009, at 107 tbl.7 (2009) (tabulating worldwide data on “total expenditures on health as [a percentage] of gross domestic product”).

⁷⁷ One might question how representative my informal polling was when comparing it with the data in the “Customer Satisfaction Index of Singapore,” Singapore’s first-ever customer satisfaction survey, conducted by the Institute of Service Excellence at Singapore Management University. See *Through the Looking Glass: Singapore’s First Customer Satisfaction Survey*, KNOWLEDGE@SMU (May 6, 2008), <http://knowledge.smu.edu.sg/article.cfm?articleid=1137>. Singaporeans reported a relatively low level of satisfaction with service in the health care sector generally (67.7 out of 100) and, in particular, with the service in public hospitals (64.6 out of 100) and polyclinics (62.1 out of 100), compared with private hospitals, which were viewed more favorably (72.8 of 100). *Id.* However, in my view, these satisfaction numbers are not that low and, moreover, their health care system gives Singaporeans ready access to private hospitals, which had higher satisfaction ratings.

⁷⁸ Cf. Peter S. Heller, *Asia: Ready or Not*, FIN. & DEV., Sept. 2006, available at <http://www.imf.org/external/pubs/ft/fandd/2006/09/heller.htm> (noting that de-

was below four percent of the nation's gross domestic product (GDP).⁷⁹ That level of spending, as a percentage of GDP, is roughly half the global average and one quarter of U.S. expenditures;⁸⁰ and still Singaporeans were concerned about cost escalation. But in all the debate there was never a murmur of doubt about maintaining the country's commitment to universal health care. Demographics and geography play a substantial part in underpinning that commitment. Close to eighty percent of Singaporeans are of Chinese descent and they all speak a common language.⁸¹ Singapore is a nation about the size of the Philadelphia metropolitan area; what happens to one segment of the population—the outbreak of a communicable disease, for instance—potentially affects the entire population. In this setting—which combines a homogeneous population, a high societal level of literacy and education, and a generally high level of socioeconomic status, all factors that encourage a cohesive society⁸²—achieving consen-

spite Singapore's various effective cost-saving supply and demand restraints, "medical cost pressures are nevertheless emerging in Singapore. . . . These have not been reflected in a rising medical expenditures share yet only because of Singapore's rapid economic growth."). Concern about rising health care costs predates 2006. See, e.g., Phua Kai Hong, *Health Care Costs Revisited*, 34 SMA NEWS 11, 11 (2002), available at http://www.sma.org.sg/sma_news/3410/editorial.pdf (acknowledging large public concern about the increase in hospital prices, despite the fact that, at that time, Singapore was only spending three percent of its GDP on health care—two percent less than the World Health Organization's recommended amount); Press Release, Ministry of Health, Sing., Reaching Out to Address Public's Concerns on Healthcare Costs (Sept. 25, 2001), available at <http://www.moh.gov.sg/mohcorp/pressreleases.aspx?id=1014> (discussing plans in 2001 for the Senior Parliamentary Secretary of Health to initiate "a series of community reach-out efforts to address to [sic] public's concerns on rising healthcare costs and correct common misconceptions").

⁷⁹ See WORLD HEALTH ORG., WORLD HEALTH STATISTICS 2009 *supra* note 76. Surprisingly, the WHO report documents that in 2006 Singapore's total expenditure on health as a percentage of its GDP was 3.3%, as opposed to 3.5% in 2000. This downward trend was not reflected in the concerns leading up to the 2006 elections.

⁸⁰ *Id.*

⁸¹ Somewhat surprisingly, the official language is English. This choice is not just a remnant of British Colonial rule—Singapore gained its independence in 1965, after 135 years as a British Crown colony—but is a choice carefully made to be neutral among the three major ethnic groups (Chinese, Malay, and Indian) and further to give Singaporeans "a window to the knowledge, technology, and expertise of the modern world." See Anne Pakir, *Bilingual Education with English as an Official Language: Sociocultural Implications* (quoting then-Minister for Education Tony Tan Keng Yam), in *ROUNDTABLE ON LANGUAGES AND LINGUISTICS 1999*, at 341, 342 (James E. Alatis & Ai-Hui Tan eds., 2001).

⁸² Exactly what makes for social cohesiveness is far from settled. See generally William Easterly et al., *Social Cohesion, Institutions, and Growth* (Ctr. for Global Dev., Working Paper No. 94, 2006).

sus on health care issues is far less difficult than in the far more diverse United States.

In addition to race, ethnicity, language, socioeconomic status, and geography, age is an important demographic factor that affects the quest for universal health care. For evidence of this impact one need not look beyond American borders. As noted above, the establishment of Medicare in 1965 was one of the most significant advances toward universal health care achieved in American history. Medicare went into effect when the oldest of the post–World War II baby boom generation was just entering its adulthood.⁸³ Baby boomers had their entire working lives ahead of them before they would become Medicare beneficiaries.⁸⁴ They would pay into the Medicare trust fund throughout this period, some forty to fifty years, and then would draw upon that fund for health care services throughout their remaining years, however long that might be. By design, Medicare, like Social Security, does not maintain separate trust accounts for each participant. During their working lifetimes, people pay into a common Medicare trust fund and once they are eligible, their benefits are drawn from it.⁸⁵ As eligible Medicare beneficiaries are drawing benefits from the fund, other individuals, not yet eligible for benefits, are paying into it—not only laying aside assets to cover their own cohort’s future needs, but also covering whatever current shortfalls the fund might experience.⁸⁶ Ideally, the amount paid into the trust fund by an age cohort would cover all the costs of health care for that cohort when they eventually became beneficiaries. But since funding shortfalls for

⁸³ According to the U.S. Census Bureau, “The population born between 1946 and 1964 is commonly referred to as the Baby Boom generation.” U.S. CENSUS BUREAU, SELECTED CHARACTERISTICS OF BABY BOOMERS 42 TO 60 YEARS OLD IN 2006, at 2 (2006), available at <http://www.census.gov/population/www/socdemo/age/2006%20Baby%20Boomers.pdf>.

⁸⁴ The majority of Medicare beneficiaries are sixty-five or older. A relatively small percentage of this group is comprised of people under age sixty-five who become eligible because of permanent disabilities. In 2007, this percentage was seventeen percent—just over eight million beneficiaries. See KAISER FAMILY FOUND., MEDICARE AT A GLANCE 1 exhibit 1 (2010), available at <http://www.kff.org/medicare/upload/1066-12.pdf>.

⁸⁵ For a broad overview of Medicare’s funding arrangement, see *How is Medicare Funded?*, CENTERS FOR MEDICARE & MEDICAID SERVICES., <http://www.medicare.gov/Publications/Pubs/pdf/11396.pdf> (last visited Mar. 15, 2011).

⁸⁶ See Edgar K. Browning, *The Anatomy of Social Security and Medicare*, 13 INDEP. REV. 5, 17 (2008) (“Today there are 3.3 workers paying taxes for every retiree receiving benefits. The average worker must therefore pay a tax that will provide about 30 percent of the average retiree’s benefits. If the 3.3 to 1.0 ratio of workers to retirees does not change, a given tax rate on workers’ earnings can fund benefits indefinitely.” (footnotes omitted)).

one generation have to be covered by the next generation's payments, Medicare reflects, in effect, an "intergenerational compact." Each generation receiving benefits relies on the next generation to pick up the slack and make the system work.⁸⁷ Younger generations presumably bear this burden willingly, knowing that when they reach age sixty-five, they too will be supported by those behind them. Each generation is "paying it forward," so to speak.⁸⁸ A key flaw in the scheme, as it turned out, was that the later generations were much smaller than anticipated.⁸⁹ Oral contraceptives came into widespread use at about the time of Medicare's passage⁹⁰ and, for the first time in U.S. history, the succeeding generation was smaller than the one before.⁹¹ We are just now starting to feel the difficulties this population shortfall creates as

⁸⁷ See Will Marshall, *The Rule of Reciprocity*, BLUEPRINT (Apr. 1, 1999), http://www.dlc.org/ndol_ci.cfm?kaid=115&subid=145&contentid=1435 ("Social Security and Medicare are based on an intergenerational compact: We work and pay taxes to support our parents' retirement and health care; in turn, we expect our children to do the same for us.").

⁸⁸ The reference is principally to the movie *PAY IT FORWARD* (Warner Bros. Pictures 2000) and more generally to the idea of "doing a favor for another person without any expectation of being paid back. . . . [and requesting] that the recipient of that favor do the same for someone else—ideally, for three other people." See *Pay It Forward Foundation FAQ*, PAY IT FORWARD FOUND., <http://www.payitforwardfoundation.org/faq.html> (last visited Mar. 15, 2011).

⁸⁹ Cf. Gregory A. Petsko, *Life Is a Ponzi Scheme*, 10 GENOME BIOLOGY 101.1, 101.3 (2009) ("The World Health Organization has estimated that the proportion of older people requiring support from adults of working age will increase globally from 10.5% in 1955 and 12.3% in 1995 to 17.2% in 2025. In 1955, there were 12 people aged over 65 for every 100 aged under 20. By 1995, the old/young ratio was 16/100; by 2025 it will be 31/100."); David G. Surdam, *At Least Ponzi Didn't Threaten Violence*, IDEAS ON LIBERTY, Mar. 2003, at 14, 15 ("[T]he Baby-Boom generation opted for fewer children and productivity may have slowed down after 1973.").

⁹⁰ See Suzanne White Junod & Lara Marks, *Women's Trials: The Approval of the First Oral Contraceptive Pill in the United States and Great Britain*, 57 J. HIST. MED. 117, 117 & n.1 (2002) (discussing the conditional FDA approval of the first oral contraceptive, Enovid, in May 1960). As Junod and Marks explain, "By the end of the twentieth century oral contraceptives had become a feature of everyday life, with more than 70 million women reaching for their pill packet on a daily basis around the globe." *Id.* at 117.

⁹¹ Contributing to this seismic demographic shift, man's first foray into space revealed, in a way never before fully appreciated, the finiteness and fragility of our planet, "Spaceship Earth," creating an ethos and pressure for "Zero Population Growth." See Frank W. Notestein, *Zero Population Growth: What Is It?*, 2 FAM. PLAN. PERSP. 20, 20 (1970) ("From one point of view, favoring zero population growth is like favoring the laws of motion. . . . Zero growth is, then, not simply a desirable goal, it is the only possibility in a finite world.").

the first baby boomers become eligible to receive Medicare benefits.⁹² To make matters worse (from a financial standpoint, that is), Americans' average lifespan has increased substantially since Medicare was enacted (surely in significant part because of the improved health care to which its beneficiaries have access) and longevity continues to increase.⁹³ Seniors are living substantially longer; and they expect not only to have more years of life, but also that their golden years will be a time of healthy mobility and active functionality.⁹⁴ Meeting these expectations requires ready access to the growing range of increasingly expensive medical technology. Various factors, demographic and otherwise, have put increasing financial pressure on Medicare over its forty-five-plus year lifespan.⁹⁵ Watching these demographic time bombs explode in our health care system has made Americans—policy wonks and average folks alike—far more sensitive than previous generations were to the potential effects of future reforms. One wonders if the Congress that fashioned and enacted Medicare would have taken the plunge if it had foreseen the demographic shifts that would eventually burden Medicare so substantially. Surely Americans' willingness to take on a permanent commitment to universal health care has been challenged by our heightened realization and understanding of the impact of demographic factors. As America has become older and wiser, one of the things we have become wiser about is the impact of aging on the health care system.

VI. NATIONAL CHARACTER

A nation's actions are a telling measure of its citizens' composite values and culture—its national character. Similarly telling is when a nation fails to act, in this case failing to assure all our citizens access to at least a minimally adequate level of health care services. The preceding sections examined various factors that help to explain this fail-

⁹² See Marshall, *supra* note 87 (“Up until now, the [Medicare funding arrangement] has worked well, but it can no longer be sustained as the number of older Americans explodes and the workforce that supports them fails to grow apace.”).

⁹³ See Kenneth D. Kochanek et al., *Deaths: Preliminary Data for 2009*, 59 NAT'L VITAL STAT. REP. no. 4, 2011, at 1, 32 fig.2 (documenting the increase in average life expectancy from 1975 to 2009).

⁹⁴ See, e.g., Catherine Mayer, *Amortality: Why It's No Longer Necessary to Act Your Age*, TIME, Apr. 25, 2011, at 45 (reporting that older Americans today continue to engage in many activities previously thought to be reserved for younger people).

⁹⁵ See Browning, *supra* note 86 (noting that the sharp increase in population growth during the baby boom period, the sharp decrease that followed, and increasing life expectancies are all problematic for Medicare's future).

ure: the economic situation at key times; the structure and functioning of our political system; historical developments; the complex of individuals, entities, and vested interests that constitute our existing health care delivery and financing system; and the demographic composition of our population. These factors overlap and interact in a variety of ways, and all of them reflect and affect the character of the American people. But who we are as a people is also a stand-alone, intrinsic feature of our country. The American national character influences what we attempt, how we go about it, and how likely we are to succeed. In fact, our national character may be the single most important determinant of these things. What is it that is unique, or at least different and special, about us, and how far does it go toward explaining our lack of a universal health care solution?

Some may conclude that Americans are more selfish than the citizens of other nations and that we lack the communitarian spirit and the national solidarity to secure universal health care. As I spoke with people in the five nations I studied, many expressed or implied such a belief. Some spoke of American history as the source of their belief. Apparently the story of our pioneer ancestors settling in the North American continent has been widely told around the world. A key element of that story that has stuck in people's minds has been our national ideal of rugged individualism and self-sufficiency—Americans' determination and ability to stand on our own two feet. Notwithstanding that our land was settled as much by teamwork and community cooperation as by individual effort,⁹⁶ the national mythology that has

⁹⁶ Settlers traveled in wagon trains where every pioneer looked out for and received support from fellow travelers. Frontier towns were built by teams of people pulling together at barn raisings and other communal events. Although our current national rhetoric may not reflect it as clearly, America's history is as much a story of communitarian spirit and cooperation as it is of individual endeavor. Discussing the stereotypical view of America as a land of rugged individuals, Roger Rosenblatt stated:

Everyone always says that rugged individualism is the backbone, and the jawbone, of America; that a country as grand and sturdy as this could only have been built by the self-propelled and self-interested strivings of wild-eyed non-conformists, each fur-laden Daniel Boone pursuing his independent errand into the wilderness. . . .

Of course, the picture is pure hokum, and everybody knows it. The West was won by wagon trains, the East by sailing ships, and they all had plenty of passengers aboard, by necessity working together. "In history," Librarian of Congress Daniel Boorstin explained, "even the great explorer had been the man who drew others to a common purpose." Try to imagine an individual so rugged he could raise a roof beam on his own.

Roger Rosenblatt, *The Rugged Individual Rides Again*, TIME, Oct. 15, 1984, at 136.

endured has disproportionately celebrated individual enterprise. If the notion of individuals looking out for themselves, amplified through generations of national literature and lore, has indeed become our core ethos, or the essential “American spirit,” then one could well believe that our prospects for moving toward universal health care are quite dim. “Every man for himself” is hardly a rallying cry for constructing a comprehensive social safety net.

Nevertheless, although national character is more than just a surface veneer, it may not be immutable. National events and history can have a powerful transformative effect. Perhaps if, deep down, humans are all similar then the apparent differences reflect and can be attributed to our recent history. I have heard many of my contemporaries speak about how deeply their parents’ attitudes and values were affected by living through the Great Depression and how their own approaches to life’s challenges were molded by their second-hand exposure to this historical experience. European nationals bonded over the fears, struggles, and privations of World War II, creating the solidarity that not only sustained them during wartime but caused them to continue to pull together after the war, the time when Britain, France, and Italy made their respective national commitments to universal health care. Although more than two generations have passed since the experiences of World War II, the commitment of current Europeans to universal health care owes much to beliefs and attitudes forged during that conflict. Much has been made of how Americans were drawn together by the terrorist attacks on September 11, 2001, but how realistic is this rhetoric? Did people in Utah or South Dakota ever experience the sense of togetherness that Manhattanites did? Can the events of one day, no matter how dramatic and how often memorialized in speeches and video clips, even begin to transform a people the way years of shoulder-to-shoulder wartime struggle and collective suffering did for the Europeans? Probably not, but surely one would not hope for some horrific and more sustained disaster to bond Americans and propel us toward universal health care.

Charismatic leaders, often in conjunction with dramatic events, can also change how a nation’s people will feel and act. We all have heard the recorded radio voice of FDR reassuring Americans during the Depression that “the only thing we have to fear is fear itself”⁹⁷ and

⁹⁷ In his first Inaugural Address, President Franklin D. Roosevelt stated,

This is preeminently the time to speak the truth, the whole truth, frankly and boldly. Nor need we shrink from honestly facing conditions in our country

the challenge JFK issued to “[a]sk not what your country can do for you—ask what you can do for your country.”⁹⁸ Leaders can reach deep into people’s hearts and souls and persuade them to view the world differently and raise themselves up. LBJ’s words in support of a “Great Society” may not be as quotable, but he will long be remembered for his leadership toward achieving that goal and the specific advances—including the passage of Medicare and Medicaid—that are a key part of its promise.

Barack Obama’s call to America to pass health care reform because it is the right thing to do has not yet been engraved in our national conscience, but he has been steadfast in his commitment to this goal in the face of great opposition. Perhaps in time President Obama’s calls to assure health care for all Americans, echoing those of Senator Kennedy, will take their place in our nation’s history as defining moments—moments when we began to view our shared responsibility to one another very differently.

A second element of our national character is also essential to understanding how Americans have approached the issue of universal health care—our longstanding and deep-seated distrust of govern-

today. This great Nation will endure as it has endured, will revive and will prosper. So, first of all, let me assert my firm belief that the only thing we have to fear is fear itself—nameless, unreasoning, unjustified terror which paralyzes needed efforts to convert retreat into advance. In every dark hour of our national life a leadership of frankness and vigor has met with that understanding and support of the people themselves which is essential to victory. I am convinced that you will again give that support to leadership in these critical days.

Inaugural Address, 2 PUB. PAPERS 11 (Mar. 4, 1933).

⁹⁸ In his Inaugural Address, President John F. Kennedy famously said,

I do not shrink from this responsibility—I welcome it. I do not believe that any of us would exchange places with any other people or any other generation. The energy, the faith, the devotion which we bring to this endeavor will light our country and all who serve it—and the glow from that fire can truly light the world.

And so, my fellow Americans, ask not what your country can do for you—ask what you can do for your country.

My fellow citizens of the world; ask not what America will do for you, but what together we can do for the freedom of man.

Finally, whether you are citizens of America or citizens of the world, ask of us here the same high standards of strength and sacrifice which we ask of you. With a good conscience our only sure reward, with history the final judge of our deeds, let us go forth to lead the land we love, asking His blessing and His help, but knowing that here on earth God’s work must truly be our own.

Inaugural Address, *in* 1961 PUB. PAPERS 1, 2-3 (Jan. 20, 1961).

ment.⁹⁹ Many of the earliest American settlers were running from governments they felt had excessive control over their lives. Many would argue that the Constitution, with its structural separation of powers and system of checks and balances reflects a deep-seated libertarian, antigovernment ethos.¹⁰⁰ Add to that the fact that our national

⁹⁹ It should be obvious that a nation founded on rebellion would carry with it some antigovernment sentiments. See President George Washington, Farewell Address (Sept. 19, 1796) (praising the American people for the independence and liberty that they had jointly achieved, but warning that this same independent sensibility could lead to the end of the Union), in 1 A COMPILATION OF THE MESSAGES AND PAPERS OF THE PRESIDENTS 205 (James D. Richardson ed., 1897). President Washington emphasized the trade and defense benefits of remaining one nation, and urged all citizens to love and respect the Constitution at least “till changed by an explicit and authentic act of the whole people” *Id.* at 209; see also THE FEDERALIST NO. 51 (James Madison). Despite being one of the most prominent voices in favor of ratifying the Constitution, Madison frequently remarked on his distrust of government generally, and the difficulty in creating a government that will not eventually lead to tyranny: “In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place oblige it to control itself. A dependence on the people is, no doubt, the primary control on the government; but experience has taught mankind the necessity of auxiliary precautions.” *Id.* For a historical look, see generally GARRY WILLS, A NECESSARY EVIL: A HISTORY OF AMERICAN DISTRUST OF GOVERNMENT (1999). And for a modern look at American distrust in government, see *Distrust, Discontent, Anger and Partisan Rancor: The People and Their Government*, PEW RES. CENTER FOR PEOPLE AND THE PRESS (Apr. 18, 2010), <http://people-press.org/report/606/trust-in-government>, which reports that 22% of Americans polled in March 2010 said that they trust the government “always or most of the time,” 17% said that Congress was doing a good job, and 43% said that the federal government had a negative effect on their daily lives.

¹⁰⁰ We generally accept that the average American is, to some extent, a libertarian at heart. See Eric Foner, *Why Is There No Socialism in the United States?*, 17 HIST. WORKSHOP J. 57, 60-61 (1984) (reviewing several “prominent explanations” for why socialism has not flourished in the United States, including the success of American capitalism, the relative ease of social mobility, and the dominance of “a Lockean, individualistic outlook against which neither socialism on the left nor serious conservatism on the right can make any headway”). But see John Halpin & Ruy Teixeira, *Progressivism Goes Mainstream: New Research on Ideology Refutes the Conservative Myth That America Is a “Center Right” Nation*, AM. PROSPECT, May 2009, at 26, 26 (evaluating the results of a survey designed to determine Americans’ policy preferences and finding “that public acceptance of the Reagan-Bush model of conservatism—limited government, tax cuts, traditional values, and military strength—has given way to a broad and deep cross section of the American public now holding solidly progressive attitudes about government and society”); Press Release, Pew Research Ctr. for the People & the Press, A Political Rhetoric Test: “Socialism” Not So Negative, “Capitalism” Not So Positive 1-2 (May 4, 2010), available at <http://people-press.org/report/610/socialism-capitalism> (“More than four-in-ten independents (44%) react positively to the word ‘libertarian,’ while 32% have a negative reaction. Democrats are nearly evenly divided (39% positive, 37% negative). However, Republicans on balance have a negative impression of this term (44% negative, 31% positive).”). For an example of American libertarianism respond-

success and wealth are largely attributable—or, at least, are widely attributed—to our development of a capitalistic, competitive, free-enterprise economic system. Americans believe not just that strong government is somehow to be feared, but also that the private sector can do most things better.¹⁰¹ Harking back to a point made earlier, perhaps this amalgam of beliefs was heightened by our long contest with the Soviet Union, which ended not through military confrontation but rather because the frailty of the Soviet's government-controlled economic system brought their regime to the brink of collapse.¹⁰²

As noted above, the interplay among the six “stars” is substantial. Whether our current health care reform efforts are driven by our national economic situation, politics, history, health care infrastructure, demographics, national character, or a complex and uniquely American amalgam of all these factors, the bottom line is that any reform will necessarily rely heavily on the private sector. The calls for a single-payer government-run system that were heard in the debates leading up to the Affordable Care Act will not likely be heard again, at least not with any impact in the foreseeable future.¹⁰³ Even the substantially less extreme form of government intervention reflected in the “public

ing to the recent health care developments, see Jason Mazzone, Opinion, *Can Congress Force You to Be Healthy?*, N.Y. TIMES, Dec. 17, 2010, at A39.

¹⁰¹ See WILLIAM A. GALSTON & ELAINE C. KAMARCK, THE THIRD WAY ECON. PROGRAM, CHANGE YOU CAN BELIEVE IN NEEDS A GOVERNMENT YOU CAN TRUST 4-5 & tbl.1 (2008) (tracking the historical decline in trust in government); William Galston, *Americans Still Don't Trust Government—But They Could Go for a Health Care Plan Modeled Like This . . .*, NEW REPUBLIC (Sept. 3, 2009, 12:00 AM), <http://www.tnr.com/blog/william-galston/americans-still-dont-trust-government%E2%80%94they-could-go-health-care-plan-modeled> (discussing opinion polling that found that more Americans trust private insurance companies to provide health care coverage than they do the government).

¹⁰² For an examination of the American reaction to socialism, see Foner, *supra* note 100. For a modern look at the complex economic factors that led to the Soviet Union's collapse, see Johannes F. Linn, Economic (Dis)Integration Matters: The Soviet Collapse Revisited 4-9 (Oct. 2004) (unpublished paper prepared for a conference on “Transition in the CIS: Achievements and Challenges” at the Academy for Nat'l Economy, Moscow), available at http://www.iet.ru/files/text/confer/2004_09_13-14/linn_en.pdf, which examines a variety of factors that led to economic collapse, including the inefficiencies of large-scale centralized economic management, underconsumption of mandated products, and high military spending.

¹⁰³ The standard-bearer for a single-payer system is the organization Physicians for a National Health Program, along with its outspoken and eloquent representatives, David Himmelstein and Steffie Woolhandler. For background on the organization, see *PNHP Research: The Case for a National Health Program*, PHYSICIANS FOR NAT'L HEALTH PROGRAM, http://www.pnhp.org/single_payer_resources/pnhp_research_the_case_for_a_national_health_program.php (last visited Mar. 15, 2011), which provides findings and statistics generated by the Physicians for a National Health Program in favor of a single-payer national health program.

option”¹⁰⁴ is not likely to gain any traction, especially given the more right-leaning composition of the 112th Congress. As America pushes forward—*if* it pushes forward, as I hope and believe it will¹⁰⁵—toward implementing comprehensive health care reform and achieving universal health care, it most certainly will take an approach that does not resemble “European-style Socialism.” Instead, it is more likely to adopt an approach that emphasizes individual responsibility and rests heavily on private sector entities and initiatives. It will be, as it long has been, a uniquely American solution. But, just as certainly, it will have a substantial government component. The role and influence of government, both state and federal, is simply too pervasive and too necessary to be written out, however much some people may fail to acknowledge this truth. The Town Hall protester who insisted “Keep your government hands off my Medicare”¹⁰⁶ will not likely have his way.

CONCLUSION

This has not been an easy article to write, just as this was not an easy symposium issue for the *University of Pennsylvania Law Review's* editors to pull together. Symposium issues assemble and integrate the papers presented at an event that took place at a single point in time. It is not uncommon for some things to change between the date of a symposium and the date the symposium issue hits the streets: that is inevitable and expected. But the events that have transpired and will continue to unfold between October 2010, when this Symposium was held, and the date when this article will first be read are especially substantial, dramatic, and fluid. Last October, the sole federal court that had ruled on the merits of the constitutional challenge to the Af-

¹⁰⁴ For a post-mortem analysis of the public option, which was ultimately not included in the Affordable Care Act, see David M. Herszenhorn, *Congressional Memo: A Grand Achievement, or a Lost Opportunity?*, N.Y. TIMES, Mar. 25, 2010, at A21; Brian Beutler, *Post Mortem: Who Killed the Public Option*, TPM (Mar. 15, 2010, 9:56 AM), <http://tpmdc.talkingpointsmemo.com/2010/03/post-mortem-why-the-public-options-cause-of-death-remains-a-mystery.php>.

¹⁰⁵ Other articles from this Symposium have addressed the question of whether the Affordable Care Act will survive judicial review. See Patrick McKinley Brennan, *The Individual Mandate, Sovereignty, and the Ends of Good Government: A Reply to Professor Randy Barnett*, 159 U. PA. L. REV. 1623 (2011); Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PA. L. REV. 1825 (2011); Abigail R. Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209 (2011).

¹⁰⁶ See, e.g., Timothy Noah, *The Medicare Isn't Government Meme*, SLATE (Aug. 5, 2009, 2:04 PM), <http://www.slate.com/id/2224350/> (chronicling the emergence of the illogical argument of some Medicare supporters that the government should not be involved in health care).

fordable Care Act had upheld the law.¹⁰⁷ In late November another ruling joined that decision, likewise rejecting arguments against the Act's constitutionality.¹⁰⁸ But the *Cuccinelli* opinion, issued in December, struck down the controversial individual mandate to purchase health insurance;¹⁰⁹ and suddenly all bets were off. Another nail, a big one at that, was driven into the coffin by Judge Vinson's decision in *Florida ex rel Bondi v. U.S. Department of Health & Human Services*,¹¹⁰ a challenge to the law brought by twenty-six states and various individuals. Vinson's opinion goes a considerable step further, finding not only that the individual mandate is unconstitutional¹¹¹ but that it is integral to the overall legislative scheme and, therefore, not severable;¹¹² consequently, the entire Act must fail.¹¹³ Although a fifth opinion has recently come down, this one upholding the law,¹¹⁴ it seems clear that the constitutionality of the Act will ultimately require Supreme Court review. Does anyone care to bet on the outcome? I certainly would not.

As if the flurry of recent court decisions was not enough, the mid-term elections of November 2010, just days after the Symposium, changed the political playing field dramatically, albeit not unexpectedly. Given the composition of the new Congress, repeal of the Act is a real possibility that must be acknowledged, although it would not be easy to achieve;¹¹⁵ and it will be faced in an economic climate that is far from predictable. Numerous presenters at the October Symposium made prognostications of various sorts; and while they took care to hem them in with qualifications, they likely had a tougher job re-reading their papers for publication than this author. The road to

¹⁰⁷ See *Thomas More Law Ctr. v. Obama*, 720 F. Supp. 2d 882, 891-95 (E.D. Mich. 2010) (holding that Congress legitimately exercised its power under the Commerce Clause in enacting the Affordable Care Act's individual mandate provision).

¹⁰⁸ See *Liberty Univ. v. Geithner*, No. 10-0015, 2010 WL 4860299, at *11 (W.D. Va. Nov. 30, 2010) (upholding the constitutionality of the individual mandate provision).

¹⁰⁹ See *Virginia ex rel. Cuccinelli v. Sebelius*, 728 F. Supp. 2d 768, 788 (E.D. Va. 2010) (holding the individual mandate provision unconstitutional but finding it severable and, thus, preserving the rest of the Act).

¹¹⁰ *Florida ex rel Bondi v. U.S. Dep't of Health & Human Servs.*, No. 10-0091, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

¹¹¹ *Id.* at *33.

¹¹² *Id.* at *39.

¹¹³ *Id.* at *40.

¹¹⁴ *Mead v. Holder*, No. 10-0950, 2011 WL 611139 (D.D.C. Feb. 22, 2011).

¹¹⁵ For a discussion of recent efforts to repeal the Affordable Care Act, see *supra* notes 9-10 and accompanying text.

health care reform and to universal health care in the United States stretches on far ahead of us. One hopes it is not a “road to nowhere.”¹¹⁶ Moreover, the author hopes the insights and context offered here will help those who care deeply about the future of our nation’s health care to better understand where we Americans are coming from and where we are headed as we travel down this winding road. May this article make it easier to see the stars pointing toward universal health care and to know when and how they may come into alignment.

¹¹⁶ See HACKER, *supra* note 12.