Beyond the Market: The Role of Constitutions in Healthcare System Convergence in the United States of America and the United Kingdom.

Mr Jamie Fletcher* and Dr Jane Marriott+

*Lecturer in Law, University of Winchester, United Kingdom.

+Senior Lecturer in Law, University of Surrey, United Kingdom.

Introduction

Two narratives have emerged to describe recent healthcare reforms in the United States of America (US) and the United Kingdom (UK). One narrative speaks of *revolution*,¹ that the adoptions of the Affordable Care Act 2010 (ACA) in the US, and the Health and Social Care Act 2012 (HSCA) in the UK, have resulted in fundamental, large-scale philosophical, political and legal change in the jurisdictions' respective healthcare systems.² The other narrative evokes *evolution*,³ identifying each new legislative scheme as a natural development of existing governance structures.⁴ Policymakers in both the US and UK face the problem of a healthcare system which, as traditionally envisaged, cannot offer universal access to healthcare at a reasonable, or politically acceptable, price.⁵ In an attempt to solve this problem, policymakers shop around, with the result that each of the two jurisdictions' reformed healthcare system includes features normally associated with a free market healthcare model, as this has been seen to increase quality and lower costs, but both also demonstrate characteristics of a state run model, which provides a safety net for citizens and a buffer against the commodification of health.

Here, we argue that neither the revolutionary nor the evolutionary narrative adequately characterizes these policy initiatives since, although each jurisdiction has effected significant change, neither has detached its reformed healthcare system from the moorings of its

traditional healthcare model and neither takes adequate account of the broader settings in which those reforms have occurred.⁶ The narrative of revolution pays insufficient attention to party politics and the extremes of partisan rhetoric, and lacks a considered exposition of the political bargaining behind reform and the crafting of legislation intended to balance past and future manifestations of a healthcare system. On the other hand, we are skeptical of the evolutionary narrative, based on its claim that the ‘new’ systems are typologically consistent with their predecessors, which misrepresents the reforms’ extent. The introduction of the individual mandate requiring individuals to purchase healthcare insurance in the US,⁷ and the marketization of the National Health Service (NHS) in the UK,⁸ pushes each system into previously uncharted territory, namely the middle ground between free market and government run (social insurance) healthcare.⁹ Forced to choose, for reasons which will become apparent we would dismiss the revolutionary narrative in favour of its evolutionary counterpart. We do, however, consider the evolutionary narrative too narrowly focussed and insular.

In seeking to examine and explain the jurisdictions’ apparent drive to the middle, we propose a distinctive evolutionary narrative, that of convergence, which, as well as adopting a less parochial perspective on developments in healthcare policy, also situates the reforms politically, constitutionally and comparatively. The idea of convergence in relation to healthcare systems is not, in itself, unusual or unknown. Wendt et al. note, for example, a “tendency of convergence from distinct types towards mixed types of healthcare systems”¹⁰ occurring in the two jurisdictions. Convergence does not have to be purposeful or coordinated since the emergence of similar characteristics in healthcare systems, or any system, may occur entirely independently.¹¹ To illustrate why convergence better describes healthcare reform in the UK and the US, we will explore the reforms’ interaction with each

jurisdiction's fundamental political principles, as expressed in their respective constitutions.¹² Constitutions have played a crucial role in both jurisdictions. By policing the revolutionary elements of reform, they guarantee that policymakers have not overlooked fundamental political principles,¹³ while ensuring that political opponents do not dismantle reform so as to render it merely, and mildly, evolutionary.¹⁴

Roadmap

To substantiate the idea of convergence this paper is divided into three parts. Part One demonstrates that, where superficial analysis of healthcare politics in the US and the UK might indicate that this paper's proposed thesis of convergence is outlandish, deeper inquiry demonstrates otherwise. The revolutionary narrative is revealed as a false reality, built upon an over-reliance on the observation of formal voting patterns and unquestioning acceptance of extreme political rhetoric as truth. Looking behind this representation of the reform process, the positions of independent politicians and intra-party concessions of extreme positions, for example, indicate that healthcare politics has been far more subtly conducted than the idea of revolution suggests. To suggest that 'revolution' has taken place in either jurisdiction thus overplays the form and rhetoric of healthcare politics at the expense of the nuance, bargaining and balance that underpin its reality.

In Part Two, we analyse the narrative of evolution. This analysis drives us towards the conclusion that evolution insufficiently reflects the nature of the change brought about by the ACA and HSCA. Aspects of both jurisdictions' reformed systems are impossible to reconcile with their traditional model of healthcare and, therefore, the idea of linear evolution does not truly explain what has occurred. Policymakers on both sides of the Atlantic have incorporated elements of the other's system, meaning that neither reformed system can truly be considered a direct, transformational evolution of the pre-existing regime. Given the apparent failures of

the revolutionary and evolutionary narratives, we conclude Part Two by advocating an offshoot narrative of evolution - that of convergence.

Convergence is not, however, a path easily trodden. The primary reason for this is that in order for convergence to occur, elements of it *must* be revolutionary, albeit tempered by the presence of limiting mechanisms. Part Three therefore adds to the existing literature on healthcare convergence by suggesting that constitutions and constitutional law undertake the important and, in this narrative sphere, often overlooked role of policing and restraining the most revolutionary elements of reform. Constitutions and constitutional law function to ensure that aspects of reform are not so revolutionary that they undermine a jurisdiction's fundamental principles and values, as expressed by its constitution.

Part 1: Rhetoric and Reality in Healthcare Reform

Contemplating the ACA, Dolgin and Dietrich described American healthcare reform as "sweeping",¹⁵ Barnett, Gazino and Stewart as "unprecedented",¹⁶ and Blackman as "comprehensive".¹⁷ In the UK, Davies warned that, this time, medicating the healthcare system was "for real",¹⁸ suggesting that, unlike previous reforms, the HSCA truly established a free market in healthcare. More forcefully, Pownall contended that the coalition government's "strong commitments to neoliberal values"¹⁹ underpinned the reforms, which began "a new chapter for the NHS"²⁰ where the HSCA's increased role for private enterprise marked a "significant departure from the traditional model of publicly provided care."²¹ All of these accounts of reform accentuate the perception of revolution. We cannot, however, begin to make an assessment of the weaknesses in that narrative without first outlining, briefly, the reforms themselves.

1. Healthcare Reform Realised

Despite their distinctive approaches, Secretary of State for Health, Andrew Lansley, and President Barack Obama - the architects of new millennium healthcare reform in the UK and US - were described respectively as having written a “political suicide note”²² and embarked on a “political suicide mission”²³, reflecting the danger inherent in attempting to question articles of faith.²⁴ It is, of course, impossible to detail the HSCA’s 309 sections and 12 schedules, or the ACA’s 1,900 pages here. As such, below are described those elements of the acts identified as effecting, in the UK’s case, a shift from nationally tax-funded, budget-limited, equal-access healthcare provision, towards a market-based system, and vice versa for the US.

a. The UK’s Health and Social Care Act 2012

The HSCA received Royal Assent on 27 March 2012 and implemented the coalition government policies set out in the White Paper *Equity and Excellence: Liberating the NHS*²⁵, albeit those policies had now been through the democratic mangle and suffered death-by-a-thousand-cuts in a brutal legislative process.²⁶ The HSCA came into force in April 2013, changing both the consumption and provision functions of the NHS, and, for the first time, placing health policy on a statutory footing, ensuring a degree of resistance to fleeting fashions and executive whim.²⁷

The HSCA introduced General Practitioner (GP) commissioning via local Clinical Commissioning Groups (CCGs) as the principal means of procurement of services. CCGs administer the lion’s share of the NHS budget. Individual CCG’s budgets are set by NHS England, which holds CCGs accountable for obtaining value for money in the procurement of services and for improving outcomes for patients. Neither NHS England nor the CCGs may engage in anti-competitive behaviour.²⁸ Both have a duty to promote patient choice.²⁹ The more localised approach of the HSCA is further reflected in its transfer of responsibility for

local health services from central to local government authorities (LAs) and Health and Well-Being Boards (HWBs), a species of LA sub-committee comprised of CCG representatives, LA directors of services and local councillors, responsible for the strategic direction of health and social care services in the geographical area covered by its LA. The HSCA also created Public Health England, an executive body of the Department of Health designed to undertake the Secretary of State's public health functions, and expanded the role of Monitor, from simply regulating NHS service providers, to economic regulator overseeing access to and competition in the NHS.³⁰ Thus, the HSCA hands Monitor responsibility for, inter alia, protecting and promoting the interests of healthcare service users; licensing NHS healthcare providers; addressing anti-competitive practices and behaviour in the provision of healthcare services³¹ and working with NHS England to set and regulate NHS service costs through a national tariff. Responsibility for the pricing of healthcare was thereby removed from the Department of Health and placed on a statutory footing. The Secretary of State for Health retains ministerial responsibility, however, and is accountable to Parliament for the provision of a health service, as well as having two key duties under the HSCA. Firstly she must promote a comprehensive national health service in England and, secondly, must foster autonomy where this is consistent with the interests of the health service, a crucial one of which is, now, the maintenance of competition by way of a market in healthcare.

b. The US's Patient Protection and Affordable Care Act 2010

The ACA was signed into law on 23 March 2010. Its constitutionality was upheld by the Supreme Court on 28 June 2012. In broad terms the ACA effects change in five areas. Firstly, it expands the Medicaid programme, already the largest source of categorical entitlement health funding for the socially disadvantaged, by increasing the number of eligible citizens. The Act increases federal funding to meet States' costs in expanding Medicaid coverage. Secondly, employers of 50 or more workers will face increased tax

liability if they do not provide health insurance for their workers. Thirdly, insurance is expanded, and significant numbers of low and middle income earners brought within its scope, via the 'Health Insurance Marketplace', a federal or state-administered, regulated, online facility where citizens and small businesses can see, compare and purchase private health plans and, provided that they qualify, receive federal assistance with premium costs. The ACA also introduced the individual mandate, which requires Americans to maintain "minimum essential" health insurance coverage. In particular, those not covered via their employer or government must meet the requirement by purchasing insurance privately. Non-compliance with the mandate attracts a penalty, to be paid to the Internal Revenue Service. Finally, providers of private health insurance may not refuse or limit coverage on the basis of existing or predicted health conditions and, whilst they may vary their rates by age, insurers may not take account of past or predicted future use of health services. The ACA thus introduces more government regulation into American healthcare via the expansion of social insurance.

Leflar describes the reform arena as being characterised by "polarized ideology, complex and brutal politics, [and] perverse economics."³² Alongside the academic community, policymakers have made strong rhetorical statements about the revolutionary nature of healthcare reform. Opposition politicians in the UK stress the future dominance of free market principles in the NHS,³³ whereas in the US political criticism focuses upon how reform will increase state involvement in healthcare.³⁴ Critics declare that the reforms selected fit better with philosophical concepts regarded as alien to the model of healthcare to which they are accustomed and attached and, more fundamentally, alien to the principles and values that underpin their jurisdiction's political landscape.³⁵ The use of these alien philosophical concepts is an attempt to expose reform as underpinned by foreign values,

which are orthogonal to the host's. Most often, the rhetoric is loaded and is an expression of pure ideological caricature lodged at the extremes of an untrammelled free market,³⁶ or a fully centralised socialist system,³⁷ or perhaps reversion to some less desirable point in history.³⁸ Ideologues on both sides appear entrenched in their refusal to acknowledge the compromises that emerge from the “wide and fertile space between Utopia and Armageddon”³⁹ where, in reality, healthcare reform is worked out. As a result, accounts of healthcare reform confuse and undermine reasonable and legitimate political dispute and debate.

Reform is also a response to empirical fact; healthcare in both the US and the UK is unaffordable. In the US, healthcare accounts for 17.9% of GDP.⁴⁰ Moreover, pre-ACA 16.3% of the US population did not have health insurance⁴¹ and, consequently, was unable to access the market. Meanwhile, in the UK, spending on the NHS accounted for 18% of the 2013 government budget, at roughly £139 billion.⁴² It is only appropriate, therefore, in an economic climate in which government coffers are running low, that policymakers should look to reform healthcare and acknowledge that there is nothing inevitably symbiotic about reform and revolution.

2. The Revolutionary Narrative as Represented in Legislative Voting Patterns.

In the UK, the House of Commons conducted 18 votes during the passage of the Health and Social Care Bill.⁴³ In 17 of these votes, no Member of Parliament (MP) from the Conservative Party - the majority party of the coalition government - voted against the Bill, and no Member of Parliament from the opposition Labour Party, voted for it. A similar pattern can be seen in the voting record of the Conservative Party's coalition partner. Across 18 votes, only 35 of a potential 795 Liberal Democrat votes were cast in rebellion. The uniformity of voting, for and against the HSCA, is highly indicative of the partisan cleavage

provoked by the proposed reforms. We have, it should be noted, eliminated one vote from this analysis. On 7 September 2011, the House of Commons considered the HSCA's provisions on independent abortion advice.⁴⁴ This was the only vote which exhibited irregular, cross-party voting patterns, something to be expected given that, routinely, on abortion, MPs are permitted to vote with their conscience.

Even in the upper chamber, the House of Lords, which is considered far less "partisan" than the Commons "most obviously due to the presence of the Bishops and Crossbenchers, but also because the parties operate in subtly different ways",⁴⁵ an almost unbridgeable gulf existed between the Labour and Conservative/Liberal Democrat peers. The House of Lords divided on 32 occasions to consider the HSCA. Only one Conservative peer, Lord James of Blackheath, rebelled,⁴⁶ meaning that, of 4,463 Conservative votes cast over the 32 debates, only one was cast against the government. Likewise, in opposition, 4,645 Labour votes saw only one cast against the Labour party whip - Lord Warner electing, on 12th October 2011, not to reject the Bill at second reading.⁴⁷ Meanwhile, out of the 1,981 votes cast by Liberal Democrat peers only 37 were cast in rebellion. These statistics hardly vindicate Russell's claim that the House of Lords is less partisan than the House of Commons but they do lend support to the claim that healthcare reform provokes division on party lines.⁴⁸ A bare reading of voting in the US's legislative chambers reveals a similar pattern to that in the UK. In consideration of the ACA and the Affordable Healthcare for America Act, clear bi-partisan lines can be drawn between Republicans and Democrats, which is evident in both Houses of Congress.⁴⁹

The House of Representatives voted on healthcare reform eight times.⁵⁰ Republicans cast 1,407 votes in total, of which six ignored the party whip. Rebellion in the House was more prevalent amongst Democrats where, out of 2,028 votes, 183 were revolts. Democrat rebels therefore accounted for 9% of all votes cast in the House of Representatives. This statistic is

not remarkably out of step with Representatives in the 111th Congress, who rebelled 6.1% of the time.⁵¹ Rebellion is, in any case, more prevalent in American politics where a strong separation of powers ensures a weak connection between the executive and members of the legislature.⁵² Moreover, the two-year election cycle often drives members of the House of Representatives to eschew the party line for the purposes of satisfying electors⁵³ and responding to Madison's demand that they should feel "an immediate dependence on, and an intimate sympathy with, the people."⁵⁴ Whilst at face value, rebellion in the House of Representatives appears more extreme than in the House of Commons, it is, as indicated above, not out of step with American political culture and is much more typical of American than British politics. When considered contextually, therefore, it appears that rebellion on the ACA was indicative of rebellion in American politics generally.

Similar levels of partisanship can be recognised in Senate voting patterns. The Senate voted on the ACA 35 times,⁵⁵ though we have discounted two of these votes from our analysis. Both took place on December 15th 2009 and concerned the importation of drugs, on which matter Senators voted based on local necessity rather than party line. On the other 33 voting occasions, just as in the House of Representatives, Republican and Democrat Senators seldom rebelled: Republicans recorded 19 rebellious votes out of 1,292 cast and Democrats 67 out of 1,961. Senators, therefore, voted almost uniformly with their party.

Analysing votes cast in Parliament and in Congress clearly indicates rigid partisan divide, with politicians rarely willing to oppose their party's position on healthcare reform, and almost universally voting along ideological lines. It is obvious that merely accessing the voting patterns in both countries might lead to the conclusion that the reforms were radical and divisive rather than convergent and consensual. Of course, it could be suggested that partisan division like this is predictable in democracies with political parties⁵⁶ but scrutinising voting patterns does not paint the full picture. Exploration of the extremes of political rhetoric

demonstrates hyper-partisanship within healthcare politics beyond the normal partisan divides that exist in other policy areas. It will be shown that, to a degree, this is charged by the belief that reform cannot be reconciled with pre-existing, and fundamental, political values. There are, however, several factors that appear to demonstrate that reform was not, perhaps, as revolutionary as partisan voting and rhetoric indicate. Within the constraints of this essay, we will examine two such factors. Firstly, we explore the position of independent members of the legislatures on reform. Secondly, we consider how intra-party bargaining prevented some of the more revolutionary aspects of reform from occurring.

3. Reconsidering the Revolutionary Narrative 1: Independents

The first evidence that may be marshalled against the revolutionary thesis is the reaction of independent members of the UK and US legislatures. Crossbench peers in the House of Lords and Independent Senator, Joe Lieberman, in Congress, offer a unique insight into why reform is not revolutionary. The role these groups and individuals played in reform, and how they supported certain aspects of reform but not others, is indicative of the fact that reform is less revolutionary than bi-partisan debates convey.

In the House of Lords, over the 32 voting occasions, Crossbench peers accounted for 942 votes cast in favour of reform, while 774 cast their vote in opposition, equating to a 55% to 45% split in favour of reform.⁵⁷ Crossbench peers are those members of the House of Lords who have no party allegiance. Of course, it does not obviously follow that because Crossbenchers have no party connection, they are ideologically neutral politically. Russell, cites the left-wing suspicion that;

“large numbers [of Crossbenchers] sit independently; they listen independently; they weigh the arguments independently; and then they independently vote Conservative...

The fact that people call themselves independent, with great respect, does not make them so”⁵⁸

but concludes that, “the views of the contemporary Crossbench group are far more balanced than sceptics ... believe ... Independent Crossbench members, on average, placed themselves squarely at the centre of the left– right spectrum.”⁵⁹ The fact that Crossbench peers divided so evenly with their support indicates that the HSCA is not revolutionary but far more moderate than superficial analysis of party voting patterns and political rhetoric suggests.

A similar, though less statistically robust, conclusion emerges from considering how Joe Lieberman, Independent (formerly a Democrat) of Connecticut, used his position as the Democrats sixtieth Senate vote to ensure that the eventual healthcare reform package was more moderate than federal government intended.⁶⁰ Lieberman’s significance becomes apparent once the importance of having the support of 60 Senators is considered.⁶¹ During the 111th Congress, Senate standing rules required a three-fifths majority to end a filibuster, that being a delaying tactic minority groups within the Senate could use to prevent the passage of legislation.⁶² If the Democrats could not command 60 Senate votes, Republicans could obstruct the ACA’s passage. Having Lieberman’s support, therefore, would allow the Democrats to censure any Republican opposition mobilised in the cause of delaying reform. Lieberman’s vote would, thus, make reform easier to achieve, giving him significant bargaining capacity and a key role in producing a more moderate healthcare reform programme.⁶³ Lieberman opposed the idea of a public option within the ACA.⁶⁴ A public option would have introduced a government-controlled health insurance package, operating in direct competition with the private insurance market.⁶⁵ Shapiro observes that Lieberman “killed the public option”⁶⁶ by his refusal to block a filibuster if Democrats included a government run healthcare option within the ACA. To gain Lieberman’s support overall,

Democrats had to drop the public option from the ACA, thereby tempering one of its more radical provisions.

As Kang has identified, Lieberman's threat was clear, and present: "Lieberman [has] made regular practice of siding with Republicans on high-profile concerns, including the failed filibuster of Justice Samuel Alito's nomination, the Terri Schiavo controversy, and Bush's Social Security privatization proposals, among others"⁶⁷ all of which signify that the Democrats had to take Lieberman seriously as "holding Barack Obama to ransom"⁶⁸ over the public option. Lieberman has been declared "crucial"⁶⁹ and "essential"⁷⁰ not only to mustering the 60 votes necessary to defeat Republican filibusters but also to careful reform by terminating any, revolutionary, public option.

4. Reconsidering the Revolutionary Narrative 2: Party Members

Within the US and UK's governing parties, the political bargaining that occurred to produce legislation capable of carrying enough support to reach the statute books also provides evidence of how reform is not revolutionary. Bargaining was most apparent, and most necessary, in the UK, where the government comprised a coalition of Conservatives and Liberal Democrats.⁷¹ Political bargaining in the US was more subtle, manifesting in modifications made by President Obama to appease and satisfy the demands of numerically strong southern, conservative Democrats without whose support in Congress the reforms would not have been written into law.⁷² What is clear is that, in both jurisdictions, reformers were coaxed into modifying their proposed programmes – by dropping the more controversial components – in order to give them a more consensual appeal within their party.

The Conservative-Liberal Democrat coalition has governed Britain since May 2010. Whilst overlaps in the parties' political ideologies exist, making coalition viable, this is not the case in the realm of healthcare. The easiest way to appreciate the marked difference between the

parties' approaches to healthcare governance is via brief analysis of their 2010 election manifestoes. Whilst there was no desire to dismantle the nationalised system, the Conservative Party sought healthcare founded on "decentralise[d] power ... real choice... doctors and nurses accountable to patients, not to endless layers of bureaucracy and management... that puts targets before patients."⁷³ Its manifesto stated that, if elected, it would "give patients more choice and free health professionals from the tangle of politically-motivated targets that get in the way of providing the best care."⁷⁴ From the Conservative perspective, central to reforming the NHS was the introduction of a more 'fully-fledged' free market, with the ideas of freedom, choice, and entrepreneurship at the heart of that vision. Had the HSCA been a piece of legislation passed by a purely Conservative government, it is likely that its free market principles would have been stronger but its coalition partner put the brakes on.⁷⁵

A key difference between the Liberal Democrat's manifesto and the Conservative Party's is a shift in language, away from freedom and choice, and towards "fairness" and "democracy".⁷⁶ The Liberal Democrats stress that the NHS, being "built on the basic British principle of fairness"⁷⁷ had, at its core, the idea of citizen empowerment rather than fiscal savings. While it could be argued that the two manifestoes arrive at the same conclusion, namely a more decentralised and people-driven health service, the means employed to achieve that end differed. As the King's Fund reported, the distinction is ideological, with "[t]he Conservatives believing in markets ... [and] ... the Liberal Democrats believing in democracy."⁷⁸

The Liberal Democrats are proud of how their role in coalition government softened the free market principles embedded in the HSCA.⁷⁹ In fact, to highlight the moderation of the Conservatives on the free market, the Liberal Democrats published a list of their achievements in relation to the HSCA:

“We have... (1) enshrined stronger duties on healthcare bodies to promote the integration of health and social care and to tackle health inequalities... (2) made sure that competition in the health service will be based on quality of care and not on price... (3) guaranteed that ... any profit from private patients will be used to improve services for NHS patients... (4) preserved the Secretary of State’s legal and political responsibility to maintain a universal comprehensive health service.”⁸⁰

Another way in which the Liberal Democrats motivated mindful reform was through the establishment of the NHS Future Forum,⁸¹ a large-scale government listening exercise that sought out professional, patient and public opinion and which, in an unprecedented hiatus, occurred mid-way through the legislative passage of the HSCA.⁸² Through this listening exercise, which provided evidence of levels of public support, the Liberal Democrats managed to achieve a raft of changes to the Bill relating to the new NHS’s structure,⁸³ its regulation,⁸⁴ the extent of its privatisation,⁸⁵ its emphasis on social care,⁸⁶ the creation of a more democratic and decentralised service,⁸⁷ and the shoring up of the Secretary of State’s constitutional responsibility for the health service.⁸⁸

The interaction between the Conservatives and Liberal Democrats during the reforms’ development demonstrates that the HSCA is not as revolutionary as some politicians suggest. Firstly, through both parties having approached reform from different ideological positions, the HSCA blends the Conservative commitment to the free market with Liberal Democrat fidelity to fairness and democracy. Secondly, the reforms’ faltering legislative passage demonstrates the reality of the pulling and hauling that occurs in the reconciliation of the parties’ antithetical tendencies. Thirdly, so successful was the Liberal Democrat assault on the marketisation of the NHS that the party made a point of visibly indicating its ameliorating influence on the excesses of the proposed reforms.

In the USA, things worked slightly differently. President Obama achieved reform during the 111th Congress, when the Democrats had control of all political branches of the federal government; the executive, the Senate and the House of Representatives. This level of control meant that the Constitution's mechanisms, which provide for divided government,⁸⁹ could not restrict Obama's policy choices. Passing such a statute during the 112th or 113th Congress would not have been possible, since the Republicans now control the House of Representatives.⁹⁰ Yet in the 111th Congress President Obama still could not pass the Act he fully desired because of the more decentralised character of the American political party.⁹¹ President Obama was required to craft a package of reforms that would gain the support of the more conservative, and typically southern, members of his own party.⁹²

As Adams and Gibbs note, "The Democratic Party in the United States is far from monolithic. The divide between liberal and conservative members of the Democratic Party became more apparent with the healthcare debate that took place in 2010."⁹³ There is faction, then, which Adams and Gibbs perceive as creating five party caucuses - "Black, Hispanic, Women, Progressive and Blue Dog"⁹⁴ - which disagreed over the course of reform that should be taken. The most interesting of these caucuses for exposing the non--revolutionary character of the ACA is Blue Dog.

Blue Dog Democrats are "conservative".⁹⁵ It is their mission to bring a "common sense, bridge building ... to forge middle ground bipartisan answers to challenges facing the country."⁹⁶ In the 111th Congress, the Blue Dog Caucus made two demands of the ACA. Firstly, it must be cost neutral and, secondly, government involvement in healthcare regulation had to be minimised.⁹⁷ Jacobs and Skocpol believe that when the House and Senate voted on their final healthcare reform packages, concessions to Blue Dog Democrats emerged in both pieces of legislation.⁹⁸ For example, when the House passed its final bill it included a watered down public option and a unified national insurance exchange.⁹⁹ The

restriction of abortion services under the ACA is a further key example of a Blue Dog concession.¹⁰⁰ Senator Ben Nelson, the most conservative of Democrats, threatened to withdraw his support for the ACA if it provided federal funding for abortion.¹⁰¹ Nelson and the Obama Administration managed to negotiate a compromise position: the ACA does not require that insurance plans fund abortion and states may pass laws preventing plans included within the state controlled exchange scheme from including abortion.¹⁰² The result is that no federal government money will be spent on abortion and states have the ability to opt out of promoting insurance plans that include abortion services. This was a genuine compromise, as Ben Nelson had previously supported the House's Stupak-Pitts Amendment, which would have introduced a more pro-life emphasis to the ACA.¹⁰³ The most compelling evidence of concession to Blue Dog Democrats, and of the moderate nature of the ACA, is that, even with the Democrats in overall control of government, Obama did not attempt to create an ambitious project like Hillarycare.¹⁰⁴ Moreover, the eventual omission of even a public option indicates the ACA's relative conservatism.¹⁰⁵ Whilst we noted that, with his threatened refusal to prevent a Republican filibuster, Senator Joe Lieberman played a large role in killing off the public choice provision, Blackman highlights the distaste for the public option across the whole Democratic Party.¹⁰⁶ Progressive Democrats could not wholeheartedly support it because it was not radical enough, whilst conservative Democrats could not countenance further government involvement in the regulation of healthcare. As a result, the regulatory framework that ultimately emerged was heavily moderated by the requirement that any reform package crafted by President Obama must carry the support of his own party.

Evidently, the reaction of independents, and the way in which each jurisdiction's governing party had to fight to gain the support of those within its own ranks, undermines the claim that the US and UK's recent healthcare reforms are revolutionary. The dominance of the revolutionary narrative has not merely been limited to the number of legislative positions

taken, however, since it extends to the magnitude of qualitative rhetoric used in opposition to reform. A second significant problem with the revolutionary narrative is that it focuses too heavily on politicians' partisan rhetoric, particularly in interpreting opponents' proposed reforms as radical.

Part 2: Dismissing the use of The Other's Healthcare System as a Political Device for Revolution

The most striking examples of revolutionary rhetoric are to be found where opponents of reform measure their existing, and fetishized, healthcare system against the evils of *The Other*. *The Other* refers to the fabled, and often demonised, version of the comparator jurisdiction's healthcare system. We note, however, that factual accuracy is often a quality that is absent from these rhetorical exchanges. In both supporting and opposing reform, politicians have made inaccurate or misleading claims about and false portrayals of *The Other*. For example, it is very rare for politicians in the UK to appreciate that any social welfare safety net exists within the US to aid those unable to afford care whereas, in fact, The Emergency Medical Treatment and Active Labor Act 1986 provides all individuals with access to the most essential healthcare services, regardless of their purchasing power.¹⁰⁷ Similarly, politicians in the US present the UK's healthcare system as coercive, with a Stalinesque control over life or death decisions,¹⁰⁸ but whilst, in the UK, individuals must contribute to the national healthcare system, they may still opt for private healthcare by joining a private insurance scheme.¹⁰⁹ There are two apparent reasons for politicians to discredit *The Other*. Firstly, each jurisdiction's healthcare system is a powerful political symbol. In the UK, the 2013 Ipsos-Mori British Future poll¹¹⁰ found that, in a list including the armed forces, its 2012 Olympic Team, the Royal Family and the BBC, the NHS makes people most proud to be British:

“we ought to take pride in the fact that, despite our financial and economic anxieties, we are still able to do the most civilised thing in the world—put the welfare of the sick in front of every other consideration.”¹¹¹

Moreover, in 2012 the UK informed the world of the NHS’s centrality to its citizens’ lives, through its inclusion in the Olympics opening ceremony.¹¹² Similarly, in the United States, privatised healthcare has enormous cultural, constitutional, political and philosophical significance.¹¹³ Consistently, polls demonstrated that President Obama’s reforms provoked opposition because they represented government intrusion on individual liberty¹¹⁴:

“American political culture places an extraordinarily high value on liberty for both individuals and corporations to form political and economic and social associations as they wish. This is what gives a presumptive legitimacy to the behaviour of insurance companies. Health insurance was viewed by many as just another product provided in the market in accord with the rules of the market.”¹¹⁵

Fleck argues that this is because “the deepest value shaping the policy process was respect for individual and corporate economic liberty, and non-interference by government in making healthcare financing decisions.”¹¹⁶ Whereas, in the UK, there is a shared sense of pride in the free-at-the-point-of-access NHS, in the US the people are willing to accept that “some serious health needs go unmet, but they regard such failures as unfortunate and regrettable side effects of a system of liberty, not injustices that would warrant the coercive interventions of government.”¹¹⁷

Clearly, then, healthcare politics is constrained by much deeper considerations than service provision alone. As a result, choices made in healthcare policy and regulation also stand for a jurisdiction’s belief in key political ideas, among these, justice,¹¹⁸ equality,¹¹⁹ individualism,¹²⁰ and collectivism.¹²¹ Developing this sentiment, Fleck notes that

“[N]o simple story can be told about the public or private funding of healthcare... No one component can be dominant ... especially if our ultimate practical political goal is to have a conception of healthcare justice that can be understood and endorsed by reflective citizens in our liberal pluralistic society.”¹²²

Inevitably, any shift in the structure of healthcare governance will result in strong political opposition but reform needs to be viewed through a more refractive lens. In any pluralistic society, including the US and UK, change is normally of degree, readjusting how healthcare replicates society’s understanding of justice, equality, individualism, and collectivism.

1. Use of the *Other* in revolutionary discourse

Here are two typical examples of the use of *The Other* in debate;

“It is unfortunate that much of the campaign we have experienced has relied on convincing the public that the NHS is set to be privatised. Many are convinced that we are heading for an American-style system and I am sure that we have all had e-mails saying that we do not want to see that.”¹²³ Baroness Hussein-Ece, Member of the House of Lords.

“The government picks winners and losers in the United Kingdom, and the government picks who lives and who dies. That doesn't seem to be a healthy solution for healthcare.”¹²⁴ Mr. Poe of Texas, member of the House of Representatives.

Both of these statements cultivate the belief that *The Other’s* healthcare system is diametrically opposed to their own and founded upon a concept of justice incompatible with the values that underpin their domestic healthcare system. One of the worst criticisms that can be levelled at the proposed reforms is that they will produce a new system akin to *The Other*. Baroness Hussein-Ece clearly indicates the British public’s discomfort with, and

distaste for, the perceived inequities created by the privatisation of healthcare, US-style. MP Frank Dobson, addressing the House of Commons, further exposes the differences between British and American anxieties over healthcare reform. In complete contrast to Poe, Dobson views the removal of government intervention and an increased free market as opting for a loss of freedom. For Dobson, less government involvement in healthcare will result in fewer people accessing the care they require. Asking the rhetorical question, who will benefit from the HSCA, Dobson responds;

“The answer is American health corporations, almost all of which have been indicted in the United States for defrauding US taxpayers, doctors, patients and, sometimes, all three. I asked the Secretary of State whether he would rule out any of those outfits obtaining contracts, and I am afraid his answer was, ‘I can't say.’”¹²⁵

The principles at the heart of our healthcare systems do, of course, differ. Broadly speaking, the NHS was founded upon equality and American healthcare on championing free market individualism. Poe’s statement focussing on the loss of liberty flowing from the ACA is a clear testament to that. In a bid to highlight some Americans’ paramount concerns, Poe catalogues the perceived horrors of a system like the NHS, driven by strong government intervention, where healthcare is: “rationed based on cost, age, and survivability rate”¹²⁶ and where the government will “decide that someone can't have a cancer treatment because it's too expensive.”¹²⁷

Building the case against the ACA because of its disregard for individual liberty, Mr. Price, Representative from Georgia, stated;

“Yesterday was an historic day in this Nation. The problem for our citizens is that it was historically dark ... Our Founders are weeping over the incredible vote taken

yesterday that was an affront to federalism, an affront to individual liberty, and an affront to freedom.”¹²⁸

Even when we do appreciate the same principle, such as ‘liberty’, transatlantic understanding of the term’s meaning differs. Opponents of the UK’s HSCA view the introduction of free market principles as bearing potentially negative consequences for liberty.¹²⁹ Liberty would be undermined because individuals’ access to healthcare would become limited by their ability to pay.¹³⁰ Demonstrating the mistrust of private healthcare, Baroness Williams of Crosby recalled how, in the US, despite the advice of the National Institute of Health on the possibility of damaging side effects, doctors continued to administer a test that helped identify prostate cancer because of its profitability. Williams saw this as “a frightening account of the conflict between medicine and its values and the pursuit of profit”¹³¹, noting that underpinning opposition to the HSCA was “[a]n abiding theme [of] privatisation and the Americanisation of our health service.”¹³²

In the US, opponents of the ACA claim that it offends liberty for conflicting reasons. They contend that, through commandeering people into purchasing health insurance, the ACA limits an individual’s liberty by denying them the choice to forgo joining the market.¹³³ Judge Vinson, in the Northern Florida District Court, summed up this interpretation of liberty, when he claimed that;

“It is difficult to imagine that a nation which began, at least in part, as the result of opposition to a British mandate giving the East India Company a monopoly and imposing a nominal tax on all tea sold in America would have set out to create a government with the power to force people to buy tea in the first place.”¹³⁴

Of course, the presentation of these caricature versions of *The Other* could be easily dismissed, were it not for the fact that even proponents of reform were in on the act. For

example, Earl Howe, the government minister for the HSCA in the House of Lords, noted with interest the common concern that the HSCA could lead to an “American-style market free-for-all, with competition harming patients' interests”¹³⁵ but countered:

“Let me be clear about what the Bill does and does not do. The Bill does not introduce a free market for all. It does not change competition law, or widen the scope of competition law. It does introduce a framework in which competition can be effectively managed as a means to benefit patients. ... The Bill does not do anything which might or could lead to the privatisation of the NHS. What it does do is create a level playing field between different providers, putting an end to the subsidies and guarantees given to the private sector under the last Government.”¹³⁶

Important to note are Lord Howe’s attempt to distance the HSCA from a US-style system of healthcare governance, his categorical rejection of reform resulting in “the privatisation of the NHS”¹³⁷ and his clarification of the HSCA as introducing only minimal, targeted reforms to bolster beneficial competition.

The fact that proponents of reform deem it necessary to differentiate between their system and the other jurisdiction’s is evidence of a shared belief, across the political spectrum, in ideological differences between the two. When assessing the credibility of reform, proponents, rather than point out the virtues of the other system, tried distinguishing their reforms from the other’s system. In order to sell reform, proponents clarified how changes maintained their system of healthcare, while cherry picking elements of *The Other* to reinforce their own. Proponents were never willing to accept that reform resulted in fundamental departure, nor did they go so far as to recognise that reform inevitably led to the possibility of convergence between the two systems.

2. Dismissing the Rhetoric of the Other and Considering Evolution

Revolutionary rhetoric seems disingenuous when it is considered that current opponents of particular reforms have, at one point or another, been the proponents of similar reforms. Political rhetoric should be dismissed as just that, political. It is partly because opponents of reform, through their previously held political convictions, have supported similar reforms,¹³⁸ that we also dismiss the revolutionary narrative in favour of evolution.

In the US, for example, the individual mandate's provenance is as a Republican, conservative think-tank led policy.¹³⁹ Blackman states that former Republican Speaker of the House, Newt Gingrich, supported an individual mandate to purchase health insurance up until May 2011.¹⁴⁰ The scheme was originally proposed by the Heritage Foundation to the Republican Party in 1993 as a free market alternative to Hillarycare.¹⁴¹ Supporters of the individual mandate within the Republican Party, would, however, "throw consistency to the wind in their pursuit of partisan gains"¹⁴² once the Democrats proposed a healthcare system based on an individual mandate in 2008.¹⁴³ Moreover, and federalism arguments aside,¹⁴⁴ the only such scheme adopted at state level in the US has been that of Massachusetts' Republican Governor, Mitt Romney.¹⁴⁵ It, therefore, seems impossible to accept the claim that the individual mandate is revolutionary and an 'unprecedented' socialisation of healthcare. Quite the opposite, with both parties having supported it, the introduction of the individual mandate seems like a natural evolution.

Similarly, in the UK, opening the NHS to free market principles has been a goal not merely of Conservative governments, but also Labour.¹⁴⁶ Speaking on the 60th anniversary of the NHS former Conservative Health Secretary, Kenneth Clarke, reflected on Tony Blair's 1997-2007 Labour government:

"Labour secretaries of state have got away with introducing private sector providers into the NHS on a scale which would have led the Labour Party onto the streets in

demonstration if a Conservative government had ever tried it. In the late 1980s I would have said it is politically impossible to do what we are now doing. I strongly approve.”¹⁴⁷

Davies adds credibility to Clarke’s taunt, stating “[s]uccessive governments have ... encouraged the idea that there should be competition, or at least contestability, in the market.”¹⁴⁸ While Blair’s government briefly ran a very centrally controlled health service from 1997-1999, it quickly “reverted to the Conservatives’ more market-like approach.”¹⁴⁹ Blair’s Labour government was responsible for two key, market based initiatives. Firstly, it established NHS Foundation Trusts, which transformed government-controlled hospitals into autonomous institutions.¹⁵⁰ Secondly, it created Monitor, which ensures that the NHS remains competitive. It seems unlikely that, with the Conservatives now at the helm as the coalition’s majority party, this drive will change.¹⁵¹ The Labour Party’s 2010 general election manifesto had, in any case, promised to “expand patient choice, empowering patients with information, and giving individuals the right to determine the time and place of treatment.”¹⁵² Consequently, the Labour Party’s track record in government, combined with its manifesto commitment to competition, evokes the disingenuity of the Republican’s switch.

What has become apparent is that policymakers in the US and UK no longer see a largely free market system or completely state controlled system as capable of solving healthcare regulation’s principal dilemma, controlling the cost of health while ensuring universal levels of coverage.¹⁵³ Policymakers have instead mixed aspects of internal system evolution with the inclusion of revolutionary transplants¹⁵⁴ from the other’s system. In pursuit of equilibrium, they have introduced concepts conventionally conceived as abrasive to their own constitutional order. As a result of seeking to tackle the same problem, policymakers in the US and the UK have moved towards establishing two ideologically similar healthcare systems, yet it is important to note that the two systems remain substantially different

because, whilst they are moving closer ideologically, they began at opposite ends of the spectrum.

Evolution does not, however, fully convey what is occurring here because it does not describe the direction of reform. What is interesting is that both jurisdictions' chosen path of evolution is towards *The Other*. In both jurisdictions evolution is convergent, moving towards the same - middle - ground. In light of this, we agree with Glennerster and Lieberman's contention that, while *The Other's* healthcare system may be viewed as a "curiosity at best and an abomination at worst"¹⁵⁵ there are, in fact, fewer differences between the two than ever before. What has occurred is evolution, so much so that it could be argued to amount to "hidden" convergence.¹⁵⁶ Behind this notion is what Glennerster and Lieberman perceive as a reverse flow of ideas, meaning that while the two systems took remarkably different forms after the Second World War, since then piecemeal policy changes have been informed and underpinned by the successes of *The Other*.¹⁵⁷ "Powerful forces" such as "economic, political, and demographic challenges... have bent these apparently opposite systems"¹⁵⁸ to *The Other's* shape.

There is one aspect neglected in Glennerster and Lieberman's study which is the role played by constitutions and constitutional law in this process. We contend that constitutional actors, including constitutions themselves, have, and will continue to, play a key role in evolutionary convergence. Constitutional law has provided a necessary and principled buffer, preventing reformers from engaging in outright revolution. The presence of this buffer is imperative in healthcare reform because policymakers do not know the middle ground for which they search. On neither side of the Atlantic can politicians profess to have the solution to providing universal access to healthcare whilst maintaining the financial viability of the healthcare system. Evolutionary convergence is, therefore, blind and the quest for equilibrium likely to take many twists and turns.

Constitutions and constitutional law have a role to play in policing this search. A constitution is, after all, our “plan for politics”¹⁵⁹ and all policy choices must be made in the context of this plan. If a policy choice conflicts with the plan, either the policy must be altered or the constitution amended. In this sense it is a primary task of a constitution to act as a roadblock to potentially revolutionary policy.¹⁶⁰

We will demonstrate through consideration of the Supreme Court of the United States (SCOTUS) judgment in *National Federation of Independent Small Business v Sebelius*¹⁶¹ (*NFIB*) and the UK’s House of Lords Select Committee on the Constitution report on the HSCA,¹⁶² how constitutional law and politics have suppressed the revolutionary elements of reform. In both instances, within the scope of their respective powers, constitutional actors have measured healthcare proposals against their constitution and acted to diminish the revolutionary components of reform.

Part 3: Constitutional Law as Balancer

We have argued elsewhere that the US and UK’s healthcare reforms do not necessarily ‘fit’ (to varying degrees) their respective constitutions.¹⁶³ The argument goes that the reforms’ constitutional fit has been rationalised post-hoc, and that policymakers did not sufficiently consider constitutional mores when drafting reform legislation. While we do not believe that reformers paid sufficient attention to the constitutional dimension when crafting new healthcare systems, we see that, post-reform, constitutions and constitutional law have taken centre stage. Proponents and opponents of reform have sought to confirm or cast off parts of the new system on the basis of compatibility with the jurisdiction’s underlying political philosophy, as represented in its constitution, or ‘plan for politics’.¹⁶⁴ As plans for politics, constitutions capture the framework commitments and values of a society, setting the ground rules for future generations. Constitutions, while largely ill-considered in the creation of these

systems, have played a significant role in setting, revising and policing the boundaries of reform.

1. Rethinking the Supreme Court's Judgment in *National Federation of Independent Business v Sebelius*

In *NFIB* the Attorney Generals of 27 state governments,¹⁶⁵ NFIB (a non-profit organisation, representing over 350,000 small businesses), a variety of academics, pressure groups and right leaning policy units, in 81 amicus briefs, petitioned SCOTUS to declare the ACA unconstitutional. Their primary contention was that the ACA's constitutionality rested upon Congress being granted powers "unprecedented and unbounded"¹⁶⁶ under the American Constitution.

Two provisions within the ACA shaped the oppositions' cases. Firstly, the mandate that all individuals must purchase healthcare insurance rested upon the allegedly questionable assumption that Article 1 powers provided Congress with the authority to make that demand.¹⁶⁷ Secondly, the withdrawal of funding from States for refusing to accept the enlarged Medicaid state-funded health insurance scheme under the ACA was argued to contradict *South Dakota v Dole*,¹⁶⁸ which sought to limit Congress's spending power for the purposes of maintaining America's federal structure of government.¹⁶⁹ If SCOTUS agreed, opponents invited a ruling that would hold the whole of the ACA unconstitutional on the basis that it would be impossible to sever these elements and for the Act to work.¹⁷⁰ At their core, these arguments assert that the ACA undercut American federalism by granting institutions of the federal government powers in excess of those "few" and "defined" powers granted within the Constitution.¹⁷¹

While SCOTUS in *NFIB* did not hand opponents the victory they wanted, its ruling was not entirely favourable to the federal government either. In fact, the SCOTUS judgment has gone

a long way to ensuring the ACA's ideological conformity.¹⁷² That is, the SCOTUS decision has made the ACA less antagonistic to the American concept of liberty than it had been prior to the judgment.¹⁷³ Right leaning libertarian Professor Randy Barnett contends that "we lost on healthcare. But the Constitution won"¹⁷⁴, though a more moderate conclusion might be that post-*NFIB* the ACA comports better with the Constitution's commitment to liberty.

An example of this toning down comes in the SCOTUS's answer to the first question, whether Congress has the power to mandate individuals to purchase health insurance? SCOTUS determined that Congress did not possess the power to force individuals to purchase health insurance under the Commerce Clause,¹⁷⁵ but it could tax those who did not under the Taxing Power.¹⁷⁶ Prima facie, this might indicate that the court is merely splitting hairs, after all the conclusion remains that Congress can introduce a mandate but Barnett suggests why this adjustment, while not what opponents wanted, could still be regarded as a victory:

"this power [to Tax] is not nearly as dangerous as the commerce power that was rejected. Congress can punish violations of its commerce power regulations with imprisonment. But under the tax power, the worst that can happen is a fine. And if lawmakers try similar legislation in the future, everyone will know that Congress is raising taxes and can fight back politically."¹⁷⁷

Consequently, rooting the individual mandate's constitutionality within the Taxing power makes the ACA less revolutionary within America's constitutional structure. By resting its legality on the taxing power, SCOTUS reduced the ACA's coercive strength,¹⁷⁸ meaning that the individual mandate was no longer a command from the federal government to purchase healthcare insurance but, depending one's perspective, either a tax break for those who do, or a tax on those who do not. The SCOTUS decision, to a lesser degree, undercut the

Constitution's federal division of powers by framing the individual mandate as within a power which, it claimed, Congress always had.¹⁷⁹ The *NFIB* judgment should thus be seen as a decision that balances the legitimate need to find a solution to the healthcare dilemma of cost versus access against the equally legitimate need to protect values central to the Constitution.

Rivkin, Casey and Grossman have dismissed *NFIB* as "fig-leaf federalism", which is "long on principles and platitudes but short on enforcement".¹⁸⁰ We disagree with this statement, and view SCOTUS's approach in *NFIB* as an attempt to reduce any abrasion between the ACA and the Constitution. Evidence of this, and proof that the Commerce Clause's substitution for the Taxing Power was not merely window dressing, emerges from how the Court dealt with the second question.

The ACA required states to increase Medicaid access to those below 133% of the poverty line and under the age of 65.¹⁸¹ The federal government would fund this expansion fully through 2016, after which, federal support funding would gradually decrease to 90% with state governments footing the remaining 10% of the cost. Section 1396c decreed that, if a state did not agree to the expansion of Medicaid it would forfeit all Medicaid funding (offered in this and previous conditional spending programs), which accounted for 10% of the states' overall budgets. The issue SCOTUS had to confront was whether the condition imposed by s1396c was "economic dragooning [leaving] the States with no real option but to acquiesce in the Medicaid expansion."¹⁸² If s1396c did "pass the point at which 'pressure turns into compulsion'"¹⁸³, SCOTUS had to consider whether the ACA "runs contrary to *our* system of federalism."¹⁸⁴

By a majority of 7-2, SCOTUS held that Congress could not withdraw all Medicaid funding from a state if that state refused to accept the ACA's new terms. It could only refuse any

additional funding. Chief Justice Roberts held that, if Congress could withdraw all funding from state governments for their refusal to accept added terms, it would allow them to hold “a gun to the head”¹⁸⁵ of the State governments and turn the *conditional* spending clause into compulsion. Section 1396c’s level of coercion was, for the majority, unacceptable because the financial consequences of refusing to accept expansion would be so dire that it deprived state governments of a legitimate choice in whether to accept the new scheme or not.¹⁸⁶ Chief Justice Roberts outlined how American federalism relies on states having the choice to decline involvement with a federal spending program, concluding that “when the State has no choice, the Federal Government can achieve its objectives without accountability.”¹⁸⁷ While the textual basis for this argument seems weak, it is an issue of first principle, namely how best to maintain the federal division of powers mandated by the Constitution. Guerreo has summarised the logic behind finding the Medicaid expansion as unconstitutional, in the following way;

“in the US federalist system of dual sovereignty, states are sovereign entities, and it is inappropriate for the federal government to operate in ways that ignore that fact by compelling or conscripting state officials into carrying out federal projects.”¹⁸⁸

Two further considerations underscore *NFIB*’s credentials as equilibrium discovery between healthcare’s policy requirements and America’s constitutionally entrenched structure of government and political principles. Firstly, Chief Justice Roberts clarified that the coercive power of the Spending Clause, here deployed to withhold federal funding from a State for its failure to adopt a federal spending program, should not create a federal black hole, affording Congress unlimited power.¹⁸⁹ Congress should not be able to use the Spending Power to justify policies it could not undertake through its enumerated powers.¹⁹⁰ If the Spending Clause permitted Congress the power to compel state governments, it would make any attempt to regulate federal power via any other part of the Constitution worthless. Secondly, while a

majority of the Justices voted for eliminating part of the Medicaid provision, a majority of Justices did not vote for dismantling the expansion entirely. The four dissenting Justices (Scalia, Thomas, Kennedy and Alito) would have gone further and held the Medicaid expansion to be wholly unconstitutional, however.¹⁹¹ These Justices believed the coercive element to be essential to the Medicaid expansion and thus refused to sever s1396c from the rest of the ACA. This is a far more radical position than that adopted by Chief Justice Roberts.¹⁹² In merely striking down s1396c the rest of the statute was saved, upholding the constitutionality of the majority of the ACA, which was not constitutionally abrasive, while reframing and striking down those elements which were.

2. The House of Lords Select Committee on the Constitution and Ministerial Responsibility

In the UK, constitutional concerns over the HSCA have also led to modification. A major difference to note is in that the UK's forum for constitutional amendment has, thus far, been the legislature rather than the judiciary. Unlike in the US, where the SC settled the policy initiative-constitutional fidelity equilibrium, in the UK the House of Lords in its legislative capacity performed this task.¹⁹³ The cause of this institutional shift is the departure from America's judicially enforceable constitution, which limits Congressional power, to the UK's political constitution, whereby Parliament possesses unlimited sovereignty and its decisions are typically viewed as incontestable.¹⁹⁴ Whilst political developments resulting in, for example, membership of the European Union and the passing of the Human Rights Act 1998, appear to signify a limiting of parliamentary sovereignty, that is by legislative, rather than judicial, initiative and may be undone. One subsidiary issue of note is that this shift in forum means equilibrium is achieved in the UK at an earlier stage than in the US. With the HSCA, constitutional debate occurred in the upper chamber of Parliament in reaction to the government's plans as outlined in the lower chamber.

The House of Lords Committee on the Constitution (HLCC) had the same kinds of reservations about the HSCA as SCOTUS had about the ACA and, similarly, wanted to ensure that reform fitted within the UK's prevailing, and longstanding, constitutional arrangements and structure.¹⁹⁵ The HLCC's formal remit is "to examine the constitutional implications of all public bills coming before the House; and to keep under review the operation of the constitution."¹⁹⁶ With the HSCA, the HLCC wanted to confirm that the post-reform NHS, as a government-owned service, would maintain provision for democratic accountability to Parliament.¹⁹⁷ Accountability for government services, through parliamentary supervision, is imperative to the UK's constitution. Without ministerial accountability for activities occurring within the NHS, a democratic deficit would emerge.¹⁹⁸ Decisions concerning the spending of public money, raised through taxation, would be devoid of any political control or repercussions if that democratic linkage was not maintained.¹⁹⁹ Severing ministerial accountability from the NHS would create a constitutional black hole. Furthermore, the legitimacy of the British constitution rests upon the notion that Parliament is omnipotent, and its decisions democratically legitimate, because it is the only branch of government that is representative of the people.²⁰⁰

Section 1 of the original version of the HSCA, which passed House of Commons scrutiny, read;

(1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—

- (a) in the physical and mental health of the people of England, and
- (b) in the prevention, diagnosis and treatment of illness.

(2) For that purpose, the Secretary of State must exercise the functions conferred by this Act **so as to secure that services are provided** in accordance with this Act.

The HLCC contested this clause because the provision it replaced - s3 of the National Health Service Act 2006 - contained a functionally equivalent clause that imposed a wider duty on the Secretary of State:

(1) The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of illness.

(2) The Secretary of State must for that purpose **provide or secure the provision of services** in accordance with this Act.

Where, under s3 of the NHS Act 2006, the Secretary of State had to “provide or secure” health services needed, by s1 of the original Health and Social Care Bill the Secretary of State would merely need to “secure that services are provided”. Moreover, while s3(1) of the NHS Act 2006 charged the Secretary of State with responsibility for providing “throughout England, to such extent as he considers necessary to meet all reasonable requirements... hospital accommodation, other accommodation, medical, dental, ophthalmic, nursing and ambulance services”²⁰¹, Clause 10 of the HSCA shifted this duty onto the newly established Clinical Commissioning Groups, thus severing a direct link to the government.

Voicing its concern over these changes, the HLCC stated;

“The combination of these changes matters, constitutionally, because it is not clear whether the existing structures of political and legal accountability with regard to the NHS will continue to operate as they have done hitherto if the Bill is passed in its current form. As such, the House will wish carefully to consider whether these changes pose an undue risk either that individual ministerial responsibility to

Parliament will be diluted or that legal accountability to the courts will be fragmented.”²⁰²

The HLCC’s apprehensions are a clear appeal to the government to consider how limiting the responsibility of the Secretary of State would constitutionally undermine the NHS, and to reconsider its position on the matter. Consultation with the government resulted in the HLCC producing concrete recommendations, the most important being,

“that the Bill be amended to include a new subsection 1(3) in the 2006 Act as follows:
Page 2, line 4, at end insert— “() The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England.”²⁰³

The effect of this amendment would be to ensure that the Secretary of State remained constitutionally responsible for the NHS through his political accountability to Parliament.

Unlike the SCOTUS jurisprudence, the HLCC’s reports and recommendations are not binding. The working out of issues thus occurs through the political, rather than legal, process. The government-controlled House of Commons took seriously the HLCC’s warning and amended s1 of the HSCA, which now reads “The Secretary of State retains ministerial responsibility to Parliament for the provision of the health service in England.”²⁰⁴ The HLCC thereby blunted the transfer of power from government minister to department bureaucrat. The result of this is that the free market accountability structure the government aimed to install by “giving CCGs the confidence to act as market players, free from the fear of ministerial ‘interference’”²⁰⁵ has been diminished, ensuring that Parliament maintains control over the executive, and democratic accountability still counts, even in a marketised NHS. In this regard, the HLCC used the constitution to remove the most revolutionary aspect of the HSCA, the placing of large sections of the publicly funded healthcare service beyond democratic oversight. Like SCOTUS, the HLCC did not condemn the reforms outright on the

basis of constitutional problems. Rather than recommend wholesale overhaul, the HLCC, like SCOTUS, demanded the excision of the most revolutionary elements of reform, whilst upholding the rest.

Policymakers in the US and UK have proceeded to mix aspects of internal system evolution with the inclusion of revolutionary concepts imported and adapted from the other's system. In search of healthcare equilibrium, they have introduced notions conventionally conceived as abrasive to their own constitutional order. As a result, we conclude that the healthcare systems of the US and UK are converging on the same ground.

There is another species of equilibrium that must be attained or maintained, however, and that is constitutional equilibrium. In that sense, the actions of both SCOTUS and the HLCC are testament to the idea of evolution as opposed to revolution, bringing the necessary constitutional perspective, and balance, to the politics of healthcare. That is to say that each jurisdiction's healthcare system, despite the inclusion of some conceivably contradictory or alien concepts on the face of it, is enabled to comport with its plan for politics through the constitution's role as a mechanism for sustaining commitment to certain ideological values and ensuring evolution rather than revolution.

Conclusion

This paper takes no position on the jurisdictions' reforms, neither agreeing nor disagreeing with opponents or proponents of the respective healthcare systems. It recognizes that healthcare reform is as much about practical politics as it is about principle. In that context, it finds the evolutionary narrative more persuasive than the revolutionary, which manifests practical politics to the detriment of principle, albeit that, in that revolutionary narrative, practical politics masquerades as an overweening commitment to principle. It also finds that the healthcare systems of the UK and US are not as different as the revolutionary narrative's

depiction of the political positions suggests. There is convergence, an external fact that the evolutionary narrative is more able to account for along with its depiction of internal change. At the heart of our convergence narrative is how, in order to maintain internal constitutional fidelity, reform has been tempered post-hoc by constitutional actors. Firstly, constitutional adjudication has moulded the outer limits of reform, revising or reversing those parts of the new healthcare systems perceived to be (too) revolutionary.²⁰⁶ When measured against fundamental political principles, as manifested by the constitution, some elements of the reforms have been confirmed as fitting within the constitutions' frameworks, others have not. Secondly, through entertaining questions of constitutionality, and supporting certain elements of new healthcare systems, constitutional actors implicitly undermine the evolutionary narrative. Convergence enables us to embrace and account for change that is more than moderate, linear evolution but which falls short of revolution due to the presence of mechanisms of restraint. Whilst we identify convergence as an important outcome of independently undertaken healthcare reform, that convergence is, we conclude, blind. In neither jurisdiction do policymakers know the precise equilibrium between free market and state support that will achieve universal access at the lowest cost. Nor can they envisage what overall shape the converged healthcare system will ultimately take.

¹ J. Blackman, *Unprecedented: The Constitutional Challenge to Obamacare* (New York: Public Affairs, 2013): at Foreword. ; D. B. Rivkin Jr., and L. A. Casey, 'Mandatory Insurance is Unconstitutional,' *Washington Post*, September 18, 2009, at <http://online.wsj.com/news/articles/SB10001424052970204518504574416623109362480> (last visited Jan. 20th 2014) ; A.C.L. Davies, 'This Time, it's for Real: the Health And Social Care Act 2012,' *Modern Law Review*, 76 (2013): 564-588; H. Pownall, 'Neoliberalism, austerity and the Health and Social Care Act 2012: the Coalition Government's Programme for the NHS and its implications for the public sector workforce,' *Industrial Law Journal*, 42 (2013): 422-433; The King's Fund, *Never Again? The Story of the Health and Social Care Act 2012*, Institute for Government (2012); David J Hunter, 'Will 1 April mark the beginning of the end of England's NHS? Yes,' *British Medical Journal*, (2013): 346.

² See Blackman, *supra* note at 1, xx; See Pownall, *supra* note at 1, 422-424.

³ J. Hacker, Healthcare For America, Economic Policy Institute Briefing Paper, #180 (January 11th, 2007) 11; C. Cooper, Cameron speech: NHS reforms will be 'evolution not revolution', GP Online, at <<http://www.gponline.com/News/article/1070089/Cameron-speech-NHS-reforms-will-evolution-not-revolution>> (last visited Feb. 2, 2014); J. Le Grand, 'Will 1 April mark the beginning of the end of England's NHS? No', British Medical Journal, (2013): 346.

⁴ See Davies, *supra* note 1, at 565-566. Similar principles to those contained within the HSCA find their roots in a report published by the previous Labour Government in 2002, see, Department of Health, Delivering the NHS Plan (Cm 5503 April 2002) [2].

⁵ N. Maclean, *Distributing Healthcare: Principles, Practices and Politics* (Charlottesville: Imprint Academic, 2007): at 2-3; Democratic Policy and Communications Committee, The Patient Protection and Affordable Care Act: Detailed Summary 1 2010, available at <http://dpc.senate.gov/healthreformbill/healthbill04.pdf> (last visited 17 Jan. 2014); Audit Commission, More For Less (Health briefing November 2009) at < <http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/AuditCommissionReports/NationalStudies/20101216moreforless200910.pdf>> (last visited 19 Jan. 2014); Department of Health, Health and Social Care Act 2012 Fact Sheet, at <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/138257/A1.-Factsheet-Overview-240412.pdf> (last visited Feb. 2, 2014) [2]-[5].

⁶ N. Lameie, P. Joffe and M. Wiedermann, 'Healthcare systems- an international review: an overview,' *Nephrol Dial Transplant* 14 [Suppl 6] (1999): at 3-9A

⁷ See 26 U.S.C. § 5000A(a); W. E. Parmet, 'The Individual Mandate: Implications for Public Health Law,' *Journal of Law Medicine and Ethics* 39 (2011): 401-423 at 401.

⁸ See Davies, *supra* note 1, at 567.

⁹ A consideration for the future is whether this 'convergence' is upon a Bismarckian ground, however, this is outside the scope of this essay.

¹⁰ Wendt, Grimmeisen, Helmert, Rothgang and Cacace, 'Convergence or Divergence of OECD Healthcare Systems? Trans State,' (Working Paper No. 9, University of Bremen, Collaborative Research Center 597: Transformations of the State, 2004)

¹¹ Organization for Economic Cooperation and Development, *The Reform of Healthcare Systems: A Review of Seventeen OECD Countries*, Health Pol'y Stud. No. 5, 45 (1994) at 61; "The most remarkable feature of the health system reform among the seventeen countries is the degree of emerging convergence."; M. Minow, 'Is Pluralism an Ideal or a Compromise?' *Connecticut Law Review*, 40 (2008): 1287-1314, at 1300.

¹² While the United Kingdom does not have a 'Constitution', in the American sense, as in a written document, it does have a constitution, as in a collection of rule for government. See V. Bogdanor, *The New British Constitution* (Oxford: Hart Publishing, 2003): at 3-11; A. J. Zurcher, *Constitutions and Constitutional Trends since World War II: An Examination of Significant Aspects of Post war Public Law with Particular Reference to the New Constitutions of Western Europe* (Oxford: OUP 1952): at 175-176.

¹³ B. Friedman, *The Will of the People: How Public Opinion Has Influenced the Supreme Court and Shaped the Meaning of the Constitution* (New York: Farrar Straus, 2010): at 367-68.

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- ¹⁵ J. Dolgin & K. Dieterich, 'Social and Legal Debate About the Affordable Care Act,' *University of Missouri-Kansas City Law Review* 80, (2011): 45-90, at 45.
- ¹⁶ Randy Barnett, Nathaniel Stewart & Todd F. Gaziano, 'Why the Personal Mandate to Buy Health Insurance Is Unprecedented and Unconstitutional,' (The Heritage Found, Dec. 9, 2009) <<http://www.heritage.org/research/reports/2009/12/why-the-personal-mandate-to-buy-health-insurance-is-unprecedented-and-unconstitutional>> (last visited Feb 6 2014)
- ¹⁷ See Blackman, *supra* note 1, at 1.
- ¹⁸ See Davies, *supra* note 1, at title.
- ¹⁹ See Pownall, *supra* note 1, at 422.
- ²⁰ *Ibid*, 423.
- ²¹ *Ibid*, 424.
- ²² R. Klein, *The New Politics of the NHS: From Creation to Reinvention* (London: Radcliffe, 2013): at 279.
- ²³ P. Wehner, *Obama and Healthcare: His Suicide Mission for Democrats*, at <http://www.eppc.org/publications/obama-and-health-care-his-suicide-mission-for-democrats/> (last visited Jan. 13 2014)
- ²⁴ N. Lawson, *The View from Number 11: Memoirs of a Tory Radical* (London: Bantam, 1992): at 613.
- ²⁵ Department of Health, Equity and Excellence: Liberating the NHS (Cm7881, July 2010).
- ²⁶ See Klein, *supra* note 22, at 279.
- ²⁷ See King's Fund, *supra* note 1, at 4.
- ²⁸ Health and Social Care Act 2012, s75(1)(c).
- ²⁹ *Ibid*, a75(1)(b).
- ³⁰ *Ibid*, ss61-70. One potentially tricky consequence of competition in UK healthcare is the extent to which it renders the NHS and its associated bodies subject to both domestic and European Union competition law. Space precludes a discussion here but Goulding's overview provides a flavour of the issues: <http://eutopialaw.com/2013/07/19/is-the-nhs-subject-to-competition-law/> (last visited Apr. 29 2014)
- ³¹ *Ibid*, ss72-80.
- ³² R. B. Leflar, 'Reform of the United States Healthcare System: An Overview,' *Arkansas Law Notes*, (2013): 1171 at [2].
- ³³ Hansard, Debbie Abrahams (Oldham East and Saddleworth) (Lab), HC, 31 Jan 2011 : Column 646; Hansard, Malcolm Wicks (Croydon North) (Lab), HC, 31 Jan 2011 : Column 671; Hansard, John Healey (Wentworth and Dearne) (Lab) HC: 31 Jan 2011 : Column 624.
- ³⁴ Representative Poe (Tx.) "Will We Choose Tyranny or Liberty?" *Congressional Record* (21 Mar 2010) Daily Ed. H1821; Representative Price, "Dark Day for America," *Congressional Record* (22 March 2010) [H2175]; Representative Foxx (State) "Government Takeover of Healthcare," *Congressional Record* (23 Sept 2009) [H9812].
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- ³⁶ Hansard, John Healey (MP) (Lab) HC, 31 Jan 2011 : Column 627, "will create the monster of a full-blown market in healthcare which GPs will not control and nor will Ministers or Parliament"; Hansard, Baroness Donaghy, HL, 12 Oct 2011 : Column 1693.
- ³⁷ Representative Poe, "No to Government-Run Healthcare," Congressional Record (6 Nov 2009) H12554; Representative Poe, 'Healthcare Rationing could result in Death Penalty in the United Kingdom,' Congressional Record (12 June 2009) H6622.
- ³⁸ Hansard, Geraint Davies (Swansea West) (Lab/Co-op) HC, 31 Jan 2011 : Column 687.
- ³⁹ W. Brennan, 'Why Have a Bill of Rights?' Valparaiso University Law Review 26 (1991): 1-19, at 19.
- ⁴⁰ Worth Bank, Health Expenditure Totals (& of GDP), <<http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>> (last visited Feb 2 2014).
- ⁴¹ U.S. Census Bureau, Income, Poverty and Health Insurance Coverage in the United States: 2010, <http://www.census.gov/newsroom/releases/archives/income_wealth/cb11-157.html> (last visited Feb 5 2014).
- ⁴² UK Public Spending, Spending Figures for Government, <http://www.ukpublicspending.co.uk/total_spending_2013UKbn> (last visited Feb 4 2014).
- ⁴³ Record of Stages of Health and Social Care Act's passage through the Houses of Parliament, <<http://services.parliament.uk/bills/2010-12/healthandsocialcare/stages.html>> (last visited Feb 3 2014); House of Lords Reform Bill [HL] — Committee, HL, 21 Oct 2011 : Column 475.
- ⁴⁴ Hansard, Health and Social Care Act Debate, HC, 7 Sep 2011 : Column 362.
- ⁴⁵ M. Russell, *The Contemporary House of Lords: Westminster Bicameralism Revived* (Croydon: OUP, 2013): at 108.
- ⁴⁶ Hansard, Health and Social Care Bill — Committee (7th Day), HL, 22 Nov 2011 : Column 990.
- ⁴⁷ Hansard, Health and Social Care Bill — Reject at Second Reading, HL, 12 Oct 2011 : Column 1711.
- ⁴⁸ See M. Russell, *supra* note 45, at 103-104.
- ⁴⁹ Open Congress, at <<http://www.opencongress.org/bill/hr3590-111/votes>> (Last visited Feb. 3 2014)
- ⁵⁰ *Ibid.*
- ⁵¹ Open Congress, at <<http://projects.washingtonpost.com/congress/111/house/members/>> (Last visited Feb. 3 2014): identifies that Representatives sided with their party position 94% of the time.
- ⁵² "Congress is becoming more like a parliamentary system—where everyone simply votes with their party and those in charge employ every possible tactic to block the other side. But that is not what America is all about, and it's not what the Founders intended. In fact, the Senate's requirement of a supermajority to pass significant legislation encourages its members to work in a bipartisan fashion."- Senator Snowe, 'Why I'm Leaving the Senate', at <<http://readersupportednews.org/opinion2/270-37/10252-focus-why-im-leaving-the-senate>> (last visited Feb. 1 2014)
- ⁵³ James Madison, Alexander Hamilton, and John Jay, *The Federalist Papers* (US: Signet Classic, 2003): at 348. Federalist Paper 57.
- ⁵⁴ *Ibid.*, at 324. The Federalist No. 52.
- ⁵⁵ See Open Congress, *supra* note 49.
- ⁵⁶ Loyd Marcus, *Evil Democrat Paradigms*, Am. Thinker, at <http://www.americanthinker.com/2010/09/evil_democrat_paradigms.html> (last visited Feb 1 2014).

⁵⁷ Public Whip, Voting Records, < <http://www.publicwhip.org.uk/divisions.php?house=lords&sort=subject>> (last visited Feb 6 2014)

⁵⁸ M. Russell and M. Sciara, 'Independent Parliamentarians En Masse: The Changing Nature and Role of the 'Crossbenchers' in the House of Lords,' Parliamentary Affairs, (2008): at fn17; Hansard, Lord Richard, HL, 14 October 1998, Columns 945-6.

⁵⁹ Ibid, M. Russell and M. Sciara, at 8.

⁶⁰ H. Halpin and P. Harbage, 'The Origins And Demise Of The Public Option,' Health Affairs, 29 (2010): 1117-1124, at 1119; M. Raju, 'Joe Lieberman: I'll block vote on Harry Reid's plan,' <<http://www.politico.com/news/stories/1009/28788.html>> (last visited Feb 1st 2014)

⁶¹ See Halpin and Harbage, supra note 60, at 1121.

⁶² C. Fisk and E. Chemerinsky, 'The Filibuster,' Stanford Law Review, 49 (1997): 181-254, at 181, 199-200- explaining the tradition of the filibuster.

⁶³ L. Jacobs and T. Skocpol, Healthcare Reform and American Politics: What Everyone Needs to Know (US: OUP, 2012): at 191 defining Lieberman as "necessary".

⁶⁴ J. Brasfield, 'The Politics of Ideas: Where Did the Public Option Come from and Where Is It Going?' Journal of Health Politics, Policy and Law, 36 (2011): at 455-459; D.M. Herzenhorn, "Lieberman vs. the 'Public Option' Patriarch." New York Times, Prescriptions blog (December 15). <<http://prescriptions.blogs.nytimes.com/2009/12/15/lieberman-vs-the-public-option-patriarch>> (last visited December 1st 2013)

⁶⁵ L. Jacobs and T. Skocpol, supra note 63, at 77-82.

⁶⁶ I. Shapiro, 'A Long Strange Trip: My First Year Challenging the Constitutionality of Obamacare,' Florida International University Law Review, 6 (2010): 29-59, at 31.

⁶⁷ M. Kang, 'Sore Loser Laws and Democratic Contestation,' Georgetown Law Journal, 99 (2013): 1013-1077, at 1050.

⁶⁸ C. McGreal, 'Why Joe Lieberman is holding Barack Obama to ransom over healthcare,' <<http://www.theguardian.com/world/2009/dec/16/joe-lieberman-barack-obama-us-healthcare>> (last visited Feb 1st 2014)

⁶⁹ K. A. Strassel, 'No Way, No How, to the Public Option,' <<http://online.wsj.com/news/articles/SB10001424052748704007804574574652325364622>> (last visited 20th Feb 2014)

⁷⁰ J. Brasfield, Supra note 64.

⁷¹ V. Bogdanor, 'The Coalition and the Constitution,' (Oxford: Hart, 2011): at 1-9. Provides a good summary of the party positions post 2010 General Election.

⁷² J. Cannan, 'A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History,' Law Library Journal, 105 (2013): 131-179, at 163. ; M. Hall, 'Healthcare Law Raises Questions on Abortions,' USA Today, <[http:// www.usatoday.com/news/washington/2010-07-15-abortion15_ST_N.htm](http://www.usatoday.com/news/washington/2010-07-15-abortion15_ST_N.htm)> (last visited Feb 8th 2014)

⁷³ Conservative Party Manifesto 2010 General Election, Invitation to Join the Government of Britain, at 45.

⁷⁴ Ibid.

⁷⁵ See King's Fund, *supra* note 1, at 131-133. Liberal Democrat leader, Nick Clegg, in fact told his party that because of their work, NHS reform was now "evolution and not revolution."

⁷⁶ See The King's Fund, *supra* note 1, at 48.

⁷⁷ Liberal Democrat Manifesto 2010 General Election, at 40.

⁷⁸ See The King's Fund, *supra* note 1, at 48.

⁷⁹ Liberal Democrats, Health and Social Care Bill Achievements,

<<http://www.libdems.org.uk/siteFiles/resources/docs/policy/Health/HSC%20Bill%20Achievements%20March%202012.pdf>> (last visited Feb. 6 2014) "The Bill in its current form is markedly different to the original legislation, and many of the changes are the direct result of the hard work and scrutiny of Liberal Democrats."

⁸⁰ *Ibid.*

⁸¹ Department of Health, Government Response to the NHS Future Forum report, Cm 8113, June 2011

⁸² See King's Fund, *supra* note 1, at 126-138.

⁸³ See Liberal Democrats, *supra* note 79, at 2-4, at 7.

⁸⁴ *Ibid.*, at 3.

⁸⁵ *Ibid.*, at 3, at 7-8.

⁸⁶ *Ibid.*, at 4.

⁸⁷ *Ibid.*, at 3.

⁸⁸ See King's Fund, *supra* note 1, at 118-119.

⁸⁹ Over the past fifty years, The President, House of Representatives and Senate have only been controlled by the same party for sixteen years.

⁹⁰ Molly Moorhead, Obamacare Stands, <<http://www.politifact.com/truth-o-meter/promises/gop-pledge-o-meter/promise/655/repeal-the-health-care-bill/>> (last visited Feb 5 2014) Between January 2011 and July 2012, The Republican Party, now in control of the House of Representatives attempted to repeal the PPACA 30 times.

⁹¹ J. Donahue, *Disunited States* (New York: Perseus Books Group, 1997) The U.S. is one of the few western liberal democracies in which political parties, at different institutional levels, are not expected to follow the same policies.

⁹² K. Adams and B. Gibbs, 'Landmark Reform: An Examination of Support for the Healthcare Reform Bill among Minority Groups in the 111th Congress.' *Nebula*, (2011)

<www.nobleworld.biz/images/Adams_and_Gibbs.pdf> (last visited Feb 3 2014): at 2.

⁹³ *Ibid.*, a 1.

⁹⁴ *Ibid.*

⁹⁵ Blue Dog Coalition, Mission Statement, < <http://bluedog.schrader.house.gov/about/mission.htm>> (last visited Feb 2 2014).

⁹⁶ See Adams and Gibbs, *supra* note 92, at 1.

⁹⁷ *Ibid.*, at 2-3.

⁹⁸ See Jacobs and Skocpol, *supra* note 63, at 116-117.

⁹⁹ *Ibid.*, at 80.

¹⁰⁰ *Ibid.*, at 99-100. Jacobs and Skocpol discuss the 'old issue' of federal spending on abortion.

¹⁰¹ J. K. Iglehart, 'Rallying the Caucus- The Democrats' Struggle for Unity on Reform,' *New England Journal of Medicine*, 64 (2014): at 1-3.

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- ¹⁰² Executive Order 13535-- Patient Protection and Affordable Care Act's Consistency with Longstanding Restrictions on the Use of Federal Funds for Abortion.
- ¹⁰³ Text available, <http://housedocs.house.gov/rules/3962/Stupak3962_108.pdf> (last visited Feb 1 2014).
- ¹⁰⁴ L. Jacobs and T. Skocpol, *supra* note 64, at 57.
- ¹⁰⁵ V. L. Frakes, 'Partisanship And (un)compromise: A Study Of The Patient Protection And Affordable Care Act,' *Harvard Journal on Legislation*, 49 (2012): 135-149, at 137-139; P. D. Jacobson and J. R. Lauer, 'Health Reform 2010: Incremental Advance Or Radical Transformation?' *Arizona State Law Journal*, 42 (2010): 1277-1291, at 1281.
- ¹⁰⁶ See Blackman, *supra* note 1, at 30-31.
- ¹⁰⁷ 42 U.S. Code § 1395dd (1986)
- ¹⁰⁸ H. Glennerster and R. Lieberman, 'Toward a Historical Comparison of U.S. and U.K. Health Policy,' *Journal of Health Politics, Policy and Law*, 36 (2011): 5-33, at 7.
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- ¹¹⁰ IPSOS Mori, 'State of the Nation Poll 2013,' <<http://www.ipsos-mori.com/researchpublications/researcharchive/3111/State-of-the-Nation-2013.aspx>> (last visited 1st Feb 2014)
- ¹¹¹ Anurin Bevan, *HC Debates*, Vol. 447, col. 50 9 February 1948.
- ¹¹² Opening Ceremony show, viewed worldwide by 900m people.
- ¹¹³ L. Fleck, 'Just Caring: The Ethical Challenges of Healthcare Reform in the USA,' in N. Maclean, *Distributing Healthcare: Principles, Practices and Politics* (Imprint 2007): 141-189.
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- ¹¹⁵ See Fleck, *supra* note 113, at 148.
- ¹¹⁶ *Ibid*, at 144.
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- ¹¹⁹ Neil Daniels, 'Justice, health, and healthcare,' *American Journal of Bioethics*, 1 (2001): 2-16.
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- ¹²¹ *Ibid*.
- ¹²² See Fleck, *supra* note 113, 145.
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- ¹²⁵ Hansard, Frank Dobson (Holborn and St Pancras) (Lab) HC, 31 Jan 2011 : Column 631.
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- ¹²⁷ *Ibid*.
- ¹²⁸ Representative Price, "Dark Day for America," *Congressional Record* (22 March 2010) [H2175].
- ¹²⁹ See Pownall, *Supra* Note 1.
- ¹³⁰ See H. Glennerster and R. Lieberman, *supra* 108, at 7.
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¹³² Ibid.

¹³³ R. Barnett, 'Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional,' New York Journal of Law and Liberty, 5 (2010): 581-637; T. P. Miller, The Individual Mandate: Ineffective, Overreaching, Unsustainable, Unconstitutional and Unnecessary, Am. Enterprise Inst. (Mar. 23, 2012), <http://www.aei.org/paper/health/healthcare-reform/ppaca/the-individual-mandate-ineffective-overreaching-unsustainable-unconstitutional-and-unnecessary/> (last visited Jan 20 2014)

¹³⁴ *State of Florida v. United States Department of Health and Human Services*, 780 F.Supp.2d 1256 (2011): at 1286.

¹³⁵ Hansard, Earl Howe, (Con) HL, 12 Oct 2011 : Column 1706.

¹³⁶ Ibid.

¹³⁷ Ibid.

¹³⁸ For a comparison between the ACA and Heritage Foundation Report, See J. Wiggins, 'Mandates, Markets, and Risk: Auto Insurance and the Affordable Care Act,' Connecticut Insurance Law Journal, 19 (2012): 275-318, at 285-287, and fn14 extensively.

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¹⁴¹ Jacob Hacker, 'The Road to Somewhere: Why Health Reform Happened Or Why Political Scientists Who Write about Public Policy Shouldn't Assume They Know How to Shape It,' Perspective on Politics, 8 (2010): 861-876, at 867.

¹⁴² See Blackman, supra note 1, at 24.

¹⁴³ Michael Cooper, Conservatives Sowed Idea of Healthcare Mandate, Only to Spurn It Later, N.Y. Times, Feb. 15, 2012.

¹⁴⁴ See Blackman, supra note 1, at 42. Blackman is critical of Romney for failing to make this argument with any conviction during the 2012 presidential election.

¹⁴⁵ A. D. Holan, 'RomneyCare & ObamaCare: Can you tell the difference?' <www.politifact.com/truth-o-meter/article/2011/may/18/romneycare-and-obamacare-can-you-tell-difference> (last visited Feb 1 2014)

¹⁴⁶ See The King's Fund, supra note 1, at 18-21.

¹⁴⁷ See The King's Fund, supra note 1, at 6.

¹⁴⁸ See Davies, note 1, at 565.

¹⁴⁹ See The King's Fund, supra note 1, at 18.

¹⁵⁰ A.C.L. Davies, 'Foundation hospitals: a new approach to accountability and autonomy in the public services?' Public Law, (2004): 808-828.

¹⁵¹ See The King's Fund, supra note 1, at 18-19.

¹⁵² The Labour Party Manifesto 2010: A Fair Future for All, <<http://www2.labour.org.uk/uploads/TheLabourPartyManifesto-2010.pdf>>, 4:3.

¹⁵³ See Glennerster and Lieberman, supra note 108, at 5-8.

¹⁵⁴ A. Watson, Legal Transplants (Georgia: University of Georgia Press, 1993): at 21.

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¹⁵⁶ Ibid, at 26-28.

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¹⁵⁸ Ibid, 26-28.

¹⁵⁹ See Balkin, supra note 14, 4.

¹⁶⁰ J. Tolson, 'The Union As A Safeguard Against Faction: Congressional Gridlock as State Empowerment,' Notre Dame Law Review, 88 (2013): 2267-2287; F. H. Easterbrook, 'On Constitutional Changes to Limit Government,' Northwestern University Law Review, 102 (2008): 469-473; R. A. Dahl, How Democratic Is the American Constitution? (New Haven: Yale University Press, 2004): at 24-25.

¹⁶¹ *National Federation of Independent Small Business v Sebelius*, 132 S.Ct. 2566 (2012)

¹⁶² House of Lords Select Committee on the Constitution. 2001. Reviewing the Constitution: Terms of Reference and Method of Working (HL 2001-2002, 11); House of Lords Select Committee on the Constitution. 2010. Health and Social Care Bill (HL 2010-12, 197).

¹⁶³ J. Marriott and J. Fletcher, 'By Any Means Necessary? The Constitutionalisation Of Healthcare In The United States, United Kingdom And Brazil' in Fritz Allhoff and Mark Hall, The Affordable Care Act Decision Philosophical and Legal Implications (London: Routledge, 2014): at 55-72.

¹⁶⁴ See J. Balkin, supra note 14.

¹⁶⁵ Alabama, Alaska, Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, South Dakota, Texas, Utah, Virginia, Wisconsin, Wyoming.

¹⁶⁶ Appellate Brief for State Respondents on the Minimum Coverage Provision, 2012 WL 392550 (U.S., Feb. 6, 2012): at 1.

¹⁶⁷ Ibid, at 15-51.

¹⁶⁸ *South Dakota v. Dole*, 483 U.S. 203 (1987)

¹⁶⁹ See *NFIB*, supra note 161, at 2604-2605.

¹⁷⁰ Appellate Brief, Reply Brief for State Petitioners on Severability, 2012 WL 888995 (U.S., Mar. 13, 2012)

¹⁷¹ See Appellate Brief for State Respondents on the Minimum Coverage Provision, supra note 166, at 18.

¹⁷² T. Jacobi, 'Obamacare As A Window On Judicial Strategy,' Tennessee Law Review, 80 (2013): 763-849, particularly at 778. This whole article, however, wrestles with how Roberts' judgment recasts the ACA.

¹⁷³ Ibid, at 777, this "reduced the cost."

¹⁷⁴ R. Barnett, We lost on healthcare. But the Constitution won, <http://www.washingtonpost.com/opinions/andy-barnett-we-lost-on-health-care-but-the-constitution-won/2012/06/29/gJQAzJuJCW_story.html> (last visited Feb 5 2014).

¹⁷⁵ 132 S.Ct. 2566 (2012), 2589-2591.

¹⁷⁶ Ibid, 2594-2601.

¹⁷⁷ See Barnett, supra note 174, [14].

¹⁷⁸ Brietta Clark, 'A Moral Mandate & The Meaning Of Choice: Conceiving The Affordable Care Act After NFIB,' St. Louis University Journal of Health Law and Policy, 6 (2013): 267-317, at 285; R. Cooter and N. Siegel, 'Not The Power To Destroy: An Effects Theory Of The Tax Power,' Virginia Law Review, 98 (2012): 1195-1250.

¹⁷⁹ See *NFIB*, supra note 161, at 2579. Congress may also "lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States." U.S. Const., Art. I, § 8, cl. 1. Put simply, Congress may tax and spend. This grant gives the Federal Government considerable influence even in areas where it cannot directly regulate. The Federal Government may enact a tax on an activity that it cannot authorize, forbid, or otherwise control."

¹⁸⁰ D. B. Rivkin Jr., L. E. Casey & A. M. Grossman, '*NFIB v. Sebelius* and the Triumph of Fig-Leaf Federalism,' *Cato Supreme Court Review*, 31 (2011): 31-65, at 32.

¹⁸¹ § 1396a(a)(10)(A)(i)(VIII).

¹⁸² See *NFIB*, supra note 161, at 2605.

¹⁸³ *Ibid*, at 2634.

¹⁸⁴ *Ibid*, at 2602.

¹⁸⁵ *Ibid*, at 2604.

¹⁸⁶ *Ibid*, at 2602-2605.

¹⁸⁷ *Ibid*, at 2603.

¹⁸⁸ A. A. Guerrero, 'Coercion, Political Accountabilkity, and Voter Ignorance: The Mistaken Medicaid Expansion Ruling in *NFIB v Sebelius*,' *Public Affairs Quarterly*, 27 (2013): 199-214, at 202-203.

¹⁸⁹ See *NFIB*, supra note 161, at 2608.

¹⁹⁰ See Jacobi, supra note 172, at 813-821.

¹⁹¹ See *NFIB*, supra note 161, at 2667.

¹⁹² See Jacobi, supra note 172; Of course, this is partial due to the Dissent believing the ACA's use of the Spending Clause to be far more draconian than any before... M. Minow, 'Affordable Convergence: "Reasonable Interpretation" and the Affordable Care Act,' *Harvard Law Review*, 126 (2012): 117-153, at 130.

¹⁹³ K. Ewing, 'The Resilience of the Political Constitution,' *German Law Journal*, 14 (2013): 2111-2136, at 2135. "The underlying legal principle is the principle of parliamentary sovereignty, which is no more than a legal principle underpinning the idea of popular sovereignty, whereby the people through their elected representatives and accountable government should be free to determine the rules by which they are governed."

¹⁹⁴ A.V. Dicey, *Introduction to the Study of the Law of the Constitution*, 10th Edn, (Basingstoke:, Macmillan, 1959).

¹⁹⁵ See House of Lords Select Committee on Constitution- Health and Social Care Bill, supra note 162, at [18].

¹⁹⁶ See House of Lords Select Committee on Constitution- Reviewing the Constitution: Terms of Reference and Method of Working, supra note 162, at [4].

¹⁹⁷ See House of Lords Select Committee on Constitution- Health and Social Care Bill, supra note 162, at [18].

¹⁹⁸ *Ibid*.

¹⁹⁹ *Regina v Secretary of State for the Environment, Transport the Regions* [2001] UKHL 23, [144] Lord Clyde outlines how removing any link between the Secretary of State or Government Department and Parliament would undermine a convention "rooted in the ideas of democracy and the rule of law."

²⁰⁰ J. E. K. Murkens, 'The Quest for Constitutionalism in Public Law Discourse,' *Oxford Journal of Legal Studies*, 29 (2009): 427-455, at 432-436.

²⁰¹ This list is far more exhaustive.

²⁰² See House of Lords Select Committee on Constitution- Health and Social Care Bill, supra note 162, at [18].

²⁰³ See House of Lords Select Committee on Constitution- Health and Social Care Bill Follow Up, *supra* note 162, at [8].

²⁰⁴ Health and Social Care Act 2012, *supra* note 162, s1(3).

²⁰⁵ See Davies, *supra* note 1, at 576.

²⁰⁶ R. E. Barnett, 'No Small Feat: Who Won the Healthcare Case (and Why Did So Many Law Professors Miss the Boat)?' *Florida Law Review*, 65 (2013): 1331-1348, at 1337-1338; See House of Lords Select Committee on the Constitution, *supra* note 162.