### 1ac – practitioners

#### The advantage is Practitioner Shortages:

#### Scope of Practice – or “S.O.P.” – restrictions *block access* and *hamper options for patient health*

LDI 20 Internally quoting Dr. Margo Brooks Carthon - LDI Senior Fellow, a Nurse Practitioner, PhD, RN, FAAN, and is also an Associate Professor at Penn’s School of Nursing. The LDI is the Leonard Davis Institute of Health Economics at the University of Pennsylvania (Penn). Six expert panelists are quoted and we are quoting the section from Margo Brooks Carthon – “Scope of Practice Restrictions and Vulnerable Populations: LDI Virtual Conference Explores The Issue's Changing Dynamics” - November 21, 2020 - #E&F - https://ldi.upenn.edu/our-work/research-updates/scope-of-practice-restrictions-and-vulnerable-populations/

The most heavily publicized debates around the SOP issue over the last 60 years have been about nurse practitioners whose work is often focused on underserved communities that lack the most basic kinds of medical care. Panelist and LDI Senior Fellow Margo Brooks Carthon, PhD, RN, FAAN, is an NP and health services researcher in that field. She is also an Associate Professor at Penn’s School of Nursing, and a core faculty member at the Penn Center for Health Outcomes Policy Research.

“There are over two hundred thousand NPs in the United States working under varying degrees of scope of practice restrictions, depending on the states where they’re employed,” Carthon said. “These barriers have implications for population health as well as health equity.”

“Twenty-two states and the District of Columbia fully license NPs to practice independently. Others require career-long collaborative agreements with a supervising physician. Some require a physician to review a percentage of NP charts — ten percent every year in Alabama and Georgia; twenty percent every 30 days in Tennessee. NPs are often limited in the distance they can be from a physician and are required to jump through other hoops just to provide basic care.”

#### The FTC can challenge State-Level SOP restrictions on Nurse Practitioners – they lose now due to Parker immunity – cements the “physician-only” model

McMichael 20 Internally quoting the Udalova and MEPS data sets. Benjamin McMichael – Faculty, University of Alabama School of Law. McMichael earned a BS in Mathematical Economics from Wake Forest University and a JD and PhD in law and economics from Vanderbilt University. Before joining the faculty at Alabama, Benjamin served as a law clerk to Judge Carolyn Dineen King on the United States Court of Appeals for the Fifth Circuit. Benjamin’s research is interdisciplinary, relying on empirical methods developed in the social sciences—particularly economics—to generate new insight into the ways in which the law influences the provision of healthcare - “Occupational Licensing and the Opioid Crisis” 54 U.C. Davis L. Rev. 887 - December, 2020 – some footnotes included for context and elaboration – but no text omitted other than the OG Table of Contents after the opening abstract - #E&F - https://lawreview.law.ucdavis.edu/issues/54/2/articles/files/54-2\_McMichael\_color.pdf

The United States’ affordable care crisis and chronic physician shortage have required nurse practitioners to assume increasingly important roles in the healthcare system. Nurse practitioners can address critical access-to-care problems, provide safe and effective care, and lower the cost of care. However, restrictive occupational licensing laws — specifically, scope-of-practice laws — have limited their ability to care for patients. Spurred by interest groups opposed to allowing nurse practitioners to practice independently, states require physician supervision of nurse practitioners. Research has discredited many of the traditional reasons for these restrictive laws, but emerging arguments assert that independent practice will deepen the ongoing opioid crisis by allowing unsupervised nurse practitioners to overprescribe opioids. The opioid crisis has become one of the defining public health emergency of this generation, so these arguments warrant serious investigation. If granting nurse practitioners independence will exacerbate the opioid epidemic, restricting their practices may be justified despite the clear benefits that independence could create for patients and the healthcare system.

This Article provides new empirical evidence on the role of nurse practitioner independence in opioid prescriptions by analyzing a dataset of approximately 1.5 billion individual opioid prescriptions. Containing information on approximately 90% of all prescriptions filled at outpatient pharmacies between 2011 and 2018, this dataset provides unprecedented insight into the ongoing opioid epidemic. An analysis of these data reveals that allowing nurse practitioners to practice independently reduces the quantity of opioids prescribed across all physicians and nurse practitioners. Thus, this Article demonstrates that, contrary to exacerbating the opioid crisis, granting nurse practitioners independence is a valid policy option for addressing this crisis. These results can inform the ongoing state and national debates over nurse practitioner scope-of-practice laws and the opioid epidemic more generally. And based on these results, the Article proposes several policy options at the state and federal levels that could both address restrictive scope-of-practice laws and ameliorate the ongoing opioid crisis.

INTRODUCTION

For many people, access to healthcare means the difference between life and death, the difference between constant pain and the ability to get out of bed in the morning, or the difference between an all-consuming mental illness and the ability to remain an active member of society. Even nearly a decade after the passage of the Affordable Care Act (“ACA”), however, access to healthcare continues to dominate local and national health policy debates, and the issue remains unresolved. The ACA certainly reinvigorated the country’s interest in access to care in unprecedented ways, and it drastically altered healthcare and healthcare provision in the United States. Unfortunately, it effected both of these changes with a near laser-like focus on increasing access to health insurance.1 For all of its virtues, this treatment of access to healthcare as effectively coextensive with access to health insurance has obscured a more fundamental problem with access to care as the following example from the New York Times illustrates.

A lifelong resident of rural Nebraska and registered nurse, Murlene Osburn saw a desperate need for mental health care in her community.2 To meet this need in an area where psychiatrists refused to practice, Osburn completed a master’s degree and a national certification process to become a psychiatric nurse practitioner (“NP”).3 Unfortunately, when she was ready to begin caring for patients, Osburn found herself stymied by the problem that spurred her to action in the first place: the lack of psychiatrists. Nebraska law prohibited NPs from practicing without physician supervision, and the nearest physician who could supervise her “was seven hours away by car and wanted to charge her $500 a month” for that supervision.4

This example illustrates the importance of access to healthcare providers in addition to access to health insurance. 5 And access to providers is far from given, with many areas of the country experiencing shortages of healthcare providers that experts expect to worsen over the next decade. 6 The New York Times example also highlights both a viable policy option to address these shortages - the increased use of NPs to provide care - and an important obstacle to implementing this policy - restrictive laws.

NPs are registered nurses who have undergone additional training to provide healthcare services historically provided by physicians. 7 They represent the principal source of care in many geographic areas 8 and are more likely than physicians to practice in rural and underserved communities. 9 This makes the 200,600 practicing NPs a natural option to address chronic, critical, and worsening physician shortages across the country. 10 While NPs provide healthcare services across the country, their ability to do so is not equal in all areas. State scope-of-practice ("SOP") laws - a subset of the occupational licensing laws that govern NPs and many other professionals - determine what services [\*891] NPs may provide and the conditions under which they may provide those services.

States often justify SOP laws as necessary to ensure patient safety by preventing unqualified individuals from providing care. 11 Though these laws can further this goal, excessively restrictive SOP laws undermine the ability of NPs to care for patients. Prior work has shown that eliminating restrictive SOP laws and allowing NPs to practice independently of physicians can facilitate access to care, 12 improve the quality of care, 13 reduce the use of intensive medical procedures, 14 and reduce the price of some healthcare services. 15 Based on this evidence, the Obama and Trump administrations along with the National Academy of Medicine and other organizations have urged states to relax their SOP laws. 16 A minority of states have responded by granting NPs the authority to practice independently, but the ongoing debate and [\*892] political battle over SOP laws has only intensified over the last decade. 17 Physician organizations, in particular, vigorously oppose the relaxation of these laws and have been successful in discouraging states from granting NPs independence. 18

9 See Peter I. Buerhaus, Catherine M. DesRoches, Robert Dittus & Karen Donelan, Practice Characteristics of Primary Care Nurse Practitioners and Physicians, 63 NURSING OUTLOOK 144, 144-50 (2015) [hereinafter Practice Characteristics] (finding that NPs are more likely to care for Medicaid patients, vulnerable populations, and rural populations); Grant R. Martsolf, Hilary Barnes, Michael R. Richards, Kristin N. Ray, Heather M. Brom & Matthew D. McHugh, Employment of Advanced Practice Clinicians in Physician Practices, 178 JAMA INTERNAL MED. 988, 988-89 (2018) (finding that NPs are likely to be employed in primary care).

10 Occupational Employment and Wages, May 2019, 29-1171 Nurse Practitioners, U.S. BUREAU LAB STAT., https://www.bls.gov/oes/current/oes291171.htm (last visited Nov. 11, 2020) [https://perma.cc/5A4C-9H7S].

11 See Morris M. Kleiner, Enhancing Quality or Restricting Competition: The Case of Licensing Public School Teachers, 5 U. ST. THOMAS J.L. & PUB. POL’Y 1, 3, 8 (2011) (“The general rationale for licensing is the health and safety of consumers. Beyond that, the quality of service delivery . . . [is] sometimes invoked.”).

12 Benjamin J. McMichael, Beyond Physicians: The Effect of Licensing and Liability Laws on the Supply of Nurse Practitioners and Physician Assistants, 15 J. EMPIRICAL L. STUD. 732, 764-65 (2018) [hereinafter Beyond Physicians]; Jeffrey Traczynski & Victoria Udalova, Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes, 58 J. HEALTH ECON. 90, 103-04 (2018); see also John A. Graves, Pranita Mishra, Robert S. Dittus, Ravi Parikh, Jennifer Perloff & Peter I. Buerhaus, Role of Geography and Nurse Practitioner Scope-of-Practice in Efforts to Expand Primary Care System Capacity, 54 MED. CARE 81, 83-88 (2016).

13 Traczynski & Udalova, supra note 12, at 97

14 See, e.g., Sara Markowitz, E. Kathleen Adams, Mary Jane Lewitt & Anne L. Dunlop, Competitive Effects of Scope of Practice Restrictions: Public Health or Public Harm?, 55 J. HEALTH ECON. 201, 209-16 (2017) (showing a reduced probability of intensive procedures related to pregnancies in states that allow nurse practitioners to practice with no barriers).

When opposing NP independence, physician groups often argue that requiring physician supervision promotes patient safety and the delivery of high-quality care. 19 Although existing clinical evidence undermines these claims, 20 physician groups have recently emphasized the troubling possibility that allowing NPs to practice independently will increase opioid prescriptions. 21 The reasoning offered is straightforward: If NPs can prescribe opioids without physician supervision, then they will inappropriately overprescribe opioids and deepen the ongoing opioid crisis. 22 This Article engages with the debate [\*893] over NP SOP laws by empirically analyzing the impact these laws have on opioid prescriptions. Given the severity of the ongoing opioid crisis, the claim that allowing NP independence will deepen that crisis by increasing opioid prescriptions warrants careful consideration. On one hand, allowing NPs to practice independently can address critical access-to-care issues and improve the healthcare system in other important ways. On the other hand, restricting the practices of NPs may be justified despite these benefits if doing so avoids exacerbating the opioid crisis. This Article provides critical new evidence on the effect that NP SOP laws have on opioid prescriptions. Specifically, I analyze a dataset of approximately 1.5 billion individual opioid prescriptions, which represent approximately 90% of all opioid prescriptions filled at outpatient pharmacies between 2011 and 2018. This dataset provides unprecedented insight into the ongoing opioid epidemic and the role of healthcare providers in that epidemic. Because this dataset covers nearly the universe of opioid prescriptions in the United States over eight years and is organized at the individual-prescription level, I am able to develop more complete and more granular evidence on the role of NP SOP laws in opioid prescriptions than has previously been possible. The analysis reveals that allowing NPs to practice independently reduces the quantity of opioids prescribed across all physicians and NPs by approximately 4.4%. 23 In contrast to physician groups' claims, the evidence developed here suggests that relaxing NP SOP laws reduces opioid prescriptions. Thus, this Article demonstrates that, rather than exacerbating the opioid crisis, granting NPs independence is a valid policy option for addressing that crisis. These results can inform the ongoing debates over both NP SOP laws and the opioid epidemic more generally, and this Article uses this evidence to recontextualize the debate over SOP laws and offer specific policy recommendations. In addition to joining various scholars and [\*894] organizations in urging states to reform their SOP laws, this Article engages with potential federal policy options that can both address the dire healthcare provider shortages across the country while ameliorating the opioid crisis. Federal options, such as the ones discussed below, will become increasingly relevant as state legislation has proven difficult to obtain in certain states. 24 This Article proceeds in four parts. Part I details the contributions that NPs make to the healthcare system and the ways SOP laws impact their ability to do so. 25 Part II provides context for the empirical analysis that is the focus of the Article by detailing the progression of the opioid crisis. 26 Part III discusses the empirical methodology and reports the results of the empirical analysis. 27 Part IV engages with the policy implications stemming from the results of that analysis, 28 and a brief conclusion follows.

I. REGULATING HEALTHCARE PROVIDERS

Historically, physicians have delivered most of the healthcare in the United States. While other providers, such as registered nurses, have always played important roles in healthcare, physicians have been responsible for directing most care delivery. Physician dominance, however, has begun to recede as NPs and other types of healthcare providers are providing "[a] growing share of health care services." 29 And this trend will likely continue because the growth rate of NPs outstrips that of physicians, 30 which only adds urgency to resolving the debate over NP SOP laws. To provide context to that debate, this Part [\*895] begins by discussing the role of NPs in the healthcare system before outlining the contours of the debate over the SOP laws that regulate NPs.

A. Nurse Practitioners and the Laws that Govern Them

To qualify as an NP, an individual must first become a registered nurse, which often involves completing a bachelor's degree in nursing. 31 Most registered nurses practice for several years before returning to complete a master's or doctoral degree to become an NP. 32 Their training involves clinical and didactic courses that prepare future NPs to diagnose and treat patients, order and interpret tests, and prescribe medication. 33 Following their training, NPs practice in a wide variety of medical settings, but over 60% choose to provide some form of primary care. 34 With this training, NPs provide care alongside physicians across the country, 35 but where they choose to practice and which patients they choose to care for often differs substantially from the choices made by physicians. Relative to physicians, NPs more often choose to practice in primary care and to care for underserved populations, including Medicaid patients. 36 They also provide care in rural or underserved areas to a [\*896] greater extent than physicians. 37 The predilection of NPs to practice in isolated areas and care for patients who have difficulty accessing care is particularly important in an era of worsening physician shortages. For example, the Association of American Medical Colleges estimates that, by 2032, the United States will face a physician shortage of between 46,900 and 121,900. 38 Such a shortage has implications for the country generally, but it will impact rural areas to a greater degree. Recent estimates suggest that the number of physicians practicing in these areas could decline by 23% by 2030. 39 With approximately 200,600 NPs delivering care in 2019 40 NPs can alleviate physician shortages in rural and other areas. Indeed, NPs outnumber primary care physicians, 41 practice in convenient locations like retail and urgent care clinics, 42 and represent the principal source of healthcare in many parts of the country. 43 However, the ability of NPs to function as the principal source of healthcare depends heavily on the SOP laws in place. Prior work has [\*897] classified NP SOP laws in slightly different ways. 44 Each classification system has advantages and disadvantages, but I adopt a classification scheme based on two recent studies that that focus on specific statutory and regulatory language. 45 Where necessary, I updated the classifications based on more recent statutory and regulatory information. This approach to classification eliminates the risk of mis-classification that can occur by relying on inconsistent secondary sources. It also isolates the specific statutes and regulations that policymakers may change to achieve specific results in their healthcare systems. 46 Using these statutes and regulations, I classify each state in each year as either allowing NPs to practice independently or restricting the practices of NPs. To be classified as allowing "independent practice," a state must (1) have no requirement that physicians supervise NPs and (2) grant NPs full prescriptive authority, i.e., allow NPs to prescribe the same range of medications as physicians. 47 States that either require physician supervision of NPs or restrict their prescriptive authority fall into the "restricted practice" category. [\*898] Figure 1 provides an overview of NP SOP laws during the time period analyzed here. In 2011, fourteen states allowed NPs to practice independently, and thirty-seven states restricted the practices of NPs. 48 Of the thirty-seven states restricting NP practice, fourteen changed their laws prior to the end of 2018 to allow NPs to practice independently. 49 Figure 1 separately highlights each of the states that always allowed NPs to practice independently, always restricted NP practice, and changed from restricted to independent practice. As Figure 1 illustrates, the trend among states decidedly favors NP independence, with half of all states that currently allow independent practice adopting a law to that effect in the last decade. This trend has not emerged without opposition, however, and the debate between opponents of relaxing NP SOP laws and advocates of greater NP autonomy has become quite heated. The next subpart engages with this [\*899] ongoing debating, tracing the contours of each side's arguments and the evidence that supports their arguments.

B. The Scope-of-Practice Debate

As NPs have assumed greater roles in the delivery of care, some groups have objected to liberalizing the SOP laws that govern NPs to allow them to provide more services and practice with greater autonomy. Principal among the opponents of relaxing NP SOP laws are physician groups, with the American Medical Association ("AMA") offering some of the strongest resistance to granting NPs greater independence. 50 Advocates of greater NP autonomy include nursing groups, policy think tanks of various political orientations, the National Academy of Medicine, and the Obama and Trump administrations. 51 Opponents of greater NP autonomy often emphasize the greater education completed by physicians and argue that NPs cannot provide safe or high-quality care without physician supervision. 52 Proponents often respond that NPs deliver care of similar quality as physicians and that allowing greater NP autonomy lowers the cost of care and improves access to care. 53 This Part engages with each of these sets of arguments in turn.

1. Independent Nurse Practitioners and the Quality of Care

Perhaps the most contentious point in the debate over NP SOP laws concerns the ability of NPs to deliver high-quality care without physician oversight. Opponents of NP independence generally argue that, without physician supervision, NPs cannot safely care for patients. For example, the California Medical Association has stated that it "opposes any attempts to remove physician oversight over [NPs] and believes that doing so would put the health and safety of patients at risk." 54 Some groups frame their arguments about quality of care in [\*900] terms of the different levels of education completed by NPs and physicians. 55 These arguments require the additional inferential step that more education is required to provide the type of care delivered by NPs, but they are effectively equivalent to statements that unsupervised NPs cannot safely care for patients. 56 Advocates of greater NP autonomy respond to these arguments by pointing to the available evidence that demonstrates NPs generally deliver care of comparable quality to that delivered by physicians. 57 Multiple studies have investigated the ability of NPs to deliver high-quality care, often comparing NP-supplied care to physician-supplied care. 58 A recent comprehensive analysis compared the quality of care delivered to Medicare beneficiaries by NPs and physicians and found that physicians perform better on certain quality measures and NPs perform better on other measures. 59 Related work has found no meaningful differences between NPs and physicians in caring for HIV [\*901] patients, 60 managing diabetes, 61 providing primary care, 62 prescribing medications, 63 or providing critical care. 64 Reviewing the evidence, the National Academy of Medicine concluded "that access to quality care can be greatly expanded by increasing the use of ... [NPs] in primary, chronic, and transitional care." 65 Opponents of broader NP SOP laws have criticized this evidence as irrelevant because these studies are often "performed in a setting of physician oversight and collaboration." 66 They argue that "using data from studies of nurse practitioners working under physician supervision to demand independent practice is a flawed practice, as there is no proof that nurse practitioner care without physician oversight is either safe or effective." 67 However, studies that have explicitly examined the role of relaxing NP SOP laws - as opposed to the role of NPs generally - in promoting the delivery of high-quality care have concluded that NP independence either improves or has little effect on the quality of care delivered. A 2017 study found that NP "independence had no statistically significant effect on any of the three [clinically verified indicators of [\*902] healthcare quality] studied." 68 In contrast to claims that NP SOP laws are necessary for the protection of patients, 69 this study "did not substantiate the use of [SOP] restrictions for the sole purpose of consumer protection." 70 A separate study "cast[] further doubt on the theory that state regulations limiting NPs practice are associated with quality of care." 71 Examining patient-reported quality across many years of a nationally representative dataset, a recent study found that NP independence increases the probability that patients report being in excellent health. **72** Another study found that NP independence had no effect on infant mortality rates, an important indicator of healthcare quality. 73 Overall, existing evidence does not support the contention that unsupervised NPs provide unsafe or low-quality care. To be sure, physician groups are correct in their assertion that NPs are not trained to provide the same range of services as physicians - NPs do not perform surgery, for example. Within the scope of their training, however, the evidence demonstrates that NPs perform similarly to physicians.

**72** Traczynski & Udalova, supra note 12, at 98, 99 tbl.7.

2. Scope-of-Practice Laws and the Cost of Healthcare

Though healthcare quality tends to receive the most attention from experts within the SOP law debate, concerns over the cost of care predominate among the patients who are most affected. Indeed, the health policy conversation over the last two decades has focused heavily [\*903] on the ability of patients to obtain affordable care. 74 Advocates of greater NP autonomy have argued that removing restrictive SOP laws will facilitate the use of lower cost providers and ultimately reduce costs within that system. For example, Kathleen Adams and Sara Markowitz have explained that "achieving productivity gains is one way to reduce cost pressures throughout the health-care system" and that such gains can be realized "by using lower-cost sources of labor to achieve the same or better outcomes." 75 The "high payment rates for physicians in the United States" makes the increased use of NPs a particularly appealing strategy for cost-reduction. 76 Recent research has demonstrated that abrogating restrictive SOP laws can reduce costs within the healthcare system to the benefit of patients and the public. A study by Morris Kleiner and others found that granting NPs independence reduces the price of a common medical examination by between 3% and 16%. 77 A separate economic evaluation estimated that liberalizing SOP laws would save approximately $ 543 million annually in emergency department visits alone. 78 Though specific to certified nurse midwives instead of NPs, a recent study found that eliminating restrictive SOP laws for nurse midwives would save $ 101 million by reducing reliance on more intensive forms of care during birth. 79 Other studies have found that payments in connection with Medicare beneficiaries cared for by NPs were between 11% and 29% lower than those cared for by physicians, 80 the savings achieved by using retail health clinics in lieu of emergency departments are higher when NPs have more independence, 81 and Medicaid costs either decrease or remain flat when NPs are granted more autonomy. 82 On the other side of the debate, opponents of NP independence can point to some evidence that NPs and SOP laws allowing them to practice independently may increase healthcare costs. In a recent report, the [\*904] Medicare Payment Advisory Commission ("MedPAC") highlighted several studies finding that NPs tend to increase costs. 83 One study found that NPs utilized more healthcare resources in caring for patients than physicians, suggesting that more extensive use of NPs may increase costs. 84 A separate study found that NPs order more medical imaging services than physicians in primary care settings. 85 Medical imaging, such as magnetic resonance imaging ("MRI") and computed tomography ("CT") scans can be expensive, so this study suggests that NP independence may increase costs over time. More recent work that examines a larger population contradicts these results, however. Examining data on Medicare and commercial insurance claims, a 2017 study found that NP independence does not result in more medical imaging and does not increase healthcare costs. 86 Similarly, research conducted by economists at the Federal Trade Commission ("FTC") revealed no evidence that relaxing NP SOP laws increases healthcare costs or prices. 87 Overall, a growing body of research suggests that allowing NPs to practice independently can reduce costs and the prices patients must pay for care, while only a few studies have found evidence to the contrary. 88

3. Nurse Practitioners and Access to Healthcare

Turning to the debate over the role of SOP laws in access to healthcare, the evidence more heavily favors advocates of greater NP autonomy than it does in either the cost or quality debates. Advocates of greater NP autonomy have argued that "by unnecessarily limiting the tasks that qualified [NPs] can perform, SOP restrictions exacerbate [healthcare provider] shortages and limit access to care." 89 An Obama administration report noted that "easing scope of practice laws for APRNs represents a viable means of increasing access to certain primary care services," 90 and the evidence generally supports this conclusion. For example, one study concluded that states with less restrictive SOP laws "overall had more geographically accessible" NPs. 91 Similarly, a 2018 study found that relaxing SOP laws increases access to healthcare generally but has the largest positive effect in counties that have the least access to healthcare. 92 This evidence suggests that "restrictive licensing laws limit the growth in the supply of [NPs] who could deliver care in communities with relatively few practicing physicians." 93 Extending this evidence to more specific measures of healthcare access, a third study concluded that granting NPs more autonomy increases the likelihood that individuals receive a routine check-up, have access to a usual source of care, and can obtain an appointment with a provider. 94 NP independence also reduces the use of emergency departments for conditions that can be addressed in less intensive (and less expensive) settings, as patients can more easily access a healthcare provider when NPs can practice independently. 95 [\*906] The response to the argument that allowing NPs greater autonomy increases access to healthcare by opponents of NP independence often does not focus explicitly on healthcare access. While not every study has found that relaxing SOP laws increases access to healthcare providers, 96 the existing evidence generally supports this conclusion. 97 Opponents, therefore, typically offer only indirect arguments on the access issue. In opposing a bill that would relaxing California's SOP laws, the president of the California Medical Association offered an example of a common argument: "We must ensure that every American, regardless of age or economic status, has access to a trained physician who can provide the highest level of care. Expanding access to care should not come at the expense of patient safety and we will not support unequal standards of care... ." 98 In other words, expanding access to NP-supplied care does not amount to expanding access to care generally because NPs provide inferior care. Though framed as an access-to-care argument, this contention is more accurately characterized as an argument about the quality of care provided by NPs, which as addressed above, appears to be equal in basic practice areas.

4. The State of the Scope-of-Practice Debate

The debate over NP SOP laws is not new, and multiple national organizations - both governmental and non-governmental - have weighed in on this debate after conducting extensive reviews of the available evidence. Perhaps the most relevant organization to opine on SOP laws to date has been the National Academy of Medicine (formerly, the Institute of Medicine). The Academy criticized restrictive SOP laws, noting that "what nurse practitioners are able to do once they graduate varies widely for reasons that are related not to their ability, education or training, or safety concerns, but to the political decisions of the state in which they work." 99 Calling for an end to restrictive SOP laws, the Academy clearly stated that NPs "should practice to the full extent of their education and training." 100

[\*907] Researchers at the FTC reached a similar conclusion, albeit for somewhat different reasons. The FTC has no authority to enforce federal antitrust laws against states that restrict the practices of NPs with SOP laws because these laws fit squarely within the state-action immunity articulated in Parker v. Brown. 101 However, FTC researchers applied the economic principles that underlie those antitrust laws and concluded that restrictive SOP laws "deny[] health care consumers the benefits of greater competition." 102 They further concluded that the harms to healthcare services markets - higher prices and decreased access to care - associated with restrictive SOP laws were not offset by any attendant benefits. 103 Consistent with these conclusions, the FTC has regularly opposed state laws that restrict the practices of NPs and supported the passage of bills that relax the SOP laws. 104

#### First – studies and empirics confirm SOP laws costs many lives *per day* *per State*. Solvency is *empirical* and the *impact is significant*.

Chung 20 Bobby W. Chung is a labor economist. He receives his Ph.D.in Economics at Clemson University. He is now a postdoctoral research associate at the School of Labor and Employment Relations in the University of Illinois (Urbana-Champaign). He is also a network member of the Human Capital and Economic Opportunity Global Working Group. His recent work includes social network, occupational licensing, and kidney-exchange network. “The Impact of Relaxing Nurse Practitioner Licensing to Reduce COVID Mortality: Evidence from the Midwest” - #E&F - http://publish.illinois.edu/projectformiddleclassrenewal/files/2020/06/The-Impact-of-Relaxing-Nurse-Practioner-Licensing8413.pdf

Nurse practitioners (NP) are well-trained health care personnel for primary, acute, and specialty care in the US. However, 32 states have restrictions on their scope of practice and Illinois is one of them.

In response to the shortage of health care workers during the coronavirus pandemic, twenty-one states granted NP full practice authority to cope with the increasing demand for health care services. In the Midwest, Kansas, Indiana, Michigan, Missouri, and Wisconsin, adopted a more expansive scope of service for NP.

This report evaluates the effect of this policy change on the rate of COVID-related deaths in the Midwest states, which expanded NP authority and sheds light on healthcare policy in Illinois.

Findings:

NP in Illinois have full practice authority only if they have had 4,000 hours of clinical experience and completed 250 training hours.

Illinois and Ohio are the only two Midwest states, which did not expand the scope of practice for NP during the pandemic.

In the states that did expand the scope of practice for NP, COVID related deaths were potentially reduced by 10 cases per day

If Illinois had expanded the scope of practice, 8% fewer COVID-19 deaths would have occurred in Cook County, which is the most affected area in the state.

The findings reveal that granting NP full practice authority is effective in easing the shortage of health care workers and improves health care quality. Our result echoes the findings by other healthcare researchers that granting NP independent practice authority improves patient outcomes. This report recommends that health care regulators in Illinois grant all NP independent practice authority in order to meet the states’ growing health care demand.

Introduction

The shortage of healthcare professional in the US has been a notable concern among health policy makers. According to the Bureau of Health Workforce, in 2017 only 55 percent of the need for primary care professional was met.1 For Illinois, the Bureau estimated that 468 extra primary care health providers were needed to address the shortage problem, which is roughly 188% of the existing number of primary care providers in the state. The shortage problem is the biggest in the Midwest.

The nationwide healthcare labor force shortage manifests itself even more during the COVID-19 pandemic. To address the health workforce shortage, a number of states temporarily expanded the scope of practice for nurse practitioners (NP). NP are well-trained health care personnel, typically requiring post-graduate training. According to the American Association of Nurse Practitioners (AANP), NP with full autonomy are authorized to \evaluate patients; diagnose, order and interpret diagnostic tests; and initiate and manage treatments".2 Although they are well-prepared to provide primary, acute, and specialty care, their scope of practice varies by state. According to the classification by AANP, in a state with "restricted/reduced practice," NP need to have a collaborative agreement with, or work under direct supervision of a licensed health professional (e.g. physician, dentist). The limited authority of NP has not only reduced health access in rural areas, but also significantly increased the administrative burden of the supervising personnel. It has also reduced the amount of time dedicated for patient care (Traczynski and Udalova, 2018). Healthcare researchers have claimed that granting NP independent practice authority would have a positive impact on patient outcomes.

This report estimates the impact of expanding the scope of practice for NPs on COVID mortality in the Midwest. In the region, seven states were classified prior to the pandemic as "restricted/reduced NP practice" by the AANP. Among those, Kansas, together with Indiana, Michigan, Missouri, and Wisconsin granted NPs independence, whereas Illinois and Ohio did not implement changes.3 In the empirical exercise, we leverage on this quasi-experimental setting to compare daily COVID mortality in the treated states with that in Illinois and Ohio before and after the emergency response. Although the discussion evaluates the recent emergency response under the pandemic, the finding here contributes to the ongoing debate of whether NP should be granted independent authority.

According to our estimates, expanding the scope of practice for NPs potentially reduced COVID-related deaths by ten per day. To put this figure into context, the number amounts to a reduction of 8% of in those states that implemented the changes the average death toll in Cook County during the sample period. These results add support to granting NP full independent authority to ease the healthcare workforce shortage.

Restriction on NP and State Emergency Response

The scope of practice for nurse practitioners varies by state. According to the American Association of Nurse Practitioners (AANP), five of the Midwest states allow full practice (light blue in Figure 1a), meaning that NP can work independently and are authorized for patient diagnosis and prescription.

Illinois with four other Midwest states (Figure 1a) classify NP under "reduced practice" restrictions. Illinois regulations amended in 2017 do allow a subset of NP full practice authority, but the change only applies to NP who have had at least 4,000 hours of clinical experience and completed 250 training hours.4 In contrast, North Dakota, South Dakota, Nebraska, Minnesota and Iowa permit a full scope of practice for all NP without a minimum threshold of accrued work hours.

In Illinois, NP are required to have a collaborative agreement with a health professional (e.g. licensed physician), listing the types of care, treatment and procedures the NP is allowed to perform. NP in Illinois and five other Midwest states can work quasi-independently because physicians are not required to be physically present with the NP. Prior to the pandemic outbreak, Missouri and Michigan had the most restrictive rules, requiring that NP work under direct supervision of a physician (Figure 1a).

As the pandemic unfolded, states with reduced or restricted practice authority began to expand the scope of practice for NP. The aim of the change was to enlarge the healthcare workforce capable of providing COVID-19 care.

Among the Midwest states shown in Figure 1b, Missouri and Indiana were the first to waive part of the supervision requirements. At the date of this report, Illinois and Ohio were the only two states, which have not taken action to expand the scope of practice for NP.

Policy Effect on COVID-related Mortality

To evaluate the effectiveness of expanded scope of practice, this report looks into the impact on COVID-related mortality. Data on county level daily mortality are retrieved from the New York Times.5

To estimate a cause-and-effect relationship between expanded scope of practice and COVID-19 mortality, this report employs the synthetic control method (Abadie and Gardeazabal, 2003; Abadie, Diamond, and Hainmueller, 2010). The essence of this statistical technique is to construct a counterfactual which mirrors the post-policy mortality that would have been observed had the policy not happened. We then obtain the daily policy effect by directly comparing the counterfactual mortality with the observed mortality. To ensure the counter-factual offers a valid comparison, we make use of several important indicators that would predict COVID-related deaths. These include the pre-policy number of COVID death, pre-policy number of confirmed cases (also retrieved from the New York Times database), and county characteristics (number of NPs, population size, percent of 65+ population, percent of black, number of hospital, and number of beds) obtained from the Area Health Resource Files (AHRF, 2020).

An important property of the synthetic control technique is that the pre-policy number of COVID death has to be informative enough to produce reliable post-policy predictions. In other words, we rely on the pre-policy trend to predict the post-policy movement. This limits the start of the sample period to late March because many counties did not record any COVID deaths until then. For this reason, we are not able to produce a dependable counterfactual for the counties in Missouri and Indiana because they granted authority to NP prior to reporting any COVID-19 deaths.

Figure 2, shows the estimation result for Kansas, Wisconsin, and Michigan. The solid line of each graph represents the actual daily mortality of a state (average of all counties), whereas the dotted line shows the predicted counterfactual using the synthetic control technique. The red vertical line in the middle of each graph represents the day before the policy takes place. For example, in the top-left corner, the solid line shows that Kansas counties recorded an increasing number of COVID-related death with a modest decline in magnitude since April 22, which is the date Kansas started to authorize temporary independent practice for NPs. The trend afterward clearly diverges from the predicted no-policy counterfactual, which implies that the policy slowed down the death toll. Until the end of the sample period, the maximum impact by the policy reduces the daily death toll by 10 cases. We also observe a similar pattern in Wisconsin and Michigan, though the magnitude of death reduction in Michigan is smaller.

There is however the possibility that the reduction in deaths was caused by some other concurrent policies and any reduction in fatalities would then be falsely attributed to the expanded scope of practice. This concern is particularly valid because there were many policies adopted in response to the nationwide health risk.

Therefore, to check the robustness of our prediction of reduced deaths associated with NP scope of authority, we tested to see if the social distancing policy, a major attempt by states in response to the pandemic, had the same associated improvement on the cases of COVID-19 deaths.

For Kansas, Wisconsin, and Michigan, social distancing measures were implemented in late March. We therefore implemented the same estimation procedures using the synthetic control method but moving the treatment date in each state to correspond to the start of the state's shelter-in-place order. As shown in Figure 3, in each of the three states, the actual cases of death continues to grow at a higher rate than the predicted counterfactual. This finding suggests that the lock down policies did not produce the same reduction in the number of COVID-related fatalities as the expanded scope of practice

Conclusion and Policy Implication

Amid the unprecedented health crisis, it is important that state regulators consider the cost of occupational regulations.

The argument for occupational licensing is that it protects the consumer. In the case of NPs scope of practice, regulators often worry about the quality of service if the scope is widened. This report however suggests there is empirical evidence that granting NPs independent authority has contributed to a reduction in COVID-19 deaths.

#### Second – Plan’s a vital structural enabler of increased access and collaboration between communities and health care systems – key to mitigate the distrust that magnifies the impact of structural racism on maternal health outcomes

Cortés et al 21 (Yamnia I. Cortés, PhD, MPH, FNP-BC, University of North Carolina—Chapel Hill School of Nursing; and Khadijah Breathett, Division of Cardiovascular Medicine, Sarver Heart Center, University of Arizona; “Addressing Inequities in Cardiovascular Disease and Maternal Health in Black Women,” Circulation: Cardiovascular Quality and Outcomes, 14(2), February 2021, DOI: 10.1161/CIRCOUTCOMES.121.007742)

Recommendations and A Call to ACTION

Bond et al7 present the Association of Black Cardiologists’ (ABC) working agenda to address the Black maternal health crisis. The ABC was founded over 40 years ago to address inequities in CVD burden and access to cardiovascular care in populations of color. On June 13, 2020, ABC convened the Black Maternal Heart Health Roundtable, a collaborative task force of stakeholders (eg, community partners, state agencies, researchers, clinicians), to identify strategies to improve Black women’s maternal health. ABC is a stakeholder organization in the Black Maternal Health Caucus and has endorsed the Black Maternal Health Momnibus,11 which calls for investment in: (1) social determinants of health; (2) community-based organizations; (3) women veterans; (4) diversifying the perinatal workforce; (5) data collection and quality measures; (6) maternal mental health care; (7) digital tools to improve maternal health; (8) maternal health of incarcerated women; and (9) innovative payment models supporting quality care and health insurance coverage from pregnancy to one year postpartum. With Black women being disproportionately affected by CVD and the maternal health crisis, “ABC is proud to be the cardiovascular society at the forefront in addressing the disparate maternal morbidity and mortality.”

The ABC has developed several recommendations to improve Black maternal heart health, many of which address the downstream impact of structural racism. ABC calls for collaborative efforts between community partners, the media, health care workers, educators, researchers, government agencies, and the private sector. An overview of some of these recommendations follows:

Developing community partnerships: Health care systems and organizations can work with community members to understand and address issues most pertinent to the cardiovascular health of the community. Cardiovascular health has been successfully promoted through outreach programs partnered with churches, faith-based organizations, and local businesses. Dissemination of similar programs can encourage conversations, offer health care services, engage community members to share their experiences, and establish trustworthy relationships.

Using media to enhance public education: Bond et al7 point to the use of media outlets to raise awareness and highlight the stories of influential Black women who can share their experiences. In addition to diversifying the stories that are published, there is a call to include more women of color in the media workforce.

Using multidisciplinary care teams: Access to multidisciplinary care teams is needed across the care continuum from preconception to postpartum care with inclusion of obstetricians, perinatologists, cardiologists, primary care clinicians, emergency medicine professionals, nurses, midwives, and doulas. Moreover, Bond et al7 underscores the need to diversify the maternal health care team and incorporate education on racism and bias during their training.

Increasing access to maternal health care: Insurance coverage is needed beyond the immediate postpartum period. Postpartum care is important for monitoring the health of women and preventing complications, particularly among women with chronic conditions. Expanding access to doulas and coverage for doula services is also highlighted. Bond et al7 stress investment in maternal health care for veterans, rural communities, low-income communities, and incarcerated women.

Innovative technologies and telehealth: The use of innovative technologies, particularly during the COVID-19 pandemic, is one strategy to improve access to maternal health care that allows women to interact with specialists’ who are not local. Tools that support telecommunication and remote diagnosis can provide patients more immediate access to care and enhance efficiency of care. However, Bond et al7 caution that the lack of in-person interactions may contribute to patient-provider distrust.

Research: There is a need to address critical gaps in knowledge in the identification and care of Black women at elevated risk for CVD during the care continuum. Recommendations from ABC include standardizing the management of patients with heart disease in pregnancy and the development and use of interdisciplinary care registries such as the Heart Outcomes in Pregnancy: Expectations Registry. Availability of evidence-based information and data sets, including the Office of Research on Women’s Health Maternal Morbidity and Mortality web portal and Centers for Disease Control and Prevention Pregnancy Mortality Surveillance System, is necessary to adequately track and measure inequities in maternal morbidity and mortality.

The current position article from the ABC is the first comprehensive statement from a cardiovascular society addressing the Black maternal health crisis. While we present a summary of key recommendations from the Black Maternal Heart Health Roundtable, Bond et al7 provide a working agenda and detailed strategies to reduce Black women’s maternal morbidity and mortality through education, research, advocacy, and collaborative efforts.

Current work by Boakye et al6 and Bond et al7 provide an important opportunity for a paradigm shift from models of maternal health that focus on individual behaviors and socioeconomic status, to a more comprehensive approach that addresses the social and structural factors underlying maternal health inequities. As the impact of structural racism on Black maternal health is increasingly documented, the time has come to focus on upstream structural solutions. Only then can we improve existing policies and health care practices to tackle the Black maternal health crisis in the United States.

#### Those inequalities are NOT pre-determined by social factors – policy changes can measurably reduce violence

Rust 17 (George Rust, Center for Medicine and Department of Behavioral Sciences and Social Medicine, Florida State University College of Medicine, “Choosing Health Equity: Investing in Optimal and Equitable Health for All,” American Journal of Public Health, 107(3), March 2017, p.361–363)

Health equity is a choice. Worldwide, humanity is consciously choosing to make progress toward health equity. The World Health Organization has reported more than a 50% reduction in under-five child mortality since the year 2000. The Lancet Commission’s Global Health 2035 report asserted that, with strategic investments, nearly all countries could achieve “a grand convergence in health within a generation,” reducing maternal–child deaths in high-mortality countries to the levels of the best-performing middleincome nations by 2035.1 The World Health Organization has similarly endorsed the Sustainable Development Goal of eliminating preventable deaths of infants and children under age five years. WHAT IS A STRATEGIC INVESTMENT? Spending money does not automatically buy better health outcomes. In an American Journal of Public Health report published in 2014, Barthold et al. found “robust differences” among Organization for Economic Cooperation and Development (OECD) nations from 1991 to 2007 in the efficiency of their health spending, as measured by life-expectancy improvements achieved for each one percent increase in annual health care expenditures.2 The United States ranked poorly in these international comparisons, ranking number one in per capita health expenditures, but 19th among OECD nations in the translation of spending into increased OECD life expectancy. The human return on US health dollars invested was only one fifth to one sixth that of Germany and Switzerland. A most basic choice is total spending. Budhdeo et al. showed that a one percent decrease in health care spending in European Union countries was associated with short- and long-term increases in mortality across a wide range of age–gender groups.3 How the money is spent also matters. Among nations, greater public-sector spending had far greater impact on survival than total spending, and up to a certain level, publicsector government spending was significantly more efficient.4 The United States continues to be the outlier in these international comparisons. The moral choice to favor health care provider autonomy and free market economics over the collective good provides an ongoing demonstration of the US capacity to achieve market fragmentation and collective inefficiency in spending. A related outcome is the persistence of gaping inequalities in health care access and health outcomes, which exact not only a human cost, but also a significant and avoidable economic burden. ELIMINATING HEALTH DISPARITIES Eliminating health disparities and making progress toward health equity comes down to a series of choices. Expanding Medicaid and providing health insurance subsidies in the Affordable Care Act were small steps toward the progressive universalism that is necessary but not sufficient for ensuring population health. Repealing only those portions of the Affordable Care Act preferentially supporting the poor while maintaining only the provisions supported by families already able to purchase health insurance for themselves and their families will be a decision to move away from health equity, a choice violating the moral principles of justice and nonmaleficence. Even so, we can choose to make progress on racial/ethnic disparities in health outcomes. Fuchs recently documented mounting evidence of Black gains in life expectancy, and even greater gains among lower-income segments of the Black population.5 More than a decade ago, under the intellectual and moral leadership of David Satcher and Robert Levine, our team at the National Center for Primary Care at Morehouse School of Medicine dared to imagine, “What if we were equal?”6 We demonstrated that although Black–White disparity rate ratios had changed little over the decades from 1960 to 2000, the 40-year flatline was actually the average of significant reductions in Black–White disparities for women and increasing disparities for men. The choices we made as a nation mattered. Black women’s income as a percentage of White women’s increased significantly, even as antipoverty programs explicitly favoring women and children (the Special Supplemental Nutrition Program for Women, Infants, and Children; Medicaid; family planning; etc.) were being implemented. Black– White disparities for women declined. At the same time, our nation chose to systematically exclude men from these same programs, and to disproportionately incarcerate Black men, exacerbating male Black–White mortality disparities. Research on local-area variation in disparities shows that some communities are moving toward more optimal and equitable health outcomes without necessarily making conscious choices to pursue health equity or even being aware of their own progress. We have documented US counties that have moved from high levels of racial disparity to near equality in measures ranging from infant mortality to breast and colorectal cancer mortality across the entire population, as well as significant county-level variation in racial disparities in the low-income Medicaid population for conditions ranging fromasthma toHIV. At the root of health disparities are social determinants. When policy decisions and systems combine to increase inequalities in equity. Behavioral health. Resiliency. Social cohesiveness. All of the above. Many income, wealth, and opportunity, they represent an explicit choice to move away from health equity. Even so, social determinants are not entirely deterministic, and demographics are not destiny. Levine et al. found 66 counties in the United States [have] with lower Black male mortality rates than the US average White male mortality rate, with no significant difference in Black– White poverty rate ratio or residential segregation index.7 Perhaps we can find replicable paths to health equity by learning from these positive outlier communities that have succeeded in making a way out of no way. The road out may not be the same as the road in. PROMOTING INTEGRATION It will not be easy. There are highly complex, bidirectional associations among upstream, midstream, and downstream factors driving disparities. No single intervention will produce health equity. We must consciously connect our efforts across sectors to achieve collective impact. We must become a cohesive and effective movement, promoting integration and managing the in-betweens of all sectors. Medical care. Public health. Community leadership development. Income equality. Economic development. Wealth equality. Educational communities have individuals or agencies working in each of these areas, but let us ask—whose full-time job is it to build the coalitions, to maximize collaboration, to deepen partnerships, to measure collective impact, and to create structures for mutual accountability on the specific objective of health equity? Who is actively measuring and reporting explicitly on progress toward equality of health outcomes and social determinants repeatedly in real time, to energize rapid cycle improvement across entire communities and nations? Global health research and US health equity research alike suggest that population health and economic efficiency are not incompatible. They are mutually reinforcing. We can choose both health equity and economic efficiency by demanding the most effective human return on investment (whether measured as improved survival, or decreased suffering, or best possible health) for the greatest number of people—in other words, committing to spend every dollar efficiently to achieve optimal and equitable health outcomes for all. Other nations are achieving much higher economic efficiencies and much better health outcomes by using public-sector investments for the collective good. So let us choose to spend our money wisely. Let us demand the greatest human return on investment for every dollar we spend. Let us pursue optimal and equitable health outcomes for all with precise economic efficiency. We can achieve health equity—if we choose to.

#### Third – NPs’ approach to care is transformative, accounts for social and economic determinants of health outcomes, and meaningfully distinct from physicians

Trotter 20 [LaTonya J. Trotter, Assistant Professor of Sociology at Vanderbilt, More Than Medicine : Nurse Practitioners and the Problems They Solve for Patients, Health Care Organizations, and the State 2020]

When I first arrived at the Grove, I was taken aback by the kind of intensive management that happened in its exam rooms. Very little of the activity in the clinic looked anything like what I expected to see within the medical encounter. But after months of observation, my initial surprise had settled into expectation. The case of Ms. Payne was not an outlier. Nor was Michelle an organizational aberration. The knitting together she performed for Ms. Payne was emblematic of the work of all the Grove’s NPs—not only for patients undergoing low-risk surgeries but also for those living with end stage renal disease, struggling through the uncertainties of multiple sclerosis, or dying from cancer. After months of watching these NPs at work, I confess that I had started to take this state of affairs for granted: this was the work these NPs did; this was the work the Grove needed them to do. Michelle, however, may not have seen things in quite the same way. As we ended our last conversation about Ms. Payne, Michelle flashed a smile that was not really a smile and asked, “Now what part of all that was medical care?” Her question shook me out of my analytical complacency and, to a large extent, animates the questions at the heart of this account. How should we understand the care that NPs provide? And whose problems are they intended to solve?

From the ten-thousand-foot view of policy, the answers to both questions seem fairly clear. The care NPs provide should, ideally, be the same as that of physicians. Physician indignation notwithstanding, the scholarly consensus is that this is the case. Fifty years of research has demonstrated that patients who see NPs largely have the same outcomes as those who see physicians; when there is a discrepancy, it is usually in the NPs’ favor (Buerhaus et al. 2018; DesRoches et al. 2017; Horrocks, Anderson, and Salisbury 2002; Landsperger et al. 2016; Laurant et al. 2004; Lenz et al. 2004; Martínez-González et al. 2014; Mundinger et al. 2000; Naylor and Kurtzman 2010; Newhouse et al. 2011; Ohman-Strickland et al. 2008; Ramsay, McKenzie, and Fish 1982; Stanik-Hutt et al. 2013). This robust evidence of equivalence grounds our collective assumptions about what NPs are for: to fill in for the missing physician.

Nurse practitioners were, in fact, intentionally created to deal with the growing scarcity of primary care physicians. In the 1960s, that scarcity was triggered by increased demand for services caused by the baby boom and the creation of public health insurance in the form of Medicare and Medicaid (Fairman 2008; Silver, Ford, and Steady 1967). Today, that scarcity is exacerbated by our aging population and the expansion of insurance through the Patient Protection and Affordable Care Act. Meeting this growing demand comes with a cost for insurers as well as health care organizations. That NPs are cheaper to train and less costly to employ than physicians has led to their being championed by policy makers and economists alike.

The NP as policy solution rests on a logic of substitution: when physicians cannot be found or afforded, the NP is a reasonable facsimile. The story of Ms. Payne suggests an alternate view of NP utility. Although paying for medical care remains an issue for many, it was not one for Ms. Payne. Like most Americans, she became eligible for Medicare when she reached the age of sixty-five. However, despite having a payer for medical services, she did not always have access to the full range of assistance she required. Ms. Payne needed help getting back and forth to medical interventions such as her cataract surgery. She needed help adhering to medical regimens such as her postoperative care instructions. Even before any of this practical work commenced, she needed someone to help her think through the help she needed and to coordinate with a range of people and organizations to make it happen. None of this assistance is paid for by Medicare because none of it qualifies as medical care. Even if she qualified for public or charitable programs to meet these needs, accessing and navigating those resources would require both knowledge and time. Although much has been made of the physician shortage, Ms. Payne’s hurdles equally arose from the scarcity of supportive care.

Ms. Payne’s story is also an illustration of the intertwined problems of economic and social precarity. Ms. Payne was not only a beneficiary of Medicare; she was also a recipient of Medicaid. Because poverty is the primary eligibility criterion for Medicaid, we often think of it as health care for the poor. However, it might be more accurate to call it long-term care for the ~~disabled~~. While long-term care sometimes includes skilled nursing, it is primarily designed to assist with the activities of daily living, such as bathing, dressing, eating, and toileting. Because these services are excluded from Medicare, individuals and families have to pay for them on their own.

Few can shoulder these costs for years on end. In 2018, the yearly cost for forty hours a week of home care assistance was just under forty-six thousand dollars (Genworth 2018). These expenses are in addition to the mounting costs of medical care. Even the insured are expected to pay some portion of the costs of medications, hospitalizations, and provider visits. If nursing home placement becomes necessary, these costs can increase exponentially. In 2018, the annual cost of a semiprivate nursing home room was just over eighty-nine thousand dollars (Genworth 2018). While some may enter older adulthood in poverty, a great many others become poor as a consequence of failing health and mounting costs. For adults, it is often the combination of poverty and disability that results in eligibility for Medicaid. As a consequence, Medicaid 6 has become the single largest payer for long-term care in the US. In 2015, Medicaid paid for 36 percent of all home health care and 31.7 percent of all nursing home care (Burwell 2016).

Entering older adulthood intensifies not only economic needs but also social needs. In addition to paid care, most older adults rely on the unpaid assistance of family and friends (Freedman and Spillman 2014). Much of this assistance is material, such as help with transportation, grocery shopping, or household maintenance. Social support is also important. While aging itself does not increase social isolation, the illness and disability that often accompany it do (E. Y. Cornwell and Waite 2009a, 2009b; B. Cornwell, Laumann, and Schumm 2008). As one’s needs increase, the resources in one’s personal networks can become strained and sometimes exhausted. Medical vulnerability is often exacerbated by economic and social vulnerability, which in turn can negatively impact health and quality of life (Krause, Newsom, and Rook 2008; Newman 2003).

At the Grove, patients like Ms. Payne, faced with the interconnected problems of aging, illness, and poverty, turned to their NPs for a kind of work that was more than medical care. And at least some of the time, they found it. This book is an on-the-ground account of how a group of NPs cared for four hundred African American older adults living with poor health and limited economic resources. I followed these NPs as they saw patients, met with colleagues, and spoke with family. What I witnessed was less a facsimile of physician practices than a transformation of them. These NPs expanded the walls of the clinic to include not just medical complaints but a broad set of ~~indigenous~~ complaints. Patients presented with serious medical problems, such as congestive heart failure and diabetes, but they also brought a broader set of social and economic problems that, for them, were of equal importance. In response, the NPs practiced a professional openness to information and problems that are usually filtered out of the exam room. In response to this openness, patients and their families turned to the clinic as the place to get a diversity of needs met. Through this iterative cycle of openness and turning to, both the encounter and the work performed within it were transformed.

Clinic Work

The proposition that NPs are doing different work from physicians is grounded in a broader historical distinction between medicine and nursing. If physicians are the iconic providers of medical work, nurses are the iconic providers of care work. Broadly speaking, care work is defined as labor—paid and unpaid—that cares for members of society who cannot care for themselves because of age, illness, or disability (Duffy 2005; England 1992). While some scholars make further divisions between types of care work, what fundamentally distinguishes care work from other forms of labor is how it is performed and, often, who performs it (Duffy, Albelda, and Hammonds 2013; England 2005).7

Care work is based less on discrete services than on a general responsiveness to the needs of a person. In this way, care work is inherently relational. To use an example outside health care, kindergarten teachers are involved not just in educational instruction but in helping their charges eat, visit the toilet, and learn to socialize with one another. Moreover, how the work unfolds depends on the quality of the relationships that form between students, teachers, and parents. These features of the work cannot be separated from the fact that most care workers are women. Care work often overlaps with labor historically performed by women in the domestic sphere. Those who perform such work today continue to be marked by gender and the lower status associated with “women’s work” (Charles and Grusky 2005; England 2010; England, Budig, and Folbre 2002). Despite the gendered devaluation that comes with seeing nursing as care work, nurses continue to claim care as a category and relationship as a feature that distinguishes the practice of nursing from the practice of medicine (Apesoa-Varano 2007, 2016; Evans 1996; Radwin 1996; Tanner et al. 1993).

In this account, I advance the notion of clinic work to illustrate the ways in which the Grove’s NPs brought care work into the medical encounter. I employ this term for two reasons. First, it reflects the reality that the NPs’ work was different in both form and content from the medical work of their physician colleagues. This difference was a consequence not of formal role distinctions but of a very different embodiment of what it meant to address patient complaints. When family disagreements and economic challenges were allowed to enter the clinic as part of the problem of disease management, what “disease management” meant was fundamentally altered. The observation of this difference came not only from me but also from the physicians—the providers best situated to evaluate what medical work was and was not. However, the NPs did address bodily complaints. Moreover, they were held to account by billing paperwork that required their work be made visible as medical work. Because they were doing this work from within the medical visit, this expansive form of clinic work had consequences not only for constructions of NP work but also for changing expectations of the medical encounter.

Second, I use clinic work to underline the ways in which the NPs’ work invoked a different form of relationality—it was in deep relationship with the organization or clinic in which it was located. The Grove’s NPs worked in a context organized around teams. The traditional boundaries one might draw between forms of expertise were less apparent in this organizational context. For patients whose problems were defined as much by poverty as by illness, and whose care was as much a feat of coordination as one of curative treatment, the lines between medical problems, social problems, and organizational problems were not easy to draw. In order to understand the construction of clinic work, I had to account for the ways in which some problems became NP problems while others did not. I discovered that the transformation of the clinic encounter was about neither the rearrangement of tasks nor the renegotiation of turf alone, but rather the working out of much deeper questions about what these problems were, and who was responsible for solving them. The organizational context in which this working out occurred is as much a part of the story as the providers themselves.

Organizational Care Work

Forest Grove Elder Services is not an ordinary outpatient clinic. It is a federally backed policy experiment to evaluate whether a comprehensive care model could ameliorate the state’s economic burdens for long-term care. The pillars of the Grove’s cost savings are coordination and capitation. The team model was its primary strategy for coordinating care. Each team consisted of a mandated mix of providers who worked together not only to provide direct medical, nursing, and supportive care but also to coordinate access to specialists, home care aides, and a host of ancillary services. To pay for this care, the Grove received monthly per capita or per member payments instead of fee-for-service reimbursements. This system provided an incentive to control costs and incentivized preventive over interventionist forms of care. Yet the Grove still operated under the quasi-market logic of all US health care: if its members did not believe they were receiving quality care, they could take their Medicaid and Medicare insurance elsewhere. The Grove had to provide not just cheaper care, but care of sufficient quality to successfully compete with other health care organizations. In some ways, the Grove’s experimental objective was to figure out how to deliver care work under the aegis of medical care. Its mission of intensive management and service coordination necessitated a layered understanding of each patient that required it to be responsive to a broad and variable set of individual needs. Even speaking of its patients as “members” was a nod to the expectation of relationship and responsibility. How does an organization—whose payment structure and regulatory environment still make it primarily accountable for medical work—deliver on the promise of providing the kind of patient-centered relationality required of care work? At the Grove, the answer was through its NPs. One of the unique features of the Grove was that the NP, rather than the physician, was the formal head of the team. What it meant for the NPs to lead, however, was unclear. I observed that NP leadership was often reworked as NP responsibility. The NPs became solely responsible for ensuring that the Grove’s mission of coordination was achieved. Within the expansive category of clinic work, the NPs were expected to deal with a broad set of problems not only as a way of helping their patients but also as a way of managing “difficult patients” for their employer. Doing so was not a simple matter. Various departments inside the Grove had to work together for member care, and the Grove had to communicate with a range of external organizations and family members. Moreover, the work of coordination seemed to generate as many problems as it solved. For the NPs, solving member problems often involved helping them navigate the inefficiencies of the organizations in which they sought care—including those at the Grove. I argue that these NPs were not simply performing an expansive form of work on behalf of their patients; they were also providing an expansive form of organizational care work for their employer. As the NPs put out a range of social and organizational fires in the exam room, they were tasked with the invisible work of caring for the organization as they cared for patients. Clinic work was not in opposition to organizational demands but was partly constructed through the NPs’ responsiveness to them. Problems not solved within the exam room became organizational problems. Patients whose social problems were significant hurdles to medical stability might transition to higher and more expensive forms of care. Members who struggled to navigate the Grove’s inefficiencies might leave the program, expressing their dissatisfaction with the Grove in a way that was visible to the state. The NPs’ performance of organizational care work made them a different kind of provider to patients, as well as a different kind of worker for their employer. I entered the Grove attentive to the work of the NP. My main finding is that their labor became the primary means through which the Grove embodied its own mission of being a caring organization. How these NPs turned a broad set of concerns into clinic concerns reflected the expectations of their colleagues and employer as much as those of patients. I argue that these NPs were doing more than practicing medicine sprinkled with nurse-branded empathy; they were transforming the nature of the work itself.

Nursing’s Utility under State Retrenchment

In exploring how these NPs solved problems for members and their employing organization, I had to grapple with the larger context in which these problems came into being. Physician scarcity is often treated as a naturally occurring problem inherent to developed countries with high demand for medical care. Yet this scarcity is not simply a consequence of consumer demand; it is a consequence of inequality. Not everyone struggles to find a physician; those with the least lucrative problems and the fewest resources are the most likely to have trouble accessing physician care. Perhaps one might wish that physicians would behave more altruistically. However, I argue that this uneven distribution of workers and work is a consequence of state inaction rather than individual career choices. While the federal government has decried the physician shortage, it has largely taken a noninterventionist approach in addressing it. The state may coax or convince, but if physicians prefer dermatology to pediatrics, it will not compel. This reticence to use state power is not matched by a reticence to provide state funding. In 2015, the federal government provided 14.5 billion dollars to support medical residents working in teaching hospitals (Villagrana 2018). Even the economic disincentives to working in primary care are a function of state inattention. The comparative lucrativeness of specialty care is partly a consequence of unregulated prices. The federal government treats health care as a commodity and largely declines to interfere in the medical marketplace. It becomes impossible to understand the creation of NPs without placing them within the context of what the state has decided not to do. In the years since I began this research, I have often been asked how NPs in the US compare to those in other parts of the world. The simple answer is that there is no other country that uses NPs in quite the same way. Governments that are less reluctant to directly control costs and personnel have less need for this new provider. Some countries, such as Canada, the United Kingdom, and Australia, are in the process of experimenting with NPs. Referencing the US as a model, they are deploying NPs to counter physician shortages in medically underserved areas. However, the NPs’ extensive use and level of practice autonomy is a uniquely US phenomenon because the US is singular in having a ~~hands-off~~ approach to health care while largely financing its provision. In 2013, the federal government financed nearly two-thirds of all US health care (Himmelstein and Woolhandler 2016). In this context, the NP becomes a privatized, professional response to a set of policy problems that the state has declined to address through other means. The pairing of state financing with privatized solutions has come to characterize not just health care policy but the US welfare state more broadly. Since the 1980s, the US has been the chief evangelist and implementor of neoliberal policy reforms (Centeno and Cohen 2012). Most of these reforms have been directed at deregulating money and labor; however, the general tenet of favoring markets over state influence has had a significant impact on social policy. A move toward smaller government has resulted in the downsizing and privatization of state and federal safety-net programs (Morgen 2001; Smith and Lipsky 2009). The socially and economically vulnerable have been the chief casualties of this approach. But there have also been professional ones. Social workers were once the professional ~~foot~~ ~~soldiers~~ of the welfare state. In the early to mid-twentieth century, the robustness of professional social work reflected prevailing ideas about the state’s role in addressing the symptoms and structural causes of poverty. As the government established relief programs and national efforts such as the War on Poverty, it relied on social workers to carry them out (Ehrenreich 1985). However, the use of state power to address inequality has fallen out of favor. Many of the programs that social workers once implemented have languished or disappeared. Those that remain are increasingly privatized, with social work’s purview narrowed to policing client eligibility rather than providing therapeutic assistance or community development (Lipsky 1980; Schram and Silverman 2012; Smith and Lipsky 2009). With little to no state support, social work’s professional decline was all but inevitable. The story of social work’s falling fortunes is more than just an interesting piece of occupational history. Its diminished status reflects the state’s disavowal of any moral obligation to ameliorate social inequality. Although individual social workers continue to fight on behalf of their clients (Aronson and Smith 2010; Fabricant, Burghardt, and Epstein 2016), social work is in danger of becoming a disciplining agent of the state rather than the agent of social change its pioneers envisioned it to be (Schram and Silverman 2012; Soss, Fording, and Schram 2011). How this shift occurred is a question best addressed by historical analysis. But the logic of its reproduction can be understood through attention to the work that social workers do, and don’t do, within the multidisciplinary environment of a health care organization. The Grove was not unusual in employing NPs, but it was unusual in employing social workers. Social workers are a rarity in outpatient care because, usually, there is no payer for their work in this setting. At the Grove, social worker inclusion was required by the federal regulations that governed the program. Their presence raised an important question: How did the clinic encounter, rather than the social work encounter, come to be the appropriate location for the “sticky” problems of coordination and social precarity? I found that the social workers occupied a marginal position within an organization whose economic solvency was based on the performance of medical work. The logic of medical necessity that set priorities for the Grove’s resources led to an institutional disinvestment in both the social workers and their realm of expertise. The social workers found that what they thought of as real social work had been replaced by labor that was largely in service to state-required paperwork and the regulatory requirements of medical work. Comparing the plights of the Grove’s NPs and its social workers revealed that the appearance of social problems in the exam room was a function not just of NP professional openness within the clinic encounter, but of the lack of resources given to address these problems outside it. The federal government has largely withdrawn itself as a payer for the problems of poverty even as its financing of medical care has soared. I argue that the saliency of the NP is as much a story of welfare state retrenchment as one of economic utility. The hurdles faced by the Grove’s social workers illustrate the limitations of analyzing occupational strategies without placing them within a larger political economy. The NP as policy solution is based on the logic of substitution. Once we start interrogating this logic, a new set of questions arises. As the sociologist Everett Hughes (1970) observed, experts do not just solve our problems; they shape our conceptions of them. The NP might be the kind of solution that rearranges the problem in new ways. Accordingly, the chapters that follow do more than describe the work of a particular category of clinician. They provide a view, from the ground up, of a broader reorganization of medical labor and its relationship to the ever-shifting division between medical problems and social problems. Nurse practitioners are often thought of as filling in for the absent physician. Together, these pages make the case that NPs are just as often filling in for the absent state.

The arguments I make in this book speak to broad changes in health care delivery. Although these arguments are far-reaching in their implications, they are made through the materiality of Forest Grove Elder Services. The first chapters of the book speak directly to the idea of NPs as a policy solution. In part I, I situate the Grove as both a professional and an organizational solution to the problems of health care, old age, and poverty. The Grove and its NPs do not exist in a vacuum; they coexist in a policy environment in which both nursing and health care organizations are seeking to capitalize on state support. I illustrate that the expansion of nursing’s terrain is intertwined with changes in the organization and provision of care for older adults. I then describe the professional resources that these NPs used to construct a notion of clinic work within this expanded terrain. In following the journey of member problems—how they are generated, to whom they are brought, and who fixes them—I reveal organizational logics about the type of expertise the Grove collectively believed resided within the clinic. Part of the work of this section is to reinterpret the clinical encounter as more than a meeting between a medical provider and the patient’s chief complaint, but as an institutionally situated meeting of a range of complaints. I make the case for the NPs’ performance of organizational care work by paying attention to the work they do and contrasting it with the work the physicians do not.

In part II, I demonstrate how the new notion of clinic work effectively reconstructs physician understandings of what constitutes medical work. I begin by looking directly at the relationship between NPs and physicians. The NPs I followed had three distinct views of who physicians were in relationship to their own practice: consultants, captains, or teammates. These three framings led to very different ways of being what each considered a competent NP. I then investigate how the physicians reoriented their own domain of work in the face of the NPs’ view of their role. I pay particular attention to the unease experienced by physicians who found themselves working within NP-led teams, as well as how that unease was managed through actively relocating physician expertise outside the clinic. In doing so, I show that the NPs’ clinic work was a relational concept that required adjustments in how physicians understood their own work.

In part III, I consider how the expansion of clinic work is inextricably tied to the shrinking domain of social work, both as a profession and as an orientation to social problems. Empirically, I ground my analysis in the everyday work of the Grove’s social workers, who are positioned at the margins of an expanding clinic. I situate these observations within a broader view of social work’s precarious professional position. Part of the challenge of claiming expertise for social work is its location in the devalued world of social problems. In this section, I argue that the legitimacy of the NP is related to the delegitimization of social work. The different fates of these two professions do not simply represent a problem of professional strategy; rather, they reflect an unwillingness, in policy and in ideology, to recognize the economic and political character of social problems. I end by questioning professionalization more generally as a privatized response to collective concerns.

Through illustrating these arguments, this book is both a meditation on and an empirical excavation of the possibilities NPs are forging within the confines of the medical encounter. When NPs fill the space that physicians have absented, they are embodying a different set of possibilities for what the health care encounter could be. In doing so, they are positioned to make [recognizable] ~~visible~~ not just the scarcity of physician labor but that of caring labor. Although sometimes self-conscious of the claim, nursing still relies on care as the bedrock of its professional identity and legitimacy. To care is not empty rhetoric; it is work. And although it is usually seen as ancillary to the main stage of medical interventions, health care organizations have never been more reliant on such work. The Grove’s NPs may have been unique in the wealth of organizational resources available to them as they embodied nursing expertise. However, I believe they are not alone in being asked to solve different problems than their physician colleagues.

I suggest that, as providers with different professional experiences and held accountable to different expectations, NPs are opening the exam room to a different kind of clinical performance. Not only is this performance reshaping our ideas about medical work, but it is also a mirror that reflects how we choose to care for our most vulnerable citizens. In this account, I have avoided revisiting the question of what kind of work NPs should or should not do. Rather, I provide a closer look at the work they are actually doing, not just for their patients but for the health care organizations that employ them and for the state, which chooses to care in some ways but not others. In focusing on the work NPs do, I hope to both illuminate and trouble the relationship between who we think should solve our problems and what we understand those problems to be.

#### It better accounts for social determinants – incremental reforms are meaningful

Heath 20 [Sara Heath, health care journalist for PatientEngagementHIT 7-20-2020 https://patientengagementhit.com/news/why-nurse-practitioners-are-pivotal-in-health-equity-work]

When COVID-19 first came ashore in the United States, it quickly became apparent that the virus would bring to light racial health disparities that have long pervaded the healthcare industry.

It didn’t take long for the virus, which can become more harmful when an individual has comorbidities, to show itself more harshly among certain populations. Across the country, more Black patients have suffered from COVID-19 and in worse forms, according to Centers for Disease Control & Prevention (CDC) data.

In the agency’s weekly report ending on July 11, 2020, CDC said there were 227.1 COVID-19 hospitalizations per 100,000 non-Hispanic Black patients, compared to only 49 COVID-19 hospitalizations per 100,000 white patients.

For non-Hispanic American Indian or Alaska Native patients, that rate came in at 273 hospitalizations per 100,000 patients, and 224.2 hospitalizations per 100,000 Latinx patients.

Across the industry, leaders were largely unanimous in saying that these health disparities are not new in the age of coronavirus; instead, coronavirus has shown an unflattering spotlight on health disparities that were already there.

“Sadly, the health disparities that are making the news today aren't new and they're not specific to COVID-19,” said Sophia Thomas, DNP, APRN, FNP-BC, PPCNP-BC, FNAP, FAANP, the president of the American Association of Nurse Practitioners (AANP).

For Thomas, health inequity has been a long-standing issue. Nurse practitioners and those working within the AANP specifically have been sounding the alarm on healthcare disparities for years, she said. The current climate with COVID-19 has provided a tangible example of how health inequities ultimately manifest.

Health inequities start with the social determinants of health, Thomas explained, and how those social risk factors limit an individual’s ability to achieve wellness. Because traditionally underserved populations, like Black, Hispanic, and Indigenous populations, must contend with structural and cultural limitations to care and other resources, they adversely experience social determinants of health.

“When you think about long-term health outcomes and assisting in staving off short-term health complications, providers need to consider things such as poverty, economic stability, safe and accessible housing, and food security,” Thomas, a practicing nurse practitioner herself, told PatientEngagementHIT.

“We talk about food deserts, dependable transportation, and then probably most importantly from our aspect, training and education that provides a pathway for all patients to have greater access to primary care.”

Again, this isn’t a new trend, Thomas acknowledged. Decades of institutional inequities have set the stage for a health equity crisis to come to bear like it has during the COVID-19 pandemic.

“Really, the CDC's recent racial and ethnicity data are proof positive that health systems, policy makers, healthcare providers all need to work together now more than ever to stop the COVID-19 impact on communities of color,” Thomas explained.

And it’s nurse practitioners who can play a pivotal role in that, she asserted.

“What makes us unique is that we have a foundation in nursing and with that we also have a holistic approach to patient care,” Thomas stated.

“So when we, for example, tell a patient she has diabetes and give her a prescription for her medication, we're not just prescribing medication and saying ‘follow up with us in three months.’ We're making sure that she can afford that medication. We're discussing with her at that time some diet and lifestyle changes.”

And it’s that very discussion that Thomas said truly makes a different in self-management for a chronic illness and can ultimately tame those comorbidities that have manifested themselves during the COVID-19 outbreak.

Delivering that care management across every community, especially traditionally underserved ones disproportionately experiencing social determinants of health, will be the first step to addressing health equity, at least on a micro scale.

“The most important thing is listening. But with that, before we start the office visit or discussing the reason why patients are there, we may just do a little bit of small talk to get to know them to hear about their life,” Thomas advised, outlining what an encounter that addressing social determinants of health with a nurse practitioner can look like.

“In hearing the stories, they key us into possible issues that may happen,” Thomas said.

During the coronavirus pandemic specifically, Thomas has been taking advantage of the widespread use of telemedicine to understand the social circumstances in which her patients live. Telemedicine lets Thomas see her patients’ housing situations, or during a conversation about nutrition Thomas can prompt her patients to show her their pantries, if they are interested and engaged.

And perhaps most important, nurse practitioners are poised to establish trust with their patients, something that is essential for discussing sensitive topics like social needs and is important when working with traditionally marginalized communities.

“We call on our nursing foundation of compassion and empathy to build a relationship with patients and their family members,” Thomas explained. “Surveys year after year show that nurses are listed as one of the most trusted professions.”

Patients will tell Thomas things they have never felt comfortable admitting to their doctors, she shared, underscoring the important role nurses play in being a trusted confidante for underserved patients.

But nurse practitioners can’t accomplish these goals without some support. Importantly, Thomas said nurse practitioners need expanded scope of practice regulations in order to fulfill their potential while treating patients.

“There are 77 million Americans that live in communities that don't have adequate access to primary health care, and about 80 percent of rural America is actually designated as medically underserved,” Thomas said.

At the same time, the 10 states with the best health outcomes also have the most flexible scope of practice laws for nurse practitioners, Thomas said, citing the US News and World Reports rankings. In the 10 states with the worst health outcomes, nurse practitioners face the strictest scope of practice laws.

When access to quality care is at the crux of health inequities, Thomas said this is a huge issue.

#### Our multi-method analysis foregrounds the contextual interactions between semiotic violence and epidemiological patterns in communities of syndemic disadvantage – avoiding reductionism is key to effective praxis

Rylko-Bauer & Farmer 16 (Barbara Rylko-Bauer, medical anthropologist, adjunct associate professor, Department of Anthropology, Michigan State University, Ph.D. anthropology, University of Kentucky, B.S. microbiology, University of Michigan; and Paul Farmer, anthropologist and physician, co-founder of an international social justice and health organization, Partners In Health, Kolokotrones University Professor at Harvard University, former Presley Professor of Medical Anthropology in the Department of Social Medicine at Harvard Medical School, attending physician and Chief of the Division of Global Health Equity at Brigham and Women's Hospital, chairman of Harvard Medical School's Department of Global Health and Social Medicine, Ph.D., M.D. medical anthropology, Harvard University, B.A. medical anthropology, Duke University; “Structural Violence, Poverty, and Social Suffering,” in *The Oxford Handbook of the Social Science of Poverty*, eds. David Brady and Linda M. Burton, May 2016, http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199914050.001.0001/oxfordhb-9780199914050-e-4)

Structural violence is the violence of injustice and inequity—“embedded in ubiquitous social structures [and] normalized by stable institutions and regular experience” (Winter and Leighton 2001:99). By structures we mean social relations and arrangements—economic, political, legal, religious, or cultural—that shape how individuals and groups interact within a social system. These include broad-scale cultural and political-economic structures such as caste, patriarchy, slavery, apartheid, colonialism, and neoliberalism, as well as poverty and discrimination by race, ethnicity, gender, sexual orientation, and migrant/refugee status. These structures are violent because they result in avoidable deaths, illness, and injury; and they reproduce violence by marginalizing people and communities, constraining their capabilities and agency, assaulting their dignity, and sustaining inequalities. While these outcomes are “experienced individually, structural violence targets classes of people and subjects them to common forms of lived oppression. Hence, the experience of structural violence and the pain it produces has been called ‘social suffering’ ” (Singer and Erickson 2011b:1). Like structural violence, this concept defies neat categorization, since it “results from what political, economic, and institutional power does to people, and reciprocally, from how these forms of power themselves influence responses to social problems” (Kleinman, Das, and Lock 1997:ix). Social suffering captures the lived experience of distress and injustice, while exposing the “often close linkage of personal problems with societal problems,” thereby challenging the problematic tendency in the social, health, and policy sciences to focus mainly on the individual and ignore broader determinants (Kleinman et al. 1997:ix). Structural violence focuses attention on the social machinery of exploitation and oppression—“the ways in which epic poverty and inequality, with their deep histories, become embodied and experienced as violence” (Farmer 2010:293). We have yet to (p. 48) find a better phrase to convey these harmful and often fatal processes. We begin with a vignette from the poorest country in the Western Hemisphere that vividly illustrates such processes and puts a face on structural violence. We then discuss the historical roots and characteristic features of this concept, explore its relationship to other types of violence, and survey how it has been applied across various disciplines to enhance our understanding of social problems linked to profound poverty and social suffering. We conclude with an overall assessment of the utility and relevance of structural violence to social analysis. The Face of Structural Violence Mirebalais is a busy market town in the middle of Haiti’s Central Plateau. It appears on maps from the colonial era, when French slaveholders extracted great bounty from their most productive colony until a slave revolt that began in 1791 brought at least this form of exploitation to a bloody end. Through the first century of Haiti’s independence, Mirebalais was a small agricultural hub where peasant farmers—the descendants of the victorious rebel slaves—gathered on Saturdays to buy and sell their wares. In the 1920s, the Central Plateau was the site of skirmishes between the United States’ Marine Corps, who were then occupying Haiti, and the armed resistance that ensued. The remainder of the twentieth century was not particularly kind to Mirebalais either. While its population grew, the town enjoyed very little in the way of modern infrastructure development. A few paved roads crossed the town square, and a single bridge spanned the Latem River. This relative modernity may have accounted for the decision in 2004 to site the regional hub of the UN’s peacekeeping mission there. In 2008, four hurricanes hit Haiti in less than two months. During the third of these, a tributary of the Latem rose in fury through the peacekeepers’ camp, manned largely by Nepali troops, sweeping white containers emblazoned with the UN logo first into the river and then against the bridge, which collapsed. The bridge over the Latem has never been repaired; only a cement ford connects the Central Plateau to Haiti’s western coast. The hurricanes, powerful though their impact was, did not change life in Haiti as radically as the 2010 earthquake that killed over a quarter-million people and displaced over three million more, including 500,000 to the Central Plateau. One consequence was the nation’s first recorded cholera epidemic. The lack of clean water in Haiti had been earlier identified as a predisposing risk factor for epidemic illness, including cholera (Varma et al. 2008). With few sources of water for drinking and cleaning other than the local rivers, the stage was set for the introduction of waterborne pathogens and their rapid spread throughout the country. Among the most vulnerable were those living with both poverty and mental illness (Ivers and Walton 2012). From the age of 12, Pierre (a pseudonym) and his family knew that something was wrong. Pierre “heard things,” and his auditory hallucinations evolved into frank paranoia and grossly disorganized thought. He left his family and took to wandering (p. 49) the streets of Mirebalais, often naked, sometimes taunted by local children and passersby, but mostly left alone as moun fou (crazy person). He regularly bathed and drank directly from the Latem River, living a fragile, often miserable existence on the city’s streets. On October 12, 2010, Pierre, now in his 30s, suffered a violent onset of profuse watery diarrhea. He returned home but quickly died before his family could seek medical attention. They contacted a funeral home in Mirebalais, where Pierre was bathed, dressed, and laid out for a classic Haitian wake. When two of the helpers who had prepared Pierre’s body for burial fell ill with similar explosive diarrhea, suspicions of communicable disease were raised. By October 20, less than two weeks after Pierre’s attack of sickness, there were scores of cases of profuse diarrhea in Mirebalais and in the villages connected to it by the Latem and its tributaries. The epidemic raced west along Haiti’s largest river, reaching the coastal cities of Gonaïves and Saint-Marc. By October 22, the Haitian authorities, working with international authorities, announced that for the first time in recorded history, cholera had reached Haiti—likely brought there by Nepali UN forces and introduced into the river system through faulty sanitary practices at the UN base camp at Mirebalais. In reporting on this first case, Ivers and Walton (2012:37–38) conclude: “This patient’s case illustrates the relationship between an infectious disease epidemic, mental health, and globalization. It highlights the fact that to provide and maintain health in circumstances of destitute poverty where many factors are at play … attempts to address individual pieces of health without consideration of the whole are as the Haitian proverb goes, ‘like washing your hands and drying them in the dirt.’ ” Understanding Structural Violence Historical Roots The term “structural violence” was introduced in a 1969 essay by Norwegian sociologist Johan Galtung, the main founder of peace and conflict studies and of the Journal of Peace Research. He defined peace as the absence of not only direct physical violence—ranging from interpersonal to collective violence—but also indirect structural violence, caused by forces such as poverty, marginalization, and exploitation.1 According to Weigert (1999:432), the notion of peace as more than the absence of war originates with Quincy Wright (1942:1305), who in A Study of War wrote that “the positive aspect of peace—justice—cannot be separated from the negative aspect—elimination of violence.” Galtung (1969:183) further conceptualized “positive peace” as the “absence of structural violence” and explicitly linked structural violence to unequal power, especially “the power to decide over the distribution of resources,” which results in “unequal life chances” (1969:171). He claimed that structural violence led to more death and suffering than physical violence, an observation later (p. 50) confirmed by Köhler and Alcock (1976), who estimated that the fatal consequences of structural violence globally for 1965 were about 130 times greater than for direct violence (Gilligan 1999). Galtung illustrated the idea of structural violence as avoidable harm by noting that deaths from tuberculosis in the eighteenth century were unavoidable, “but if [a person] dies from it today, despite all the medical resources in the world, then violence is present,” and he similarly argued that “differential social impact” from earthquakes is preventable (Galtung 1969:168, 186). Since then, others have linked the structural violence of poverty and environmental destruction to the increased risks and consequences of “so-called natural disasters, where conscious policies have made populations vulnerable and unprepared for predictable harms triggered by dramatic weather events” (Demenchonok and Peterson 2009:53; Kagawa 2005). The tragic aftermath of the 2010 Haitian earthquake, for example, included immediate fatalities and injuries as well as subsequent deaths and disease that were due to largely avoidable circumstances—lack of clean water, inadequate shelter, insufficient food, and poor access to medical care. It brutally exposed the pervasive, deeply rooted, and multifaceted structural violence that has plagued Haiti for decades (Farmer 2011a). The earthquake was, to use a term from clinical medicine, an “acute-on-chronic” event—direct violence on layers of structural violence. “It was devastating because a history of adverse social conditions and extreme ecological fragility primed Port-au-Prince for massive loss of life and destruction when the ground began shaking on January 12” (Farmer 2011b:3). Johan Galtung expanded on structural violence in later writings, suggesting ways of measuring its impact (Galtung and Høivik 1971), examining “social science as structural violence” (1975:264), and exploring how all types of violence are legitimized (1990). There were even attempts to compute an “index of structural violence” (Høivik 1977) that focused on differential outcomes, such as life expectancy, death rates, or loss of life years. Other scholars and advocates of social justice have explored the relationship of violence and injustice. Martin Luther King Jr. (1966) referred to “the violence of poverty” (see also Lee 1996; Gilligan 1997), and others have written about the violence of racism (Geiger 1997) and of hunger in the midst of plenty (Brown 1989). Newton Garver characterized violence as the violation of fundamental human rights, illustrated through examples from inner city ghetto life. His category of covert institutional violence that “operates when people are deprived of choices in a systematic way by the very manner in which transactions normally take place” is similar to Galtung’s structural violence (Garver 1973:265). The feminist movement also played a role “in opening up the definitions of violence to include a range of behaviours including … physical, emotional and psychological abuse” (Morgan and Björkert 2006:442). Around the same time, Latin American liberation theologians, such as Gustavo Gutiérrez (1973, 1983) and Dom Helder Camara (1971) were applying tools of social analysis to understand violence in that part of the world. Social structures such as profound poverty and racism, in conjunction with pervasive political oppression, were (p. 51) causing great suffering. Brazilian philosopher Paulo Freire (2004:118) wrote in 1977 that violence “refers not only to direct, physical violence, but also to … violence and hunger, violence and the economic interests of superpowers, violence and religion, violence and politics, violence and racism, violence and sexism, violence and social classes”—in other words, structural violence. Structural Violence: A View from Below For the last three decades, considerable effort has been devoted to critically examining and analyzing the epidemiology, political economy, and sociocultural nature of two deadly but treatable infectious diseases of global proportions: AIDS and tuberculosis—both the “centuries-old” TB and the “new” TB in its multi-drug-resistant forms (see Farmer 1992, 1997a, 1999, 2003, 2010). The aim of this work was to use theory and knowledge to advance praxis—to improve prevention and treatment for those most at risk of acquiring these diseases and dying from them. AIDS and TB serve as perfect laboratories for the study of structural violence (Farmer 1997b; Farmer et al. 2006), and are best understood as biosocial phenomena shaped by history, geography, and political economy, as well as the biological and social context of individuals and their communities (Farmer 2004). Both diseases disproportionately target populations living in great poverty. And such poverty is closely linked with gender inequality, racism, lack of access to the basic necessities of life, and lack of access to resources that maintain well-being, such as healthcare, education, jobs, and security (Farmer 2003; Mukherjee 2007). All diseases that affect primarily the poor are, by definition, neglected diseases, and cholera offers an object lesson. One hundred fifty years after John Snow took the handle off the Broad Street pump, more than a century after his suspicions of bacterial origin were confirmed, 60 years after antibiotic therapy was discovered, and 30 years after a safe and effective oral vaccine was developed, cholera remains—among the world’s poorest—a leading infectious killer. The cholera epidemic in Haiti, an island nation of 10 million, is the world’s largest in recent history. In its first year, cholera claimed some 6,500 lives and caused half a million cases (Farmer and Ivers 2012). These official numbers are undoubtedly low because there is little reporting capacity in rural areas, where the disease struck first and hardest. If we know so much about cholera and its pathophysiology, epidemiology, treatment, and prevention, how did it become the leading infectious killer of young adults in Haiti during the international humanitarian response to the January 2010 earthquake? The short answer is that expectations are lowered for diseases that disproportionately afflict poor people. Investment in long-term public-sector water and sanitation systems, the bulwark against cholera and other waterborne diseases, have stalled or failed to keep (p. 52) up with demand. Safe, effective, and affordable oral vaccines exist, and yet remain largely unavailable in Haiti, and the same is true for timely diagnosis and care. We have the knowledge and tools for prevention and treatment; what we lack is an equity plan linked to a delivery system (Farmer and Ivers 2012). The Haitian epidemic also demonstrates why structural violence is so often hard to describe. It is distant. In our postmodern world of global connections and instant images, “being a spectator of calamities taking place in another country is a quintessential modern experience” (Sontag 2003:18). Nevertheless, while the suffering of individuals whose lives and struggles recall our own tends to move us, the anonymous suffering of those more remote, geographically, culturally, or socially is often less affecting (Farmer 2006a). It is largely invisible. Physical violence shows, whereas “structural violence is silent … [and] may be seen as about as natural as the air around us” (Galtung 1969:173). Many structural inequities are long-standing; they seem a natural part of the social order. But as anthropologist Nancy Scheper-Hughes reminds us (1996:889), “invisible” does not mean “secreted away and hidden from view, but quite the reverse…. [T]‌he thin.gs that are hardest to perceive are often those which are right before our eyes and therefore simply taken for granted.” Haiti’s extreme poverty and underdevelopment has certainly been visible for decades (Farmer 1997a; 2006b). Another factor is the preoccupation of politicians and the media with dramatic forms of violence. “Injustice—in either deed or word—is never linked to violence but rather interpreted in an economic, symbolic, or psychologist register…. [P]hysical violence … is never related to that other violence—of exclusion, discrimination, and humiliation” (Fassin 2009:117). It is massive. The sheer weight and enormity of suffering is not easily or effectively conveyed by statistics or graphs. Economist Amartya Sen (1998:2) has argued for moving beyond “cold and often inarticulate statistics of low incomes” to look in detail at the various ways in which agency—“the capabilities of each person”—is constrained. In other words, we need individual case studies that are embedded in the larger matrix of culture, history, and political economy. While no single axis of inequality—gender, race, ethnicity, immigrant status, sexual orientation, class—can fully define extreme human suffering, we argue for the primacy of poverty, which is often linked with other structures of inequity. “Today, the world’s poor are the chief victims of structural violence—a violence that has thus far defied the analysis of many who seek to understand the nature and distribution of extreme suffering” (Farmer 2003:50). Typologies and Intersections of Violence In an effort to address violence as a global public health problem, the World Health Organization (WHO), developed a typology (Krug et al. 2002) that focuses on a (p. 53) “minimalist” notion of violence as direct and physical force, with no mention of structural violence despite recognizing poverty as an important risk factor in all kinds of violence (Bufacchi 2007:23; Perry 2009:377). As this example illustrates, typologies of violence, while useful (Rutherford et al. 2007), can lead to narrow conceptualizations of social issues. In addition, within real-life contexts, such categories are fluid and not so easily delineated. For example, in their discussion of how interpersonal physical violence becomes a routine part of everyday urban life for vulnerable and marginalized groups, Singer and Erickson (2011a) identify the subsets of “street violence” and “private violence,” subcategories that often overlap or merge. Rape, especially gang rape, can be a form of street violence but most often (certainly in the United States) occurs out of public view. In both instances it is often linked to structural factors, such as poverty and gender inequality, and to sociocultural meanings ascribed to women and their bodies. Rape can also be political violence when used systematically as a weapon of aggression or war (Stark and Wessells 2012), and its consequences often lead to increased structural violence. The global distribution of the AIDS epidemic, for example, is determined to a large degree by structural violence and “rape is a major factor driving the AIDS epidemic” (Mukherjee 2007:117). In such circumstances, rape encompasses several kinds of violence, with roots well established in “peacetime meanings of sexuality” (Olujic 1998b:33). Similarly, in the context of refugee and IDP (internally displaced persons) camps, rape may have all of these connotations and be a manifestation of structural violence, since it goes largely unreported and is often dismissed by humanitarian organizations and their staff as an “unfortunate” part of the refugee context (Whiteford 2009). This complex relationship between direct and structural violence was noted over 150 years ago by German physician and anthropologist Rudoph Virchow, who wrote that “war, plague and famine condition each other” (cited in Rather 1985:115). There is ample evidence that war and political violence have grave impacts on the health and well-being of individuals, communities, and nations—beyond the immediacy of conflict-induced injury and death (Geneva Declaration Secretariat 2008; Levy and Sidel 2008; Pedersen 2002; Taipale et al. 2002). Anthropologists, in particular, have shown that war and conflict not only affect infrastructures supporting local health care, education, markets, and farming activities, but also disrupt families and community support systems, damage the environment, interrupt means of livelihood, and displace populations (Leatherman and Thomas 2008; Rylko-Bauer and Singer 2010; Rylko-Bauer, Whiteford, and Farmer 2009; Singer and Hodge 2010). These impacts are often mediated by preexisting forms of structural violence which, in the aftermath of conflict, contribute to even greater levels of poverty, political marginalization, and racism (Fassin 2009; Miller and Rasmussen 2010; Nordstrom 2004; Panter-Brick 2010; Quesada 2009). Moreover, these consequences often have a long half-life (Becker, Beyene, and Ken 2000; Das 2007; Johnston 2007, 2011; Johnston and Barker 2008). Women are especially victimized by multiple forms of violence, which often interact and are shaped by both gendered dimensions of conflict and preexisting gender discrimination (Annan and Brier 2010). And children are (p. 54) particularly vulnerable, but the “costs [they] pay for the actions of war and its devastating aftermath … are often neglected” (Quesada 1998:64–65; see also Kent 2006; McEvoy-Levy 2001; Nordstrom 2009; Olujic 1998a). Structural violence, in turn, contributes in complex ways to the preconditions for explosive direct violence (Bonnefoy, Burgat, and Menoret 2011; Rylko-Bauer and Singer 2010; Rylko-Bauer et al. 2009; Singer and Hodge 2010). Armed conflict is more likely in low to middle-income countries with slower economic growth, greater gaps in income and resource distribution, and high rates of poverty, hunger, and poor health (Krug et al. 2002; Pinstrup-Andersen and Shimokawa 2008; Stewart 2002). Structural violence has even been examined as a form of genocide (Ahmed 2007; Lewy 2007). Rwanda is a compelling example. Decades of colonial and imperialist exploitation, coupled with the construction of ethnic difference, laid the groundwork for the explosive violence of 1994 (Farmer 2009). Western development aid ignored structural inequities and human rights violations, thus contributing to already existing poverty, unequal distribution of land and resources, social exclusion, and class divisions—so that by “the 1990s, the interaction between structural violence and racism created the conditions for genocidal manipulation by the elites” (Uvin 1999:54). Several models have been proposed for exploring how both direct and indirect violence serve as precursors to collective physical violence (De Jong 2010). One example is the notion of a continuum of violence (Scheper-Hughes 1996, 2007; Scheper-Hughes and Bourgois 2004), based on the recognition that social tolerance of “everyday” structural violence, and the humiliation that accompanies it, sets the stage for normalization of more overt and visible forms, from police brutality and state-directed political violence to massacres and genocides (Scheper-Hughes 1996; Uvin 1999). This is particularly applicable to Latin America where there has been a shift from the brutal political violence of the latter twentieth century to the more recent growth in criminal and interpersonal violence (Briceño-León and Zubillaga 2002; Sanchez 2006). These rates correlate with lower levels of development and higher income inequality within the region (Bliss 2010; United Nations Office on Drugs and Crime 2011). While conventional analyses link these trends to drug trafficking, gang membership, readily available firearms, and a weak criminal justice system (World Bank 2011), a number of anthropologists see a deeper link with the past (Bourgois 2001; Heggenhougen 2009; Manz 2009; Metz, Mariano, and García 2010), a “continuum of violence spanning the civil war years to the present … [the] outcome of a history of structural violence, gender norms, and political repression” as well as racism directed against indigenous populations (Bourgois 2009:36). Layered upon this legacy of political violence is the more recent “structural violence [of] rampant economic inequality, social exclusion, and persistent poverty arising from the imposition of neoliberal economic policies,” namely structural adjustment programs linked to development aid and unfair international trade agreements (Sanchez 2006:179; Quesada 2009). Similar processes in other parts of the Global South have exacerbated the poverty, dislocation, and lack of jobs in the (p. 55) formal economy that serve “as a trigger” for growing rates of “reactive” social and criminal violence (Winton 2004:166–67). Understanding Invisible Violence Structural violence is only one among several forms of less visible violence that are interconnected in complex ways. Anthropologist Philippe Bourgois (2009) has proposed a conceptual framework for critically examining how the invisible processes of structural, as well as symbolic, and normalized violence are linked across time and space to various kinds of direct violence. A central element in all three concepts is the normalization of unequal power relations. Symbolic violence is associated with sociologist Pierre Bourdieu (2000) and refers to sociocultural mechanisms and relations of unequal power and domination that exist within interpersonal relationships and in other spheres of life. It is embedded in ordinary daily life, manifested through language, symbolism, and actions that are perceived by both perpetrator and victim as normal or deserved, a legitimate and inevitable part of the natural social order. “Symbolic violence is … so powerful precisely because it is unrecognizable for what it is.” Its power “rests precisely in its lack of visibility—in the fact that for those exposed to it the doubts and the fear engendered by it cause them to question themselves” (Morgan and Björkert 2006:448). A classic example is that of intimate partner violence, where women blame themselves and are blamed by others for the violence perpetrated against them. Symbolic violence harms both psychologically and emotionally and is often used to justify everyday interpersonal and structural violence, as Simić and Rhodes (2009) demonstrate in their study of street sex workers in Serbia. Similarly, in his research of Puerto Rican crack dealers in New York’s East Harlem, Bourgois (2003) shows how structural and symbolic violence interact and set conditions for the everyday interpersonal conflicts “that the socially vulnerable inflict mainly onto themselves (via substance abuse), onto their kin and friends (through domestic violence and adolescent gang rape), and onto their neighbors and community” (Bourgois 2001:11). The normalized violence that Bourgois (2001, 2009) refers to is an adaptation of the concept of everyday violence initially developed by Scheper-Hughes (1992) to highlight the extreme poverty and high infant and child mortality that characterized life in Brazilian shantytowns. She later applied this concept to life circumstances affecting other socially marginalized people, such as Brazilian and South African street youth or the elderly in U.S. nursing homes (Scheper-Hughes 1996, 2007). The concept of normalized violence recognizes the indifference in broader society and identifies mechanisms by which violence becomes an inevitable part of daily life for its victims. For example, in his life history of a street drug addict named Tony, Merrill Singer (2006:72) observes that “the threat of violence—emotional and physical—daily preparation for violence on the street, and enduring the agony of violence-inflicted (p. 56) pain were all commonplace to [Tony] as an integral part of the world of street drug use and sales. He had come to accept violence as he had bad weather, harsh but unavoidable.” Some scholars have called for more detailed and nuanced analysis. For example, in examining the “routinization of political violence as a social violence of the everyday” in communist China, Kleinman (2000:235) concludes that we should pay closer attention to the “multiplicity of violences of everyday life” across classes of people and social contexts, each with “different histories, sustained by different social dynamics,” and varied “outcome[s]‌ in trauma and suffering.” Applying Structural Violence in Social Analysis Recent social science reviews call for multidisciplinary perspectives on violence (Bufacchi 2009; Krause 2009; Panter-Brick 2010) that counter the tendency to compartmentalize, with “few links among different … approaches” (McIlwaine 1999:455). We decided to examine the potential of structural violence as a unifying cross-disciplinary concept by surveying the literature in social science, social medicine, and public health from the last 15 years (1997–2012). We focused on published articles and limited the search to structural violence per se. The articles covered a broad range of topics, varied methodologies, and often appeared in cross-disciplinary journals, which made it difficult at times to assign articles to one particular discipline.2 We begin with general remarks on how this concept has been used and then provide a more disciplinary-focused assessment. Structural violence has definitely become part of the social science and public health lexicon. It seems to be used most often by scholars who take a critical materialist or political economy approach to social problems and issues. The majority reference Galtung’s classic 1969 essay, and others refer to Farmer and his colleague’s elaboration of this concept.3 The nature of structures of violence and the harms they inflict are context specific, which may explain the variability we found in how authors define structural violence. Many definitions are quite general: “violence inherent in the social order” (Eckermann 1998:304); “institutionalized injustice” (Nevins 2009:915); or “political and economic inequality” (Shannon et al. 2008:914). More detailed definitions tend to stress specific elements, such as exclusion, unequal distribution of resources, avoidable harm, or historically rooted, large-scale forces: “the systematic exclusion of a group from the resources needed to develop their full human potential” (Mukherjee et al. 2011:593); “processes historically rooted in … institutions that differentially enrich or deprive individuals of resources based on the individual’s membership in a specific group” (Kohrt and Worthman 2009:239); and “social arrangements that systematically bring subordinated and disadvantaged groups into harm’s way and put them at risk for various forms of suffering” (Benson 2008:590). (p. 57) Authors refer to structural violence variously as a lens, frame, rubric, model, theory, or perspective, but in most cases, it seems to primarily serve as a conceptual framework that broadens levels of analysis. Many note its utility in countering traditional explanatory models that narrowly focus on individual-level proximate causes relating to biology, behavior, attitudes, and cultural values of vulnerable persons or groups (e.g., Banerjee et al. 2012; Chakrapani et al. 2007; Huffman et al. 2012; Parker 2012; Sinha 1999; Towle and Lende 2008) or that assume agency, choice, and individual control over behavior and circumstance (Adimora et al. 2009; Mukherjee 2007; Shannon et al. 2008).4 A structural violence framework shifts attention to “what puts people at risk of risks” (Link and Phelan 1995:80); it moves “beyond identifying health disparities to a clear understanding of the inequalities that shape inequalities” and the power relations that structure and sustain them (Leatherman and Goodman 2011:33); and it gets at cumulative root causes (Peña 2011) by addressing historical forces and social, economic, and political processes that shape risk and local reality. This has important implications for the kinds of measures chosen to restore social stability, security, and peace in the aftermath of violence (Sanchez 2006). Critiques of the concept urge greater attention to how structural violence is understood locally, by examining emotions, perceptions, and meanings within studies of how those affected by poverty, exclusion, and discrimination respond against or adapt to these assaults (Biehl and Moran-Thomas 2009; Bourgois and Scheper-Hughes 2004). This includes assessing how poverty, racism, and exclusion create contexts of shame, stigma, humiliation, loss of respect, and violation of self-integrity, which in turn affect health, well-being, and interpersonal relations, and sometimes lead to self-destructive behavior, extralegal activities, and physical—even collective—violence (Benson 2008; Bourgois 2003; Bufacchi 2007; Gilligan 1997; Metz et al. 2010; Uvin 1999). Many of the articles we looked at can be classified as reviews or analytic essays, but there were also a number of largely qualitative empirical studies, They focus on varied sets of structural factors, depending on the topic being analyzed, but only a few attempt to operationalize and measure dimensions of structural violence (James et al. 2003; Kohrt and Worthman 2009). Variables chosen as proxies for structural violence are often not readily applicable to other research problems or contexts. For example, one study identified childhood malnutrition and diarrhea as the dependent variable and operationalized structural violence along dimensions such as development and gender inequality, measured by country and individual-level indices (Burroway 2011). Another multilevel study identified the closing of supermarkets in poor urban neighborhoods of Syracuse, New York, as an outcome of the structural violence of poverty and racism. The resulting poor access to food variety was associated with statistically significant increased risk for intrauterine growth restriction, a premature condition linked to low birth weight and other subsequent health problems (Lane et al. 2008). The most detailed example of operationalization is the National Index of Violence and Harm, developed to measure trends in the United States by explicitly quantifying both direct violence and the harm “done through negligence” or “the structuring of society (p. 58) overall” (Brumbaugh-Smith et al. 2008:352). The Societal subindex is divided into two domains: institutional and structural. Variables of structural harm include social negligence in addressing “basic human needs” relating to food, housing, health care, and education; infant mortality and life expectancy, as general indicators of quality of life; hate crimes, as reflections of prejudice; employment discrimination; poverty disparity, examined along lines of class, race, gender, and age; and gang membership, as a measure of disenfranchisement (Brumbaugh-Smith et al. 2008:355–57). Some studies explicitly examine the interaction of a select group of such factors by incorporating multiple levels of analysis (Annan and Brier 2010; Shannon et al. 2008), modeling how structural violence relates to other kinds of violence (James et al. 2003), or developing a heuristic framework that includes facets of structural violence along with other factors that operate at different ecological levels—in one case, to understand the social epidemiology of HIV/AIDS (Poundstone, Strathdee, and Celentano 2004). Other studies diagram how structural violence within family, community, legal, and health care systems leads to interpersonal violence, discrimination, stigmatization, and increased HIV vulnerability (Chakrapani et al. 2007); model the interactions of factors—within employment, legal, and health care contexts—that increase vulnerability to tuberculosis and reduce treatment access for poor Uzbek labor migrants in Kazakhstan (Huffman et al. 2012); and identify ecological pathways for how macrolevel risk factors interact to increase HIV vulnerability for women of color (Lane et al. 2004b). Structural violence clearly covers a long list of structures and harms. This has been a point of critique by some (Nichter 2008:148–49) who argue that it conflates different kinds of violence (Wacquant 2004) or labels all inequality as violent (Boulding 1977), critiques that both Galtung (1987) and Farmer (2004) have responded to. We believe that this flexibility is a positive feature of structural violence, making it applicable to a wide range of problems and issues which can be characterized as unjust, historically and socially determined, insidious, widespread, and causing avoidable social suffering. Use of Structural Violence across Disciplines The largest number of sources was distributed across political science and peace studies, public health and social medicine, and anthropology, but our survey starts with philosophy. Vittorio Bufacchi (2007, 2009) broadly defines violence as violation of a person’s physical and psychological integrity and proposes a theory of violence that incorporates social justice without requiring a separate concept. While acknowledging that structural violence focuses needed attention on victims and the harm and humiliation they suffer from forces such as poverty and oppression, he critiques it for overlapping with the notion of social injustice. Others concerned with the ethics of peace (p. 59) have looked at the relationship between the globalization of violence and the structural violence of globalization (Demenchonok and Peterson 2009). Critical geographers, in turn, have used the concept as an analytic tool to examine the geographies of disease (Hunter 2007); the shift in postsocialist Poland from intentional structural violence of the state, as in expulsions of minorities, to the indirect structural violence of the market (Fleming 2012); the geopolitics of militarization, disease, and humanitarianism (Loyd 2009); the relationship of increased violence and crime to unequal development in the aftermath of political repression in different parts of the world (McIlwaine 1999; Winton 2004); and negative impacts of postcolonial imperialism that have stymied justice and reparations for wrongs perpetuated during Indonesia’s invasion and occupation of East Timor (Nevins 2009). These studies affirm that geography matters in the global distribution of injustice. Articles with sociological analyses focus largely on issues of gender inequality and sexuality in relation to poverty and health. Several studies demonstrate the links between gendered structural violence and intimate partner violence (Morgan and Björkert 2006); disenfranchising economic policies that force poor women into sex work (Hudgins 2005); exploitative working conditions that result in poor quality of elder care and increased risk of physical violence against female caretakers (Banerjee et al. 2012); and the feminization of poverty due to neoliberal policies in sub-Saharan Africa (Ezeonu and Koku 2008). Others focus attention on the less studied topic of children as victims of structural violence, millions of whom are condemned to die from easily preventable and treatable diseases (Kent 2006). For example, structural factors relating to economic development and women’s status, such as maternal education, control over reproduction, and political participation, were found to predict variation in childhood malnutrition and diarrhea across a sample of developing countries (Burroway 2011). Clearly, addressing gendered structural violence and improving the status of women are critical to continued progress in children’s well-being and broader global health and development (Mukherjee 2011). Galtung’s influence is especially evident in peace psychology, which is concerned with “theories and practices aimed at the prevention and mitigation of direct and structural violence,” and focuses on the devastating impact of social forces and structures such as moral exclusion, patriarchy, militarism, globalization, and human rights violations (Christie, Wagner, and Winter 2001:7). Social psychology has also been increasingly concerned with the causes and psychological antecedents of both direct and structural violence, especially regarding racism and discrimination against ethnic minorities (Vollhardt and Bilali 2008), and this is reflected in articles on gender, poverty, and violence (James et al. 2003); the consequences of historical racism and assimilation policy for Aboriginal Australian children (Bretherton and Mellor 2006); and the importance of historically determined poverty in understanding domestic violence within African American communities (Conwill 2007). Psychiatrist James Gilligan (1997:192), who incorporates structural violence into his key work on the root causes of violence, argues for shifting attention “from a clinical or psychological (p. 60) perspective, which looks at one individual at a time, to the epidemiological perspective of public health and preventive medicine.” Examples from peace and conflict studies or political science include critiques or expansions of Galtung’s notion of structural violence (Barnett 2008; Parsons 2007); how structural inequalities shape peace-building efforts (McEvoy-Levy 2001); attempts to conceptualize and measure different facets of institutional and structural violence (Brumbaugh-Smith et al. 2008); explorations of how violent activism in the Persian Gulf region (Bonnefoy et al. 2011) or interpersonal violence in Latin America (Sanchez 2006) are shaped by historically rooted contexts of structural and everyday violence; assessment of the role of gendered inequality in predicting intrastate conflict (Caprioli 2005); and analyses of historic and contemporary global economic policies, such as transatlantic slavery, colonization and imperialism, artificial famines, and neoliberalism (Ahmed 2007; Prontzos 2004). Many of these studies crossover into development economics since they deal with the harmful consequences of global economic policies (Briceño-León and Zubillaga 2002; Uvin 1999). The frequency of articles from public health, social epidemiology, and social medicine reflects, in part, the influence of those who have helped redefine notions of epidemiological risk by shifting attention from individual to sociocultural, political-economic, and environmental factors that constrain or shape behavior (Janes and Corbett 2011:139; Krieger 1994, 2005; Marmot and Wilkinson 2005). Many studies are cross-disciplinary and often focus on how poverty, racism, and gender inequity become embodied or expressed as disease and illness, in contrast with the “predominant public health approach to … health disparities” that targets health promotion and has “each person take responsibility for his/her own health” (Lane et al. 2008:417). A fair number examine how structural violence shapes increased risk for HIV infection or decreased access to prevention and treatment among vulnerable and disadvantaged populations, such as poor women, male and female sex workers, and ethnic minorities (Adimora, Schoenbach, and Floris-Moore 2009; Cameron 2011; Chakrapani et al. 2007; Lane et al. 2004b; Renwick 2002; Shannon et al. 2008; Simić and Rhodes 2009). Several qualitative empirical studies link these broader social and structural contexts to individual experiences, perceptions of self, or cultural norms and prejudices that determine the reality of those at risk or living with HIV/AIDS. For example, Towle and Lende (2008) demonstrate how cultural constraints on women’s decision-making and roles in childbearing, childrearing, and health-care seeking intersect with poverty and women’s disenfranchisement to negatively impact effective prevention of mother-to-child HIV transmission. They support the assertions that “structural violence … is the shadow in which the AIDS virus lurks” (Mukherjee 2007:116) and that AIDS is “a symptom of ‘structural violence’ ” (Hunter 2007:691). Others look more specifically at how stigma and prejudice based on HIV/AIDS status and other health conditions, or sexual orientation, or immigrant/migrant laborer status, lead to discrimination and structural barriers to care, resulting in poor outcomes for health and well-being (Abadía-Barrero and Castro 2006; (p. 61) Chakrapani et al. 2007; Huffman et al. 2012; Larchanché 2012; Parker 2012). For example, stigmatization, coupled with poverty, homelessness, and disproportionate incarceration, adversely influence the presentation, management, and outcome of mental illness and limit the role and voice of the mentally ill in civic and social life (Kelly 2005), which translates into “a lack of emphasis on mental health issues on social and political agendas” and inadequate services for the mentally ill (Kelly 2006:2121). Gender inequality, poverty, and marginalization also play a role in explaining women’s experiences and risk for depression and anxiety in parts of India and Nepal (Kohrt and Worthman 2009; Rao, Horton, and Raguram 2012). Expanding Structural Violence: Anthropology’s Perspective Structural violence was introduced to anthropology primarily through the work of Farmer (2003, 2004) and colleagues (Farmer, Connors, and Simmons 1996), whose understanding of the concept includes the importance of global connections, historical processes, and social context in shaping local realities; the embodiment of these inequalities as disease and social suffering; the interaction of biology with culture and political economy; and the limits of resistance and agency. Other anthropologists have expanded on this in creative ways (many have been cited throughout this chapter), some of whom have focused their ethnographic attention specifically on those forces that constrain agency and create suffering (Vine 2009). For example, one case study of environmental degradation and labor safety in Ciudad Juárez, Mexico, incorporated the previously mentioned elements of structural violence in a multifactorial analysis of health risks associated with a foreign-owned chemical plant and their consequences to well-being for nearby residents and workers (Morales et al. 2012). Another example is Akhil Gupta’s (2012) multilayered ethnography of bureaucracy and poverty in India, which highlights key mechanisms of structural violence enacted by the state: corruption, the use of written records in a context where the poor are largely illiterate, and the expansion of bureaucratization. These result in the normalization of high poverty rates and avoidable deaths, despite large state investment in less-than-successful programs aimed at improving the lives of the poor. Biological anthropologists, who take a critical biocultural approach, have found the concept useful in understanding how history and political economy help explain “the causes of malnutrition, disease, and other biological outcomes of social processes,” such as poverty and racism (Leatherman and Goodman 2011:40) and in analyzing the origins and impact of conflicts (Leatherman and Thomas 2008; Martin 2008). Critical archaeologists have used a structural violence framework to address academic inequities (Bernbeck 2008); expand analyses of the slave trade and African diaspora (p. 62) (Eiselt 2009:139); and examine the misuse of archaeology in revising national histories, reinforcing nationalism and state control, and appropriating land and cultural heritage within the Israeli-Palestinian context (Hole 2010; Starzmann 2010). The widest application of structural violence has been in medical anthropology, especially among proponents of critical medical anthropology, some of whom have used this framework in much of their research (e.g., Lane and Rubinstein 2008; Lane et al. 2004a, 2004b, 2008; Leatherman and Thomas 2008; Leatherman 2011; Singer 2009a). Linda Whiteford, for example, highlights how particular groups are systematically excluded from basic resources—the poor from health care access in the Dominican Republic, volcano-relocated families from access to their lands and livelihoods, indigenous peoples in highland Ecuador from clean water and sewage disposal, and refugee women from reproductive health care—resulting in increased disease, illness, and social suffering (Whiteford 2000, 2005, 2009; Whiteford and Tobin 2004). Others have integrated structural violence with an environmental justice perspective (Johnston 2011; Morales et al. 2012; Peña 2011) or with critiques of unhealthy public policies, shaped by racism and political-economic interests, that increase vulnerability to harm, prevent access to care, deny human rights, and sustain poverty and other inequalities (Benson 2008; Castro and Singer 2004; Holmes 2013; Quesada, Hart, and Bourgois 2011; Rylko-Bauer and Farmer 2002). Medical anthropologists have called for refining structural violence “as a theoretical frame, a method of inquiry, and a moral/ethical imperative” by paying attention to “the complexity and the contradictions of the lives of the poor” (Green 2004:319–20); by documenting how structural violence “operates in real lives” (Bourgois and Scheper-Hughes 2004:318) and how it is expressed “physically and psychically in everyday social suffering” (Walter, Bourgois, and Loinaz 2004:1167); by analyzing how past and present oppression and discrimination are inscribed in public policy and discourse, and on bodies and biographies (Fassin 2007, 2009); and by fleshing out the subjective aspects—emotions, meanings, perceptions—of social suffering and exploring the interconnections of structure and agency (Biehl and Moran-Thomas 2009), as well as examining how structural forces are mediated by cultural understandings. Building upon Leatherman’s (2005) notion of a “space of vulnerability,” Quesada and colleagues have proposed extending “the economic, material, and political insights of structural violence to encompass … cultural and idiosyncratic sources of physical and psychodynamic distress” through the concept of structural vulnerability (Quesada et al. 2011:341), which they apply to their analysis of the living and working conditions of Latino immigrants in the United States. (Cartwright 2011; Holmes 2011). Others have noted the cumulative nature of structural vulnerabilities (Huffman et al. 2012; Ribera and Hausmann-Muela 2011). Finally, syndemics offers another means of refining the concept of structural violence. Developed initially by Merrill Singer (1996) to describe the complex interaction between substance abuse, violence, and AIDS among inner city poor, syndemics is “the concentration and deleterious interaction of two or more diseases or other health conditions in a population, especially as a consequence of (p. 63) social inequality and the unjust exercise of power” (Singer 2009b:xv). It underscores the synergistic “adverse health effects arising from connections among epidemic disease clustering, disease interaction, and health and social disparities” (Singer 2009b:18), and has been applied to a wide variety of cases (Cartwright 2011; Ribera and Hausmann-Muela 2011; Singer 2009a; Singer et al. 2011). Using this perspective, Singer (2009b:140–53) notes that the impact of structural violence on health and well-being can be direct via factors such as poverty and racism that often have a cumulative effect, or it can be mediated through mechanisms such as stress, environmental conditions, diet, and self-destructive strategies for coping with the social suffering that structural violence inflicts. Conclusion: The Relevance and Utility of Structural Violence As the chapters in this Handbook demonstrate, poverty is a complex phenomenon linked to other forms of social, political, and economic inequities and often rooted in long-standing, historically determined social structures. The analytic framework of structural violence focuses attention on mechanisms that support poverty and other forms of inequity, highlights the interdependence of these structural factors and their relationship to other forms of violence, and identifies the ways by which they cause unequal distribution of harm. We have described how structural violence redefines the notion of risk by expanding the analytic gaze from individual characteristics or interpersonal relations to a nested series of broader social contexts and structural forces. Many authors argue that the understandings gained from such an approach, grounded in the real-life experiences of vulnerable populations, can lead to more effective local interventions, better social policy, and social change that addresses the roots of poverty, inequality, and social suffering (e.g., Abadia-Barrero and Castro 2006; Adimora et al. 2009; Towle and Lende 2008; Whiteford and Whiteford 2005). Structural violence is a morally weighted term, not only because “structures of violence” clearly carry a negative social valence, but also because it is firmly linked to the notion of social and economic human rights (Lykes 2001). The “violence” part of the concept lends “the needed sense of both brutality and intent” (Mukherjee et al. 2011:593) and focuses attention on “the premature and untimely deaths of people. Violence here is not so much the violation of the everyday but the reduction to bare life” (Gupta 2012:21). The emphasis on avoidable harm is at the heart of structural violence and raises issues of social responsibility, redefines global ethics, and challenges the prevailing social change paradigm that is guided by utilitarian economics, where basic human needs like food, clean water, housing, and health—all too often denied to the poor—are viewed dispassionately as variables in global economic development. (p. 64) Finally, structural violence challenges the notion of a purely descriptive and objective social science. It demands that we look at the world through the eyes of those least able to change it and that our research be linked in some way to advocacy and action. The end result will be a more engaged social science with a better chance of making a difference in alleviating poverty and addressing other pressing social issues of our time.

#### Independently, the aff is an anti-racist approach to antitrust – Parker immunity blocks enforcement of anticompetitive practices sanctioned by state licensing boards. These boards entrench incumbent interests and exclude communities that lack socio-economic privilege

Weissmann 21 Shoshana Weissmann, Senior Manager, Digital Media, Communications; Fellow, 3-11-2021 – modified for language that may offend - https://www.rstreet.org/2021/03/11/we-need-antitrust-reform-for-the-little-guy/

Overhauling antitrust is in vogue. Just last month the House Judiciary Committee launched a new series of hearings to flesh out potential changes to America’s current approach to antitrust enforcement. On Thursday, the Senate Judiciary Committee’s Subcommittee on Competition Policy, Antitrust, and Consumer Rights is having a hearing on antitrust reform. And, in a sign of the times, left-of-center advocates want to ensure antitrust enforcers adopt an “anti-racist” agenda that places marginalized communities at the front of the discussion.

So often when we ~~hear~~ (consider) about antitrust, we think about the government seeking to break up large corporate monopolies. Before Google and Facebook, it was Microsoft. Before that, Ma Bell. But there is plenty of anti-competitive behavior that takes place outside of the realm of big business, and there is a way to reform such behavior that also places an emphasis on protecting disadvantaged communities: Congress can overturn the “state action doctrine” as applied to occupational licensing boards. This doctrine has long allowed semi-governmental occupational licensing boards to act in a blatantly anti-competitive manner—one that has a stark and disproportionate impact on ~~minorities~~ (those lacking socio-economic and-or racial privilege), the poor, and small-business entrepreneurs.

The overwhelming burden these occupational licensing requirements place on these groups is staggering, keeping people from earning an honest living, providing for their families, and contributing to society in the profession of their choice. These requirements include expensive schooling to certify practical skills that can be learned in other ways, or policies that limit participation in fields in the name of “safety,” when those safety issues are overblown.

In the 1950s, 1 out of every 20 people in the United States needed a license to do his or her job. Today, it’s 1 out of every 4. From the Obama administration to President Donald Trump to President Joe Biden, virtually everyone recognizes that something is horribly amiss. Even the Federal Trade Commission (FTC) released a detailed report in 2018 highlighting the dangers of overly burdensome occupational licensing and its disproportionate negative effects.

Bad board behavior is rampant. In recent years, Arizona’s cosmetology board cracked down on a student helping his community by cutting hair for people experiencing homelessness. Had Republican Gov. Doug Ducey not stepped in to help, the student’s career could have been ruined. African hair braider Isis Brantley was once arrested for braiding hair without a cosmetology license—a license that wouldn’t have even taught her to braid hair. In Louisiana, elderly widow Sandy Meadows was prevented by the board from earning a living arranging flowers because Louisiana requires a license to do so and she couldn’t pass an exam with a lower pass rate than the state’s bar exam. When she died, she was living in poverty.

The dirty open secret of occupational licensing boards is that they are often composed almost exclusively of people in the industry who have a direct stake in keeping others out. Cosmetology boards are often stocked with salon owners, for example. This kind of collusive, anticompetitive behavior aimed at entrenching incumbents to the detriment of workers, consumers, and society more broadly is exactly why we have antitrust laws in the first place.

The problem isn’t that enforcers don’t want to act—it’s that they can’t because of the “Parker” or “state immunity” doctrine. For nearly 80 years, there have been severe limits on how federal agencies and private plaintiffs could enforce America’s antitrust laws against a state-sanctioned entity, like an occupational licensing board. Under this doctrine, states are overwhelmingly protected from any kind of antitrust scrutiny, minus a few narrow exceptions.

Thankfully, courts have somewhat pulled back on this doctrine in recent years. In 2015, in a case involving non-dentists who were offering inexpensive teeth-whitening services, the Supreme Court refused to extend this immunity to North Carolina’s state dental licensing board because it was not actively supervised by the government and was composed of self-interested market participants. This decision was a step in the right direction, although its holding was narrow and the Parker doctrine was left largely intact.

Excluding competitors and keeping new entrants out of the market without reason is anticompetitive and should be punished, even when given a state’s stamp of approval. With its laser focus on antitrust, Congress is well-suited to take up the mantle on this issue.

Congress should empower antitrust enforcers like the FTC and DOJ to bring suits against these collusive bodies for their blatantly anticompetitive conduct. It can do this by overturning the state action doctrine’s application to licensing boards and allowing courts to look behind the veil of these “governmental” boards to gauge meaningfully whether they are engaging in intentionally anticompetitive conduct.

### 1ac – plan

The United States Federal Government should prohibit state action immunity doctrine protections for anticompetitive Scope of Practice restrictions that are geared to benefit private sector physicians at the expense of nurse practitioners.

### 1ac – solvency

#### Malleability holds in contingent instances - Health access is distinct from other modes of violent power. Claiming it as “liberalism” creates false equivalencies. Such State-Alarmism is wrong and generates support for ACA rollback

Schotten 15 Dr. C. Heike Schotten is an Associate Professor of Political Science and an affiliated faculty in Women’s and Gender Studies at The University of Massachusetts-Boston. What following is from Schotten’s own faculty bio: Her research lies at the unlikely intersection of Nietzsche studies, queer theory, and revolution. “Against Totalitarianism: Agamben, Foucault, and the Politics of Critique,” Foucault Studies, No. 20, pp. 155-179, December 2015, Modified for language that may be objectionable - #E&F – the letter “u” is moved from Capitalized to a lower-case in one instance – this is for readability. <http://rauli.cbs.dk/index.php/foucault-studies/article/view/4935/5361>

III. Moralism and Totalitarianism

Foucault’s methodological and political commitments are all the more significant in light of Agamben’s demanded corrective of Foucaultian biopolitics and understanding of sovereignty. For even as Foucault expands his methodological rejection of the state as ahistorical political principle or sociological object, Agamben effects not simply a return to sovereignty, as already argued, but a return to sovereignty in what, following Foucault, we must recognize as totalitarian forms. This is the case not only methodologically, as will become clear, but also morally, an aspect of political critique that does not even enter into the Foucaultian schema. Methodologically, Agamben’s persistent focus on Auschwitz as the West’s political paradigm and Nazism as the teleological culmination of sovereignty’s political trajectory results in his offering an “anti-totalitarian” theory of sovereignty that renders any other historical or political outcome besides totalitarianism impossible. Hence Agamben’s dispute with Foucault is actually a “corrective” of Foucault, a disappointingly moralizing rebuke rather than a constructive scholarly engagement.

In BB, Foucault says his choice to talk about governmentality rather than the state is purposeful, a methodological choice that is “obviously and explicitly a way of not taking as a primary, original, and already given object, notions such as the sovereign, sovereignty, the people, subjects, the state, andcivil society, that is to say, all those universals employed by sociological analysis, historical analysis, and political philosophy.”92 Rather, Foucault says, he would like to do “exactly the opposite” and, instead of using “state and society, sovereign and subjects, etcetera” as points of departure, he wants to show how they “were actually able to be formed” so that their status can be called into question.93 At one level, this is simply Foucault’s methodological preference. At another level, as we have seen, it is a political commitment, insofar as refusing to begin with these sociological givens facilitates resistance to the power-effects of what he calls “totalitarian theories.” While, in “SMBD,” these totalitarian theories were Marxism and psychoanalysis, in BB the target is now what Foucault calls “historicism,” which he describes as a practice of taking universals and running them through the mill of history in order to deduce their “meaning.” Significantly, historicism, like Marxism and psychoanalysis, unfolds a similarly reductive and deductive logic that “starts from the universal and, as it were, puts it through the grinder of history.”94 Instead, Foucault suggests the supposition “that universals do not exist. And then I put the question to history and historians: How can you write a history if you do not accept a priori the existence of things like the state, society, the sovereign, and subjects?”95 Insofar as historicism in BB functions the way Marxism and psychoanalysis do in “SMBD,” then historicism can also be considered a totalitarian theory that Foucault seeks to critique. In seeking to undertake an analysis that is “exactly the opposite of historicism,”96 Foucault is in some sense continuing his practice of thwarting or undermining totalitarian theories, a methodology that is animated by a specifically political commitment to insurrection.97

Foucault is also cautious about indulging the fearful discourse of the all-powerful state. He names this anxiety “state ~~phobia~~” 98 (“state alarmism”) and says it has two related versions: first,

the idea that the state possesses in itself and through its own dynamism a sort of power of expansion, an endogenous imperialism constantly pushing it to spread its surface and increase in extent, depth, and subtlety to the point that it will come to take over entirely that which is at the same time its other, its outside, its target, and its object, namely: civil society.99

If this leaves the impression of a kind of suffocating beast whose tentacled grasp is ever extending over and sliding in between any cracks of resistance to its domination, this is no accident: Foucault refers to this as the “cold monster” version of the state, the “threatening organism above civil society.”100 Foucault does not spend much time unpacking the problems with this theory, presumably because they are self-evident on the basis of his earlier work: not only is the state here presupposed as a causal entity that exists “above” its subjects, but it is also possessed of a kind of vitalism or life principle that Foucault dismisses out of hand as an inadequate or irresponsible account of power. The state as “cold monster” is, quite literally, yet another version of the Leviathan, the great sea monster from the book of Job, for whose beheading Foucault has already vigorously advocated.

The second bit of “critical commonplace”101 regarding the state that Foucault seeks to avoid is the notion that there are no significant differences between or among different forms of it. This is the notion that, as Foucault puts it,

there is a kinship, a sort of genetic continuity or evolutionary implication between different forms of the state, with the administrative state, the welfare state, the bureaucratic state, the fascist state, and the totalitarian state all being, in no matter which of the various analyses, the successive branches of one and the same great tree of state control in its continuous and unified expansion.102

Here Foucault explicitly puts totalitarianism and the state together in order to distinguish “the totalitarian state” as a *distinct*ive state form, rather than the paradigm case of the state itself.

Indeed, here we might understand Foucault as attempting to disentangle a kind of doubling of totalitarianism in state phobia, wherein the cold monster view anoints the state with the kind of omniscience and omnipotence often ascribed to totalitarian versions of it. This specifically totalitarian version ultimately becomes synonymous with the state itself.

What links the “cold monster” view and the “genetic continuity” view is their consideration of the state as a malevolent principle in itself, such that distinctions among types become irrelevant and any state action can be interpreted as a sign of its increasing repressiveness and violence. Foucault uses the example of an unduly harsh criminal sentence, which he says can be interpreted as evidence of the increasing fascism of the state, regardless of whatever may actually be true—this is once again a correct answer produced by the particular truth mill that is “state phobia.” Foucault warns that this kind of thinking can verge on ~~paranoid~~ (alarmist) fantasy, which ~~sees~~ (perceives) evidence of the ever-growing, increasingly-fascistic state everywhere it looks. In this case, one’s “grasp of reality”103 is not what matters, but rather the endless confirmation and reproduction of the theory itself. It can also issue in absurd (illogical) conclusions, such as the following:

As soon as we accept the existence of this continuity or genetic kinship between different forms of the state, and as soon as we attribute a constant evolutionary dynamism to the state, it then becomes possible not only to use different analyses to support each other, but also to refer them back to each other and so deprive them of their specificity. For example, an analysis of social security and the administrative apparatus on which it rests ends up, via some slippages and thanks to some plays on words, referring us to the analysis of concentration camps. And, in the move from social security to concentration camps the *requisite* specificity of analysis is diluted.104

While Foucault is referencing right-wing fantasies about governmental power (one is reminded of **Sarah Palin’s warnings about “death panels”** should Obama’s **A**ffordable Health **C**are **A**ct pass the U.S. Congress), his caution is also apposite to left anarchist discourses that similarly ~~see~~ (perceive) the state as a malevolent principle in itself. In suggesting that the state has no essence or is “nothing else but the mobile effect of a regime of multiple governmentalities,”105 Foucault is not claiming that we should be uncritical of the state or exercises of state power. Quite the opposite. In destabilizing the operative presumptions about the state in history, sociology, philosophy, and politics, Foucault is instead working to make the state something that is possible to critique and resist. We lose sight of this possibility when the state is presumed to be a prime mover of history or politics, an omnipotent principle or an essentially annihilatory institution that culminates, inevitably, in the genocidal logic of concentration camps. Part of the task of proceeding in the exact opposite manner as that of historicism is admitting that mechanisms of power **are** transferable and that they do not exhaustively characterize **any** particular society.106 Foucault’s resistance to historicism and state phobia, then, are yet further resistances to totalitarianism—of theory (or science) but also of specific state forms and beliefs about the state and its forms that function in totalitarian ways.

As is perhaps already evident, Agamben’s approach to the state in Homo Sacer epitomizes both the historicism and state ~~phobia~~ (“state alarmism”) that Foucault explicitly rejects. Rather than seeking, from below, to untangle and document the subjugated knowledges that have produced existing dominations, Agamben instead seeks to read these latter for what they reveal about the essential workings of Western politics. Indeed, Agamben presumes that power inheres in the sovereign demarcation of the zoē/bios divide, the status of which exhaustively defines life and politics in “the West” (itself an underspecified geographical and historical entity). The method of Homo Sacer is thus clearly expressed in Foucault’s description of “historicism”: Agamben starts from a universalist claim regarding the sovereign exception and then proceeds to examine how history has inflected it in the West. This is what allows him to conflate all versions of the state with the totalitarian one and also to suggest that all versions of sovereignty culminate inevitably in the Nazis’ creation of concentration camps. As he says, the camp is “the hidden paradigm of the political space of modernity, whose metamorphoses and disguises we will have to learn to recognize.”107

Like all declension narratives, this one too echoes the chronology of the fall from grace, except that, in Agamben’s version, the pre-lapsarian moment dates from Aristotle rather than the Creation. The result, however, is a valorized hypostatization of an at-best questionable moment of origin, from which the logic of the events of Western history can be understood to have unfolded and to be still in the process of unfolding to this day.108 At one end, then (at “the beginning,” or archē), stands the Aristotelian distinction between zoē and bios; at the other end (“now,” or in modernity), lie the Nazi death camps. These two moments are tied inevitably, irretrievably together by the exceptional logic of sovereignty:

The totalitarianism of our century has its ground in this dynamic identity of life and politics, without which it remains incomprehensible. If Nazism still appears to us as an enigma, and if its affinity with Stalinism (on which Hannah Arendt so much insisted) is still unexplained, this is because we have failed to situate the totalitarian phenomenon in its entirety in the horizon of biopolitics. When life and politics—originally divided, and linked together by means of the no-man’s-land of the state of exception that is inhabited by bare life—begin to become one, all life becomes sacred and all politics becomes the exception (148, original emphasis).

Nazism will remain “an enigma,” on this telling, insofar as we fail to “situate” it within the essential principle of Western biopolitics—the sovereign exception, the zoē/bios divide. Once we do that, however, the meaning of Nazism becomes clear and we understand how there could ever have been death camps, perhaps the real question Agamben is trying to answer in this text. Already latent in the zoē/bios divide, then, is the concentration camp, which is why its historical development inevitably culminates there.

Agamben’s political theory thus not only re-iterates the assumptions of the sovereign model as Foucault explains it, but itself becomes a kind of totalitarian theory of sovereignty in the West that can only ever issue in the same answer over and over again: the camp. Agamben’s methodological historicism is what allows him to come to the political conclusions Foucault explicitly repudiates above; namely, that there is no meaningful difference between democratic states and totalitarian ones, and this because the sovereign exception is a formation of power that fundamentally defines the entity “Western politics” from its earliest days through to its catastrophic contemporaneity. Thus it is perhaps also unsurprising that Agamben concludes there is no difference between democratic and totalitarian regimes insofar as their “fundamental referent” is bare life; the “only real question to be decided,” he says, is “which form of organization would be best suited to the task of assuring the care, control, and use of bare life.”109 As well, Agamben’s state ~~phobia~~ (“state alarmism”) , in which we can recognize both the “cold monster” and “genetic” versions, predictably culminates, as do the absurdist theories Foucault documents, with nothing other than concentration camps. U(u)nless the enigma of the sovereign exception is solved, Agamben insists, we will remain mired in totalitarianism and death camps: “Today politics knows no value (and, consequently, no nonvalue) other than life, and until the contradictions that this fact implies are dissolved, Nazism and fascism—which transformed the decision on bare life into the supreme political principle— will remain stubbornly with us.”110 The consequence of Agamben’s methodology here is not simply a return to sovereignty, then, but in fact a resurrection of the sovereign and the restoration of his omnipotence in what, following Foucault, can be called totalitarian forms. Agamben’s reading of the text of Western politics from the guiding principle of the sovereign exception leaves us no other option, no other conclusion, than that with which Foucault claims his work is constantly being misinterpreted as saying: “This is the way things are; you are trapped.”111 This outcome is all the more ironic, of course, given that the entire exercise of Homo Sacer was ostensibly spurred by Agamben’s desire to “correct” Foucault’s oversight regarding 20th century totalitarian regimes and, presumably, overcome the disastrous legacy of Nazism and totalitarianism.

\*Note to students: the word “endogenous” means having an internal cause or origin)

#### Elements of the squo echo this call for an untouched market. Loss of access places *millions of lives at risk*

Gee 20 et al; Emily R. Gee is a senior fellow and the senior economist for Health Policy at American Progress. In her role, she guides policy development and advocates for reforms to expand coverage and improve care. Her areas of expertise include health coverage and affordability, health care financing, and the Affordable Care Act. She has been quoted and her work has been cited in The New York Times, The Washington Post, Politico, Forbes, Vox, and other publications. Prior to joining American Progress, she was an economist in the Office of the Assistant Secretary for Planning and Evaluation at the U.S. Department of Health and Human Services and worked on implementation of the Affordable Care Act. Gee also served as an economist on the staff of the Council of Economic Advisers in the Obama White House, tracking health care coverage and reviewing regulation related to provider payments, prescription drugs, and insurance. Gee earned her doctorate in economics from Boston University, where she researched health insurance markets and taught health economics. She holds a bachelor’s degree in government from Harvard College. “10 Ways the ACA Has Improved Health Care in the Past Decade” - March 23, 2020 - #E&F – modified for language that may offend - https://www.americanprogress.org/issues/healthcare/news/2020/03/23/482012/10-ways-aca-improved-health-care-past-decade/

Ten years ago this month, the Affordable Care Act (ACA) was signed into law. Since then, the law has transformed the American health care system by expanding health coverage to 20 million Americans and saving thousands of lives. The ACA codified protections for people with preexisting conditions and eliminated patient cost sharing for high-value preventive services. And the law goes beyond coverage, requiring employers to provide breastfeeding mothers with breaks at work, making calorie counts more widely available in restaurants, and creating the Prevention and Public Health Fund, which helps the Centers for Disease Control and Prevention (CDC) and state agencies detect and respond to health threats such as COVID-19.

Despite the undeniably positive impact that the ACA has had on the American people and health system, President Donald Trump and his allies have (~~been on a mission~~ (strived) to dismantle the law and reverse the gains made over the past decade—first through Congress and now through a lawsuit criticized by legal experts across the political spectrum. Even if the U.S. Supreme Court rules the ACA constitutional after it hears the California v. Texas health care repeal lawsuit this fall, President Trump’s administration cannot be trusted to put the health of the American people ahead of its political agenda. Trump’s administration hasn’t delivered on Trump’s commitment to “always protect patients with pre-existing conditions.”

The consequences of ACA repeal would be dire:

Nearly 20 million people in the United States would lose coverage, raising the nonelderly uninsured rate by more than 7 percent.

135 million Americans with preexisting conditions could face discrimination if they ever needed to turn to the individual market for health coverage.

States would lose $135 billion in federal funding for the marketplaces, Medicaid, and the Children’s Health Insurance Program (CHIP).

Insurance companies would no longer be required to issue rebates when they overcharge Americans. In 2019, insurance companies returned $1.37 billion in medical loss ratio rebates to policyholders.

The tax revenue that funds the expanded health coverage under the ACA would become tax cuts for millionaires, who would receive an average of $46,000 each.

As the nation awaits a final ruling on the lawsuit, the Center for American Progress is celebrating how the ACA has helped the American people access affordable health care in the past decade. In honor of the law’s 10th anniversary, here are 10 ways in which it has changed Americans’ lives for the better. Each of these gains remains at risk as long as the Trump administration-backed lawsuit remains unresolved.

1. 20 million fewer Americans are uninsured

The ACA generated one of the largest expansions of health coverage in U.S. history. In 2010, 16 percent of all Americans were uninsured; by 2016, the uninsured rate hit an all-time low of 9 percent. About 20 million Americans have gained health insurance coverage since the ACA was enacted. The ACA’s coverage gains occurred across all income levels and among both children and adults, and disparities in coverage between races and ethnicities have narrowed.

Two of the biggest coverage expansion provisions of the ACA went into full effect in 2014: the expansion of Medicaid and the launch of the health insurance marketplaces for private coverage. Together, these programs now cover tens of millions of Americans. Nationwide, 11.4 million people enrolled in plans for 2019 coverage through the ACA health insurance marketplaces. Medicaid expansion currently covers 12.7 million people made newly eligible by the ACA, and the ACA’s enrollment outreach initiatives generated a “welcome-mat” effect that spurred enrollment among people who were previously eligible for Medicaid and CHIP.

2. The ACA protects people with preexisting conditions from discrimination

Prior to the ACA, insurers in the individual market routinely set pricing and benefit exclusions and denied coverage to people based on their health status, a practice known as medical underwriting. Nearly 1 in 2 nonelderly adults have a preexisting condition, and prior to the ACA, they could have faced discrimination based on their medical history if they sought to buy insurance on their own.

The ACA added a number of significant new protections for people with preexisting conditions. One group of reforms involved changes to the rating rules, prohibiting insurers from making premiums dependent on gender or health status and limiting their ability to vary premiums by age. The ACA also established guaranteed issue, meaning that insurers must issue policies to anyone and can no longer turn away people based on health status.

Another crucial protection for people with preexisting conditions is the ACA’s requirement that plans include categories of essential health benefits, including prescription drugs, maternity care, and behavioral health. This prevents insurance companies from effectively screening out higher-cost patients by excluding basic benefits from coverage. The law also banned insurers from setting annual and lifetime limits on benefits, which had previously prevented some of the sickest people from accessing necessary care and left Americans without adequate financial protection from catastrophic medical episodes.

3. Medicaid expansion helped millions of lower-income individuals access health care and more

To date, 36 states and Washington, D.C., have expanded Medicaid under the ACA, with 12.7 million people covered through the expansion. While the Medicaid program has historically covered low-income parents, children, elderly people, and disabled people, the ACA called for states to expand Medicaid to adults up to 138 percent of the federal poverty level and provided federal funding for at least 90 percent of the cost.

Medicaid expansion has led to better access to care and health outcomes for low-income individuals and their families across the country. A large body of evidence shows that Medicaid expansion increases utilization of health services and diagnosis and treatment of health ailments, including cancer, mental illness, and substance use disorder. Medicaid expansion is associated with improvements in health outcomes such as cardiac surgery outcomes, hospital admission rates for patients with acute appendicitis, and improved mortality rates for cardiovascular and end-stage renal disease. Beyond health outcomes, evidence points to improved financial well-being in Medicaid expansion states, including reductions in medical debt and improved satisfaction with one’s current financial situation. A study that assessed eviction rates in California found that Medicaid expansion is “associated with improved housing stability.”

Evidence shows that Medicaid expansion saves lives. According to a 2019 study, Medicaid expansion was associated with 19,200 fewer deaths among older low-income adults from 2013 to 2017; 15,600 preventable deaths occurred in states that did not expand Medicaid. As the Center on Budget and Policy Priorities points out, the number of adults ages 55 to 64 whose lives would have been saved in 2017 had all states expanded Medicaid equals about the number of lives of all ages that seatbelts saved in the same year.

#### We do not defend the law in all instances – but in the contingent realm of health provision, government policy is much better than the de facto Alt of an untouched market.

Parento 12 Professor Emily Whelan Parento is as Associate Professor and the Gordon D. Schaber Health Law Scholar at McGeorge School of Law at the University of the Pacific. Her primary scholarly focus is the intersection of domestic health law and policy with the human rights framework for the right to health and health equity. The author holds a JD and LLM, from The Georgetown University Law Center and a BBA, from the University of Notre Dame. Earlier in her career she served as a federal judicial clerk and practiced litigation at Davis Polk & Wardwell in New York and California. From the article: “Health Equity, Healthy People 2020, and Coercive Legal Mechanisms as Necessary for the Achievement of Both” - 58 Loyola Law Review 655 - Fall, 2012 - #CutWithRJ – Modified for potentially offensive language – This Loyola Law Review article was re-published at Racism.org – http://www.racism.org/index.php?option=com\_content&view=article&id=1424:racisthealthcare&catid=88&Itemid=274&showall=1&limitstart=

Although health equity was not a part of seventeenth-century political discourse, Montesquieu accurately captured the conflict that surrounds the concept today. In theory, people are born with equal potential for healthy lives, yet the minute their lives begin, a confluence of factors render some people immensely more likely than others to have the capability to lead healthy lives. These disparities in individuals' capabilities to achieve good health raise important social justice questions--What obligation does society have to take measures to reduce health disparities based on race or ethnicity, socioeconomic status (SES), gender, sexual orientation, education, disability, and other factors, particularly where behavioral risk factors are a contributing factor to disease? Stated differently, how much “choice” do individualstruly possess regarding their health, and what can and should government do to address the societal influences that negatively impact health status?

Routinely, society looks at an individual health outcome and ascribes the result to modifiable lifestyle choices, good or bad, with the implicit assumption that people who are healthy deserve praise for their responsible choices and those who are not deserve at least partial blame for failing to act in ways that would improve their health. However, this personal responsibility framework fails at a population level. It is well-documented that there is a socioeconomic gradient to health, in which individuals are likely to be healthier as their socioeconomic status increases. But no serious scholar ascribes population level socioeconomic health disparities to the superior willpower of the wealthy in making healthy lifestyle choices. Similarly, there is a persistent racial and ethnic component to health that is not explained by other factors, pursuant to which certain racial and ethnic groups are more likely to have worse health outcomes than others. But no one argues that African-Americans have worse health outcomes on average than whites because African-Americans are not as motivated as whites to protect their health. There is no basis for making such population-wide generalities about motivation regarding health behavior. Yet in the face of these widespread and presumptively inequitable disparities, the law has done little. This paper argues that coercive legal mechanisms are an essential element of eliminating health disparities and achieving health equity. Moreover, the paper argues that Healthy People 2020 (HP 2020), which is the nation's “master blueprint for health” and explicitly seeks to achieve health equity, has not fully incorporated the principles of health equity in the formulation of its objectives and indicators because HP 2020 fails to recognize the varying distributive effects of policies that could achieve population health targets. To truly incorporate the principles of health equity, HP 2020 should advocate for those demonstrably effective coercive legal mechanisms that would both achieve its population health objectives and reduce health disparities.

The federal government has monitored health disparities in one form or another since at least 1985 and has advocated for the elimination of health disparities since at least 2000, with the release of the Healthy People 2010 goals. However, decisive action on the reduction of disparities has been lacking, and, on average, disparities have not improved over at least the past fifteen years. Although health equity is a mainstay of health law and policy discourse, the concept has not had a significant role in mainstream political discussions. As it is commonly understood, health equity exists when “all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health.” There are strong philosophical and social justice reasons that support government action to reduce disparities--among them are human rights principles of equality underlying the right to health; Nussbaum's theory of health as an essential human capability necessary to fully function in life; Amartya Sen's theory of the capability for health as an instrumental human freedom; and principles of equality and nondiscrimination among people based on characteristics such as SES, race or ethnicity, gender, sexual orientation, religion, disability, rural/urban geography, and other characteristics historically linked to discriminatory treatment.

The question, then, is, What means are both necessary and effective for reducing health disparities and achieving health equity? It is here that distributive consequences of policies become important, leading to the conclusion that coercive legal mechanisms such as direct regulation and taxation are essential to a serious strategy to reduce disparities. While coercive legal mechanisms are not suited to solve every problem and must always be balanced against concern for personal liberties and principles of autonomy, there are many instances in which coercive legal mechanisms are demonstrably the most effective way of reducing health disparities and improving population health. Unfortunately, when discussing these mechanisms, advocates are often cowed by advocates of “personal choice” into watering down interventions to the point that the likely result is--even with an improvement in population health--no change or a worsening in health disparities. This approach is problematic from a health equity standpoint, given that health equity by its nature requires the elimination of health disparities associated with social disadvantage.

The U.S. government has made the achievement of health equity and the elimination of health disparities a national priority in HP 2020, recognizing the importance of working toward the realization of health equity. Every ten years since 1979, the Department of Health and Human Services (HHS) issues new “Healthy People” nationwide health goals for the forthcoming decade, the most recent of which are HP 2020. The essential aim of the Healthy People project (the Project) is to establish national health priorities by setting targets for improvement of health across a broad spectrum of topics, ranging from access to health services to environmental health to more discrete diseases such as cancer and heart disease and, for the first time in HP 2020, including the social determinants of health. In some instances, HP 2020 advocates the adoption of specific coercive legal mechanisms that would both further a population health goal and reduce disparities--for example, passage of smoke-free legislation would both reduce overall population exposure to secondhand smoke and more strongly affect disadvantaged groups (who have higher rates of smoking and are more likely to work in places where smoking is permitted), thereby resulting in a reduction in the disparity in rates of exposure to secondhand smoke. This advocacy is laudable. However, in most instances, HP 2020 chooses to set broad, population-based targets for health measures without expressing a preference between means of achieving those targets, as in the case of access to health insurance coverage, where HP 2020 sets a target of 100% coverage without acknowledging the obvious--that there is no evidence that anything other than a coercive legal mechanism is a realistic way to achieve that goal.

The determination of which coercive legal mechanisms HP 2020 supports appears to be made not on the ground of epidemiological evidence of a policy's effectiveness; rather, HP 2020 seems to be willing to advocate for direct regulation only in areas that are relatively politically uncontroversial, such as helmet laws and certain tobacco control measures. This paper argues that a **true** internalization of the principles of **health equity** **requires** that HP 2020 acknowledge the predictably different distributive consequences of various policy interventions and urge the adoption of those coercive legal mechanisms that are demonstrably effective in reducing health disparities. Without such a framework under which to operate, the likely result is that, even if overall population health improves, health disparities will widen between the most vulnerable population groups and the already advantaged, or remain essentially stagnant, as they did under HP 2010.

More broadly, this paper argues that health equity demands the use of coercive legal mechanisms in certain circumstances given the existence of current disparities and the evidence of effectiveness of direct regulation as compared to its alternatives. This is true for a number of reasons, including that purely voluntary policy initiatives often result in little impact on the most vulnerable populations (e.g., in the case of trans fat initiatives, discussed infra Part III.B.3), and because market-based initiatives have failed to adequately account for the health needs of certain population groups (as in the case of access to health services, discussed infra Part III.B.1). Only with a candid assessment and acceptance of the critical role that coercive legal mechanisms play in furthering population health can progress be made toward the achievement of the HP 2020 goals and ultimately, health equity. Part II of this paper discusses health equity in the U.S. and how HP 2020 incorporates health equity into its goals. Part III discusses the importance of law in public health and health equity and uses specific HP 2020 goals and objectives as examples of the essential role of coercive legal mechanisms in achieving those goals while also furthering health equity. Part IV proposes certain additional legal mechanisms that could inform selection of strategies for achieving the HP 2020 goals and health equity, including the use of a “health in all policies” approach to government, the use of health impact assessments in policymaking, and the use of various indices to measure the effects of various policies and assess progress toward disparities reduction.

#### Access and a broader set of health options are good: Medicine once exerted power over patients. Such concerns are increasingly dated – health is *now* a site to invert dyads of power

Hudson 15 Dr. Janella Nicole Hudson is now with The Centers for American Indian and Alaska Native Health at The Colorado School of Public Health. Specifically, the author is a postdoctoral fellow in the department of Health Behavior and Outcomes at the Moffitt Cancer Center where Janella contributes to the study of doctor-patient communication with adolescent and young adult cancer patients. The author also serves as the Program Manager for Education and Research at The Academy of Communication in Healthcare. Janella’s research examines health communication processes with diverse medically underserved groups, including black patients, to produce culturally tailored educational interventions. Janella’s research features expertise in Qualitative Social Research, Communication and Media. The methodology for this paper studied a cohort consisting solely of those that identified as black patients. The cohort was predominately “low income” – which the authors define as having an annual income of less than $30,000.00 per year. The cohort was predominately those that identified as “black women”. The paper is a follow-up to a larger principal study by Dr. Louis Penner of Wayne State University. In that parent study, 98.5% of participants identified as black. This paper was written while the author held an MA and was the author’s dissertation paper for obtaining a PhD. "Agency And Resistance Strategies Among Black Primary Care Patients" (2015). Wayne State University Dissertations. Paper 1340. Submitted to the Graduate School of Wayne State University, Detroit, Michigan in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY - #CutWithRJ – One modification – that is not highlighted in the card and doesn’t alter the reading of this evidence – adds the word “century” because it appears to have been left out of editing - <http://digitalcommons.wayne.edu/cgi/viewcontent.cgi?article=2339&context=oa_dissertations>

Despite their benevolent intentions, Pauley (2011) asserts that providers are ultimately gatekeepers, with the power to influence the course of the interaction. As such, negotiations within clinical interactions are not always easy. Physicians may have expert power, but increasingly savvy patients (who increasingly access the Internet and other sources to secure information) complicate the negotiation for power. In addition, physicians should attempt to address the power disparity by improving the patient's bargaining position with efforts such as increased display of personal vulnerability (Pauley, 2011).

Indeed, clinical communication represents the struggle for dominance between the physician and patient. Roter and McNeilis (2003) assert:

The medical dialogue is the fundamental instrument through which the battle over paradigms is being waged; the patient problems will be anchored in either a biomedical and disease context or a broader and more integrated illness context that incorporates the patient perspective. In other words, the nature of the patient's problems will be established and the visit's agenda and therapeutic course will be determined by whatever wins out (p. 122).

Mishler (2003) further expands upon this idea and offers recommendations for a change in clinical communication. Referring to the discourse of medicine, which is most often characterized by a physician-dominated interview, Mishler urges practitioners to develop alternative practices that "interrupt the voice of medicine" and give priority to hearing patients' narratives and contextualized explanations of illness that use everyday language" (p.437). Such an approach centralizes the needs of the patient as opposed to allowing the physician to dominate the encounter with a biomedical approach to identifying and treating illness.

Mishler's assertion shows the importance of attending to surrounding context. While physicians may be primarily concerned with attending to the biomedical and technical aspects of the patient's illness, they must also allow room for the patient's "knowledge." All too often, the expert knowledge of practitioners and scholars is given the designation of trusted knowledge, while patient knowledge is given little credence (Airhihenbuwa, 2000). In order to centralize patient needs, physicians must allow for the emergence of the voice of the life world during clinical interactions. This approach promotes the enactment of patient agency, which might manifest in several ways. Such an "interruption" of the voice of medicine (Mishler, 2003) allows the patient and the physician to connect through collaborative discourse. This ultimately empowers the patients to take control of their health plans, actively supporting or resisting suggested treatment plans as they attempt to identify the best contextual fit.

Mishler's recommendation represents an ideal in contemporary healthcare that has resulted from a lengthy evolution in patient-physician literature. Whereas greater patient power is promoted in contemporary patient-physician literature, *previous literature* features an extensive history of a physician-dominated ideal.

The Patient Role

In keeping with the ever-evolving nature of the health care system, conceptualizations of the ideal roles for patients and physicians have evolved over time. For many years, the physicians were expected to exert professional dominance during the clinical interaction and patients were expected to take a submissive role (i.e., paternalism) (Roter & McNeiHs, 2003). In twenty-first (century) health care settings, however, patients are encouraged to assume a greater degree of participation during the clinical interaction (i.e., consumerism). The evolution of the patient and physician roles has provided a platform for a dyad shift in power, setting up a "battlefield" where wars over power and paradigms are waged (Rotter & McNeilis, 2003).

#### The status quo denies *the option* of health access. That hurts agency and advances the violently essentialized trope of the passive black patient.

Hudson ‘15

Dr. Janella Nicole Hudson is now with The Centers for American Indian and Alaska Native Health at The Colorado School of Public Health. Specifically, the author is a postdoctoral fellow in the department of Health Behavior and Outcomes at the Moffitt Cancer Center where Janella contributes to the study of doctor-patient communication with adolescent and young adult cancer patients. The author also serves as the Program Manager for Education and Research at The Academy of Communication in Healthcare. Janella’s research examines health communication processes with diverse medically underserved groups, including black patients, to produce culturally tailored educational interventions. Janella’s research features expertise in Qualitative Social Research, Communication and Media. The methodology for this paper studied a cohort consisting solely of those that identified as black patients. The cohort was predominately “low income” – which the authors define as having an annual income of less than $30,000.00 per year. The cohort was predominately those that identified as “black women”. The paper is a follow-up to a larger principal study by Dr. Louis Penner of Wayne State University. In that parent study, 98.5% of participants identified as black. This paper was written while the author held an MA and was the author’s dissertation paper for obtaining a PhD. "Agency And Resistance Strategies Among Black Primary Care Patients" (2015). Wayne State University Dissertations. Paper 1340. Submitted to the Graduate School of Wayne State University, Detroit, Michigan in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY - #CutWithRJ - <http://digitalcommons.wayne.edu/cgi/viewcontent.cgi?article=2339&context=oa_dissertations>

Discussion of Goal and Agenda Setting/Management. Participants' demonstrations of patient agency throughout the diagnosis and treatment sequences of the interaction signal a clear intent to participate and partner with the physician. *Previous* literature has examined how the process of setting the agenda during the medical visit often disadvantages the patient, as the physician often chooses a patient problem to discuss without fully exploring the patient's full spectrum of concerns (Marvel, 1999). Manny and Ray (2002) for example, describe a pattern of agenda setting that often consists of the physician initiating the opening sequence with a name exchange/check, brief pleasantry and a first topic initiator. As the interaction continues, the authors note that the inherent power imbalance within the dyad becomes evident as the physician assumes his prerogative to speak first and then manages the agenda for the duration of the interaction. Our findings, however, demonstrate that participants were comfortable exerting their agency in order to influence the unfolding of the interaction and shepherd the physician back to their previously identified topics of interest as needed. This vigilance and focus is understandable when interpreted within the larger context of the interactions. Several participants reported not having received medical care for an extended period of time, and as a result, several health issues that required treatment had accumulated. Participants were aware of the time constraints of the medical visit and therefore worked strategically to ensure that all of their needs could be addressed during the interaction.

In addition to setting the agenda, participants demonstrated a clear desire for partnership with their physician when reviewing treatment plans and determining their suitability. While literature shows that not all patients want to participate in decision making (Levinson, Kao, Kuby, & Thisted, 2005) and that physicians often underestimate black patients' desire for partnership during the interaction (Street & Haidet, 2011), our findings clearly show that some patients desire partnership from their physicians when reviewing, discussing and deciding upon diagnosis and treatment.

Participants in our study consistently pressed physicians for additional information and details concerning their decision-making during clinical interactions, and these findings mirror some findings in existing literature. Cooper-Patrick et al. (1999) reported that black patients rated their medical visits as less participatory when compared with white patients. However, participants in our study assumed a more active role when discussing diagnoses and treatments, often in response to a minimal education and explanation on the part of the physician. The vigilance that participants demonstrated during these interactions is justified as participants identified instances of misinformation and inadequate understanding of patients' health concerns. Our findings show that black primary care patients can actively participate and partner with the physician during the clinical action, and perhaps are more motivated to do so when the attempting to optimize the visit's outcomes.

It should be noted that all of our participants, who consist of low-income, black patients with a history of discrimination, demonstrated agency during interactions with physicians. The nature of these interactions, coupled with participants' explanations of how information, services and resources were often badly needed, show that these patients were proficient in demonstrating "active" or agentive behaviors in order to obtain health resources. In fact, it is safe to assume that these patients were already active, or already equipped to exercise their agency when interacting with the physician. This is compelling, given that much of patient-centered literature does not reflect this population in this way. These findings show that these marginalized patients are capable (without prior prompting) of demonstrating active behaviors, and as a result of having to endure constraints in access to healthcare and health services, they may become more proficient or likely to exercise their agency.

RQ 3a: What are the resistance strategies used among marginalized patients with a history of previous discrimination?

Resistance strategies consisted of participants' efforts to challenge and reject the physician's recommended diagnosis or the recommended treatment plan. We reviewed previously identified instances of patient agency in order to identify the instances in which patients' enactments of agency simultaneously functioned as resistance. As Koenig (2011) discusses, resistance is a manifestation of patient agency. Building upon this conceptual understanding, we identified the instances of agency in which patients used both active and passive tactics for enacting resistance to the physician's treatment and/or diagnosis. Using context and Stivers' (2005) definition as a guide, we identified instances of passive resistance (behavior that didn't align with the physician's treatment plan), and several instances of active resistance (behavior that challenged or queried the diagnosis as well as the effectiveness of medication of alternate treatments, p.950).

#### There’s no one cause of health disparities – malleability, not root causes should frame the impact

Gaffney 16 Adam Gaffney, Instructor in Medicine at Harvard Medical School and a Pulmonary/critical care doctor. The author holds an MD from New York University and expressly identifies as an “advocate for Single-Payer” as the lead on the author’s Twitter handle. Internally quoting Damon Tweedy – the author of the book Black Man in a White Coat. Tweedy identifies as black and is a graduate of Duke University School of Medicine. He is an associate professor of psychiatry at Duke University School of Medicine and staff physician at the Durham Veteran Affairs Health System. Also internally quoting Dayna Bowen Matthew, a leader in public health who focuses on racial disparities in health care. Matthew identifies as a black female. Matthew joined the faculty at the University of Virginia in 2017. She is the author of the book Just Medicine: A Cure for Racial Inequality in American Health Care. Matthew previously served on the University of Colorado law faculty as a professor, vice dean and associate dean of academic affairs. “Is the Path to Racial Health Equity Paved with “Reparations”? The Politics of Health, Part II” – LA Review of Books - 3-7-2016 – #CutWithRJ - [https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/#](https://lareviewofbooks.org/article/is-the-path-to-racial-health-equity-paved-with-reparations-the-politics-of-health-part-ii/)!

Only through the combined force of the civil rights movement, the Civil Rights Act of 1964, a number of key legal challenges, and the passage of Medicare in 1965 could the rollback of American apartheid medicine begin, as will be discussed in more detail below. For now, it’s worth noting that the impact of the civil rights movement on black health was not insignificant, as demonstrated in a revealing 2013 study by epidemiologist Nancy Krieger and colleagues. In the early 1960s, these investigators found that black infant death rates were significantly higher in “Jim Crow” states (the 21 states, plus the District of Columbia, with racial discrimination on the law books) than in non-Jim Crow states. This is hardly surprising. Yet, during the late 1960s, the death rate of the former group did improve, and by the 1970s the difference had evaporated. This can be touted as evidence that political change can yield real improvements *in health* over time. But two additional facts complicate this interpretation. First, after 2000, the gap again opened up, albeit to a lesser extent. And, second, regardless of the impact of the Civil Rights movement on disparities among blacks, throughout this period black infant death rates were still twice that of whites.[10]

Meanwhile, in terms of life expectancy, recent years have seen the reduction — but not the elimination — of black-white inequalities. As the Centers for Disease Control reported last November, the difference in life expectancy between the two groups fell from 5.9 years (in 1999) to 3.6 years (in 2013). However, even this may not be entirely goods news. A widely covered study published last fall found a unique and disturbing rise in mortality among middle-aged whites (of lower socioeconomic status) between 1999 and 2013, leading the investigators to conclude that falling white-black mortality disparities in this age group “was largely driven by increased white mortality.”[11]

Moreover, during this same period and on into the present, a series of events have functioned as starkly visible and undeniable examples of ongoing structural health racism. Following the death last year of Freddie Gray while in polic[e] custody, many made note of the enormous chasm in health and mortality between black neighborhoods like his and adjacent wealthier and whiter ones. Other commentators have highlighted “environmental racism,” or inequities in exposure to environmental hazards by race, emblematic of embedded structural inequality. Revealing reporting by the Washington Post, for instance, described Gray’s history of childhood lead poisoning, an exposure that is in part racially patterned. More recently, mass poisoning by lead in Flint, Michigan — the disastrous consequence of dimwitted austerity and structural marginalization — has provided yet more evidence of the downstream health consequences of political exclusion.

Inequalities in criminal justice itself — specifically mass incarceration and police violence — are now being explicitly contextualized within a framework of health.[12] In protest of such inequalities (made starkly visible by the killings of men like Eric Garner and the ensuing “Black Lives Matter” protests), medical students throughout the country have begun to advocate for change — for instance, with a solidarity “die-in” action on December 10, 2014, which in turn led to the formation of a new racial health justice organization (“White Coats for Black Lives”) on Martin Luther King Day in 2015.[13]

Finally, two new books are tackling head-on the problem of racial health inequality, albeit from very different “expert” perspectives — one from within medicine and the other from a legal perspective. Damon Tweedy’s Black Man in a White Coat, released last year, is a thoughtful memoir that explores the nexus of race and medicine through the eyes of a black physician. Law professor Dayna Bowen Matthew’s Just Medicine: A Cure for Racial Inequality in American Health Care, on the other hand, is an integration of legal analysis and social science that culminates in an overarching policy recommendation.

In what follows, I’ll first examine the issue of racism within the medical profession, turning to Tweedy’s experiences and reflections as described in his book. Next, I’ll focus on Matthew’s book, and examine the problem of explicit and implicit medical discrimination historically and in the present — and how civil rights law might be used to combat it. From there, I’ll discuss the place of the health system in the perpetuation of inequalities, and the largely neglected role that health care universalism plays in “health equality.”

Lastly — but most importantly — I’ll explore how health inequities by race and by class intersect. To phrase the question plainly: Does confronting the problem of racial health inequality mean that we must embrace the cause of economic redistribution, as discussed in the first part of this essay? If so, should this economic redistribution proceed within the context of social democracy (or democratic socialism?), or should it — must it — proceed along explicitly racial lines? Is the path to racial health equity paved with “reparations”?

2. Black doctors: Discrimination within the profession

The plotline of Steven Soderbergh’s unnerving and beautifully shot series The Knick tackles racism within the medical profession by making it viscerally visible in another era. Set in a downtown Manhattan hospital at the turn of the 19th century, the black, eminently qualified physician, Algernon Edwards (Andrew Holland), is treated with derision and disdain by many of the hospital’s white staff and administrators. At the same time, the hospital turns away black patients from its outpatient clinic; Edwards surreptitiously begins treating them — under rather suboptimal operative conditions — in the hospital’s basement.[14]

But what about after the time period depicted in this series? Into the mid-20th century, blacks were excluded from many medical schools, and those who graduated faced intense discrimination in the course of practice. For instance, even decades after the events depicted in the Knick, black physicians were unable to provide care for their hospitalized patients in the South. This was because physicians needed to gain entry into county medical societies as a prerequisite to hospital-admitting privileges; and, in the South, these societies entirely or almost entirely denied blacks membership. The AMA virtuously professed that it opposed discrimination, and yet excused itself from doing anything, claiming it was impotent to compel integration. It took decades of political pressure to force change. In 1968, the Medical Committee for Human Rights, a health-oriented civil rights group, took matters into its own hands, invading the AMA’s convention at the extravagant Fairmont Hotel in San Francisco. Such actions — in conjunction with the Civil Rights Act and the passage of Medicare — ultimately contributed to the AMA’s vote later that year to expel county societies that excluded black members, at long last forcing their disgracefully delayed integration.[15]

This is, of course, not to say that blacks subsequently gained equal footing within the medical profession. Black representation in US medical schools has remained proportionally low over the decades, especially for men. Indeed, a report from the Association of American Medical Colleges last year showed that the number of black male matriculants in medical school is lower now — in absolute terms — than it was in the late 1970s. Tweedy, now an assistant professor of psychiatry at Duke University Medical Center, was one of these matriculants. In his book, he describes some of the challenges he faced.

In addition to being one of only “a handful of black students” in his class at Duke Medical School, Tweedy came from a working class family, in stark contrast to the majority of his classmates. On the one hand, Tweedy highlights the importance of affirmative action: “So there it was: Not only was I admitted to Duke, when in a color-blind world I might not have been, but I had arrived with a full-tuition scholarship in hand.” On the other hand, his first exchange as a first year student with a medical school professor was markedly inauspicious: the professor approached him to ask if he was there to fix the lights. While he was a medical student, patients routinely queried him about his presumed basketball skills. Far worse was his interaction as a resident with a racist patient and his confederate-flag adorned family (“I don’t want no nigger doctor,” the patient told a nurse). Tweedy’s diligence and persistence ultimately, however, won them over. On another occasion, a black patient rejected him, presuming his medical skills to be inferior and seeing the assignment as evidence of racist mistreatment of him as a patient. Given the insecurities that afflict medical students and trainees in general, we can only imagine the additional strain created by such presumptions and prejudices.

Tweedy’s book is also very much about the experience of black patients. He bears witness to the second-class care they too frequently experience when, for instance, as a medical student he spends time in a makeshift rural clinic, “nestled within a group of dingy trailers and makeshift houses.” The clinic serves poor black patients who cannot afford prescribed treatments. They are likely to see a different doctor at every visit and receive grossly insufficient preventive care. In another chapter, he describes how one black patient, who quite reasonably declines one of his team’s medical recommendations, is dispatched with a punitive psychiatric diagnosis.

Toward the conclusion of his book, Tweedy briefly explores the larger and looming question: what is the cause of racial health inequalities? Early in his medical career, he had assumed — like many others — that genetic differences were the primary factor. And indeed, for years, a huge amount of resources have gone into uncovering the genetic sources of health disparities. However, as Jason Silverstein explains in a revealing article in The Atlantic (“Genes Don’t Cause Racial-Health Disparities, Society Does”), this money may have been better spent elsewhere. He describes a 2015 paper that systematically reviewed the collective evidence thus far for the proposition that genetic factors explain racial cardiovascular disparities. It’s worth quoting from the study’s conclusion:

The results reveal a striking absence of evidence to support the assertion that any important component of observed disparities in these diseases arises from main-effect genetic mechanisms as we currently understand them … Despite the enormous social investment in genomic studies, this research program has not yet provided valuable population-relevant insights into disparities in the most common cause of morbidity and mortality.[16]

Why then, Silverstein asks the study’s lead author, do genomics still get so much attention? The author responds with a sentiment I’ve long suspected: if inequalities are built into the very base pairs of our genetic code, what can we really do to alleviate them? More research? In effect, as the investigator tells Silverstein, the fact is that racism and inequities are let off the hook if our genes are the culprits. Tweedy notes that he came to reject this genetic explanation: even if genetic factors play some role with respect to specific diseases, they explain little of the overall differences in health between races.

In contrast, there are reams of evidence that point to social and economic inequalities as drivers of racial inequalities. In the first part of this essay, I focused on the impact of economic injustices on health: a large body of literature has demonstrated that poverty, for instance, is associated with a panoply of poor health outcomes, and some researchers argue that inequality itself causes worse health for everyone in society (perhaps via increased psychosocial strain as well as other factors).[17] No doubt such socioeconomic factors are a major factor in racial health inequalities, given the tight association between economic status and race.[18] Similarly, differences in health care access associated with race (like being uninsured) are no doubt factors as well.

But what might be said about the role of racially discriminatory treatment itself? This issue has received increased attention since the 2002 publication of an Institute of Medicine evidence report, Unequal Treatment: Confronting Racial Disparities in Health Care. Tweedy quotes from the report’s conclusion: “Although myriad sources contribute to [health] disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of the healthcare providers may contribute to differences in care.” Or, as he puts it, the “doctor-patient relationship itself serves as a catalyst for differing outcomes,” which is in part the result of the fact that “some doctors are prone to hold negative views about the ability of black patients to manage their health and therefore might recommend different, and possibly substandard, treatments to them.”

This issue — namely, the problem of racially disparate treatment — is the central focus of Dayna Bowen Matthew’s book. She explores how “implicit bias,” as she terms it, deforms physician behavior; in her view, it constitutes the most neglected determinant of inferior health among blacks.

3. Jim Crow medicine: Past and present

Matthew is a law professor with appointments at both the University of Colorado Law School and the Colorado School of Public Health. Matthew is also one of the founders of the Colorado Health Equity Project, a multidisciplinary organization that works to “remove legal barriers to equal health access and health outcomes for Colorado’s vulnerable populations,” as its website puts it. Her ambitious book lays out a case for a legal remedy for racial health inequality.

Key to her argument is the historical context of civil rights law, which she sees as a swinging pendulum. Hill-Burton, as we’ve seen, legally enshrined the “separate-but-equal” standard — established in the Supreme Court case Plessy v. Ferguson — within the health care system. Legal challenges to this standard were unsuccessful, until Simkins v. Moses H. Cone Memorial Hospital, the “watershed case,” as Matthew puts it, initiated its unraveling. As she recounts it, the case was brought by black practitioners and patients against a discriminatory hospital in North Carolina that received Hill-Burton funds. The Fourth Circuit Court of Appeals decided in favor of the plaintiffs, declaring, as quoted by Matthew, that “Racial discrimination by hospitals visits severe consequences upon Negro physicians and their patients.”

She describes two consequences that flowed from this decision. First, the case helped catalyze subsequent *successful* health-care related civil rights litigation throughout the country. Second, the decision — which the Supreme Court importantly declined to reconsider — helped lead the way to Title VI of the Civil Rights Act of 1964. According to Matthew, Congress took the Supreme Court’s decision not to accept the case as a signal that it saw hospital segregation as unconstitutional (and, indeed, several legislators explicitly cited the Simkins decision during debate over the bill). Much good came from this: “From 1963 through the early 1990s,” Matthew writes, “Title VI proved an effective weapon against the segregation and discrimination that minority patients and physicians had experienced in American health care since the colonial era.” For instance, the Johnson administration required hospitals to comply with Title VI in order to be eligible for Medicare payment. Few could afford not to, and so the age of explicit hospital segregation finally came to a close.

Yet Matthew asserts that, to an extent, this more auspicious era ended abruptly in 2001, when a more conservative Supreme Court ruled in Alexander v. Sandoval, in a decision written by Justice Antonin Scalia, that Title VI was applicable only in cases of deliberate discrimination; disparate impact was not enough.[19] This new standard precluded a great deal of civil rights litigation because it required that plaintiffs produce tangible evidence that racist health care was intentional, which is made difficult when, as she notes, “few Americans are careless enough to create an evidentiary record of outright bigotry.” Thus, according to Matthew, with respect to health care discrimination, this decision effectively rendered Title VI “a dead letter.” This decision, she argues, must be undone if progress against racial health inequalities is to proceed. In short, unconscious racism in health care must, according to her, be made illegal through an act of Congress and an expansion of Title VI.

This may sound Orwellian to some. Is it meaningful, after all, to talk about outlawing sentiments or attitudes that lie deep within the dark depths of our unconscious? Can we root out biases if we are, by definition, unaware of their very existence? Matthew marshals a body of literature from various disciplines to answer *in the affirmative*. Conscious racism, she argues, is slowly being replaced by the unconscious variety: “But while overt racism is subject to nearly universal derision, unconscious racism due to implicit bias is hidden, is tolerated, and even excused despite its destructiveness.” She persuasively explores various literatures demonstrating that physicians harbor unconscious negative perceptions of blacks. She cites studies that show that patient race affects which treatments doctors recommend, how much time they spend with patients, “the level of verbal exchange and shared decision-making in which they engage” with patients, and even the manner of their nonverbal engagement. She concludes that there is a sufficient base of evidence to conclude that these implicit biases contribute to disparities, that there is reason to believe that such biases, even though they are implicit, are remediable, and that health care providers — both on the individual and institutional level — can therefore be held legally responsible for the results of their implicit biases.

The “evidence of malleability” is strong, according to Matthew. In other words, she thinks specific interventions can mitigate implicit biases and, as a result, disparate outcomes. The sorts of interventions she envisions, however, seem of mixed applicability and utility. Nonetheless, overall, she makes a strong case that clinicians make racially biased decisions, whether or not they intend to, and that this issue must be directly addressed. People like me — that is to say, white physicians who believe they are immune from racially biased thought and action — have a great deal to gain from reading this book.

That said, it is also important to examine the larger picture. There is no question that more needs to be done to address physician bias. Yet we also have to keep in mind that, in the pre-Alexander v. Sandoval era (when Title VI was, according to Matthew, more robust), there were still large racial inequalities. Litigation may be a useful tool, but it’s a limited, post-facto modality.

More broadly, the recommendations of both Tweedy and Matthew ultimately seem inadequate. Neither gives much credence to the notion that further increasing the universalism of the health system might play an important role in reducing inequalities. Moreover, Tweedy says nothing, and Matthew only a little,[20] about the notion of economic redistribution as a tool against racial health inequalities. In fairness, these concerns are not the focus of their books. However, to my mind, they are crucial considerations in the larger discussion of racial health care justice.

4. Health equity and health system universalism

Martin Luther Kings Jr.’s statement on the evils of health inequality is frequently quoted, but not usually in its full form. In his 1966 speech at the annual meeting of the aforementioned Medical Committee for Human Rights, he said, “Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death.”[21] Indeed, studies have shown a statistical association between lack of insurance and mortality. Removing the boundaries between individuals and the health care system is a critical step in the movement toward health care equality.

Tweedy, for instance, sees firsthand the harm inflicted on the uninsured when he works at the rural health clinic described earlier. But, even so, like Matthew, he gives insufficient attention in his book to the fact that, even with the reforms of the Affordable Care Act, we will continue to lack universal health care.[22] For instance, under current reforms, 27 million are expected to remain uninsured 10 years from now, according to an approximation of the Congressional Budget Office. We know that ~~Hispanics~~ (LatinX) and blacks are disproportionately represented among the uninsured.[23] Covering these excluded millions seems critical. Moreover, neither author discusses the fact that the US health care system imposes substantial financial burdens at the “point of use,” in the form of copayments, deductibles, and co-insurance for medical care, which may deter care for those who need it. Some have legitimately suggested that these forms of cost-sharing disproportionately harm minorities, who have lower median income and net wealth.[24] In other words, the potential harm of, say, a $2,000 medical deductible is dependent on your income and assets: those with fewer resources may lose out on important health care. And finally, though Tweedy refers to the shortcomings of Medicaid, neither he nor Matthew emphasizes that a health care system with a separate tier of access for the poor may be inherently unequal.

But would “true” universal health care do much to combat racial health inequalities, if it were, say, a single-payer system that eliminated out-of-pocket expenses and was equally accessible by all, without tiers or walls?[25] Or would it replicate current biases and inequalities? To some extent, the answer is yes to both questions. But even so, a body of research has suggested that, even if these biases persist, a fully universal system might nonetheless be a powerful tool in reducing racial health care inequalities. That evidence comes from what is arguably a quasi-single-payer system located in the US: the Veterans’ Administration (VA). Notwithstanding recent scandals that are indeed of great concern, the modern-era VA has justifiably earned praise for delivering a high — indeed, comparatively superior — quality of health care.[26] There is also evidence that it may indeed effectively reduce, even potentially eliminate, some racial health inequalities.

Last fall, a study published in Circulation, the premier journal of the American Heart Association, received wide coverage in the media for some provocative findings. “The US Veterans Health Administration (VHA),” as the study notes in its introductory section, “is a healthcare system that does not impose the typical access barriers of the US healthcare system that may disproportionately impede enrollment of blacks.” The investigators therefore hypothesized that racial inequalities in cardiovascular outcomes and mortality found in the general population might be reduced in the VA, a “healthcare system that allows enrollment independent of race or socioeconomic status.”[27] Consistent with previous studies, in their analysis of data from the general (non-VA) population, they found racial inequalities much as they expected to find them: blacks had a much higher mortality (after adjusting for various other factors) as compared to whites (indeed, approximately 40 percent to 50 percent higher).[28]

In striking contrast, in the VA population, even though the risk of stroke was either higher or similar among blacks as compared to whites depending on which statistical adjustments were used, the risk of coronary heart disease as well as overall death was actually lower among blacks. This is, of course, only a single study, albeit a rather large one with more than three million subjects. An accompanying editorial concedes that a number of factors may be at play. Nonetheless, the fact is that, as described by the investigators, these findings build on an existing literature consisting of multiple studies that together point to a reduction of racial health inequalities within the VA for critically important outcomes like mortality.[29]

No doubt, there are still discriminatory practices in some or all of these facilities, and we can assume that there are conscious or unconscious biases at work in the minds of some of its clinicians, as there are elsewhere. Indeed, other studies clearly show that, even after the significant reorganization and reform of the VA in the late 1990s, there are still racial disparities in the VA.[30] If we moved to a single-payer system on a national level, such biases would still need to be addressed along the lines Matthew argues. But the point is that a more egalitarian structure of the health care system itself might go even further in reducing them. Indeed, in light of this research, it seems fair to say that health care universalism could be a very powerful tool in combatting ubiquitous racial health inequities. Attaining health care equality, in other words, *requires* true *equality of access*. And *yet this* simple notion *is* all too *often ignored* entirely *in* any *discussion* of health “disparities.”

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## AFF

#### Here’s more ev establishing unique offense vs. the Alt.

Garrett ‘16

et al; A. Bowen Garrett is an economist and senior fellow in the Health Policy Center at the Urban Institute. His research focuses extensively on health reform and health policy topics, combining rigorous empirical methods and economic thinking with an understanding of the policy landscape to better inform policymaking. Previously, Garrett was chief economist of the Center for US Health System Reform and has taught quantitative methods and economic statistics at Georgetown University. “Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live? ACA Implementation—Monitoring and Tracking” - December 2016 #E&F – modified for language that may offend - https://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf

The Affordable Care Act (ACA) became law nearly seven years ago. Today the number of Americans lacking health insurance ~~stands~~ (is) at a historic low, and the ACA is credited with reducing the number of uninsured by about 20 million. In this brief, we take stock of who has gained coverage since 2010 and where they live. Using data from the American Community Survey, we examine health insurance coverage changes from 2010 to 2015 by demographic groups based on age, gender, race/ethnicity, education status, and state. Our main findings are as follows:

• An estimated 19.2 million nonelderly people gained health insurance coverage from 2010 to 2015, based on our analysis that accounts for population changes over the period.

• Coverage gains were broad-based; the number of uninsured fell substantially among all Americans under age 65, for both men and women, and across subgroups based on race/ethnicity, levels of educational attainment, and states.

• An estimated 2.8 million children from birth to age 18 gained coverage, suggesting that coverage expansions under the ACA and other policy changes for children’s coverage implemented from 2010 to 2015 reached children in families above the progress made by prior expansions targeting low-income children.

• The number of uninsured adults ages 19 to 34 declined by 8.7 million (42 percent), and the number of uninsured adults ages 35 to 54 declined by 5.6 million (33 percent). More than 2 million adults ages 55 to 64, who are at or approaching typical retirement ages, gained coverage from 2010 to 2015.

• Approximately 5 million women of childbearing age (19 to 44 years old) gained coverage from 2010 to 2015.

• Among those gaining coverage from 2010 to 2015, 8.2 million (43 percent) were non-Hispanic white, 2.8 million (15 percent) were non-Hispanic black, 6.2 million (32 percent) were Hispanic, and 2.0 million (10 percent) were other non-Hispanics.

• The large majority (87 percent) of adults gaining coverage from 2010 to 2015 did not have a college degree. Among them, 6.2 million were non-Hispanic white and 7.9 million were nonwhite or Hispanic.

• Americans in every state gained health insurance coverage. States that expanded Medicaid under the ACA saw larger percentage reductions in their number of uninsured residents than did states that chose to not expand Medicaid (45 percent compared with 29 percent). Nonetheless, 6.9 million people living in states that did not expand Medicaid gained health insurance.

• California’s uninsured rate fell 53.4 percent, translating into 3.8 million people gaining coverage. More than 2.3 million people gaining coverage from 2010 to 2015 lived in the Midwestern states of Illinois, Michigan, Ohio, and Wisconsin, with uninsured rates declining between 38 and 49 percent. Florida and Texas, two non-expansion states in the South, saw about 3.3 million people gain coverage as statewide uninsured rates fell 36 percent and 27 percent, respectively.

Congress is now considering options to repeal and replace the ACA. Repeal of the ACA without new policies capable of maintaining the coverage gains achieved since 2010 would result in millions of Americans, of all ages and backgrounds and in all states, losing health insurance along with the access to health care and financial protections it affords.

## Cap K

#### Alt fails and learning a Policy framework’s better *even if fiat’s not real.*

Bryant ‘12

(Levi Bryant is currently a Professor of Philosophy at Collin College. In addition to working as a professor, Bryant has also served as a Lacanian psychoanalyst. He received his Ph.D. from Loyola University in Chicago, Illinois, where he originally studied 'disclosedness' with the Heidegger scholar Thomas Sheehan. Bryant later changed his dissertation topic to the transcendental empiricism of Gilles Deleuze, “Critique of the Academic Left”, http://larvalsubjects.wordpress.com/2012/11/11/underpants-gnomes-a-critique-of-the-academic-left/)

Unfortunately, the academic left falls prey to its own form of abstraction. It’s good at carrying out critiques that denounce various social formations, yet very poor at proposing any sort of realistic constructions of alternatives. This because it thinks abstractly in its own way, ignoring how networks, assemblages, structures, or regimes of attraction would have to be remade to create a workable alternative. Here I’m reminded by the “underpants gnomes” depicted in South Park:¶ The underpants gnomes have a plan for achieving profit that goes like this:¶ Phase 1: Collect Underpants¶ Phase 2: ?¶ Phase 3: Profit!¶ They even have a catchy song to go with their work:¶ Well this is sadly how it often is with the academic left. Our plan seems to be as follows:¶ Phase 1: Ultra-Radical Critique¶ Phase 2: ?¶ Phase 3: Revolution and complete social transformation!¶ Our problem is that we seem perpetually stuck at phase 1 without ever explaining what is to be done at phase 2. Often the critiques articulated at phase 1 are right, but there are nonetheless all sorts of problems with those critiques nonetheless. In order to reach phase 3, we have to produce new collectives. In order for new collectives to be produced, people need to be able to hear and understand the critiques developed at phase 1. Yet this is where everything begins to fall apart. Even though these critiques are often right, we express them in ways that only an academic with a PhD in critical theory and post-structural theory can understand. How exactly is Adorno to produce an effect in the world if only PhD’s in the humanities can understand him? Who are these things for? We seem to always ignore these things and then look down our noses with disdain at the Naomi Kleins and David Graebers of the world. To make matters worse, we publish our work in expensive academic journals that only universities can afford, with presses that don’t have a wide distribution, and give our talks at expensive hotels at academic conferences attended only by other academics. Again, who are these things for? Is it an accident that so many activists look away from these things with contempt, thinking their more about an academic industry and tenure, than producing change in the world? If a tree falls in a forest and no one is there to hear it, it doesn’t make a sound! Seriously dudes and dudettes, what are you doing?¶ But finally, and worst of all, us Marxists and anarchists all too often act like assholes. We denounce others, we condemn them, we berate them for not engaging with the questions we want to engage with, and we vilify them when they don’t embrace every bit of the doxa that we endorse. We are every bit as off-putting and unpleasant as the fundamentalist minister or the priest of the inquisition (have people yet understood that Deleuze and Guattari’s Anti-Oedipus was a critique of the French communist party system and the Stalinist party system, and the horrific passions that arise out of parties and identifications in general?). This type of “revolutionary” is the greatest friend of the reactionary and capitalist because they do more to drive people into the embrace of reigning ideology than to undermine reigning ideology. These are the people that keep Rush Limbaugh in business. Well done!¶ But this isn’t where our most serious shortcomings lie. Our most serious shortcomings are to be found at phase 2. We almost never make concrete proposals for how things ought to be restructured, for what new material infrastructures and semiotic fields need to be produced, and when we do, our critique-intoxicated cynics and skeptics immediately jump in with an analysis of all the ways in which these things contain dirty secrets, ugly motives, and are doomed to fail. How, I wonder, are we to do anything at all when we have no concrete proposals? We live on a planet of 6 billion people. These 6 billion people are dependent on a certain network of production and distribution to meet the needs of their consumption. That network of production and distribution does involve the extraction of resources, the production of food, the maintenance of paths of transit and communication, the disposal of waste, the building of shelters, the distribution of medicines, etc., etc., etc.¶ What are your proposals? How will you meet these problems? How will you navigate the existing mediations or semiotic and material features of infrastructure? Marx and Lenin had proposals. Do you? Have you even explored the cartography of the problem? Today we are so intellectually bankrupt on these points that we even have theorists speaking of events and acts and talking about a return to the old socialist party systems, ignoring the horror they generated, their failures, and not even proposing ways of avoiding the repetition of these horrors in a new system of organization. Who among our critical theorists is thinking seriously about how to build a distribution and production system that is responsive to the needs of global consumption, avoiding the problems of planned economy, ie., who is doing this in a way that gets notice in our circles? Who is addressing the problems of micro-fascism that arise with party systems (there’s a reason that it was the Negri & Hardt contingent, not the Badiou contingent that has been the heart of the occupy movement). At least the ecologists are thinking about these things in these terms because, well, they think ecologically. Sadly we need something more, a melding of the ecologists, the Marxists, and the anarchists. We’re not getting it yet though, as far as I can tell. Indeed, folks seem attracted to yet another critical paradigm, Laruelle.¶ I would love, just for a moment, to hear a radical environmentalist talk about his ideal high school that would be academically sound. How would he provide for the energy needs of that school? How would he meet building codes in an environmentally sound way? How would she provide food for the students? What would be her plan for waste disposal? And most importantly, how would she navigate the school board, the state legislature, the federal government, and all the families of these students? What is your plan? What is your alternative? I think there are alternatives. I saw one that approached an alternative in Rotterdam. If you want to make a truly revolutionary contribution, this is where you should start. Why should anyone even bother listening to you if you aren’t proposing real plans? But we haven’t even gotten to that point. Instead we’re like underpants gnomes, saying “revolution is the answer!” without addressing any of the infrastructural questions of just how revolution is to be produced, what alternatives it would offer, and how we would concretely go about building those alternatives. Masturbation.¶ “Underpants gnome” deserves to be a category in critical theory; a sort of synonym for self-congratulatory masturbation. We need less critique not because critique isn’t important or necessary– it is –but because we know the critiques, we know the problems. We’re intoxicated with critique because it’s easy and safe. We best every opponent with critique. We occupy a position of moral superiority with critique. But do we really do anything with critique? What we need today, more than ever, is composition or carpentry. Everyone knows something is wrong. Everyone knows this system is destructive and stacked against them. Even the Tea Party knows something is wrong with the economic system, despite having the wrong economic theory. None of us, however, are proposing alternatives. Instead we prefer to shout and denounce. Good luck with that.

#### Link is reductionist and can’t explain US-EU divergences

Foster 19 [Chase Michael Foster was a Doctoral Candidate at Harvard University at the time of this dissertation. The author has served as a Election Observer (OSCE, ODIHR) in Moldova, Belarus, Russia, Georgia and as a Teaching Assistant at the Harvard Kennedy School of Government. At the time of this writing, the author held a MPP (Democracy, Politics, and Institutions) from the Harvard Kennedy School of Government. “The Politics of Delegation: Constitutional Structure, Bureaucratic Discretion, and the Development of Competition Policy in the United States and the European Union, 1890-2017” – Doctoral dissertation to The Department of Government, Harvard University, Graduate School of Arts & Sciences. In partial fulfillment of the requirements for the degree of Doctor of Philosophy in the subject of Government - January 2019 - #E&F –https://dash.harvard.edu/bitstream/handle/1/41121359/FOSTER-DISSERTATION-2019.pdf?sequence=1]

Ideational Theories

Any analysis of the change in antitrust enforcement over time must begin with a consideration of ideas. Most of the existing social scientific scholarship on competition policy emphasizes the role of changing economic paradigms in spurring the transformation of European and American competition policy. A number of scholars of American antitrust have explained the dramatic decrease in antitrust enforcement as stemming from the shift in authority from lawyers to economists at the antitrust agencies (Eisner 1991). Others have emphasized the institutionalization of Chicago School-inspired economic ideas within antitrust jurisprudence (Ergen and Kohl 2017; Davies 2010; Pitofsky 2008). Both of these sets of accounts capture an important component of the shift. As theories of economic efficiency changed in the US academy during the 1960's and 1970's, much of the postwar enforcement program was delegitimized. Beginning in the early 1970's, both the prevailing judicial opinion on antitrust and the enforcement program of the antitrust agencies dramatically shift, leading to a precipitous drop in enforcement output, especially in areas such as vertical restraints, monopolies, and exclusionary practices.

The increase in the intensity of European enforcement has also been explained as the result of ideational change. Some EU scholars have argued that the institutionalization of neoliberal economic ideas in European regulatory law has led to the intensification of regulatory enforcement (Thatcher 2013; Buch-Hansen and Wigger 2010; Wigger 2008). Concomitant to the Single European Act, the European competition directorate began to more intensely apply competition rules, and to shift its enforcement focus to state aid, publicly-owned companies, and the promotion of competition in previously protected network industries (Quack and Djelic 2005). During the late 1990's, competition law modernization led to a more neoliberal approach to the evaluation of market competition, while also expanding the breadth and intensity of enforcement (Wigger and Nolke 2007).

While each of these accounts points to some of the real ways that ideational change affected competition policy in each system, there are problems with explaining opposite trends as the result of the same paradigm shift. An ideas-only approach leaves us in the awkward position of explaining both the increase in the intensity of competition enforcement in the EU and the decrease in antitrust enforcement in the US as resulting from the same (or similar) neoliberal policy paradigm. While any analysis of competition policy developments must account for ideational change, we need to understand why the same set of ideas has produced different patterns of enforcement in Europe and the United States.

Additionally, there are empirical gaps in the ideational explanation. Certainly, the influence of the Chicago School cannot account for why US regulators have failed to follow much of the neoliberal prescription for liberalization and industrial policy. Chicago School economists, after all, have long supported the application of antitrust in these areas (Van I lorn 2015; McChesney 1986; Bork 1978). Moreover, there is no shortage of classically-trained economists in the European competition system.

#### Bifo’s Semio-captialism thesis is flawed. Even if semiotics are prevalent – people have agency and conceptualize out side of it.

#### Semiotic exhaustion and collapse is nonsense

Harris 11 – Malcolm Harris, Senior Managing Editor and Columnist for The New Inquiry, Writer and Editor for Sharable, “*I Sure Hope Bifo Doesn’t Count Vibrators as Tools of Estrangement”,* Destructural, 2-20, <https://destructural.wordpress.com/2011/02/20/i-sure-hope-bifo-doesnt-count-vibrators-as-tools-of-estrangement/> [**Note – Bifo is the pen/nickname for Franco Berardi – they’re the same person]**

I just finished Franco Berardi’s The Soul at Work, and though there’s a lot to agree with in there, the conclusion left me feeling argumentative. In reviving Baudrillard’s critique of the politics of desire, Berardi argues that horizontalism and affirmation – two cornerstones of Deleuze and Guatarri’s schizo thought – have been irredeemably co-opted by capital. Our social pathology is no longer Freudian repression, but overabundance of affirmation, of injunctions to consume and desire that produce panic and depression. When our very affective expressions have been colonized, the multitude is nothing but a robotic swarm:

“The multitude can speak hundreds of thousands of languages, but the language that enables it to function as an integrated whole is that of the economic automatisms embodied in technology. Seized in a game of mirrors of indeterminacy and precariousness, the multitude manifests its dark side and follows automatisms that turn its wealth into misery, its power into anguish and its creativity into dependency.”

“The effective exercise of politics (that is to say of political government) presupposes a conscious possibility of elaborating of the information collectively shared by the social organism. But the information circulating within digital society is too much: too fast, too intense, too thick and complex for individuals or groups to elaborate it consciously, critically, reasonably, with the necessary time to make a decision. Therefor the decision is left to automatisms, and the social organism seems to function ever more often according to evolutionary rules of an automatic kind, inscribed in the genetic cognitive patrimony of individuals. The swarm now tends to become the dominant form of human action.”

As the ultimate horror, Berardi looks to a biotechnological post-humanism as described by Bill Gates. The idea of a literal hive-mind, a freely flowing general intellect, is too much for Berardi; he offers the only solution he can think of to this dangerous acceleration of affective communication: slow down. In a more recent article, he calls, in the middle of the largest wave of global youth insurrection in over forty years, for a process of growing old. “[T]he process of senilization may open the way to a cultural revolution based on the force of exhaustion, of facing the inevitable with grace, discovering the sensuous slowness of those who do not expect any more from life than wisdom—the wisdom of those who have seen a great deal without forgetting, who look at each thing as if for the first time.” The assumption underlying this call to inaction is that the system of semiocapital is nearing its inevitable collapse. Berardi sounds like an aged and depressive Saint-Simon when he writes a hopeful narrative in which the machines will make stuff for us which, combined with income delinked from employment, will give us all the necessary time we need to play mahjong and dominoes, which is the goal of life. Actually, to be fair, Berardi never ceases to use sex as the goal, the time necessary to fuck is what we must carve away from capitalist control.

Baudrillard’s critique of Foucault and Deleuze that Berardi revives was prescient in some ways. He saw the appropriation of affirmation by capital coming, and he asks essentially how we can stand to read Deleuze while wearing Nike. “Affirm your desires” is an advertising slogan, and it could handle even the queer negation of Gregg Araki which it transformed into Hot Topic. In the final scene of Araki’s breakout film The Living End, two HIV-positive lovers are entangled half-fighting half-fucking in the desert. While one sucks off a pistol, the other yells at him to “just do it!” – four years after it became a shoe slogan. Berardi thinks we’ve been overtaken and the only solution is switching into reverse. (Which is going to happen whether we like it or not because semiocapital is collapsing anyway.) Always already co-opted, the multitude has no choice but to break down its constitutive links and start over. The only thing left is catastrophe: made by us, but not done by us.

Okay, my issues:

1. Berardi should be the last one to think a brain of any sort is univocal. He’s horrified by Bill Gates’s idea of business at the speed of thought, but what is the speed of thought really? Brains can be and are used to produce value for the market, but any friend of Felix Guattari should know brains are chaotic. They produce ideas for the boss, but they inevitably produce jokes and nightmares as well. Just because capital has organized a social brain – transcending more spatial and interpersonal barriers than ever before – doesn’t make it the hive’s necessary owner. The processes that Berardi outlines (“wealth into misery, power into anguish, creativity into dependency”) present the possibility that it could be otherwise, that there could be a reverse movement. What capital offers is this impoverished multitude, but we ought not treat this as an offer to be either accepted or refused.

2. I feel pretty derisive about this fear of speed. Certainly a lot of his critiques about the schizogenic nature of contemporary knowledge-work are valid, but the worry that society is not able to deliberate “reasonably” at these speeds is misplaced. The swarm has been empirically capable of making decisions contrary to its instructions in Egpyt, Tunisia, The UK, Wisconsin, etc., and these actions have been successful to the degree that they’ve been fast and unreasonable. Crisis calls on creativity and innovation, and sabotage requires the multitude to seize the boss’ networks. In Madison, WI, the Capitol occupiers are engaged in the sabotage of the labor of citizenship, which is, as Tahrir Square was/is in Egypt, productive of new relations and subjectivities. Berardi points to the role of prescription drugs in pacifying and anesthetizing young people as intrinsically related to the speed technology requires, but I’m willing to bet there are a bunch of students in Madison who may be on Twitter, but haven’t needed to take their ADD meds.

#### Alt fails---transition is impossible and causes conflict. Even if transition occurs, it doesn’t solve

Smith 19 [Noah; 4/5/19; Bloomberg Opinion columnist, former assistant professor of finance at Stony Brook University; "Dumping Capitalism Won’t Save the Planet," https://www.bloomberg.com/opinion/articles/2019-04-05/capitalism-is-more-likely-to-limit-climate-change-than-socialism]

It has become fashionable on social media and in certain publications to argue that capitalism is killing the planet. Even renowned investor Jeremy Grantham, hardly a radical, made that assertion last year. The basic idea is that the profit motive drives the private sector to spew carbon into the air with reckless abandon. Though many economists and some climate activists believe that the problem is best addressed by modifying market incentives with a carbon tax, many activists believe that the problem can’t be addressed without rebuilding the economy along centrally planned lines.

The climate threat is certainly dire, and carbon taxes are unlikely to be enough to solve the problem. But eco-socialism is probably not going to be an effective method of addressing that threat. Dismantling an entire economic system is never easy, and probably would touch off armed conflict and major asdasd upheaval. In the scramble to win those battles, even the socialists would almost certainly abandon their limitation on fossil-fuel use — either to support military efforts, or to keep the population from turning against them. The precedent here is the Soviet Union, whose multidecade effort to reshape its economy by force amid confrontation with the West led to profound environmental degradation. The world's climate does not have several decades to spare.

Even without international conflict, there’s little guarantee that moving away from capitalism would mitigate our impact on the environment. Since socialist leader Evo Morales took power in Bolivia, living standards have improved substantially for the average Bolivian, which is great. But this has come at the cost of higher emissions. Meanwhile, the capitalist U.S managed to decrease its per capita emissions a bit during this same period (though since the U.S. is a rich country, its absolute level of emissions is much higher).

In other words, in terms of economic growth and carbon emissions, Bolivia looks similar to more capitalist developing countries. That suggests that faced with a choice of enriching their people or helping to save the climate, even socialist leaders will often choose the former. And that same political calculus will probably hold in China and the U.S., the world’s top carbon emitters — leaders who demand draconian cuts in living standards in pursuit of environmental goals will have trouble staying in power.

The best hope for the climate therefore lies in reducing the tradeoff between material prosperity and carbon emissions. That requires technology — solar, wind and nuclear power, energy storage, electric cars and other vehicles, carbon-free cement production and so on. The best climate policy plans all involve technological improvement as a key feature.

#### Cap’s sustainable and ensures global prosperity and environmental protection

Rhonheimer 20—teaching professor at the Pontifical University of the Holy Cross (Martin, “Capitalism is Good for the Poor – and for the Environment,” <https://austrian-institute.org/en/subjects-en/catholic-social-doctrine-2/capitalism-is-good-for-the-poor-and-for-the-environment/>, dml)

It is not social policy but capitalism that has created today’s prosperity.

What is important is that what made today’s mass prosperity possible – a phenomenon unprecedented in history – was not social policy or social legislation, organised trade union pressure, or corrective interventions in the capitalist economy, but rather market capitalism itself, due to its enormous potential for innovation and the ever-increasing productivity of human labour that resulted from it.

Increasing prosperity and quality of life are always the result of increasing labour productivity. Only increased productivity enabled higher social standards, better working conditions, the overcoming of child labour, a higher level of education, and the emergence of human capital. This process of increasing triumph over poverty and the constantly rising living standards of the general masses is taking place on a global scale – but only where the market economy and capitalist entrepreneurship are able to spread.

From industrial overexploitation of nature to ecological awareness

The first phase of industrialisation and capitalism was characterised by an enormous consumption of resources and frequent overexploitation of nature, which soon gave the impression that this process could not be sustainable. Since the end of the 19th century, disaster and doom scenarios have repeatedly been put forward, but in retrospect they have proved to be wrong: The combination of technological innovation, market competition, and entrepreneurial profit-seeking (with the compulsion to constantly minimise costs) have meant that these scenarios never occurred. The ever-increasing population has been increasingly better supplied thanks to innovative technologies, ever-increasing output with lower consumption of resources less harmful to the environment – e.g. less arable land in agriculture, or oil and electricity instead of coal for rapidly increasing mobility. More recent disaster scenarios, such as those spread by reputable scientists since the late 1960s and in the 1970s, have also proved to be inaccurate.

The reason things developed differently was the always underestimated innovative dynamism of the capitalist market economy, a growing ecological awareness and, as a result, legislative intervention that took advantage of the logic of market capitalism: As a result of the ecological movement that had come out of the United States since 1970, wise legislation began to use the price mechanism to apply market incentives to internalize negative externalities. Environmental pollution was given a price-tag.

This led to an enormous decrease in air pollution and other ecological consequences of growth, which is only possible in free, market-based societies, because the production process here is characterized by competition and constant pressure to reduce costs, i.e. to the most profitable use of resources. On the other hand, all forms of socialism, i.e. a state-controlled economy, have proved to be ecological disasters and have left behind destruction of gigantic proportions, without providing the population with anything that is near comparable in prosperity, often even by destroying existing prosperity, such as happened in Venezuela.

Capitalist profit motive combined with digitalization as a solution: Increasing decoupling of growth and resource consumption

Moreover, technological innovations combined with capitalist profit-seeking and market competition have led to a new and surprising phenomenon over the past decades, which is still hardly noticed in the public debate: the decoupling of growth and resource consumption (“dematerialization”). In a wide variety of industrial sectors, the developed countries, above all the U.S., are now achieving ever greater productive output with increasingly fewer resources. This has a lot to do with technology, especially the digitalization of the economy and of our entire lives.

As the well-known MIT professor Andrew McAfee shows in his book More from Less, published in October 2019, this process also follows the logic of capitalist profit maximization. To get it going, we do not need politics, even though wise, properly incentivizing legislation can be helpful and sometimes necessary. Above all, however, it is the combination of technological innovation, capitalist profit-seeking, and market-based entrepreneurial competition that will also solve the problem of man-made global warming.

In addition, property rights and their protection are decisive for the careful use of natural resources. And where this is not possible, legal support for collective self-governing structures, in accordance with the principle of subsidiarity, are important—as is analysed by Nobel Economic Prize winner Elinor Ostrom. By contrast, the growing ideologically motivated anti-capitalist eco-activism, and the policies influenced by it, are leading in the wrong direction, distracting precisely from what would be best for the climate and the environment—and distracting us from what could help protect us against the inevitable consequences of global warming.

#### Wholesale rejection of neoliberalism is impossible and insisting on theoretical purity dooms crucial short-term measures to avoid violence---it’s better to combine structural approaches with non-reformist reforms that propel mobilization.

Schram 15 – Sanford F. Schram, Visiting Professor of Social Work and Social Research at Bryn Mawr College, Professor of Political Science at Hunter College, PhD and MA in Political Science from St. Lawrence University, The Return of Ordinary Capitalism: Neoliberalism, Precarity, Occupy, p. 178-186 [language modified]

The Movement of Movements: The Occupy Left Versus the Organized Left

In the current era, there is much intellectual, if not political, credibility to be gained by refusing to practice the multilevel mobilizing of an Occupy Left and subsequent efforts like Black Lives Matter. There is a growing consensus that Occupy was a failure and its current extensions just fritter away energy that should be concentrated on building an organized Left that can push successfully for wholesale change.16 Some on the left refuse to work with diverse groups on their different issues in real time. Instead, they insist on taking the long view that says such work is a distraction to the larger and critical cause of organizing for fundamental transformation of the existing political economic system.

A major concern for this faction is maintaining the purity of the Left, striving to remain uncontaminated by the compromises of coalitional politics that are necessary when addressing the myriad of specific issues associated with the inequities of neoliberalism.17 In this way, activism remains true to the tradition of radical politics as it was practiced during the age of revolution and especially the heyday of communist organizing. Sometimes this nostalgia for the history of radical politics can lead to blaming the victim, this time not so much blaming the poor for their own poverty but blaming the subordinated for their failure to organize effectively to enact fundamental change.18 Sometimes, the nostalgia for “one big union” to challenge the capitalist power structure is born of letting historical understanding crowd out the exigencies of the moment. In discussing the problem of combining scholarship and activism among leftist academics in the humanities, Bruce Robbins makes a point that has direct relevance to the academics of the organized Left as I am characterizing it. He asserts: “One trap the Left faces, at least to the extent that that Left is located in the academy, is an overemphasis on making a political program out of what it already does for a living.”19 Robbins is talking about bringing too much history into efforts to mobilize people who are focused on immediate concerns. Knowing about the history of the labor movement surely could help members of the precariat think about how to address their plight; from the perspective of ordinary citizens, they may not be all that open to hearing all that history when they are mostly concerned about landing a job once their unemployment has been cut off and they have had to declare bankruptcy. The bottom-up perspective encourages us to see things the way they do. And that might mean pushing to raise the minimum wage rather than holding out for the demise of capitalism or the adoption of a basic income.

Too much history can be matched with too much theory.20 Too often today, the organized Left is joined by the theoretical Left. An overemphasis on theory produces what John Gunnell calls “epistemic privilege,” that is, the idea that theory comes first and underwrites and authorizes the action that follows. Exercising epistemic privilege involves unquestioned acceptance of the cliché that without a sound theory there can never be effective political action.21 Yet it is questionable to what extent we need to be able to theorize why things are the way they are to be able to do something about them. Theory is undoubtedly important for placing political action in context, deepening meaning, and clarifying the conditions of political possibility.22 Yet an overemphasis on theory can be politically [destructive] ~~paralyzing~~. The preoccupation with theory can undermine the needed focus on strategy,23 especially when theory is concerned with the big picture of understanding the current situation overall and over time, and strategy is more narrowly focused on what will connect with ordinary people’s immediate concerns as they struggle to cope with the effects of a neoliberalizing economy.24

In other words, being an academic can get in the way of being an activist. A preoccupation with theory can distract us from working to achieve modest but worthwhile reforms that directly address people’s immediate concerns. This is doubly unfortunate if those reforms actually work to lay the groundwork for larger, transformational change in the future. Epistemic privilege can lead us away from the radical incrementalism of making small, realistic changes now that can lay the groundwork for larger ones down the road.

In fact, the very idea of modest reform can be dismissed by those seeking more dramatic change because it poses the real possibility that it will defuse anger among the politically diverse precariat and thereby forestall the more dramatic systemic change that is needed to put the inequities of the new normal of neoliberalism safely behind us. While largely limited to the ruminations of bloggers, it seems that many on the left have their own crisis strategy that is premised on the idea that if things get bad enough, spreading from the lower to the middle classes, mass mobilization against the existing structure of power will finally gain traction and political transformation will result. Yet this crisis strategy is indebted to the very same dichotomous thinking that prevents some on the left from appreciating the value, and even the need, to mobilize on multiple levels. It is a crisis strategy that trades off addressing people’s immediate needs in the short run for building up popular support for more dramatic change in the long run. It pits a “politics of survival” against a “politics of social change,” seeing them as mutually exclusive.25

This bloggers’ crisis strategy, however, seems at best an imagined strategy that no one is really actively working to execute (especially since it would impose growing hardship on the very people whom the Left wants to help). Yet even those among the Occupy Left are vulnerable to this type of misplaced crisis thinking. Chris Hayes, in his otherwise thoughtful examination of U.S. politics in the current age of hyperinequality, looks to a radicalized middle class that has become frustrated with its ability to move ahead.26 Hayes writes:

Crisis is not something to be longed for or embraced: as we’ve seen, war, financial crisis, natural disaster visit their most punitive blows upon the weakest, the poorest, the least powerful members of society. But political crises, moments when the keystone of authority of some major governing institution is whisked away like a Jenga block, can produce a tumbling cascade of new forms of politics. We’ve been looking at the tower for so long we forget it’s made of blocks; we forget it can be put back together in a different way.27

Hayes sees the economic malaise spreading upward to the point that the privileged with resources can now be mobilized to redress the situation and push for dramatic change. While the middle classes can indeed be a source of change, especially today (see chapter 2), this type of top-down, elite-driven political mobilization is vulnerable to being defused by concessions for those higher up at the expense of those below them.

Yet a better crisis strategy actually was implemented. It was made famous by Richard Cloward and Frances Fox Piven as the central means of mobilizing support in the 1960s for reform of the welfare system and transition to a guaranteed income.28 It was premised on a win-win that saw a politics of survival and a politics of social change as working synergistically. Piven and Cloward premised their strategy on their research, which estimated that about half of those eligible for welfare nationwide were not receiving it. If everyone who was eligible enrolled it would overload the system, create a crisis, and force elites to consider moving to a better system such as a guaranteed income (now called a basic income). The strategy worked in good part, with millions of people getting public assistance and Congress twice voting on a guaranteed income plan that was proposed by President Richard Nixon. While the plan was never adopted, many people got aid in the process. Signing up people for welfare helped address their immediate needs while growing membership in the cause for welfare rights intensified concern in the public that something had to be done to transform the broken system of aiding the poor. A politics of survival and a politics of social change were not pitted against each other; choosing one over the other was not required. Instead, the real crisis strategy was premised on the idea the two could work together synergistically.

This confusion about what is an effective crisis strategy is premised on overly dichotomous thinking that leads many on the left away from multilevel mobilizing. It also might explain why they are often better at resisting anything less than total transformation to a new society than in finding ways to support improvements that reduce people’s suffering in the here and now. This resistance to reform also reflects nostalgic preoccupations with a lost past, when the revolution by the laboring classes was a real possibility. In contrast today the diverse people whose economic condition is made precarious by the changing economy are less available to be organized for mass mobilization on behalf of a fundamental transformation of the inequitable neoliberal political economy. As a result, many on the left are at risk of passing up on politics as it actually occurs today and instead contenting themselves with perfecting theoretical purity. Even left-leaning alternative political parties, such as the initially quite successful Working Families Party, get dismissed as not deserving of support as soon as the party makes questionable compromises as part of the effort to leverage power within the existing system.29 In the hothouse environment born of frustration over the Left’s inability to make a concerted and effective effort for transformational change, any misstep potentially becomes an excuse for continued inaction. Sometimes it seems the only political action the purists would support is a coup. They long for days when revolution was a real option. In this way, the Left continues to practice one of its more dominant forms of melancholia.

We may, however, come to look nostalgically on the academic Left, regardless of its disabling preoccupations. Today, that group is rapidly being replaced by academics fortunate enough to secure appointments but too insecure in them to dare to think of combining activism and scholarship.30 This new generation is not even positioned to freely protest its own plight in the face of the ongoing corporatization of the academy, let alone start to work with ordinary Americans outside the academy who suffer the worst effects of the inequitable neoliberal economy. Confronting growing professional and institutional pressures from performance measurement schemes to publish in “high-impact” journals (i.e., highly cited, not highly influential politically), many academics now must publish constantly; however, their work is often assiduously theoretical and methodically arcane, as well as apolitical and disconnected from ongoing political struggle. Many of these younger academics are of the Left in their hearts and minds, but not on the printed page or in the streets.

Too often an insistence on organizing only for dramatic change can lead to immobilization on the grounds that proposed actions are less than entirely consistent with some blueprint about what is to be done to produce long-term structural change of society. Instead activism should be more humble, accepting that not all contingencies can be anticipated and social movement mobilization is not entirely predictable and cannot be planned out before it occurs.31 In particular, the Left needs to stop making political action an either/or proposition and begin to think seriously about how political mobilization on multiple levels—protests, parties, policy, and program administration—can be made to work together to bring into being a better world for those suffering on the bottom of the socioeconomic ladder. Radical movement politics in a variety of forms is what is needed today. Efforts focused on dramatic regime change still have their place, especially when there is a gnawing need to call out injustice and identify its structural sources embedded in the very foundations of the existing neoliberalized society. Yet what are we to do in the meantime? Is it possible to help alleviate suffering even while we work for more fundamental change? The ongoing resistance to anything less than wholesale societal change stems from the fact that it poses a falsely stark choice between radical movement politics and more conventional electoral and policy politics. This kind of thinking is overly dichotomous and fails to appreciate that mobilizing for change to redress the injustices of the neoliberalized economy does not always involve seeing the options as mutually exclusive.32

In fact, many activists today appreciate and participate in the diversity of movements involved in creating noteworthy changes in cultural practices, social relations, economics and politics.33 Much of the energy of these movements comes from outside the academy where people are not weighed down with theoretical preoccupations. When big ideas, theory included, get to matter are when ordinary people confronting their difficulties in their everyday lives come to see the relevance of those ideas.34 Today, there is a veritable movement of movements where change efforts take a diversity of forms, with some even working with, rather than against, the market system in ways that create more freedom and less oppression for ordinary people.35 Just as we should not see protest politics and electoral politics as mutually exclusive, so should we learn to appreciate the value of a radical incrementalism that works to address people’s problems in the here and now, while laying the groundwork for larger political transformation in the future. The protest politics of Occupy Wall Street has contributed to creating a context for the electoral successes of candidates such as Bill de Blasio, who became mayor of New York City with the support of the Working Families Party, which has strong ties to Occupy movement participants.36 How de Blasio works with protest groups, including those that have become embroiled in the volatile issue of racialized policing, suggests real challenges but also hope for change.37 Radical incrementalism suggests just this kind of synergy. It combines a politics of survival with a politics of social change to get significant improvements in state policy, following the successful model of welfare mobilization in the 1960s.38

The Road to Radical Incrementalism

Radical incrementalism is not really an option: it is the prevailing reality of politics. It realistically recognizes the economic, social, and political constraints that limit mobilization on behalf of radical change. It also is based on an appreciation often shared by proponents for radical change that efforts at sustained political mobilization are not something that happen overnight. Instead, it works to help people in the short run within existing constraints but in ways that make more dramatic political transformation eventually more likely.

As much as people on the left hope for a radical swing away from neoliberal social welfare programming in the current era, the arc of history under U.S. capitalism suggests a more modest process of incrementalism. Incrementalism is defined in the public policy literature as a process of policymaking where a series of small remedial, corrective steps enable change in existing policy.39 Yet the criticism of incrementalism is that it amounts to no more than tinkering with the existing system in ways that do nothing more than fine-tune the status quo. Perfecting neoliberalism means little more than making the ascendant disciplinary regime more effective in managing the poverty population and by extension everyone else who is made economically precarious by the transformed economy.40 Incremental changes in neoliberal policies can result in nothing more than improving the system for embedding market logic more deeply into society and our daily lives.41 It could amount to no more than perfecting the system for incentivizing market-consonant behavior in ways that end up leaving most people having to make do with the inadequate resources and opportunities afforded them in a changing economy.

Nonetheless, especially in an age of extreme political polarization that begets policy gridlock, incrementalism may be the prevailing reality more than ever. Under these conditions, it may be that ideas about more dramatic change need to be tempered with the reality of working for more limited changes that nonetheless do more than reinforce the existing system.42 The issue then becomes how to practice a radical incrementalism.43 By “radical incrementalism,” I mean a process in which people push for change recognizing it will not necessarily be as large as they might like but also in which small changes can do more than fine-tune the existing system. Radical incrementalism is not about tweaking what is already in place to help perpetuate the status quo and the existing structure of power. It rejects changes that in all likelihood are going to lead to the continuation of the very problems that people are trying to address. Instead, the small changes of radical incrementalism lay the groundwork for further changes that over time can help build to a transformation of the existing structure of power, the source of the problems being attacked.44 The key then is that when pushing for change as activists we must be able to distinguish radical incrementalism from the status-quo-reinforcing incrementalism most often offered by elites. This is often not easy but the goal is to try as much as possible to resist the cooptation elites will seek to gain by making minimal concessions. That is the focus we need today in an era of political gridlock born of polarization that stems in no small part from the wealthy using their wealth to block constructive responses to address the problems extreme inequality creates.

André Gorz highlighted the challenge in distinguishing between status quo incrementalism and radical incrementalism in his own terms when he distinguished what he called “non-reformist reform” from “reformist reform.”45 Gorz recognized that what distinguished progressive reform from statusquo-reinforcing reform was not easy to always identify, but nonreformist reforms are the progressive reforms that are essentially laying the groundwork to get beyond the inequities of capitalism by restructuring power relations. More recently David Harvey has called for appreciating the value of what he calls “revolutionary reforms” that provide the basis for challenging capitalist power over time.46 Radical incrementalism similarly involves making small changes that lay the basis for restructuring embedded power relations that prevent more ambitious changes from happening.47

Radical incrementalism is focused on changing power relationships but it is not against the use of power, and it is focused on finding ways for government and the governance of populations to work to improve the lives of ordinary people. It does not simply resist oppressive state power, it seeks to bend it toward enhancing the conditions under which people live with, participate in, and benefit from state power. Radical incrementalism works to offer constructive answers to such questions as: what type of governance is appropriate for ordinary people today and how can we rework power relations to realize it?48

Radical incrementalism can be practiced on multiple levels and across different dimensions of the policy process. It can involve protest movements adroitly deciding to accept particular concessions elites offer to quell dissent.49 It can also involve participating in electoral campaigns for candidates who resist capitulating to conventional politics as usual. It can involve pushing for changes in public policy that redistribute power and lay the foundation for broader changes in the future. Reallocating resources, such as to improve wages so that people can do more than just survive but also be better positioned to participate in the political process, is but one example.

#### No war or root cause

Geras 5 (Norman, Emeritus Professor of Politics at the University of Manchester, "The Reductions of the Left," Dissent, 52:1, Winter, p. 57-58)

THE SECOND PART of the answer- to which I now turn—is a seeming lack of ability, of the imagination, to digest the meaning of the great moral and political evils of the world and to look at them unflinchingly. This is a complementary failure. Elsewhere I have argued that Marxism is as familiar as any other intellectual tradition with the realities of human violence and oppression and the more negative traits and potentialities in the makeup of human beings. At the same time, because of its Utopian aspiration—-which I do not mean in any pejorative sense—because of its progressive and meliorative impulse, there has always been a tendency within this tradi¬tion to minimize, or sometimes just deny, the independent force of such negative character¬istics. They come to be treated, genericallv, as the product of class societies and, today, as the product of capitalism. The affinity between this overall intellectual tendency within Marxist and other left thinking, and the practical reductionism I have just described—in which America is identified as the source of all worldly wrongs—should be transparent. The effect of the tendency, however, is, to denature what one is looking at when one looks at the horrors of the world: a massacre of in- nocents; a woman being beaten in a public place or hanged in a football stadium; a place in which a man can have his ears surgically re¬moved or his tongue cut out, or be broken and destroyed, to be followed by the next such vic-tim, and the next, in a continuous sequence ol atrocity; or a place in which a parent can be forced to watch her child tortured and mur¬dered in front of her; or a place in which a hus¬band can be forced to watch his wife repeat-edly raped; an "ethnic^leansing" or a genocide in progress, in which entire communities are pulled up by the roots-arid people are shot or hacked or starved to death by the thousands or the tens of thousands; mass graves opened to yield up their terrible story. The list, as anyone knows who keeps read¬ing when the overwhelming temptation is to look away, could be much extended. The items on it are moral and political realities in their own right. They need to be registered and fully recognized as such. To collapse them too quickly into their putative original causes, to' refer them immediately, or refer from them, to other things that have preceded them is not to give them their due as the specific phenomena they are, the horrors, tor those destroyed by them or enduring them, for those whose lives are torn and wrecked and filled with grief by them, are in a double sense reduced by this quick and easy reference back to something else, putatively their real cause or origin. Furthermore, not all the contributory causes of such grim events are of the type that the section of the left under discussion here likes to invoke—that is, causes arising else- where, either geographically (in the United States) or societally (in the dynamics of capi- talism). Moral and political evils of this order and I make no apology for calling them that— can and generally do have causes that are more local in a spatial sense; and they are governed or influenced by political, ideological, and moral specificities every bit as real as the capitalist economy. Not everything is systemic, in the sense of being an effect of pressures or ten¬dencies of economic provenance, whether from the global economy or from some more par¬ticular region of it. There are independent patterns of coercion and cruelty, both interper¬sonal and embedded within political structures; forms of authoritarian imposition; types of invasive assault and violence, at the micro-level and at the macro-level, involving large social forces.

#### Combining unlike ontologies better informs political action than singular viewpoints. Radical refusal causes infinite repetition, engaging with politics solves back the cycle.

**Deudney 13** [Daniel Deudney, Associate Professor and Director of Undergraduate Studies in PoliSci, John Hopkins. ”Theory Talk #60: Daniel Deudney on Mixed Ontology, Planetary Geopolitics, and Republican Greenpeace.” Theory Talks, 2013.] JCH-PF

In many parts of both European and American IR and related areas, Postmodern and constructivist theories have significantly contributed to IR theorists by enhancing our appreciation of ideas, language, and identities in politics. As a response to the limits and blindnesses of certain types of rationalist, structuralist, and functional theories, this renewed interest in the ideational is an important advance. Unfortunately, both postmodernism and constructivism have been marked by a strong tendency to go too far in their emphasis of the ideational. Postmodernism and constructivism have also helped make theorists much more conscious of the implicit—and often severely limiting—ontological assumptions that underlay, inform, and bound their investigations. This is also a major contribution to the study of world politics in all its aspects. Unfortunately, this turn to ontology has also had intellectually limiting effects by going too far, in the search for a pure or nearly pure social ontology. With the growth in these two approaches, there has indeed been a decided decline in theorizing about the material. But elsewhere in the diverse world of theorizing about IR and the global, theorizing about the material never came anything close to disappearing or being eclipsed. For anyone thinking about the relationships between politics and nuclear weapons, space, and the environment, theorizing about the material has remained at the center, and it would be difficult to even conceive of how theorizing about the material could largely disappear. The recent ‘re-discovery of the material’ associated with various self-styled ‘new materialists’ is a welcome, if belated, re-discovery for postmodernists and constructivists. For most of the rest of us, the material had never been largely dropped out. A very visible example of the ways in which the decline in appropriate attention to the material, an excessive turn to the ideational, and the quest for a nearly pure social ontology, can lead theorizing astray is the core argument in Alexander Wendt’s main book, Social Theory of International Politics, one of the widely recognized landmarks of constructivist IR theory. The first part of the book advances a very carefully wrought and sophisticated argument for a nearly pure ideational social ontology. The material is explicitly displaced into a residue or rump of unimportance. But then, to the reader’s surprise, the material, in the form of ‘common fate’ produced by nuclear weapons, and climate change, reappears and is deployed to play a really crucial role in understanding contemporary change in world politics. My solution is to employ a mixed ontology. By this I mean that I think several ontologically incommensurate and very different realities are inescapable parts the human world. These ‘unlikes’ are inescapable parts of any argument, and must somehow be combined. There are a vast number of ways in which they can be combined, and on close examination, virtually all arguments in the social sciences are actually employing some version of a mixed ontology, however implicitly and under-acknowledged. But not all combinations are equally useful in addressing all questions. In my version of mixed ontology—which I call ‘practical naturalism’—human social agency is understood to be occurring ‘between two natures’: on the one hand the largely fixed nature of humans, and on the other the changing nature composed of the material world, a shifting amalgam of actual non-human material nature of geography and ecology, along with human artifacts and infrastructures. Within this frame, I posit as rooted in human biological nature, a set of ‘natural needs,’ most notably for security-from-violence and habitat services. Then I pose questions of functionality, by which I mean: which combinations of material practices, political structures, ideas and identities are needed to achieve these ends in different material contexts? Answering this question requires the formulation of various ‘historical materialist’ propositions, which in turn entails the systematic formulation of typologies and variation in both the practices, structures and ideas, and in material contexts. These arguments are not centered on explaining what has or what will happen. Instead they are practical in the sense that they are attempting to answer the question of ‘what is to be done’ given the fixed ends and given changing material contexts. I think this is what advocates of arms control and environmental sustainability are actually doing when they claim that one set of material practices and their attendant political structures, identities and ideas must be replaced with another if basic human needs are to going to continue to be meet in the contemporary planetary material situation created by the globalization of machine civilization on earth. Is it easy to plug your mixed ontology and interests beyond the narrow confines of IR or even the walls of the ivory tower into processes of collective knowledge proliferation in IR—a discipline increasingly characterized by compartimentalization and specialization? The great plurality of approaches in IR today is indispensible and a welcome change. The professionalization of IR and the organization of intellectual life has some corruptions and pitfalls that are best avoided. The explosion of ‘isms’ and of different perspectives has been valuable and necessary in many ways, but it has also helped to foster and empower sectarian tendencies that confound the advance of knowledge. Some of the adherents of some sects and isms boast openly of establishing ‘citation cartels’ to favor themselves and their friends. Some theorists also have an unfortunate tendency to assume that because they have adopted a label that what they actually do is the actually the realization of the label. Thus we have ‘realists’ with limited grasp on realities, ‘critical theorists’ who repeat rather than criticize the views of other ‘critical theorists,’ and anti-neoliberals who are ruthless Ayn Rand-like self aggrandizers. The only way to fully address these tendencies is to talk to people you disagree with, and find and communicate with people in other disciplines

#### Radical positions that refuse the system *cede the political* – that risks extinction and turns K impacts – it’s try or die for engaging the state.

Boggs 97 [Carl Boggs, Senior Fellow at the National University. “The great retreat: Decline of the public sphere in late twentieth-century America.” Theory and Society, Volume 26, Number 6, December 1997.] A Classic

The decline of the public sphere in late twentieth-century America poses a series of great dilemmas and challenges. Many ideological currents scrutinized here – localism, metaphysics, spontaneism, post-modernism, Deep Ecology – intersect with and reinforce each other. While these currents have deep origins in popular movements of the 1960s and 1970s, they remain very much alive in the 1990s. Despite their different outlooks and trajectories, they all share one thing in common: a depoliticized expression of struggles to combat and overcome alienation. The false sense of empowerment that comes with such mesmerizing impulses is accompanied by a loss of public engagement, an erosion of citizenship and a depleted capacity of individuals in large groups to work for social change. As this ideological quagmire worsens, urgent problems that are destroying the fabric of American society will go unsolved – perhaps even unrecognized – only to fester more ominously in the future. And such problems (ecological crisis, poverty, urban decay, spread of infectious diseases, technological displacement of workers) cannot be understood outside the larger social and global context of internationalized markets, finance, and communications. Paradoxically, the widespread retreat from politics, often inspired by localist sentiment, comes at a time when agendas that ignore or sidestep these global realities will, more than ever, be reduced to impotence. In his commentary on the state of citizenship today, Wolin refers to the increasing sublimation and dilution of politics, as larger numbers of people turn away from public concerns toward private ones. By diluting the life of common involvements, we negate the very idea of politics as a source of public ideals and visions. 74 In the meantime, the fate of the world hangs in the balance. The unyielding truth is that, even as the ethos of anti-politics becomes more compelling and even fashionable in the United States, it is the vagaries of political power that will continue to decide the fate of human societies. This last point demands further elaboration. The shrinkage of politics hardly means that corporate colonization will be less of a reality, that social hierarchies will somehow disappear, or that gigantic state and military structures will lose their hold over people’s lives. Far from it: the space abdicated by a broad citizenry, well-informed and ready to participate at many levels, can in fact be filled by authoritarian and reactionary elites – an already familiar dynamic in many lesser-developed countries. The fragmentation and chaos of a Hobbesian world, not very far removed from the rampant individualism, social Darwinism, and civic violence that have been so much a part of the American landscape, could be the prelude to a powerful Leviathan designed to impose order in the face of disunity and atomized retreat. In this way the eclipse of politics might set the stage for a reassertion of politics in more virulent guise – or it might help further rationalize the existing power structure. In either case, the state would likely become what Hobbes anticipated: the embodiment of those universal, collective interests that had vanished from civil society. 75

#### Only policy demands solve – exclusive focus on social demands gets coopted and destroyed by the right wing. Uniqueness overwhelms the link – radical movements exists in the SQuo and they’re losing.

Chomsky 16 [Aviva, Prof of History and coordinator of Latin American studies, Salem State. “Student Protest, the Black Lives Matter Movement and the Rise of the Corporate University.” Truthout.org, May 22, 2016.] JCH-PF

During the past academic year, an upsurge of student activism, a movement of millennials, has swept campuses across the country and attracted the attention of the media. From coast to coast, from the Ivy League to state universities to small liberal arts colleges, a wave of student activism has focused on stopping climate change, promoting a living wage, fighting mass incarceration practices, supporting immigrant rights, and of course campaigning for Bernie Sanders. Both the media and the schools that have been the targets of some of these protests have seized upon certain aspects of the upsurge for criticism or praise, while ignoring others. Commentators, pundits, and reporters have frequently trivialized and mocked the passion of the students and the ways in which it has been directed, even as universities have tried to appropriate it by promoting what some have called "neoliberal multiculturalism." Think of this as a way, in particular, of taming the power of the present demands for racial justice and absorbing them into an increasingly market-oriented system of higher education. In some of their most dramatic actions, students of color, inspired in part by the Black Lives Matter movement, have challenged the racial climate at their schools. In the process, they have launched a wave of campus activism, including sit-ins, hunger strikes, demonstrations, and petitions, as well as emotional, in-your-face demands of various sorts. One national coalition of student organizations, the Black Liberation Collective, has called for the percentage of black students and faculty on campus to approximate that of blacks in the society. It has also called for free tuition for black and Native American students, and demanded that schools divest from private prison corporations. Other student demands for racial justice have included promoting a living wage for college employees, reducing administrative salaries, lowering tuitions and fees, increasing financial aid, and reforming the practices of campus police. These are not, however, the issues that have generally attracted the attention either of media commentators or the colleges themselves. Instead, the spotlight has been on student demands for cultural changes at their institutions that focus on deep-seated assumptions about whiteness, sexuality, and ability. At some universities, students have personalized these demands, insisting on the removal of specific faculty members and administrators. Emphasizing a politics of what they call "recognition," they have also demanded that significant on-campus figures issue public apologies or acknowledge that "black lives matter." Some want universities to implement in-class "trigger warnings" when difficult material is being presented and to create "safe spaces" for marginalized students as a sanctuary from the daily struggle with the mainstream culture. By seizing upon and responding to these (and only these) student demands, university administrators around the country are attempting to domesticate and appropriate this new wave of activism. In the meantime, right-wing commentators have depicted students as coddled, entitled, and enemies of free speech. The libertarian right has launched a broad media critique of the current wave of student activism. Commentators have been quick to dismiss student protesters as over-sensitive and entitled purveyors of "academic victimology." They lament the "coddling of the American mind." The Atlantic's Conor Friedersdorf has termed students "misguided" in their protests against racist language, ideas, and assumptions, their targeting of "microaggression" (that is, unconscious offensive comments) and insensitivity, and their sometimes highly personal attacks against those they accuse. One of the most vocal critics of the new campus politics, the Foundation for Individual Rights in Education, argues that such rampant "liberalism" and "political correctness" violate academic freedom and freedom of speech. (In this, they are in accord with the liberal American Civil Liberties Union. Free speech advocates Daphne Patai and the ACLU's Harvey Silvergate, for example, bemoan a new diversity requirement at the University of Massachusetts for its "politicization of education.") In a response that, under the circumstances, might at first seem surprising, college administrators have been remarkably open to some of these student demands -- often the very ones derided by the right. In this way, the commentators and the administrators have tended to shine a bright light on what is both personal and symbolic in the new politics of the student protesters, while ignoring or downplaying their more structural and economically challenging desires and demands. The Neoliberal University University administrators have been particularly amenable to student demands that fit with current trends in higher education. Today's neoliberal university is increasingly facing market pressures like loss of state funding, privatization, rising tuition, and student debt, while promoting a business model that emphasizes the managerial control of faculty through constant "assessment," emphasis on "accountability," and rewards for "efficiency." Meanwhile, in a society in which labor unions are constantly being weakened, the higher education labor force is similarly being -- in the term of the moment -- "flexibilized" through the weakening of tenure, that once ironclad guarantee of professorial lifetime employment, and the increased use of temporary adjunct faculty. In this context, universities are scrambling to accommodate student activism for racial justice by incorporating the more individualized and personal side of it into increasingly depoliticized cultural studies programs and business-friendly, market-oriented academic ways of thinking. Not surprisingly, how today's students frame their demands often reflects the environment in which they are being raised and educated. Postmodern theory, an approach which still reigns in so many liberal arts programs, encourages textual analysis that reveals hidden assumptions encoded in words; psychology has popularized the importance of individual trauma; and the neoliberal ideology that has come to permeate so many schools emphasizes individual behavior as the most important agent for social change. Add together these three strands of thought, now deeply embedded in a college education, and injustice becomes a matter of the wrongs individuals inflict on others at a deeply personal level. Deemphasized are the policies and structures that are built into how society (and the university) works. For this reason, while schools have downplayed or ignored student demands for changes in admissions, tuition, union rights, pay scales, and management prerogatives, they have jumped into the heated debate the student movement has launched over "microaggressions" -- pervasive, stereotypical remarks that assume whiteness as a norm and exoticize people of color, while taking for granted the white nature of institutions of higher learning. As part of the present wave of protest, students of color have, for instance, highlighted their daily experiences of casual and everyday racism -- statements or questions like "where are you from?" (when the answer is: the same place you're from) or "as a [fill in the blank], how do you feel about..." Student protests against such comments, especially when they are made by professors or school administrators, and the mindsets that go with them are precisely what the right is apt to dismiss as political correctness run wild and university administrations are embracing as the essence of the present on-campus movement. At Yale, the Intercultural Affairs Committee advised students to avoid racially offensive Halloween costumes. When a faculty member and resident house adviser circulated an email critiquing the paternalism of such an administrative mandate, student protests erupted calling for her removal. While Yale declined to remove her from her post as a house adviser, she stepped down from her teaching position. At Emory, students protested the "pain" they experienced at seeing "Trump 2016" graffiti on campus, and the university president assured them that he "heard [their] message... about values regarding diversity and respect that clash with Emory's own." Administrators are scrambling to implement new diversity initiatives and on-campus training programs -- and hiring expensive private consulting firms to help them do so. At the University of Missouri, the president and chancellor both resigned in the face of student protests including a hunger strike and a football team game boycott in the wake of racial incidents on campus including public racist slurs and symbols. So did the dean of students at Claremont McKenna College (CMC), when protest erupted over her reference to students (implicitly of color) who "don't fit our CMC mold." Historian and activist Robin Kelley suggests that today's protests, even as they "push for measures that would make campuses more hospitable to students of color: greater diversity, inclusion, safety, and affordability," operate under a contradictory logic that is seldom articulated. To what extent, he wonders, does the student goal of "leaning in" and creating more spaces for people of color at the top of an unequal and unjust social order clash with the urge of the same protesters to challenge that unjust social order? Kelley argues that the language of "trauma" and mental health that has come to dominate campuses also works to individualize and depoliticize the very idea of racial oppression. The words "trauma, PTSD, micro-aggression, and triggers," he points out, "have virtually replaced oppression, repression, and subjugation." He explains that, "while trauma can be an entrance into activism, it is not in itself a destination and may even trick activists into adopting the language of the neoliberal institutions they are at pains to reject." This is why, he adds, for university administrators, diversity and cultural competency initiatives have become go-to solutions that "shift race from the public sphere into the psyche" and strip the present round of demonstrations of some of their power. Cultural Politics and Inequality In recent years, cultural, or identity, politics has certainly challenged the ways that Marxist and other old and new left organizations of the past managed to ignore, or even help reproduce, racial and gender inequalities. It has questioned the value of class-only or class-first analysis on subjects as wide-ranging as the Cuban Revolution -- did it successfully address racial inequality as it redistributed resources to the poor, or did it repress black identity by privileging class analysis? -- and the Bernie Sanders campaign -- will his social programs aimed at reducing economic inequality alleviate racial inequality by helping the poor, or will his class-based project leave the issue of racial inequality in the lurch? In other words, the question of whether a political project aimed at attacking the structures of economic inequality can also advance racial and gender equality is crucial to today's campus politics. Put another way, the question is: How political is the personal? Political scientist Adolph Reed argues that if class is left out, race politics on campus becomes "the politics of the left-wing of neoliberalism." As he puts it, race-first politics of the sort being pushed today by university administrators promotes a "moral economy... in which 1% of the population controlled 90% of the resources could be just, provided that roughly 12% of the 1% were black, 12% were Latino, 50% were women, and whatever the appropriate proportions were LGBT people." The student movement that has swept across the nation has challenged colleges and universities on the basics of their way of (quite literally) doing business. The question for these institutions now is: Can student demands largely be tamed and embedded inside an administration-sanctioned agenda that in no way undermines how schools now operate in the world? Feminist theorist Nancy Fraser has shown how feminist ideas of a previous generation were successfully "recuperated by neoliberalism" -- that is, how they were repurposed as rationales for greater inequality. "Feminist ideas that once formed part of a radical worldview," she argues, are now "increasingly expressed in individualist terms." Feminist demands for workplace access and equal pay have, for example, been used to undermine worker gains for a "family wage," while a feminist emphasis on gender equality has similarly been used on campus to divert attention from growing class inequality. Student demands for racial justice risk being absorbed into a comparable framework. University administrators have found many ways to use student demands for racial justice to strengthen their business model and so the micro-management of faculty. In one case seized upon by free-speech libertarians, the Brandeis administration placed an assistant provost in a classroom to monitor a professor after students accused him of using the word "wetback" in a Latin American politics class. More commonly, universities employ a plethora of consulting firms and create new administrative positions to manage "diversity" and "inclusion." Workshops and training sessions proliferate, as do "safe spaces" and "trigger warnings." Such a vision of "diversity" is then promoted as a means to prepare students to compete in the "global marketplace." There are even deeper ways in which a diversity agenda aligns with neoliberal politics. Literary theorist Walter Benn Michaels argues, for example, that diversity can give a veneer of social justice to ideas about market competition and meritocracy that in reality promote inequality. "The rule in neoliberal economies is that the difference between the rich and the poor gets wider rather than shrinks -- but that no culture should be treated invidiously," he explains. "It's basically OK if economic differences widen as long as the increasingly successful elites come to look like the increasingly unsuccessful non-elites. So the model of social justice is not that the rich don't make as much and the poor make more, the model of social justice is that the rich make whatever they make, but an appropriate percentage of them are minorities or women." Or as Forbes Magazine put it, "Businesses need to vastly increase their ability to sense new opportunities, develop creative solutions, and move on them with much greater speed. The only way to accomplish these changes is through a revamped workplace culture that embraces diversity so that sensing, creativity, and speed are all vastly improved." Clearly, university administrators prefer student demands that can be coopted or absorbed into their current business model. Allowing the prevailing culture to define the parameters of their protest has left the burgeoning Millennial Movement in a precarious position. The more that students -- with the support of college and university administrations -- accept the individualized cultural path to social change while forgoing the possibility of anything greater than cosmetic changes to prevailing hierarchies, on campus and beyond, the more they face ridicule from those on the right who present them as fragile, coddled, privileged whiners. Still, this young, vibrant movement has momentum and will continue to evolve. In this time of great social and political flux, it's possible that its many constituencies -- fighting for racial justice, economic justice, and climate justice -- will use their growing clout to build on recent victories, no matter how limited. Keep an eye on college campuses. The battle for the soul of American higher education being fought there today is going to matter for the wider world tomorrow. Whether that future will be defined by a culture of trigger warnings and safe spaces or by democratized education and radical efforts to fight inequality may be won or lost in the shadow of the Ivory Tower. The Millennial Movement matters. Our future is in their hands.

# 1AR

#### Those conclusions exist in cognitive dissonance. Contingent deployments of law that don’t throw the baby out with the bathwater is best

Foster 19 [Chase Michael Foster was a Doctoral Candidate at Harvard University at the time of this dissertation. The author has served as a Election Observer (OSCE, ODIHR) in Moldova, Belarus, Russia, Georgia and as a Teaching Assistant at the Harvard Kennedy School of Government. At the time of this writing, the author held a MPP (Democracy, Politics, and Institutions) from the Harvard Kennedy School of Government. “The Politics of Delegation: Constitutional Structure, Bureaucratic Discretion, and the Development of Competition Policy in the United States and the European Union, 1890-2017” – Doctoral dissertation to The Department of Government, Harvard University, Graduate School of Arts & Sciences. In partial fulfillment of the requirements for the degree of Doctor of Philosophy in the subject of Government - January 2019 - #E&F –https://dash.harvard.edu/bitstream/handle/1/41121359/FOSTER-DISSERTATION-2019.pdf?sequence=1]

The Implications for Public Policy Finally, this study has implications for several policy questions of relevance to students of the American and European regulatory states. The traditional view among regulatory scholars in both the United States and Europe is that political control helps to increase democratic legitimacy. Among many Americanists, political control is seen as the only thing preventing regulatory capture and bureaucratic degeneration (e.g. Miller 2005; Epstein and O'i Ialloran 1999).'' And much of the reform program of the last century has focused on the need to constrain federal bureaucrats in the name of democratic accountability—whether through procedural rights that mostly empower industry vis-a-vis government (Grisinger 2012) 'private attorneys general' provisions that allow citizen groups to participate in enforcement directly (Burke 2002), or cost-benefit analysis that structures decision-making (Sunstein 1993). In a different vein, the European Union is seen as having a "democratic deficit", in part, because the Commission and other technocrats possess extensive discretionary authority. While it is recognized that technocratic policymaking can increase regulatory effectiveness, many reformers think this 'output legitimacy' is limited by the weak degree of' input legitimacy.' Consequently, the institutional reforms most often proposed are to limit bureaucratic discretion and push European policymaking processes to look more like those found in the United States: to increase private enforcement opportunities (Kclcmen 2006), to expand administrative procedure limitations (Meuwese et al. 2009), to enlarge the power of the European Parliament (Follesdal and Hix 2006), and to create a directedly elected European executive. The findings of the dissertation provide some reason to challenge the presumption that constraining the Commission would lead to more democratic legitimacy. As we have seen in the analysis of US antitrust enforcement, extensive political controls over regulatory decision-making may, in some circumstances, undermine regulatory effectiveness, while providing little by way of increased democratic legitimacy. If there is one consistent theme across the long history of the US antitrust system, it is dissatisfaction, expressed by politicians and economic interests coming from a variety of ideological positions. While political controls have, on the one hand, ensured that antitrust regulators were not overzealous in their enforcement. On the other hand, it has arguably led to underenforcement, as regulators have found it too difficult to use the law to address a range of economic challenges. Even during periods when the law has been actively applied, the pattern of enforcement has been volatile, providing little by way of rationalization in the economy or consistent limits on corporate behavior. Furthermore, as we have seen in the analysis of European competition policy, much of the regime's apparent success stems from bureaucratic discretion. Examining the competition policy field, I have shown that the Commission's broad discretionary authority has allowed it to apply competition law in ways that fostered economic cooperation, contributed to economic development, held companies accountable and benefited consumers. At the same time, we have seen how the Commission's decision-making has, at certain moments, lacked political accountability. Additionally, in its eagerness to use whatever vehicle appears available to advance the integration project, the Commission may have over-emphasized liberalization at the expensive of other goals (Jabko 2006). Consequently, the focus on negative integration may, in certain respects, created a 'neoliberal' bias in policymaking (e.g. Hopner and Schafer 2012). Yet, in seeking to improve accountability, European policymakers should not throw out the bureaucratic baby with the neoliberal bathwater. As the "guardians of the Treaty", the Commission's agenda setting authority and monitoring powers, along with the European Court of Justice's power of judicial review, have arguably been the sine qua non for the process of European integration. As we have seen in the case of competition, the bureaucratic discretion and semi-autonomous structure of its decision-making process has, in certain respects, facilitated the regime's effectiveness, allowing the law to be applied to new economic challenges as they emerged. Increased accountability measures may be needed, but in pursuing these reforms, policymakers should be careful not to undermine the Commission's independence and the significant capacity and expertise that has been built up over the years. The study also has policy implications for the design of the US antitrust system. As Robert Kagan has frequently emphasized, in addition to its myriad problems, American adversarial legalism also has strengths, not least the many opportunities the system presents to private actors who are overlooked by the state to seek justice. Another "strength of the weak state/' is the way it encourages a high degree of regulatory compliance (Dobbin and Sutton 1998). Cognizant that law can be enforced from all directions, companies may become more likely to comply with regulator)' rules, and even go beyond them, internalizing regulatory norms in their own internal policies and procedures. Such a system has arguably worked quite well in the development of capital markets, the rooting out of foreign corruption, and the protection of consumers against fraud. But within regulatory arenas such as antitrust where compliance is not usually a matter of following or not following hard-lined rules, the American structure is hardly ideal. As we have seen in this study, when applied to complex economic problems, the adversarial legal system is marred with problems. Whether addressing problems presented by economic concentration, regulatory liberalization, or new technologies, it has been difficult for antitrust authorities to direct the law toward a consistent, coherent purpose. And it has been far too easy for the regime to be deployed toward the self-interested goals of organized interests or the parochial concerns of Congress. Consequently, within fields such as antitrust, reforms should be considered that increase bureaucratic discretion. One idea would be to increase the funding available to both antitrust agencies, so they can play a more active role studying new industries and monitoring new market developments. Another would be to make it possible to pursue some enforcement through administrative actions, which are not as easily gamed by large corporations armed with teams of lawyers. Political principals could also delegate to the PTC the authority to write competition rules to promote liberalization in markets dominated by incumbent companies or within other emerging sectors. Eliminating some of the exemptions for regulated sectors and state-sponsored activity, while reducing the number of incentives that encourage private litigation would also be salutary. Finally, Congress should do what it can, within its constitutional limitations, to reduce the 'race to the bottom' in public subsidies. As the European model demonstrates, state aid rules need not eliminate public involvement in the economy. However, they can provide an important constraint on beggar-thy-neighbor policies that leave everyone but large companies worse off.

#### Prefer aff-specific ev. Limiting Parker’s exemption is the baby. The perm solves their other links.

* Reform like lifting categorical Parker exemptions \*can\* make a difference;
* Aff plan paves way to contingent enforcement patterns – akin to more successful EU actions ;
* Especially jives with Neg’s Green and Ag impacts – as exempt industries include energy-intensive sectors like aviation, municipal waste, transportation, and gg.

Foster 19 [Chase Michael Foster was a Doctoral Candidate at Harvard University at the time of this dissertation. The author has served as a Election Observer (OSCE, ODIHR) in Moldova, Belarus, Russia, Georgia and as a Teaching Assistant at the Harvard Kennedy School of Government. At the time of this writing, the author held a MPP (Democracy, Politics, and Institutions) from the Harvard Kennedy School of Government. “The Politics of Delegation: Constitutional Structure, Bureaucratic Discretion, and the Development of Competition Policy in the United States and the European Union, 1890-2017” – Doctoral dissertation to The Department of Government, Harvard University, Graduate School of Arts & Sciences. In partial fulfillment of the requirements for the degree of Doctor of Philosophy in the subject of Government - January 2019 - #E&F –https://dash.harvard.edu/bitstream/handle/1/41121359/FOSTER-DISSERTATION-2019.pdf?sequence=1]

In terms of market coverage, European competition law is more extensive than American antitrust, applying to more economic sectors and types of economic activity. European competition law applies to the vast majority of economic activity that affects inter-state trade. In the increasingly integrated EU economy, this has become an expansive category that includes public and private sector activities, global corporations and SMEs, markets that are global in scope such as aviation or pharmaceuticals, as well as ostensibly local economies such as sports clubs or municipal waste collection. While special competition rules still apply to agriculture4, fisheries, and some transportation sectors, the number of exceptions has declined with time. Moreover, even in areas still subject to special consideration, industry is still constrained by competition law. While this does not mean rules are always enforced robustly, it does mean that, in terms of law, no sector is fully exempt from considerations of competition. In Europe, competition rules also apply to most public activities, which are regulated by four articles in the European Treaties.3 From the design of public housing and environmental subsidies, to the practices of publicly owned companies, governments throughout Europe must comport with the European state aid regime. For public subsidies over €200,000, and which do not fall within exempted categories, member states must provide notification to the European Commission. If competition experts at the Commission determine that the aid is not appropriately tailored to address a horizontal objective, if it distorts the single market, or if it otherwise is found to be outside of the Community interest, the body can order the member state to revise its policy, and frequently does so. The Commission can also initiate its own cases against unreported state aid, launch sectoral inquiries involving multiple member states, and issue what is called a state aid recovery order, which compels a member state to collect money that has already been dispensed. American competition rules remain more narrowly tailored. Explicit exemptions or modifications of the application of U.S. antitrust have been enacted by Congress for a range of sectors, including insurance, healthcare, financial markets, banks, sporting activities, media, utilities, and many industries involved in defense procurement. Additionally, there is implied immunity in many highly regulated industries such as telecommunications and transportation, which limits the ability of antitrust regulators to bring cases within these sectors. The high number of derogations and exemptions in US competition policy has been noted widely by the OECD. In their assessment of the "scope of action" of competition policy in 48 countries, Alemani et al. (2013) rank the US ninth to last—below every country in the EU. Additionally, US antitrust law provides no specific provisions addressing state owned companies, state regulation, or state aid. Under current jurisprudence, all state-sponsored activities, including most state-owned and state-regulated industries, are entirely exempt from federal antitrust liability (Garland 1987).7 [Footnote 7] In a 1941 case, Parker v. Brown, the U.S. Supreme Court established the Parker immunity doctrine, now called the state action exemption doctrine, for most governmental activities. See Parker v. Brown, 317 U.S. 341 (1943). Accessible at < http^://^uprcmc.iustia-c()m/ca^e^/fedcral/u^/317/341/>. As noted by the Antitrust Bar of the American Bar Association in 2001, "(state action immunity drives a large hole in the framework of the nation's competition laws" (42). The exemption is quite wide, covering all government owned enterprises such as port authorities, electric power systems, and hospitals as well as thousands of state and local regulations that restrict and limit competition, including many laws regulating hospitals, transportation, insurance, retail distribution, utilities, rent for residential and commercial buildings, advertising, and a wide range of professional services, especially law, funerary services, engineering, medicine, dentistry, and real estate (OECD 1998). Generally speaking, states and municipalities can also enact industrial aid schemes—including direct monetary subsidies—without concern about antitrust liability. The most important of these differences are summarized in Table 2.1.

#### There’s no residual link – the antimonopoly tradition mobilizes reform coalitions, and it’s compatible with the goals of redistribution

Berk 19 [Gerald Berk, Professor of Political Science at the University of Oregon, 11-25-2019, "Antimonopoly and the Democrats," Dissent Magazine, <https://www.dissentmagazine.org/online_articles/antimonopoly-and-the-democrats>]

Democrats are waking up to the realities of economic power. Less than a decade ago, the subject was taboo. Even with the economy in ruins, Democratic leadership saw no option beyond neoliberalism. But since the 2016 primaries, a split has opened up in the party. With it has come a resurgence of antimonopoly politics that neoliberal leaders can no longer ignore. At first blush, it looks like antimonopoly heightens the conflict between socialists committed to overcoming capitalism and establishment centrists seeking to save it from populist attacks on the left and right. But antimonopoly once contributed to mobilization, coalition building, and sustained reform across the liberal-left spectrum, and it might do so again today. The Antimonopoly Tradition Democracy and markets are fragile and demanding systems, easily corrupted by formidable concentrations of power. The antimonopoly tradition recognizes this fragility, and it makes no sharp distinction between economic and political power. Excessive concentrations of political power undermine economic prosperity no less than excessive concentrations of economic power corrupt democracy. The problem for law and public policy in a democracy with markets seems simple: how to check the constant tendency to concentrated power. There’s no clear-cut way to do that, because those who seek to attain power and lock in privilege are endlessly inventive. Under the right conditions, institutions designed to check power can be used to opposite ends. As a result, antimonopoly is far more than an ideology. It is a political project that requires vigilance, action, and constant adaptation. Reformers have drawn on the antimonopoly tradition—which is far more wide-ranging than just antitrust, a set of policies designed to prevent predatory competition and break up concentrations of economic power—throughout U.S. history. In the 1830s, Jacksonians used it to authorize privatization, dismantling the Second Bank of the United States because it locked in the privilege of an overweening aristocracy. Abolitionists in the 1840s and 1850s drew on the antimonopoly tradition to dismantle the slave power. In the 1880s, populists enacted state antitrust laws to check the growth of corporate power. In the first decades of the twentieth century, Progressives went further, breaking up corporate power and boosting countervailing forces in government, unions, and proprietary enterprise. In the New Deal, the antimonopoly tradition broke the power of banks and industrial corporations and paved the way for regulation, collective bargaining, and welfare provision. In the 1940s, liberals drew on it to outlaw discriminatory pricing and check the predatory power of chain stores. In the 1950s and 1960s, antitrust administrators broke up patent monopolies, opening the way to high technology. The antimonopoly tradition, as this sketch demonstrates, has enabled diverse political projects. In the first Gilded Age, it provided a challenge to laissez-faire constitutionalism—the legal doctrine that markets were autonomous from politics, and that property and contracts always protected individual liberty. In today’s Gilded Age, the antimonopoly tradition confronts market fundamentalism: the belief that liberty is best realized in market transactions insulated from democratic interference; that it is possible to organize markets effectively without government supervision; and that we ought not worry about concentrations of economic power, either because they are efficient or temporary. The turn to market fundamentalism had a major impact on the practice of antitrust, severing it from its roots in the antimonopoly tradition. The University of Chicago–trained lawyer Robert Bork, who published The Antitrust Paradox in 1978, convinced Reagan’s Justice Department that antitrust blocked efficient forms of business organization. Left alone, corporations and capital markets could decide better than government regulators whether mergers, hostile takeovers, outsourcing, or breaking up and selling off corporate assets would serve consumers. If the result was concentrated power, so be it. In time, the Democrats agreed that the only goal of antitrust was to protect consumers. By 1992, antitrust had disappeared from their platform for the first time in a century. The resurgence of the antimonopoly tradition among Democrats indicates a sea change in how they approach economic governance. Rather than limiting debate to after-the-fact redistribution, they have begun to ask how markets and business organizations can be structured to check concentrations of power. Many Democrats are converging on a platform to rebuild a more democratic economy, even as they disagree in fundamental ways over what that means, who should benefit, and how to achieve it. Still, the antimonopoly tradition’s shared appeal could open new possibilities for party politics and reform. This might seem overly optimistic, but a closer look at how the antimonopoly tradition has informed three ideological factions within the Democratic Party—democratic socialists, (neo)liberals, and antimonopolists proper—illustrates the potential for a broader politics focused on challenging concentrated power and building a more democratic economy.

#### The aff addresses an example of uniquely violent capitalism that cloaks private entities in the power of the state

Shapiro 14 [Ilya Shapiro, Senior fellow in constitutional studies at the Cato Institute and director of the Robert A. Levy Center for Constitutional Studies, 10-20-2014 https://www.cato.org/commentary/will-real-government-crony-please-stand]

Whatever one’s opinion of antitrust law—mine isn’t too favorable because the law is typically too slow‐​acting to befit a dynamic marketplace—existing immunity doctrines are dangerous because they allow private entities cloaked in government authority to raise prices and restrict choice. Worse, state‐​established cartels frequently harm constitutional rights, such as the right to earn a living, by barring new businesses from opening. The North Carolina case is a prime example of private actors arbitrarily abusing government power to block entrepreneurs from entering an industry and providing for themselves and their families. Occupational Licensing Laws Are a Government Racket As George Will put it in his recent column on the case, occupational licensing laws and the monopoly power they grant “are growth‐​inhibiting and job‐​limiting, injuring the economy while corrupting politics. They are residues of the mercantilist mentality, which was a residue of the feudal guild system, which was crony capitalism before there was capitalism. Then as now, commercial interests collaborated with governments that protected them against competition.” Cato and PLF filed a Supreme Court brief supporting the FTC—you know it’s a bad case when we’re on the federal government’s side!—arguing that courts should only rarely immunize private parties who act on government’s behalf. The Fourth Circuit was not only correct in applying the “active supervision” requirement, but existing immunity doctrines are too lax. Instead, courts should grant antitrust immunity to private entities acting under state law only where state law commands their restraint on competition, and where that restraint substantially advances an important state interest. This test would help protect the constitutional right to economic liberty against the only entity that can normally create monopolies and yet which today enjoys immunity from antimonopoly laws: the government.