## 1ac – msu mm – texas

### 1ac – advantage

#### The advantage is Practitioners, or “NPs”:

#### Scope of Practice laws are anticompetitive barriers to autonomy for Nurse Practitioners

Smith 21 (Laura Barrie Smith, Health Policy Center, Urban Institute, Washington, District of Columbia, “The effect of nurse practitioner scope of practice laws on primary care delivery,” October 8th, 2021, <https://doi.org/10.1002/hec.4438)//NRG>

Like all health care providers, NPs are subject to considerable state-level regulation, and a key aspect of this regulation is their SOP. Most broadly, SOP dictates the range of procedures and services that NPs are legally allowed to perform. SOP laws also specify the degree of practice and prescriptive authority for NPs and outline requirements for collaborative practice agreements between NPs and physicians. Most collaborative practice agreements require physician review of NP patient charts. The agreements can also include practice protocols, require physician supervision, limit the number of NPs with whom each physician can have a collaborative practice agreement, and/or impose restrictions on NP prescriptive authority (Adams & Markowitz, 2018).

The American Academy of Nurse Practitioners considers a state to have “full practice authority” when NPs can legally practice and prescribe without any physician oversight and under the exclusive licensure authority of the state Board of Nursing (American Association of Nurse Practitioners, 2018c). As of 2020, 23 states and the District of Columbia grant NPs full practice authority. All other states maintain reduced or restricted authority (Phillips, 2020).

In 2011, an influential report by the National Academy of Medicine (formerly the Institute of Medicine) urged states to allow NPs to practice to the full extent of their training (Institute of Medicine, 2011). Since then, many research institutions, non-governmental organizations, and government agencies have advocated for states to relax their SOP laws in order to grant NP full practice authority (Adams & Markowitz, 2018; Buerhaus, 2018; Gilman & Koslov, 2014). A recent policy proposal from the Brookings Institution concisely summarized the problems with restrictive SOP laws, calling them “anticompetitive policy barriers” that “restrict competition, generate administrative burdens, and contribute to increased health-care costs, all while having no discoverable health benefits” (Adams & Markowitz, 2018). Following the National Academy's report, 12 states relaxed their NP SOP laws between 2011 and 2017 to increase NP practice authority (Figure 1). These relaxations of SOP laws eliminated requirements for collaborative agreements between NPs and physicians (sometimes following a limited, post-graduation period of collaboration/supervision), and abolished requirements for NP practice protocols if there were any.

Despite the momentum for relaxing SOP laws, considerable political resistance remains, particularly in southern states. Some legislators frame the debate over SOP as a professional turf war (Chesney & Duderstadt, 2017). Physician groups such as the American Medical Association and the American Academy of Family Physicians oppose full practice authority, and physician group political action committees have historically been successful in maintaining strict SOP laws (American Academy of Family Physicians, 2020). Political spending by physician interest groups is shown to be strongly correlated with restrictive SOP laws for NPs, while spending by hospital interest groups is shown to be correlated with NP autonomy (McMichael, 2017). While opponents of relaxed SOP laws cite concerns are about patient safety – emphasizing that NPs receive fewer years of formal education than physicians – evidence does not show that NP-provided care is unsafe for patients (American Academy of Family Physicians, n.d.; American Medical Association Advocacy Resource Center, 2017; McMichael et al., 2018).

#### The FTC can challenge State-Level SOP restrictions now – that fails due to immunity – cements the “physician-only” model

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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

#### State action immunity blocks enforcement of anticompetitive practices sanctioned by incumbent interests – expanding prohibitions solves

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/

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 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.

#### The impact is massive – SOP restrictions block nurse-led clinics that expand access to 81 million people

Morgan 21 (Larissa, The Regulatory Review, “Law Reforms Promote Nurse-Managed Care,” September 1st, 2021, <https://www.theregreview.org/2021/09/01/morgan-law-reforms-promote-nurse-managed-care/)//NRG>

Advanced practice registered nurses lead nurse-managed clinics, which offer primary care and wellness services through partnerships with federally qualified health centers, academic institutions, nonprofits, and social services agencies. These clinics address the social determinants of health by increasing access to care and improving patient satisfaction, health outcomes, and behaviors that affect health. Hailed as “the future of primary care in the United States” by some health policy experts, nurse-led clinics support medically underserved populations, particularly in areas with a shortage of primary care physicians.

Nurse practitioners offer the same—and, on some metrics, better—quality of care than primary care physicians, while also providing cost savings to the U.S. health system.

For routine wellness visits, Medicare—the federal health insurance program for elderly U.S. residents and certain younger people—reimburses nurse practitioners at 85 percent the rate of doctors. Primary care from nurse practitioners is also less expensive for private insurers and patients who pay out-of-pocket. In addition to lower payments, nurse-managed care may decrease expensive emergency room visits by focusing on preventive services.

Nurse-led clinics were federally recognized as a health care delivery model following the passage of the Affordable Care Act (ACA). Although the ACA increased the number of Americans with health insurance, the supply of primary care physicians has remained insufficient to match the needs of the insured population.

To address this shortcoming, the ACA established a $50 million grant program to expand the financial capacity of safety net providers, such as nurse-led clinics. The federal government distributes funding under this program based on a number of factors, including the financial need of the safety net provider and other available funding at a state, local, and organizational level. To qualify for funding, nurse-led clinics must meet certain regulatory requirements. First, nurses must serve as the primary providers at such clinics where at least one advanced practice registered nurse works in a management capacity. Second, the nurse-led clinic must offer a full range of primary care and wellness services to all patients, regardless of their socioeconomic or insurance status. Finally, nurse-led clinics must create community advisory committees composed of patients to oversee the impact of the clinic and seek civic input.

Although some health policy experts have praised the ACA’s funding for nurse-managed clinics as “the beginning of a new era for nurse-led health care,” variability across state regulations in nurse practitioner practice authority creates barriers to expanding these clinics.

Specifically, states differ in the amount of authority they grant nurse-led clinics to practice without physician oversight. Many states require nurses to enter into collaborative practice agreements with physicians before they can practice independently. To gain full practice authority, some states require nurse practitioners to complete several thousand hours or, in some cases, years of training under the supervision of a physician. Other states extend physician oversight into operations of nurse-led clinics.

For example, in addition to mandating 4,000 hours of supervised practice, Alabama requires supervising physicians to visit nurse-led sites at least twice per year. For nurse practitioners who have yet to complete their mandatory supervised practice, a physician must oversee a minimum of 10 percent of their work at the clinic. Some medical experts argue that collaborative practice regulations are necessary to protect patient safety and quality of care. Other health experts, however, explain that—compounded with a growing insured and aging population—these regulations hinder health care for the 81 million Americans who lack access to a primary care physician. To keep up with these demands in Alabama, for example, the state would need to increase its number of primary care physicians by 23 percent over the next nine years.

In response to these mounting pressures for access to additional medical professionals, some states have changed their laws to grant nurse practitioners full practice authority. Following 22 other states’ existing laws, California recently passed legislation that permits nurse practitioners to practice independently starting in 2023. Currently, nurse practitioners in California are required to work under the direction of a physician, and to collaborate with the physician and the larger health system in which they operate to establish treatment and care practices.

This new state legislation does not completely abandon this partnership, but it does afford nurse practitioners more freedom. Under the new law, nurse practitioners must complete a three-year, supervised “transition to practice” period before they are eligible to operate clinics independently, similar to a regulatory model used in states such as Connecticut, Delaware, and Nebraska. Although the legislation permits nurse practitioners to offer primary care and some diagnostic services, they must refer patients to physicians when medical needs exceed the scope of their practice capacity. This new legislation has sparked debate in the medical community. Proponents of physician-based care argue that easing supervision could compromise patient health. To resolve physician shortages, the state should instead focus on increasing training and education of providers, suggests the California Medical Association. Advocates of full practice authority welcome the legislation as an opportunity to expand care to needy patients while promoting the development of new health care delivery models, such as nurse-managed clinics. As the shortage of medical workers has worsened during the coronavirus pandemic, other states—most recently, Massachusetts—have granted full practice authority to nurse practitioners as part of larger health care reform efforts.

States will likely continue to update their health care laws to address the systemic inequalities that have intensified amid the pandemic. With heightened awareness of the social determinants of health, disparities in access to care, and rising health care costs, nurse-led care appears to serve as one solution to the existing challenges faced by patients across the United States.

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

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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.

#### COVID highlights the pivotal role of SOP laws – shortages are classist and racist in nature

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~~ [they] 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.

#### Policy changes can measurably reduce violence – malleability 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.”

#### Second is chronic illness – NPs empower access and collaboration between communities and health care systems – especially over chronic illness

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.

#### Third is holistic care – NPs are a foundational element of care reform – rejecting nursing cements patient barriers, physician negligence, and failing healthcare – expanded autonomy is a critical enabler of imagining a better system

Trotter 21 (LaTonya J. Trotter, Associate Professor in the Department of Bioethics and Humanities at the University of Washington, “The Invisible Work of Nurse Practitioners,” Spring 2021, https://www.aft.org/hc/spring2021/trotter)//NRG

Today, the NP as physician substitute is a fairly well-known story, at least within healthcare policy circles. What is less often considered is whether or not the problem they are addressing is only or even primarily about physician scarcity. Not everyone struggles to find a doctor; those with the least profitable conditions and the fewest resources are far more likely to have difficulty. As a consequence, NPs are more likely to treat populations whose care is often socially as well as medically complicated: people who are poor, are uninsured, receive Medicaid, and/or qualify for Medicare due to a disability.14 Far from being a simple substitute, NPs systematically care for different patients than physicians.

While some may believe NPs are best suited to provide “routine” care, the reality is that by becoming the provider to the socially marginal and medically vulnerable, NPs are often managing the most complicated patients. And the available evidence suggests they are up to the challenge. Fifty years of research on the safety and effectiveness of NP-led care supports the conclusion that their patients do at least as well as those who see physicians.15 This evidence suggests a possibility that few health policy experts have considered. Perhaps the utility of NPs is found not in their similarity to physicians, but in their difference from them. And maybe, just maybe, the problems NPs are a solution to have less to do with physician scarcity than with deeper questions of social inequality and how we choose to care for our most vulnerable citizens. These are the questions I brought with me as I spent two and a half years following a group of providers at a place I call Forest Grove Elder Services (a pseudonym).16

Forest Grove is best understood as a nursing home diversion program. All of its patients were eligible for nursing home care due to various physical or cognitive needs. In order to avoid institutional care, the Grove provides a comprehensive set of services that includes, but goes well beyond, medical care. In addition to primary care, the Grove provides physical and occupational therapy, recreational activities, and social work services. It also coordinates and manages the care its patients receive outside its walls, from specialist appointments to rehabilitation services. A dedicated fleet of accessible vans ferry patients to and from the Grove, as well as to these outside services.

From a funding perspective, what is unique about the Grove is the way it tries to manage costs. The state authorized the use of Medicare and Medicaid dollars to pay for these enhanced services as an experiment to test if providing comprehensive, community-based care could save money through averted hospitalizations and nursing home placement. But in the time I spent at the Grove, I found that what was truly unique about the organization is the way its NPs make this model work. Like many healthcare organizations, the Grove employs both physicians and NPs to provide medical care. However, what makes the Grove different from other collaborative environments is that its NPs are the formal leaders of the healthcare team. What it meant for NPs to lead was not just about decision making, but about fundamentally reshaping how care happens.

More Than Medicine When I first met Michelle, she had been an NP for almost 20 years. But she had been a nurse for longer still. Like most NPs, she started her career as a registered nurse (RN); her first job was at the hospital bedside. She had already amassed over two decades of experience before she went back to school to become an NP. Maybe that is why when I spent time with Michelle, it became impossible to think of her as a substitute physician. To watch Michelle was to watch a nurse at work. “Ms. Payne. Can you think of anyone else who could come by a few times a day?” Ms. Payne was 86 years old. Like most of the Grove’s patients, she lived with a litany of complaints: diabetes, rheumatoid arthritis, congestive heart failure. Yet none of these were why she was sitting in Michelle’s office on that day. In two weeks, Ms. Payne was scheduled to have cataract surgery to improve her increasingly cloudy vision. Michelle’s aim was to make sure Ms. Payne was prepared for the operation. Cataract removal is a low-risk outpatient procedure. The surgery was not the problem. The problem was what would happen afterward. I sat in the corner, trying to be unobtrusive in a room that seemed full with three people. I listened as Michelle reviewed the surgeon’s postoperative instructions. Ms. Payne would need to apply a series of prescription eye drops—four times a day for four weeks—to control inflammation, prevent infection, and minimize complications. There is nothing remarkable about their application. One would simply stretch an arm upward, tilt one’s head skyward, arch the arm over a selected eye, grip the bottle with a personal selection of fingers, and then squeeze with the right amount of pressure. These coordinated steps, however, require a set of abilities that not everyone possesses. Ms. Payne had rheumatoid arthritis, a condition that not only inflames the joints but also often deforms them. This condition had left her hands curled in on themselves like talons. As Michelle described how often the drops would need to be applied, all three of us looked at these hands, our eyes filling with doubt. In everyday life, when we cannot administer our own medication, parents, children, or even a good friend might be enlisted to assist. This practice is both common and legal as long as it is done for free, which explains why Michelle asked Ms. Payne whether she could think of anyone who might help. Anyone would have sufficed. However, when payment enters the equation, the universe of anyone shrinks considerably. In most states, only physicians and nurses can administer medication outside of an institution. This includes prescription eye drops. Justifying the expense of paying for an RN to visit Ms. Payne four times a day, every day, for four weeks, might not have been impossible, but it certainly would not have been easy. Yet, sending her home after surgery with no plan for applying the eye drops bordered on medical malpractice. Over the next two weeks, I watched as Michelle “knit together” a range of resources on Ms. Payne’s behalf. She called the surgeon to see if a simpler regimen might work on weekends. She asked an RN colleague to meet separately with Ms. Payne to go ask if she were sure that no one could assist her, even once a day. A cousin? A neighbor? Someone from her church? The nurse reminded Ms. Payne, gently but firmly, that not wanting to ask is not the same thing as being unable to ask. With the RN’s help, Michelle eventually crafted a plan that is one part neighbor, one part modified regime, and one part approval for some nursing visits on weekends. Arriving at this complex calculus took more than a little time and a great deal of work. The surgeon performed the technical miracle of curing the patient; Michelle performed a miracle of her own in helping to ensure the best possible outcome. With Ms. Payne’s eyesight improved, the odds are good that she will be able to stay in her own home for some time to come.

Among elder care professionals, there is a saying: “The best long-term care insurance is a daughter.” Even with Medicare and Medicaid paying for services, navigating bureaucracies, coordinating care, and knitting together complex information is someone’s full-time job. Yet, for many, these idealized daughters are in short supply. Few families have access to a physically healthy adult whose time is not taken up by work in the paid labor market or by unpaid responsibilities such as caring for dependent children. Moreover, this work is not unskilled; an adult’s availability does not necessarily signal possession of the knowledge or expertise to do what needs to be done. To categorize this as the work of daughters reveals it as the kind of invisible work that money cannot always buy, and for which insurers rarely reimburse.17 But if this work happens within the reimbursed medical visit, there is a greater chance that it might occur. The NPs I spent time with did this kind of work as part of the medical exam, making it not just an adjunct to medical work, but a transformation of it. And when they did it well, there was a good chance that their patients would experience fewer complications—and that the state would incur fewer costs.

The Hard Work of Being an NP “The NPs do all the hard work.” That was Joanne’s assessment. Joanne was one of the RNs who supported the work of the NPs within the clinic. In spending time with Joanne, I learned that she was currently taking classes for a master’s degree in business. She did not want to do the work of an RN for the rest of her life. “Why business?” I asked. “Why not become an NP of some kind?” She answered from the perspective of someone who had spent several years making her own observations of what the NPs spent their time doing. Because, she explained, it was hard work. And after being a nurse for almost a decade, she was ready for something a little less hard. When I asked what made the work hard, she responded, “Let’s say you’re Mr. Smith. And you’re in the hospital right now. And the hospital calls one of our doctors [to get his medical history]. Chances are, they don’t know Mr. Smith like an NP knows Mr. Smith: his family situation, including his financial situation; what’s going on; what hospital work we’ve done in the past; what has worked for him in the past.” Joanne marshaled her own data to back up this claim. “You pull a physician note [from the medical record], and it’s empty. Not empty, but there’s nothing in there but, you know, a few words.… But you have the NP notes going much deeper into what is found. You find the situation and the conditions of daily living because they’re coming in from their nursing background when you access all those things that you’re adding to the problem.” From Joanne’s perspective, the hard work that the NPs performed gave them a better relationship with their patients, which in turn gave them a better understanding of their clinical care. I pondered Joanne’s words for some time. To speak of relationship is usually to invoke the intangible world of emotions. Yet when Joanne illustrated this term, she did not describe an affective tie between NP and patient, but one born of deep, layered knowledge. Moreover, she was explicit in calling out the action required to cultivate that knowledge. For Joanne, this was not the result of an emotional attachment; it was the result of hard work. As I spent more time in the clinic, I began to understand how the NPs’ work might improve patient care. One afternoon, I sat with Michelle as she met with Mr. George. His weight had gone up by seven pounds in less than two weeks. This was of particular concern to Michelle because Mr. George had congestive heart failure. Rapid weight gain from fluid retention is one of the classic signs that something is amiss. It could be a worsening of his heart; it could be a change in his diet; it could be a problem with his medication. What Michelle knew for sure was that if Mr. George retained too much fluid, he might find himself struggling to breathe.

This was the kind of slow-moving emergency that Michelle faced on a daily basis. Because it was not just age that defined her patients; it was medical frailty. All of Michelle’s patients had multiple chronic conditions like diabetes, arthritis, and hypertension—as well as an array of physical and cognitive impairments that interfered with daily life. Her job as their primary care provider was not just to provide medical care, but to manage the full range of services upon which her patients depended. Mr. George saw a regular cardiologist for his heart failure. But if the problem could be treated without that level of care—and cost—it was Michelle’s job to make it happen. As Michelle met with Mr. George, I recognized a technique that I had often seen her employ. When she wanted to understand a problem, either from a patient, family member, or colleague, she asked questions that did not reveal her own suppositions. Instead, she let the person to whom she was speaking give their own rendering of the facts. I watched as Michelle spent half an hour listening to Mr. George describe how he took his medications and when. She was meticulous in her questioning. Because Mr. George was not conversant with the names of the medications he took, she showed him pictures of each of his pills as she asked him when he took them. When Michelle got to one of his last medications, he said, “This one I take halfways.” She stopped and asked, “What do you mean by halfways?” In the conversation that followed, Michelle learned that Mr. George was only taking half of this pill; he was concerned about side effects and believed he felt better when he took less of it. He did not know that the pill he was taking less of was one of the medications that helped him manage his heart failure.

The case of Mr. George could be described as an issue of noncompliance or patient education—the kind of nonmedical problem you had to be neither an NP nor a physician to solve. But the nature of the problem was only apparent in hindsight. Michelle not only had to ask the right questions, she had to listen. If she had simply inquired, “Are you taking your medications?,” Mr. George may have reported—honestly, from his perspective—that he was. If she had sent him directly to the cardiologist, Mr. George might have had his medications changed or increased without addressing his underlying concern of side effects—the concern that had motivated him to modify his medications without understanding the risks. It was listening, conversation, and medical knowledge that led Michelle to the right conclusion and the best plan of action. What Joanne had described as “the hard work” of being an NP did not just make Mr. George feel listened to or cared for, it was a crucial part of keeping him medically stable and independent. When Michelle did this work well, she not only helped Mr. George but also saved his insurer from paying for a more expensive trip to the cardiologist. But their conversation would have benefits beyond any single exam. Michelle’s questions were open-ended. Therefore, along with hearing what she might have thought was important, she heard information that was important to Mr. George. He had his own ideas about how each of his medications made him feel. He asked questions of his own about why he was taking certain pills or why the pharmacy had switched him from a brand name to a generic version. And as they talked, Michelle learned just a little bit more about Mr. George. Such as how he reasoned about which pills to take and when. That despite not knowing which pills were for which condition, he was otherwise willing and compliant with taking them. She learned more about his relationship with a neighbor who came over to help him put groceries away and brought him dinner on Sundays. In addition to learning why he was retaining fluid, she learned more about his support network and personal resources. If she needed to help him address a different issue, she would have new information to draw from to make that happen.

The Nursing Model of Care “The nursing model is much more holistic [than the medical model]. You’re looking at the whole person. Yes, disease is part of the person, but so is their environment, so is their mentation, their spirit, so is their social environment. So I think instinctually, we all—nurses—that’s how we look at some things.” These were the words of Norah, an NP who worked alongside Michelle. These words were in response to a question I had asked about how NPs differed from physicians. For Norah, it was nursing’s whole-person orientation that allowed them to “hear things,” and to “identify needs” that a physician would not necessarily notice. Norah was quick to make sure I did not misunderstand her. “Look,” she said. “There’s a lot of things that [the physicians] understand way better than I do.” However, for Norah, recognizing the physician’s expertise did not take away from her own. “NPs have really taken on that kind of responsibility,” she told me. “It’s the nature of the profession.” When I watched NPs like Michelle and Norah at work, I came to understand how that different responsibility looked in action. And why it mattered for patients.

A Crisis of Care Nurse practitioners were originally created to address the problem of physician scarcity. When the issue is defined as a numbers problem, leveraging a more quickly trained provider seems both a creative and practical response. However, to watch NPs at work is to discover that the numbers are not the whole story. Because the Grove’s patients were not getting “less skilled physicians.” They were getting differently skilled—and highly skilled—nurses. This distinction is not just about semantics or even much-deserved recognition: it is about making visible the true problems we face in healthcare.

Because we are not simply facing a crisis of cost or personnel; we are facing a crisis of care. For the Grove’s patients, the work of knitting together information, resources, and systems was not a luxury, it was a necessity. Certainly, not all NPs care for patients as ill as those the Grove served. But in becoming the primary care providers for people who are poor, disabled, or otherwise medically marginalized, NPs across the country are often asked to meet a fairly high bar of expertise. Moreover, while the expertise required includes that of medicine, it often goes beyond it. Because what ails patients like Ms. Payne and Mr. George is as much about inequality as illness. A lifetime of poverty and racial discrimination are known causes of poor health.18 These social conditions not only make it difficult to access quality healthcare, there is good evidence that they literally age the body and directly produce illness. The NPs who listen, advocate, and coordinate will not solve these problems. Nonetheless, they can and do serve as on-the-ground lifelines for patients navigating the interwoven terrain of organizational, medical, and social problems that all too often go unnamed and unaddressed.

This crisis, however, goes beyond the exam room. Because the scarcity at work is less about providers than policy. We should not forget that the creation of the NP is only one of many possible responses to the crises we face. Despite being organized as a private system, healthcare’s largest payer in the United States is the government.19 Given this reality, what might have happened if we, as a nation, had matched the weight of our financial investment with a cohesive, national healthcare policy? What if, when faced with the growing evidence that health disparities were caused by social inequality, we had invested in social policies to ameliorate the worst excesses of poverty? Or used the full weight of the law to eradicate entrenched forms of racial discrimination? These are paths we did not take. Instead, we unraveled the national safety net, leaving individual providers to knit together the last threads of what remained.

Many have argued that the pandemic has exposed the cracks in our healthcare system. I hope it also shines light on the workers who are often called upon—and feel a calling within themselves—to span those cracks. In the hours I spent watching NPs like Michelle and Norah at work, I came to the conclusion that it is often nurses who are left with the invisible work of holding healthcare together. Before, during, and after the pandemic, nurses do not only the visible work of patient care but also the invisible work of shoring up a healthcare system that is crumbling under the weight of social inequality. As of the writing of this article in the first months of 2021, most of the executive orders that expanded NP practice autonomy have already been rescinded, even as the pandemic rages on. NPs like Renee Collins are back to paying physicians for oversight. But her patients in rural Tennessee will never know the difference because Collins is clear in her purpose: “Nurses are not wanting to be doctors.… We are simply wanting to fill the gap for access.”20

#### It’s reductive and wrong to think of NPs as a facsimile for physicians and problematic medical structures – the approach of NPs to care is transformatively different

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.

#### Fourth, agency – healthcare access is key to it for patient medical choices

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 and pathologizes black patients as passive and incompetent

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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.

### 1ac – plan

#### The United States federal government should prohibit state action immunity protections for anticompetitive barriers to full practice authority for nurse practitioners.

### 1ac – solvency

#### NPs are inherently transformative and their history of reform proves solvency

\*FPA = full practice authority, something that SOP laws restrict

Brunelle 21 (Rebecca, pediatric nurse practitioner with experience in telephone triage, pediatric critical care, and pediatric cardiology, “5 Reasons Nurse Practitioners Need to Advocate for Full Practice Authority,” August 20th, 2021, https://online.marymount.edu/blog/full-practice-authority-for-nurse-practitioners)//NRG

NPs Are Advocates for Change

Nurses and NPs consistently advocate for patients’ rights and for increased access to care. The American Nursing Association (ANA) emphasizes the important role of advocacy in nursing. According to the ANA, “Advocacy is a pillar of nursing. Nurses instinctively advocate for their patients, in their workplace, and in their communities; but legislative and political advocacy is no less important to advancing the profession and patient care.”

Echoing the need for political advocacy to advance the profession, NPs have taken their passion for improving patient care to the policy level. A recent study published in the Journal of the American Association of Nurse Practitioners highlights how changes in the health care market, like the passage of the Affordable Care Act in 2010, have been leveraged to increase FPA for NPs. Between 2011 and 2016, eight states passed full practice authority legislation for NPs, which is an eight-fold increase from the previous 10 years.

The Expanding Role of Nurse Practitioners NPs’ scope of practice is still significantly limited in some states despite the fact that NPs are an essential part of the U.S. health care system and have been providing affordable, safe, and quality health care to millions of patients since the 1960’s.. The ability of nurse practitioners to work independently and provide the best care to their patients increases when they are granted full practice authority.

Policies that increase the autonomy of NPs are well founded and improve patients’ access to care. A recent systemic review published in the Journal of Evidence Based Nursing indicates that patients are more satisfied with the care they receive from NPs versus physicians. This may be because NPs tend to have a longer consultation time and do a more thorough investigation of the patient’s chief complaint. Furthermore, the systemic review indicated that there is no decrease in health outcomes when patients are cared for by NPs.

Nurse Practitioners Deserve Full Practice Authority NPs consistently demonstrate their worth in the health care market. Patients are more satisfied with the level of care provided and health care costs are lower in markets in which NPs have FPA. These statistics are not surprising given the rigor of NP education programs. The AANP policy statement on FPA clearly outlines why NPs should be granted FPA throughout the U.S.: NPs are required to meet national education standards. Prior to practicing, NPs are required to obtain national certification in their specialty. The NP model of care encourages collaboration among disciplines. NPs are held accountable for the quality of care that they provide by their state board of nursing and the public. Nurse in blue scrubs putting on gloves Advocating for Nationwide Full Practice Authority NPs need to advocate for expanding FPA privileges in the remaining 27 states in which their scope of practice is limited. There are five key ways that expanding FPA privileges benefits the U.S. health care market. It increases patients’ ability to access care. It results in more choices in the health care market. It creates a more efficient health care system. It lowers health care costs. It Increases job satisfaction among NPs.

NPs fill a critical role in the U.S. health care system. They tend to serve in underserved areas, drive down the cost of health care, and provide phenomenal care. Multiple studies have demonstrated the benefits of FPA for NPs. Furthermore, states that restrict NPs’ scope of practice have a higher shortage of primary care providers and lower standings on national health metrics. Increasing the number of states that offer FPA to NPs improves patient care and advances the profession of NPs.

#### Michigan is front and center in the crisis of SOP restrictions and advocating positive reform for NP autonomy is in line with localized politics of expanding health access

Jacek et. al. 21 (Michigan Council of Nurse Practitioners based in Okemos, MI, Authors: Grace A. Jacek, DNP, APRN, FNP-BC, Barbara C. Jaquith, DNP, APRN, PNP-BC, FNP-BC, Ann P. Sheehan, DNP, APRN, PNP-C, Denise Soltow Hershey, PhD, APRN, FNP – BC, “Improving Access to Health Care in Michigan through Full Practice Authority for Nurse Practitioners: Legislative Task Force White Paper,” February 19th, 2021, <https://cdn.ymaws.com/micnp.org/resource/resmgr/legislation/final_white_paper_2021.pdf)//NRG>

Michigan is facing a healthcare provider shortage. It is estimated that by 2025 Michigan will need approximately 1000 primary care providers (United States Health Resources and Services Administration [HRSA], 2016). This is compounded by the fact that many residents of Michigan do not have reasonable geographic access to a regular healthcare provider. Michigan nurse practitioners (NPs) are committed to the health and well-being of the residents of the state of Michigan. Patients cared for by NPs have fewer unnecessary emergency department visits, reduced hospital admissions and readmissions within 30 days, receive regular preventive health screening, and are more compliant with recommended treatments.

NPs are licensed professional practitioners, educated at the master’s or doctoral levels, and “practice at the highest level of professional nursing practice” (American Association of Nurse Practitioners [AANP], 2015). Several decades of data demonstrate that NPs with full practice authority (FPA) increase access to safe, high-quality, cost-effective care; while facilitating flexible, innovative healthcare business models (Dill, et al., 2013; Leach et al., 2018). FPA is the legal permission of a professional to be able to practice to the full extent of their education, training, and certification. Twenty three states have FPA for NPs to facilitate access to health care. Michigan is considered one of the 12 most restrictive states for NP practice, requiring NPs to practice under supervision of physicians. Access to care is hindered in Michigan, by unnecessary, restrictive legal statutes that do not recognize NPs’ education, training, and certification. This limits NPs’ ability to practice in the communities where physicians are not working.

Michigan Council of Nurse Practitioners (MICNP) recommends that lifting restrictions on NP scope of practice is a prudent decision to facilitate access to care. NPs improve access to health care by increasing the health care workforce capacity of fully qualified professional providers who are available to care for patients in diverse care settings. MICNP calls for Michigan legislators to modernize statutes to adopt and authorize FPA inclusive of full prescriptive authority for NPs in all healthcare settings, permanently. This will make NP practice in Michigan current with evolving national standards of care 3 and improve Michigan residents’ access to affordable health care. This reflects Governor Whitmer’s health care priorities which focus on making health care more affordable; expanding access to health care; improving health care quality; and investing in public health.

Introduction/Background Michigan is facing a healthcare provider shortage; it is estimated that by 2025 Michigan will need approximately 1000 primary care providers (HRSA, 2016). Michigan nurse practitioners (NPs) are committed to the health and well-being of the residents of the state of Michigan. As board certified professionals, NPs support innovative healthcare delivery models that provide health systems the flexibility to implement processes that maximize effectiveness with efficiency to improve access to care and the overall patient experience. The success of Michigan’s health care system to adequately respond to health care needs and provide access to care for residents depends on health care providers being able to practice to the full extent of their education, training, and certification. NPs are licensed professional practitioners, educated at the master’s or doctoral levels, and “practice at the highest level of professional nursing practice” (American Association of Nurse Practitioners [AANP], 2015). NPs integrate the nursing model of care-emphasizing health, wellness, disease prevention and early intervention to prevent complications, including patient education, advocacy, and population health, when caring for their patients. NPs, as a profession, have more than five decades of expertise within diverse clinical settings in both rural and urban communities. These clinical settings include primary care, specialty care, acute care (inpatient/ ED/ urgent care) and long-term care settings (residential facilities/ hospice).

AANP (2019) issued the following statement about NP scope of practice (SOP): "As licensed, independent practitioners, NPs practice autonomously and in coordination with health care professionals and other individuals. NPs provide a wide range of health care services including the diagnosis and management of acute, chronic, and complex health problems, health promotion, disease prevention, health education, and counseling to individuals, families, groups, and communities. NPs serve as health care researchers, interdisciplinary consultants, and patient advocates". Twenty-three states, the District of Columbia and two territories have full practice authority (FPA) for NPs to facilitate access to health care. FPA is the legal permission of a professional to be able to practice to the full extent of their education, training, and certification. AANP (2020) defines FPA as legal authorization of NPs to “evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments - including prescribing medications and controlled substances- under the exclusive license authority of the state board of nursing”, without the requirement of physician supervision.

Several decades of data demonstrate that NPs with FPA increase access to safe, high-quality, costeffective care; while facilitating flexible, innovative healthcare business models (Dill, et al., 2013; Leach et al., 2018). NPs mitigate health disparities by improving access to care and quality of care. Patients cared for by NPs have fewer unnecessary emergency department visits, reduced hospital admissions and readmissions within 30 days, receive regular preventive health screening, and are more compliant with recommended treatments than those cared for by other health care providers (Dill, et al., 2013; Leach et al., 2018). Collectively, these patient behaviors contribute to lower health care costs, overall, as problems are identified early and complications are avoided or minimized (Martin-Misener et al., 2015; Neff, et al., 2018; Newhouse et al., 2011; Phillips & Bazemore, 2010; Sonenberg & Knepper, 2017; Xue, et al., 2016). In 2018, $44.5 billion was saved in Medicare spending in 3,143 counties in the United States (U.S.) in which NPs have FPA. It is recommended to require NP patient encounters to not be billed for services under “incident to” billing. The Commission estimates the Medicare program will reduce spending by $50 – 250 million in the first year and by $1 – 5 billion over a 5-year period (Medicare Payment and Advisory Commission [Medpac], 2019). Cost of clinic visits in states with restricted NP practice averaged the highest in the U.S. (Chattopadhyay & Zangaro, 2019). Studies have also shown NPs are more likely to practice in rural and health care shortage areas and are more likely to provide primary care (Westat, 2015). NPs working in critical care settings have demonstrated reductions in the number of inpatient days (length of stay), shortened time to consultation and treatment, improved mortality, improved patient satisfaction, and cost reductions (Jennings et al. 2015; Woo et al., 2017). It has been noted that NPs are cost effective, provide savings to patients, insurance payers, health systems and society (taxpayers) (Chattopadhyay & Zangaro, 2019; Martin & Alexander, 2019; Poghosyan et al., 2019). Additionally, in states with full NP practice authority, patients received more health education services from NPs as compared to other providers.

States that are highest in health rankings have NP FPA laws (see Appendix A). The United Health Foundation (UHF), American’s Health Ranking Report, is an annual snapshot of over 30 measures reported out as a composite index score. States are ranked in order of best outcomes. Michigan ranks 32nd and has restricted NP practice authority. As compared to other states, in 2019, Michigan underperformed in the following core measures, ranked by order of severity: smoking, frequent physical distress, cardiovascular deaths, frequent mental distress, obesity, infant mortality, cancer deaths, preventable hospitalizations, drug deaths, premature deaths, diabetes, excessive drinking, pertussis, childhood immunizations, and physical inactivity (UHF, 2020). NPs have master’s or doctoral degrees in advanced practice nursing from universities that meet national accreditation standards for nursing curriculum. NPs pass competency exams for national board certification in their areas of expertise. Board certifications indicate specialized advanced-practice education in caring for specific patient populations. For primary care NPs, practice populations include family practice, adult/geriatrics, pediatrics, psychiatric mental health, or womens’ health. Additionally, there are NPs who specialize in acute care and populations such as adults, pediatrics, neonatal, psychiatric, or emergency. It is important to note that prior to entry into an NP program, candidates have already earned a baccalaureate degree, and have passed state licensure examination as professional registered nurses (RNs).

Statement of the Problem Michigan has 138,155 actively licensed registered nurses (RNs) as of March 2020 (Michigan Department of Licensing and Regulatory Affairs [LARA], 2020), with 11,708 (8.4%) of those RNs additionally holding specialty certification. Seventy-three percent or 8,602 of the RNs who hold specialty certification in Michigan are listed as NPs (6.2% of total RNs). Michigan recognizes the NP as an advanced practice registered nurse (APRN) in statute 2016 PA 499 (in effect in April 2017). Michigan is considered one of the 12 most restrictive states for NP practice, requiring NPs to practice under supervision of a physician. Currently NPs do not have a defined SOP in statute in the state of Michigan (Patel, Petermann & Mark, 2019; Michigan Public Health Code [PHC], 1978/2017).

Patient access to care is hindered in Michigan, by unnecessary, restrictive legal statutes that do not authorize NPs to have FPA. Access to health care involves more than just a geographic component. Health care is accessible when it is available (timely, near to home), appropriate (evidence-based for the condition and measured by health outcomes; given in the appropriate healthcare setting: primary, specialty, long term, or acute care), affordable (cost effective, efficient), and accountable to patients, as evidenced by provider education, training and certification. This is consistent with Governor Whitmer’s health care priorities which focus on: making health care more affordable; expanding access to health care; improving health care quality; and investing in public health (Mich.gov, 2021). According to Hart, Ferguson & Amiri (2020), states with restrictive NP scope of practice laws experience: 1) reduced overall access to care, 2) increased cost of care with no appreciable increase in quality, and 3) stifling of healthcare organizations due to fewer options for innovative business models that respond to market conditions.

#### Our analysis foregrounds the contextual interactions between 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.

#### Government policy is much better than an untouched market

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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.

#### Incumbent forces call for an untouched market – loss of access places *millions at risk*

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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.

#### Restrictive SOP specifically causes practitioner burnout

Smith 21 (Laura Barrie Smith, Health Policy Center, Urban Institute, Washington, District of Columbia, “The effect of nurse practitioner scope of practice laws on primary care delivery,” October 8th, 2021, <https://doi.org/10.1002/hec.4438)//NRG>

Together, these findings imply that relaxing SOP laws may lead to a decrease in costs, an increase in transparency, and no increases in low-value care provision – overall, a value gain. Primary care practices and the NPs and physicians they employ may see additional benefits from relaxed SOP. First, relaxed SOP laws may improve professional satisfaction for NPs; survey data indicate that NPs who feel their skills are being fully utilized also report significantly higher job satisfaction (Athey et al., 2016). Second, by allowing NPs to practice at the top of their license, relaxing NP SOP laws may alleviate growing concerns about primary care physician shortages and burnout (Bodenheimer & Smith, 2013; Linzer et al., 2009, 2017) – particularly as team-based models of care delivery prove promising in primary care (Pany et al., 2021). Finally, as value-based payment models gain popularity (Muhlestein et al., 2017), relaxed SOP laws will enable primary care practices to increase the value of the care they provide by employing NPs with the authority to practice and bill independently.

#### Second, doctor normalization – medical power is currently re-shaping as doctors learn from patients. Any logical Neg offense converts the waiting room to “all-white” which cements ignorance

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 Interrupting the Physician. These findings illustrate a dynamic and often fluid flow of power throughout patients' interactions with their physicians. In many cases, patients' interruptions serve as a source of power-claiming discourse (Ainsworth-Vaughn, 1992). Kettunen, Poskiparta and Gerlander (2002) further support this notion, explaining that patients often counter the expert power of providers by using interruptions as power messages. The authors provide an example of this by describing how a nurse practitioner's attempt to interrupt a patient fails as the patient steadfastly holds the floor. The findings from this study resonate with our own findings, as several patients in our study also refused to relinquish their speaking turn when the physician attempted to interrupt them. In many of these cases, patients demonstrated a determination to provide an exhaustive accounting of their symptoms or concerns, especially in cases where the participant had visited the clinic previously to address the same issue or was previously misdiagnosed.

Interruptions clearly function as power-claiming discourse. It is also important to note however, that interruptions do not always function as a bid for power. As Kettunen, Poskiparta and Gerlander (2002) note, while interruptions can function as dominance, one should keep in mind that interruptions are a "many-sided phenomenon" that should always be considered within the larger context of the interaction. Other authors have explored the complex nature of interruptions (Li, 2001) and proposed distinctions such as "intrusive or cooperative and "power" and "nonpower." Our findings support this, as there were cases in which interruptions served to interrupt the physician's speaking turn, but there were also instances in which patients' interruptions served a supportive function.

When viewed within the context of the interaction, interruptions carried an intent that can be interpreted as more than the observed technical violation of the physician's speaking rights. In these instances, participants do disrupt the physician, but with the intent to aid in the diagnostic process by providing as much relevant information as possible. Murata's (1984) defmition of "assistance," a cooperative form of interruption, states that one speaker discerns that another speaker needs assistance and interrupts to provide the speaker with words, phrases, sentences or ideas (Li, 2001). From this perspective, we understand some participants' interruptions are not intended only as power moves or impolite behavior. This is especially true for our participants, several of whom had not yet received an effective treatment plan or correct diagnosis after several visits to the clinic.

These findings are significant for several reasons. First, the findings demonstrate that the participants, low-income black patients, are capable of vying for dominance during the interaction and often use interruptions and persistence as a vehicle for claiming this power. Second, participants often used interruptions and persistence as a means of "helping" the physician identify the best course of treatment for their care. The implications of this point are worth noting: In cases where patients may be perceived as disruptive or difficult, they may in fact be advocating on their own behalf as they attempt to assist the doctor in delivering a better quality of care. In our study, participants consistently described feelings of frustration when relaying the winding road towards a correct diagnosis. In these cases, the participants are not necessarily intending to supplant the power of the physician during the physician's attempt to diagnosis their condition - they are, in fact, dependent on the physician's expert knowledge and ability to render the correct diagnosis and address their health issue. Rather, they are using their agency to ensure that the physician has all the pertinent information in order to render the best informed diagnosis and treatment plan. In this context, we can understand that patients who may be perceived by physicians as "difficult" are in fact using their agency to fully participate during the interaction and hopefully, obtain the health services that they need.

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## Case

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#### Says its necessary, but not sufficient

Roberts 12 [Dorothy, George A. Weiss University Professor of Law and Sociology and the Raymond Pace and Sadie Tanner Mossell Alexander Professor of Civil Rights @ Penn Law, “Debating the Cause of Health Disparities: Implications for Bioethics and Racial Equality,” *Faculty Scholarship*, pp. 333-4 https://pdfs.semanticscholar.org/31c0/9246f8bb186457630ac92d7a218905d02bc3.pdf]

In my view, it makes more sense to interpret the geography of healthcare as evidence of racism: government and private business have developed inadequate and inferior healthcare resources where black people are concentrated.5 Yet providing equal access to healthcare would not be enough to close the racial divide. Racial inequality causes health disparities apart from blocking access to high-quality care. It makes people of color sicker in the first place—before they get to a doctor’s office or a hospital emergency room. Access to healthcare alone does not determine an individual’s health, because health is affected primarily by the social environment. The way society is organized drives group disparities in health. Because they reflect social inequality, a more accurate word for the racial gaps is health inequities. As British public health champion Margaret Whitehead defines them, health inequities are ‘‘systematic, socially produced (and therefore modifiable) and unfair,’’ and result from the unjust distribution of social, economic, political, and environmental conditions that determine health.6 It has been firmly established that the best predictor of health is an individual’s position in the social hierarchy. Hundreds of studies tracking the health of people along the social ladder show that health gradually worsens as status declines.7 In any society, people with low socioeconomic status have poorer health than people with higher socioeconomic status. The classic Whitehall Study of British Civil Servants, lasting for more than two decades, published in 1978, compared heart disease and mortality in employees at four civil service levels: administrators, professional and executive employees, clerical staff, and menial workers. The study found not only that the administrators at the top had far better health than the janitors at the bottom, but also that health got worse and mortality increased with each step down the occupational ladder.8 These social gradients in disease occurred despite everyone’s access to the British universal healthcare system. The question, then, becomes whether this relationship between economic inequality and health applies equally to America’s glaring racial disparities. Racial inequality also produces huge gaps in advantage and disadvantage that parallel the relative health of people in different racial groups. A growing number of scientists from a variety of disciplines, including medicine, biology, psychology, anthropology, and epidemiology, are investigating how racial inequities in income, housing, and education, along with experiences of stigma and discrimination, translate into bad health. More than one hundred studies now document the adverse effects of racial discrimination on health.9 Three of the main biology-related pathways these researchers have identified are chronic exposure to stress, segregation in unhealthy neighborhoods, and transmission of harms from one generation to the next through the fetal environment.10 Their effects on health stem specifically from racism that is separate from, and added to, the harmful consequences of lower socioeconomic status. A recent study of health in a racially integrated, low-income neighborhood of southwest Baltimore, Maryland, highlighted the causal link between health disparities and residential segregation, which leaves racial groups ‘‘exposed to different health risks and with variable access to health services based on where they live.’’11 The researchers found that when black and white Americans lived in an integrated setting, the nationally reported gaps in hypertension, diabetes, obesity among women, and use of health services either vanished or substantially narrowed. The researchers did not interpret the study as showing that racial inequality does not matter to health disparities; rather, they concluded that racial differences in social environments explain a significant portion of the health disparities revealed in national statistics. The economic approach ignores the role of residential segregation in maintaining inequitable treatment for blacks and fails to question why whites have the privilege of living where there is better access to high-quality care. Instead of explaining away race by adjusting for the myriad of factors that add up to inferior healthcare, researchers should be asking why it is that being a person of color in America is linked to all these negative factors. It is not bad luck: as the studies mentioned previously show, blacks and other minorities are systematically denied access to equal treatment and exposed to conditions that are harmful to their health. A proposed market solution will only reproduce—if not worsen—disparities based on race, because it avoids the need to eliminate individual and institutional bias.

### 2ac – at: doctor bias link

#### Third, turn – expanded NPs are key to correcting physician bias

#### a) solves misdiagnosis and nurse respect – NPs are patient advocates

Trotter 18 (LaTonya, sociologist at Vanderbilt University, “’I’m Not a Doctor. I’m a Nurse’: Reparative Boundary-Work in Nurse Practitioner Education,” July 15th, 2018, https://journals.sagepub.com/doi/10.1177/2329496518783683)//NRG

Similar invocations were embedded in informal stories. Faculty sometimes leavened the hours of didactic material with accounts from their own practice. Rachel Steele, MSN, CRNP, shared such a story. She described a woman who had come into her office, ‘for something small; like a cold.’ During the encounter, the woman reported that she had been experiencing a recurrent pain in her chest. The woman had recently been to see her parents’ cardiologist, the one who had treated both her parents for myocardial infarctions (MIs). Rachel emphasized ‘both parents for MIs’ by raising her voice slightly and opening her eyes a little wider. The signal was unambiguous: this was important to Rachel and should be important to us. But it seemingly was not important to the cardiologist. According to the patient, the cardiologist had ordered a stress test, but it had come back normal. ‘Based on that test,’ Rachel told us, ‘he told her she was crazy. The pain was all in her head, and she should go home and get a life.’ A few days later, Rachel got a phone call. The woman was having chest pains. Rachel told her to go to the hospital ER while she called ahead and ‘told them to please, please cath her,’ referring to a diagnostic procedure that images the heart and blood vessels. Catheterization revealed that one of the woman’s arteries was 90 percent blocked. Rachel could not explain why the stress test was normal, but she explicitly located the diagnostic error within the narrow vision of the cardiologist. ‘The doctors were just looking at the tests and not the whole picture. They weren’t listening to the patient. With her family history? Heart doctors look at the heart, lung doctors look at the lungs, but the job of the nurse practitioner is to look at the whole person.’ Clinicians of all stripes share stories of the time they “had a hunch” that something was wrong. But what Rachel emphasized was neither luck nor intuition but the skills necessary to be a good NP. Rachel listened to the patient instead of telling her to “go home and get a life.” She paid attention to the whole person rather than relying solely on diagnostic tests. Nursing’s emphasis on whole person care was reworked into an NP strategy of action for the exam room.

Whole person care required one to not only pay attention to what happened in a singular encounter. One had to know the patient. Relationships with patients appeared often in clinical decision-making narratives. In one lecture on acute respiratory infections, guest lecturer Suzanne Weathers, MPH, CRNP, discussed treatment options for community-acquired pneumonia. She explained that one of the key decisions they will need to make is whether treatment should be provided at home or in the hospital. ‘We’re moving away,’ she warned, ‘from pure “gut” decision making.’ To make this point, she demonstrated a severity index calculator that was designed to take the guesswork out of treatment setting. ‘However, you also need to evaluate the context of the patient.’ And she began to tell a story.

Suzanne described seeing a 78-year-old woman who had been her patient for years. The woman presented with pneumonia. According to the guidelines, the age of the patient indicated hospital treatment. The patient was opposed; she had a cat she did not want to leave alone. Suzanne decided to treat the patient at home. She knew that the woman had a support network that could alert her to any changes in mental functioning. She also called the patient daily. As Suzanne finished her story, a student raised her hand: ‘What if you didn’t know her and she didn’t want to go to the hospital?’ Suzanne paused before answering: ‘Well, nobody wants to go to the hospital. But if she had just walked into my office and I hadn’t seen her before? I would have sent her to the hospital.’ Without knowing the patient, an algorithm limited provider discretion. Because Suzanne knew her patient, she was able to provide whole person care.

Other stories directly addressed the clinical importance of relationships. Steve, the case informed us, was a 28-year-old Caucasian male complaining of chronic back pain. He had been in a car accident six years ago, but the pain never went away. He requests a prescription for Percocet, a combination of a narcotic and an over-the-counter pain reliever. He tells you that his last doctor refused to renew the prescription. Steve was presented as “an ethical” rather than clinical case. The ethical dilemma was primarily that Steve was instantly recognizable as a drug-seeking patient. Despite this recognition, the conversation began with an assertion of complexity. Jenna believed this was “a sticky situation.” ‘Perhaps he is addicted to Percocet. But addiction is a medical condition that needs to be addressed.’ Matt counters, ‘But this is Steve’s first visit; it’s probably not the time to bring up drug addiction. He’d never come back.’ Matt, half seriously and half in jest, suggested giving Steve a prescription for 10 pills and making a follow-up appointment to see whether they could come up with a different plan for treating his pain. The instructor reminds them of their responsibility for the evidence. ‘Is Percocet indicated for this kind of pain? For back pain?’ There is agreement that no, according to the guidelines, Percocet is not indicated. ‘But,’ the instructor adds, ‘Matt is right about one thing. This is a dilemma of the first visit. How do you go forward with someone where you don’t have a relationship but would like to build one?’ The relationship between the provider and patient became the crucial point on which the discussion hinged. Published guidelines provide clear limits for pharmacological treatment of back pain. However, addressing Steve’s needs was more complicated than ushering him out of the office. The primary strategy for managing this complexity revolved around the possibility of future relationship. The skill of the NP would be gauged by whether or not Steve returned.

Remaking Relationships: Physician Recognition

The construction of NP skill is not only an internal matter; it requires cultural work on the physician side of the boundary. NPs define their new relationship to physicians as collaborative. Collaboration invokes mutuality in that it requires that physicians recognize NP expertise. It is questionable how much influence this ideal has on physician action. However, there was room to work on narrated physicians in NP educational accounts. When physicians appeared, they were congenial colleagues who respected the NP’s expertise. Lecturing NPs would routinely cast the physicians with whom they worked as coworkers to whom they turned for advice. However, they would also tell stories in which physicians did the same.

In one example, we listened to guest lecturer Catherine Brady, MSN, CRNP, deliver a lecture about urology. As with most speakers, she embedded stories about her professional orientation within the didactic content. For Catherine, the line between physician and NP expertise was hard and bright. ‘I tell patients before I even do the exam, “I’m going to examine you to see if I can treat you as a nurse. I’m not a urologist; I’m not a doctor. So if I see something that’s out of my league, I’m going to have you see someone else.”’ Catherine was unusual in voicing explicit deference to medical knowledge, but she was not unusual in telling stories with a physician presence. As Catherine delivered a lecture about urinary incontinence, she described a case from her own practice.

The case was an 83-year-old woman whom Catherine had successfully treated for incontinence in the past. The woman returned because her incontinence reappeared.

Well, we did a dipstick, and there was blood in her urine. I spoke to the doctor, and he said, “blood in the urine—she may have bladder cancer.” I said, well, she has lots of vaginal dryness and I think this may be part of the problem. The doc said, “well, I’d send her right to urology. But I’ll go with you Cat, to see what happens.” So, I gave her estrogen cream, and on follow-up, the UA [urine analysis] was clear. No more blood in the urine and her incontinence had gone away. (Reconstructed from field notes)

Catherine’s story dramatized both nursing deference to medical expertise and physician consideration of nursing’s expertise. Catherine was “not a doctor.” She was a nurse. But in her telling, that designation carried its own weight. As Catherine continued her lecture, she narrated a fuller sense of what it meant to treat a patient “as a nurse.” She referred to “nursing interventions” she used in her practice. Much like the estrogen cream in the narrated case, these interventions were marked by simplicity and effectiveness. The simplicity was not about the problem itself but about a professional approach. Catherine simultaneously recognized physician knowledge of the esoteric while asserting the difference and utility of nursing knowledge.

Students also brought back stories of the possibilities for physician recognition. Matt recounted a conversation with one of his physician preceptors where he asked directly about the physician’s feelings about NPs. The physician answered by talking about the NP in the office, noting that she had been practicing longer than he had. “And he said, ‘there are some things she knows that I don’t know. And if she has questions, she can come to me.’” Acknowledgment of NP expertise was not only about whether an NP might have knowledge that a physician does not have but that he or she might have a different approach. Brooke described her first day at one of her clinical sites. She was “chit-chatting” with Dr. Morris, the owner of a suburban primary care practice.

He was telling me about seeing four generations of patients. And I said, “oh, they must love you.” And he said, “No, not really. But they love Simone [the NP]. They ask for Simone; they want to talk to Simone.” Because you know, Dr. Morris is very—it’s like the medical model. “Okay, what’s wrong with you? Okay, fix it. Done. Okay, next.” And the nurse practitioner comes from the nursing model, which is very holistic [and] relationship-based.

The value of nursing’s difference was about both patient preferences and clinical outcomes. During a set of lectures on childhood immunizations, Darlene Palmer, MSN, CRNP, began to tell a story of a mother who resisted immunizing her son. The mother’s first child had a seizure following a set of vaccinations. Consequently, she was adamantly opposed to vaccinations for her second child. Darlene explained that some physicians try to reason with the parent. But she advised, ‘I don’t go head-to-head, cognitively. I don’t ask them to show me evidence.’ Darlene stressed that they needed to directly address the real problem, which was fear. Their job as NPs was to acknowledge that fear and to use it to build common ground. Darlene advised, ‘come at this just like a nurse would; not like a scientist.’ As NPs, they would prove their value to both patients and collaborating physicians by demonstrating the utility of nursing-centered practice.

### A2: Moore and Drake

#### SOP laws are a relic of slavery rooted in anti-black professionalization of nursing – the aff is a necessary prerequisite to healthcare transformation

Moore & Drake 21 (Shawana S. Moore, DNP, MSN, CRNP, WHNP-BC, and Diana Drake, DNP, APRN, WHNP-BC, FAAN, FNAP, “We are the solution to our problem: A brief review of the history of racism and nursing,” August 2021, https://www.npwomenshealthcare.com/wp-content/uploads/2021/08/2021\_WH-August\_History.pdf)//NRG

Some of the most obvious examples of healthcare’s history of racial injustice include the exclusion of African Americans from medical and nursing education.8 American nursing history often excludes the Black nurse experience and its leaders. The professional nursing role emerged in the late 19th century amid the recent end of slavery and deeply entrenched racism. In 1878, Mary Mahoney, the first Black professional nurse in the US, was admitted to a nursing education program in a New England hospital under a policy that limited admissions to other than White European Americans to one African American and one Jewish student for each training class.21 Mahoney became the first US Black professional nurse. Just 17 years earlier, Florence Nightingale was recognized for founding the first formalized training school for nurses at St. Thomas Hospital in London in 1860. Nightingale selected small contingents of White European women of the “right caliber” (eg, character) to train for 1 year.14 Since that time, nursing practice as an “all-white female profession” has persisted in many forms and iterations despite numerous examples of Black Nightingales such as Mary Seacole, Susie King Taylor, James Derham, Bernice Redmon, Anna DeCosta Banks, and Estelle Osborne, to name a few.21

In US nursing schools, Black women continued to be restricted or denied admission.22 Some of the Black physicians and nurses who were often barred from practice privileges at local hospitals, collaborated with the Black community and opened their own hospitals with schools of nursing to educate Black women.23 In 1906, the National Association of Colored Graduate Nurses was created to address the specific needs of the Black nurse and timely issues such as racial segregation.24 In 1916, the American Nurses Association (ANA) required members to join via state nurses’ associations. At the time, most state nursing organizations denied membership to Black nurses, effectively excluding them from this national professional organization. Many states prevented Black nurses from taking the examination to become registered nurses and in agencies that employed Black and White nurses, Black nurses were often paid considerably less than White nurses.

Over time, incremental and hardwon social justice changes were accomplished through mass social movements that challenged structural racism.8 These changes resulted in laws that countered, but did not end, the long history of discrimination in academic admissions and work environments. In 1946, the Hill Burton Act provided funds for racially integrated hospitals. In 1954, the Brown vs Board of Education struck down “separate but equal,” and the 1964 Civil Rights Act prohibited discrimination by race in public places, schools, and any public facility. In summary, the historical roots of racism in nursing and healthcare in the US have a long history of opposing desegregation and broader access to care, of barring or restricting Black nurses and physicians from receiving training and working, of championing racism in research, and of perpetuating race as a biologic variable.8 The necessary work to dismantle structural racism continues to be at the forefront of an urgent call for the large and trusted nursing profession to confront and lead the work for healthcare transformation. As one author wrote: “Only when we consider racism and racial inequality to be persistent and implicit in our norms of practice and the ordering of society and not the exception, can we effectively begin to confront this issue.”

## K

### 2ac – fw

#### Antitrust policy debates solve the historical inaccessibility of legal change and are prerequisite to radical re-structuring

Greer and Vallas 21 (**Jeremie Greer**, Co-Founder and Co-Executive Director at Liberation in a Generation, a national movement support organization building the power of people of color to totally transform the economy, Soros Equality Fellow, racial justice activist who began his career as a community organizer in the Columbia Heights and Shaw neighborhoods in Washington, DC, and national policy expert on the causes and the policy solutions to close racial wealth gap, formerly working at the Government Accountability Office, the Local Initiative Support Corporation, and Prosperity Now (formerly CFED), MPP George Mason University, BA Social Work, University of St. Thomas, currently working on an Executive Education Certificate in Nonprofit Leadership from Harvard University’s Kennedy School of Government; interviewed by **Rebecca Vallas**, senior fellow at The Century Foundation, work focuses on economic justice, formerly spent seven years at the Center for American Progress, built and lead CAP’s Poverty to Prosperity Program, and helped to establish CAP’s Disability Justice Initiative, the first disability policy project at a U.S. think tank, as well as the organization’s criminal justice reform work, her policy and advocacy work flows from her years as a legal aid lawyer, representing low-income individuals and families at Community Legal Services in Philadelphia, creator and host of Off-Kilter, a nationally distributed podcast about poverty, inequality, and everything they intersect with, JD University of Virginia, BA psychology, Emory University; “Reimagining Anti-Monopoly Activism Through Racial Justice — feat. Liberation in a Generation’s Jeremie Greer,” Off-Kilter Podcast, 3-26-2021, https://offkiltershow.medium.com/reimagining-anti-monopoly-activism-through-racial-justice-feat-e3a124c1c61)

VALLAS: Well, and hearing you mention that you’d experienced, and I think very justifiable, dissatisfaction with the way that some of the kind of traditional Washington-based think tanks work on these issues, right? Often it’s about cutting poverty or reducing homelessness, right? And just the contrast with some of what you at Liberation in a Generation and Solana and the team that you guys are building there are, the things that you’re pushing for, right, are just on a different scale. And in some ways, it’s about helping people understand that maybe we can imagine a different world rather than just tinker at the edges.

I want to read another paragraph from this report. You write, “Imagine a world where the unemployment rate for people of color is zero, the unhoused rate for people of color is zero, a world in which 100 percent of people of color have quality healthcare, a livable wage, quality education. We at Liberation in a Generation,” you write, “believe that this is possible if we strive to create a liberation economy where all people of color have their basic needs met, are safe and secure, are valued and fully belong, including people of color who are immigrants, formerly incarcerated, LGBTQ, and have a disability. You finally write, “In order to get to this liberation economy, we must dismantle the oppression economy that monopoly power has colluded with the government to maintain.” And this gets us into really talking about the topic in this report, which is anti-monopoly activism.

Start with a little bit of a primer of what we’re facing. I mentioned a couple of stats up top in the intro helping put sort of a recent and updated lens on how good it is to be a monopolist these days, right? By contrast to everybody else who’s living through this pandemic and not experiencing billions and trillions of dollars of wealth increases. Start with a little bit of a primer of what we’re facing: the rise of unchecked capitalism and monopoly power such that we’re essentially living in a new gilded era, as the report argues.

GREER: Yeah, and just, I mean, you have to, to fully understand the power of, monopoly, you have to understand it through the lens of people of color who have to deal with it. So, in Iowa, and, you know, there’s folks with People’s Action that are organizing people in rural communities around the threat of monopoly. But if you’re looking at Iowa, a corporation like Tyson Foods has managers who are sitting around on the floor (and this is documented in the media) making bets about what worker was going to get sick and die from COVID. Like, the inhumanity of that, I think, is just appalling. But it just shows the dehumanization that monopolies have created for workers, for consumers, for small businesses, and everybody that’s impacted.

And the reason why is because at the core, monopoly power is about exactly that: power, who has it and what they do with it. And what we have when you have monopolies, it’s not just about the size of the firm. There’s a lot of focus on the size of the firm. But what it’s really about is does that firm have a disproportionate amount of power, and what are they doing with that power? And what monopolies today are doing — Amazon, Moderna, Pfizer, JPMorgan Chase, Bank of America, Wells Fargo, Facebook, Google — they’re taking the power that they have around consumer prices, around workplace conditions, around wages, around the impact that they have in community, and the influence that they have on government, and they’re using that power to profit off of blatant systemic racism that is falling down upon Black and brown workers. And that is, for us, the real fight that we feel when you look at monopolies. And that the current system in which we use to try to govern monopoly power is totally inadequate in dealing with the kind of impact that the monopolies have on Black, Indigenous, Latinx, and Asian-American people in this country.

VALLAS: Now, folks who are listening probably all assume that they know what a monopoly is. But I’m going to sort of poke a hole in that and say, you may think you know what a monopoly is. But Jeremie’s got a slightly broader, and I think, more updated definition that’s used in this report. How do you define a monopoly for purposes of what you guys are doing in this work? And why do you propose a somewhat broader definition?

GREER: Yeah. So, you’re right. The current kind of anti-trust definition of a monopoly really focuses on the impact that monopoly power or corporate power has on consumers, and particularly on consumer prices. So, will you pay more for a product because of the monopoly power that a company has? And as I mentioned, we believe that that’s totally inadequate to really understand the full breadth of what a monopoly is. Monopolies have, yes, they have incredible control over consumer markets and prices. And we see that in healthcare, you know. So, the price of insulin is much higher because of the monopoly power that a company, that pharmaceutical companies hold.

But monopolies also have power over worker wages, the working conditions in which workers show up to work and have to live through. They have incredible power over small businesses. All across the country, we see small businesses being crowded out by monopoly power. They have the political power to almost dictate to local communities how much they’re willing to pay in taxes, which means the crowding out of essential services that are provided to communities. And what we observe in the report is that too often, the impact of that monopoly power falls squarely on the shoulders of people of color, whether they’re workers of color, consumers of color, whether they’re small business owners of color, or whether they’re just people of color living in communities that are looking to their local government to really help them navigate life in the economy.

VALLAS: And I want to quote you, because you offer, I think, a really, really smart definition here in the report. You say, “We define monopoly as a corporate entity — a single corporation, or a group of corporations — whose sheer size and anti-competitive behavior grant it disproportionate economic power and governing influence.” And as you’ve been describing, you say, “This negatively affects the well-being of workers, consumers, markets, local communities, democratic governance, and the planet.” That’s a somewhat broader definition than maybe the sort of technical antitrust definition of monopoly. But for all the reasons you’re starting to get into, you really, you argue in this report that it’s necessary that we think a little more broadly and a little more functionally about who’s operating like a monopoly, and therefore where we need to be thinking about challenging unchecked corporate power.

You’ve already started to delve into the link between unchecked corporate power, monopolistic behavior, and the numerous types of racial injustice and structural racism that run rampant throughout the U.S. economy and our broader society. But you have a very powerful way that you phrase this in this report. You say, “Racial wealth inequality,” and you specifically are talking there about racial wealth inequality, “is the consequential disease caused by the oppression economy.” I can’t remember reading another publication about monopolistic behavior and the need for an anti-trust movement that draws such a direct causal link between monopolies and the ways that they operate, and racial wealth inequality and structural racism. Talk a little bit about how monopolies are contributing to the immense and historic levels of racial wealth inequality that folks are maybe more familiar with, but not aware of that link.

GREER: Yeah. No, thanks for that question. And what I think of an important distinction around the framing there is that, yes, it is driving, monopolies are driving racial wealth inequality. And yes, monopolies are a product of an oppressive economy that is, you know, where racism is baked into the design of the economy. But they’re also a profit tier, they are gaining profit from the existence of that oppression economy. So, it is in their interest to sustain it and maintain it and to keep it going. And an example that we draw out in the paper that I think is so important and I think really illustrates this is, as we mentioned, one of the pillars that holds up the oppression economy is the criminalization of people of color. That people of color as criminals, or defined as criminals, and mass incarceration, the over-policing of Black and brown communities is something that upholds this oppression economy. And then when you have a company like Amazon who purchases the Ring Corporation —

And for those that may not be familiar, Ring is a product that’s provided by Amazon in which they provide surveillance and home security to everyone. You can get a little Ring doorbell where someone rings the door. You could be at work, you can open it. It’s like, “Oh, cool. Leave my package there.” That’s how they market it. But what that does is that that Ring device pulls in a lot of data. And what we have is cameras in homes all across the country that can be used to surveil people. And what we know is one of the things that police do is they over-surveil Black and brown communities, which leads to the type of mass incarceration that we’ve seen in this country. Well, Amazon has contracts, in fact, 770 contracts with police departments so that they can get the data from those Ring devices. So, I think that really illustrates that not only are monopolies driving racial inequality through the low wages that they pay workers, through the way that they crowd out Back businesses, from the way that they treat immigrants at the workplace, but they’re also actively doing things to prop up and uphold this oppression economy because they are profiting from it.

VALLAS: And I really want to encourage folks to read the report, especially activists and advocates who I know we have lots who listen to the show, folks in grassroots-based work who I think are really going to find this report very much geared towards them. That’s another really, I think, significantly unique aspect about what you guys have done here. This isn’t the kind of think tank report that you traditionally read, right? In a lot of ways, you actually really wrote this for, and almost to, grassroots leaders of color as sort of a primer on anti-monopoly activism, but also as something of the beginning of a tool kit that really could help people start to take this on as part and parcel of their work. I’d love to get a little bit into kind of why you structured the report this way, why you took this somewhat different approach in writing, not just for the media and for policymakers and for the Washington elites, but actually for grassroots leaders of color on the ground.

I’m going to quote you again. You write, “This paper aims to contribute a major step in the long journey of bridging the divide between anti-monopoly researchers and policy advocates and grassroots leaders of color.” And you write, “The first step on that journey is knowledge.” What does the current anti-monopoly fight look like? And why do you believe, and Solana as well, why did you guys prioritize bridging this divide?

GREER: Yeah, so, as I mentioned in my opening about Liberation in a Generation, we believe that the leaders that are going to lead us into having a liberation economy and dismantling this oppression economy that we’ve been talking about are grassroots leaders of color who are building power in communities. And the reason why we believe that is one, they are closest to the people who are experiencing the pain and harm of systemic racism. They are in there with them, they understand, they hear their stories, and they’re organizing them for change. The other thing that we believe is so important is that they are in the business of building the power, the political power, of those people. They’re not there to serve them, which there’s people that do that. And there’s a reason for that, and it’s important. But they see their role in helping those people build power so that they can have the agency to force their government, whether it’s a local, state or federal, to act on their behalf.

And we believe that if one of the government’s roles is to curb corporate monopoly power, they should be the ones driving that change. Because they will come with experiences, which we try to reflect in the report, of how monopoly power is impacting communities. You know, how a Amazon distribution center in the Inland Empire in California is impacting not just the economic life, but the quality of life of people in those communities. They could speak to that in real terms. And that not only does the advocacy need to be informed by that, but also the policy making needs to be informed by that.

So, what we did was, with that kind of assumption, we went to groups like the Athena Coalition, who is organizing people against Amazon across the country. We went to Color of Change, who’s an organization that is focusing on curbing the power of big tech: Facebook, Amazon, Google, Apple. We went to ACRE: Action Center for Race and the Economy. And they’re doing a lot of work focusing on big banks and the corporate and monopoly power of big banks. And we said, you know, what is holding the kind of grassroots movement back from really diving in, into this anti-monopoly issue? And they came up with, there was a lot of reasons, a lot of varies they identified, and some of them that we’re working with them to solve.

But one of them was, you know, we don’t have kind of a global understanding of how monopoly power impacts people of color in particular. We understand it through the lens of a particular firm, Amazon, Bank of America, like that. But we don’t really have a good grounding in how it happens globally. Therefore, our policymaking doesn’t have kind of an eye towards how could we globally and kind of more broadly address this problem in a way that impacts people across the economy? So, that’s what we hope that this paper would do: would provide that kind of grounding for grassroots leaders so that they can begin to build the type of strategies that kind of have that massive economy-wide impact for people of color.

VALLAS: And it might be eye-opening for grassroots leaders who are learning about this issue, who are exploring whether this is something that they can get involved with. But it’s also potentially eye-opening for people who already think they know the antitrust movement or the anti-monopoly movement, given that it is incredibly rare, as you point out, for conversations about the economy to really discuss human impacts. They’re often extremely technocratic conversations, right, that have lots of facts and figures and jargon. But something that you really make a point of doing in this report, which I can’t say I’ve ever seen in a report on monopoly power or anti-trust, is you really walk through the human impacts on people of color as workers, as consumers, as residents in local communities, as small business owners and entrepreneurs, and also as subjects of surveillance, similar to the Amazon Ring concerns that you were raising before. Share some of the examples in the report of those kinds of human impacts on people of color who can obviously be more than just one of those things in that list of categories.

GREER: Yeah, I’ll share a couple. There’s one that really, I mean, really broke my heart when I first read about it was Alec Raeshawn Smith, whose mother — and this is something that’s in the media. So, it’s not as if I’m violating any confidentiality here — but Alec Raeshawn Smith, whose mother, he aged off of his mother’s insurance plan. And this is a story we heard a lot during the ACA kind of debate and the debate around universal healthcare. But he aged off of his mother’s insurance plan, and he made this diff-, had to make this difficult choice about whether he continued to allow his mother to bear the burden of his insulin medication that he needed to regulate his diabetes, or whether he would try to do it kind of on his own. And he determined, he decided to do it on his own. And it’s a hard decision that people have to make every single day, but the cost of that insulin was so high that he was rationing it, that he wasn’t taking what the doctor prescribed. And he passed, and he died from his diabetes.

And this is the type of story that we see all too often. You know, his insulin costs were $1,300 a month without insurance. And we see that a corporation that can control pricing of pharmaceuticals for a lifesaving drug like insulin is how this plays out in real life. And we can get into a law, you know, you can get into a law classroom or into a debate on Congress, and you can start to forget about the real lives that are impacted by these policies. And the reason why we wanted to talk about these stories is because that is what organizers are dealing with every day: They’re working with people that are on insulin, you know. They are working with people who are working at a Amazon fulfillment center. They’re working with people who can’t get a bank account because Bank of America has all these fees on their credit cards and their checking accounts and things like that. So, bringing these stories out is what is going, and this real human impact, is what is going to mobilize, we believe, the type of effort that’s needed to fight back against monopoly power.

VALLAS: And I think we’ve got time for a few more examples, because it just, it isn’t the part of the conversation that usually gets any airtime. And it’s part of why I wanted to have you on the show is really to put a human face on some of the impacts. Share a few more examples that really, that popped for you as you were pulling this report together.

GREER: Sure. I’d love to talk about John Ingram, who is a Black farmer in Jackson, Mississippi, and he’s a chicken farmer. He grows chickens, and he sells his chickens to Koch Foods, K-o-c-h Foods. And they are the fifth largest poultry company in the country that provides food to places all across the country. But the model which they work with John is very much in the model of the sharecropping model from post-Civil War and on into the Jim Crow era. You know, they determine the way in which John must run his farm, like to how much he feeds his chickens, to the types of facilities he keeps his chickens in, all the way to the price that they will pay to buy his chickens. And what this does is create incredible power over Black farmers like John. And what you have is — And this is pretty much allowed to take place by the USDA.

He had complained, and Black farmers, many Black farmers complained to the Obama-era USDA. And because of the power of those poultry monopolies — you know, I mentioned one in the beginning, Tysons and Koch is another — they really didn’t do anything. And what we see across the country are Black farmers being forced out of business because of the power that these monopolies have.

Another example that I think is really good is also in Mississippi. There’s a Nissan plant that was built in Canton, Mississippi. They relocated there. And they had gotten there because they had gotten a lot of tax breaks from the local government, from the state of Mississippi. And they did so with the promise of good jobs. They talked about jobs would be between $26 and $26 an hour. Well, the type of jobs that they provided were called perma-temp jobs. And these are basically permanent temporary jobs, which I can’t really wrap my mind around what that is, because those are conflicting. Like, what is something that’s permanent and temporary? But they created these jobs that were permanent and temporary, which basically meant that they could at will fire people from their jobs.

So, these aren’t real sound jobs. The wages were low. They did not get great benefits. So, a lot of the promise that was offered was not delivered upon. And that these were primarily the jobs that were provided in this part of Mississippi, despite the millions in tax breaks that Nissan got from, again, the state of Mississippi and the local government there.

VALLAS: And there’s so many more examples throughout the report. We’ve got a link and show notes so folks can go in and can sort of page through. It’s written in an incredibly accessible way, right? So, I want to just make that point. You intentionally set this up so that you don’t have to be a lawyer to read this. You don’t have to be a deep antitrust expert to be able to read this. This is actually really for people who might be a little bit newer to the issue.

And one of the big kind of frames of the report as well is you spend a lot of time discussing how, you know, hey, we know folks are busy. We know folks are fighting a lot of fights right now and probably don’t feel like they’ve got one more to take on, space for one more to take on. But you really make the point that for folks who are working on, say, advancing the Green New Deal or the Homes Guarantee or other policies within the social and the economic and the racial justice advocacy sphere, you really make the point that challenging monopoly power is actually a prerequisite to succeeding in those other fights. What’s your message to advocates and to activists and policy folks, anyone who’s listening or who might read the report, what’s your message to them about why they should see the anti-monopoly fight as their own, even if they feel like that’s not the space that they work in?

GREER: Yeah, I mentioned Action Center for Race and the Economy. Mo BP-Weeks, who is a co-director there, often says, You just have to follow the money.” And I think organizers know that when you follow the money, you usually find exactly the targets that you need. And there’s a section in the report called Monopoly Power Is Corporate Power Magnified and Maximized. And we believe, and I think that we’re right, that if you focus in on and treat these monopolies like corporate entities, you can begin to see change in a lot of the transformative movements that people are having, for example, the Green New Deal and efforts to create a more equitable and healthy environment and to curb climate change. You know, the targets are Big Oil and Big Energy. And those institutions, while they’re large, still operate like corporations. They have a CEO, they have Board of Directors, they have shareholders. And all of those people have some stake in the company and have some culpability to the issues that you are trying to solve. So, it becomes another tool in the toolbox.

We believe that anti-monopoly advocacy is just another tool in the toolbox that could be used to curb corporate power so that you can begin to get wins on other issues that you may be focusing on, whether it is the environment, whether it is affordable housing, whether it’s creating higher wages for workers, whether it is to create a safer community free of police violence. We think that by focusing on curbing the monopoly power of the corporations that are causing that pain is just another tool that can be used in the advocacy for those broader kind of movement priorities that we hear a lot about.

VALLAS: Now, one of the things that you and I have talked about a good amount before, and something that we actually get into a lot on this podcast, is the narratives that are out there that we’re often sort of fighting against that might be invisible, but that shape people’s views about, say, the economy and economic policy, even if they’re not aware that that’s the sort of lens that they’re looking through or the pair of glasses that they’re looking through. It’s also something that you really spend a lot of time working on. And it’s very, it’s central, really, to a lot of what Liberation in a Generation is advancing, is narrative change, right? Especially dismantling, for example, the neoliberal narratives that are really at the root of so many of the social injustices that folks who listen to the show are out there fighting every day.

You talk about government, in the case of the anti-monopoly fight, as a villain and as complicit with corporations in allowing unchecked corporate power to do the damage that you’ve been talking about, that we’ve been discussing up to this point. But you actually talk about them in the context of the anti-monopoly fight government as the villain who could turn into the hero. Talk about why you think it’s so important to construct a narrative with a villain, with a hero. And we’ll get back now into kind of the policy conversation of this, why government has the potential to turn from being a villain to being a hero in this context.

GREER: Yeah, I mean, it’s really, when you look at the history of anti-monopoly advocacy, you see that there once was a time where the government was an active participant in curbing corporate power and was doing so on behalf of workers. You know, you see there were passages of transformative legislation like the Sherman Act or the Clayton Act or the Federal Trade and Commissions Act. And these were all passed in the early 20th century. And they were meant to curb this kind of corporate monopoly power in, you know, back in the Gilded Age when we saw the trust corporations, the railroads, the Carnegie steel industry. And there was this active role of government doing this.

But what we’ve seen since then is, as corporate power grew, begin to influence government more, a real devolution of that activist role the government played. And what we began to see really, you know, and probably the heyday of this for the monopolies began in the 1980s and continues on today, was actual collusion between the government and these monopolies. And that what we saw, what we see today is there have been, there were more mergers and acquisitions under Obama administration than any other administration before it. So, we’re at the point now where the government is really seen as a, it’s really a collaborator in building monopoly power.

What we need to get back to is a place where the government is playing its role in making sure that not just the, it’s not just about the size of the company, but that the company’s power is not getting to the point where they’re bringing down the standard of living for workers, particularly Black, Latinx, Indigenous, and Asian-American workers. That consumers are seeing the type of prices so that they can afford the things that they need to live a daily life. That small businesses, particularly Black businesses, are not being crowded out. And that that is a role for government. So, government can be the hero, and it should be the hero because it is our government, you know.

We are a democracy. We should have say, each and every one of us, in what our government does, and our government should be working on our behalf, not on behalf of Jeff Bezos, Warren Buffett, or Elon Musk. We should be expecting the government to play that active role, and not just recognizing that it should be done for all workers, but ensuring that workers of color in particular and people of color, households of color in particular, are being protected against the tyranny of monopoly power.

VALLAS: And one of the later chapters in the report really offers kind of a primer in some of that early 20th century history that you were just summarizing around the time when government in the U.S. actually did take action to rein in monopoly power. You mentioned the Sherman Act and the Clayton Act and the creation of the Federal Trade Commission, all of that, I would encourage folks to go in and read. And there’s probably a lot that folks don’t know about that era following the gilded era, that really was the time when the federal government in the U.S. did actually take action to check corporate power. Who are the key players with power in the federal government to do something about this? And what are some of the existing solutions that are being advanced?

GREER: Yeah. So, today, I mean, it’s your Congress, of course, has a lot of power. Because there’s an, I believe, there’s a need for new kind of legislation that new powers be created, new constructions of how we regulate monopoly that only Congress could do by passing laws. But under our current laws, the Federal Trade Commission is responsible for responding and kind of being the first, the cop on the beat to make sure that companies aren’t violating any of our current antitrust laws. They can issue criminal and civil penalties, and they are the ones who are in charge of enforcing those kind of monumental legislation that we’ve talked about.

The Justice Department also has a important role in moving legislation forward. In fact, they are the entity that when you hear about breaking up corporations, the Justice Department is the one that usually does that. And they’ve done it in the past. You know, they did it. They broke up the big railroad monopolies of the past, and they broke up AT&T in the 1970s into what they call the Baby Bells. And they currently have a lawsuit today against Google to look at Google’s monopoly power. And in the lawsuit, there’s a call for breaking it up into smaller pieces. So, there’s that.

And then there’s other agencies, you know. As it relates to banking, it’s the Department of Treasury with the Comptroller of the Currency and the Federal Deposit Insurance Agency, the CFPB in banking. In agriculture, it’s the U.S. Department of Agriculture. In energy, it’s the Department of Energy and the Environmental Protection Agency. Each of these industries kind of have their own government entity that is responsible for regulating the work that they do. And they play a role in curbing corporate power. And one other one that I’d mention is states. State Attorney Generals also have a lot of power to curb corporate power, because one thing that’s little known is that states are the ones that incorporate corporations. And so, they have a lot of ability and a lot of power to regulate agencies.

As far as solutions go, there’s a lot of solutions that are kind of out there. And what this report does not do is propose to put forth a particular solution that would work for people of color, because we actually think that that’s the work that grassroots leaders of color should embark on in the future, is designing and developing those particular solutions. But some of the solutions that we have in our toolbox today are, for example, breaking up large corporations. That is something that we can do today. We can also regulate, tightly regulate corporations using the existing tools in the toolbox. The CFPB and what it’s done in the banking industry is a good example of that.

But one idea that’s been batted around, and I think Elizabeth Warren proposes for big tech in particular, is new enforcement agencies that are more in line with the realities that we see in the economy today and the way in which monopolies form. A lot of our laws are meant, were developed to regulate railroad and steel monopolies, and those aren’t the monopolies that we’re seeing today. So, there is a group of folks out there talking and saying that there’s a real need to think about new agencies with new authorities that could regulate monopoly power.

VALLAS: And of course, it’s not exactly a pie-in-the-sky idea to think about creating those new agencies. Elizabeth Warren, who you mentioned, right, was the godmother of the Consumer Financial Protection Bureau, the CFPB, which is pretty young as far as federal agencies go. It was created during the Obama years. Although that may feel like a different lifetime at this point in a lot of ways.

We’re going to run out of time. But the last couple of minutes that we have, I’d really love to spend delving into the recommendation that really is, in a lot of ways, the kind of central call of this report. A lot of it is really addressed to grassroots leaders, and for the reasons you’ve discussed, right, about bridging that divide. But it’s also addressed to the existing anti-monopoly tent: the folks who are already working within research and advocacy spaces on these issues. And you say very pointedly, “The anti-monopoly movement, within research and advocacy spaces especially, should embolden grassroots leaders of color to deliver anti-racist policy solutions aimed specifically to curtail monopoly power.” So, there you’re describing that agenda that you think grassroots leaders really should be centered in developing. But you continue. You actually, you sort of raise the ante with this call. You also say, “It’s not enough to speak virtuously about racial equity and economic justice. We have to intentionally center people of color in the development of policy change.”

And you call explicitly for a reimagination of this movement through a racial justice lens that broadens the tent and intentionally makes this work more accessible and more human-impact focused so that it’s not just about bringing folks in and centering the work differently. It’s actually about doing the work differently, entirely, so that it’s not just that technocratic and sort of small-tent D.C. elite approach to changing these policies. Talk a little bit about what that actually would look like. You have some pretty specific ideas that, I agree with you, would actually transform the anti-monopoly movement in ways that would reimagine it and approach the work differently. Get concrete. What would that actually look like?

GREER: Yeah, and thank you for this question, Rebecca. You know, I mentioned that history. And I think what we know about public policy and the history of public policy in the United States, whether it was this antitrust movement in response to the Gilded Age, whether it was the New Deal, is that when it’s done in a race-neutral way, it doesn’t just leave people of color behind — Black, Indigenous, Latinx, Asian Americans — it also harms people of color. And what we need to do is, of course, what we can learn from that history is that we should not repeat it. And we should not repeat it, by centering people of color as the core beneficiaries of the policy. Because we believe if that is done, not only will they be served, but we will all then be served because we’re ensuring that we’re not leaving anyone behind, and we’re not intentionally harming anyone. And we think that that’s so critically important in this kind of new era of antitrust policy that could come forth.

You know, we talk about this renaissance of antitrust back in the early part of the century, but at the time, many Black people could still not join a union. Many, many Black people could not get jobs in these new corporations that were being formed by the railroad, by the breaking up of the railroads. So, we have to acknowledge that the implementation of policy and ensuring that all people are a part of it are critically important. And we believe that no one is better at that than people that organize, that are in fellowship, and work with people of color every single day closest to the problem can do. And that that knowledge that they have, that expertise that they have in those folks’ lived experience, is exactly what policymakers need to craft the type of policies necessary. It is what the think tanks in Washington need. It is what the policymakers on Capitol Hill need. It is what the entire advocacy apparatus needs. And we would like to see that being applied to this area.

But what that means is not bringing people to the table in a kind of like, you know, tell us what you think, and then we’ll get back to you. We actually believe that those folks should be leading those conversations. They should be leading the crafting of that policy. And that the role of the think tank or of the policymaker or the antitrust lawyer should be to support them in that endeavor, but with them at the helm. And we think that that is critically important in all areas of policy, but especially in this one that has been so technocratic, so legalistic, so academic, and really devoid of many of the lived experiences that people have navigating the economy and fighting back against these monopolies.

### Link – Antitrust

#### Antirust K all wrong. Reductionist *and* rejects tools that curtail violence.

* … post-dating oddly matters bc past examples don’t assume how the Aff/Khan might deploy anti-trust.
* … more than link D – Alt forgoes workable option to re-shape the very power they criticize.
* Author = uber-qual’d… peer-reviewed cultural theory journal recent lit..

Paul ‘22

Sanjukta Paul - Assistant Professor of Law, Romano Stancroff Research Scholar, Wayne State University - J.D., Yale Law School - From the article: “A Democratic Vision for Antitrust” - From the Journal – Dissent - Published by University of Pennsylvania Press - Volume 69, Number 1, Winter 2022, pp. 56-62 (Article) – modified for language that may offend - available via Project Muse

Last spring, prominent Big Tech critic Lina Khan became the new chair of the Federal Trade Commission (FTC)—an appointment widely ~~seen as~~ (considered) a coup for progressive reform. In her confirmation hearing, she characterized the agency’s overarching goal in terms of “fair competition.” This choice of emphasis is significant for understanding the antitrust reform project of which Khan is a leader. At its core, the project is a policy paradigm aimed at creating fair markets—markets characterized by socially beneficial competition, fair prices, and decent wages.

While both proponents and detractors of this reform project sometimes conflate competition policy with the goal of maximizing economic competition for its own sake, in reality, competition law has always assessed economic rivalry and coordination in relation to broader social ends. For a long time, that assessment has been obscured—not to mention insufficiently tethered to the original goals of federal antitrust law. The reform project aims to reorient the use of antitrust in expressly egalitarian and democratic directions.

For decades, competition law and policy have been dominated by the neoclassical law and economics paradigm, which claims that visible market design and coordination interfere with competitive dynamics that would otherwise lead to an efficient allocation of social resources, and thus to the maximization of social welfare. While recent shifts in mainstream economic thinking have led to more discussion of imperfect competition, particularly in labor markets, the “market failures” and power imbalances that justify interventions are on this view still essentially special cases. Moreover, this idealized picture of markets still obscures certain forms of background coordination—especially the often hierarchical and extractive coordination that happens within business firms—while treating other coordination mechanisms as exceptional, with the potential to distort ideal market outcomes.

Conventionally organized business firms are just one of the many means we have to coordinate economic activity; others include labor unions, producers’ cooperatives, and public price boards, to take just a few examples. Because competition law makes ground-up decisions about many forms of economic coordination, and influences the regulatory stance toward others, antitrust reforms hold the potential to affect a broad set of economic policies.

We should not act as if putatively neutral, technocratic appeals to idealized competition can replace moral and political choices about economic life. Nor, however, should we treat actual competition as inherently tainted by its association with neoclassical theory. Channeled appropriately, competition is healthy rivalry: it encourages technological and operational innovations that can have broad social benefits, and it represents an important check on arbitrary bureaucratic power by preserving outside options for workers, consumers, and businesses. Channeled inappropriately, competition can lead to the destructive undermining of rivals (in contrast to constructive outperformance), overwhelm socially valuable independent enterprises, and destroy existing market settlements characterized by fair prices and decent wages. There is no universal logic of competition for policymakers to apply, either dark or redemptive: it is legal, social, and political choices (almost) all the way down.

To move from principles to some specifics, we can ~~look at~~ (consider) the approach the reform project might take in three policy areas: policing corporate mergers and acquisitions, accommodating horizontal and bottom-up economic coordination, and re-regulating the law of vertical restraints. *These* reforms, which are mutually reinforcing, all have the power to help build a more equal and democratic legal organization of the economy.

## Health Links

### Woodly

We’re straight turning it -

#### Care” K *doesn’t apply*, *boosts material violence*, and ignores the Aff as a *“non-reformist reform”.*

Woodly ‘22

Dr. Deva Woodly is an Associate Professor of Politics at The New School. She is the author of The Politics of Common Sense: How Social Movements Use Public Discourse to Change Politics and Win Acceptance (Oxford University Press, 2015) and Reckoning: Black Lives Matter and the Democratic Necessity of Social Movements (Oxford University Press, 2022). In this journal article, Dr. Woodly is being interviewed by Sarah Leonard - who is the Publisher and Co-Editor of Lux, a magazine of socialist feminism, as well as a member of Dissent’s editorial board, and a contributing editor to the Nation. From the article “The Political Philosophy of Care” - From the Journal – Dissent - Published by University of Pennsylvania Press - Volume 69, Number 1, Winter 2022, pp. 28-35 (Article) – modified for language that may offend - available via Project Muse

The rhetoric of care pervades contemporary politics, from social movements to congressional spending debates. Some ~~see~~ (regard) “care” as a new framework for redistributive politics; others denigrate it as a self-indulgent language in which bubble baths get reframed as revolutionary praxis. In her forthcoming book, Reckoning: Black Lives Matter and the Democratic Necessity of Social Movements, New School professor Deva Woodly makes a case for radical Black feminist pragmatism as “a new approach to politics, one that takes lessons from many twentieth-century ideologies and forges them into a political ethic for our times,” and describes care as one of its key elements. The politics of care “holds that the activity of governance in a society that hopes to be just must be oriented toward the responsibility to exercise and provide care for those most impacted by oppression and domination.” The care paradigm has become popular, she notes, *after* decades of eroding social supports, stagnating wages, and demands to work longer hours.

I spoke with her about care as both a practice within social movements and as a new governance model. The transcript below has been edited and condensed for clarity. —Sarah Leonard

Sarah Leonard: Why do you think the framework of care is getting attention right now?

Deva Woodly: One of the things I noticed in 2014, when the Movement for Black Lives really became catalyzed in the streets, was its notion from Black feminism, particularly Audre Lorde, that self-care is a revolutionary act. Self-care was of course quickly commodified. *But* people were at their wit’s end, and the notion that caring could be revolutionary was something that people took up across political spectrums, across income levels, across other kinds of cleavages. It’s partly because people have been yearning so strongly for a language to talk about something that had been missing from mainstream politics. *Until recently* care wasn’t something that you could make a case for legislating about. Instead, people talked almost exclusively in terms of rights or prosperity.

Leonard: As this goes to press, we’re looking at all this potential social spending in the Build Back Better bill. Is this legislation part of a vision that you share, or does it feel like plugging holes rather than any kind of reorientation?

Woodly: I’m all for social spending that makes people’s lives better. The child tax credit is not a revolutionary policy, but it is a policy that has lifted half of America’s impoverished children out of poverty, and that matters. What’s being considered in Congress would reduce harm and make it possible for more people to care for themselves and others.

That does not absolve anyone of the need to continue to push to reorient politics away from the notion that having state funds be distributed directly to people creates an “entitlement society.” Instead, some of the people that we have elected recently, like Alexandria Ocasio-Cortez and Cori Bush, are saying that public money should be used for public goods. Period.

We can think in terms of what [the abolitionist activist] Mariame Kaba calls non-reformist reforms. When it comes to child care, even if some people are talking about it just in terms of allowing everybody to go to work, people become used to having affordable child care, which would be frankly a revolutionary change. Once you have a universal, not a targeted, program—targeted programs are not non-reformist reforms, because they’re always vulnerable—you can build upon them in the future. People become accustomed to not suffering.

Leonard: It seems like people are resisting that suffering more and more.

Woodly: This whole so-called labor shortage has a lot of origins. Part of it is a capital strike. But part of it is also about people having realized what [labor journalist] Sarah Jaffe says, that work won’t love you back. People rearranged their lives so that they could survive COVID-19, and having rearranged their lives, lost loved ones, and suffered in various ways, they are making different choices. That is one way that people are choosing to be self-determining. It opens up possibilities for new arguments to be made and new policies to be passed. Even if the Democrats in Congress mess up this bill, which they better not, the fact that it is so popular is also something to be aware of. It’s popular to give people what they need.

Leonard: It does make the right’s case against social programs seem very thin.

Woodly: Albert O. Hirschman wrote in the 1970s that when people in power want to discredit popular ideas, they use a rhetoric of reaction, which has three techniques: perversity, futility, and jeopardy. They would argue that the policy that you want to pass is not really going to help people; it’s going to have perverse effects. Futility means that it’s not really going to help that many people, and we’re going to waste all this time and money. And then the jeopardy argument is that you’re actually going to be endangering the people that you want to help. This has been the right wing’s rhetoric for most of the twentieth century. It’s produced insane arguments, like Paul Ryan saying that children didn’t want free lunch.

I always think about that comment now because of what happened during the COVID-19 era. In my area in New York, school lunches became free. It wasn’t only that it’s good to feed the children; they were also trying to keep jobs for people who otherwise might have been fired. They were trying to spend the money that had been allocated, even though the schools were set to shut down. This confluence of circumstances made it so that people are now used to free lunch. This year, when the children are in school five days a week, their lunches are free.

Leonard: Turns out kids like it.

Woodly: Turns out everybody likes it. You have people like the middle school principal here, *who’s not a revolutionary*, standing up in front of the orientation class at the beginning of the school year saying, “They finally got it right on free lunch.” This is how it moves. There’s not a utopian transformation that happens all at once where everybody ~~sees~~ (notices) the light. It’s these hardscrabble political opportunities, which people are organized to take advantage of, where you move forward an agenda that relieves people of *some* of their *suffering.* That’s how you win.

Leonard: In some places, COVID-19 really showed what productive things the state could actually do.

Woodly: It didn’t only show what the state could do. It also showed what the people do. When we were in lockdown, the largest mass mobilization in American history happened, and that was, in part, because people had the time to get together and to make community. They had the time to be democratic citizens.

Since things have begun to reopen, we have ~~seen~~ (noticed) a very fierce battle from the right to reclaim ground. So even if the school gives free lunch, conservatives argue, they give it with a side of critical race theory. These ideas [like free lunch] are otherwise so popular that they would gain a supermajority that would be hard to overcome.

### 2ac – at: biosecurity link – Ahuja

#### Ahuja’s too sweeping – making a historical observation, NOT prescriptive – AND doesn’t deny case outweighs

Kenney 17 (Martha Kenney, Assistant Professor, Women and Gender Studies, San Francisco State University, “Review of Bioinsecurities: Disease Interventions, Empire, and the Government of Species by Neel Ahuja,” Feminist Formations, 29(1), Spring 2017, <https://muse.jhu.edu/article/658650/pdf>)

Although Ahuja provides a necessary critique of colonial and imperial public health discourses and policies, where Bioinsecurities falls short is in offering imaginative alternatives to “dominant forms of state vision and media assemblages” (201). In order to critique common sense public health logics, Ahuja chooses to suspend “normative judgements about the threats posed by viruses and bacteria” (11). Thus, throughout the book he refers to the illness and death caused by infectious disease as “bodily transitions” and writes about the “queer potentials of contact” with microbes (27). Although I understand the reasons he would want to avoid dominant discourses about transnational epidemics, ignoring the suffering caused by infectious disease seems out of place in this otherwise exacting analysis of state violence. As Ahuja himself shows, vulnerability to illness and medical neglect can also be the result of imperialism, colonialism, and global capitalism. Although it is important not to stigmatize debility and to learn to live with mortality, it seems dangerous to conflate bodily transitions that are life making and bodily transitions that are death dealing. And because infectious diseases like smallpox and HIV/AIDS have been so deadly, it feels necessary not to dismiss every effort to treat and eradicate illness as inherently imperialist. Although humanitarian medical projects can also be murderous (see also Stevenson 2014), I do not think we can afford to be cynical—or only cynical— about public health and medical care writ large. In the alarmist coverage of Zika with accompanying images of brown-skinned babies with small heads, the one thing that has been lost is the babies themselves. The hypervisibility of these infants reveals a pervasive ableism that continuously bemoans their disability, but is not curious about their lives. Most state policies around Zika have been about prevention and securitization; I have not read any that are explicitly about care for those already born (beyond screening for impairment). Care is a tricky term, because, as Ahuja illustrates, care can be violent, paternalistic, and in the service of empire. However, not all practices of care are equally violent; it is important for scholars to develop the critical and creative capacities to differentiate. In this way, the histories Ahuja offers in Bioinsecurities can help us to move away from the default mode of racialized panic toward more critical discourses and practices of care in the context of epidemics that cross borders and harm unevenly.

#### Particularly, does NOT contextualize to our non-communicable disease impacts – where absence of any scenario for global spread defangs militarized responses – only helps desecuritize already-circulating pandemic discourses

Fidler 16 (David P. Fidler, Professor of Law at Indiana University School of Law, one of the world's leading experts in international law and infectious diseases and has published widely in this area, including International Law and Infectious Diseases (1999), “A Pathology Of Public Health Securitism: Approaching Pandemics as Security Threats,” in *Governing Global Health: Challenge, Response, Innovation*, 4-22-2016, Routledge, p.41-64)

Paradigm Aggregation: Public Health Securitism and Public Health Governance The emergence of public health securitism has produced paradigm aggregation rather than a paradigm shift. Post-securitisation public health governance involves three frameworks that converge to produce the political, economic, and moral context in which public health policy operates. The sea change that public health securitism represents is best viewed in light of security considerations entering into a governance context previously oriented by concerns involving economic considerations and aspirations grounded in concepts of human dignity. As historians of international health diplomacy have made clear, international cooperation on public health originated in the concerns of the European great powers with the economic burdens their trade and commerce suffered through the application of disparate, uncoordinated, and often irrational national quarantine systems (Goodman 1971; Howard-Jones 1950. 1975). The threat of the international spread of communicable diseases was thus constructed predominantly as a threat to the economic opportunities that trade and commerce provided states. This template dominated how states approached international health cooperation in the first century of such cooperation. The focus of international health efforts slowly drifted away from national economic self-interest as humanitarian concerns about health in other countries gradually emerged prior to World War II. The establishment of the WHO in 1948 accelerated this trend because the organisation directed most of its energies toward trying to improve public health in developing countries (Pannenborg 1979). Animating this concern with health conditions in poor countries was the vision for health proclaimed in the preamble of the WHO constitution (WHO 1994). The idea that the enjoyment of the highest attainable standard of health was a fundamental human right was central to this vision. The humanitarian and rights-bascd framework taking shape through WHO activities was connected to efforts in development being pushed by developing countries in the aftermath of decolonisation. The Declaration of Alma-Ata in 1978, which launched the Health for All by the Year 2000 initiative, captured the convergence of humanitarianism, the right to health, and the new thinking on development (International Conference on Primary Health Care 1978). The declaration reaffirmed the right to health, asserted that health inequalities between developed and developing countries were unacceptable, and linked health for all to the economic and social development strategies found in the so-called New International Economic Order (NIEO). The emergence of linkages between security and public health since 1995 adds yet another governance template to the economic-based and human dignity based frameworks that prevailed in earlier periods. Some concerns expressed about the securitisation of public health involved fears that security-based attitudes are eclipsing or subordinating the human dignity template that prevailed in international health governance from the WHO's establishment. As explored below, the securitisation process docs create tensions with the human dignity agenda; but this process has not been a zero-sum game among the economic, human dignity, and security templates of public health governance. Without question, security-based arguments have contributed to a new emphasis on the material self-interests of states with respect to public health governance. These arguments resonate with the original governance template for international health cooperation that reflected the economic concerns of the great powers. The security-related perspectives also help highlight the increasing economic costs that countries face from the globalisation of disease, especially with respect to their export interests. With disease rising as a threat to the state’s material power and wellbeing, states have started to engage public health governance with more intensity. Human dignity has not, however, dropped off the agenda. The securitisation process has included security concepts, especially human security, that conceive of security more broadly than the traditional narrow emphasis on the material power and interests of states. In addition, one of the dominant themes of the securitisation process has been that international cooperation and the national and global involvement of non-state actors are essential in public health governance to achieve security, whether the concept of security in question is narrow or broad. The commonalities of the strategies required to engage in successful public health governance in the early 21st century allow the economic, human dignity, and security templates to coexist, held together by the epidemiological requirements of addressing diseases effectively in an intensely globalising environment. Pathology of Public Health Securitism Understanding that public health securitism has taken public health governance into a post-securitisation phase is important, but it is not sufficient for comprehending the seminal nature of this change in attitudes, strategies, and tactics concerning public health governance. This section provides a pathology of public health securitism, or an exploration of the causes, processes, and consequences of this important development in public health governance.1 This brief examination supports the belief that security-based arguments have utility for public health policy. Causes The rise of public health securitism has many causes. But cutting across these causes is the realisation that the danger presented by diseases to states, peoples, and individuals has increased in the last decades of the 20th century- and early stages of the 21st century. The Oxford English Dictionary defines security as ‘the condition of being protected from or not exposed to danger\*. The trend toward using security-based thinking and concepts in a time of increasing disease danger makes sense, at a basic level. The key to understanding the causes of public health securitism involves the scrutiny of the reasons why diseases are more dangerous in the early part of the 21st century than they were in the post-World War II period. Analyses of communicable disease emergence provide insight into the increasing dangers these diseases present. In its well-known report, the U.S. Institute of Medicine's C ommittee on Microbial Threats to Health in the 21st Century identified 13 factors that produce microbial dangers for the U.S. and other countries (see Tabic 4-1) (Smolinski, Hamburg, and Lederberg 2003). Similarly, public health experts argue that dramatic changes in patterns of product consumption, stimulated [[TABLE 1 OMITTED]] by the globalisation of trade and lifestyle choices, significantly increase risks to health, as evidenced by growing pandemics of chronic diseases related to tobacco use and obesity (Beaglehole and Yach 2003). Increasing risks and dangers from diseases arise in an environment in which public health governance has proved ill equipped to respond. The turn to security-based arguments involves the perception that the human dignity and economic templates that prevailed in earlier historical periods are insufficient bases, on their own, for the kind of robust governance required in the early 21st century. With disease dangers rising, the rallying cries of the right to health and Health For All no longer carry the weight they previously did. Framing disease dangers in terms of security has proven to be attractive across political and ideological spectrums as an approach that can motivate states and communities to strengthen national and global public health. Processes In order to understand how the belief that security-related arguments could provide policy traction for public health governance developed as rapidly and strongly it is necessary to look at various processes through which this transformation occurred. These processes can be divided into practical, tactical, and strategic categories. At the practical level, many people concerned about growing disease dangers in a context of weak to non-existent public health capabilities used every argument available to raise policy attention about this governance challenge. Thus, security-based arguments were intermingled with economic rationales and appeals to humanitarian impulses in a melange that reflected a call for urgent action rather than a desire for theoretical coherency. At the tactical level, there have been modifications made to accommodate public health concerns in traditional security concepts and practices. Thinking on U.S. national security attempted to graft public health into its priorities. This grafting process involved two aspects. First, the traditional Cold War definition of national security as security against the military power and potential military- violence from other states began to look anachronistic when the U.S. felt threatened by potential violence from non-state actors, notably terrorists. Although national security was still defined in terms of threats of exogenous violence, the range of potential actors that could pose a security threat expanded in light of the terrorist threat. Part of that terrorist threat involved the possible use of bioweapons against the U.S., a threat that came to pass with the anthrax attacks of October 2001. This threat against the U.S. meant that the quality of public health systems in the U.S. and in other countries grew in national security importance. Second, the post-Cold War period also encouraged policy makers and policy thinkers to question the narrow perspective on U.S. national security that prevailed during the long conflict with the Soviet Union. This questioning involved experts analysing whether U.S. national security policy should consider transnational phenomena, such as environmental degradation and communicable diseases, as threats to the material power, interests, and well-being of the United States. Part of ihis approach posited whether naturally occurring communicable diseases could directly cause such material damage to the U.S. as to be a threat akin to a violent attack. Another facet of this outlook focussed on how transnational phenomena might present indirect national security problems for the United States. Could, for example, environmental degradation or communicable diseases contribute to the violent destabilisation of important countries or regions and thus damage U.S. interests and power overseas? At the strategic level, the process involved fundamentally rethinking the concept of security. Here, the rapid development of human security as a rival to the traditional, state-centric perspectives on security is the most important innovation. Human security's focus on the individual as the core subject of security policy opened more space in security thinking for public health issues. The tactical process described above allowed public health to have some national security significance, but the centre of policy attention remained the security of the nation-state in terms of its material power. Human security challenged the assumptions of the traditional national security template and thus created greater possibilities for states and the international community to consider public health more seriously as a security issue. These practical, tactical, and strategic processes do not mesh into each other to produce a harmonised process that generated public health securitism. Each individually contributed to the politics that has gradually led to public health securitism’s emergence. The messiness of the processes is one reason why public health governance faces some unfinished business in its post-securitisation phase. Consequences The last element of the pathology of public health securitism concerns its consequences. One consequence has already been highlighted — the aggregation of templates informing public health governance. This aggregation is not without competition and friction. The increased dangers that diseases present have reconnected the security and economic self-interests of states with public health governance. This reality has created tension with the governance template focussed on human dignity, with its concerns about the right to health and equitable social and economic development. At one level, these tensions merely indicate that public health governance is returning to normality in international relations. Most issues involving international politics and foreign policy experience friction between interest-based approaches and value-based approaches. Public health governance after World War II witnessed the withering of great power interest in international disease control and prevention largely because these states enjoyed steadily improving national public health outcomes. International health activities devolved to the ‘low politics' of ‘mere humanitarian ism’ in international relations, allowing the human dignity template to appear dominant in the ethos of international health cooperation. The securitisation of public health has made what appeared to be a fundamental transformation look more like a transitory mirage. The consequences of the securitisation of public health are not. however, exclusively about the potential fragmentation of public health governance into a rivalry between interests and values. The epidemiological requirements of addressing mounting disease dangers do not change according to whether an interest-based approach or a value-based perspective dominates. Surveillance remains critical under the framework of either public health securitism or human dignity. Vaccines and antibiotics do not change their physiological effects depending on whether the impetus behind their use is based on security or rights. Thus the nature of public health governance allows a degree of convergence between interest-centric and value-centric perspectives on solutions to disease dangers. This convergence of interests and values forces both sides of the debate to think about public health security in depth. Thinking of disease threats as security dangers requires understanding not only disease-specific epidemiology but also the broader determinants of disease dangers. Public health securitism does not, by definition, imply that concern with the social determinants of health is jettisoned because security becomes an organising policy framework. Seeing diseases as security dangers actually forces interest-based approaches to appreciate the depth of the policy needs required to address disease dangers. Where public health securitism has its greatest consequences for public health governance is in the area of priority setting. The attractiveness of security-related arguments Hows from the priority policy attention that security threats arc perceived to receive. The process of securitisation was a proccss of prioritisation in public health governance. This dynamic helps explain why virtually everybody has jumped on the security bandwagon since 1995. Like the various processes that produced public health securitism, the bandwagoning did not represent a coherent sorting out of priorities but rather a pluralistic endeavour that privileged security arguments without producing policy coherency on prioritisation. Л theme in the untidy bandwagoning process concerns priority setting between communicable and non-communicable diseases. Security-based arguments tend to cluster around communicable diseases. National security concerns identified bioweapons as the threat, especially those that might use contagious pathogens. The international security discourse has also centred on communicable diseases, as illustrated by the UNSC's work on HIV/AIDS. Initiatives informed by the concept of human security have gravitated toward communicable disease dangers, as evidenced by the focus on communicable disease problems in the Millennium Development Goals (MDGs) (WHO 2006a). Public health securitism need not be restricted to communicable disease problems. Rather, the securitisation of public health governance makes it more difficult to elevate many non-communicable disease problems. The nature of some of the leading problems, such as tobacco-related diseases and obesity, makes the effort to use security-based arguments more difficult both in a conceptual sense and in terms of common sense. A similar difficulty arises with respect to tobacco-related and obesity-related diseases and the human rights framework because the spread of such non-communicable diseases requires, in most cases, voluntary participation in behaviour that is bad for one’s own immediate health and the health of others. The difficulties experienced within the security and human rights frameworks perhaps explain the efforts made to cast non-communicable diseases as material burdens on the economic interests of countries and corporations. I'nfinished Business: Toward Greater Analytical Rigour in the Relationship between Security and Public Health Thus the dawn of the post-securitisation phase for public health governance does not mean that public health securitism has produced a clear and coherent consensus on the relationship between security and public health. Public health securitism has proved to be a powerful but promiscuous idea that will not disappear any time soon from the landscape of public health governance. The pathology of public health securitism points to some unfinished business, especially with respect to bringing more analytical clarity to the identification of security problems within public health governance. There are four different ways to bring order to the process of identifying what public health problems pose security threats. Each of these frameworks shares the common goal of providing parameters for deciding what public health concerns should be labelled security threats and given the policy priority such threats require. These four contribute to more rigorous analysis of the security-public health relationship. Вioweapons Framework Traditional notions of security have been based on the violence paradigm — the threat of exogenous violence against the state, its military power, or its people (Princeton Project on National Security 2005). The violence paradigm continues to have significant power because I) threats of violence clearly fall within any definition of security and 2) states have to remain vigilant against potential violent threats. The bioweapons framework maintains that securitisation of public health should only involve public health’s relationship to the identification of, and responses to, bioweapons threats. This approach produces a very narrow perspective because it rejects treating, for example, naturally occurring communicable diseases as security concerns. The legitimacy of the bioweapons framework depends on the appropriateness of relying on the violence paradigm as the exclusive basis for thinking about security nationally or internationally. This framework is parsimonious and provides clear direction in terms of how public health governance should be securitised. Although some actions taken to improve security against biowcapons violence have general public health benefits (such as surveillance), these positive externalities for public health governance are not the intended security objective. The bioweapons framework is unlikely to carry the day in the post-securitisation phase of public health governance. It recommends a drastic retrenchment in public health sccuritism that essentially throws every other perspective on security off the securitisation bandwagon. More fundamentally, this perspective rejects the broader thrust of the securitisation of public health governance — that disease dangers of multiple varieties have emerged that threaten individuals, populations, the state, and the international community. The ‘back to the future' approach counselled by the bioweapons framework does not respond to the globalisation of disease threats that public health governance must address. Communicable Disease Framew ork A second approach involves limiting securitisation to communicable diseases. As noted earlier, the securitisation of public health governance has gravitated toward communicable diseases as the most prominent dangers to public health in the early 21st century. Limiting public health securitism to communicable diseases would also provide a bright-line rule for distinguishing what public health problems should be accorded security status. With such a limitation in place, securitising public health could focus on what communicable diseases are sufficiently dangerous to warrant heightened governance attention. Unlike the bioweapons framework, the communicable disease approach does not exclude looking at communicable disease problems through security perspectives that arc broader than the violence paradigm. The communicable disease framework may, however, be under-inclusive in terms of disease threats and over-inclusive in terms of concepts of security. The choice to exclude all non-communicable disease threats from public health securitisation neglects the acute dangers that can be posed by some such diseases. International legal regimes in trade and environmental protection have long recognised that pollutants and contaminants can pose extraordinary dangers to public health and should be prevented, protected against, and, if necessary, controlled. For example, states have used international law to address transboundary pollution generally and transboundary pollution caused by industrial or nuclear accidents specifically (Bimie and Boyle 2002). To leave these types of situations outside an understanding of public health's relationship with security appears arbitrary in light of all the diplomatic activity and international law devoted to dangerous non-communicable disease threats. In terms of concepts of security, the communicable disease framework might be over-inclusive because the framework docs not contain any parameters for determining which communicable disease problems deserve security status and which do not. Not all communicable diseases should be considered security threats. Some methodology is required for determining when a communicable disease becomes a security threat. The communicable disease framework does not provide this methodology. Without such a methodology, the concept of security could bccomc little more than a rhetorical device used to bring more policy attention to a wide variety of communicable diseases. Decision Tree Frameworks A more sophisticated approach to bringing some conceptual order to the relationship between security and public health has appeared in decision tree frameworks. These break the question of a public health issue as a security threat into a series of factors that lead analysis to specific conclusions. Decision tree frameworks have appeared in the scholarship of Henry Feldbaum and Kelley Lee (2004) and of Colin Mclnnes (2004), as well as in the approach used by the WHO (2005) in the new International Health Regulations (IHR[2005J) adopted in May 2005. The work of Feldbaum and Lee and of Mclnnes focusses on the need to improve analytical approaches to deciding what health problems are global health security issues. Figure 4-1 provides the beldbaum-Lee decision tree, and Figure 4-2 provides the Mclnnes decision tree. Both construct a way to determine whether a health issue is a risk to the individual national security threat or is a global health security issue. The decision trees allow their analytical frameworks to be applied to bioweapons, communicable diseases, or non-communicable diseases. Unlike the communicable disease framework, the decision trees include a methodology for deciding whether a given problem is a security threat and what type of security threat it represents. In the IHR(2005). a decision instrument guides states parties in determining what disease events may constitute a ‘public health emergency of international concern\* for the purposes of notifying the WHO (sec Figure 4-3). Public health emergencies of international concern arc not defined in the 1HR(2005) as security threats, but the concept of a public health emergency of international concern is not far removed from identifying dangerous disease events as security problems. According to the WHO, for example, the IIIR(2005) is a core component of its strategy to improve global health security (Fidler 2005). Like the academic decision trees, the IHR(2005) decision instrument applies to communicable and non-communicable disease events (whether intentionally caused, accidental, or naturally occurring) and thus avoids the under-inclusiveness of the bioweapons and communicable disease frameworks. These decision tree approaches share the common elements of identifying acute health risks that cause, or have the potential to cause, high levels of morbidity and mortality as either security threats or public health emergencies of international concern. The Feldbaum-Lee decision tree expressly lays out these factors as securitisation criteria. The IHR(2005) is concerned with emergency situations, which clearly includes acute, high-impact disease events. The Mclnnes decision tree centres on extreme events, which appear to be defined as acute disease risks that post a threat of significant death and illness. If adopted as the key variables for securitising public health problems, the acute and high morbidity and mortality factors eliminate most non-communicable diseases that cause high levels of morbidity and mortality through chronic but not acute disease. For example, radioactive pollution from a nuclear reactor accident. such as Chernobyl, could not be defined as a security issue because the potential high morbidity and mortality would, beyond the immediate accident site, develop chronically over years rather than acutely over days. Feldbaum and Lee (2004) argue, however, that tobacco-related diseases are acute threats that cause significant morbidity and mortality. They also argue that childhood obesity does not become securitised because it is not an acute health risk. Both tobacco-related and obesity-related diseases are chronic not acute health risks, as those concepts are understood by epidemiologists. Why tobacco but not obesity gets included in the Feldbaum-Lee securitisation process is not clear. The common approach discernable from the decision trees raises questions about what constitutes an acute threat. From an epidemiological perspective, some communicable diseases, such as HIV/AIDS and tuberculosis (ТВ), damage health [[FIGURE 1 OMITTED]] over lengthy periods of time, more akin to a chronic disease than an acute infection, such as influenza, severe acute respiratory syndrome (SAKS), or haemorrhagic fever viruses (such as Ebola and Marburg). HIV/AIDS produces high levels of morbidity and mortality but not through physiological means that fit the traditional notion of an acute infection. In fact, the non-acute nature of HIV infection is part of what has made AIDS such a global public health problem. Loosening the acute factor to open up securitisation to more non-communicable disease problems and to address infections that arc chronic may, however, produce a one-branch decision tree that securitises public health problems that generate high levels of morbidity and mortality. Such a move risks equating security with public health rather than creating a framework for prioritising some public health problems as security threats. Epidemiological Elasticity Approach Another approach to identifying which public health problems constitute security issues involves assessing the level of danger posed by health risks by determining the propensity of the risks to spread and cause damage in human populations, or the [[FIGURES 2 AND 3 OMITTED]] epidemiological elasticity (epi-elasticity) of a public health threat. Л public health risk would have a high epi-elasticity if the risk demonstrates mobility within human populations and crcates adverse material impact for societies. Public health risks that exhibit high cpi-clasticity would be candidates for security consideration. Assessing the mobility of a public health risk would involve determining the means of transmission of the risk (for example, pathogen, pest, product, or pollutant), the speed with which the risk moves in human populations, and the geographical reach of the risk's mobility. The decision tree approaches showed interest in whether health risks were mobile, as illustrated by the attention paid to whether a risk was capable of cross-border, trans-border, or intra-border spread. But the spread capability of a risk only served to distinguish whether the risk was a national security issue or a global health security issue in the Feldbaum-Lee and Mclnnes decision trees. Mobility was not, therefore, a factor in deciding whether a risk was a security concern. The epi-elasticity approach makes mobility a central securitisation factor. Assessing the material impact of a public health risk would involve determining the morbidity and mortality, the economic costs, and other adverse material effects (for instance, reduction in military capabilities, fear generated in societies) actually or potentially caused by the risk. The idea is to calculate the damage the risk poses to societies. The decision trees were interested in limited aspects of material damage, namely whether a risk threatened high or low morbidity and mortality. The Feldbaum-Lee decision tree does not accommodate a low morbidity or mortality risk that otherwise causes, or threatens to cause, enormous material damage to affected countries, such as a limited bioweapons attack with a non-contagious pathogen. The Mclnnes decision tree might accommodate such a risk within the concept of an extreme risk, but without a more precise definition of extreme, such accommodation is guesswork. The epi-elasticity approach expressly broadens the impact analysis in securitisation beyond morbidity and mortality statistics to include other forms of material damage to populations. Assessments of a public health risk’s mobility and potential for material damage will involve consideration of other important factors. One such factor is the means of response available to be brought to bear against the risk, such as surveillance and intervention capabilities. The existence or non-existence of public health infrastructure can affect the mobility of a public health risk and the material damage it can inflict on a population. For example, a population universally vaccinated against a highly mobile, contagious pathogen will not, in all likelihood, suffer high morbidity and mortality from that pathogen's spread. The vaccine the means of response has a material impact 011 the epi-elasticity of the pathogen’s overall risk to public health. Another factor that flows into both mobility and material impact is the mutability of the public health risk, or its ability or potential to change, or be changed, as it enters human populations or in response to intervention efforts. The most obvious example of the importance of mutability is the development of antimicrobial resistance in communicable pathogens, such as malaria and ТВ, which make resistant microbes more dangerous public health risks because the propensity to spread and to cause damage is enhanced. The mutability factor is not. however, limited to communicable diseases. The routes by which non-communicable disease vectors affect human populations can change, or be changed, in response to public health interventions. Raising taxes and increasing regulatory burdens on tobacco and alcohol, for example, may produce an increase in smuggling and other forms of illicit trade. The cpi-elasticity approach is not a decision tree because the assessment of the mobility and material impact factors produces an objective picture of the level of danger the public health risk poses. Concluding that a risk has a high epi-elasticity does not mean that it is automatically a security problem. The epi-elasticity approach leaves open a margin of discretion in the securitisation process because, as Mclnnes (2004) argued, how security is defined in most situations involves both objective and subjective considerations. This outcome is really no different from the definitional choices that have to be made in the decision tree approaches, such as whether a public health risk is acute or extreme. However, the epi-elasticity approach’s focus on mobility and material damage provides a more robust methodology for using empirical data to aid the determination through the securitisation process of what public health problems should be prioritised as security threats. Three Pandemics: HIV/AIDS, Pandemic Influenza, and Tobacco-Related Diseases The rise of public health concern about pandemics provides an interesting lens through which to look at public health securitism, its pathology, and its unfinished business. The three pandemics involving HIV/AIDS, influenza, and tobacco-related diseases provide rich case studies for analysing the belief that public health can be improved through the use of security-based policies. Collectively, the developments related to these pandemics support the argument that public health governance has entered a post-securitisation phase. Public health securitism appears with respect to the policy discourse on each pandemic, illustrating the power of this policy belief today in public health and other circles. The pandemics also help illustrate the various parts of the pathology of public health securitism and underscore the importance of greater analytical rigour in the relationship between security and public health. Pandemics and Public Health Securitism The ubiquity of thinking about public health problems in terms of security that has developed since 1995 owes much to the re-emergence of pandemic and potentially pandemic diseases. The threat of global disease as a public health concern diminished during the post-World War II period, particularly with respect to developed countries that dramatically reduced their vulnerability to communicable diseases. In addition, for much of this period, increased morbidity and mortality caused by non-communicable diseases remained largely a rich country concern and thus did not have global implications. The re-emergence of pandemic potential for communicable diseases and the emergence of pandemic possibilities for non-communicable diseases since 1995 arc directly conncctcd to the fundamental cause behind the rise of public health securitism — the awareness that the dangers presented by diseases have significantly increased from the local to the global level. Pandemics arc not, by definition, dangerous because whether a disease is dangerous involves other considerations. But pandemics can be dangerous, and mounting concerns about the dangers to public health posed by pandemics involving HIV/AIDS, influenza, and tobacco-related diseases have stimulated policy to gravitate toward security-based arguments as a strategy to motivate public health governance on these global disease threats. The pandemic threat has acted as a counterweight to the bioweapons threat's tendency to produce narrow conceptions of the relationship between security and public health. But for the threat of pandemic communicable diseases, it is unlikely that the U.S. would have been willing to move the security-public health relationship beyond bioweapons. The grim progress of the HIV AIDS pandemic and the emergence of conditions conducive to communicable disease pandemics have contributed to shattering the complacency many developed countries exhibited toward public health in the post World War II period. The rise of pandemic threats also supported the use of different kinds of security arguments in discourse about how to deal with these dangers. Pandemics provided a background against which concepts of national, international, and human security could be advanced and debated. The HIV/AIDS pandemic proved particularly powerful in attracting diverse security-related arguments in policy and academic debates about how to respond to this crisis. The continued use of these types of arguments in the frenzy of interest around avian influenza and its potential to trigger a global pandemic has reinforced the prominence of security-based thinking with respect to pandemic disease. These observations suggest that the emergence and threat of pandemics have materially contributed to the securitisation of public health governance. This development is cold comfort because it means that diseases have emerged as global dangers for which past governance frameworks have proved inadequate. The security approach prioritises pandemic preparedness and response over other public health needs and aspirations. Securitisation Claims and the Three Pandemics The growth in the threat posed by pandemics generally also raises issues explored above concerning the identification of public health threats as security problems. Are the HIV/AIDS pandemic, the feared influenza pandemic, and the pandemic of tobacco-relatcd diseases all security threats? The hardest to analyse in response to this question is the pandemic of tobacco-related diseases. Experts have frequently securitised the HIV/AIDS pandemic and the anticipated influenza pandemic. Security-based arguments are not as frequently made with respect to the global spread of tobacco-related diseases. As already argued, part of the unfinished business of public health securitism involves the development of greater analytical rigour in the relationship between security and public health. Application of the various frameworks described earlier to the three pandemics at issue here underscores the need for such rigour. Clearly, none of these three pandemics ranks as a security threat under the biowcapons framework because none involves the intentional use of disease as a weapon. This conclusion merely reinforces the under-inclusivcness and narrowness of the bioweapons approach to the securitisation of public health problems. The communicable disease framework would cover HIV/AIDS and pandemic influenza but not the pandemic of tobacco-related diseases. Given the actual and anticipated scale of the death and illness caused globally by tobacco consumption, the exclusion of this pandemic entirely on the basis that it involves non-communicable diseases does not seem analytically justifiable. The various decision tree approaches produce important questions that cast some doubt on their utility. Although the IHR(2005) clearly applies to events involving sources of non-communicable diseases, no one has argued that the concept of a public health emergency of international concern would apply in any context to the continued spread of HIV/AIDS or tobacco-related diseases.2 Such continued spread of these established pandemics would not be considered unusual or unexpected within the meaning of the IIIR(2005). This situation might change with respect to HIV/AIDS if, for example, multi-drug resistant strains of HIV/AIDS began circulating globally, thus significantly imperilling the efficacy of antiretroviral treatment (ART) efforts. Under the Feldbaum-Lce and Mclnnes decision trees, pandemic influenza would be the only pandemic of the three under consideration here to merit dear security status. For HIV/AIDS to be securitised under these decision trees, it would have to be considered either an acute disease (Feldbaum and Lee 2004) or an extreme disease event (Mclnnes 2004). As mentioned earlier, whether HIV/AIDS is an acute infection is questionable. The problem faced by the 'acute health impact’ factor in the Feldbaum-Lee decision tree is stretching ‘acute\* to cover both pandemic influenza and HIV/AIDS, which stand at opposite ends of acuteness in epidemiological terms. Feldbaum and Lee stretch the concept further, in fact, in arguing that tobacco-related diseases should be securitised, which must mean Feldbaum and Lee think they have acute health impact; this again strains epidemiological credulity. In terms of the Mclnnes decision tree, HIV/AIDS and tobacco-related diseases would have to be perceived to be extreme health risks to be securitised pandemics. Aggregate morbidity and mortality statistics are not sufficient to achieve extreme status because, under that approach, tobacco-related diseases would be more extreme as a health risk than HIV/AIDS. The heavy securitisation of the HIV/AIDS pandemic and the lack of security-related claims for tobacco-related diseases reinforcc this conclusion. The Mclnnes decision tree, furthermore, seems to exclude tobacco-related diseases as security threats altogether because it is hard to argue that their spread over the course of decades constitutes an extreme health risk in the same way pandemic influenza. As with the concept of acute in the Feldbaum-Lee decision tree, ihc Mclnnes decision tree raises ihe question of whether the term ‘extreme’ needs to be defined more objectively. Both decision trees easily accommodate pandemic influenza, but they have both difficulty with HIV/AIDS, even though it is an intensively securitised pandemic. In contrast to the awkward application of the decision trees to the HIV/AIDS and tobacco-related disease pandemics, the cpi-elasticity approach assesses the level of danger presented by public health risks according to their respective propensities to spread and cause damage to human populations and societies. The mobility and material impact factors apply equally to all three pandemics, so the epi-elasticity approach does not exclude any pandemic for not satisfying a decision tree factor. This approach assesses the level of danger each of the pandemics presents, and policy makers can more objectively assess whether each pandemic poses a sufficient danger to warrant securitisation at the national or global level. An epi-elasticity analysis of the three pandemics would lead to the conclusion that pandemic influenza would have the highest epi-elasticity and thus be the most dangerous public health risk of the three. This outcome means that pandemic influenza’s combined mobility and material impact factors exceed those of HIV/AIDS and tobacco-related diseases. The next highest epi-elasticity would belong to HIV/AIDS, with tobacco-related diseases being third in terms of the level of danger posed to public health. In terms of the mobility factor, pandemic influenza would exhibit mobility greater than the mobility of HIV or tobacco products. As an airborne virus, pandemic influenza’s means of transmission is more efficient than that of HIV or tobacco products. Pandemic influenza would also have very high mobility because of the speed of virus transmission between humans and the potential of the virus to reach every corner of the earth very rapidly. HIV and tobacco products have also demonstrated impressive mobility locally, regionally, and globally in their respective spread and penetration of human populations. In terms of material impact, pandemic influenza again would threaten to damage populations and societies on a scale and speed that HIV/AIDS and tobacco-related diseases could not currently generate. Projections about the impact of pandemic influenza often discuss the scale of morbidity and mortality, the economic harm, and the political and social disruption pandemic influenza could cause in both rich and poor countries (Russell 2005). The global handwringing about the lack of preparedness for pandemic influenza demonstrates that an adequate means of response is currently lacking. Prospects for mitigating the material impact of pandemic influenza are, at present, not good. As between HIV/AIDS and tobacco-related diseases, HIV/AIDS is more dangerous in terms of its material impact in populations and societies. The morbidity and mortality and economic costs created by tobacco-related diseases are enormous in terms of aggregate numbers (WHO 2006b). But no one has argued that tobacco’s material impact on societies has the potential to destabilise entire countries, decimate political elites and productive-age labour forces, harm peacekeeping efforts, and create legions of orphans, as IIIV/AIDS is now doing in sub-Saharan Africa (Garrett 2005). Nor does contracting a tobacco-rclated disease involve the economic, social, and psychological costs associated historically with the stigma of HIV/AIDS. There is also the ability of HIV to mutate in ways that may render existing ART ineffective and defeat attempts to create a vaccine. The means of response available for preventing tobacco-related diseases is, on the whole, easicrandchcaperthan HIV/AIDS prevention and control strategies. Thus the overall propensity of HIV/AIDS to cause material damage to a population is greater than that of tobacco. This rough attempt to establish the level of danger these three pandemics respectively pose correlates with the way securitisation processes have unfolded. The epi-elasticity analysis supports the securitisation of pandemic influenza and HIV/AIDS because their combined mobility and material impact factors make them more dangerous risks than tobacco-related diseases. Thus pandemic influenza and HIV/AIDS deserve the public health governance priority that securitisation processes have accorded them as dangerous threats. Although the epi-elasticity analysis does not rank tobacco-related diseases as a security threat, this approach acknowledges the possibility that a non-communicable disease could represent such a threat because of its mobility and material impact on the health of populations. In fact, the epi-elasticity of tobacco-related diseases may be higher than some communicable diseases, which helps underscore the emphasis that public health authorities nationally and globally have been placing on the importance of more vigorous action against tobacco consumption. Conclusion With respect to the war on terrorism, some have expressed the hope that one day terrorism will again be treated as a law enforcement problem rather than a threat to national security. Some in public health may long for the day when disease risks are again treated as public health problems rather than security threats. Desecuritisation would signal that the disease dangers that stimulated linkages between security and public health had been reduced. Ironically, the only way to desecuritise public health might be to increase political interest and policy attention on public health through securitisation. This reasoning supports this chapter's emphasis on the strength of securitism in public health governance today and the continuing importance of this policy belief in the future. The pathology of public health securitism outlined in this chapter also highlights another reason why securitisation will not fade away any time soon as a feature of public health governance. Securitisation of public health has provided for convergences of narrow and broad conceptions of security and of interest-based and value-based approaches to health and security. In other words, the securitisation of public health creates a two-way street conceptually because it not only brings security into public health but also causes public health to inform security. The basis for a much deeper and broader governance transformation is now under construction in the post-securitisation phase of public health governance.

### Abstraction link

#### The aff calls out the colonial model of medicinal knowledge – lack of patient-centered care from NP shortages and paternalistic organization through SOP laws are colonial in nature

Wong et. al. 21 (Sarah H.M. Wong, Medical Student at UCL London, Faye Gishen, consultant physician in palliative medicine and Associate Head of the MBBS (Medicine) at UCL, London, Amali U. Lokugamage, consultant obstetrician and gynaecologist and Honorary Associate Professor at UCL, London, “‘Decolonising the Medical Curriculum‘: Humanising medicine through epistemic pluralism, cultural safety and critical consciousness,” London Review of Education, May 19th, 2021, DOI: 10.14324/LRE.19.1.16)//NRG

From a biomedical gaze to epistemic pluralism

Perhaps we should begin by problematising the term ‘Western medicine’, also referred to as ‘conventional’, ‘modern’ or ‘evidence-based’ medicine, especially when juxtaposed against ‘alternative’ medicine. This latter encompasses a whole gamut of diverse healing traditions with far-reaching historical, geographical and cultural roots, which represent the vast majority of healthcare provision worldwide (Sodi and Bojuwoye, 2011). An overt dismissal of all ‘non-Western’ modes of thinking about healing as outdated, marginal and irrelevant has characterised decades of paternalism within the medical profession (‘doctor knows best’). Various strategies have emerged in medical training, such as an emphasis on patient-centred care (Bleakley, 2014; Kitson et al., 2013; Stewart, 2001) and the expansion of the biomedical model to a biopsychosocial model (Engel, 1977) to address the discrepancy between biomedical concepts of disease and lived realities of illness. However, paternalistic thinking in medicine may not be so easily eradicated. Some of this intellectual arrogance may be traced to a colonial-era belief in the inherent superiority of a dominant culture, which justifies their encroachment on to, and even eradication of, other cultures. This attitude reinforces the key limitation of biomedicine, which is its exclusive claim to knowledge that matters.

Armed with this claim, proponents of biomedicine often adopt a defensive stance towards non-biomedical frameworks of health, citing their lack of an evidence base. However, as discussed in the Introduction, knowledge purported as ‘evidence-based’ in medicine may not live up to this descriptor (Wright, 2007). Examining guidelines published by the Royal College of Obstetricians and Gynaecologists, Prusova et al. (2014) found that only 9 to 12 per cent were supported by the highest standard of evidence (Grade A) based on systematic reviews or individual randomised control trials. Scientific academia is largely centred around a positivist, ‘one-size-fits-all’ study design (Lokugamage et al., 2020a) – a randomised control trial well-suited to investigating the efficacy of a pill can become riddled with confounding bias when applied to complex interventions. In addition, quantitative data are privileged over qualitative data, reflecting a fixed preconception in clinical research about what constitutes a good treatment outcome (see Greenhalgh et al., 2014). One example of a common bias in study design may be found in randomised control trials around medical acupuncture, which have been critiqued for their use of an inadequate control (Chae et al., 2018) and neglect of qualitative outcomes (Lokugamage et al., 2020b). Another area of bias is in research funding, which comprises epistemic, geographic and institutional disparities in resource allocation. The result of this is ‘undone science’ (Frickel et al., 2010) – research benefiting minoritised and disadvantaged groups in society that remains ‘unfunded, incomplete or generally ignored’ (Frickel et al., 2010: 445) – as resources are channelled into research that supports existing institutional agendas (Richardson, 2020). Aside from an understanding of other healing systems, students should be educated about these gaps in medical literature, to appreciate the bias inherent within research production and how it distorts our perception of the efficacy of indigenous/traditional complementary therapies with origins in the Global South.

A medically plural curriculum should accept that a health system does not exist as a discrete and immutable entity – in the same way that this is true of culture (Kleinman and Benson, 2006). Perspectives that have emerged from the field of medical anthropology suggest that closer attention be paid to the role that culture plays in shaping our perceptions of health and illness. Every system of healing is a collection of beliefs and practices shaped by a long history of interaction with other traditions within an interconnected global landscape, such as the contribution of indigenous knowledge of medicinal plants to the development of modern pharmaceuticals (Jamshidi-Kia et al., 2018; Maridass and De Britto, 2008). Biomedicine is a singular way of interpreting the world that needs to be synthesised with other perspectives to give rise to integrative and holistic medical practice (Baer, 2004). Failure to adopt an objective and critical lens towards biomedicine can lead to over-(bio)medicalisation (Lock and Gordon, 2012), complacency (Kleinman, 1995) and over-reliance on simple guidelines that do not account for complexity and individual variability in healthcare (Greenhalgh et al., 2014; Plsek and Greenhalgh, 2001). This resistance to change has led to a ‘narrowly focused therapeutic vision’ (Kleinman, 1995: 28) in much of contemporary medicine that must be broadened through an openness to epistemologies historically considered ‘other’. While components of traditional and folk medicine from Africa, the Middle East, Asia and South America – including yoga, meditation and herbal medicine – have gained a degree of mainstream acceptance in Europe and America, others that cannot be adapted for the biomedical agenda are often dismissed as pseudoscience, placebo or both. This selective co-opting of alternative therapies into biomedicine, divorced from knowledge of their historic and cultural origins, belies the ideal of epistemic pluralism and can be considered a form of medical cultural appropriation (see Lokugamage et al., 2020a: 270).

Even though concepts such as subjectivity and cultural literacy have long been mainstays in other disciplines, medicine has yet to draw deeply enough from these to equip medical students to navigate the cultural complexities of medical practice. In some ways, this reflects a colonial hierarchy of disciplines (Bhambra et al., 2018: 5) that prioritises a singular Eurocentric biomedical view, which claims neutrality (Last, 2020: 219), over the social sciences and humanities, which afford a degree of knowledge devolution. While there has been growing emphasis on sociology in medical education from a public health and health policy perspective (Collett et al., 2016), this interest has not been extended fully to the vast literature available within medical anthropology, global health, history of medicine and medical ethics. As a result, there has been focus on social determinants of health without analysis of how these determinants are deeply embedded within contexts of culture, identity and world view (Kirmayer, 2012). For medicine to progress beyond the biomedical towards a more holistic paradigm, medical education must be open to contribution from a diversity of epistemologies and disciplinary fields (Le Grange, 2016; Last, 2020).

From cultural competence to cultural safety

Diversity teaching in medical schools has mostly been delivered through a cultural competence model (Betancourt et al., 2003; Dogra et al., 2010; Kripalani et al., 2006) that is criticised for its tendency to reinforce unhelpful cultural stereotypes (George et al., 2015) and to teach political correctness rather than cultural humility (Shapiro et al., 2006). A decolonising approach to diversity challenges these assumptions and refutes simplistic conceptions of race, culture and identity, recognising how they have been utilized to further European colonial projects (Quijano, 2007: 171). Cultural safety is such an approach, which recognises the cultural destructiveness of colonial ways of thinking about (and classifying) difference. It overcomes the limitations of cultural competence by transcending superficial understandings of culture and evaluating the broader historical context of cultural prejudice that contributes to healthcare inequity (Curtis et al., 2019). Furthermore, cultural safety is a reverse innovation (an innovation brought to the forefront from a culturally colonised society) (DePasse and Lee, 2013; Lokugamage et al., 2019), pioneered by a Māori nursing educator in New Zealand to address the colonial roots of health inequities between indigenous Māori and non-indigenous populations (Ramsden, 2002). This signifies how the premise of cultural safety is formed by the lived experiences of individuals from historically oppressed communities, challenging Eurocentric conceptions of culture by foregrounding a more expansive, inclusive perspective on cultural identity and why it matters in medicine (Lokugamage et al., 2021).

Therefore, to decolonise a medical curriculum, educators need to start focusing on cultural safety rather than cultural competence. Cultural safety disputes the notion that biomedicine is acultural and impartial (Lupton, 2012), recognising that medicine’s dominant ‘culture of no culture’ (Taylor, 2003; Taylor and Wendland, 2015) can lead to ignorance in the medical profession and of health professionals towards their own cultural bias. This lack of critical self-awareness may translate to clinicians practising a superficial empathy founded on expectations of professionalism, rather than nurtured through a complex awareness of the lived realities of patients through how they relate to one’s own. Through subverting the clinician’s role as an observer, and transforming them into the object of study, the cultural safety model has the potential to neutralise some biases of the hidden curriculum in ‘diversity teaching’ (Ramsden, 2002). As Curtis et al. (2019: 17) write: ‘In contrast to cultural competency, the focus of cultural safety moves to the culture of the clinician or the clinical environment rather than the culture of the “exotic other” patient.’ Furthermore, through its broader critique of institutional racism in society as a threat to minoritised cultures, the cultural safety model positions health systems, organisations and providers as the focal point for interventions to promote health equity. By facilitating an inward process of self-examination while turning one’s gaze to the broader structural factors that produce health inequalities, it reveals the psychological, social and historical underpinnings of power imbalances in the doctor–patient relationship that disadvantage minoritised patient groups across societies today (Curtis et al., 2019).

The decolonial mindset is an uncomfortable and challenging space to occupy in medicine. Clinicians may struggle to reconcile the tension between contemporary expectations of political correctness and their personal beliefs regarding race-based differences (Hoberman, 2012). This is why opportunities for critical reflection around sociocultural issues, exposure to diverse patient narratives and the practice of reflexivity (Iedema, 2011: i84) should be offered throughout medical school, including early exposure to interdisciplinary perspectives. These enable medical students to practice engaging with complexity and ambiguity in the clinical encounter (see GMC, 2018) and develop the intellectual (Miller, 2013) and emotional (Cameron and Inzlicht, 2020) capacity for empathy early on in their professional journeys. The cultural safety model provides a platform to deepen connections between practitioners, patients and their wider community (Pimentel et al., 2020). It also represents a re-imagining of the medical curriculum that holds medical institutions accountable to their past and medical practitioners to protecting the rights of their most vulnerable patients. In the following section, we explicate how critically examining the relationship between medicine and colonial history may empower students (Harland and Wald, 2018) to advocate for structural change within their social milieu.

From sanctioned ignorance to critical consciousness

The concept of ‘critical consciousness’, developed and popularised by the Brazilian educator, philosopher and activist Paulo Freire (1973), integrates critical theory with pedagogy and social justice within a three-component formulation: (1) critical social analysis and reflection; (2) political efficacy, that is, perceived ability to enact political change; and (3) participation in civic and political action, that is, praxis (see also Watts et al., 2011). Within medicine doctors play a crucial role in advocating for patients disadvantaged by healthcare practices, policies and environments. Equipping clinicians to-be with knowledge of the origins of these structures, along with their agency to effect change within the system (Geiger, 2017), is a crucial component of the arduous task of dismantling barriers to health justice. In this section, we discuss how future doctors may learn to enact critical consciousness through praxis by incorporating teaching on global health, history of medicine and critical perspectives on race into the medical curriculum.

Globally, the COVID-19 pandemic has revealed the fragility of our health systems and networks, along with gaping disparity in the distribution of health resources across the world. The importance of global health perspectives in medical education is two-fold. First, it trains future medical professionals in global health trends and practices, strengthening the capacity for medical systems to operate more robustly within a globalised world (Drain et al., 2007; Peluso et al., 2012). There have been various efforts to challenge colonial-era paradigms of global health and to re-imagine models for equitable health partnerships and resource sharing (Bhatti et al., 2017; Boum et al., 2018; Depasse and Lee, 2013) between lower- and middle-income countries and high-income countries. Knowledge of these models may help to undo epistemic biases against evidence produced in lower- and middle-income countries that offer important contributions to the global repository of medical knowledge. Second, a global historical perspective provides insight into the contribution of empire to global health inequity internationally, as well as on migrant, refugee and asylum-seeker patient populations within our local context. As Gebrial (2020: 28) remarks, allowing the ‘classed and racialised dynamics of colonialism’ to shape conversations about migration, national identity and entitlement may facilitate an attitudinal shift away from xenophobia toward hospitability in treating foreign-born patients within public healthcare systems (Gebrial, 2020; Shahvisi, 2019; Walia, 2021).

In this article, we have described how biomedicine has often projected a neutral, acultural and apolitical image as an attempt to shed the trappings of its colonial past. Hoberman (2012: 7) suggests that ‘colour-blind writing about medicine’ has led to the dismissal of historical racism as irrelevant to medical science today, when in fact it provides insight into the more insidious manifestation of modern-day racism in clinical practice. Furthermore, it is an essential component of global health education (Greene et al., 2013). Throughout the course of imperial history, healthcare was a highly contested site, where biomedicine was regularly pitted against traditional medical systems, health beliefs and healers from indigenous cultures (Arnold, 1993). Historical commentators have highlighted various failures of public health policies implemented by the British within Australian and African colonies in the nineteenth and twentieth centuries (Bashford, 2003; Cole, 2015; Swanson, 1977), where the well-being of British officials took precedence over that of colonised populations (Cole, 2015; Frenkel and Western, 1988).

Continuous with this colonial legacy, the history of medicine reveals numerous instances of racism and outright abuse of human rights in the name of medical research. One of the most well known is the Tuskegee Syphilis Experiment (1932–72), which damaged the trust of the African American community in researchers and medical institutions, contributing to their under-representation in clinical trials in the US and reluctance to access healthcare (Alsan et al., 2020; Freimuth et al., 2001). In other cases, the veneration of White doctors within the medical profession implicated in acts of racialised violence continues unopposed, such as in the case of James Marion Sims, hailed as the ‘father of gynaecology’, who experimented with surgical techniques on Black slaves without anaesthesia (Feagin and Bennefield, 2014). Under the influence of the eugenics movement in the twentieth century, individuals from minority ethnic groups and persons with disabilities fell victim to ‘public health’ policies (for example, coercive sterilisation, institutionalisation and marriage restriction) aimed to restrict the size of their populations across Europe and America (Mitchell and Snyder, 2003). While some of these events have been chronicled and evaluated retrospectively (Hoberman, 2012; Skloot, 2011; Washington, 2006), many memories remain repressed by the passage of time and the perpetuated silencing of minoritised and indigenous voices throughout the world (Mosby, 2013). Spotlighting the darkest moments in the history of medicine reveals the lingering effects of colonial hierarchies in the present day, including notions of inferiority and superiority that remain deeply entrenched in political discourse.

Finally, a critically conscious outlook should also deconstruct essentialist conceptions of race (Chadha et al., 2020). The scientific validity of racial constructs has been disputed by findings in genome science and physical anthropology (Mccann-Mortimer et al., 2004; Morning, 2011). This has led to calls to deconstruct the notion of ‘race’ in the medical curricula (Braun, 2017; Lim et al., 2021; Tsai et al., 2016) to refute the belief that ‘Black’, ‘White’, ‘brown’ are discrete and naturally occurring categories within the human population, rather than terminology steeped in colonial connotations (Wekker, 2016). Through the lens of critical race theory, systemic racism is preserved through the false attribution of health disparities to racial difference, concealing how ethnic minority populations are disadvantaged by broader sociopolitical determinants of health (Brown, 2003; Ford and Airhihenbuwa, 2010; Jensen et al., 2020; Pollock, 2012). Exposure to such perspectives may help medical students critique with the goal of expanding their understanding of what race and ethnicity entails, challenge racialised prejudice that confounds clinical judgement and critically evaluate race-based recommendations in clinical practice.

### 2ac – NP reps

#### Their “reps” links are AMA agitprop

Galperin 20 (Roman V., McGill University - Desautels Faculty of Management, “Organizational Powers: Contested Innovation and Loss of Professional Jurisdiction in the Case of Retail Medicine,” Organization Science 31(2):508-534. https://doi.org/10.1287/orsc.2019.1314)//NRG

The model of deprofessionalization proposed here has implications for the literature on innovation in markets. Entry into professionalized markets by innovative firms—for example, retailers in primary healthcare, algorithmic advisors in financial services (Logg et al. 2019), document assembly software providers in legal services (Mountain 2007), or drone manufacturers in aviation (Helmore 2009)—is a kind of technological innovation where establishing acceptance of a new technological frame is especially important and challenging. Because incumbent professions have the incentives and the levers to resist adoption of the new frame, innovative firms may be more successful if they anticipate the resistance to the adoption of their innovation and account for it in developing their market entry strategies.

The case presented here specifically points to interprofessional tensions as an important factor in devising such strategies. For example, the feasibility of entry may depend not necessarily on the strength of the dominant profession in the field but rather on the relative strength of the second strongest profession, most often a subordinate one. The stronger the subordinate profession, the more dangerous its legal and cultural assets are for the dominant profession should these assets be repurposed by the corporate intruders to support their own entry.

The case of retail medicine also highlights the importance of a coordinated rhetorical strategy to support new entry into a professionalized market as culturally legitimate. Although research on technological frame adoption argues that innovation is not always adopted even if it has superior properties over the existing technology, the discourse around retail medicine suggests an even more extreme possibility— that technical superiority of an innovation may be construed as a liability. Although a new technology may be more efficient than the performance of the same work by expert practitioners, the efficiency need not be accepted as a universal virtue by market participants, and therefore, it does not necessarily make the innovation legitimate. When their jurisdiction is threatened, professions tend to cast economic efficiency as an undesirable feature of professional work by framing it as a property of commercialism, which puts profit ahead of service.

For the efficiency of new technology to be a virtue, those who bring the innovation to market ought to frame it as such. Retail clinics used NPs’ frame of efficiency as an answer to the problem of access to care. By pointing out the lack of access, especially among the most vulnerable populations, retail clinics (as NPs before them) pointed out physicians’ failure to follow through on their moral responsibility as a dominant profession. A history of moral arguments made by subordinate professions may therefore be a valuable asset for new entrants seeking to legitimize their innovation.

Generalizability and Future Research

Because the focus of this paper is on the emergence of one organizational form, the analysis presented here is necessarily limited. Some observers of the retail clinics industry claim that growth of retail medicine has increased access to primary care and may have lowered costs while maintaining quality (Mehrotra et al. 2009, Schleiter 2010). Given that the healthcare industry accounts for a large part of the economy in the United States and many other countries, the policy implications of understanding the drivers of increased efficiency of services in this case alone are consequential.

## Alt

#### Licensing is critical to worker wellbeing – the alt wrecks nurse practitioners

Robinson 18 (Nick, Affiliated Fellow, Center on the Legal Profession, Harvard Law School, “The Multiple Justifications for Occupational Licensing,” Washington Law Review, vol. 93, no. 4, December 2018, p. 1903-1960. HeinOnline, <https://heinonline.org/HOL/P?h=hein.journals/washlr93&i=1937)//NRG>

D. Buffering Producers from the Market

By limiting entry into an occupation and prescribing standards of practice, occupational licensing protects practitioners from at least some of the competitive forces of the larger market. Because of this effect, economists and others have often criticized licensing for being anticompetitive.131 This anticompetitive effect may be justified because a licensing requirement protects consumers from harm or has some other social benefit, like fostering communities of knowledge or promoting social trusteeship.

Yet, this anticompetitive effect may itself serve the public interest in some contexts. For example, occupational licensing may protect producers from market instability in a market that the public relies on for needed goods or services. In Nebbia v. New York,232 the U.S. Supreme Court rejected a Fourteenth Amendment challenge to a law that fixed the price of milk because it "prevent[ed] ruthless competition from destroying the wholesale price structure on which the farmer depends for his livelihood, and the community for an assured supply of milk." '33 A similar argument can be made for using occupational licensing to protect certain occupations from price wars that may otherwise repel talented practitioners from the labor market or stop capable students from entering the occupation.

Such anticompetitive protectionism may also be used to explicitly stabilize the labor market for the benefit not of consumers, but of labor. Karl Polyani famously maintained that a key role of the state should be to slow the chum of modem capitalism and its dislocating effects on members of society.23 4 Occupational licensing can be seen as one way of achieving this end. Although occupational licensing may increase the price of some services for the poor and middle class, it also provides those in an occupation that requires a license (a significant portion of the workforce) with a higher income and other benefits, like less chance of being unemployed and a greater probability of receiving a pension plan. 35 Many in the poor and middle class aspire to be in an occupation that requires a license, as they once aspired to be in a union job, in the hopes of building their lives around the relative stability, prestige, and security licensing can bring.236 Like union jobs, these better-paid, more secure positions may provide broader positive externalities to society, such as creating a stable environment for families to prosper.

In this way, occupational licensing may be viewed as an imperfect check against some of the harshness of the modem economy, whether this is volatile labor markets, wage stagnation or decline, or reduction in worker autonomy.23 Unlike alternative strategies to deal with economic volatility, such as resource transfers from winners to losers, licensing provides a buffer that can allow those in these occupations to continue to build skills and work with dignity.

### 2ac – at: nurses bad/medical norms link

#### Elevating the role of NPs is an active demystification of physician centrality – embedding NPs in healthcare is an injection of care work that can better navigate medical norms

Trotter 18 (LaTonya, sociologist at Vanderbilt University, “’I’m Not a Doctor. I’m a Nurse’: Reparative Boundary-Work in Nurse Practitioner Education,” July 15th, 2018, https://journals.sagepub.com/doi/10.1177/2329496518783683)//NRG

In our interview, Matt noted, “I mean it’s not that hard to do primary care. Don’t get me wrong. Patient comes in and says, ‘I’ve been dizzy for 6 months’; that could be anything. But if you ask good questions, do a good exam you’ll eventually get an answer.” His words were echoed by a nursing faculty member who when we met over lunch, leaned forward conspiratorially and lowered her voice as she said, ‘primary care is really not that hard.’ These sentiments resonate with historical accounts of pioneering NPs. In her history of U.S. NPs, Fairman summarized, “After the initial excitement of learning and practicing, most nurses understood what their physician colleagues always knew but rarely divulged—there wasn’t any magic in the skills, and the knowledge was something nurses could take on and safely apply” (Fairman 2008:85).

This demystification would seem to be a direct assault on the value of medicine’s expertise. However, this downgrading of primary care to mere technique paradoxically protected physician expertise. Throughout its history, nursing has often taken on work once done by medicine. Equipment such as the stethoscope, syringes, and fetal monitors, once considered the sole province of physicians, are now routinely used by RNs (Fairman and Lynaugh 2000; Sandelowski 2000). The rhetoric behind these expansions has always been double-edged: nurses were competent enough to take on new work; however, the work was rewritten as “easy enough for a nurse to do.” There are echoes of that rhetoric in the assertion that the NP’s new work of diagnosis in primary care “is not that hard.” Borrowing medicine’s skills was not a challenge to jurisdictional boundaries; it simply reified the boundary that defined the expertise as belonging to medicine. The skill of diagnosis in primary care was not an expansion of nursing expertise; it was an expansion of nursing work.

If one followed the script and treated in accordance with the evidence, nurses could learn to implement these skills, but diagnostic expertise still belonged to professional medicine.

Yet, it would be inaccurate to portray Stanton’s classrooms as absent of struggle. What threatens to “unsettle the settlement” between nursing and medicine is not the work itself but the existential position of being the one who decides. Even deciding when to seek the opinion of a collaborating physician is an autonomous decision, not unlike the one a primary care physician makes when referring a patient with uncontrolled diabetes to an endocrinologist. When I spoke with 29-year-old Lauren about transitioning to the NP role, she stated, “Taking on a whole different responsibility and a whole new way of looking at things? It’s like going to nursing school all over again!” Other students relayed stories of existential struggle between “how we are” as nurses and who they were becoming as NPs. Some used the language of role conflict; others talked concretely about differences in the outpatient versus the hospital setting. Embedded in those stories of struggle were also resolutions. Students narratively resolved these struggles through a language of revelation. In becoming NPs, they were revealing the nurses they already were.

Reparative Work: Becoming Who We Already Were

Diagnosis and treatment separates the work of the RN and NP, but what fundamentally distinguishes these roles is the responsibility such work entails. Forty-three-year-old Jenna explained that while hospital nurses have responsibility, “there are lots of checks to make sure you don’t screw up. So, in that way, it’s slightly less professional.” As NPs, students would be differently accountable for their decisions. However, students remade this new responsibility into one they already possessed as individuals, if not as an occupational group. Some students located the source of that possession within their nursing experience. Hana attributed her sense of responsibility to working in the intensive care unit (ICU). “In the ICU, it’s not always the doctor’s job to look through the chart and see what’s wrong. We always report what’s going on. And depending on the doctor, we really collaborate.” For Brooke, it was working in the emergency room (ER).

In the ER, you have a lot of autonomy because things are moving really fast and you get to know the doctors who are always there, compared to other floors where different doctors are floating in and out. And you have a lot of standing orders, which means you can treat—you know—if somebody comes in with chest pain, you don’t have to ask a doctor if you can give nitroglycerin because that’s part of a standing order.

Other students attributed this responsibility to their professional orientation. When Matt described what he enjoyed about bedside nursing, he stated, “I liked the sense of autonomy and decision-making for yourself. Which I always felt I had in the hospital. I’ve never been somebody who thought I worked under a physician or just followed orders.” Whether students located these possibilities in their work experience or in their professional orientations, there was a collective sense of the possibilities for autonomy that preceded their NP training. Becoming an NP did not give them an unaccustomed responsibility; it was something they already possessed.

The NP’s responsibility was not just a question of attitude. It was about knowledge. These students were returning to the classroom to learn new information about the primary care of children and adults. A focus on evidence was part of the script for technical proficiency, but the responsibility for knowing why one makes one decision versus another was a major shift for many students. While a responsibility for the evidence was a new experience, some students described a form of déjà vu where they found they were learning what they already knew. Jenna reported, “I can sit in our lectures and I know about 85 percent of what they’re teaching us in terms of the science and the treatments and the symptoms.” This was not a variation on the theme: “primary care is not that hard.” Neither Jenna nor any of her cohort members reported that managing the coursework and clinical training was easy. Rather, the feeling of “already knowing” was revealed from being in the program. Jenna explained, “In the beginning, it all seems so different and new. But then, I realized, little by little, that I have a lot of knowledge from 10 years of being a nurse.” Although she started out “feeling like an idiot,” by the end of the program she felt as if she had gotten her “memory back.”

Jenna was not alone in drawing connections between what nurses already know and what NPs were expected to learn. Brooke explained, “You’re taking all of the disease processes—the anatomy and physiology—that you learned as a nurse. Then it gets reinforced in a nurse practitioner curriculum. Then you have to practice applying it.” Whether referring to the educational process as revealing or reinforcing, both models exemplified what was a common story: in becoming NPs, they were becoming the kind of nurse they already were.

Claims of preexisting nursing knowledge, however, are shaky grounds for nursing difference. What NPs know about the biological body is indistinguishable from what physicians know, with the glaring exception that physicians arguably know more. Nursing, however, does marshal claims of difference around what nurses know about their patients and what they do with that knowledge. Scholarship on nursing practices have identified “whole person care,” “knowing the patient,” and “relational interaction” as unique to nursing forms of care (Apesoa-Varano 2016; Benner and Tanner 1987; Evans 1996; Radwin 1996; Tanner et al. 1993). Although these practices are difficult to define, practicing nurses consistently identify them as central features of what makes nursing unique (Apesoa-Varano 2016). What I found in NP educational narratives was a reworking of these orientations to fashion NP-specific strategies of action. NP expertise would not come from what was borrowed from medicine but from remembering to be nurses.

A useful example can be found in revisiting student case presentations. Faculty mentored students through not only how to borrow effectively from medicine but also how to embody nursing expertise. Stephanie was assigned to present a hypothetical case of a male with tuberculosis (TB). Stephanie began with a close adherence to the script: “Chuck is a 35-year-old white male.” He has come into her office complaining of a persistent cough and weight loss. After a brief description of his history, Stephanie begins to answer her list of questions. She walks us through each of the evidence-based guidelines for TB treatment. She even called the county health department; the guidelines for primary care providers recommend doing so because of widespread treatment-resistance.

Stephanie had followed all the right steps. But as she prepared to end her presentation, she was interrupted by Julia Waggoner, CRNP. ‘Excuse me, Stephanie. Before you go on, I’m wondering if we can talk about what to do for Chuck right now.’ In the case write-up, we learned more than the physical findings. Chuck uses heroin and lives in a homeless shelter. ‘Given this situation,’ Julia asks, ‘what would you do?’ ‘Perhaps,’ Stephanie offers, ‘the health department would be a good resource?’ When she had called the health department, she had learned that they not only investigate TB cases but also coordinate treatment.

For Julia, this was not enough. She turned away from Stephanie and addressed the room: ‘Chuck is actively using [heroin]. How likely do you think it is that Chuck will come back, every day, for treatment? Do you let him go back to a shelter with active TB?’ Another student suggests sending Chuck to the hospital. Julia counters with more questions. ‘Do you think someone who needs to use heroin is going to willingly stay in the hospital? And do you think the hospital will admit him for that long with no insurance?’ Julia works in a local ER and speaks from experience. ‘This is not a cut-and-dried situation,’ she concludes.

Julia’s concerns were not idiosyncratic. They were woven throughout the script. Of the 10 questions on the case write-up, Question 6 inquired, “How would this patient’s lack of insurance and social situation impact your plan?” Question 9 asked, “What cultural, spiritual, or ethical issues are relevant?” Julia’s initiation of this discussion communicated that these were not marginal questions to be glossed over; they had real import in clinical decision-making. Certainly not every case featured such intractable problems. However, it was through such cases that discretion became possible and in which NP expertise became visible. There was the case of Martin whose blood pressure was well controlled until he lost his health insurance; there was Yalda who despite her high cholesterol seemed unable to stay away from high fat foods; and Luke, an 11-month-old with asthma whose parents depend on a grandmother who smokes to assist with childcare. Students were responsible for identifying the right physical findings to make a diagnosis and choosing the right guidelines for treatment decisions. But they had to go “off script” to address situations that were not “cut-and-dried.” They had to learn to use medicine’s tools, but to transcend mere technique, they had to remember to be nurses.