Chapter 1

Health Politics and Political Action

Health Crisis by the Numbers: Data Update from the Physicians for a National Health Program's Newsletter Editors

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UNINSURED

- 60.3 million Americans (19.8 percent) were uninsured for at least part of 2010, up from 58.5 million people in 2009, according to the National Center for Health Statistics. 48.6 million Americans (16.0 percent) were uninsured at the time of interview for the 2010 survey, up from 46.3 million people in 2009, with the majority, 35.7 million Americans (11.7 percent of all Americans), uninsured for more than one year, up from 32.8 million people the previous year, according to an analysis of data from the National Health Interview Survey.

  Nine million working-age Americans—57 percent of people who had health insurance through a job that was lost—became uninsured between 2008 and 2010, according to a survey by the Commonwealth Fund. Among those who lost employer-sponsored coverage, only 25 percent were able to find another source of coverage, and only 1 in 7 were able to retain their job-based coverage through COBRA. Additionally, 32 percent of working-age adults (49 million people) spent 10 percent or more of their income on health care and premiums (meeting the definition for being "underinsured"), up from 21 percent, or 31 million adults, in 2001. In 2010, 75 million adults went without necessary

Source: Physicians for a National Health Program. (2011, Fall). Health crisis by the numbers: Data update from the PNHP newsletter editors. PNHP Newsletter, 3–9.

> health care due to cost, 73 million reported having trouble paying bills or were in medical debt, and 29 million used up all of their savings to pay medical debts. A quarter of adults with chronic conditions skipped prescriptions due to cost ("New health insurance survey: 9 million adults joined ranks of uninsured due to job loss in 2010," The Kaiser Family Foundation 3/16/11).

- Between 23 and 40 million people will remain uninsured after the federal health law is fully implemented, according to estimates by the Congressional Budget Office (CBO) and the McKinsey consulting firm, respectively (McKinsey Quarterly, "How US health care reform will affect employee benefits," June 2011).
- One-third of people under 65 who are diagnosed with cancer are uninsured during or after diagnosis, with 75 percent reporting that their lack of coverage is due to high premium costs or a pre-existing condition exclusion (American Cancer Society, "A National Poll: Facing Cancer in the Health Care System," 2010).

UNDERINSURED

> Nearly half (48 percent) of families with chronic conditions in high deductible health plans (HDHP) report financial burdens related to medical costs, compared to 21 percent of families in traditional plans. In addition, nearly twice as many lower-income families in HDHP spend more than 3 percent of their incomes on health care as lower-income families in traditional plans (53 percent versus 29 percent). High deductible health plans are defined as a health plan with at least a $1,000 deductible for individual coverage or $2,000 for family coverage. Families with high deductible plans were also older, on average, than those in traditional plans, and were more likely to have had no other choice of health plan due to cost (Galbraith et al., "Nearly half of families in high deductible health plans whose members have chronic conditions face substantial financial burden," Health Affairs, 2/11).

- Cancer patients face high out-of-pocket costs. Using data from the National Medical Expenditure Panel Survey, researchers found that 13.4 percent of non-elderly adult cancer patients spent at least 20 percent of their income on health care and insurance, compared to 9.7 percent of people with other chronic conditions and 4.4 percent of people without cancer or chronic diseases. Cancer treatment was most unaffordable for those with non-group private insurance: 43 percent of cancer patients with individual health insurance spent over one-fifth of their income on medical expenses, compared to 9 percent of patients with employer-sponsored

insurance and 26 percent of the uninsured (Bernard et al., "National Estimates of Out-of-Pocket Health Care Expenditure Burdens Among Nonelderly Adults With Cancer: 2001 to 2008," Journal of Clinical Oncology, June 2011).

A cancer diagnosis is also a risk factor for personal bankruptcy. A study linking data from Washington state bankruptcy-court records and a National Cancer Institute registry of 231,799 cancer cases found that 4,805 of the individuals, 2.1 percent, sought personal bankruptcy protection in the years following the diagnosis. Sufferers of lung, thyroid, and leukemia/lymphoma cancers found themselves most likely to turn to Chapter 7 or Chapter 13 at the one-, two-, and five-year marks after their diagnosis. For example, five years after receiving a diagnosis of lung cancer, 7.7 percent of victims sought bankruptcy (Rachel Feintzeig, "Study Illuminates Link Between Cancer, Bankruptcy," Wall Street Journal blog, Bankruptcy Beat, 6/7/11).

- The number of hospital emergency departments (ED) in non-rural areas declined 27 percent between 1990 and 2007. Safety-net hospitals, hospitals in counties with a high poverty rate, and for-profit hospitals with low profitability or located in highly competitive markets were more likely to close their EDs. For-profit hospitals were twice as likely to close their EDs as facilities that were nonprofit or publicly owned (Hsia, Kellermann, and Shen, "Factors Associated with Closures of Emergency Departments in the United States," JAMA, 5/18/11).

Although access to care problems are most severe among the uninsured, they also affect a large proportion of the general population. Eighty-five percent of the uninsured report delaying needed medical care due to costs in 2010, while 48 percent report trouble paying medical bills. Overall, fifty-four percent of Americans report delaying needed care in 2010, while 25 percent report having trouble paying medical bills, according to a survey by the Kaiser Family Foundation (December Health Tracking Poll, 2010, Kaiser Family Foundation).

SOCIOECONOMIC INEQUALITY

- Federal revenues as a proportion of GDP are at their lowest level in 60 years. In 2010, federal revenues were equivalent to 14.9 percent of the GDP, down from 20.6 percent a decade earlier.
- Meanwhile, income inequality in the U.S. is rising dramatically. From 1980 to 2005, more than four-fifths of the total increase in American's incomes went to the richest 1 percent. In 2010, the share of income going

to the top 1 percent of taxpayers jumped to 24 percent, up from 9 percent in 1976. The CEOs of America's largest corporations make 531 times more than the average worker, up from 42 times as much in 1980 (Reducing the Deficit, Congressional Budget Office, March 2011, and Nicholas Kristof, "Our Banana Republic," The New York Times, 11/06/10).

> The economic crisis has hit Hispanic and black households the hardest. Between 2005 and 2009, the median wealth of Hispanic households dropped by 66 percent, compared to a 53 percent drop in median wealth of black households and a 16 percent drop among non-Hispanic white households. The declines have led to the largest wealth disparities in the 25 years that the Census Bureau has been collecting the data. Median wealth for non-Hispanic white households is now 20 times higher than for black households, and 18 times higher than for Hispanic households (Sabrina Tavernise, "Recession Study Finds Hispanics Hit the Hardest," The New York Times, 7/26/11).

COSTS

- Health care premiums will rise 8.5 percent in 2012, according to a PricewaterhouseCoopers survey of 1,700 firms. Employers are offering workers more meager plans in response to rising costs: 17 percent of employers surveyed most commonly offered high-deductible health plans to their workers this year, up from 13 percent in 2010 (Merrill Goozner, The Fiscal Times, 5/18/11).
- U.S. health expenditures in 2011 are projected to be $2.7 trillion, $8,649 per capita, 17.7 percent of GDP. Over the next decade, health spending is predicted to grow 5.8 percent annually. In 2020, after the Patient Protection and Affordable Care Act is fully implemented, health spending is projected to be $4.6 trillion, $13,709 per capita, 19.8 percent of GDP (Office of the Actuary, CMS, National Health Spending Projections Through 2020, Health Affairs, July 28, 2011).
- Starbucks spent over $250 million on health insurance for its U.S. employees in 2010, more than it spent on coffee (Jennifer Haberkorn, "Starbucks CEO rethinks health law," Politico, 3/22/11).
- The total cost of health care for a family of four covered by a preferred provider plan (PPO) in 2011 is estimated to be $19,393, up 7.3 percent from 2010, according to the Milliman Medical Index. Employer contributions account for 59 percent, $11,385, of the total, while employees pay 41 percent of the cost, $8,008. Employees contribute an average of $4,728 to premiums and pay $3,280 in out-of-pocket costs (Don

McCanne, www.pnhp.org/blog, "The Milliman Medical Index ($19,393) in perspective, 5/12/11).

> The average cost of employer-sponsored health coverage rose 5 percent to $13,770 ($1,147 per month) for family coverage and $5,049 ($421 per month) for individual coverage in 2010. Twenty percent of plans for families cost $16,524 or more. The cost of employer-sponsored coverage has more than doubled since 2000 (Employer Health Benefits Annual Survey, 2010, Kaiser Family Foundation).

MEDICAID

- Medicaid spending is set to decline for only the second time in the program's 46-year history as additional federal funding from the 2009 economic stimulus package dries up as of July 2011. Medicaid spending was up 8.2 percent to $354 billion in 2010 due to a 14.2 percent increase in federal funding. With enrollment expected to grow 6.1 percent in the coming year due to the continued economic downturn, 24 states are planning to cut payments to providers and 20 states are planning to cut benefits. Medicaid currently consumes about 22 percent of state budgets (Robert Pear, "As Number of Medicaid Patients Goes Up, Their Benefits Are About to Drop," The New York Times, 6/15/11).
- Ignoring the state's disastrous experience with for-profit Medicaid managed care in the mid-1990s (when up to 50 percent of funding was diverted to overhead and profits by unscrupulous firms), Florida legislators are again pushing for privatization of the state's Medicaid program, claiming it will control costs. In fact, per capita Medicaid spending rose much more slowly between 2001 and 2009 than spending on private coverage by large employers (up 30 percent vs. 112 percent, respectively) (Greg Mellowe, Florida Center for Fiscal and Economic Policy, 4/1/11; investigative reporters Fred Schulte and Jenni Bergal published a series of articles on fraud in Florida's 1990s Medicaid managed care programs in the Florida Sun Sentinel).

> Children with Medicaid coverage are much more likely to be denied treatment or made to wait long periods for an appointment with medical specialists. Across eight different specialties, 66 percent of children with Medicaid were denied an appointment at a doctor's office compared to 11 percent with private coverage. In clinics that accepted both, the average wait time for an appointment was 22 days longer for a child with Medicaid compared to

one covered by private insurers. The study increased concern about the quality of care for patients under the Affordable Care Act, which relies heavily on Medicaid expansion to increase health coverage nationwide (Bisgaier and Rhodes, "Auditing Access to Specialty Care for Children with Public Insurance," NEJM, 6/16/11).

- Enrollment in Oregon's "standard" Medicaid program plummeted from 104,000 in 2003 to 24,000 in 2005 after higher premiums, higher cost-sharing, and strict payment deadlines were imposed on enrollees. Compared to the beneficiaries of Oregon's "plus" Medicaid program, which remained unchanged, the 104,000 beneficiaries in the original "standard" plan had worse health outcomes, more unmet health needs, reduced use of medical care, and greater medical debt and financial strain (Wright et al., Health Affairs, December 2010).

MEDICARE

Administrative costs for Medicare were 1.4 percent in 2008, excluding overhead in private Medicare Advantage and Part D pharmaceutical plans, according to the 2010 Medicare Trustees report. Medicare's administrative overhead fell slightly to 1.3 percent in 2009. Including the overhead from private plans in Medicare's overhead raises it to 5.3 percent, the figure reported in the National Health Expenditure Accounts (2008) (CMS, 2009 and 2010 Annual Reports of the Boards of Trustees, www.cms.gov and CMS, National Health Expenditures by Type of Service and Source of Funds, calendar years 2008 to 1960).

- Medicare benefits are inadequate. Medicare households on average spent $4,620 on health care in 2009, more than twice what non-Medicare households spent, according to the Kaiser Family Foundation. The program for 47 million seniors and the permanently disabled currently covers less than half of the health care costs of beneficiaries, who, on average, subsist on incomes below $22,000 a year and have less than $33,100 in retirement accounts and other savings.

  On top of standard premiums of $115.40 a month, enrollees pay a $1,132 deductible for each hospital stay, and hundreds of dollars a day more for long hospital stays. Medicare beneficiaries are also responsible for 20 percent of the bills for most outpatient care. Medicare doesn't cover dental, vision, hearing or long-term care, and has no cap on out-of-pocket spending (Levey, "Making Medicare beneficiaries pay more," Los Angeles Times, 7/15/11).

- It's old, but we hadn't seen it: The Veterans Health Administration provides care at a lower cost than Medicare, according to a study that compared the cost of care at six VA facilities to the cost of the same care delivered in the private sector at Medicare payment rates. The study conservatively estimated that contracting out services provided by the VA would have cost the taxpayer 21 percent more than the VA's actual budget. About half of the savings came from the VA's discounted prices for outpatient pharmaceuticals; the VA also saved substantial sums on inpatient care, rehabilitation and partial hospitalization, outpatient diagnostic care, and durable medical equipment (Nugent et al., "Value for Taxpayers' Dollars: What VA Care Would Cost at Medicare Prices," Med. Care Res. and Rev. 61:4, 12/04).

  "Costs for Medicare patients are being better contained than those covered under commercial insurance plans," according to David Blitzer, chairman of the Standard and Poors (S&P) Index Committee. Medicare spending, as measured by the S&P Medicare Index, increased by 2.8 percent between March 2010 and March 2011, a far lower rate of inflation than seen for private medical coverage, which rose 7.6 percent, according to the S&P. Medicare's hospital costs also rose more slowly, at 1.2 percent, compared to an 8.4 percent jump in the hospital commercial index (Maggie Mahar, "Medicare Breaks the Inflation Curve," Health Beat Blog, 5/20/11).

- Private Medicare Part D plans pay substantially higher prices for brand-name drugs than Medicaid, according to a study by the Office of the Inspector General. Both Medicaid and Part D plans receive rebates on brand-name drug purchases. While rebates reduced Part D expenditures by 19 percent for the 100 brand-name drugs reviewed (from $24 billion to $19.5 billion) in 2009, Medicaid's rebates reduced their expenditures 45 percent (from $6.4 billion to $3.5 billion). (Higher Rebates for Brand-Name Drugs Result in Lower Costs for Medicaid Compared to Medicare Part D, Office of the Inspector General, DHHS, August 2011).

CORPORATE MONEY AND CARE

- U.S. physicians spend nearly four times more on billing and insurance-related overhead each year ($82,975 vs. $22,205 per physician) than their Canadian counterparts, with U.S. medical practice staff spending over 20.6 hours per week on bureaucratic tasks, compared to just 2.5 hours

per physician per week under Canada's single-payer program (Morra et al., "U.S. physician practices versus Canadians," Health Affairs, 8/11).

- Seven top executives at drug, insurance, and hospital trade associations received a total of $33.2 million in compensation during the height (2008-2009) of the health care reform fight. PhRMA's Billy Tauzin topped the list at $9.1 million, followed by Scott Serota at Blue Cross/Blue Shield ($7.2 million), Charles Kahn III, Federation of American Hospitals ($4.5 million), Karen Ignani, America's Health Insurance Plans ($3.8 million), Richard Umbdenstock, American Hospital Association ($3.8 million), Stephen Ubl, Advanced Medical Technology ($2.4 million), and James Greenwood, Biotechnology Organization ($2.4 million). (Kaiser Health News, How Top Health CEOs Were Paid 2008–2009, 1/5/11).

  The nation's five largest for-profit health insurers netted $11.7 billion in profits in 2010, up 51 percent from 2008, because medical costs grew slower than forecast as insured patients skimped on medical care to avoid costly co-pays and deductibles during the severe recession. UnitedHealthcare was the leader in profitability, taking in over $4.6 billion in profits, followed by WellPoint ($2.9 billion) and Aetna ($1.8 billion). Profits were up 361 percent over 2008 at Cigna, to $1.3 billion in 2010, and up 70 percent at Humana, to $1.1 billion. Meanwhile, health insurers are proposing double-digit premium increases, claiming that demand for medical services may surge at the end of the year ("Health Insurers Pocketed Huge Profits in 2010 Despite Weak Economy," Health Care For America Now, 3/03/11 and Reed Abelson, "Health Insurers Making Record Profits as Many Postpone Care," The New York Times, 5/13/11).

- Share prices of the 51 health care companies listed in the S&P 500 rose an average of 6 percent in the year after the federal health reform passed in March 2010, triple the S&P 500 average (Russ Brit, "Insurers gain big in health reform's first year," MarketWatch, 3/22/11).

  CEOs at the nation's five largest for-profit insurance companies garnered $54.4 million in compensation in 2010. The top-paid executive was Cigna's David Cordani ($15.2 million), followed by WellPoint's Angela Braly ($13.5 million), UnitedHealthcare's Stephen Hemsley ($10.8 million), Aetna's Mark Bertolini ($8.8 million), and Humana's Michael McCallister ($6.1 million) (Executive PayWatch, AFL-CIO, 2011).

- The nation's seven largest for-profit health insurers made a mistake in processing nearly one out of every five (19.3 percent) medical claims in 2010, according to the American Medical Association. Anthem Blue

Cross Blue Shield was the worst, with an error rate of 39 percent. Medicare, which uses private intermediaries to process claims, had an error rate of 3.8 percent. Physicians received no payment at all from commercial health insurers on nearly 23 percent of claims they submitted, most commonly because of deductibles that shifted responsibility for payment to patients (American Medical Association, 2011 National Health Insurer Report Card).

- UnitedHealth, WellPoint and Aetna profited a record $2.51 billion in the second quarter of 2011. Based on their strong performance during the first half of this year, UnitedHealth, WellPoint and Aetna have all raised their profit forecast for 2011. Aetna's chief financial officer, Joseph Zubretsky, assured investors that the firm would not risk adding people to its rolls who might have substantial medical needs. "We would like to have both profit and growth, but if you have to choose between one or the other, you take margin and profit and you sacrifice the growth line." In 2008, WellPoint's Angela Braly promised analysts that the firm would "not sacrifice profitability for membership." (Wendell Potter, "Fresh evidence that insurance companies value profits over people," Huffington Post, 8/1/11).
- Seven of California's largest health insurers were fined close to $5 million by state regulators in 2010 for failing to pay doctors and hospitals in a fair and timely fashion. Investigators determined that insurers paid about 80 percent of claims correctly, well below the legal requirement of 95 percent. Five of the insurers were also found to have improper provider appeals processes, sometimes requiring providers to appeal to the same person who denied their claim. Insurance companies will also be required to pay tens of millions in compensation to unpaid doctors and hospitals (Victoria Colliver, "California Largest Insurers Continue to Cheat," San Francisco Chronicle, 11/30/10).

Despite publicly claiming to support health reform and making substantial contributions to Democratic politicians, the insurance industry lobbying group, America's Health Insurance Plans (AHIP) also funneled $86.2 million to the U.S. Chamber of Commerce in 2009 to oppose the federal health law. Moreover, the nation's five largest health insurance companies have started a new coalition to lobby exclusively for their own interests and profits, independent of the small and non-profit insurers that are also represented by AHIP. The "Big Five"—Wellpoint, UnitedHealthcare, Aetna, Cigna, and Humana—have already enlisted the services of corporate public relations firms APCO Worldwide and Weber Shandwick as well as law firm Alston & Bird LLP to help craft

political strategy. For starters, they seek to strip the 2010 health reform bill of provisions such as minimum requirements for the proportion of insurance premiums spent on paying for health care rather than for overhead and profit (Drew Armstrong, "Insurers Gave U.S. Chamber $86 Million Used to Oppose Obama's Health Law," Bloomberg, 11/17/10, and "UnitedHealth Joins WellPoint to Hone Health-Law Lobby," Bloomberg, 1/31/11).

- Indianapolis-based WellPoint was among the top donors to Republican organizations active in the Wisconsin recall elections. The giant insurer gave $450,000 to the Republican State Leadership Committee (RSLC), which spent about $370,000 on the special elections, and $250,000 to the Republican Governors Association. Wellpoint gave $842,000 to the RSLC for the 2010 elections (Salant, WellPoint Joins Koch Help Fight Wisconsin State Senate Recalls, Bloomberg.com, 8/4/11).
- Health insurance giants are on a buying spree for firms in health IT, physician management, and other industries that are "much less regulated" than health insurance, and will give them an advantage in controlling health care costs, according to UnitedHealth's Rick Jelinek. Since June 2009, the seven largest insurance companies have made 25 major corporate acquisitions, including only six that were health plans. In December, Humana purchased Concentra, a network of urgent and occupational care centers in 40 states; over one-third of Humana enrollees live within 10 miles of a Concentra clinic (Christopher Weaver, "Health Insurers Respond To Reform By Snapping Up Less-Regulated Businesses," Kaiser Health News, 3/19/11).
- Judgments and settlements under the False Claims Act for defrauding the U.S. government have resulted in over $25 billion in repayments to the federal government since 1986, with 19 of the 20 highest payments coming from health care corporations. In 2009, pharmaceutical giant Pfizer paid a total of $2.3 billion, including $1 billion under the False Claims Act and $1.3 billion as a criminal fine for paying kickbacks to physicians and other criminal offenses. Hospital chain HCA has paid $1.7 billion to the federal government, including a $900 million settlement in 2000 for Medicare payment manipulation, kickbacks, bill coding fraud and padding. Major settlements and judgments, each involving hundreds of millions of dollars, have hit the nation's largest health firms including Tenet Healthcare, Merck, GlaxoSmithKline, Serono, Bayer and many others (Donald R. Soeken, International Whistleblower Archive, www.whistleblowing.us).

- With two million prisoners, the U.S. incarcerates a higher proportion (1 percent) of its adults than any other nation. For-profit companies have found ways to exploit this unconscionable situation. Private prisons, like private insurers, avoid the medically needy to boost profits. A study in Arizona found that by cherry-picking inmates and skimping on care, private prisons are able to reap profits even as they fictitiously appear to lower states' costs. In 2009, after adjusting for medical costs, medium-security state run prisons in Arizona cost $2,834 less per prisoner than privately-run prisons. (Monica Almeida, "Private Prisons Found to Offer Little in Savings," The New York Times, 5/18/11).

BIG PHARMA

- The Pharmaceutical Research and Manufacturers of America (PhRMA) lobbying group spent at least $101.2 million to influence the national health reform debate in 2009 alone. Billy Tauzin, then-CEO of PhRMA, reports that spending went towards advertising, "grassroots" efforts, lobbying, polling and consulting. PhRMA also donated to right-wing organizations such as the Heritage Foundation, National Review, Pacific Research Institute and the Hudson Institute (Bara Vaida and Christopher Weaver, "Drug Lobby's Tax Filings Reveal Health Debate Role," Kaiser Health News, 12/01/10).
- Drug companies claim to spend an average of $1.3 billion on R&D to bring a single new drug to market, but the true net median cost was likely closer to $59.4 million in 2000 ($98 million in 2011 dollars), according to a new study. The $59.4 million figure excludes research (including the cost of discovery and early development), because it cannot be accurately measured and is, in any event, likely to be small for large pharmaceutical firms net of taxpayer subsidies; over 84 percent of all funds for discovering new medicines come from public sources. Previous research has shown that, net of taxpayer contributions, drug companies spend just 1.3 percent of revenues on basic research to discover new molecules. Pharmaceutical R&D is increasingly churning out products ("me-too drugs") that have few benefits over existing drugs; these slightly modified copies enable companies to profit from high-cost, patented drugs without the risks of original drug development (Light and Warburton, "Demythologizing the high costs of pharmaceutical research," BioSocieties, 2011, and Light and Lexchin, "Foreign free riders and the high price of U.S. medicines," British Medical Journal 2005; 331).

- Novo Nordisk will pay $25 million to settle claims of illegally marketing a hemophilia drug, Factor VII, to the U.S. Army as a treatment for trauma wounds and severe bleeding. Despite only being approved by the FDA for hemophilia treatment, the military began using Factor VII (sold as NovoSeven) as a treatment for combat wounds in Iraq in 2003, and it was soon adopted by trauma centers worldwide. Clinical studies have since shown that Factor VII does not control severe bleeding and can cause blood clots that lead to heart attack or stroke. In 2010, Novo Nordisk reported $1.6 billion in sales of NovoSeven, including approximately $250 million for unapproved usage (Robert Little "Drugmaker pays $25 million to settle military claim," The Baltimore Sun, 6/10/11).
- The pharmaceutical industry spent $6.1 billion in 2010 to influence American doctors, and another $4 billion on direct-to-consumer advertising, according to IMS Health (Erica Mitrano, "Just say no to drug reps," SoMdNews.com, 7/15/11).
- Two giant pharmacy benefit management firms are merging in a $29.1 billion deal. St. Louis-based Express Scripts is buying rival Medco based in Franklin Lakes, New Jersey. The new firm, Express Scripts Holding Company, will be based in St. Louis (Jaimy Lee, Modern Healthcare Business News, July 21, 2011).

HOSPICE, INC.

- For-profit hospices are expanding rapidly and may be cherry-picking the most profitable patients, according to a recent study. The number of for-profit hospices increased from 725 in 2000 to 1,660 in 2007, while the number of nonprofit hospices remained stable at 1,205 in 2007. Overall, 52 percent of facilities are for-profit, 35 percent are nonprofit and 13 percent are government-owned. Hospice care is funded by Medicare on a per-diem basis, with a fixed rate ($143 in 2010) paid to providers for each day that a patient is in a facility. Because the first and last days of care are more expensive to provide, longer length of stay generates higher profit. The study found that patients in for-profit facilities averaged a 20-day stay, compared to 16 days in nonprofit centers. For-profit hospices also had twice as many dementia patients compared to nonprofits and had fewer cancer patients; end-of-life care is much more expensive for cancer patients than for those with dementia. An earlier (2005) study

found that large, investor-owned hospices generate margins nine times higher than those of large nonprofits due to cherry-picking and paying lower salaries and benefits to less-skilled staff (Wachterman MW et al., "Association of Hospice Agency Profit Status With Patient Diagnosis, Location of Care, and Length of Stay," JAMA, Feb. 2, 2011).

> Hospice care costs for nursing home patients jumped nearly 70 percent between 2005 and 2009, from $2.5 billion to $4.3 billion, while the number of hospice patients increased by only 40 percent, according to the Office of the Inspector General (OIG). Hospices with a large share of patients in nursing homes were typically for-profit and appeared to seek out patients with certain characteristics associated with a longer life expectancy and lower demand for care.
>
> The Medicare program paid for-profit hospices more for patients than it paid nonprofit and government-owned hospices in 2009. For-profit hospices received about $12,600 per patient, while nonprofit and government entities received between $8,200 and $9,800 per beneficiary. (Charles Fiegl, "Medicare hospice care to face increased scrutiny," Amednews, 7/28/11; DHHS Office of the Inspector General, "Medicare Hospices that focus on Nursing Facility Residents," July, 2011).

- For-profit hospices also provide poorer care: a full range of end-of-life services is provided half as often, and family counseling services are received only 45 percent as often at for profit facilities compared to nonprofits. For-profit hospices are also only half as likely to provide palliative radiotherapy, a symptom-relieving treatment for cancer patients. Hospice facilities are usually not chosen by the family: they are recommended by nursing home or hospital staff. For-profit hospices also recruit patients directly from nursing homes and hospitals; Miami-based VITAS Hospice Services, the largest nationwide hospice chain, pays a commission to recruiters who provide incentives to hospital and nursing home staff to refer profitable hospice patients. For-profit hospices have been indicted for paying kickbacks to medical staff for certifying patients as hospice-eligible without examining them. In 2008, Medicare expenditures on hospice exceeded $11 billion, serving more than 1 million patients (Marlys Harris, "The Big (and Profitable) Business of Dying, CBS MoneyWatch, 5/21/11; J. Perry and R. Stone, "In the Business of Dying: Questioning the Commercialization of Hospice," Journal of Law, Medicine and Ethics, 5/18/11).

PPACA—THE NEW HEALTH LAW

- High-risk insurance pools for people with pre-existing conditions covered only 18,313 people by mid-2011, far below the 375,000 projected for the program created under the federal reform law. In an attempt to beef up enrollment, people will no longer have to produce a letter of denial from an insurance company, brokers will receive commissions for signing people up, and premiums will be lowered (but not eliminated) in 17 of the 23 states where the plan is federally administered ("Changes to the Pre-Existing Condition Insurance Plan in Your State," HealthCare.gov, 5/31/11).

  Under PPACA, an estimated 28 million people, over half of all adults with family incomes below 200 percent of poverty, will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse, each year. PPACA expands coverage by expanding both Medicaid eligibility and premium subsidies for the purchase of private coverage through state insurance exchanges. Unfortunately, the new coverage will be very unstable, due to fluctuations in family income and composition, which are common in low-income families (Sommers and Rosenbaum, "How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," Health Affairs, February 2011).

- Three states (Maine, New Hampshire, and Nevada) have received a waiver from the PPACA rule that requires health insurers to spend at least 80 percent of insurance premium revenues on medical care, rather than administrative overhead or profits. Ten more states have waiver requests pending (AP, 6/04/11 and "Companies, unions wrestle with new health care requirement," John Fritze, The Baltimore Sun, 6/4/11).

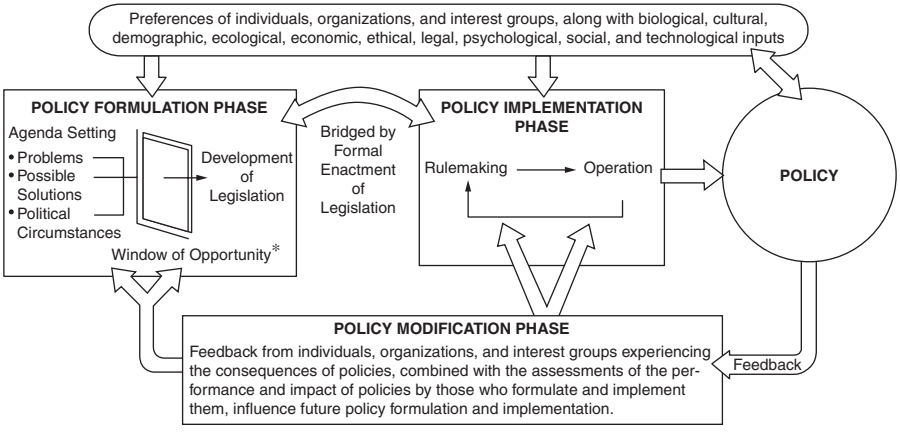
  In a case that will likely end up in the Supreme Court, the 11th Circuit Court of Appeals ruled 2–1 that the individual coverage mandate in the Patient Protection and Affordable Care Act is unconstitutional. The U.S. District Court for the Northern District of Florida went further, with Judge C. Roger Vinson arguing that the entire law be struck down because the rest of the law could not serve its purpose without the individual mandate. As former Labor Secretary Robert Reich said, "[no] federal judge has struck down Social Security or Medicare as being an unconstitutional requirement that Americans buy something . . . if the individual mandate to buy private health insurance gets struck down by the Supreme Court or killed off by Congress, I'd recommend President Obama immediately propose what he should have proposed in the beginning—universal health care based on Medicare for all, financed by payroll taxes." ("26 States Challenge Health Care Law in Court," Sarah Clune, PBS NewsHour, 6/08/11, and John Nichols, "Can we have health reform without an individual mandate?" 8/13/11).

- Most health insurance plans sold after Sept. 23, 2010, must provide at least $750,000 in coverage, increasing to $1.25 million in 2011 and be unlimited thereafter. However, four state governments (Florida, New Jersey, Ohio and Tennessee) and 1,372 companies and unions, covering a combined total of 3 million workers, have received federal permission to ignore PPACA and continue to offer skimpy coverage, such as so-called "mini-med" plans covering less than $10,000 in medical costs.
- McDonald's offers two levels of coverage to their employees: up to $2,000 in annual benefits for $56/mo. or up to $5,000 in annual benefits for $97/mo. Ruby Tuesday's mini-med plans restrict annual benefits to $1,250 in outpatient care and $3,000 in inpatient care; employees pay $18.43/wk. for the first 6 months, and $7/wk. thereafter. Dennys' hourly employees are provided up to $300 for doctor's visits annually, with no inpatient coverage ("What is a Mini-Med Plan?" The Henry J. Kaiser Family Foundation, 7/05/11).

The Process of Public Policymaking: A Conceptual Model

Beaufort B. Longest, Jr.

The most useful way to conceptualize a process as complex and intricate as the one through which public policies are made is through a schematic model of the process. Although such models tend to be oversimplifications of real processes, they nevertheless can accurately reflect the component parts of the process as well as their interrelationships. **Figure 1-1** is a model of the public policymaking process in the United States. A brief overview of this model is presented in this section.



*The window of opportunity opens when there is a favorable confluence of problems, possible solutions, and political circumstances.

Figure 1-1 A model of the public policymaking process in the United States.

Source: Longest, B. B., Jr. (2003). The process of public policymaking: A conceptual model. In P. R. Lee & C. L. Estes (Eds.), *The nation's health* (7th ed., pp. 129–142). Sudbury, MA: Jones & Bartlett.

Several general features of the model should be noted. First, as the model clearly illustrates, the policymaking process is distinctly cyclical. The circular flow of the relationships among the various components of the model reflects one of the most important features of public policymaking. The process is a continuous cycle in which almost all decisions are subject to subsequent modification. Public policymaking, including that in the health domain, is a process within which numerous decisions are reached but then revisited as circumstances change. The circumstances that trigger reconsideration of earlier decisions include changes in the way problems are defined as well as in the menu of possible solutions to problems. The new circumstances that trigger modification in previous decisions also routinely include the relative importance attributed to issues by the various participants in the political marketplace where this process plays out over time. For example, a problem with a low priority among powerful participants in the policymaking process may elicit a limited or partial policy solution. Later, if these participants give the problem a higher priority, a policy developed in response to the problem is much more likely. Another important feature of the public policymaking process shown in the model is that the entire process is influenced by factors external to the process itself. This makes the policymaking process an *open system*—one in which the process interacts with and is affected by events and circumstances in its external environment. This important phenomenon is shown in **Figure 1-1** by the impact of the preferences of the individuals, organizations, and interest groups who are affected by policies, along with biological, cultural, demographic, ecological, economic, ethical, legal, psychological, social, and technological inputs, on the policymaking process. Legal inputs include decisions made in the courts that affect health and its pursuit. Such decisions are themselves policies. In addition, decisions made within the legal system are important influences on the other decisions made within the policymaking process. Legal inputs help shape all other policy decisions, including reversing them on occasion when they are not consistent with the constitution.

A third important feature of the model is that it emphasizes the various distinct component parts of phases of the policymaking process, but also shows that they are highly interactive and interdependent. The conceptualization of the public policymaking process as a set of interrelated phases has been used by a number of authors, although there is considerable variation in what the phases of activities are called in these models as well as in their comprehensiveness. Brewer and de Leon (1983) provide a good generic example; Paul-Shaheen (1990) applies such a model specifically to health

policymaking. The public policymaking process includes three interconnected phases:

- policy formulation, which incorporates activities associated with setting the policy agenda and, subsequently, with the development of legislation;
- policy implementation, which incorporates activities associated with rulemaking that help guide the implementation of policies and the actual operationalization of policies; and
- policy modification, which allows for all prior decisions made within the process to be revisited and perhaps changed.

The formulation phase (making the decisions that lead to public laws) and the implementation phase (taking actions and making additional decisions necessary to implement public laws) are bridged by the formal enactment of legislation, which shifts the cycle from its formulation to implementation phase. Once enacted as laws, policies remain to be implemented. Implementation responsibility rests mostly with the executive branch, which includes many departments that have significant health policy implementation responsibilities—for example, the Department of Health and Human Services (DHHS) (http://www.dhhs.gov) and the Department of Justice (DOJ) (http://www.usdoj.gov), and independent federal agencies, such as the Environmental Protection Agency (EPA) (http://www.epa.gov) and the Consumer Product Safety Commission (CPSC) (http://www.cpsc.gov). These and many other departments and agencies in the executive branch of government exist primarily to implement the policies formulated in the legislative branch.

It is important to remember that some of the decisions made within the implementing entities, as they implement policies, become policies themselves. For example, rules and regulations promulgated to implement a law and operational protocols and procedures developed to support a law's implementation are just as much policies as is the law itself. Similarly, judicial decisions regarding the applicability of laws to specific situations or regarding the appropriateness of the actions of implementing organizations are decisions that are themselves public policies. It is important to remember that policies are established within both the policy formulation and the policy implementation phases of the overall process.

The policy modification phase exists because perfection cannot be achieved in the other phases and because policies are established and exist in a dynamic world. Suitable policies made today may become inadequate with future biological, cultural, demographic, ecological, economic, ethical, legal,

psychological, social, and technological changes. Pressure to change established policies may come from new priorities or perceived needs by the individuals, organizations, and interest groups that are affected by the policies.

Policy modification, which is shown as a feedback loop in **Figure 1-1**, may entail nothing more than minor adjustments made in the implementation phase or modest amendments to existing public laws. In some instances, however, the consequences of implementing certain policies can feed back all the way to the agenda-setting stage of the process. For example, formulating policies to contain the costs of providing health services—a key challenge facing policymakers today—is, to a large extent, an outgrowth of the success of previous policies that expanded access and subsidized an increased supply of human resources and advanced technologies to be used in providing health services.

One feature of the public policymaking process that the model presented in **Figure 1-1** cannot adequately show—but one that is crucial to understanding the policymaking process—is the *political* nature of the process in operation. While there is a belief among many people—and a naive hope among still others—that policymaking is a predominantly rational decision-making process, this is not the case.

The process would no doubt be simpler and better if it were driven exclusively by fully informed consideration of the best ways for policy to support the nation's pursuit of health, by open and comprehensive debate about such policies, and by the rational selection from among policy choices strictly on the basis of ability to contribute to the pursuit of health. Those who are familiar with the policymaking process, however, know that it is not driven exclusively by these considerations. A wide range of other factors and considerations influence the process. The preferences and influence of interest groups, political bargaining and vote trading, and ideological biases are among the most important of these other factors. This is not to say that rationality plays no part in health policymaking. On a good day, it will gain a place among the flurry of political considerations, but "It must be a very good and rare day indeed when policymakers take their cues mainly from scientific knowledge about the state of the world they hope to change or protect" (Brown 1991, 20).

The highly political nature of the policymaking process in the United States accounts for very different and competing theories about how this process plays out. At the opposite ends of a continuum sit what can be characterized as strictly public-interest and strictly self-interest theories of the process. Policies made entirely in the public interest would be those that

result when *all* participants act according to what they believe to be the public's interest. Alternatively, policies made entirely through a process driven by the self-interests of the diverse participants in the process would reflect an intricate calculus of the interplay of these various self-interests. Policies resulting from these two hypothetical extremes of the way people might behave in the policymaking process would indeed be very different.

In reality, however, health policies always reflect various mixes of public-interest and self-interest influences. The balance between the public and self-interests being served are quite important to the ultimate shape of health policies. For example, the present coexistence of the extremes of excess (e.g., exorbitant incomes of some physicians and health plan managers, esoteric technologies, and various overcapacities in the healthcare system) alongside true deprivation (e.g., lack of insurance for millions of people and inadequate access to basic health services for millions more) resulting from or permitted by some of the nation's existing health policies suggests that the balance has been tipped too often toward the service of self-interests. This aside, public policymaking in the health domain in the United States is a remarkably complex and interesting process, although, as in all domains, clearly an imperfect process. One should keep in mind, as the separate components of the public policymaking process are examined individually and in greater detail, that policymaking, in general, is a highly political process; that it is continuous and cyclical in its operation; that it is heavily influenced by factors external to the process; and that the component phases and the activities within the phases of the process are highly interactive and interdependent.

SUMMARY

Health policies, like those in other domains, are made within the context of the political marketplace, where demanders for and suppliers of policies interact. The demanders of policies include all of those who view public policies as a mechanism through which to meet some of their health-related objectives or other objectives, such as advantage. Although individuals alone can demand public policies, the far more effective demand emanates from organizations and especially from organized interest groups. The suppliers of health policy include elected and appointed members of all three branches of government as well as the civil servants who staff the government.

The interests of the various and very diverse demanders and suppliers in this market cannot be completely coincident—often they are in open conflict—and the decisions and activities of any participants always affect and

are affected by the activities of other participants. Thus, public policymaking in the health domain, as well as in other domains, is very much a human process, a fact with great significance for the outcomes and consequences of the process.

The policymaking process itself is a highly complex, interactive, and cyclical process that incorporates formulation, implementation, and modification phases.

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What Is a National Health Policy?

Vicente Navarro

A key objective of a national health policy should be to create the conditions that ensure good health for the entire population. Needless to say, all sectors and agencies in society should be responsible for creating those conditions, but the primary responsibility for ensuring the conditions for good health lies with the collective agencies that represent the interests of the population (freely expressed through democratic institutions)—that is, the public authorities and their public administration. Government (at the national, regional, and local levels), therefore, is the primary agency responsible for developing a national health policy.

What are the major components of a national health policy? There are three main types. The first includes public interventions aimed at establishing, maintaining, and strengthening the political, economic, social, and cultural *structural determinants of good health*. They are called *structural* because they are part of the political, economic, and social structure of society and of the culture that informs them. Although rarely listed in most national health plans, these are the most important public policies in determining a population's level of health. Indeed, there is very robust scientific evidence that shows, for example, that countries with lower class, race, and gender inequalities in standard of living also have better levels of health for the whole population (1).

The second type of intervention includes public policies aimed at individuals and focused on changes in individual behavior and lifestyle. These *lifestyle determinants* are also very important and have been the most visible among national health policies. One reason for the higher visibility of interventions of this type is that health policy makers perceive them as more manageable and easy to deal with than the first type, the structural determinants. However, we cannot exclude the possibility that another reason for this difference in visibility is that the lifestyle determinants focus the responsibility

Source: Navarro, V. (2007). What is a national health policy? *International Journal of Health Services, 37*(1), 1–14.

for a population's health on the individual rather than on the public institutions that are primarily responsible for the structural determinants.

The third type of public intervention, which I would call *socializing and empowering determinants*, links the second type (lifestyle determinants) with the first (structural determinants). Socializing and empowering interventions establish the relationship between the individual and the collective responsibilities for creating the conditions to ensure good health. This type of intervention would include the encouragement of individuals to become involved in collective efforts to improve the structural determinants of health, such as reducing the social inequalities in our societies or eliminating the conditions of oppression, discrimination, exploitation, or marginalization that produce disease.

STRUCTURAL DETERMINANTS: POLITICAL, ECONOMIC, SOCIAL, AND CULTURAL HEALTH POLICY INTERVENTIONS

The agents that carry out interventions of this type are collective (i.e., they are not individual persons), including political parties, trade unions, neighborhood associations, and others. The subjects of these interventions, too, are not individual persons but public and private institutions whose actions affect the conditions that ensure good health for the entire population. These interventions can be summarized as follows.

Public Policies Aimed at Encouraging Participation and Influence in Society

These extremely important interventions are aimed at facilitating the development of institutions and practices that create the conditions for persons (as members of social classes, genders, races, ethnic backgrounds, regions, or nations) to make decisions about and control their own lives. Interventions of this type are aimed at establishing institutions and practices that minimize popular alienation and powerlessness—conditions that cause a huge amount of pathology and ill-health (2). Of particular importance are interventions aimed at *providing political and social instruments* (such as political parties, trade unions, neighborhood associations, social movements, patients' groups) for the population and its different components. These instruments then facilitate and stimulate the population's active involvement in its members' political and social lives, deciding on the matters that affect their lives.

Economic and Social Determinants

These are the interventions that aim at creating security and facilitating accomplishment. They include the following.

Full-employment policies aimed at creating good, well-paid, satisfying jobs. Access to plenty of jobs gives everyone a greater sense of security—including those who do not currently have a job (because they feel they could easily get one if they wanted to). Not being able to work because one cannot get a job creates huge health problems (3). These unhealthy consequences of unemployment are due not only to lack of resources but also to the feelings of insecurity that unemployment entails.

Social security and welfare state policies provide a sense of security to people who are at risk, providing them with the instruments, knowledge, practice, and resources to feel secure and have a chance to progress. The indicators of these interventions are the social rights in existence in a society (access to medical care, education, home care, child care, social services, public housing, and pensions for elderly persons and people with disabilities) and the resources for developing these rights. Populations of countries with higher social rights and public social resources (including public funds and legislative power) are healthier than those of countries with lower social protections (1).

Policies on Reduction of Inequalities

Policies that reduce social inequalities (including income inequalities) by class and by gender, race, ethnicity, and region diminish the distance between social classes (and occupational, educational, and income groups within each social class) as well as between genders and among races, ethnic groups, and regions. Social inequalities can generate pathology and reduce the opportunities for persons to become healthier (4). Policies on reducing inequalities should include measures aimed at diminishing the social distances among all classes and groups, not only between rich and poor. There is strong empirical evidence that the most effective intervention to save lives and decrease mortality would be one that guaranteed a mortality rate for all social classes that is the same as that of the upper class (5). In this sense, antipoverty programs and programs aimed at preventing social exclusion (which characterize the Blair government's approach to reducing inequalities in Great Britain) are very important components of inequality-reducing policies, but they are just one component, and not the most effective. Policies aimed at reducing inequalities among all sectors of the population (that is, universal policies rather than antipoverty or anti-exclusion policies), such as those carried out by the social democratic governments in Sweden, are more effective in reducing mortality and morbidity (including among the poor and/or excluded groups) than are poverty-oriented policies (6).

Cultural Interventions

Cultural interventions are aimed at creating a culture of solidarity rather than a culture of competition. A strong sense of competition creates enormous insecurity and stress, which produces a lot of pathology. This was shown when Thatcher's liberal policies were established and developed in Great Britain, with a consequent fall in the rate of mortality decline across all age groups (7). A culture of high competition that focuses on individual competitiveness (reflected in the slogan "everyone should fly on their own") is unhealthy, because this creates anxiety and frustration.

Some cultural traits can also be very unhealthy, such as the excessive commercialization of society and the preponderance of the values of egocentrism, narcissism, consumerism, violence, and hedonism, which also create stress and frustration. The definition of beauty as "young and sexy," for example, is very exploitative; it generates great frustration among the majority of people who are not young or sexy (but feel they must strive to appear so in order to be accepted in our society). Also, the ubiquitous presence, in most countries, of members of the upper middle class as the main characters in television programs creates frustration among viewers, most of whom are working class (whose lives are rarely presented in the media).

Healthier Working Life Interventions

These interventions aim at creating safe, satisfying, creative, and enjoyable work. There is strong evidence to suggest that the nature, type, and conditions of work are among the most important variables determining a population's level of health (8).

Environmental and Consumer Protection

This protection is aimed at improving the physical environment for workers, consumers, and residents, thus ensuring conditions that protect and promote health.

Secure and Favorable Conditions During Childhood and Adolescence

Interventions of this type are among the most effective ways of reducing poverty and preventing social exclusion. Here, again, there is plenty of evidence that children and adolescents in families that are poor feel excluded (9). It is therefore of great importance to provide good remedial education from birth to age 18 (including good child care services) and good jobs for parents (especially for single mothers) in order to prevent social exclusion.

Health Care Interventions That Promote Health

These policies should emphasize public health interventions, both outside and within medical care services that cover the entire population. The medical care services should be designed in a way that facilitates access, comfort, and satisfaction for users and the population at large. Also, health promotion should be a key element of the medical care system, and all health personnel (particularly physicians and other health professionals) should be trained in the political, economic, social, and cultural determinants of health as well as in individual lifestyle interventions.

LIFESTYLE INTERVENTIONS

Lifestyle interventions, as the name indicates, are aimed at changing the unhealthy behaviors of individuals. These are the most classical interventions and the most visible components of health promotion. They include the following.

Interventions on Safe Sexual Behavior and Good Reproductive Health

These interventions are aimed at developing sexuality as a human right, separating enjoyment and pleasure from reproduction. Sexuality should be seen as an enjoyable activity and a component of human caring, and positive views about sex should be promoted. Information about sexuality should be available to all age groups, starting with the young. People should be able to express their sexual identity freely, without discrimination, and reproductive health information and care should be available to all persons who may benefit from it.

Increased Physical Activity

This is an important but not highly visible health-enhancing intervention that prevents, among other diseases, hypertension and type 2 diabetes, which are increasing among obese and sedentary people. The public authorities should promote physical activity in preschools, schools, and centers of work and learning, and should encourage the use of bicycles and walking.

Good Eating Habits and Safe Food

This type of intervention addresses one of the most important aspects of improving health, because at least 30 percent of disease can be related to eating behaviors. Being overweight is now one of the main health problems

in developed countries. It is imperative, therefore, that (a) good and healthy food should be widely available to the whole population, including a wide variety of food choices; (b) food should be safe, with delinquent corporate behavior, as well as restaurants responsible for food poisoning, strongly penalized; (c) the public should be fully informed about the caloric content and composition of all food products; and (d) the public should be educated about the relationship between food and health.

Reductions in Tobacco and Alcohol Consumption, Drug Use, and Excessive Gambling

Tobacco addiction is a disease and should be cured by helping the individual control his or her addiction. The tobacco industry should be prohibited from encouraging that addiction. Tobacco advertising targeted to the young should be made illegal, and advertising should be restricted to certain forums, with restriction of ads on radio and television. Tobacco should be highly taxed, with the collected funds assigned to programs aimed at curing tobacco addiction. Tobacco industry contributions to political parties or candidates or to political and social causes should be outlawed. Smoking should be forbidden in all public spaces, restaurants, theaters, streets, and workplaces.

Alcohol consumption should also be reduced (it has increased in the countries of the Organization for Economic Cooperation and Development), and alcoholic beverages should be taxed according to their alcohol content. Alcohol consumption should be allowed only in restricted areas and not in public places, such as streets, theaters, or sports forums.

Individuals who are addicted to drugs should be assisted and not penalized (except when drugs are consumed in public places), but the distribution of drugs should be strongly penalized.

EMPOWERMENT STRATEGIES

Empowerment strategies should help individuals link their personal struggle for improved health with the collective struggle to improve everyone's health. Individual commitment to improving other people's health improves one's own health—that is, commitment and solidarity are good for your health. *Commitment* means a desire to serve others; *solidarity* means development of networks of support in a joined cause to improve individual and collective health. Moreover, a collective response strengthens individual efforts to gain power, thus empowering the individual. These linkages between individual response and the collective, based on commitment and solidarity, are critical to achieving the structural determinants of good health.

Linking the individual and collective struggles (which has characterized the history of the labor movement, among other movements) predates the faulty concept of "social capital," widely used by some researchers in the field of inequality, which trivializes the concept of solidarity and its purpose. The famous Putnam vision (10) of encouraging social capitalists to be even better capitalists (as one of his chapter titles phrases it) and to win in the competitive world is different from the concept of solidarity. It is the opposite of what healthy social behavior should be and the opposite of what is advocated here—that is, to link the struggle for individual liberation and health with the collective struggle. The objective should not be to enhance competitiveness in our societies but rather to enhance solidarity (11).

I also disagree with the widely used concept of "social cohesion." This concept was established by the conservative and Christian Democratic traditions as a response to the labor movement's struggle to change society (12). Social cohesion can exist side-by-side with enormous exploitation. There are many cohesive societies, where the social order is widely accepted, but where cohesiveness masks widespread exploitation and high levels of disease. In fact, a healthy intervention may be needed to facilitate a collective response, by those who are exploited, against that very cohesiveness.

There is a need to favor the concept and use of solidarity and a solidarious society as an alternative to a highly competitive society in which social capital helps individuals compete better. The ideas outlined in this article present an alternative to the dominant and hegemonic views in our societies. Still, we have recently witnessed some developments that are encouraging. Among them is the Swedish social democratic government's national health plan, which includes many of the structural and individual determinants of health and represents a gigantic step in the correct direction. It is important to expand these interventions along the lines outlined in this article, as well as to include the empowerment strategies referred to here. As it now stands, Sweden's national health plan is the most progressive such plan in existence. It is developing a strategy that far surpasses the narrow, reductionist view that tends to limit health policy to medical care interventions. Still, more needs to be done.

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Passing Legislation Requires More Than Good Ideas and Prayers

Catherine J. Dodd, MS, RN, FAAN

The result of Otto von Bismarck's famous quote, "Laws are like sausages—it is better not to see them be made" (BrainyQuote.com, 2006), is that politics is often left to those with iron stomachs. Because legislation, according to health economist Paul Feldstein, "redistributes wealth" (1996, p. 17), it is essential that pragmatic idealists—both the self-appointed guardians of the public good and elected officials—participate in the political process. Only their cooperation can ensure that health policy is not designed by and implemented by the well-financed interest groups motivated only by profit.

Politics has been defined as "the art and science of government," and political affairs as "competition between competing interest groups of individuals for power and leadership" (Morris, 1969, p. 1015). The division of scarce resources is almost without exception political, being characterized by competition between interest groups, some more powerful than others. It is rarely fair. Political decisions are not made during the hearings in the hallowed halls of the Capitol. Rather, political decisions are made long before the day of the vote and are based on external influences that may or may not include expert knowledge.

Political decisions influence many aspects of our daily lives. Politics determines the outcomes of proposals in governing bodies, in the workplace, in the neighborhood, and at the dinner table. Parents may decide which child gets the largest piece of pie based on who has been the most helpful around the house or who has completed their homework. Similarly, a state legislator may vote to fund a new health center because many voters from that neighborhood support her, even though that decision may jeopardize another

Source: Catherine J. Dodd, MS, RN, FAAN. (2006). Play to win: Know the rules. Catherine Dodd has served as the District Director for Democratic Leader, Congresswoman Nancy Pelosi. Prior to that, she was an appointee of President Bill Clinton, serving as the Regional Director for the U.S. Department of Health and Human Services, Region IX, under Cabinet Secretary Donna Shalala. This article was revised from the fifth edition of this book.

clinic in another legislative district. Those who fail to participate in the political process are allowing the decisions to be made by people who may seek to control resources for their own personal or political gain (Dodd, 2004).

Political expertise is essential for success in organizations, institutions, and local, state, and national governments. Developing and maintaining political power requires establishing and maintaining relationships. It also takes time and practice.

TEN UNIVERSAL COMMANDMENTS OF POLITICS AND REASONS TO OBEY THEM

1. The personal is political. Each of us is just one personal or social injustice away from being involved in politics.
2. In politics, friends come and go but enemies accumulate.
3. Politics is the art of the possible. The majority rules.
4. Be polite, be persistent, be persuasive, and be polite.
5. Ignore your mother's instructions. Talk to strangers.
6. Money is the mother's milk of politics.
7. Negotiate visibility. Take credit, and take control.
8. Politics has a "chit economy," so keep track.
9. Reputations are permanent.
10. Don't let 'em get to you.

1. The personal is political. Each of us is just one personal or social injustice away from being involved in politics. Every vote counts.

Injustices and tragedies, whether individual or collective, often ignite social movements that result in advocacy and collective action. Elected officials are inspired to introduce legislation because of their own personal experience or the experience of someone they know, or because of collective demands of constituents.

Representative Caroline McCarthy, LPN, ran for Congress and was elected after her husband and child were shot on the New York subway. She promised the voters that she would fight for stricter gun laws. She challenged the National Rifle Association (NRA) enthusiasts, who believe their personal freedom will be impinged upon by limiting access to automatic weapons, and who frequently initiate very successful letter writing and e-mail campaigns in key congressional districts to protect their "constitutional rights." NRA activists also raise money for *key* candidates from members all over the country.

MADD (Mothers Against Drunk Driving) was founded in 1980 by Candace "Candy" Lightner, whose 13-year-old daughter was killed by a drunk driver. Today, MADD is the largest crime-fighting organization in the country, with chapters in every state. Its members include relatives and friends of victims of drunk drivers as well as health professionals and supportive members of the public. MADD has been extremely effective in achieving its objectives at the local level, lobbying for speed bumps and the installation of stoplights; at the state level, increasing penalties for drunk driving, and at the national level, placing restrictions on alcohol advertising (Mothers Against Drunk Driving [MADD], 2011).

Many health advocacy organizations, such as Families USA (www.familiesusa.org), emerged from the movement to support access to health care. The recent proposals to privatize Social Security and Medicare helped increase the national membership of the National Committee to Preserve Social Security and Medicare (www.ncpssm.org). Environmental health (www.breastcancerfund.org) and social justice organizations have emerged to address the unfair burden of exposure to toxic chemicals borne by communities of color located in polluted neighborhoods (www.ejfoundation.org).

The more voices that participate in our democracy, the more likely that the weakest voices will be heard. Individuals who choose not to vote or not to be involved in politics, in essence, relinquish their power to those who do vote. Long ago, Plato advised that "One of the penalties for refusing to participate in politics is that you end up being governed by your inferiors" (en.thinkexist.com, 2006).

Every person can make a difference, especially when one considers how the outcome of an election may affect the lives of those who do not believe that their voices count. Many recent elections at all levels of government have been decided by one or fewer votes per precinct.

2. In politics, friends come and go but enemies accumulate.

This old adage can be applied to many relationships. Its application includes two important concepts: Never surprise your friends, and politics makes strange bedfellows. It is imperative to not jeopardize working relationships, with public officials or other advocates, by publicly opposing someone, by not inviting them to a meeting, or by voting against them without talking to them before taking action. Maintaining relationships does not require disclosing strategy; it means simply showing respect for the right of others to have a different perspective. Trust and respect are commodities in politics that once

lost, are rarely regained. While you may disagree on one issue, there may exist agreement on another issue, and a relationship sustained by respect allows for discussion, compromise, and progress. Handling conflicts respectfully will allow for future collaboration. Maintaining working relationships allows for "strange bedfellows." Managing conflicts respectfully allows for future collaboration with partners who may agree with your position on other issues.

For example, advocates for women's and children's health frequently testify to protect women's reproductive freedom and argue against the testimony of advocates from conservative religious organizations. On issues affecting children's health, however, the two organizations come together as strange bedfellows and make powerful allies. The late Senator Ted Kennedy, a strong advocate of women's reproductive freedom and health coverage for children, joined Representative Orrin Hatch, an opponent of women's reproductive freedom and supporter of children's health, to introduce the State Children's Health Insurance Program (SCHIP). Senator Kennedy and Representative Hatch had the support of religious organizations and women's and children's groups. The passage of SCHIP during the Clinton administration was an example of bipartisan efforts that would not have been possible if conflicts on other issues had not been laid aside.

3. Politics is the art of the possible. Count votes in advance. The majority rules.

The policies that are adopted and the legislation that is signed into law reflect compromise and rarely resemble what was initially introduced. Successful politicians strive for what is possible. In diverse political cultures where there are many different opinions and philosophies, the most successful legislators are those with an ability to find compromises acceptable to the majority that do not destroy the intent of the original legislation. Votes are not won during dramatic debate on the floor of the House or Senate. Instead, they are won one by one, by talking to individual legislators, seeking their support, and finding out what compromises would be required to gain their support. Sometimes asking others for assistance in lining up additional votes is necessary. Once commitments are made they are rarely changed, because trust is the basis of future relationships. If legislation is controversial, legislators may not commit to a position until the actual vote because no one wants to be the "deciding vote." Legislators do not willingly vote for legislation that is opposed by powerful lobbies if they believe the legislation is going to fail anyway (because friends come and go but enemies accumulate, and no one wants to alienate powerful lobbies if the bill will fail anyway).

For example, strange bedfellows came together to oppose the passage of the 2003 Medicare Modernization Act, which represented the first major change to Medicare in more than 25 years. The act added some coverage for prescription drugs for seniors. Conservative Republicans opposed the law because it would cost too much; almost all Democrats opposed it because it was not comprehensive and did not impose cost controls on the pharmaceutical industry. The vote count was one vote away from passage, and a handful of conservative Republicans finally agreed to support the legislation when a section was added to begin to privatize Medicare in 2010. This part of the act was not debated: The party in the majority makes the rules, and the Republicans ruled that no debate was needed, despite opposition to this move from Democrats. On the day of the vote on the Medicare Modernization Act, pharmaceutical company lobbyists, who are known for their large campaign contributions, made calls to legislators who were uncommitted and who had competitive elections, as did President George W. Bush. The vote was ultimately "held open" into the middle of the night, longer than the House rules allowed for, until enough votes had been changed to pass the bill.

If the margin for passage of a law is close, how a legislator votes usually depends on whether the voters in his or her district care about the issue and on whether major campaign contributors support or oppose the issue. Advocates need to be certain of those votes they can count on and then ensure that the supporting legislators, board members, and so forth will be in attendance the day the vote is scheduled, especially if it is expected to be close.

Many people wonder why so few pieces of legislation are passed and signed into law. Two factors explain this phenomenon.

Since the 1994 elections, Congress and state legislatures have become more partisan, and the voters have become disillusioned with "incumbents—career politicians." In 1993, Congress spent an entire year debating President Clinton's health care reform proposal. Special interests (against reform) targeted candidates in swing districts who supported reform, spending $400 million to ensure their defeat. For the first time in 40 years, the Republican Party gained a majority in both houses of Congress (the Senate and the House of Representatives; see **Tables 1-1** and 1-**2** for a summary of their organization). The 1994 elections produced a class of "freshmen" (new senators and representatives) dominated by business people/owners who lacked experience in negotiating with other people who hold entirely different philosophies or agendas. These new legislators simply refused to negotiate with their Democratic colleagues, leading to legislative gridlock. In the corporate

Table 1-1 Congress at a Glance

Senate	*House of Representatives*
• Upper House • 100 members, two from each state • 6-year terms • One-third are up for election every 2 years	• Lower House • 435 members, apportioned every 10 years based on population changes • 2-year terms • Up for election every 2 years

Table 1-2 Congressional Leadership

Senate	*House of Representatives*
• Vice President of the United States	• Speaker of the House (majority party)
• President Pro Tempore	
• Temporary Presiding Officer	
• Majority Leader	• Majority Leader
• Majority Whip	• Majority Whip
• Minority Leader	• Minority Leader
• Minority Whip	• Minority Whip

world, of course, business owners who cannot agree on terms merely find other contractors.

The Republicans elected to the 104th Congress were also very conservative, and their majority created a more conservative Congress. This same trend was echoed throughout the country at the state and local levels as conservative (religious anti-women's reproductive freedom) campaign strategists successfully ran candidates in primaries who were then elected in the 1994 general elections, defeating Democratic career-politician incumbents. All votes cast in the subsequent 104th Congress were significantly more conservative on health, education, human services, and environmental issues than those produced by previous Congresses. Democrats representing swing districts voted more conservatively than they might have previously in an attempt to appeal to moderate Republicans in their districts during an election year. Elected officials do not ordinarily have this option, because they are elected by and work for the voters rather than for themselves. However, the Republicans' control of the Congress gave them more power to determine what would be negotiated and what would not even be discussed.

After President Bush's election in 2000, the Republicans had total, one-party control of the federal legislative agenda. The majority of states also had Republican governors. Following the 2000 census, not surprisingly state legislatures redrew district lines to enhance the election of Republicans in many states. These new lines served to solidify the Republican majority in Congress for the rest of the decade.

For legislation to pass, a majority of members of the legislature need to vote in for it. The *majority* rules in more ways than one. All parties have their own philosophies and agendas. The *majority* party determines which issues will be debated and whether the debate will allow for alternatives or compromise. Many pieces of legislation are introduced and never put on the agenda for consideration if the party in the *majority* does not want the issue considered.

Partisan ideology has taken the place of pragmatic bipartisan compromise and problem solving. The Republican ideology emphasizes competition in the "market" to reduce budgets. In contrast, the Democratic ideology favors greater public protection through government regulation and support for the poor. The increased partisanship in halls of government across the United States has produced very few compromises. Leadership in both parties is necessary for legislators to work together and, one by one, meet, talk, and identify acceptable compromises. When the Democrats regained control of the House in 2007 and Representative Nancy Pelosi was elected as the first woman Speaker of the House, she successfully prevented President Bush from privatizing Social Security. After President Obama's election she led passage of more legislation than any previous Speaker. She was instrumental in passing a stimulus package that created jobs, turning around a long period of job losses and passing much-needed regulation of Wall Street and the finance industry. She also was instrumental in the passage of the Affordable Care Act of 2010 (passed without one Republican vote), which set forth a plan to cover over 40 million uninsured Americans and which ended discrimination based on preexisting health conditions (Stone, 2010).

These bold actions by the majority party, and expansion of health coverage and regulation of the insurance industry, were opposed by the insurance industry and many conservatives who opposed government's involvement in health care. Congressional campaigns in November 2010 reflected "anti-big-government" rhetoric financed by the insurance industry, which resulted in the Democrats losing their majority in the House. The majority party determines what is accomplished. In the Senate more than a simple majority is needed; three-fifths or 60 votes are required to "invoke cloture" or close

debate, so many pieces of legislation are softened in order to gain enough votes to pass out of the Senate. Many ask why a "single-payer" or "public" option was not included in health reform. In January 2010, after the Democrats lost the Senate seat vacated by the death of Senator Ted Kennedy of Massachusetts, President Obama was fortunate to get a simple majority to pass the Affordable Care Act, and it would have been impossible to pass it with the House version, which contained a "public option," because of the need for 60 votes to close debate (or end a filibuster by the opposition). In the end it's about what is possible, not what is ideal.

4. Be polite, be persistent, be persuasive, and be polite. Send thank-you notes, write, write, write, ghost write, and write.

In this era of instant messaging, it is difficult to determine the preferred method of communication for individual elected officials. Elected officials listen to those who elect them and/or support them financially in their campaigns. Perennial voters (those who vote in every election, rain or shine) tend to be more highly educated and are more likely to write a letter or craft an e-mail message. For that reason, an individually written letter (mailed, faxed, or e-mailed—but not a chain message) is the most effective lobbying tool. Preprinted letters or postcards and "linked" e-mails off advocacy Internet sites are effective only in specific mass strategy campaigns. In general, phone calls urging a vote are used in last-minute attempts and are considered an effective lobbying tool only if they are from constituents who leave their addresses and ask for a written response explaining how the elected official plans to vote (or has already voted).

Letters from voters who live in the elected official's or legislator's district do make a difference. Some elected officials, however, believe their constituency goes beyond their legislative district. For example, an RN legislator may consider and respond to the opinions of RNs regardless of where they live, or a gay legislator may consider and respond to letters from people in the lesbian/gay/bisexual/transgender community regardless of where they live.

If your legislator is not a member of the committee that will hear the bill in which you are interested, find out the staff person who is assigned to the committee, address your letter to the Chair of the Committee "care of" the staff person *at the committee's address*, and then send a copy of your letter to your legislator with a brief note.

It is best to gather information about the legislator's position in advance by communicating with the staff person responsible for the issue. Call the capitol office and ask to speak to the staff person responsible for the issue; if he or she is unavailable, ask for an e-mail address. Thousands of constituents are making similar requests, so keep your communication clear and concise. Thank the staff person for his or her assistance, and if your legislator agrees with your position, write your letter or message so that it acknowledges the lawmaker's position and states that you are pleased with it. Communication with legislators should establish the sender's credibility as a constituent (e.g., a nurse, a mother, student, expert) and should be polite, persuasive, and succinct. Communications should state the sender's position early in the communication, offer support for the position with research or personal experience or belief, and ask for a response prior to the vote. This message is not a term paper, so it need not be perfect grammatically, only persuasive. It is likely to be read only by staff (unless the sender has a personal relationship with the elected official).

Multiplying the effectiveness of your effort by demonstrating broad support or opposition can be accomplished by assisting, collecting, and mailing similar letters from friends, family, and colleagues. When 1 letter arrives in a legislator's office, it is recorded; when 10 arrive, it becomes an issue of constituent concern; when 20 individually written communications arrive, staff alert the elected official. To be effective, letters must arrive before the vote is scheduled, so send them early. If the bill fails and is introduced in subsequent years, you must write again, and again, and again, if necessary. Many bills are amended during the process, so it is important that you continue to communicate with your legislator if you no longer support or oppose the bill along the way.

Always be polite: In talking to legislators, staff, or the press, never say or put in writing anything you do not want printed on the front page of the newspaper. Reputations are permanent (Commandment 9). Many a career has ended because of an angry quote (Commandment 2: Friends come and go but enemies accumulate).

The two most effective kinds of communication are thank-you notes and letters to the editor. If the legislator, organizational board member, or coworker takes the desired action, follow your mother's advice: Write a thank-you note! Everyone enjoys being recognized and thanked. Those colorful envelopes in the mail are the first to be opened by each of us, and elected officials are no exception. This kind of communication also shows

you are monitoring their vote. Politicians, like relatives and friends, remember people who send thank-you notes.

Letters to the editor and op-ed columns in local newspapers are extremely effective lobbying tools. The editorial section of the newspaper is the first section read by political staff each day because the opinions expressed are those of voters. Politicians give extra credence to letters to the editor for two reasons. First, the people who write these missives subscribe to the paper and are more likely to be perennial voters. Second, letters are not printed unless the paper has received more than one on the subject. Letters written by women are more likely to be printed because editors try to balance the page with equal numbers of letters from men and women. Agreeing with or lauding the paper for its coverage of an issue also increases the likelihood of publication. Letters from suburbs often have a better chance of being printed because they demonstrate a wide readership for the paper.

Health professionals have very high credibility, so a letter to the editor published in a local paper will have significant public influence that is recognized by politicians. Use your credentials.

Letters should be well written (they will be read by thousands of people) but should not exceed 250 words. (Many papers have publication policies that can be acquired from the paper's website or a call to the paper.) Letters can be e-mailed, faxed, or mailed and must include the address (and often the phone number) of the sender. Editors often contact the sender to verify or clarify the content of the letter. The same letter, with a different sender, can be submitted to a paper in another geographic area of the state or country.

Op-ed pieces should not exceed 750 words and usually require a four- to six-week lead time. Communicating first with the editor of the opinion page will increase the likelihood that an op-ed piece will be printed. Op-ed pieces are published on topics of broad interest. Generating letters to the editor to demonstrate interest in the subject or position prior to submitting an op-ed piece or following the publication of an op-ed piece is a more sophisticated and very effective strategy for influencing public opinion and hence the opinion of elected officials. The best way to plan an editorial page lobbying effort is to become acquainted with the editorial pages of the newspaper. If you want to be a future source as an expert, call the reporter and compliment him or her. If you are sending a positive letter to the editor, send a copy to the reporter because reporters do not see all the responses to their work.

Whether it is voting for a piece of legislation when it comes before the legislature or voting for a candidate in an election, health professionals are very persuasive. After all, if you can convince people to change their health

behaviors, you can surely convince them to vote. Health professionals are very effective in campaigns. When health professionals walk door to door for candidates or work on phone banks, voters listen. The public especially loves nurses and health professionals. Just about everyone has a relative who is a nurse, or a relative who was just cared for by a nurse. Nurses poll higher in public trust measurements than members of any other profession.

In 2002, a political action committee (PAC) was formed called Physicians for a Democratic Majority (www.demdocs.org). Many types of health professionals and students support this organization with both their time and money. In every general election, they pay the expenses of students, nurses, and physicians who are willing to go work in elections where the race is very close. They wear lab coats and name tags, and they talk to voters about why their votes are important. Another benefit of working on campaigns in this way is that legislative staff frequently take time off to work on campaigns, so you may meet the very people you will be contacting regarding legislation in the future.

5. Ignore your mother's instructions. Talk to strangers, or network. Carry business cards. Build your network. Flaunt your professional credential proudly.

Talking to strangers comes naturally to health professionals. Every new patient/client is first a stranger. If you go to an event and know very few people, act like a host. Introduce yourself. Practice your introduction, emphasizing what you want people to remember about you. Shake hands firmly, and make eye contact. Repeat the person's name when you are ending your conversation (this both endears you to the person—people like hearing their names—and helps you remember the person's name). Exchange business cards—and include your credential on your card. Don't let the cards you collect just pile up. Immediately after the event, write the date and event on the card and something about the person. Then, enter your contacts into your database with a "note" section so you will remember them and/or can search for them.

Strangers cease to be strangers when their business cards become part of a phone list or database to be used for political action or fundraising. Follow up with an e-mail or "nice to meet you" card that endears you to your new network member. It really becomes a small world when strangers talk to strangers and they become friends and create networks.

In garnering support or opposition for issues or candidates, no one is a stranger to health professionals. If you are an RN, print "RN" on your

checks after your name so candidates will know they've received hard-earned "nursing money."

6. "Money is the mother's milk of politics." Give it early; if you don't have it,raise it.

The invention of television, which allowed candidates to speak directly but not personally to voters, has diminished the importance of political parties as the mechanism for establishing party philosophy and disseminating political messages to voters. Television has not changed who has the right to run for office (any citizen can run, and only the president must be a native-born citizen of the United States), but it has changed who wins. Candidates who cannot afford television time invest targeted direct mail to bring their messages directly to your mailbox in well-planned, nonsubstantive glossy brochures. Targeted direct mail lists are purchased from campaign consultants who obtain voter information from the local Registrar of Voters and sort the data by any number and combination of fields depending on the target audience, such as who voted in the last three elections (called likely or perennial voters), political party, sex, age, votes by mail, owns or rents home, and neighborhood. The strategy in direct mail campaigning focuses on projecting how many votes are needed from the target audiences and then tailoring the message to that audience. The narrower the target, the higher the cost of the segmented campaign literature. Likewise, the more TV spots purchased during prime time, the higher the cost of the air time. Getting messages to voters is expensive.

Campaigns require money and more money, hence the saying, "Money is the mother's milk of politics" (Jesse Unruh, former State Treasurer of California). The amount of money candidates raise early in their campaigns determines each candidate's viability later in the race. The American Nurses Association (ANA) PAC is an example of a political organization that supports candidates who support nursing's positions on issues. It has raised (from members in contributions averaging $40) and contributed more than $1 million in each congressional election since 1994. In evaluating candidates before primaries (when there are often several candidates in the field) for possible early endorsement, the PAC staff members compile information on how much money each candidate has raised and how much is projected to be spent. How much money has been raised gives an idea of the candidate's viability. PACs do not support candidates who cannot raise enough money to win their election. If some candidates have not raised much money but others have, the field of possible endorsements is narrowed to those who are serious about winning.

EMILY's List (www.emilyslist.org) is an example of a national fundraising effort for pro-choice Democratic women candidates. EMILY stands for "Early Money Is Like Yeast": The organization believes that contributing to women candidates early helps them establish their viability as credible candidates and therefore to raise other funds. Republican women have a similar organization called the Wish List (www.thewishlist.org).

People and organizations that provide early financial support are always remembered once politicians get elected, because the winners know they would not have been elected without these early supporters. Relationships made early in campaigns may have exponential returns because many elected officials run for higher office—and those relationships are forever.

Many people are not affluent and cannot afford to make large contributions. Remember the networking principle (Commandment 5), and call friends, relatives, and colleagues to collect $10 to $50 from each contact. Collecting eight $25 contributions raises $200. Volunteering to help make fundraising calls is a key campaign activity. The worst that can happen is the person will say "no."

Most people can afford a contribution of $45 per year (less than $5 per month) to a PAC that stands for their beliefs or to a political party. Raising and contributing money to friends of health care is important both for the candidate and for your profession. Some candidates are "shoe-ins" or in safe seats (where the voter registration favors their party) and are likely to be elected or re-elected. Nevertheless, they need to raise money so they can assist candidates in other parts of the state or country. Gaining leadership positions in elected bodies and recruiting allies for legislation require the support of colleagues, and one way to garner that support is to help raise money for colleagues who are in tight races who are seeking leadership positions. This is especially true when the number of terms an elected official may serve is limited by statutory term limits; this constraint requires them to climb to a leadership position much faster.

7. Negotiate visibility. Take credit, and take control.

Throughout history, different professions have had varying degrees of influence in legislative bodies. Today, the American Medical Association, the HMO industry, the pharmaceutical industry, and the nursing home industry (to name only a few) have significant power in the legislature. Not surprising, all of these entities contribute generous sums to candidates from both parties. The profession of nursing, while held in high regard by the public, has not

been given (or taken) credit for the essential role that nurses play within health care systems. Traditionally, nurses, social workers, and public health advocates have had little control over the systematic decisions being made by health corporations and the business people and physicians who often control them.

Taking control requires taking credit, whether in the health care system or in politics. When a "Nurses for Nancy Pelosi for Congress" group raises $1,000 and produces 10 volunteers every Saturday, its members must negotiate visibility for nursing or for a few key nurses in the campaign. Credit may take the form of listing nurses on every piece of campaign literature, or getting 10 seats at a large fundraising dinner instead of only 5, or being included in the candidate's policy "kitchen cabinet." Visibility is never offered; it must be asked for and negotiated. First-time candidates and candidates in swing or highly competitive races never forget individuals and constituencies who were visible in difficult races. The Physicians for a Democratic Majority ("DemDocs") PAC, for example, has been included on several citizen advisory committees organized by members of Congress because members' visibility was so effective in getting out the vote (GOTV) in key races.

8. Politics has a "chit economy," so keep track. Seniority counts.

Commandment 3 requires an ability to communicate, in some instances to ask for help, and then to count votes. Most people like to help—but this help comes at a price. The exchange of votes, lining up votes, raising money, and mobilizing volunteers to walk precincts are all activities that accrue chits. For elected officials, chits are exchanged for appointments to key committees and for leadership positions. At the federal level, the longer the tenure of the legislator, the higher his or her rank, regardless of the person's status as a member of the majority or minority party. Seniority is given consideration in committee assignments, so it is to a district's or state's advantage to re-elect incumbent legislators who have good voting records. For individuals, chits mean access, support on key issues, and appointments to board and commissions.

9. Reputations are permanent.

In politics, as in life, there is no asset more important to success than a positive reputation. No one assigns reputations; they are earned and remembered. A key ingredient in developing a positive reputation is dependability. Deliver promptly what has been promised, whether it is an article, names and addresses of possible supporters, campaign funds, or volunteers. Answer questions honestly and directly, and offer to research unknown information.

Return calls and respond to requests for assistance. These are routine practices of dependable people. If you identify yourself as an RN or as a member of an organization, the impression you leave is a reflection of the profession and the organization you say you represent, so make them proud to have you represent them.

In a congressional election for an open seat (no incumbent running), an RN activist promised to provide the American Nurses Association's position statements on issues to assist with the candidate's platform development after the candidate had been endorsed by the ANA PAC. Within two days, the RN activist had been asked to draft the candidate's statements on health care, and she later became a staff member to that member of Congress. If the RN activist had failed to follow through on the promise of assistance, her credibility and nursing's reputation would have been tarnished.

10. Don't let 'em get to you.

Remember the words of childhood: "Sticks and stones may break my bones, but words can never hurt me." Use this mantra: "I'm glad I'm here, I'm glad you're here, I know what I know, and I care about you." Or just picture those who mock you or challenge your positions sitting on a bedside commode in a hospital patient gown (nobody is attractive in a patient gown)!

Eleanor Roosevelt once said, "No one can make you feel inferior without your permission." Unfortunately, a sense of inadequacy and inferiority has often been part of the socialization of women. To overcome this ingrained subliminal sense, when addressing hostile audiences (or any audiences, for that matter) the mantra mentioned previously does two things. First, it causes you to smile because it sounds so corny. Second, that smile warms the audience and makes them more friendly. This is as true of two-year-olds as it is of adults.

Regrettably, we live in a world that thrives on crises and negativity. Negative campaigns cast doubts on the character and abilities of candidates. Doubt translates into not voting for a particular candidate, or not voting at all. Recognize that negative comments are going to be made and reported. Rebuttals are not always possible and are often wasted on hysterical, angry responses. The best defense is a good offense: Accept that comments will be misinterpreted and reported, and measure your response just as you did on the playground in grade school. Correct the misinterpretation, refute the allegation, and repeat over and over to yourself: "Sticks and stones may break my bones, but words can never hurt me."

SUMMARY

Health care professionals have a unique and broad perspective on the health care delivery needs of individuals and populations. They also have excellent communication skills and organizational skills. Few other professions are so well suited to be activists, lobbyists, leaders, and legislators. Failure to apply these skills and unique expertise in politics is to fail the patients who rely on us. As Margaret Sanger, a graduate public health nurse who founded Planned Parenthood, once said, "If one is to truly live, one must put one's convictions into action." So get involved!

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The New Economic Insecurity—And What Can Be Done About It

Jacob S. Hacker, PhD

Over the past generation, the economic risks American families face have increased substantially. Yet public programs have largely failed to adapt to these new and newly intensified risks, and private workplace benefits have eroded.[1] As a result, Americans increasingly find themselves on an economic tightrope, without an adequate safety net if, as is ever more likely, they lose their footing. This tightrope both creates anxiety about the future and causes hardship when families do lose their balance. But importantly, it also threatens opportunity by making it more difficult for families to feel sufficiently secure to look confidently toward the future and make the risky investments—in skills, education, and assets—necessary to prosper in a highly dynamic and uncertain economy.

In response to these worrisome trends, I call for a "security and opportunity society"—a vision that is starkly opposed to the ideal of an "ownership society" outlined by leading conservative critics of the welfare state.[2] The premise of the conservative ownership society is that we can be free to pursue the opportunities in our lives only if we do not share risks with others—if, for example, we have an individual Social Security account from which we alone benefit in retirement, or a personal Health Savings Account that allows us to finance routine health expenses solely on our own. A security and opportunity society, by contrast, is based on a very different premise: that we are most capable of fully participating in our economy and our society, and most capable of taking risks and looking toward our future when we have a basic foundation of financial security. In this view, economic security is not at odds with economic opportunity; it is its cornerstone. Restoring a measure of economic security in the United States today is the key to transforming the nation's great wealth and productivity into an engine

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for broad-based prosperity and opportunity in a more uncertain economic world.

AMERICA'S HIDDEN INSECURITY

We have heard a great deal about our nation's rising inequality, the growing gap between the rungs of our economic ladder. And yet, to most Americans, inequality is far less tangible and worrisome than a trend we have heard much less about: rising *insecurity*, or the growing risk of slipping from the ladder itself.

Consider some alarming facts. Personal bankruptcy has gone from a rare occurrence to a routine one, with the number of households filing for bankruptcy quadrupling between 1980 and 2005.[3] Americans are also losing their homes at record rates. Since the early 1970s, there has been a fivefold increase in the share of households that fall into foreclosure.[4]

Middle-class jobs are also less secure, and the share of workers who lose a job involuntarily has been rising. No less important, these job losses come with growing risks. For displaced workers, the prospect of gaining new jobs with relatively similar pay and benefits has fallen, and the ranks of the long-term unemployed and "shadow unemployed"—workers who have given up looking for jobs altogether—have grown.[5]

American families also face increased insecurity as a result of the erosion of workplace benefits. The number of Americans who lack health coverage altogether has increased with little interruption over the last twenty-five years as corporations have cut back on insurance for employees and their dependents.[6] Over a two-year period, more than 80 million adults and children—one out of three non-elderly Americans—spend some time without the protection that insurance offers against ruinous health costs.[7]

At the same time, companies have raced away from promising guaranteed retirement benefits. In 1980, 83% of medium and large firms offered traditional "defined-benefit" pensions that provided a fixed benefit for life. By 2003, the share was less than a third.[8] Instead, companies that offer pensions provide "defined-contribution" plans like the 401(k), which offers neither predictable nor assured benefits.

Perhaps most alarming of all, American family incomes are on a frightening roller coaster, rising and falling much more sharply from year to year than they did a generation ago. Indeed, the *instability* of families' incomes has risen faster than the *inequality* of families' incomes. Since the early 1970s, family incomes among working-age Americans (aged twenty-five to sixty-one) have become more than twice as unstable, even when government taxes

and benefits are taken into account. While instability is higher for women than for men, higher for African Americans and Hispanics than for Whites, and higher for less-educated Americans than for more-educated Americans, income instability has risen across all these groups (and virtually as quickly at high as well as low educational levels).

All of this increased income volatility is particularly worrisome because both research and common sense suggest that downward mobility is far more painful than upward mobility is pleasurable. In fact, in the 1970s, the psychologists Daniel Kahneman and Amos Tversky gave a name to this bias: "loss aversion."[9] Most people, it turns out, are not just highly risk-averse, preferring a bird in the hand to even a very good chance of two in the bush; they are also far more fearful of bad outcomes than they are desirous of good outcomes of exactly the same magnitude. The search for security is, in large part, a reflection of a basic human desire for protection against losing what one already has.[10]

We have heard about many of these trends in isolation, but there has been a curious silence about what they add up to: a massive transfer of economic risk from broad structures of insurance, both corporate and governmental, onto the fragile balance sheets of American families. This transformation, which I call "The Great Risk Shift," is the defining feature of the contemporary economy and is as important as the shift from agriculture to industry a century ago (that Americans are at increased economic risk draws on my book, *The Great Risk Shift*).[11] The Great Risk Shift has fundamentally reshaped Americans' relationships to their government, employers, and each other, and it has transformed the economic circumstances of American families—from the bottom of the ladder to its highest rungs.

PRINCIPLES FOR RESTORING SECURITY

The Great Risk Shift is not a financial hurricane beyond human control. True, sweeping changes in the global and domestic economy have helped propel it, but America's leaders could have responded to these forces by reinforcing the floodwalls that protect families from economic risk. Instead, in the name of personal responsibility, many of these leaders are tearing down the floodwalls. Proponents of these changes speak of a nirvana of individual economic management—an ownership society in which Americans are free to choose. What these advocates are helping to create, however, is very different: a harsh world of economic insecurity in which far too many Americans are free to lose.

To be sure, we cannot turn back the clock on many of the changes that have swept through the American economy and American society. Nor can we transport ourselves back to a wistfully remembered time in which men and women committed to social insurance began constructing many of the institutions of risk-pooling that are now in tatters. Accepting our new economic realities does not, however, mean accepting the new economic insecurity, much less accepting the assumptions that lie behind the current assault on insurance. Americans will need to do much to secure themselves in the new world of work and family, but they should be protected by an improved safety net that fills the most glaring gaps in present protections, providing all Americans with the basic security they need to reach for the future as workers, as parents, and as citizens.

The first priority for restoring security should be Hippocrates' "do no harm." Undoing what risk pooling remains in the private sector without putting something better in place does harm. Piling tax break upon tax break to allow wealthy and healthy Americans to opt out of our tattered institutions of social insurance does harm. And though simplifying our tax code makes eminent sense, making it markedly less progressive through a flat tax or national sales tax would do harm. A progressive income tax, after all, is effectively a form of insurance, reducing our contribution to public goods when income falls and raising it when income rises.

Yet, while we should work to preserve the best elements of existing policies, we should also recognize that the nature and causes of insecurity, as well as our understanding about how to best address it, have evolved considerably. During the New Deal, economic insecurity was largely seen as a problem of drops or interruptions in male earnings, whether due to unemployment, retirement, or other costly events. Even as working women became the norm, our programs failed to address the special economic strains faced by two-earner families. So too did they fail to address the distinctive unemployment patterns that became increasingly prevalent as industrial employment gave way to service work—for example, the shift of workers from one economic sector to another that often leads to large cuts in pay and the need for specialized retraining.

Flaws in existing policies of risk protection have also become apparent. Our framework of social protection is overwhelmingly focused on the aged, even though young adults and families with children face the greatest economic strains. It emphasizes short-term exits from the workforce, even though long-term job losses and the displacement and obsolescence of skills have become more severe. It embodies, in places, the antiquated notion that

family strains can be dealt with by a second earner—usually a woman—who can easily enter or leave the workforce as necessary. Above all, it is based on the idea that job-based private insurance can easily fill the gaps left by public programs, even though it is ever clearer that it cannot.

These shortcomings suggest that an improved safety net should emphasize portable insurance to help families deal with major interruptions to income and big blows to household wealth. They also mean that these promises should be mostly separate from work for a particular employer: a commitment that moves seamlessly from job to job. If this sometimes means corporations are off the hook, so be it. In time, they will pay their workers more to compensate for fewer benefits, and there are plenty of ways to encourage their contribution without having them decide who gets benefits and who does not.

By the same token, however, we should not force massive social risks onto institutions incapable of effectively carrying them. Bankruptcy should not be a backdoor social insurance system. Private charity care should not be our main medical safety net. Credit cards should not be the main way that families get by when times are tight. To be sure, when nothing better is possible, the principle of "do no harm" may dictate protecting even incomplete and inadequate safety nets. The ultimate goal, however, should be a new framework of social insurance that revitalizes the best elements of the present system, while replacing those parts that work less effectively with stronger alternatives geared toward today's economy and society.

DEALING WITH RISKS TO WORKERS

Nowhere is the need for both restoration and reform more transparent than in our need to upgrade protections for the unemployed after decades of drift and neglect. Unemployment insurance has eroded dramatically in the last generation.[12] Ideas for restoring it are not hard to find, however, and the cost would be comparatively modest.[13]

Restoring strong national standards that require states to cover workers who have worked for a minimum time would go a long way toward filling the gaps in the present program. An automatic trigger that extends benefits beyond their usual six-month cut-off on a progressively less generous basis would address increases in long-term unemployment while also encouraging workers to find new jobs. Long-term unemployment benefits could also be provided in the form of retraining vouchers to use for the purchase of private educational services.

Unemployment insurance, however, is not designed to deal with the most serious risk of losing a job—long-term declines, rather than temporary interruptions, in earning power and standard of living. There is increasing agreement among economists that some form of wage insurance is needed for workers displaced by trade or reengineering who are unable to find a new job with comparable pay or benefits.[14] These proposals are vastly superior to restrictions on company hiring and firing, which can lead to labor-market inflexibility. It is for this reason that even some of the most ardent free-marketeers support wage insurance.

The details of wage insurance proposals differ, but each would provide a supplement to wages to encourage workers to take new jobs even if paying less than old jobs. To encourage workers to search aggressively for a higher-paying job, such assistance should cover only a portion of the wage loss that follows a job switch, and should decline gradually over time. However, such policies should not be limited to workers displaced by trade, as is true of most existing government help for displaced workers. The experience of losing a job is just as devastating if your job disappears forever as it is if your job heads off to a country where labor costs are lower.

Unemployment insurance could also be the platform for dealing with the most serious work-family conflict faced by many Americans today: the difficulty of taking time off when children enter our families. Encouraging states to provide several weeks of paid leave to care for newborns, newly adopted children, and newly placed foster children would, in a stroke, greatly reduce the strain that working Americans face when they decide to start a family.

SECURING RETIREMENT

If young workers need assurances to raise the next generation of Americans, they also need assurances to plan for their own future. The incentives for higher-income Americans to save have ballooned with the expansion of tax-favored investment vehicles. Yet most Americans receive relatively modest benefits from these costly tax breaks. In the words of one knowledgeable commentator, our incentives for saving are "upside down," delivering most of their benefits to people who have substantial income and assets and virtually nothing to the vast majority of Americans who most need to save.[15] Replacing the current welter of tax breaks for non-retirement savings with a single Universal Savings Account that is most generous for Americans of ordinary means would go a long way toward restoring the balance.

Yet, when it comes to personal savings, the biggest challenge today is preserving a system of broad, guaranteed retirement pensions, including Social Security. Defined-benefit pensions are a thing of the past for workers who expect to retire in thirty or forty years, and defined-contribution plans, such as 401(k)s, are failing miserably to provide a secure foundation for workers' retirement. Securing our one guaranteed system, Social Security, is thus all the more essential.

The future financial threats to Social Security are well known, if often exaggerated. But dealing with them does not require abandoning the core elements of the program: guaranteed lifetime benefits paid on retirement, provided as a right, and linked to lifetime earnings. The funding shortfall within the program can be relatively easily closed by making Social Security benefits and the payroll taxes that fund them very modestly more progressive and by tying benefits to future longevity so that fortunate generations that live longer than the last receive slightly less from the program than now promised.[16]

Even with these changes, however, today's workers will need other sources of income in retirement. As they are presently constituted, 401(k)s are not the solution. Too few workers have access to them, enroll in them, put adequate sums in them, or roll the amounts in their accounts (so-called lump-sum payments) into other tax-favored retirement accounts when they leave a job.[17] Instead, we should create a universal 401(k) that is available to all workers, whether or not their employer offers a traditional retirement plan. Employers would be encouraged to match employee contributions to these plans, and the government could provide special tax breaks to employers that offered better matches to lower-wage workers.

MEDICARE PLUS

Health care is at the epicenter of economic insecurity in the United States today for two interwoven reasons: health care costs have exploded and coverage has dwindled. The only way to address these twin problems is to address them simultaneously, broadening coverage so as to exercise effective control over costs.

To see why both costs and coverage must be tackled at once, consider the ubiquitous complaints about Medicare, the federal health program for the aged and disabled. Medicare's costs are certainly rising rapidly, but that rise has little to do with Medicare and much to do with American health care. In fact, since payment controls were first introduced into the program

in the early 1980s, Medicare's costs per patient have risen slightly slower, on average, than private health insurance spending per patient—despite Medicare's older and less healthy population.[18]

Certainly, Medicare faces serious strains. In particular, because it covers only the aged, its spending will increase with the retirement of the baby-boom generation in the coming years. Yet, the common critique of Medicare—that it is overly generous—is untrue. Medicare coverage is substantially less generous than the norm in the private sector. If we decide as a nation that we cannot "afford" Medicare, then we are deciding that we cannot afford to provide even relatively basic health care to the aged.

Almost every other advanced industrial country provides insurance not just to the aged, but to all citizens, while spending much less on a per-person basis than the incomplete system of the United States.[19] Furthermore, many of these nations have older populations than we do, have citizenries that go to the doctor more often, and have better basic health outcomes. Yet, their overall health spending remains far below ours and, in many cases, has also been growing more slowly.[20] It is crucial to recognize that today's Medicare is very different from the model of thirty or forty years ago, because Medicare now allows beneficiaries to choose among a growing variety of private managed-care and fee-for-service options, which meet with overwhelming popular approval so long as they do not increase the cost of staying in the conventional Medicare program.

In the end, the main problem with Medicare has nothing to do with its effectiveness but rather with its limitation to the aged and disabled. This limitation hobbles Medicare's ability to control costs because the program's reach is so restricted. It also means that paying for Medicare inevitably pits the needs of younger Americans against the needs of older Americans. Additionally, it means that Medicare's costs are highly sensitive to the share of the population that is older than sixty-five. The United States is the only nation in which the day someone turns sixty-five, most of his or her health care costs suddenly turn up on the government's budget.

Expanding Medicare to people younger than sixty-five would solve all three problems. It would increase Medicare's ability to control costs, as well as its ability to monitor and improve the quality of care. It would even out the nation's commitments to the young and the old. And it would make Medicare's future costs less frightening because they would not spike as the baby-boom generation retires. Of course, Medicare would have to be

adapted to work for younger Americans, putting more emphasis on prevention and limiting out-of-pocket costs—but these upgrades would be good for older Americans too.

This could be simply done by giving all employers an affordable choice: provide insurance at least as generous as an improved Medicare program or pay a modest amount to Medicare to help finance coverage for their workers, who would then be enrolled automatically in the program. Medicare enrollees could then pay a small additional premium based on their income and family size, and they could choose among a range of private plans as well as traditional Medicare.

I have developed this proposal, which I call "Medicare Plus."[21] Expanding Medicare in this way would not eliminate private employment-based insurance. It would simply give employers a new choice, while requiring that they make at least a minimal commitment to financing coverage for their workers. The new framework would ensure that everyone who works has secure health insurance, that many more workers can choose their plan (including a plan with free choice of doctors and specialists), and that firms that now struggle to provide health benefits, or cannot provide them at all, have an attractive, low-cost option for doing so. Because the new Medicare Plus program would cover approximately half of all Americans, moreover, it would have strong leverage to bargain for low prices on behalf of covered Americans and their employers. Over time, the program could evolve in different directions, depending on how employers and Medicare Plus fared in controlling costs. Thus, this system would create a constructive public-private dynamic that would enroll the largest number of patients in the sector best able to provide affordable, high-quality health care—without holding the health security of ordinary Americans in the balance.

UNIVERSAL INSURANCE

I have left for last the most inclusive and novel idea for dealing with the rising economic risks facing Americans: a new program I call "Universal Insurance." Universal Insurance would protect workers and their families against catastrophic drops in their incomes and budget-busting expenses.

The guiding principle behind Universal Insurance is that working families should have access to more than the highly segmented programs that now characterize American social protection. Instead, we should work to create a framework of insurance that instead covers all working Americans,

that moves seamlessly from job to job and state to state, and that deals with the most severe risks to family finances, regardless of whether these risks fit neatly into existing program categories.

The label "Universal Insurance" is meant to connote two key features of the program. First, Universal Insurance would cover almost every citizen with any direct or family tie to the labor force, providing at least some direct benefits to virtually all families who experience covered risks. Second, Universal Insurance would cover a wide range of risks to family income. Universal Insurance is not a health program, a disability program, or an unemployment program. It is an income security program.[22]

Universal Insurance would aim to fill the gaps left by existing social insurance programs rather than replace these programs. It would thus be similar to private stop-loss insurance purchased by corporations to limit their exposure to catastrophic economic risks. By providing limited protection against large and sudden income declines, Universal Insurance would provide a much more secure backstop against catastrophic economic loss than Americans now enjoy. Moreover, Universal Insurance would provide this backdrop through the popular and successful method of inclusive social insurance, which pools risks broadly across all working families.

Under Universal Insurance, all workers and their families would be automatically enrolled through their employer, paying premiums in the form of small income-related contributions (preferably including capital gains as well as labor income). In return for their premiums, workers would receive coverage for four potential shocks to family labor income that are large, serious, primarily beyond individual control, and incompletely protected against by present policies: (1) unemployment, (2) disability, (3) illness and maternity, and (4) the death of a family earner. In addition, Universal Insurance would provide coverage against catastrophic health costs—a leading source of economic strain. This coverage would apply to all families whose income was below a relatively high threshold (the ninety-fifth percentile of family income by state), and it would be available to families with assets as well as those without assets.[23]

Universal Insurance would be especially generous for lower-income families, which are most likely to experience large financial shocks and be most in need of help when they do. Lower-income families generally have little or no wealth to protect their standard of living when income declines, and they are least likely to have access to workplace health or disability insurance. Not surprisingly, therefore, unemployment has a much larger effect on

the consumption patterns of lower-income families than it has on those of higher-income families.

A TIME FOR VISION

The goal of the reforms outlined in this article is simple, understandable, and direct: economic security for all working Americans. If you work hard and do right by your family, you should not be insecure. The American dream is about security and opportunity alike, and rebuilding it will require providing security and opportunity alike.

All these changes, of course, will not come without costs, and they certainly will not come without political struggle. Yet, against the cost, one must balance the savings. Billions in hidden expenses are currently imposed by laws that facilitate bankruptcy, mandate emergency room care, and shower massive tax breaks on those at the top of the economic ladder who already enjoy enviable security. The elimination of these expenses must be accounted for when tallying up the bill, as should the huge drain that our current system imposes when people do not change jobs, do not have kids, do not acquire new skills—in short, do not invest adequately in their own and their society's future—because they fear the downside risks.

Nor should we forget the principles at stake. If we acquiesce to the "creative destruction" of American-style capitalism, then we also have to accept that many Americans, at one point or another, will be hit with disasters that they cannot cope with on their own. Providing protection against these risks is a way of ensuring that the dynamism of our economy is politically sustainable and morally defensible. It is also a way of ensuring that Americans feel secure enough to take the risks necessary for them and their families to get ahead. Corporations enjoy limited liability, after all, precisely to encourage risk-taking. But while today we still have limited liability for American corporations, increasingly we have full liability for American families.

The reforms outlined in this article are guided by an abiding spirit—the spirit of shared fate. Today, when our fates are too often joined in fear rather than hope and when our society too often seems riven by political and social divisions, it is hard to remember how much we all have in common when it comes to our economic hopes and values. Indeed, we are more linked than ever, because the Great Risk Shift has increasingly reached into the lives of all Americans. The ever-present risk of economic loss reminds us that, in a very real sense, we are all in this together. The Great Risk Shift is not "their" problem; it is our problem, and it is ours to fix.

NOTES

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[2]*See generally* David Boaz, Cato Inst., Defining an Ownership Society (2003), http://www.cato.org/special/ownership_society/boaz.html.

[3]Elizabeth Warren, *The Vanishing Middle Class*, in Ending Poverty: How to Restore the American Dream (John Edwards, Marion Crain & Arne L. Kalleberg eds., 2007).

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[5]Katharine Bradbury, *Additional Slack in the Economy: The Poor Recovery in Labor Force Participation During this Business Cycle* 2 (Fed. Reserve Bank of Boston, Pub. Policy Brief No. 05-2, 2005), available at http://www.bos.frb.org/economic/ppb/2005/ppb052.pdf; *see* Andrew Stettner & Sylvia A. Allegretto, *The Rising Stakes of Job Loss: Stubborn Long-Term Joblessness amid Falling Unemployment Rates* 1 (Econ. Policy Inst. & Nat'l Employment Law Project, Briefing Paper No. 162, 2005), *available at* http://www.epi.org/briefingpapers/162/bp162.pdf.

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[7]Families USA, One in Three: Non-Elderly Americans Without Health Insurance, 2002–2003, at 11 (2004), *available at* http://www.familiesusa.org/assets/pdfs/82million_uninsured_report6fdc.pdf.

[8]John H. Langbein, Understanding the Death of the Private Pension Plan in the United States 3 (Apr. 11, 2006) (unpublished manuscript, on file with the Harvard Law & Policy Review).

[9]See Daniel Kahneman & Amos Tversky, *Prospect Theory: An Analysis of Decisions Under Risk*, 47 Econometrica 263 (1979).

[10]The Tarrance Group & Lake Snell Perry Mermin, George Washington Univ., GWU Battleground XXVII 12 (Mar. 9, 2005), http://www.tarrance.com/pdfs/Battleground-27-Q.pdf.

[11]Jacob S. Hacker, The Great Risk Shift: The Assault on American Jobs, Families, and Health Care—And How You Can Fight Back (2006).

[12]*See generally* Michael J. Graetz & Jerry L. Mashaw, True Security: Rethinking American Social Insurance (1999).

[13]*See* Lori G. Kletzer & Howard F. Rosen, Hamilton Project, Reforming Unemployment Insurance for a Twenty-First Century Workforce 16–21 (2006), *available at* http://www1.hamiltonproject.org/views/papers/200609kletzer-rosen.pdf; Daron Acemoglu & Robert Shimer, *Productivity Gains from Unemployment Insurance* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 7352, 1999), available at http://papers.nber.org/papers/w7352.pdf.

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[15]*Strengthening Pension Security for All Americans: Are Workers Prepared for a Safe and Secure Retirement?: Hearing Before the H. Comm. on Educ. & the Workforce*, 108th Cong. 40 (2004) (statement of Peter Orszag, Joseph A. Pechman Senior Fellow, Brookings Inst.), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=108_house_hearings&docid=f:92176.pdf.

[16]*See* Peter A. Diamond & Peter R. Orszag, Saving Social Security: A Balanced Approach 79–99 (2005).

[17]*See generally* Alicia H. Munnell & Annika Sundén, *401(k) Plans Are Still Coming Up Short* (Ctr. For Ret. Research at Boston Coll., Issue in Brief No. 43, 2006), *available at* http://www.bc.edu/centers/crr/issues/ib_43b.pdf.

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[20]Gerard F. Anderson et al., *Health Spending and Outcomes: Trends in OECD Countries, 1960-1998*, 19 Health Aff. 150, 151 (2000), *available at* http://content.healthaffairs.org/cgi/reprint/19/3/150.pdf.

[21]For a basic description of Medicare Plus, see Jacob S. Hacker, Medicare Plus: Increasing Health Care Coverage by Expanding Medicare, http://www.kaisernetwork.org/health_cast/uploaded_files/Jacob_Hacker_Presentation.pdf (last visited Nov. 11, 2006). For a review of the plan, see John Sheils & Randall Haught, Cost and Coverage: Analysis of Ten Proposals to Expand Health Insurance Coverage app. E (2003), http://www.rwjf.org/files/research/costCoverageHacker.pdf. In the summer of 2006, Congressman Pete Stark introduced legislation based on this proposal. AmeriCare Health Care Act of 2006, H.R. 5886, 109th Cong. (2006).

[22]Because Universal Insurance is an income-protection program, it would not take into account so-called in-kind benefits (such as Medicaid and subsidized child care) and would not count against eligibility for antipoverty programs (although income

from such programs would be treated as taxable income for all beneficiaries at the end of the year). Universal Insurance would, however, prevent many Americans from falling into poverty, thus reducing the need for antipoverty benefits in the first place.

[23]Families with very extensive assets, however, would not be covered.

A Critical Perspective on Health, Health Policy, and Politics

Carroll L. Estes, PhD

Many scholars working from a *critical perspective* on health and health policy employ a *conflict theory approach*, drawing upon work by Max Weber, Karl Marx, Antonio Gramsci, and Randall Collins, among others. A core proposition of conflict theory is that society and its structural arrangements are organized and held together by the *power* and *dominance* of certain groups over others, based upon their greater economic, political, and cultural resources. According to this perspective, how society is organized and functions (including health policy, the allocation of health care resources, and the distribution of health inequalities) is largely an outcome of power struggles over ideas, money, organization, and politics. Those who are most powerful in these struggles manage to impose their ideas, material interests, and political actions upon others, while aggregating these resources. Policy, regulations, and laws accord *structural* (built in) advantages to certain groups and interests *and* structural disadvantages to others (Estes, 1991).

The economic, political, and socio-cultural interests and elites of our nation and of other global entities promote, create, and institutionalize advantages and disadvantages through discourse, the definitions of problems and crises, the actions of multinational financial institutions like the International Monetary Fund (IMF), the World Bank, and other drivers of state (government) policy determination, practices, laws, regulations, and outcomes. A dynamic ongoing process of conflict thus underlies the society we live in—our neighborhood, locality, state, nation, and global community (Estes & Phillipson, 2002). The interaction of structural forces within the institutions of these geopolitical sites reflect (and are historically contingent upon) conflict ridden, power determined struggles. These conflicts pervade the processes of agenda setting, policy formation, and the critical implementation phases that potentially pose challenges and roadblocks (legal and other) at every turn. Each process and phase produces implications for different social groups and communities of race, ethnicity, social class,

nationhood, gender, age, (dis)ability, and sexual preference. These and other characteristics are relevant not only as individual attributes but also as institutional forces (for example, institutional racism and institutional sexism).

An alternative to the conflict perspective just outlined above is the *social order theoretical approach*. This theory contends that society and its institutions are structurally arranged, organized, and function through broad social consensus and shared values. *Functionalism* (building on work of Emile Durkheim and Talcott Parsons) argues that underlying agreement with and societal consent to the system are the reasons that the status quo continues in place even though there are clear advantages and disadvantages (inequalities) apportioned to different societal sectors, communities, institutions, groups, and individuals due to the organizational and policy arrangements that are structured into the way things work (for example, policy and health care organizations). Social order theorists contend that inequality and disadvantage are functional for the society and that inequality is required to reward those who contribute most to society. Critics of the social order paradigm, however, fault it for ignoring the underlying social conflicts and inherently anti-democratic policies that are imposed on the majority by the few with the power to shape (if not control) the nation's (and global) financial, media, military, and medical-industrial conglomerates.

Scholars working on health policy from a critical perspective seek both a *moral* as well as *scientific assessment* (see Navarro in this book). Critical scholars (unlike social order scholars) do not assume that the status quo is automatically the best, most efficient, democratic, or even fair course of action, as far as different groups and interests are concerned. Thus, normative questions are seen as central in critical analysis, such as asking how societies and social arrangements are (and ought to be) structured; how economic and health inequalities should be addressed; and what roles and responsibilities exist for the state, the private sector (for-profit and nonprofit enterprise), citizens, and the public. Scholars working in a critical perspective focus on how race, ethnicity, social class, gender, (dis)ability, and age affect health, health care, health policy, and population health.

Tom Bottomore notes that critical theory is

> designed with a practical intent to criticize and subvert domination in all forms.. . . It is preoccupied by a critique of ideology—of systematically distorted accounts of reality which attempt to conceal and legitimate asymmetrical power relations . . . [and how] social interests, conflicts and contradictions are expressed in thought, and how they are produced and reproduced in systems of domination. (Bottomore, 1983, p. 183)

Our critical perspective is predicated on evidence-based knowledge that:

1. Socioeconomic status (SES), whether measured by income, education, employment, or occupation, is one of the most powerful determinants of variability for morbidity and mortality in the general population and specific communities. There is an inverse association between SES and mortality in virtually all countries where this connection has been examined (Adler, Boyce, Chesney, Folkman, & Syme, 1993; Adler et al., 1994).
2. Health and economic advantages and disadvantages by race, ethnicity, class, gender, and ability accumulate across the lifespan (Crystal & Shea, 2003; Dannefer, 2003). Cumulative advantage theory (supported by a large body of empirical work) posits that systemic processes result in the selection and allocation of individuals on the basis of such attributes, influencing each individual's status, opportunities, and performance, and culminating in more stratified (and unequal) fortunes in old age than at earlier phases of the life course (O'Rand, 2003, 2006; Ferraro, Shippee, & Schafer, 2009).
3. Individual attributes (including race, ethnicity, class, sexuality, and nationality),and social processes and structures that produce cumulative advantage and disadvantage in health are inextricably linked to complex and interlocking "oppressions" in particular societies (Collins, 1990/1991). Collins demonstrates that what many consider as solely individual attributes are also "interrelated axes of social structure" and not simply "separate features of existence" (Collins as quoted in Estes, 2001, p. 13). Examples of "oppressions" are institutional racism and sexism.
4. The lived experiences and health problems of individuals are much more than the product of individual behavior, decisions, and "choices." Individual health care choices and "preferences" (in economist's terms) available to Americans and particularly to the structurally disadvantaged (for example, by race, ethnicity, or gender) are, in reality, highly circumscribed.

The critical perspective on health, health policy, and politics emphasizes two major features of existence: ideology and the role of the state.

Ideologies powerfully influence the shape and direction of social and health policy (Estes, 1979, p. 4). Ideology may be described as "an organized set of convictions . . . which enforces inevitable value judgments" (Bailey, 1975, p. 32). Most important, ideologies are partial perspectives, exclusively reflecting the beholder's social position and socially determined values.

"As belief systems, ideologies are world views competing for definition; and they hold major implications for power relations, for—in enforcing certain definitions of the situation. Ideologies have the power to compel certain types of action while limiting others" (Estes, 1979, p. 4).

Ideology is used by all political regimes to justify the regime's position and to impose its political will. The contest for ideological hegemony (dominance) is all about achieving and maintaining power through the means of the production, control, and deployment of ideas. Thus, all forms of media and communications are pivotal here, particularly as media consolidation and conglomeration increases nationally and globally.

Ideologies structure beliefs and limit a vision of alternative futures to those with the most power to shape the reigning ideology (Therborn, 1980). Dominant ideologies are accompanied by a "profoundly pessimistic view of the possibilities of change" (Therborn, 1980, p. 98). A necessary condition of acquiescence and resignation to policy "choices" that economic and policy elites proffer (such as the privatization cuts in the public entitlement to Social Security) is whether or not alternative regimes or strategies are even conceivable. The most successful ideologies are distinguished by their remarkable capacity to shape public consciousness. Successful neoliberal ideology limits the vision of the 'possible' to inherently pro-market solutions, while neoconservative ideology limits solutions to those that impose benefits (discipline) through the market and the traditional (patriarchal) family structure. In current U.S. society, pessimism (for example, about the sustainability of bedrock safety net programs) is promoted through the advancement of ideologies that promote and embed crisis discourse surrounding the deficit, entitlements, jobs, social security, the family, the economy, and globalization (Estes, 2011).

Our critical perspective deals extensively with the power struggles over ideology and what is defined (and challenged as) the legitimacy of both state actions and the nation-state itself, including the role and scope of government on our own soil and around the globe. An example of a powerful ideology of the right in current American politics is the natural superiority and sanctity of the market over the state (Levitas, 1986). Adherents of this ideological frame contend that the imperatives of international markets (that is, the success of multinational private corporations through globalization) must "trump" human needs. This may be contrasted with a social rights perspective that focused on the interdependence of generations across the life course (Twine, 1994). ("It takes a village to raise a child.") This alternative

ideology (intergenerational interdependence) is grounded in notions of the "common good" and an "inclusionary ethic of citizenship" (Somers, 2008).

The *state* is composed of major social, political, and economic institutions, including the legislative, executive, and judicial branches of government; the military and criminal justice systems; and the public educational, health, and welfare institutions (Waitzkin, 1983, 2011). Major challenges for any nation-state are accountability for a successful economy and protection for the homeland and its people. Insofar as there are crises that generate great public dissatisfaction (whether ideologically, politically, or economically produced), the state bears the brunt of disaffection and may suffer attacks on its legitimacy. As the politics of 2008 to the present confirm, enormous bitter bipartisan conflicts reside in the state and our nation. Quadagno (1999) describes conflicts in the United States that have arisen from the shift to a "capital investment state" characterized by the restructuring of public benefits to coincide with interests of the private sector; a transfer of responsibility from government to individuals and families; and a shift from cash benefits to incentives for saving—and most recently, investing (or not) to promote jobs.

The study of the state is central to understanding health, health care, and health policy, including the life chances of individuals in society. Why? Because the state is accorded the legitimate power to: (a) allocate and distribute scarce resources to ensure the survival and growth of the economy, (b) mediate between the different needs and demands across different social groups (by gender, race, ethnicity, class, and age), and (c) ameliorate social conditions that could threaten the existing order (Estes, 2011).

Ultimately, the number of resources controlled by the state or by the private economy is a political decision. The relative amounts of resources allocated to supporting the supply of capital (for reinvestment and profit), to workers, or to social welfare costs are never set. However, these allocations are constantly subject to political, economic, and ideological struggles for advantage.

From a critical perspective, questions concern structural power (the state financed advantages built into the ongoing system) and the degree to which there is real individual agency (in the form of the real ability and opportunity) to assume responsibility for one's situation, that is: Who has material, cultural, and political resources? Who has opportunity and autonomy to enter the labor market or to be educated? Who has the power to set the terms of pay (or no pay) or benefits (or no benefits) for the labor provided? Power reflects and emanates from possession and control of these and other resources.

Peter Conrad offers several assumptions of a critical perspective in his book *The Sociology of Health & Illness* that are consistent with our approach.

> (1) The problems and inequalities of health and medical care are connected to the particular historically located social arrangements and the cultural values of any society. (2) Health care should be oriented to prevention of disease and illness. (3) The priorities of any medical system should be based on the needs of consumers and not providers. A direct corollary . . . is that the socially based inequalities of health and medical care must be eliminated. (4) Ultimately society itself must change for health and medical care to improve. (Conrad, 2005, pp. 3–4)

Conrad sees the aim as generating the "awareness that informed social change is a prerequisite for the elimination of socially based inequalities in health and medical care" (2005, p. 4). He offers a critique of a medical model focused solely or largely on "organic pathology in individual patients, [while] rarely taking societal factors into account." (Conrad, 2005, p. 5).

A critical perspective calls us to investigate not only organizations inside but those increasingly powerful nongovernmental organizations that significantly (and to an unknown degree) intervene and frame the substance and outcomes of health care organization, financing, and delivery (Waitzkin, 2011). In the present era of gaping and galloping inequalities of all sorts, the lack of transparency concerning these forces commands our attention and analysis.

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