

“Shoved down our throats”: ideology and opposition to the “public option” in the 2009-2010 U.S. health care reform debate

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Figure 1: Protesters at Capitol Hill the weekend of the reconciliation bill's passage. Image courtesy of independent journalist Hannah Rappleye.

“Health Care Reform: First, You’ll Feel a Sharp Pinch:”¹ introduction

In March 2010, Barack Obama signed the Patient Protection and Affordable Care Act into law, closing roughly a year of intense congressional and public debate² over health care reform in the United States. The 2009-2010 debate, introduction, and passage represent the

¹ The chapter title is taken from an opinion piece by *The Wall Street Journal* contributor Peter Brown, published June 9, 2009.

² Sociologist and commentator on the reform debate Amitai Enzoni called the larger political and social process unfolding in today’s United States—debates not only on health care but on government regulation of economic sectors in general—a “moral megalogue.” “Societies are constantly engaged in mass dialogues of what is right and wrong...Megalogues involve millions of members of a society exchanging views with one another at workplaces, during family gatherings, in the media, and at public events. They are often contentious and passionate, and, while they have no clear beginning or endpoint they tend to lead to changes in a society’s culture and its members’ behavior” (Enzoni 2009). The health care debate at large can be viewed as a moral megalogue, though it remains necessary to be critical of precisely who was privileged, and who was excluded from the privilege, to participate in that megalogue at the level of public recognition.

latest revisiting of a nearly century-long conflict—arguably the most divisive social policy dilemma in U.S. history—over health care reform in U.S. political and social life, from Theodore Roosevelt’s advocacy for national health insurance in 1912 to Bill Clinton’s failed attempt at comprehensive reform in 1993-1994. The public health insurance option, or simply *public option*, a once possible but ultimately defeated and defunct proposal, lay at the crux of the debate: the measure that aroused suspicion of a “slippery slope toward socialism” (Geyman 2009), fears of bureaucrats deciding grandmothers’ fates,³ and renewed criticism of a bloated and overstepping government.

At its launch, the debate was marked by dramatic calls for reform and an apparent general consensus among political actors, pundits, journalists, academics, and organizations alike of the necessity and timeliness for improvements to the system of health care provision at the national level. Articulating the hopes of advocates for universal health care, some observers hoped for the fulfillment of a right to health care: “In the coming months, Americans will come to know whether or not the rumblings of reform are just sound and fury or whether the first 21st-century attempt at a health care overhaul will at long last deliver on the long-denied promise of universal access” (Dallek 2009). The public option was central to this progressive ambition. Public option advocates aspired to create a health insurance plan owned and operated by the federal government, featuring premiums below those offered by large private insurers and designed to increase competition, quality, access, and lower costs in the health insurance industry at large.

³ “Government health care kills granny dead!” read a *Mother Jones* article from August 2009, capturing the moment perhaps most characterized by heated debate, fear, and misinformation. “Republicans have come up with a counteroffensive to President Obama’s health care plan, and it can be summed up in one handy code word: rationing...the notion that Obama secretly plans to deny treatment to your grandmother—in order to free up cash for a socialized health care system” (Ridgeway 2009). The claim is unsupported; “the controversy stems from a language in health care legislation promoted by congressional Democrats that would allow payment for physicians who counsel elderly or terminally ill patients about what medical interventions they would prefer near the end of their lives and how to prepare instructions such as living wills” (Ibid.).

Others warned that the possibility of public components to health care reform would operate counterproductively to reform goals, such as decreasing federal deficits or generating economic growth, or feared the government's encroachment into a new—and deeply intimate—sphere of subjects' lives. "Health care desperately needs far-reaching reforms," wrote a commentator in June 2009, "but if Mr. Obama signs into law a 'public option,' government-run insurance program as part of health-care reform we won't be able to undo the damage" (Rove 2009). After its passage, some parties commended the Obama administration for successfully facilitating the passage of a health care reform bill, an ambition that had consumed and eluded a series of Democratic presidents over several decades. Others, including the physicians' association and universal health care advocacy organization Physicians for a National Health Program, criticized the reform for not being comprehensive or radical enough: "Instead of eliminating the root of the problem - the profit-driven, private health insurance industry - this costly new legislation will enrich and further entrench these firms," read a statement issued by the organization shortly after the reconciliation bill's passage (Physicians for a National Health Program 2009). Still, others, including groups of protesters found on Capitol Hill the day of the passage, feared the bill represented an irreversible step to excessive governmental involvement in health provision: *The Washington Post* reported that demonstrators with signs featuring slogans like "Don't Tread on Me" and "Doctors, Not Dictators" populated Washington, D.C. after the bill's affirmative vote in the House of Representatives.

Obama, like Clinton before him, campaigned on the promise of comprehensive health care reform. Six months into his term in June 2009, the presidential administration and reform-minded Congressional Democrats gathered momentum for health care reform, made the first concrete legislative proposals, and sparked debate in the press, making June the month in which health care reform came to "dominate the domestic agenda in Washington"

(Sack 2009). In the run-up to and during June, Obama and reform-minded Democrats indicated their advocacy for a public option. In the words that would become Obama's pro-public option slogan, advocates claimed the measure would offer consumers increased choice, lower costs of insurance premiums and care, and "keep insurance companies honest" by providing consumers with the presence of a more affordable and trustworthy alternative.

The public option was the core subject around which the debate pivoted in June 2009 and the most contentious reform proposal on the table from the onset. "As the debate on health care reform unfolds, no issue has caused such partisan rancor—and spawned such misleading rhetoric—as whether to create a new public insurance plan to compete with private plans," read one editorial (*The New York Times* 2009). "The 'public option' has emerged as the crux of the unfolding debate over health care reform on Capitol Hill," observed a staff writer at *The Washington Post*, characterizing the measure as an "ideological flash point" predicted to divide Congress (Murray 2009). Most editorial or opinion pieces in nationally syndicated news sources featured a decisive position on the public option in June, and several commentators referred to the measure as the "linchpin" or "litmus-test" of the Democratic agenda (Marcus 2009).

The public option was officially withdrawn by December 2009, when Senate majority leader Harry Reid (D-NV) organized a compromise between reform Democrats, conservative Democrats, and Republicans on the proposal, whose detractors threatened to divide the 60 vote Senate majority needed to advance the bill. With the compromise—which made Medicare coverage available *for purchase* to people 55 and older (expanded from the prior eligibility age of 65)—prospects for the public option's inclusion in the final legislation effectively ended.

The public option was not a proposal for single-payer national health insurance. In the words of its principal non-governmental advocates, "single-payer national health insurance is

a system in which a single public or quasi-public agency organizes health financing, but delivery of care remains largely private” (Physicians for a National Health Program 2010). The arguments in favor of the measure, offered by Democratic leadership at the highest levels of power, consistently reinforced the measure’s conformity with market-based principles of cost reduction, competition, and choice and its instrumentality to a more efficient and growing private health care economy. How, then, did the measure attract accusations of socialized health care and the inevitability of government rationing from Republicans, conservative media, and civil society actors? What background conditions facilitated the public option’s elevation to the most critical element of the health care reform? To understand what rendered the measure so contentious, a close examination of the arguments raised against it is necessary. What main criticisms did opponents of the public option lodge? What made its introduction and debate so impassioned, and its passage ultimately politically unfeasible?

Opponents first claimed that the public option was one step in a Democratic strategy to socialize the U.S. system of health care provision. This objection can be broadly deemed the suspicion of a “government takeover.” The argument tended to take one of two forms: first, that the public option would, given the logic of competitive markets, inevitably lead to socialized medicine, or second, that the public option was a deliberate “bait-and-switch” strategy—or “Trojan horse”—for surreptitiously socializing health industries by tricking the U.S. public into supporting reforms far more radical than billed (Anderson and Leavitt 2009). The two are certainly not exclusive, since some commentators cited the social democratic principle of a gradual transformation toward a more socialist economy as a supporting argument for the U.S.’s march toward a socialist order.

The notion that socialized health care would ultimately, inevitably lead to “rationed care” followed from the government takeover objection. Often drawing on examples of

rationing in Canada and Western European countries, proponents of this view claimed that governments in control of health services would seek to cut medical and administrative costs by denying care or prolonging the process to receive care. Implicit throughout opposing arguments was the assertion that the government was incapable of providing a health insurance option efficiently and effectively, given the existence of bureaucracy.

Whenever a good fulfilling a right is primarily privately administered—e.g. health care or housing—the social right to fulfill that need enters into conflict with the firms’ legal right to make a profit from its fulfillment. This essay shows how the specific language of the June 2009 debate created the conditions for a hierarchy of priorities in the 2009-2010 health care reform project: the designation of a vital economy, not a vital population, as the most important outcome of reform. I show how this feature is absolutely not extraordinary but crucial to the basic functioning of the U.S. liberal government.

Summary of following chapters

Definitions of essential terms and ideas follow in this introductory chapter. I then discuss the methodological approach guiding the work. After explaining the selection of June 2009 as a window of reform opportunity, I chronicle the June 2009 debate from start to finish in the first chapter, focusing on the key points of opposition, supporting arguments, and background assumptions. This June history will not tell the details of presidential or Congressional action, but the debate as it unfolded in mainstream media. I focus on the discourse and rhetoric employed. The second chapter outlines the animating ideas of liberalism and political economy central to a theoretical contextualization and critique of the debate. I place the health care debate firmly into the context of a classically liberal conflict between rights and the market, or put differently, justice and political economy. I conclude with reflections on the larger implications of the debate for conflicts between people’s rights

to fulfill basic needs and firms' rights to make a profit in U.S. political-economic and social life.

Definitions and context of essential terms and ideas

“‘Universal health care.’ ‘The uninsured.’ ‘Public option.’ These are the buzzwords you often hear from Democrats and proponents of President Obama’s plan for health-care reform. But if they want to see that plan enacted, they’d do well to excise those phrases from their vocabulary” (Western 2009).

The following provides the necessary context for the notions used in this essay. The key concept in social policy, and for the purposes of this research, is the distinction between universal and means tested programs.⁴ Universal social programs are guaranteed rights associated with citizenship, or other legal membership such as permanent residency, in a given polity. Means tested programs, aimed to “target” specifically needy citizens, require a test of eligibility, typically income below a determined level of entitlement. In a broad array of literature on the subject, many have argued that means tested social programs are conducive to stigmatization, in contrast with universal services, since they single one social group as a divided, “needy” population whom the society must charitably support (Townsend 1979; Gans 1995, Fraser and Gordon 1997).

Social policies can thus broadly be divided into insurance or assistance programs.

Insurance programs, such as Old Age, Survivors, and Disability Insurance (commonly referred to as Social Security) and Medicare, are universal in principle. Assistance programs

⁴ The U.S. has about a century-old history with means-tested programs. After Social Security, the U.S.’s second contributory program is Medicare, which heavily subsidizes hospital care for retired or disabled persons already covered by Social Security. Unemployment insurance is the largest noncontributory assistance program without a means test, applied to workers either laid off or unable to find work. Until 1996, Aid to Families with Dependent Children (AFDC), offered means-tested payments to either single-parent families with children or two-parent families with an unemployed breadwinner. AFDC achieved a spectacularly negative public reputation (Skocpol 1991; Quadagno 1994; Fraser & Gordon 1997) and solidified the public image of the single mother on welfare, usually a woman of color (Fraser & Gordon 1997). Three other means tested programs exist: Supplemental Security Income for persons with disabilities, Food Stamps, and the Earned Income Tax Credit, a cash subsidy or tax credit to poor working families. Finally, Medicaid pays for medical expenses for low-income families and persons according to a means test.

are designed to target those in need of additional help beyond the available universal services. Assistance is not, however, necessarily means-tested. While programs like Supplemental Security Income, food stamps, Medicaid, and the Earned Income Tax Credit use a means test to determine eligibility; Unemployment Insurance does not. Insurance programs are contributory, or funded by taxpayers, while assistance programs are noncontributory.

“If you have health insurance, the reform we’re proposing will provide you with more *security* and more *stability*,” Obama said in an address on July 22. The rhetoric of security is far from novel in the American health care debate. The notion of security is rhetorically appealing to middle and working class individuals and families that experience *risks* associated with the vagaries of the market—not, alternatively, people who experience poverty or protracted exclusion from employment markets. The prioritization of this class of people is consistent with what Nancy Fraser conceptualizes as the three-tiered social service system.⁵ At the top of the tier rests the set of social insurance services, “designed to protect people from the vagaries of the labor market” (Fraser 1997, 41). Just below on the second tier is direct, targeted support for vulnerable groups in society. Poverty relief falls into the lowest, residual tier. This tier encapsulates the means-tested programs that have historically suffered from the greatest stigmatization and garnered the most public opposition. The expectation of stigmatization and opposition is reflected in the 2009-2010 health care debate, just as it was in Clinton’s 1993-1994 episode: politicians stress that the reform’s target audience is indeed those members of society that travel within the dimensions of the top tier. Providing health care for deeply poor or socially excluded people and social groups was not a rhetorical priority for reformers.

The Great Depression and the subsequent passage of the Social Security Act in 1935 provide a concrete historical example of the exclusion of the poor, or their demotion to the

⁵ See Fraser's 1997 “After the Family Wage: A Postindustrial Thought Experiment” in *Justice Interruptus: Reflections on the ‘Postsocialist Condition.’*

residual tier of social policies during periods of reform. The 1930s yielded the great watershed period of social reforms introduced by Franklin D. Roosevelt (FDR) and codified by the 1935 Social Security Act, which assured insurance for the unemployed and elderly and assistance for the elderly, blind, and dependent children. The reason the Social Security Act did not include universal health care, or indeed any other national program apart from the politically palatable retirement insurance, was the specific political, ideological, and perhaps even social-psychological constraints faced by the FDR administration. Reform debates centered on those immediately rendered poor by the Depression, not “already-poor” or deeply poor people, particularly black Americans. Crises that affect people across class and racial lines nevertheless serve to reinforce them when political leadership separates the newly-poor from the already-poor. The persistent exclusion of what the American political commentator Barbara Ehrenreich calls the “already-poor” from the proposals and debates reinforce the political illegitimacy of universal benefits in the U.S. context (Ehrenreich 2009).

A note on the distinction between health care, health insurance, and public health is necessary. Health care is the broadest of these terms, used to describe the overall medical and social organization of health, illness, and disease. Rather than terms such as medicine, the health sector, or health industry, *health care* signifies the social distribution and management of health services. The term is uniquely capable of capturing the issues of access and distributional inequality in a society’s health service provision system. Second, health insurance (in the U.S. context) typically refers to firms that pool consumers’ risk of incurring medical expenses for a premium fee. Finally, public health usually refers to governmental efforts at preventing illness and disease through public programs, such as those promoting epidemiological resistance, nutrition, sanitation, occupational safety, environmental security, and so on. The distinctions between these terms are not immaterial; reforms to public health, such as improving preventive measures and reforming the distribution of nutritious foods or

vital medicine, are radically different from reforms that merely alter the access to curative or palliative services. With the capacity to more significantly alter the relationship between class and health, public health reforms geared at a whole population have more transformative potential than those geared only at individual, curative treatment. This is one component in a broader rubric for the transformativeness of economic reforms.

How does one measure the transformativeness of an economic reform? Modifying Dani Rodrik, I would call a transformative reform a change that somehow alters the rules of the economic game. In the case of social policy reform, extending benefits to more US residents does not change the social policy mechanics, though perhaps extending benefits on principle to a previously unprotected group of people might have been. The universalization of health benefits, conversely, is undoubtedly a transformative reform. Another rubric for the transformative potential of a particular change is Kornai's test for *systemic change* versus a *change of system*, described in his 2000 "What the Change of System from Socialism to Capitalism Does and Does Not Mean." Kornai specified a series of criteria for "building blocks" of a change of system that a reform must satisfy in order to qualify as transformative, ranging from the extent to which the reform challenges the state's relationship with private property and the market, to how the economic system satisfies consumer demand. Neither the public option nor the Patient Protection and Affordable Care Act satisfy even the first of these criteria for transformative potential.

When one refers to political economy, there is indeed a wide array of possible definitions with which she may be operating. Foucault reflects on the ambiguity of the term in his introductory lecture:

Sometimes this expression aims at a particular strict and limited analysis of the production and circulation of wealth. But, in a broader and more practical sense, 'political economy' also refers to any method of government that can procure the nation's prosperity. And finally, political economy... is a sort of general reflection on the organization, distribution, and limitation of powers in a society. Foucault 2008, 13

It is with the last definition I have in mind over the course of this essay.

I operate with a consciously Althusserian conception of *ideology*. Ideology is not only a set of beliefs about the world around one's self, but the very mechanism by which an individual is able to look out into the world as a subject. Ideologies, moreover, are not mere images or representations of the material world in the minds of individuals, but constructed by material life itself. In the case of ideological messages transmitted during the reform, they were not always blatant or even manifest. They appear in the way subjects and political actors conceive of and justify governmental practice. These background assumptions themselves expose attitudes toward poverty, inequality, and social justice.

Finally, whenever I refer to the subjects of the reform (in some cases, the hypothetical subjects of a public option or of a normative social policy discussion), I have chosen to refer to them as *subjects*—not, alternatively, citizens, residents, individuals, or Americans. I have done this for at least two reasons: first, to avoid making a reference to the massive literature on citizenship or implicitly operating with a normative ideal of the “right” “citizen” or “American” to enjoy the benefits of reform, and second, not to exclude illegal immigrants and other members of society who were blatantly un-discussed at the highest levels of power over the course of the debate.

Supposing universals don't exist: toward a different methodology

After closely observing and collecting abundant artifacts from the Clinton administration's 1993-94 reform campaign, Theda Skocpol wrote *Boomerang: Health Care Reform and the Turn Against the Government* in 1997. Skocpol was interested in precisely how the 1993 Health Security Act (HSA) was introduced, debated, and ultimately killed in Congressional committee over the course of one year. Her analysis was not policy-oriented—that is to say, it did not undertake an exegetical or practical reading of the HSA bill—but rather distinctly political, examining the “societal, governmental, and partisan terrains on which Bill Clinton devised his reform plan and on which groups and politicians maneuvered over its fate” (Skocpol 1997, 18).

Skocpol's approach is distinctly not the one animating this essay. The methodological approach behind this project is drawn from Michel Foucault's *The Birth of Biopolitics: Lectures at the College de France 1978-1979*. In the lectures Foucault articulates his intellectual approach to examining the development of particular political phenomena,⁶ an exercise he broadly designates: to “suppose universals do not exist.” I venture to make Foucault's my own approach to understanding the debate surrounding the public option.

Foucault deliberately rejected the intellectual practice of examining governmental practice *as such*—“determining the particular situations it deals with, the problems raised, the tactics chosen, the instruments employed, forged, or remodeled, and so forth” (Foucault 2008, 2). This is precisely what interested Skocpol: the particular dimensions of support and opposition that the HSA and its governmental advocates faced in Congress, the press, and the public, ultimately leading to the bill's nonfulfillment. Foucault regarded this type of approach as rendering existing governmental practice objectively given. He claimed that much of the analysis in sociology, history, and political philosophy started by implicitly accepting

⁶ In the case of 1978-1979 lectures, Foucault was interested in tracing *raison d'Etat*, liberalism, and biopolitics.

universals: “notions such as the sovereign, sovereignty, the people, subjects, the state, and civil society” (Ibid.) and advanced to their actual practice; Foucault sought instead to start from practice itself and see “how certain things—state and society, sovereign and subjects, etcetera—were actually able to be formed, and the status of which should obviously be questioned” (Ibid. 3). He studied not the objective workings of institutions but the conditions of possibility for their creation and reproduction.

Foucault was interested in casting light on the conditions that must be met in order to make a certain discourse possible (Ibid. 36). These conditions—various in scope: historical, economic, religious, social, political, academic, and so on—enable a “particular type of discourse and a set of practices” to be rendered coherent and intelligible (Ibid. 18). They provide the links by which a number of phenomena, which frequently in fact conflict, may be connected so as to make holistic sense.⁷ When a discourse enabled by a certain set of practical conditions is thus rendered coherent and intelligible, the possibility to “legislate on these practices in terms of true and false,” or the ability to identify a new fact or piece of information’s truth or falsity by its consistency with the coherent and intelligible regime, is created (Ibid.). This is the basis for Foucault’s notion of the *regime of truth*. Every society and government produces a regime of truth, the existence of which is crucial to its capability to legislate, adjudicate, punish, divide the population according to some or another classification, and so on. The most important point, of course, is that “truth” is always in fact constructed by enabling conditions and their interaction with structures of social power. Truth and falsity, sense and nonsense, consistency and irregularity are not objective facts but things produced, constructed, and constantly reinforced.

The fundamental purpose of the intellectual exercise, therefore, is not to expose the actual “truths” and “errors” in the development of a discourse on *something* that does not

⁷ Foucault replaced dialectic logic with strategic logic. Unlike dialectics, which propose the unity—or synthesis—of disparate parts, strategic logic explains how disparate parts are able to coexist despite maintaining an antagonistic relationship.

actually exist—in Foucault’s case, madness, delinquency, sexuality, and so on. It is rather to show “by what conjunctions a whole set of practices—from the moment they become coordinated with a regime of truth—was able to make what does not exist...nonetheless something, something however that continues not to exist” (Ibid. 19). Foucault’s is thus not a hunt for the development of errors or illusions. Setting out to expose *error* in a discourse implies that a truth exists exogenously of regimes of truth. Neither is the exercise about revealing the status of *illusions*, since regimes of truth are premised on material practices and power. The project, in sum, aims to show “how a particular regime of truth, and therefore not an error, makes something that does not exist able to become something. It is not an illusion since it is precisely a set of practices, real practices, which established it and thus imperiously marks it out in reality” (Ibid.). Phenomena like politics and economics, their particular practices, and associated discourses are finally “not things that exist, or errors, or illusions, or ideologies. They are things that do not exist and yet which are inscribed in reality and fall under a regime of truth dividing the true and the false” (Ibid. 20).

How is this applicable to a social policy debate, and what relation does it bear to ideology? Take, for example, the notion of *dependency* in the U.S. welfare system. In “A Genealogy of ‘Dependency:’ Tracing a Keyword of the U.S. Welfare State,” Nancy Fraser and Linda Gordon looked at the relationship between dependency and welfare expressed in mainstream U.S. social policy debates. “Dependency,” the idea that means-tested welfare benefits produce a class of people dependent on the state for their livelihoods and privately unmotivated to get off the welfare rolls,⁸ constitutes a part of a moral and economic discourse

⁸ The authors quoted two very familiar examples of the dependency discourse. The first comes from sitting Supreme Court Justice Clarence Thomas, speaking about his sister: “She gets mad when the mailman is late with her welfare check. That’s how dependent she is. What’s worse is that her kids feel entitled to the check, too. They have no motivation for doing better or getting out of that situation” (Fraser and Gordon 121). A second emblematic representation of dependency comes from former Senator Daniel P. Moynihan (D-NY): “the issue of welfare is the issue of dependency...[Dependency] is an incomplete state in life; normal in the child, abnormal in the adult. In a world where completed men and women stand on their own feet, persons who are dependent—as the buried imagery of the word denotes—hang” (Ibid.).

employed to oppose increases to social entitlements. The authors constructed a genealogy of the notion, asking how welfare came to be connoted with dependency, why dependency itself even ought to have normatively negative connotations in the U.S. context, and unearthing “the gender and racial subtexts of this discourse” (Fraser and Gordon 1997, 122). “By charting some major historical shifts in the usage of this term, we will excavate some of the tacit assumptions and connotations it still carries today but that usually go without saying,” the authors wrote (Ibid.). The authors thus engaged in the crucial exercise of deconstructing a term that constitutes a part of an American regime of truth, refusing to take it as objectively given, by demonstrating the conditions that enabled its rise to a veritable commonplace in the liberal orthodoxy.

The authors approached the term as distinctly ideological. Pegging welfare recipients, usually black urban-dwelling single mothers, as *dependent* subordinates social and economic structures—gender, the family, class, race, the state—to accusations of mere individual dysfunction: indolence, incompetence, and delinquency.

The power of this image is overdetermined, we contend, in that it condenses multiple and often contradictory meanings of dependency. Only by disaggregating those different strands, by unpacking the tacit assumptions and evaluative connotations that underlie them, can we begin to understand, and to dislodge, the force of the stereotype. Ibid. 123

The dependency discourse averts potential critiques of existing economic and social systems—from employment to gender structure, family organization, education, the justice and prison systems, and so on—by constructing an image, deeply charged with gender and race, of a privately blamable member of society failing to satisfactorily function within the given environment, the potential inequalities or injustices of which it is not necessary to question.

Just as Fraser and Gordon intended, I aim to unpack the background discourse of the public option discourse and its tacit assumptions and subtexts. The unpacking is aimed not at

the gender, racial, sexual, and citizenship subtexts, however—the subject, I hope of another research—but the guiding understanding of the role of government in economies and social security. Due to what background ideological conditions, rooted in liberal capitalism, was the public option able to inspire precisely the discussion of political economy, state intervention and overstep, and social justice it did? How was the market ideologically imbued with the power to elevate above the right to health care?

This essay analyzes news and opinion articles from nationally syndicated newspapers and news magazines: *Christian Science Monitor*, *The Washington Post*, *The Washington Post*, *USA Today*, *The Wall Street Journal*, and *The Washington Post*. These sources are not ideologically representative of either the U.S. public or media at large; I selected them on the basis of nationwide distribution. One regrettable limitation of the research is its inattention to non-mainstream media sources, such as alternative weeklies or community radio. My purpose, however, is precisely to examine the nature of the health care reform debate in mainstream media, conducted by commentators who enjoy widespread recognition. To focus on the nature of the debate in media sources whose role is precisely to challenge mainstream perspectives and ideologies would produce a meaningful but entirely different research project. The extent that some news sources are more overrepresented relative to others reflects the degree of coverage each news source devoted to the debate in June 2009; *The Washington Post*, for example, featured twelve articles about health reform, while *Christian Science Monitor* printed one. I closely analyzed these primary documents, identifying clusters around which arguments in opposition tended to clump. These clusters then became the subject of my theoretical analysis.

Finally, this essay, it must be noted, is animated by a normative view that people are indeed possessive of a right to health care. The public option is by no means a fulfillment of this imperative; by advocates' own vehement account, the option was designed to boost the

vitality of the market, not instate a universal entitlement. It is, importantly, not a transformative reform; thus neither was, the Patient Protection and Affordable Care Act, shy of the public option, transformative. The public option did not threaten to fundamentally challenge the relationship of rights to profit in the U.S. health care system.

“Sick in the U.S.A.”⁹

June 2009: a window of opportunity

Students of economic reforms and transitions have developed the notion of a “threshold of crisis:” that unique moment of political opportunity for reform when reform-minded politicians observe that the immediate, short-term costs of inaction outweigh the costs of action. In periods of thresholds of crisis, a kind of general public perception exists—produced, aided, or not, by political rhetoric—that the costs of continuing on the current path are higher than the costs associated with reform, thereby rendering any reform at least marginally better than the status quo. I do not necessarily approach June 2009 as a threshold of crisis; to determine the exact occurrence of a threshold is an economist or historian’s task. I draw from this notion the idea of a window of opportunity for reform: the period when prospects for reform are unusually improved by general conditions of economic or political disintegration and a collective, *publicly reported* readiness for change.¹⁰

The window of opportunity for social policy reform that existed during and after the Second World War and the Great Depression is frequently discussed in social policy literature (Ikenberry and Skocpol 1995; Orloff, Skocpol, and Weir 1988), and a window of opportunity existed, according to Skocpol’s analysis, in the 1990s reform effort as well. “The time seems ripe for national health care reform,” Skocpol wrote during the debate. “A belief that there are pressing problems about health care has come together with a sense of *political opportunities* to do something about those problems” (Skocpol 1995, 275). The window of opportunity is characterized by a widespread sense among the public and political leadership—including, importantly, those who previously enjoyed privileges within the

⁹ The heading is taken from an editorial piece by Timothy Noah in *Slate* magazine, June 18, 2009.

¹⁰ One major drawback to the literature on economic reforms, primarily with respect to the transition from state socialist economies to capitalism, is its insensitivity to the active role played by political actors, mainstream media, and other holders of power in producing an environment conducive to reform. The collective readiness or reluctance of a society for reform cannot be assumed; it is both possible and meaningful, however, to examine how this readiness is reported by the media and constructed by political actors.

system prior to its disintegration—that the status quo of some system of organization or provision is broken. “We are at a juncture when problems are widely perceived—even by dominant actors in the U.S. health care system and those who, until recently, were quite self-satisfied” (Skocpol 1995, 275).

Drawing on the aftermath of the credit and housing markets crises and the now widely reported political unpopularity of the 2008 Troubled Asset Relief Program (TARP), commonly known as the bailout,¹¹ Obama very frequently made use of a threshold of crisis language. Writing in a letter to chairpersons of key Congressional committees in early June, and reported in *The Washington Post*, he emphasized: “Fixing what’s wrong with our health care system is no longer a luxury we hope to achieve—it’s a necessity we cannot postpone any longer. The status quo is broken. We cannot continue this way. If we do nothing, everyone’s health care will be put in jeopardy.” During presidential addresses Obama frequently reminded the viewing public that he entered office burdened by a \$1.3 trillion deficit, on the heels of a broadly unpopular series of bank bailouts, and the touted success of the Economic Recovery Act. In a sample of at least five public presidential speeches between June and the end of 2009, Obama began each with near identical statements about the economic crisis from which Congress, with a Democratic majority, had pulled the country “back from the brink.”

Comprehensive health reform in the U.S. is indeed a genuine possibility. Discussions of social policy, particularly in the United States, which is often regarded as an international laggard, are very frequently cast in a moral light that naturalizes certain historical and political conditions as inevitable and unalterable features of an “American social personality.” “It is often claimed, for example, that Americans are a people inherently

¹¹ It is now virtually a historical commonplace that the \$700 billion Troubled Asset Relief Program (TARP), commonly known as the bailout, was a widely unpopular governmental initiative attracting vehement opposition from both ends of the political spectrum. TARP was introduced in September 2008 (still, of course, under the Bush administration) and conducted its first “stress test” of banks that had received federal monies in spring 2009, several months into the Obama administration.

opposed to taking ‘handouts’ from government” (Skocpol 1995, 6), individualistic, entrepreneurial, and so on. This view is frequently rearticulated by media commentators, who participate in the construction of an “American way” of social policymaking. The following example is particularly demonstrable:

If you ask Americans whether universal access to health coverage or lower costs for their own medical care is more important, the latter outstrips the former. And if you ask them whether they are willing to accept constraints on what procedures and medical professionals their insurance—be it private or public—will pay for, then you must be visiting from Mars. Brown 2009

By constructing Americans as a distinct and obvious *people* possessing a collective determined vision, a person who represents a different view is literally cast as an alien visiting from a foreign planet. Whether holding a U.S. passport, residing in the country, or otherwise identifying as American, one who does not adhere to this “American way” violates the American approach to economics and social policy. Operating with this view, which renders U.S. society and social policy static and determined, does not admit for the possibility of change. On the contrary, what I do in this essay—pointing out a specific period of possibility, revealing a window of opportunity, and taking seriously the specific challenges a reform proposal inspires—challenges this commonplace moralization.

There are several reasons that, by the time Obama campaigned for the presidential seat in 2008, the U.S.’s system of health care provision attracted widespread, nearly commonplace criticism and the prospect for health care reform again appeared possible, or even imminent, on the political horizon.

The first is the U.S.’s relative isolation, widely discussed and publicized, from the sphere of advanced industrialized nations, including Canada and Western European states, in terms of operating an efficient health care system capable of providing care for all its citizens.

Every day, Washington tells Americans that they live in an interdependent world with a globalized economy...But change the subject to reform of the health care system and the community of nations abruptly vanishes...Let there be no mention of any industrialized democracy save that of the United States, which is proud to claim 37th

place in the World Health Organization's rankings of the world's health systems and 15th in the Commonwealth Fund's ranking by avoidable mortality of 19 industrialized countries (the highest rank indicates the fewest such deaths). Noah 2009

Statistics such as these became a popular rallying cry for reform advocates, who sought to stoke a general sense of international inadequacy and outrage. Physician activists at PNHP similarly asserted:

Currently, the U.S. health care system is outrageously expensive, yet inadequate. Despite spending more than twice as much as the rest of the industrialized nations (\$8,160 per capita), the United States performs poorly in comparison on major health indicators such as life expectancy, infant mortality and immunization rates. PNHP 2009

These sentiments implicitly relied on a biopolitical assumption that the nation's physical health and vitality ought to be the most valued political priority.

The second reason health care reform in the U.S. is such a politically potent and contested issue is the simple fact that so many politicians tried to undertake reform and failed. The last revisiting before the Obama administration's was, of course, the Clintons' reform effort, which died in congressional committee a year after its rhetorically passionate introduction by the president. Clinton similarly appealed to a sense of immediacy, political opportunity, and the call of history:

It is hard to believe that there was once a time—even in this century—when retirement was nearly synonymous with poverty, and older Americans died in our streets. That is unthinkable today because over half a century ago Americans had the courage to change—to create a Social Security system that ensures that no Americans will be forgotten in their later years.

I believe that forty years from now our grandchildren will also find it unthinkable that there was a time in our country when hard-working families lost their homes and savings simply because their child fell ill, or lost their health coverage when they changed jobs. Yet our grandchildren will only find such things unthinkable if we have the courage to change today. quoted in Skocpol 1996, 2

His reform effort died in congressional committee a year after its proposal. Not until Democrats enjoyed a Congressional majority and executive leadership with Barack Obama's election did health care reform again become a political possibility.



Figure 2: Protesters at Capitol Hill the weekend of the reconciliation bill's passage. Image courtesy of independent journalist Hannah Rappleye.

Choice, competition, and honesty or a “March toward socialism?”¹²

The Greeks appeared to give up their attacks on Troy, boarding their ships and leaving behind a huge wooden horse as an apparent peace offering. The unsuspecting Trojans dragged the horse inside their gates. But the horse was full of Greek soldiers, who opened the gates for their invading army. Advocates for government-run health care are similarly pretending to sail away from “Medicare for All,” leaving before us the notion of a “public option.” Anderson and Leavitt 2009

What did the proposal for the public option look like in June 2009? The public option—or as the bill H.R. 4789 deemed, *Medicare You Can Buy Into*—was a proposed public plan, available to those not already receiving insurance through employers or Medicare. Eligible consumers could buy into the option through a market or Internet based

¹² “Last month the Republican National Committee considered a resolution calling on the Democratic Party to rename itself the ‘Democratic Socialist Party.’ The resolution was killed by RNC Chairman Michael Steele in favor of a supposedly milder condemnation of the Democrats’ ‘march toward socialism,’ read one opinion article that encouraged Democrats to be more honest about the socialist ambitions exposed by the party leadership’s advocacy for the public option (Goldberg 2009).”

exchange, like those offered by private firms such as Anthem Blue Cross Blue Shield. Like the private plans against which it would compete, the option was to be funded by insurance premiums, not taxes or federal subsidies. Its future, reform advocates explained, was as a self-sufficient public enterprise. Subsidies would be directed only toward individuals, not the program itself, to help defray or relieve the costs of the premium, particularly if the public option would be coupled with an individual mandate to purchase health care. This feature was designed to counteract the stigmatizing legacy of public assistance programs by establishing a public institution operating entirely in the image of a private firm.

The idea of the public option, first theoretically expressed by political scientist Jacob Hacker in the 1990s, envisioned a large federal program operated along the lines of Medicare. Hacker's vision differs radically from the one proposed by the current Democratic administration. Hacker proposed to drastically expand eligibility for existing public health insurance schemes—Medicare, Medicaid, and the State Children's Health Insurance Program—to create a large, national public plan: "All-non-elderly Americans, whether privately insured or not, would be eligible to participate, not only those left uninsured by existing private markets and public assistance schemes, and government subsidies were to be extended to those unable to afford the plan. Private insurers would furthermore be required to offer the same minimum benefits as the public plan" (Geyman 2009). The plan was therefore projected to significantly increase competition *and* include a mechanism to make private plans more accessible. "Because of its size and efficiency, such a large plan would be able to keep its premiums much lower than private plans, thereby increasing its attractiveness to enrollees" (Ibid.). In contrast, in Obama's public option, most consumers already covered by private schemes would not be eligible to "opt" for the public alternative. Neither did the proposal stipulate that existing private plans would need to conform to the minimum package offered by the public provider.

Obama had indeed expressed support for more transformative reform before June 2009, including an abstract statement of support for single-payer. In a campaign-era utterance, Obama said “were America ‘starting from scratch’ he would favor a ‘single-payer’—government-run—system” (Will 2009). The president’s support for the public option, consequently, was a compromise to existing political constraints and special interests. In the first weeks of June, when reform-minded political actors began the legislative articulation of this ambition, Obama’s comment became a popular memory for conservatives. For conservative opponents of the public option, the measure was not a yield to political realities, but a secretive strategy to win the ultimate goal of nationalized health care—the “stealth single-payer agenda” (Will 2009)—without regard for transparency or democracy. The public option was the Trojan horse dropped at the gates of U.S. public policy; once passed, opponents claimed, the measure was sure to set into motion the course toward nationalized health care provision. The notion of a secret agenda fuelled the growing sense among conservative critics and activists alike that the bill had been “shoved down the throats”¹³ of the American public in a process isolated from effective democratic participation, that is to say, Democratic leadership was determined to pass the legislation despite public and parliamentary opposition.¹⁴

¹³ The phrase “shoved down our throats” appeared across the blog and television spheres throughout 2009-2010.

¹⁴ Political economist Joan Nelson’s theoretical framework provides a particularly useful structure through which to understand the problem of reform and democratic participation. Governments that aspire to reform must sometimes, Nelson and other political economists of reform contend, behave undemocratically. The tension that lies at the heart of a reformist democratic government, and politicians’ occasional willingness to push forward a reform agenda act despite public opposition, is what in fact explains change in economies. If governments only ever implemented changes that kept their short-term interests intact, how could transformative change occur? Nelson distinguishes between two phases of any reform program: the dual stages of *launch* and *implementation*. Each requires, for Nelson, a completely different strategy with respect to overcoming opposition. Reform-minded governments, even in democratic political systems, are justified in launching reforms in a relatively authoritarian manner if they must overcome the influence of the projected short-term losers from reforms. She calls this strategy *insulation*, or the protection of government from social pressure in the early stages of reform. Nelson argued, however, that despite the commonplace assumption that authoritarian regimes are better at implementing reform plans, they are actually characterized by inefficiencies and vulnerabilities to powerful interest groups. The second implementation or consolidation stage thus requires a more inclusive strategy; governments should cooperate with diverse social actors in order to make the reform efficient and sustainable. Obviously the stage that corresponds to the period of our analysis is launch or implementation.

The public option enjoyed significant support from the highest echelons of the Democratic leadership, and more competition was the foremost argument employed in favor of the measure. In a letter to Democratic chairs of key Senate committees at the beginning of the month, Obama wrote: “I strongly believe that Americans should have the choice of a public health insurance option operating alongside private plans. This will give them a better range of choices, make the health care market more competitive, and keep insurance companies honest.” Echoing the political resolve, House Speaker Nancy Pelosi said in a television interview early in the month: “A bill will not come out of the House without a public option” (Pear 2009). “We think there should be a public plan,” the Vice President Joe Biden said on the popular weekly television news and interview program *Meet the Press*, adding: “You’ve got to have some competition” (Fritze 2009).

Offering more choice and competition via the public option was one part of a dual logic animating the larger reform proposals: regulation and competition. The public option, proponents argued, would introduce more robust competition into the market and slow the progressive increase of health care costs. It would do this, many advocates claimed, by breaking oligopolies or monopolies enjoyed by large health insurers within certain regions of the country. Statistics emerged over the course of June that exposed the lack of competition in the health insurance industry within certain regions. The Nobel Laureate in Economics and *The Washington Post* contributor Paul Krugman wrote in June:

The Justice Department considers an industry to be “highly concentrated” if one company has 42 percent of the market. In Arkansas...Blue Cross Blue Shield has 75 percent of the market. If you take government self-insurance plans out of the equation, it’s higher. The state ranks as the ninth most concentrated in the country. Is it any wonder that insurance premiums have risen five times as fast as wages?
Krugman 2009

Advocates cited statistics—two companies controlling 78% of the market in St. Louis, 76% in one rural Illinois town, and 83% on an Illinois university campus, wrote a pro-public-option Senator (Burris 2009)—to show how the public option would intervene into presently

non-competitive markets to reinstate fair competition. “Fans of the market rightly oppose monopolies. But in many places, a small number of insurance companies—sometimes only one—dominates the market. The public option is a monopoly-buster,” wrote *The Washington Post* columnist and public option supporter E.J. Dionne. Combined with more forceful direct regulation, such as the ban on discriminating applicants or consumers with preexisting conditions, the public option was billed as one component of a comprehensive reform package, which Obama and other reform-minded political actors originally aimed to pass by October.

The contest over reform, according to *The New York Times* columnist and economist Paul Krugman, was not whether or not *regulation* was an acceptable goal—unlike the outrage over uninsured Americans, the moral indignation directed toward insurers’ discrimination against consumers with preexisting conditions could be distributed across classes—but whether *competition* “in the form of a public plan” was an appropriate supplement (Krugman 2009).

Commentators across the ideological spectrum appeared to agree, however, that the excessive costs of health care combined with the existence of 46 million uninsured necessitated reform. The outrage over this fact supported the arguments of single-payer and free market advocates alike. Some expressed their support for universal access while warning of the public option’s threat to choice and competition and advocating a market-based approach. Reporters at *The Washington Post* said of the AMA: “While committed to the goal of affordable health insurance for all, the association has said in a general statement of principles that health services should be ‘provided through private markets, as they are currently’” (Pear 2009). “Every American should have access to affordable health insurance. Government must take strong action to make that possible. However, Mr. Obama’s ‘public option’ is designed to become American’s only option,” read one opinion piece (Anderson

and Leavitt 2009). The contradiction between these aims was not resolved; how could people without access to affordable health insurance be robbed of a fair choice in insurers? Why would one choice for health care provider be worse than no choice at all?

The advocacy for universal access thus became, at times, an empty assurance preceding an argument in favor of an approach with no guarantee of universality whatsoever. This contradiction represented a clear prioritization of the insured over the uninsured, of the “rights” of relatively more secure Americans over the rights of relatively less secure, and ultimately, of the market over social rights. An opinion piece by Senator Bernie Sanders summarized an alternative view: ordering the priorities of reform with the public satisfaction of universal needs firmly at the top. “We as a nation have to answer two very fundamental questions. First, should all Americans be entitled to healthcare in the same way we respond to other basic needs such as education, police, and fire protection? Second, if we are to provide quality healthcare to all, how do we accomplish that in the most cost-effective way?” (Sanders 2009).

Some critics viewed the public option as a tipping point between a market-based system of health care provision and a system based on socialist or European-style principles of organization. Karl Rove, the former senior adviser and deputy chief of staff to President George W. Bush, provided one opinion on “how to stop socialized health care” in an editorial in *The Wall Street Journal* early in June, showing how the public option would diminish competition, force persons and families who can afford insurance to subsidize those who can’t, force Americans onto the public plan, raise the federal deficit, and contaminate the doctor-patient relationship. Obama often plainly rebutted this claim with market-based competitive logic: “Just conceptually, the notion that all these insurance companies who say they’re giving consumers the best possible deal, if they can’t compete against a public plan as

one option, with consumers making the decision what's the best deal, that defies logic" (Murray 2009).

A chief insecurity emanating from the opposition was that the public option, and indeed any large-scale reform in general, would compromise consumers' capability to choose their insurance or health care providers. In response, Obama frequently reiterated the reform's commitment to consumer choice; rhetorically and politically, it became the single most unquestionable component of the reform package. In an installment of his weekly presidential radio address on June 6, Obama outlined the main building blocks upon which reform-minded political actors expected to construct the reform: "lowering costs, improving quality, and protecting consumer choice" (*The Wall Street Journal* 2009). He stressed during a mid-month address to representatives of the American Medical Association (AMA), calling it his "promise to the American people": "If you like your doctor, you will be able to keep your doctor. Period." Paul Krugman editorialized in *The Washington Post*: "Now nobody is proposing that Americans be forced to get their insurance from the government. The 'public option,' if it materializes, will be just that—an option Americans can choose" (Krugman 2009). When advocates assured that consumer choice was not only protected by the reform, but indeed one of its central goals, they responded to a larger insecurity stemming from the intervention of government into the health insurance industry via a public alternative. Opponents claimed that Obama and the Democrats were not, in fact, proposing a sincere option as Krugman clarified, but preparing a "government takeover" of the health insurance industry—either inadvertently or surreptitiously.

The main oppositional argument consisted in a political economy analysis: a public plan entering into competition with private firms would, given the government's inherent advantages and different incentive structure, inevitably eliminate the private market for health insurance. The public option would inevitably lead to single-payer, "socialized medicine" by

eliminating competition between insurance firms. Proponents of this view claimed the government-run plan could not enter the “level playing field” of the insurance market. In comments addressed to the Senate Finance Committee in early June, the AMA declared: “The introduction of a new public plan threatens to restrict patient choice by driving out private insurers, which currently provide coverage for nearly 70 percent of Americans” (Pear 2009), again evoking the danger of reducing choice or driving out private insurers for issues of access. Other arguments similarly suggested that

A public insurer wouldn’t have to hold amounts of capital comparable to private plans. It would be backed by taxpayers. Nor would it likely be subject to the same taxes that private insurers pay, including those on investment returns from holding capital. “Competition” on this level just isn’t possible. Harrington 2009

These arguments served to demonstrate how the government was structurally incapable of interacting on a level playing field with private firms.

The second interpretation of the “government takeover” claimed not just that introducing a public plan would inevitably eliminate the private market, but that reform advocates introduced the public option as a deliberate attempt to take over the health insurance industry—the “Trojan horse” interpretation. “The public option is just a phony. It’s a bait-and-switch tactic meant to reassure people that the president’s goals are less radical than they are. Mr. Obama’s real aim, as some candid Democrats admit, is a single-payer, government-run health-care system” (Rove 2009). Proponents of this view followed the logic that a public option was only one step in a social democratic transformation of the U.S. “They say Obama is merely reviving ‘New Deal economics’ to ‘save’ or ‘reform’ capitalism. But liberals themselves have long seen this approach as the best way to incrementally bring about a European-style, social democratic welfare state” (Goldberg 2009).

The suspicion of a government takeover led to the claim that the state-operated plan would inevitably lead to the rationing of care. If Obama and Democrats were committed to the establishment of a socialist economic system with universal health care access for all, a

logical step to increasing access was cutting costs by reducing care. Proponents of this view cited experiences with Canadian or Western European care. A columnist with one political blog warned: “If he follows the lead of Great Britain, Canada, or other systems of he admires, he can definitely bring down costs. He can do it the way they have, by rationing care. But Americans should bear in mind this summer that when the president promises to get health care costs under control, he is really promising less care” (Charen 2009).

One *USA Today* opinion piece had a more sophisticated insight into the question of rationing, which became an object of fear and insecurity within the public option debate:

As market enthusiasts, conservatives should stop warning that the president’s reforms will result in health care “rationing.” Every product, from a jelly doughnut to a jumbo jet, is rationed—by price or by politics. The conservative’s task is to explain why price is preferable. The answer is that prices produce a rational allocation of scarce goods. (Will 2009)

The commentator reinterpreted the problem of rationing—a phenomenon most opponents attributed to socialist economies—to a mechanism central to the supply and demand mechanisms of market economies. The task for conservatives, he indicates, is both to justify the rationing of a basic need *and* demonstrate why price is precisely the “rational” way of going about it.



Figure 3: Protesters at Capitol Hill the weekend of the reconciliation bill's passage. Image courtesy of independent journalist Hannah Rappleye.

Hands off my health care: critical theoretical analysis

What is this new type of rationality in the art of government, this new type of calculation that consists in saying and telling government: I accept, wish, plan, and calculate that all this should be left alone? I think that this is broadly what is called “liberalism.”¹⁵ Foucault 2008, 20

The preceding chapter outlined the debate over a proposal for government intervention into the health insurance industry in the form of the public option. Public option advocates rallied support for the measure in a recessionary climate primarily by showing its instrumentality to a healthier market for health insurance services. Advocates demonstrated how the option would reduce costs and encourage efficiency in a sector widely criticized for its unaffordable premiums and excessive spending on administrative and overhead costs not related to patient care. The public option, advocates showed in political economy language,

¹⁵ Foucault’s lecture includes a footnote: “The word [‘liberalism’] should be understood very broadly.”

would make the insurance industry itself more robust by increasing competition, choice, and quality. All these factors converged to make the public option a desirable way of increasing access to health insurance for millions of uninsured. Growth, however, remained the reform's end goal; increased access was a beneficial offshoot—or perhaps, a positive externality—of the public option.

Opponents of the public option, however, claimed the measure represented an unjustified governmental incursion upon subjects' lives, veering the U.S. in the direction of a socialist state. The latter was supported by the political economy argument that a public option would inevitably eliminate the private market for health insurance, given the state's inherent economic privileges. Once having established a single-payer system, some detractors continued, the government would eventually ration health care in order to cut costs in pursuit of universal entitlement expansion. These arguments were employed to demonstrate the danger of excessive state involvement in this most intimate arena of subjects' lives.

While many commentators evoked the outrage of 47 million uninsured, the right of all people to health care was rarely and sporadically used as an argument undergirding the necessity and urgency of reforms to ease and expand access, much less universalize it. Outrage over the uninsured was not adequately translated into a critique of its social injustice and a vision for its permanent resolution in the form of an entitlement to health care. The point is not that 47 million people in the U.S. found themselves uninsured at the time of June 2009, the only 47 million who would ever need to be extended access to insurance—but that private health care provision systematically excludes a portion of the population from securely accessing health care. Transformative reforms, which can penetrate to the structure of a system of production and distribution, are the only kind capable of correcting the injustice of a segment of the population structurally excluded from accessing health services in the country. Only in marginal (relative to the mainstream debate) circles of single-payer

advocacy could arguments that employed a rights-based language to support comprehensive reform with the explicit goal of universal access be heard. A rights-based discourse was absent from the mainstream debate in June 2009.

Health care reform, in particular the public option, is a conflict between a rights-based logic and the laws of the market—or, alternatively, justice and political economy—in liberal governmental practice. Appealing to political economy for justifying or opposing a reform places the debate squarely in the zone of considering reform’s economic *effects*. Appealing to rights or justice, on the other hand, creates the possibility of looking to the *sources* of a social problem, such as a private industry systematically falling short of the satisfaction of a basic need, and search for a solution to rectify an original injustice. By remaining confined within the constraints of a political economy approach, the debate was unable to escalate to a discussion of rights, justice, and the ethical role of government in insuring the health of its subject population. Only a debate animated by the latter could have produced the kind of transformative reform necessary to structurally improve—and ultimately universalize—access to health services in the United States.

The public option debate was ultimately about the government’s appropriate limits: how far could the U.S. justifiably enter into subjects’ health care provision? Advocates and opponents alike structured their arguments around justifying or resisting an expansion of state into a private industry. When a government must make a decision to intervene, or not, into some sphere of subjects’ lives, by what calculus is it able to determine arguments in favor or against that intervention? What logic informs government that entrance into a particular sphere is a trespass, if it ultimately so decides? How, put plainly, does government “decide themselves on what is to be done and what is not to be done” (Foucault 2008, 12)?

Governments in different spatial and temporal locations have dealt with the problem of limitation in various ways. Absolute governments or those following principles of *raison*

d'Etat, for example, appealed to extrinsic criteria to determine their appropriate limits of governance, namely, moral or religious boundaries and national interest respectively. “The principle of right—whether historically or theoretically defined doesn’t matter here—previously confronted the sovereign and what he could do with a certain limit: You will not step over this line, you will not infringe this right, and you will not violate this basic freedom” (Foucault 2008, 12). Because rights constituted the parameters of the sovereign’s license, any overstep was rendered an *abuse* of power, calling the sovereign’s legitimacy into question.

An archetypical example of this logic of legitimacy is found in the canonical philosophical expression of absolute government: Hobbes’s *Leviathan*. As the sovereign was authorized to govern through the abstract process of the social contract, it enjoys inherent legitimacy in Hobbes’s vision. The sovereign’s legitimacy, according to Hobbes, follows naturally from the existential necessity of government; after all, humans entered into the social contract to instate the sovereign’s seat of power after recognizing the impossibility of their peaceful coexistence in the absence of authority. When the subjects chose absolute power over absolute anarchy, they forfeited liberty to the sovereign as the price of security. Since the social contract is not a historical event but an abstraction of human nature, the sovereign’s sphere of legitimate intervention is therefore determined by the natural laws of humans and social relations. It is irrelevant that Hobbes’s sovereign in fact enjoys infinite legitimacy; the sovereign can legitimately justify any intervention as the price of collective peace. What matters is the government’s appeal to a law—here natural, moral, and religious—extraneous to itself.

While *Leviathan* may provide an obvious theoretical example of extrinsic limits to governance, more modern examples abound. Whenever a government, social movement, organization, or individual appeals to human rights, social justice, or ethics either to justify or

argue against governmental intervention, they employ a rights-based logic, thereby appealing to a logic external of its own governmental mechanisms. Contemporary uses of human rights by oppressed and marginalized social groups who tend not to enjoy support at local and national levels evokes the type of appeal to an external criterion of justice characteristic of this approach. At its broadest, the approach simply provides political agents with a rubric of governmental action external to the constraints and limited possibilities of their present moment. Rather than capturing the possibility of the existing state of affairs—burdened by a finite set of restrictions—appeals to the *right* capture the infinite potentiality of social life. They are able to set into motion a utopian vision for the future, even in a present characterized by numerous, very real limitations.

In the case of absolute government, the sovereign's sphere of legitimate power is limitless—up until the point that it encounters a limit set by a predetermined notion of justice or morality. In other words, the dynamics of governmental limitation are such that the sovereign behaves freely until obstructed by a limit. Liberalism functions in precisely the opposite way. Its status quo mode of behavior is not engagement but rather disengagement. Government does not experience a freedom of movement save its confrontation with limits; it must, conversely, be met with a sufficient argument *in favor* of intervention to justify interrupting the status quo of nonparticipation. This description of liberalism resembles what contemporary liberal philosophers call *liberal neutrality*, the doctrine that a liberal government ought not promote one particular way of life or notion of the good over another.¹⁶

The remarkably novel element of liberalism as a system of government is its internal logic of limitation, or what Foucault refers to as frugality: “The question of the frugality of government is indeed the question of liberalism” (Foucault 2008, 29). The problem of

¹⁶ See, for example, Richard Arneson's “Liberal Neutrality on the Good: An Autopsy” in G. Klosko. and S. Wall's 2003 *Perfectionism and Neutrality*.

liberalism, Foucault observes, is the problem of how not to govern too much, or to determine precisely the limit that allows government to achieve its objectives and nothing more.

Liberalism does not appeal to external criteria to determine either its objectives or limits; its regulatory logic is instead internally inscribed.

What constitutes this internal logic? Liberalism allows governments to appeal to the “laws” or principles of their own internal practice; these laws are not the product of political actors’ reflections on the right or most ethical mode of government, or of the demands or will of members of the public, but the stuff of government’s objectives. To the extent that government’s objectives are its national economic growth, for example, it will pursue that objective and look only to the laws of economic growth dictated by political economy to achieve it.

The problem of determining limits of power for liberal governments is therefore not a question of legitimacy but of *reason*. Because its internal laws are rationalized and made intelligible by its own particular regime of truth, a liberal government may behave in ways that may, in fact, be identified as true or false, reasonable or unreasonable. Moreover, because the status quo of liberal governmental action is nonengagement, the problem of an overstep—a reach beyond its appropriate scope—is rendered not as an abuse of the government’s legitimate purview but a mere excess. Government is not unjust in abusing its rightful jurisdiction, but simply too big.

This critical governmental reason, or internal criticism of governmental reason, no longer revolves around the question of right and the question of the sovereign’s usurpation or legitimacy... The whole question of critical governmental reason will turn on how not to govern too much. The objection is no longer to the abuse of sovereignty but to excessive government. Foucault 2008, 13

Yet, if the liberal limit is not abuse but excess, by what logic is it able to delimit the border between moderation and excess?

The main enabling condition of this system of internal limitation—the delimiting device, as Foucault describes, is political economy: “the intellectual instrument, the form of calculation and rationality that made possible the self-limitation of governmental reason as a de facto, general self-regulation which is intrinsic to the operations of government” (Foucault 2008, 13). Unlike absolute government, liberalism finds its laws not in “nature” as such, but in political economy. The laws to which liberalism appeals for justification are not those of humans or human relations, but those of production, distribution, supply, and demand—the market. Unlike ethics, social justice, or religious values, political economy can provide government with a rubric by which it is able to judge its actions and potential strategies not by their moral worth, its consistency with rights, or instrumentality to social justice, but by their *truth* relative to an economic logic.

Political economy

is not something like prior rights inscribed in human nature or in the history of a given society. Political economy reflects on governmental practices themselves, and it does not question them to determine whether or not they are legitimate in terms of right. It considers them in terms of their effects rather than their origins. Ibid. 15

Sources of social problems are taken as objectively given in liberal societies, determined by a set of political-economic laws that render their effects inevitable and natural. Social problems are flat surfaces upon which governmental practice can be determined, not multidimensional spaces requiring excavation, critical scrutiny, and confrontation. Returning to the ideological notion of the dependent mother, the U.S. liberal government is not poised to correct the historical *and* contemporary economic, racial, and gender structures and injustices that combine to produce the social phenomenon of the stigmatized urban black single mother. By taking seriously the sources of the phenomenon *and* its stigmatization, a liberal government would need to challenge the very structural core of its economic, social, and political organization. It would need, for example, to fundamentally alter the gender distribution of labor, employment structure, and procedure for determining and issuing social benefits,

among myriad other issues. The makeup of government itself would need to change; that is to say, people affected by social problems—women, immigrants, indigenous, lesbian, gay, and queer; black, women of color, low-income, and many more—would need to enjoy more than a marginal proportion of political power. Unlike a transformation based upon the recognition of these structural issues, a policy response consistent with the liberal approach might be the simple distribution of cash transfers—an initiative lacking the depth and momentum to correct the structural determinants of particular social groups’ exclusion and relative inequality and serving only to further the historic stigmatization of “dependent” peoples.

Liberal social policy is geared not toward a genuine confrontation of sources but an amelioration of effects.¹⁷ Sources and effects lie at opposite ends of a spectrum guiding governmental action in response to social problems. Looking to *sources* is driven by the will to rectify an injustice, the basic guiding principle of corrective justice. Underpinning this view is the assumption—or perhaps even faith—that justice, equality, and equilibrium characterize human relations in an abstract original state. This abstraction serves as both a “state of nature scenario” and an object of the utopian imagination. Existing states of affairs are altered to reflect or converge toward a utopian ideal. The nature of this utopia, it must be stressed, is the welcome subject of political, ethical, and ideological debate; no predetermined teleology enjoys the privilege of its compulsory realization in material reality. The scope of the debate is indeed infinite. Agents of this debate engage in a discussion of boundless parameters, since their subject matter is ultimately the best possible vision of action, irrespective of existing constraints. The utopian vision that emerges from this discussion is then strategically applied to the existing state of affairs’ constraints, realities, special

¹⁷ This feature of U.S. liberalism is what made an approach like affirmative action, for example, so politically plagued. Opponents to affirmative action conveyed objections in the register of social injustice; institutionalizing “reverse discrimination” against whites in university admissions violated the rights of white applicants. Some opponents offered the alternative of cash transfers to people of color to help offset the high price of college education, ignoring totally the intersectional question of class and the structural racism that pervades equal opportunity to education.

interests, and so on. The final criterion for action, however, is located in the calculation of what is *right* or *best* to do. The “rules of the game” are an ethics or morals of social justice. These are a utopian politics—a politics of justice, ethics, and sincere conflict between opposing alternatives and possibilities.¹⁸

Looking to *effects* in a liberal context, however, appeals not to justice but to political economy. A goal is identified—say, the growth of a particular economic sector—and the appropriate mechanics for the satisfaction of that objective determined; thus is the course of action decided. The scope of debate respective to this decision—be it political, ethical, or ideological—is highly circumscribed, its parameters delineated by the multitude of constraints characterizing the existing state of affairs. The possibilities are limited; potentiality rendered fantasy or foolishness. While agents in the sources-based discussion practice envisioning, expanding, and imagining, agents of the effects-based dialogue practice judging, determining, and adjudicating. The “rules of the game” in this approach appeal not to ethics or justice, but are in actuality laws. It follows that the final criterion for action is not what is right or best, but what is true. Truth and error become the final arbiters of

¹⁸ The approach I have outlined exists in a symbiosis with the theory of radical democracy. Radical democrats attribute the absence of sincere and possible alternatives in the political sphere to the hegemony of liberal democracy and neoliberal economics combined, the collapse of the socialist project, and the disintegration of the international left. However, radical democrats do not advocate for a complete upheaval of liberal democracy (though it requires the dissolution of neoliberal hegemony). They pose radical democracy itself rather as the completion of the democratic revolution. By eliminating the conditions of possibility for conflicts between political alternatives, the liberal paradigm has reduced democracy’s progressive character. Radical democrats make the role of conflict central to their political vision. Politics is a world of friends and enemies, confrontation, and irreconcilable differences. This is not normatively negative but an unavoidable result of the existence of sincere antagonism in social life. Liberalism is incapable of encouraging new alternative and hegemonies because it is “unable to adequately grasp the pluralistic nature of the social world, with the conflicts that pluralism entails; conflicts for which no rational solution could ever exist. The typical liberal understanding of pluralism is that we live in a world in which there are indeed many perspectives and values and that, owing to empirical limitations, we will never be able to adopt them all, but that, when put together, they constitute an harmonious and non-conflictual ensemble.” (Mouffe 2005, 10). Radical democrats contend, alternatively, that there are in fact interests that are irreconcilable. The social landscape of individuals’ interests and preferences does not always harbor the potential to achieve harmony. For radical democracy, its irreconcilable conflicts are, of course, responsible for today’s both progressive and conservative social movements, but they also hold the potential for introducing new systems of political organization and distribution. This process is what Mouffe calls the “counter-hegemonic:” “practices which will attempt to disarticulate the existing order so as to install another form of hegemony” (Mouffe 2005, 18).

governmental action. It should immediately be evident that *truth* is capable of legitimizing itself in a way unavailable to *right*.

Laws, of course, are not natural. They must be derived and written. Even more importantly, they must have a material base or space, with observable phenomena capable of rationalizing the laws to those whom they effect and adjudicate. This space is saturated with the power to establish and determine the laws and limits of liberal government. In liberal orders, the laws of governmental practice are articulated not by judges but by economists. The site where these laws may be ascertained is, of course, the market. The market is both the physical and abstract space where the laws of liberal governmental practice are discovered and reinforced. Finally we come upon the core animating substance behind liberal government's drive to remain absent: the laws of the free market. In the quote at the beginning of this section, Foucault makes a statement he deems characteristic of liberalism's background mode of thought: "I accept, wish, plan, and calculate that all this should be left alone." The political economy of liberal government consists in this calculation of the *truth* of the state's necessary absence from the market space. When the laws of the market—including, above all, the principle of free competition—demand an absence of state incursion, liberal government must respect that boundary. Any arguments encouraging a state intervention to the market must speak the liberal language of political economy and show the intervention's instrumentality to the flourishing of the free market.

Liberal government thus represents the triumph of market-based logic over rights-based logic in terms of an internal calculus of appropriate governmental action. The appeal to market-based logic presents a genuine problem for social policymaking in liberal governments. When the provision of a basic good satisfying a need—from housing to health care—is administered primarily by the private sector, with problems of access following, the state's decision to intervene or not is a crucial political act. Intervention, or lack thereof,

demonstrates the government's commitment either to producing the optimal conditions either for market performance or human flourishing. The act, or absence thereof, at once demonstrates on which side the government falls: people or profit?

“This time we won’t scare:”¹⁹ conclusion

The first chapter relayed the story of an American debate over public health care reform. I showed how the terms of the public option debate were structured firmly around political economy, around economic truths and mechanics, not universal rights and transformative reform. The second chapter engaged in a theoretical discussion of liberal government’s internal logic of limitation, and the trump of the right to make a profit over the right to health care.

The conflict between universal access to health care and the optimal conditions—economic, legal, and political—for health insurance companies to make a profit is unquestionably representative of the conflict between rights and political economy. At its highest levels (in terms of power), however, the 2009-2010 debate did not advance to a confrontation between the right to health care and the right to profit. Advocates of the public option at the highest levels of government appealed not to the universal right to health care, but to the public option’s projected contribution to improving the conditions for private insurers to make a profit and, more broadly, for a profitable, efficient, and expanding health insurance industry to flourish. The debate therefore remained strictly within the parameters of an argument over political economy effects. The elevation of the debate to the level of rights would indeed have represented an advance, as then reformers’ ideas would have posed an actual threat to the system of private provision of health care in the United States and thus articulated a sincere advocacy for a universal entitlement. The most powerful actors in the debate were not able to transcend the presence of special interests and the patterns of U.S. social policy discourse to effectively challenge the status quo of private health care provision that produces a class of uninsured subjects.

¹⁹ This title is taken from an editorial by Nicholas Kristof in the June 11 issue of *The Washington Post*.

By this I do not mean to suggest that the public option, had it advanced and successfully passed, could either fulfill the human right to health care or challenge fundamentally the role played by private insurers in the provision of health care in the United States. By advocates' own accounts, the public option's principal objective was the increased health and vitality of the country's insurance industry, not its human population. As I have shown, critics of the public option did emerge from the Left; the Physicians for a National Health Program, who indeed opposed the option for not being radical enough, are a good example. Some warned that the public option had lost the teeth of Hacker's original. Yet these critiques were not the reason for the public option's death; the measure was rendered politically impossible by arguments that projected its detriment to private competition. The detractors' victory in this debate is thus a step away from a rights-based victory, a regression in its own right.

One result of this victory of the market over rights is the remarkable confusion of policy objectives and priorities exhibited by the Patient Protection and Affordable Care Act. Reform to the health care system, if driven by an objective to ensure the well-being of the population regardless of individual subjects' ability to pay, should have, quite simply, sought to ease individuals' provision of health insurance. The cornerstone of the legislation, on the contrary, was an individual mandate, coupled with a completely private market. The antidote offered to this contradiction is again the distribution of direct benefits to offset the cost of premiums to low-income consumers. An individual mandate within the context of a private market does little to boost individuals' capability to appeal to the government for assistance in meeting their health needs. The legislative outcome is counterproductive to the goal that commentators across the ideological spectrum rhetorically agreed upon: quality, affordable health care for all Americans.

Only a universal health care entitlement supported by a right-based discourse could accomplish the type of progressive social policy change people hoped for in June. The debate demonstrated the triumph of private over public interest; it showed the U.S. government's spirited interest in interests. The vitality of the health insurance market was prioritized over the vitality of a healthy population.²⁰ The question of a just outcome in this debate became a question of fair competition between firms: fair market competition, not the fulfillment of an imperative based on social justice, equality, or universal rights.²¹

I would like finally to return to the problem of radical reforms pushed down the throats of the American public, the "Trojan horse" reforms, and the "stealth single-payer agenda." This paper has operated from a normative standpoint that a change to a health system that satisfies the human right to health care represents the optimal reform for the US economy and society, and that the 2009-2010 debate and bill passage fell short of this outcome. The tension between insulating reform efforts from public influence and opposition, the kind exhibited in the June 2009 debate, and the normative desire for meaningful public participation in decision-making processes raises an important question: should governments pursue reforms that face significant public opposition? Should they exercise political will and push reforms ahead, even when it may render the process undemocratic? In this debate, the influence of special interests such as the medical and insurance industries equally poses this issue. How much should political actors have yielded and compromised the transformative potential of the reform process to other agents with an economic stake? Is government justified in pushing forward reforms despite multidimensional fronts of opposition like these?

The answer is yes, when these reforms are those that will satisfy a human right. The human right to health trumps the right to economic choice, the right to make a profit, or the freedom from government intervention. The 2009-2010 revisiting of health care reform,

²⁰ I thank Brian Jefferson for this helpful insight.

²¹ I am grateful to Attila Fölsz for putting the problem in this way.

which remained on the surface of a political economy discourse and failed to tap the transformative potential produced by a window of opportunity, necessitates another revisiting of this crucial issue in the future: one structured around the question of public health, universal entitlement and access, and social justice.

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