#### The value is justice because the actor in the resolution is a just government.

While definitions of justice may vary among philosophical scholars, the definition of a just government is clear, at the very least a just government is one who grants its citizens a special status and swears to protect their freedom and wellbeing.

Thus, a just government is one who looks out for the freedom and well-being of its citizens. However, it is impossible for a just government to do so unless it aggregates the will and resources of its people.

**The criterion is maximizing well-being.** The goal in today’s debate is to determine whether recognizing an unconditional right of workers to strike will maximize the well-being of the citizens of a just government.

Prefer this criterion because it is specific to the actor in the resolution. A just government’s primary obligation is to ensure the interests of its citizens. George Kennan explains:[[1]](#footnote-1)

*.*the functions, commitments and moral obligations of governments are not the same as those of the individual. **Government[s]** **primary obligation is to the interests of the national society it represents,** not to the moral impulses that individual elements of that society may experience. **The interests of the national society for which government has to concern itself are** basically those of its military security, the integrity of its political life and **the well-being of its people.** These needs have no moral quality. **They arise from the very existence of the national state in question and from the status of national sovereignty it enjoys.**

**Observation 1:** The negative must defend the status quo; they cannot place some conditions on the right to strike and ignore others. Such would create an infinite burden on the affirmative to go through each condition and prove why they were unjust. Such a burden would be not only impossible with the time limits in today’s debate but would be counter to the purpose of this debate. Further, in the status quo the United States does not recognize a “right” of workers to strike. Even if the negative points to Section 7 of the National Labor Relations Act, the Supreme Court has upheld restrictions on the right to strike without considering their effect on the ability of workers to influence their conditions on employment. **Thus, the negative must defend the status quo, where a right to strike is not fundamental. The affirmative therefore argues that a just government would recognize an unconditional right to strike.**

The value is justice because the actor in the resolution is a just government. Justice is defined

#### CONTENTION 1 IS DEMOCRACY:

#### Global democracy is deteriorating now.

**FH 21**. (Freedom House is founded on the core conviction that freedom flourishes in democratic nations where governments are accountable to their people; the rule of law prevails; and freedoms of expression, association, and belief, as well as respect for the rights of women, minority communities, and historically marginalized groups, are guaranteed. We speak out against the main threats to democracy and empower citizens to exercise their fundamental rights through a unique combination of analysis, advocacy, and direct support to frontline defenders of freedom, especially those working in closed authoritarian societies. Founded in 1941, Freedom House was the first American organization to champion the advancement of freedom globally. Working as an independent watchdog organization dedicated to the expansion of freedom and democracy around the world, Freedom House is notable for its nonpartisan character and commitment to maintaining support for its mission among members of both major US political parties.)"New Report: The Global Decline in Democracy Has Accelerated." Freedom House, 3 Mar. 2021, freedomhouse.org/article/new-report-global-decline-democracy-has-accelerated.

Washington - March 3, 2021 — Authoritarian actors grew bolder during 2020 as major democracies turned inward, contributing to the 15th consecutive year of decline in global freedom, according to [Freedom in the World 2021](https://freedomhouse.org/report/freedom-world/2021/democracy-under-siege), the annual country-by-country assessment of political rights and civil liberties released today by Freedom House. The report found that the share of countries designated Not Free has reached its highest level since the deterioration of democracy began in 2006, and that countries with declines in political rights and civil liberties outnumbered those with gains by the largest margin recorded during the 15-year period. The report downgraded the freedom scores of 73 countries, representing 75 percent of the global population. Those affected include not just authoritarian states like China, Belarus, and Venezuela, but also troubled democracies like the United States and India. In one of the year’s most significant developments, India’s status changed from Free to Partly Free, meaning less than 20 percent of the world’s people now live in a Free country—the smallest proportion since 1995. Indians’ political rights and civil liberties have been eroding since Narendra Modi became prime minister in 2014. His Hindu nationalist government has presided over increased pressure on human rights organizations, rising intimidation of academics and journalists, and a spate of bigoted attacks—including lynchings—aimed at Muslims. The decline deepened following Modi’s reelection in 2019, and the government’s response to the coronavirus pandemic in 2020 featured further abuses of fundamental rights. The changes in India formed part of a broader shift in the international balance between democracy and authoritarianism, with authoritarians generally enjoying impunity for their abuses and seizing new opportunities to consolidate power or crush dissent. In many cases, promising democratic movements faced major setbacks as a result. In Belarus and Hong Kong, for example, massive prodemocracy protests met with brutal crackdowns by governments that largely disregarded international criticism. The Azerbaijani regime’s military offensive in Nagorno-Karabakh indirectly threatened recent democratic gains in Armenia, while the armed conflict in Ethiopia’s Tigray Region dashed hopes for the tentative political opening in that country since 2018. All four of these cases notably featured some degree of intervention by an autocratic neighbor: Moscow provided a backstop for the regime in Belarus, Beijing propelled the repression in Hong Kong, Turkey’s government aided its Azerbaijani counterpart, and Ethiopia’s leader called in support from Eritrea.

#### The right to strike is key to preserve democracy.

**IER 17**. (The IER exists to inform the debate around trade union rights and labour law by providing information, critical analysis, and policy ideas through our network of academics, researchers and lawyers. We were established in February 1989 as an independent organisation to act as a focal point for the spread of new ideas in the field of labour law. In 1994 the Institute became a registered charity.) "UN Rights Expert: Right to Strike is Essential to Democracy." IER, 10 Mar. 2017, www.ier.org.uk/news/un-rights-expert-right-strike-essential-democracy/.

The United Nations’ Special Rapporteur on the rights to freedom of peaceful assembly and of association, Maina Kiai, has reminded member states of the International Labour Organization (ILO) – including the UK – that they have a positive obligation to uphold the right to strike. Speaking at an ILO meeting on Monday 06 March 2017 in Geneva, Kiai argued that the right to strike is fundamental to the preservation of democracy. “The concentration of power in one sector – whether in the hands of government or business – inevitably leads to the erosion of democracy, and an increase in inequalities and marginalization with all their attendant consequences. The right to strike is a check on this concentration of power,” he explained. The right to strike has been established in international law as a corollary to the right of freedom of association for decades, and is enshrined in the European Convention on Human Rights as Article 11. As a member state of the ILO and of the EU, the UK is legally obliged to uphold the right to strike, although through the Trades Union Act 2016 and the anti-trade union laws that preceded it, the government is making it harder and harder for trade unions to take industrial action. Kiai criticised such actions, saying government’s have a duty not to impede workers’ ability to take industrial action. “I deplore the various attempts made to erode the right to strike at national and multilateral levels,” the expert said, reminding delegates: “Protest action in relation to government social and economic policy, and against negative corporate practices, forms part of the basic civil liberties whose respect is essential for the meaningful exercise of trade union rights. This right enables them to engage with companies and governments on a more equal footing, and Member States have a positive obligation to protect this right, and a negative obligation not to interfere with its exercise.”

#### The affirmative restores electoral legitimacy and ensures democracy in the workplace.

**Luce 20**, Stephanie. (Stephanie Luce is a professor at the School of Labor and Urban Studies/CUNY. She is the author of 'Labor Movements: Global Perspectives and Fighting for a Living Wage' and is an Editor of Organizing Upgrade. Her writing can be found at stephanieluce.net.) "Strike for Democracy! » Organizing Upgrade." Organizing Upgrade, 26 Oct. 2020, www.organizingupgrade.com/strike-for-democracy/.

Trump and the Republican Party have launched a full-fledged assault on the electoral process, from voter suppression to misleading ballot boxes. We may see violence aimed at keeping people from the polls or just meant to create general fear and chaos. Trump has dropped repeated suggestions that he may try to shut down the election, stop votes from being counted, or refuse to step down even if he loses. A range of groups have mobilized to fight for a fair election and plan around worst case scenarios. Some unions have been active in a few of these groups, such as Protect the Vote. According to experts who study coups, the best way to stop an electoral coup is by getting a large turnout and strong victory. The larger a vote for Biden, the smaller the space Trump will have to claim the vote is illegitimate. Unions are doing their part to make this happen. This is a major part of union activity every election cycle. But according to Bob Master, Assistant to the Vice President of District 1 of the Communications Workers, it was tough to get union members to volunteer for Hilary Clinton four years ago. This year, there are hundreds of members signed up to phone bank, some doing it three or four nights a week. It isn’t that they are necessarily Biden fans, he says, but they understand what is at stake. UNITE HERE is running an intensive “Take Back 2020” get-out-the-vote effort, phone banking and even knocking on doors in Arizona, Florida, Nevada and Pennsylvania. In Philadelphia, for example, over 100 hospitality workers plan to visit 100,000 homes before the election. In Arizona they are partnering with Seed the Vote. Unions such as the Communications Workers of America, SEIU, AFT and the UAW are looking to connect some of their core activists with local “protect the vote” groupings in key states and cities to show up to polls and fight to make sure every vote is counted. Unions are increasingly turning attention to possible election scenarios. “There’s some sense in the leadership that in fascist countries, unions are at the top of the list of targets,” Master says. “And it is the role of unions, which are the guarantors of some measure of democracy in the workplace, to ensure that democracy survives in the society.” A handful of activists have started to organize in their workplace for labor to be ready to respond. Postal workers in Detroit are handing out flyers that ask coworkers to sign a pledge from Choose Democracy, committing to vote then take action if needed to protect the vote. ARE UNIONS READY? Will unions be ready to strike if Trump won’t step down? The sizable share of union members backing Trump makes it tough for some unions to frame the fight as anti-Trump, or pro-Biden. But if unions commit to the integrity of the democratic process, they have more ground to stand on. The Rochester Central Labor Council in New York passed a resolution calling for a general strike in the event that Trump loses and does not step down. The resolution calls on the national AFL-CIO and all other labor organizations to “prepare for and enact a general strike, if necessary, to ensure a Constitutionally mandated peaceful transition of power as a result of the 2020 Presidential Elections.” A handful of other labor bodies have followed suit. Sara Nelson, International President of the Association of Flight Attendants-CWA, AFL-CIO, is also taking a bold stand, stating that in the event of a contested election, labor “has to be ready to mobilize in a series of strikes or leading to a general strike.” Despite high unemployment, workers still have power, she says. She points to how the federal government ended its shutdown last year, after Nelson spoke publicly about the idea of a general strike and a handful of air traffic controllers did not show up for their shifts. “Where can we actually flex that muscle in a series of strikes . . . in a way that is going to be very effective?” she asks. “And frankly, if the planes all stop that is something that will grab everyone’s attention and suddenly there has to be action to fix that.”

#### Plan solves civic participation – increases turnout and politically active laborers – it spills over.

**McElwee 15**, Sean. (Sean McElwee is a research associate at [Demos](http://www.demos.org/sean-mcelwee).) "How Unions Boost Democratic Participation." The American Prospect, 16 Sept. 2015, prospect.org/labor/unions-boost-democratic-participation/.

Labor organizer Helen Marot once observed, "The labor unions are group efforts in the direction of democracy." What she meant is that more than simply vehicles for the economic interests of workers (which they certainly are), labor unions also foster civic participation for workers. And nowhere is this clearer than in voter turnout, which has suffered in recent years along with union membership. Indeed, new data from the Census Bureau and a new analysis of American National Election Studies data support the case that unions' declining influence has also deeply harmed democracy. In 2014, voter turnout was abysmal, even for a midterm. Census data suggest that only 41.9 percent of the citizen population over 18 turned out to vote. However, as I note in my new Demos report Why Voting Matters, there are dispiriting gaps in turnout across class, race, and age. To examine how unions might affect policy, I performed a new analysis of both Census Bureau and American National Election Studies data. The data below, from the 2014 election, show the differences in voter turnout between union and non-union workers (the sample only includes individuals who were employed, and does not include self-employed workers). While only 39 percent of non-union workers voted in 2014, fully 52 percent of union workers did. As part of ongoing research, James Feigenbaum, an economics PhD candidate at Harvard, ran a regression using American National Election Studies data suggesting that union members are about 4 percentage points more likely to vote and 3 points more likely to register (after controlling for demographic factors) and individuals living in a union household are 2.5 points more likely to vote and register. This is largely in line with the earlier estimates of Richard Freeman. These numbers may appear modest, but in a close national election they could be enough to change the result. Other research has found an even stronger turnout effect from unions. Daniel Stegmueller and Michael Becher find that after applying numerous demographic controls, union members are 10 points more likely to vote. What's particularly important is that unions boost turnout among low- and middle-income individuals. In a 2006 study, political scientists Jan Leighley and Jonathan Nagler found that, "the decline in union membership since 1964 has affected the aggregate turnout of both low and middle-income individuals more than the aggregate turnout of high-income individuals." In 2014, the gap between unions and non-union workers shrunk at the highest rung of the income ladder. There was a 15-point gap among those earning less than $25,000 (40 percent turnout for union workers, and 25 percent turnout for non-union workers). Among those earning more than $100,000, the gap was far smaller (49 percent for non-union workers and 52 percent for union workers). Individuals living in union households are also more progressive than those in non-union households. I examined 2012 ANES data and find that union households aren't largely different from non-union households on many issues regarding government spending, but they are more likely to have voted for Obama, identify as Democratic, and support a robust role for the government in reducing income inequality. When looking at union members specifically, the gaps become slightly larger. More upscale union members are far more progressive than their non-union counterparts. Non-union households with an income above $60,000 oppose government intervention to reduce inequality by 11 points, with 32.2 percent in favor and 43.4 percent against. But richer union households support government intervention, with 42.5 percent in favor and 29.9 percent opposed. As Richard B. Freeman has pointed out, "union members are more likely to vote for a Democrat for the House or Presidency than demographically comparable nonunion voters." He similarly finds that "unionism moves members to the left of where they would be given their socioeconomic status," in line with the data I examined from 2012. A 2013 study by Jasmine Kerrissey and Evan Schofer finds that union members are not only more likely to vote, but also more likely to belong to other associations, and to protest. They also find that these effects are strongest among people with lower levels of education, suggesting that unions may help mobilize the least politically active groups. A recent study of European countries finds union members vote more and identifies those aspects of union membership that contribute to the higher turnout. The strongest factor is that workers who engage in democratic organizations in the workplace (via collective bargaining) are more likely to engage in democracy more broadly by, for instance, voting. Other studies support the idea that civic participation creates a feedback loop that leads to higher voting rates. Another factor is that union members make more money, and higher income is correlated with voting behavior. Finally, union members are encouraged by peers and the union to engage in politics, which also contributes to higher levels of turnout. It's not entirely surprising that politicians who savage unions often share a similar contempt for the right to vote. Democracy in the workplace leads to democracy more broadly throughout society. Workers with more democratic workplaces are more likely to democratically engage in in society. Further, when unions and progressives demonstrate that government can benefit them, Americans are more likely to want to participate in decision-making. For all these reasons, unions play a unique and indispensable role in the progressive project. As Larry Summers, certainly not a leftist, recently argued, "the weakness of unions leaves a broad swath of the middle class largely unrepresented in the political process."

#### Strong democracy is key to prevent a plethora of existential threats.

Kendall-Taylor 16 [Andrea; Deputy national intelligence officer for Russia and Eurasia at the National Intelligence Council, Senior associate in the Human Rights Initiative at the Center for Strategic and International Studies in Washington; “How Democracy’s Decline Would Undermine the International Order,” CSIS; 7/15/16; <https://www.csis.org/analysis/how-democracy%E2%80%99s-decline-would-undermine-international-order>/]

Democratic decline would weaken U.S. partnerships and erode an important foundation for U.S. cooperation abroad. [Research demonstrates](file:///C:\Users\PMeylan\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\5V2CJVRN\160715_KendallTaylor_DemocracysDecline_Commentary.docx#http://cmp.sagepub.com/content/18/1/49.abstract) that domestic politics are a key determinant of the international behavior of states. In particular, **democracies** are **more likely to form alliances and cooperate more fully with other democracies than with autocracies**. Similarly, **authoritarian countries have established mechanisms for cooperation and sharing of “worst practices.” An increase in authoritarian countries**, then, **would provide a broader platform** for coordination that could enable these countries to overcome their divergent histories, values, and interests—factors that are frequently cited as obstacles to the **formation of a cohesive challenge to the U.S.-led international system**. Recent examples support the empirical data. **Democratic backsliding in Hungary and** the hardening of **Egypt’s autocracy** under Abdel Fattah el-Sisi **have led to enhanced relations between these countries and Russia. Likewise, democratic decline in Bangladesh has led Sheikh Hasina Wazed and her ruling Awami League to seek closer relations with China and Russia**, in part **to mitigate Western pressure and bolster** the **regime’s domestic standing**. Although none of these burgeoning relationships has developed into a highly unified partnership, democratic backsliding in these countries has provided a basis for cooperation where it did not previously exist. And while the United States certainly finds common cause with authoritarian partners on specific issues, **the** depth and reliability of such cooperation is limited. Consequently, **further democratic decline could** seriously compromise **the United States’ ability to form the kinds of deep partnerships that will be required** to confront today’s increasingly complex challenges. Global issues such as **climate change, migration, and** violent extremism demand the coordination and cooperation that democratic backsliding would put in peril. Put simply, **the United States is a less effective and influential actor if it loses its ability to rely on its partnerships** with other democratic nations. A **slide toward authoritarianism could also** challenge the current global order by diluting U.S. influence in critical international institutions, including the [United Nations](https://www.washingtonpost.com/opinions/christopher-walker-authoritarian-regimes-are-changing-how-the-world-defines-democracy/2014/06/12/d1328e3a-f0ee-11e3-bf76-447a5df6411f_story.html) , the World Bank, and the International Monetary Fund (IMF). Democratic decline would **weaken Western efforts within these institutions to advance issues such as Internet freedom and the responsibility to protect**. In the case of Internet governance, for example, Western **democracies support an open, largely private, global Internet. Autocracies**, in contrast, **promote state control over the Internet**, including laws and other mechanisms that facilitate their ability to censor and persecute dissidents. Already many autocracies, including Belarus, China, Iran, and Zimbabwe, have coalesced in the “Likeminded Group of Developing Countries” within the United Nations to advocate their interests. Within the IMF and World Bank, autocracies—along with other developing nations—seek to water down conditionality or the reforms that lenders require in exchange for financial support. If successful, diminished conditionality would enfeeble an important incentive for governance reforms. In a more extreme scenario, **the rising influence of autocracies could enable these countries to bypass the IMF and World Bank all together**. For example, **the Chinese-created Asian Infrastructure** and Investment Bank and the BRICS Bank—which includes Russia, China, and an increasingly authoritarian South Africa—**provide countries with the potential to bypass existing global financial institutions when it suits their interests. Authoritarian-led alternatives pose the risk that global economic governance will become** [**fragmented and less effective**](http://www.tandfonline.com/doi/abs/10.1080/00396338.2016.1161899?journalCode=tsur20#.V2H3MRbXgdI)**.**  **Violence and instability would** also likely increase if more democracies give way to autocracy. [International relations literature](https://www.foreignaffairs.com/articles/china/1995-05-01/democratization-and-war) tells us that **democracies are** less likely to fight wars **against other democracies, suggesting that interstate wars would rise as the number of democracies declines**. Moreover, **within countries that are already autocratic, additional movement** away from democracy, or an “authoritarian hardening,” would **increase global instability**. Highly repressive autocracies are the most likely to **experience state failure, as was the case in the Central African Republic**, Libya, Somalia, Syria, and Yemen. In this way, **democratic decline would significantly strain the international order** because rising levels of instability would exceed the West’s ability to respond to the tremendous costs of peacekeeping, humanitarian assistance, and refugee flows.

#### CONTENTION 2 IS HEALTHCARE

#### Funding for healthcare systems is dwindling – support is already beginning to decrease

**Bailey 2/10,** Susan R. [MD, Susan R. Bailey, MD, an allergist/immunologist from Fort Worth, Texas, was the 175th president of the American Medical Association. Previously, she served as president-elect of the AMA for one year, speaker of the AMA House of Delegates for four years and as vice speaker for four years.] “Pandemic exposes dire need to rebuild public health infrastructure”*AMA*, Feb. 10, 2021. LB

The COVID-19 pandemic has exposed fundamental flaws in the provision of health care across our nation and exacerbated the tremendous differences in health outcomes tied to race, income and other demographic factors. What you need to know about COVID-19 Explore top articles, videos, research highlights and more from the AMA—your source for clear, evidence-based news and guidance during the pandemic. See the Latest Updates As we take a hard look at the lessons learned, we should pay particular attention to the overall capacity of our nation’s public health system—the federal, state, local, tribal and territorial health agencies that work to protect and promote the health of all people in all communities. Public health infrastructure enables every level of government to prevent disease, promote health, and prepare for and respond to both emergency situations and ongoing challenges. Public health agencies work every day to keep us healthy and safe by promoting clean air and water, and ensuring that food is safe to eat. These agencies also strive to prevent injuries and promote vaccination and other methods of controlling infectious diseases. This work is often unseen until there is a public health emergency. Health departments also play a vital role in educating the public about unexpected infectious disease threats as well as evidence-based interventions for mitigation. Adequate funding is necessary to provide these services—but state public health spending has fallen 16% over the past decade. We must provide the funding required to upgrade essential functions such as public health surveillance to identify underlying causes and etiologies, which will improve our response to existing and emerging perils. Related Coverage What doctors wish patients knew about contact tracing The task before us Right now, bringing the pandemic under control is the priority. We are encouraged by the new administration’s commitment to policies and actions grounded in science, by its efforts to expand coverage under the Affordable Care Act, and by the steps it has taken to build public trust in the COVID-19 vaccines as well as in our government’s scientific institutions. While overcoming COVID-19 will be a significant victory, the larger campaign to rebuild our public health infrastructure will remain before us. Persistent disinvestment in governmental public health agencies has limited our ability to effectively respond to SARS-CoV-2 and other crises. This neglect had serious consequences as the pandemic took hold late last winter, when our lack of widespread testing permitted faster spread of the virus. And serious consequences persist today, when our ability to perform large-scale genetic sequencing allows new variants to spread without detection. Nearly 40,000 jobs at state and local public health agencies have been eliminated since the 2008 recession, according to an Associated Press-Kaiser Health News analysis published last summer. And funding steadily reduced over that period is now at further risk of reduction from the pandemic-related economic downturn, which has thrown governmental budgets deep into the red. At the same time, federal funding for emergency preparedness and response programs administered by the Centers for Disease Control and Prevention has been slashed by 50% over the past decade, according to Trust for America’s Health (TFAH), the nonpartisan health policy research organization. That same TFAH study highlighted other concerning trends as well, such as a general decline in funding for the Strategic National Stockpile as well as the Hospital Preparedness Program. That program is the sole source of federal funding for emergency response by regional health care systems, and had its budget slashed from $515 million in 2004 to $275.5 million in 2020. Our AMA helped shape last year’s revision of the 10 Essential Public Health Services, which were created a quarter-century ago to define the activities public health organizations should undertake in every community. The revised framework better reflects current and future practice, promotes increased community involvement, and seeks to remove structural barriers that have resulted in health inequities, with the goal of achieving optimal health for all. Related Coverage Dr. Fauci: 16% boost to vaccine allotments on the way We can’t wait for the next pandemic Physicians and medical societies can play a vital role in advocating for a strong public health infrastructure. It shouldn’t take a global pandemic to make us realize the strategic importance of public health agencies and the critical role they play in protecting us. Chronic underfunding and understaffing handcuffed these agencies when we needed them most. We should avoid viewing the COVID-19 pandemic solely as a set of numbers. Each day, we monitor the new cases in our county and state, and bear witness to the number of lives that have been lost. We read and hear about national and global case totals, seven-day positivity figures, infection rates per 100,000 residents, the number of available hospital beds, and a host of other data points. And the fact is that we need all of these numbers, and more, as we continue to formulate an effective response; timely and accurate data collection and dissemination is a foundational element of evidence-based science. The pandemic has demonstrated repeatedly the need for increased federal, state, and local funding to modernize our nation’s public health data systems and improve the quality and timeliness of that data to better inform our response. The budget numbers and staffing headcounts of our nation’s public health agencies deserve our attention as well. Our AMA will always advocate for the financial resources necessary for a robust public health system. The investments we make today will help us prevent or respond to health crises tomorrow.

#### American infrastructure and health system are wildly shaky – pandemic exposed cracks in foundation and changes are needed now

**Scott 20,** Dylan. [Policy Reporter]. "Coronavirus is exposing all of the weaknesses in the US health system", Vox, March 16, 2020. LB

The international response to the novel coronavirus has laid this bare: America was less prepared for a pandemic than countries with universal health systems. There is a real concern that Americans, with a high uninsured rate and high out-of-pocket costs compared to the rest of the world, won’t seek care because of the costs. Before the crisis even began, the United States had fewer doctors and fewer hospital beds per capita than most other developed countries. The rollout of Covid-19 testing has been patchy, reliant on a mix of government and private labs to scale up the capacity to perform the tens of thousands of tests that will be necessary. “Everyone working in this space would agree that no matter how you measure it, the US is far behind on this,” says Jen Kates, director of global health and HIV policy at the Kaiser Family Foundation. People need to go to the doctor and get checked if they have Covid-19 symptoms, yet Americans may avoid medical care, even for serious conditions, because of the costs. Hospitals will need rooms for the people who require close monitoring in a clinical setting, and ICU beds and ventilators for patients who take a turn for the worse and require mechanical support to keep their bodies functioning. Kaiser Permanente medical workers take swabs from people for the coronavirus at a drive-through testing facility in San Francisco, California on March 12, 2020. Josh Edelson/AFP via Getty Images But none of those units are sitting empty right now — they already have non-coronavirus patients who need them and will continue to need them through the crisis. New York Gov. Andrew Cuomo said Sunday that nearly 80 percent of New York City’s intensive care units were already filled, even with the Covid-19 outbreak still expanding. By any of these metrics on pandemic preparedness, America trails most of the rest of the developed world. “The U.S. performs worse than average among similarly large and wealthy countries across nearly all measures of preparedness for a pandemic,” Cynthia Cox, director of the Peterson-Kaiser Health System Tracker, told me. “The coronavirus outbreak is already exposing inefficiencies and inequities in our health system, and it is likely to put much more strain on the system in the coming weeks.” And the slow start to testing in the US is only going to exacerbate those problems. Testing is important not only because it gets people diagnosed and on an appropriate treatment if they do have an infection. It also establishes how widespread a virus actually is. Experts know the size of the problem, they know the rate at which people are being hospitalized or dying, and they can follow its movements. That leads to a more informed response. But the United States has faltered in rolling out coronavirus tests, putting us far behind our economic peers in tracing the outbreak. A manufacturing problem with the test kits that were initially sent out in the field, and a delay in approving commercial tests, set the nation back in stopping or slowing down Covid-19. Christina Animashaun/Vox “The testing failure is putting additional strain on our already challenged health system,” Cox said. “The combination of all of these factors will make the U.S. worse off than similar countries.” Universal health care is not a perfect treatment for emergencies like this. Italy has a universal health care system, a federalized national health insurance program similar to Canada’s, but an uncontained outbreak has still forced the country to lock itself down as cases and deaths continue to pile up. Nevertheless, other countries are still generally better prepared for a pandemic than the US is, and we are seeing right now the consequences of that gap. For the time being, US politicians are proposing to make American health care more like these other nations: making care free or cheap at the point of service, either by having the government cover more of the cost or by mandating private insurers cover services related to the outbreak. They are, however, only a temporary patch on these structural problems. Why America is less prepared for a pandemic than other countries On many measures, the United States has one of the worst health systems among developed economies. A bigger share of the population lacks health insurance. We carry more medical debt. We die more often from preventable causes. The weaknesses in this system, which already puts the US behind its peers on many health outcomes, are exposed in an outbreak. And the biggest single problem, the one most unique to the American system, is costs. Americans face higher out-of-pocket costs for their medical care than citizens of almost any other country, and research shows people forgo care they need, including for serious conditions, because of the cost barriers. Patients here are much more likely than those in most other countries to say they had a cost-related barrier to getting medical care: 33 percent in America vs. between 7 percent (Germany) and 22 percent (Switzerland) in other developed economies. Americans are more likely to say they struggled to afford or couldn’t afford medical bills and that their insurance plan had refused to cover some of their medical claims. Peterson-Kaiser Health System Tracker We know Americans delay care as a result of these cost barriers: in 2019, 33 percent of Americans said they put off treatment for a medical condition because of the cost; 25 percent said they postponed care for a serious condition. A 2018 study found that even women with breast cancer — a life-threatening diagnosis — would delay care because of the high deductibles on their insurance plan, even for basic services like imaging. Those cost barriers hit patients at several points in a pandemic situation. First, they might be wary about going to the doctor at all because they are afraid they can’t afford the check-up or any testing. But then if they do get a Covid-19 diagnosis and require hospitalization, they have the bills from the hospital, the doctors they see, and any treatment they receive to worry about. In America, and only in America among developed countries, do patients risk thousands of dollars in medical bills by seeking help in a crisis. Some Americans have already been billed nearly $4,000 over a government-imposed quarantine, as the New York Times reported. Making matters worse is our system’s health care infrastructure, built on top of this fractured payer system. There are capacity shortages that put us at further disadvantage in a time of pandemic, when they are most needed. Hospital beds, for example, will be necessary for Covid-19 patients with more serious symptoms. America has fewer hospital beds per capita than most other countries in the developed world. Peterson-Kaiser Health System Tracker A potential shortage of hospital beds is compounded by the fact that the US has higher rates of hospitalizations for chronic conditions that, with proper management, shouldn’t require the patient to go to the hospital. Those conditions include congestive heart failure, diabetes, and asthma. Researchers think a lack of access to primary care, and the high costs of seeking even this routine care compared to other countries, drive potentially preventable hospitalizations in the US. That means our hospitals are already taking in patients they wouldn’t have to if the system functioned better, and now they will have to accommodate an influx of Covid-19 patients. We have fewer doctors per capita too: 2.6 per 1,000 people, well below the comparable country average of 3.5 and lower than every country tracked by Peterson-Kaiser except for Japan. Experts blame the high cost of a medical education in the US, inextricably linked to America’s world-leading health care prices, for much of that shortfall. And, likely as a result, Americans struggle more than people in most other places to get a same-day or next-day appointment with their doctor. Peterson-Kaiser Health System Tracker Take these structural problems together with America’s slow start to testing for coronavirus, and we are far behind where we should be. “A failure to widely test and slow the spread means that we could have large spikes in the number of people who need medical care all at once, putting exceptional strain on our health system,” Cox told me. “By not acting quickly enough to prevent spread, our health system will be under greater, more concentrated strain.” Many countries with universal health care are doing better than the US, but some have problems too Countries with universal health care are testing more people and seem to be faring better with Covid-19 death rates than the United States. More centralized planning is an asset in a crisis. Taiwan has seen a remarkably low level of coronavirus cases despite high traffic with the Chinese mainland. As Vox’s Kelsey Piper reported: As of March 10, Taiwan has just 45 coronavirus disease (Covid-19) cases, and only one death. Health experts do not expect that Taiwan is overlooking many cases, either. That’s many fewer than its neighbors like Japan and South Korea and one of the best containment track records in the world so far. The Netherlands, with a comparable population, has five times as many cases despite having much less frequent direct travel with China. In Taiwan, with its single-payer health program, every citizen has their digital medical records loaded into the same system. In the coronavirus outbreak, the country has added travel records to that online medical file, so every doctor can check whether their patients have visited an area affected by the outbreak. And by getting jumpstarted on their response, those countries are able to lower the burden on their health systems. The primary goal with the coronavirus outbreak at this point is to slow the spread so health care providers aren’t overrun: to flatten the curve in this chart so patient needs don’t exceed the system’s capacity. Christina Animashaun/Vox So even though, as you may have noticed above, countries like Canada and United Kingdom have about the same number of hospital beds as the United States does, they should be better positioned to mitigate the outbreak. They are already testing a lot more people. More testing allows them to take smarter protective measures, because they have a better idea of the scope of the pandemic, which helps to reduce the burden on their health system during the worst peak of the outbreak. But even universal health care cannot fully prepare a country for the unpredictable movements of a pandemic virus. Italy, with a national health service that provides care to each of its citizens, has seen its coronavirus situation spin quickly out of control. On Monday, the country decided to close its borders in a desperate attempt to stem the crisis. As Vox’s Julia Belluz reported, there are competing theories for the problem. Perhaps the aggressive testing had just made the scale of the problem clear earlier than in other places. It’s hard to say for sure. Or: Another is that intense spread of the virus in the hospital system, before doctors realized there was a problem, may have amplified the outbreak. Some 10 percent of medical workers in Lombardy have been infected, according to a March 3 Washington Post report, and health workers account for 5 percent of those infected in the country. (Bolstering this explanation: The WHO-ECDC joint mission report suggests Italy should work on its infection prevention and control measures in hospitals.) There’s also speculation about whether Italy’s burden is particularly severe because of the country’s aging population. Covid-19 is known to hit the elderly particularly hard. That, along with the fast rise in confirmed cases, has tested the limits of the health system. And yet, Italy still has more hospital beds per capita and doctors per capita than the United States, according to OECD and World Bank estimates. As experts worry whether Italy shows a glimpse of what’s to come in America, it’s worth remembering their health system still had a bigger capacity to handle a surge in patients than the US system currently does. But the point is, pandemics are unpredictable. Their spread and containment depends a lot on human factors that even the most well-designed health system, or pandemic response plan, can’t fully anticipate. And if the pandemic does overcome a country’s best preparedness efforts, some other countries could conceivably be at a deeper disadvantage than the US. RELATED Taiwan has millions of visitors from China and only 45 coronavirus cases. Here’s how. Patients who develop pneumonia because of Covid-19 may require mechanical ventilators. The Johns Hopkins Center for Health Security reported in 2018 that Canada, Australia, and New Zealand (each with their own version of national health insurance) had fewer ICU beds with mechanical ventilation capability per capita than America does, though we too are not equipped to handle a crisis on the scale of the Spanish flu. Nevertheless, “these numbers suggest that the capacity of other countries to provide ventilation therapy might be significantly lower than our own,” the Johns Hopkins experts wrote. For now, US officials want to temporarily make our health care more like other places America’s fractured health system has made it more vulnerable to coronavirus. And in response, members of Congress and state governors keep proposing to make our health care more like other countries’ systems — at least during this emergency. Some states are doing what they can to lower those burdens. New York Gov. Andrew Cuomo announced last week he would require insurers and Medicaid in New York to cover treatment and testing cost-free with an emergency declaration. States have some discretion with what their Medicaid programs cover, and more states are taking their own actions: California Gov. Gavin Newsom issued a similar order in the last few days. Members of the National Guard attend the opening of a drive-through coronavirus mobile testing center in New Rochelle, New York, on March 13, 2020. Spencer Platt/Getty Images States are limited in what they can do, though ERISA, the federal law regulating the large employer health insurance plans that cover about 100 million Americans, is a barrier to state officials who want to do more. Cuomo’s order, for example, noted it applied to private health plans regulated by the state — the plans available to small businesses or individuals — but not the self-funded employer plans covered by ERISA. It’s another way a more decentralized health system complicates the response to an outbreak. Rep. Ruben Gallego (D-AZ) announced last week he would introduce a bill that would make Medicaid cover testing for and treatment of Covid-19 for every American, no matter how they get their insurance. This would be an important change to US health care: The federal government would assume responsibility for medical care for every American under these particular circumstances. And the Trump administration appears to see a need to do something drastic, too, even if experts don’t think some of their proposed actions will have a significant effect. Vice President Mike Pence, for example, said Covid-19 testing and treatment would be treated as an “essential health benefit” (a standard established by the Affordable Care Act) to cover everyone’s care. But that change would actually not apply to the self-funded plans, nor to Medicare, as Nicholas Bagley, a law professor at the University of Michigan, wrote for The Incidental Economist: Even if they did, insurers can (and do!) impose cost-sharing for EHBs, and could do so for a COVID-19 test. It’s a completely meaningless statement. Though that may be, Pence’s statement still reflected a real need to put at least a temporary patch on our health system. Everybody seems to agree on that. But these problems don’t go away when the coronavirus disappears. They are still there, if treated less urgently than in a crisis, affecting the lives of millions of Americans every day.

#### Health care strikes all across the globe prove effectiveness – crackdown meant health care systems weren’t fully reformed – calls for infrastructure updates now provide solutions to crumbling healthcare

**Essex**, Ryan, **and** Sharon M. **Weldon 7/17.** [Dr. Ryan Essex BHSc, GradDipPsych, BSocSc (Psych) (Hons), MHL, MPH, PhD, Sharon M. Weldon RGN, BSc (Hons), MSc, PhD Reader in Nursing Research and Education] “Health Care Worker Strikes and the Covid Pandemic.” New England Journal of Medicine, vol. 384, no. 24, 2021, doi:10.1056/nejmp2103327.

Despite having been warned for decades, many countries were unprepared for the Covid-19 pandemic. Though some have managed to contain the virus, in most countries, the pandemic response has been poor at best; in some countries, it’s been disastrous. As of mid-March 2021, nearly 2.7 million deaths had been attributed to SARS-CoV-2, and many more aspects of the health and social impact are likely to come to light over the long term. Though there are no official global figures, among the casualties are likely to be tens of thousands of health care and other frontline workers; in late 2020, Amnesty International estimated that more than 7000 health care workers had died from Covid. Beyond risking their lives, such workers have had a challenging year, to put it mildly. Many continue to work in underresourced systems, with inadequate personal protective equipment (PPE), dealing with a situation that was both unprecedented and completely foreseeable. While the heroics of health care workers have been celebrated and we’ve gained a renewed appreciation of the risks that many frontline workers face while providing fundamental services, less attention has been paid to those who have refused to work under such dangerous conditions and those who have pointed out that no health care workers needed to be placed at such high risk. Many have rightly argued that heroics were required only because of government neglect, underfunding, and lack of preparation for a pandemic that we knew was coming. Many workers are justifiably angry. Although there are no official figures, Covid-19 appears to have led to a substantial uptick in strike actions by health care workers. In February 2020, facing an unknown “pneumonia,” experts in Hong Kong called for closing the borders in an effort to mitigate its spread until more could be ascertained about the nature of the virus (which would be labeled Covid-19 on February 11 and deemed a pandemic roughly a month later). The Hong Kong government failed to act, despite calls from experts and health care workers, with support from the general public. In late January, labor unions repeatedly called for dialogue with the government regarding border closure. When that effort failed, a vote was held on strike action, for which there was overwhelming support. From February 3 through 7, 2020, health care workers in Hong Kong went on strike, making a number of demands, including the closure of borders and a sufficient supply of PPE and facilities to manage the potential spread of the virus. Such action has not been restricted to Hong Kong. Amid multiplying cases of Covid-19, health care workers in Zimbabwe went on strike in June 2020 because of a lack of PPE and low salaries. Indeed, strike action by health care workers has been a global phenomenon. In the United States, nurses have gone on strike, and in the United Kingdom pharmacists and nurses have threatened strike action. Doctors in South Korea launched a nationwide strike in August, and health care workers in Kenya, Spain, Bosnia, and Peru have all gone on strike at some point during the pandemic. Health care workers even went on strike after the military coup in Myanmar in February 2021, with a spokesperson noting that they “simply [did] not want to work for the regime that staged the military coup.”1 Such action must be understood in the context of broader unrest. In Venezuela, for example, many health care workers have had no option to stop working during the pandemic. In what has been described as a crisis within a crisis, Covid-19 has exacerbated many of the problems of Venezuela’s ailing health care system. Though there has been unrest, the Venezuelan government has attempted to silence critics, deny PPE shortages, and blame health care workers. The government also denies that an estimated 200 health care workers have died, contending that there have been only 12 deaths attributable to Covid-19.2 Though these situations are distinct in multiple ways and health care workers have gone on strike (or protested) for myriad reasons, common demands underlying nearly all these actions relate to inadequate responses to Covid-19 and inadequate protections for frontline workers; every group taking action has explicitly demanded more PPE. Experts in law, ethics, and medicine have long debated whether and when strike action by health care personnel can be justified. Although these debates have centered on the risks that strikes carry for patients, these actions also pose risks for health care workers — they may damage morale and team cohesion, for example, and in many countries strikes have been repressed violently. Other risks relate to public perceptions and to potentially broader harms for both society and the health care community as a whole.3 Perhaps most fundamentally, however, strikes raise questions about what health care workers owe society and what society owes them. Past debates, however, have perhaps not had to consider such unprecedented circumstances: Should doctors in Myanmar, for example, have to continue to work under a military government during a pandemic? Although we can’t readily answer this question, there are some key considerations in assessing strikes during Covid-19. Perhaps the most obvious is that the pandemic has raised the stakes for such actions. On the one hand, it could be argued that health care workers are needed more than ever; on the other, it could also be argued that they should not be expected to work with inadequate PPE and other protections in place. Beyond these dilemmas, Covid-19 has not only highlighted our collective vulnerability, but also revealed the impact of decades of underfunding and neglect as well as a more recent disdain for science. In many ways, debates about the risks associated with strike action have led to a stalemate, as these dilemmas are only present because of deeper structural problems. In an article published about 6 months before the first cases of Covid-19 were reported, entitled “Invest in public health now, or store up problems for the future,” Finch argues that the ongoing underfunding of public health in England was likely to have future implications, increasing the need for services and raising costs in the longer term.4 Underfunding was one of many problems faced by health care in the United Kingdom before the pandemic, with decades of austerity believed to have contributed to tens of thousands of preventable deaths.5 Covid-19 has led to some of the most profound changes to social life in living memory. It has also shed light on many challenges that might otherwise have been brushed aside: underfunding, neglect, and indifference to health and health care. It has left us with two related issues: What should be done to avert strike action? And more important, how can we address broader structural failings? How we get to the root cause of these problems will vary from country to country, as will who should be accountable for them and what can be done to solve these problems. Contrasts can be drawn here among well-resourced countries, but even starker differences exist globally, especially given the likely future impact of Covid-19 in low- and middle-income countries. Yet some immediate steps could be taken everywhere in response to warnings about long-term effects on the mental health of health care workers: support should be provided, now and into the future. Though it is tempting to say that we also need to pay health care workers more and improve their working conditions, and we do, such actions will have little long-term impact if health care systems remain neglected. It would be nice to say that it shouldn’t take a pandemic or a strike to force countries to confront these issues, but the past 12 months justify a certain skepticism. Even as Covid-19 continues to affect millions of people, we can only hope it prompts a reassessment not only of how health care workers are treated, but also of the value we place on health and health care.

#### Increased health infrastructure now spills over to curb deadlier pandemics.

**Craven et al. 20**.,  Matt Craven, [Adam Sabow](https://www.mckinsey.com/our-people/adam-sabow), [Lieven Van der Veken](https://www.mckinsey.com/our-people/lieven-van-der-veken), and Matt Wilson, . "Not the Last Pandemic: Investing Now to Reimagine Public-health Systems." McKinsey & Company, 13 July 2020, [www.mckinsey.com/industries/public-and-social-sector/our-insights/not-the-last-pandemic-investing-now-to-reimagine-public-health-systems#](http://www.mckinsey.com/industries/public-and-social-sector/our-insights/not-the-last-pandemic-investing-now-to-reimagine-public-health-systems).

The COVID-19 pandemic has exposed overlooked weaknesses in the world’s infectious-disease-surveillance and -response capabilities—weaknesses that have persisted in spite of the obvious harm they caused during prior outbreaks. Many countries, including some thought to have strong response capabilities, failed to detect or respond decisively to the early signs of SARS-CoV-2 outbreaks. That meant they started to fight the virus’s spread after transmission was well established. Once they did mobilize, some nations struggled to ramp up public communications, testing, contact tracing, critical-care capacity, and other systems for containing infectious diseases. Ill-defined or overlapping roles at various levels of government or between the public and private sectors resulted in further setbacks. Overall, delayed countermoves worsened the death toll and economic damage. Correcting those weaknesses won’t be easy. Government leaders remain focused on navigating the current crisis, but making smart investments now can both accelerate COVID-19 response and strengthen public-health systems to reduce the chance of future pandemics. Investments in public health and other public goods are sorely undervalued; investments in preventive measures, whose success is invisible, even more so. Many such investments would have to be made in countries that cannot afford them. Nevertheless, now is the moment to act. The world has seen repeated instances of what former World Bank president Jim Kim has called a cycle of “panic, neglect, panic, neglect,” whereby the terror created by a disease outbreak recedes, attention shifts, and we let our vital outbreak-fighting mechanisms atrophy.1 And while some are calling the COVID-19 crisis a 100-year event, we might come to see the current pandemic as a test run for a pandemic that arrives soon, with even more serious consequences. Imagine a disease that transmits as readily as COVID-19 but kills 25 percent of those infected and disproportionately harms children. The case for strengthening the world’s pandemic-response capacity at the global, national, and local levels is compelling. The economic disruption caused by the COVID-19 pandemic could cost between $9 trillion and $33 trillion—many times more than the projected cost of preventing future pandemics. We have estimated that spending $70 billion to $120 billion over the next two years and $20 billion to $40 billion annually after that could substantially reduce the likelihood of future pandemics (Exhibit 1). These are high-level estimates with wide error bars. They do not include all the costs of strengthening health systems around the world. A comprehensive program of health-system strengthening at all levels would cost substantially more and also contribute to effective outbreak management. Our preliminary findings call for further investigation, but we hope the overall message is clear: infectious diseases will continue to emerge, and a vigorous program of capacity building will prepare the world to respond better than we have so far to the COVID-19 pandemic. In this article, we describe the five areas that such a program might cover: building “always on” response systems, strengthening mechanisms for detecting infectious diseases, integrating efforts to prevent outbreaks, developing healthcare systems that can handle surges while maintaining the provision of essential services, and accelerating R&D for diagnostics, therapeutics, and vaccines (Exhibit 2). From ‘break glass in case of emergency’ response systems to always-on systems and partnerships that can scale rapidly during pandemics Responding to outbreaks of infectious diseases involves different norms, processes, and structures from those used when delivering regular healthcare services. Decision making needs to be streamlined; leaders must make no-regrets decisions in the face of uncertainty. But much of our present epidemic-management system goes unused until outbreaks happen, in a “break glass in case of emergency” model. It is difficult to switch on those latent response capabilities suddenly and unrealistic to expect them to work right away. A better system might be founded on a principle of active preparedness and constructed out of mechanisms that can be consistently used and fine-tuned so they are ready to go when outbreaks start (Exhibit 3). We see several means of instituting such an always-on system. One is to use the same mechanisms that we need for fast-moving outbreaks (such as COVID-19) to address slow-moving outbreaks (such as HIV and tuberculosis) and antimicrobial-resistant pathogens. Case investigation and contact tracing are skills familiar to specialists who manage HIV and tuberculosis. But few areas have deployed their experts effectively in responding to the COVID-19 pandemic.

#### Future pandemics will cause extinction – it only takes one ‘super-spreader’ – US prevention is key.

Bar-Yam 16 Yaneer Bar-Yam 7-3-2016 “Transition to extinction: Pandemics in a connected world” <http://necsi.edu/research/social/pandemics/transition> (Professor and President, New England Complex System Institute; PhD in Physics, MIT)//Elmer

Watch as one of the more aggressive—brighter red — strains rapidly expands. After a time it goes extinct leaving a black region. Why does it go extinct? The answer is that it spreads so rapidly that it kills the hosts around it. Without new hosts to infect it then dies out itself. That the rapidly spreading pathogens die out has important implications for evolutionary research which we have talked about elsewhere [1–7]. In the research I want to discuss here, what we were interested in is the effect of adding long range transportation [8]. This includes natural means of dispersal as well as unintentional dispersal by humans, like adding airplane routes, which is being done by real world airlines (Figure 2). When we introduce long range transportation into the model, the success of more aggressive strains changes. They can use the long range transportation to find new hosts and escape local extinction. Figure 3 shows that the more transportation routes introduced into the model, the more higher aggressive pathogens are able to survive and spread. As we add more long range transportation, there is a critical point at which pathogens become so aggressive that the entire host population dies. The pathogens die at the same time, but that is not exactly a consolation to the hosts. We call this the phase transition to extinction (Figure 4). With increasing levels of global transportation, human civilization may be approaching such a critical threshold. In the paper we wrote in 2006 about the dangers of global transportation for pathogen evolution and pandemics [8], we mentioned the risk from Ebola. Ebola is a horrendous disease that was present only in isolated villages in Africa. It was far away from the rest of the world only because of that isolation. Since Africa was developing, it was only a matter of time before it reached population centers and airports. While the model is about evolution, it is really about which pathogens will be found in a system that is highly connected, and Ebola can spread in a highly connected world. The traditional approach to public health uses historical evidence analyzed statistically to assess the potential impacts of a disease. As a result, many were surprised by the spread of Ebola through West Africa in 2014. As the connectivity of the world increases, past experience is not a good guide to future events. A key point about the phase transition to extinction is its suddenness. Even a system that seems stable, can be destabilized by a few more long-range connections, and connectivity is continuing to increase. So how close are we to the tipping point? We don’t know but it would be good to find out before it happens. While Ebola ravaged three countries in West Africa, it only resulted in a handful of cases outside that region. One possible reason is that many of the airlines that fly to west Africa stopped or reduced flights during the epidemic [9]. In the absence of a clear connection, public health authorities who downplayed the dangers of the epidemic spreading to the West might seem to be vindicated. As with the choice of airlines to stop flying to west Africa, our analysis didn’t take into consideration how people respond to epidemics. It does tell us what the outcome will be unless we respond fast enough and well enough to stop the spread of future diseases, which may not be the same as the ones we saw in the past.

1. **Morality and Foreign Policy**[George F. Kennan](http://www.foreignaffairs.org/author/george-f-kennan/index.html) From *Foreign Affairs*, [Winter 1985/86](http://www.foreignaffairs.org/1985/2.html) *George F. Kennan is Professor Emeritus at the Institute for Advanced Study, Princeton. Copyright © 1985 by George F. Kennan* [↑](#footnote-ref-1)