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### 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 significantly increase prohibitions on anticompetitive business practices by the private sector shielded by the state action immunity doctrine.

### 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.

#### Antitrust authorities can effectively limit state action immunity

Crane 19 [Daniel A. Crane, Frederick Paul Furth Sr. Professor of Law, University of Michigan, 60 Wm. & Mary L. Rev. 1175, 2019, Lexis]

C. Institutional and Procedural Distinctions

Antitrust preemption and constitutional review are differently situated in one significant way: Constitutional equal protection, substantive due process, and dormant commerce clause principles are privately enforceable by any party that meets the Article III standing requirements--which, in this context, means at least anyone directly affected by a regulation impairing competition. 160 Antitrust has its own private right of action standing rules, 161 as well as an additional institutional feature that might significantly limit some of the abuses associated with Lochnerizing. One proposed route for increasing the preemptive scope of federal antitrust law over anticompetitive state and local regulation is to hold the [\*1208] Parker doctrine inapplicable to the FTC. 162 This would give the FTC enhanced power to challenge anticompetitive state and local regulations. Not only would this limit the incidence of challenges to state regulation (the FTC Act is not privately enforceable and only the Commission can initiate an action under the Act), 163 but it would also put the Commission itself, rather than an Article III court, in the position of making an initial decision on the case. An Article III court could ultimately become involved, as adverse Commission decisions are appealable to any federal court of appeal in which the case could have been initially brought. 164 However, lodging the antitrust review function in the FTC would grant the Commission an initial regulatory review function and the power to make factual findings subject to "substantial evidence" review. 165

#### Enforcement high now and thumps links

Ingrassia 1-4 [John Ingrassia, Proskauer Rose LLP, 1-4-2022 https://www.law360.com/articles/1452119/how-to-navigate-the-coming-antitrust-policy-tests]

2021 will be remembered in antitrust law. Not since the 1970s has there been so much chatter over the fundamental purposes of antitrust policy, or such potential for actual sea change.

Half a century ago, Robert Bork and the Chicago School argued that antitrust law had lost its way and should focus on consumer welfare. Bork's view was that antitrust enforcement was getting in the way of legitimate competition, and the U.S. Supreme Court was quick to embrace the consumer welfare standard.

Now, Federal Trade Commission Chair Lina Khan and the new Brandeisians argue that antitrust law has again lost its way and must shed the constraints of the consumer welfare standard.

Khan's view is that consolidation has gone unchecked in the American economy, resulting in structural harms to competition that the consumer welfare standard is unable to address.

She believes the agency has historically defined markets too narrowly to effectively police broader economic impacts of sustained consolidation, and favored gerrymandered remedies over outright challenges.

Khan has imposed sweeping changes aimed at chilling merger activity and shaping the future of merger enforcement. Against dissents from Republican Commissioners Christine Wilson and Noah Phillips, and charge of going rogue from the U.S. Chamber of Commerce, the FTC stripped away long-standing exemptions and interpretations that streamlined merger review.

The action came in response to an unprecedented merger wave — 3,845 acquisitions filed with the agencies in the first 11 months of 2021, substantially more than most full years.

The changes are having an impact, making investigations more intrusive, lengthy and less predictable. Still, policy precedes practice, and while the FTC has been heavy on policy, it has yet to test those policies in the courts.

The tests may come in the next year. Meanwhile, we can also expect the FTC and the U.S. Department of Justice under Assistant Attorney General Jonathan Kanter's leadership, to not only continue the trajectory of policy changes but also begin the task of entrenching them in agency practice.

Here, we review the year in FTC policy moves, what they mean and how to navigate the newly laid minefields.

Warning Letters After the Close of HSR Waiting Periods

In an unprecedented move, the FTC recently began issuing letters to parties in transactions the agency may intend to investigate after expiration of the Hart-Scott-Rodino Act waiting period. According to the agency in an Aug. 3, 2021, blog, this is the result of "a tidal wave of merger filings that is straining the agency's capacity to rigorously investigate deals ahead of the statutory deadlines." Wilson, however, said on Twitter on Aug. 12, 2021, that she was "gravely concerned that the carefully crafted HSR framework is suffering a death by a thousand cuts," following her Aug. 9 statement that said "For the HSR Act to retain meaning, it cannot be that the FTC will keep merger investigations open indefinitely, as a matter of routine, every time there is a surge in filings." The FTC's jurisdiction to review transactions is independent of the HSR reporting requirements, with the power to investigate any transaction before or after closing, whether subject to reporting or not, and whether the HSR waiting period has expired or not. There are examples of the agencies reviewing nonreportable transactions, and even investigating reportable transactions after expiration of the HSR waiting period, though they are rare. The warning letters do not assert new authority not already existing under law, but notifying parties that an investigation may remain open post-HSR clearance implicates finality and certainty of investigations, but not every transaction gets a warning letter. Those with no issues go through unscathed. Those with clear issues are investigated. The deals that might pose some issues, but not enough to draw an investigation, might trigger the newly minted warning letter. To show the letters have teeth, the FTC will sooner or later have to challenge a deal post-HSR waiting period, putting it to the test before courts, where it is likely to face hurdles to the extent the deal did not warrant a full investigation in the first instance. Still, the practice is ushering a change in how provisions are drafted in deal documents. A buyer asserting that it is not required to close over the — arguably — still-pending investigation may face an uphill battle depending on how the closing conditions are drafted, for they typically point to the expiration of applicable waiting periods and not the absence of potential ongoing investigations or issuance of warning letters. So careful buyers seek closing requirements that no investigations are threatened and that no warning letters have been issued. Recent examples include the 3D Systems Corp.'s agreement to acquire Oqton Inc. and Universal Corp.'s agreement to buy Shank's Extracts Inc. The parties' agreements provided that if a warning letter is issued, the investigation would be treated as closed 30 days after receipt of such letter. Buyers may want to consider similar provisions until more emerges on how the FTC will proceed with warning letter transactions.

More Intensive Merger Investigations

The FTC announced plans on Aug. 3, 2021, to make the second request process both "more streamlined and more rigorous." The changes include the following: Merger investigations will address additional potentially impacted competition, such as labor markets, cross-market effects, and the impact on incentives of investment firms. Modifications to second requests will be more limited. The agency will require parties to provide more information relating to their use of e- discovery in responding to the investigation. Additional information will be required with respect to privilege claims. The FTC said these changes are in recognition that "an unduly narrow approach to merger review may have created blind spots and enabled unlawful consolidation." Possibly in response to such steeped up investigative techniques and resistance to find common ground with merger parties, Sportsman's Warehouse Holdings Inc. and Great Outdoors Group LLC abandoned their proposed merger at the end of 2021, citing indications that the FTC would be unlikely to approve the outdoor sporting goods transaction. The changes, though, do little to streamline the second request process. They make it more complex, burdensome and time-consuming. Perhaps most notable is the use of the process to delve into labor markets. Republicans Wilson and Phillips argued that FTC leadership may have themselves to blame for the merger review crunch, saying in a Nov. 8, 2021 statement: If the agency is lowering thresholds of concern and broadening theories of harm, this certainly would explain why the FTC is unable to conduct merger reviews in a timely manner while our sister agency remains capable of addressing the same increased filing volumes within statutory timeframes.

More Onerous Consent Decree Provisions

Where merger parties settle a challenge rather than litigate, the consent decree process sets out the parties' obligations. Historically, such consent decrees, among other things, required parties to notify the agency prior to certain future acquisitions. The FTC rescinded this long-standing policy, noting that it: Returns now to its prior practice of routinely requiring merging parties subject to a Commission order to obtain prior approval from the FTC before closing any future transaction affecting each relevant market for which a violation was alleged. The agency will also require divestiture buyers to agree to prior approval for any future sale of the assets they acquire. Khan explained the move was to avoid "drain[ing] the already strapped resources of the Commission" on "repeat offenders." The FTC included the new provision in its Oct. 25, 2021, consent decree settling a proposed transaction by DaVita Inc., a dialysis service provider. DaVita is now required to receive prior approval from the FTC of 10 years before any new acquisitions, a dialysis clinic business in Utah being in question. This is a significant change and will chill not only settlements with the FTC, but also M&A transactions at the outset where such provisions are commercially untenable. Wilson and Phillips noted in dissent that "a prior approval requirement imposes significant obligations on merging parties and innocent divestiture buyers." The FTC clearly aims to chill M&A activity, and merger agreements that provide more optionality to abandon deals will become more common, though parties intent on pushing their deal through may see a consent decree with 10-year approval provisions as less palatable than litigating, and force the FTC to cave or go to court.

Withdrawal of the Vertical Merger Guidelines

In another party-line vote, the FTC withdrew the vertical merger guidelines, which were issued just last year. Democratic commissioners criticized the guidelines as based on "unsound economic theories that are unsupported by the law or market realities," and reflecting a "flawed discussion of the purported procompetitive benefits (i.e., efficiencies) of vertical mergers." Vertical transactions are between firms at different levels in the supply chain. Historically, antitrust enforcement of exceptional vertical mergers were rare and difficult given the previously presumed efficiencies. Vertical mergers can eliminate double marginalization, in which firms at each level mark up prices above marginal cost. Elimination of one markup results in lower prices and can be pro-competitive. Khan, however, argues the guidelines' "reliance on [elimination of double marginalization] is theoretically and factually misplaced." Going forward, "the FTC will analyze mergers in accordance with its statutory mandate, which does not presume efficiencies for any category of mergers." This too drew a strong rebuke from the Republican commissioners, who said "The FTC leadership continues the disturbing trend of pulling the rug out under from honest businesses and the lawyers who advise them." The commission's challenges to chipmaker Nvidia Corp.'s $40 billion acquisition of U.K. chip design provider Arm Ltd. alleged the transaction would combine one of the largest chip producers with a firm that has essential design technology — critical inputs. In a Dec. 2, 2021, statement, the FTC said the acquisition "would distort Arm's incentives in chip markets and allow the combined firm to unfairly undermine Nvidia's rivals." The FTC's lawsuit should "send a strong signal that we will act aggressively to protect our critical infrastructure markets from illegal vertical mergers that have far-reaching and damaging effects on future innovations," FTC Bureau of Competition Director Holly Vedova said in the statement. Given that vertical mergers will be closely scrutinized as a matter of course, parties need to consider concerns the FTC may identify and prepare strong counters — other than elimination of double marginalization. For example, parties could argue that the transaction expands access to products and expands consumer choice. Parties willing to go the distance with a vertical merger should also remain mindful that the guidelines have never been cited or relied on by a court, and it is the established jurisprudence on vertical transactions that will carry the day.

Rescinding the Consumer Welfare Standard

In July 2021, the FTC rescinded its policy interpreting its statutory mandate to root out "unfair methods of competition" as coterminous with promoting consumer welfare under the Sherman and Clayton Acts. In a July 19, 2021, statement, the FTC called the rescinded policy was "bind[ing] the FTC to liability standards created by generalist judges in private treble-damages actions under the Sherman Act." Still, the consumer welfare standard has been entrenched in antitrust jurisprudence for decades, and the FTC cannot change that. The immediate impact is thus more likely to be seen in administrative actions in the FTC's own court. In a dissenting statement, Republican commissioners countered that FTC leadership does not propose a replacement standard and "that efforts to distance Section 5 from the consumer welfare standard are a recipe for bad policy and adverse court decisions," adding that, "unlike those in academia, the FTC will have to defend its interpretation of Section 5 in court, where it should expect a hostile reception if it cannot offer clear limiting principles."

Labor Market Scrutiny

Government investigations and private litigation relating to no-poach and wage-fixing agreements are ballooning, and criminal indictments are now a reality. Encouraged by President Joe Biden's executive order on competition, the FTC and the DOJ have doubled down on investigating labor markets. Merger investigations now routinely include requests for employee compensation data, inquiries regarding noncompete and nonsolicit agreements, and are more likely to delve into both the merger's effects on labor, and the parties' prior labor practices. The DOJ's challenge to Penguin Random House LLC's proposed acquisition of Simon & Schuster Inc. focuses on harm to the labor market — for authors. In his first public comments, the DOJ's Kanter said: We will fight for American workers including in connection with illegal mergers that substantially lessen competition for laborers. Going forward, you can expect efforts like these not only to continue but to increase. Khan echoed the sentiment, saying: Competition and conduct can hurt us not just as consumers who buy products from a shrinking number of large firms, but also as workers who are especially vulnerable and subject to the whims of a boss we can't equally or practically escape. Antitrust compliance policies now must extend to addressing practices with respect to employee recruiting and compensation. Antitrust compliance training must extend beyond the sales team, and include HR. Businesses are reviewing and revising their compliance policies, and beginning new antitrust training programs to ensure that they are not subjected to claims of depressed wages and barriers to worker mobility.

Looking Ahead to the Year to Come

The year 2021 has been like no other for antitrust enforcement. While the FTC's various policy pronouncements are clearly intended to chill merger activity, it does not appear to have had the intended outcome.

HSR filings continue at off-the-charts levels. Amid this strong showing of M&A activity, the advice is to keep moving transactions forward, stay ahead of the new tacks the agencies might take, and account for newly injected risk and uncertainty.

Looking ahead, expect another energetic year. So far, the FTC's policy changes have not seemed to slow the pace of merger activity, but the frenzy cannot last forever. Nonetheless, merging parties are now going into the merger review process with eyes open, knowing it is likely to be more intense and uncertain. Parties to vertical transactions will no longer ride easy on double marginalization theories, and parties will be handing over their HR and payroll files.

At the same time, the heavy resistance to these changes will continue, if not strengthen, and will play out not just in courts and the halls of Congress, but will also spill into the political mainstream.

The U.S. Chamber of Commerce is planning to spend hundreds of thousands of dollars on an ad campaign across 10 states denouncing what it calls the FTC's overstepping of regulatory authority.

#### Only federal legal remedies solve – failure to explicitly narrow Parker over-immunizes private entities and chills state action

Weber 16 [Jayme Weber, University of Arizona, James E. Rogers College of Law, J.D., 2016 https://www.cato.org/sites/cato.org/files/pubs/pdf/teladoc-285th-cir-29.pdf]

III. REFUSING SELF-INTERESTED BOARDS IMMUNITY FROM ANTITRUST LIABILITY IS FULLY CONSISTENT WITH FEDERALISM

“Federal antitrust law . . . is ‘as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.’” Dental Exam’rs, 135 S. Ct. at 1109 (quoting United States v. Topco Assocs., Inc., 405 U.S. 596, 610 (1972)). Every business, regardless of its size, is guaranteed the freedom “to assert with vigor, imagination, devotion, and ingenuity whatever economic muscle it can muster.” Topco, 405 U.S. at 610. Antitrust laws—particularly the Sherman Act—are “the Magna Carta of free enterprise,” and play a crucial role in upholding the national policy of economic freedom for anyone wishing to compete in the marketplace. Id.

In line with this national policy, the states clearly have an interest in preventing anticompetitive behavior and fostering robustly competitive markets within and across their borders. State governments also have an interest in reserving the ability to create regulatory subdivisions to which they can delegate some of their authority to accomplish specific tasks. At times, the states may deem it appropriate to design a regulatory body to deliberately exempt it from antitrust laws to achieve a specialized purpose.

States may confer antitrust liability on regulatory bodies—but only under certain conditions. Applying the state-action immunity doctrine too broadly and giving private actors a limitless ability to claim antitrust immunity for themselves would empower state-created cartels to “make economic choices counseled solely by their own parochial interests and without regard to their anticompetitive effects,” disrupting the free enterprise system that protects the national policy of economic freedom. Lafayette, 435 U.S. at 408.

Furthermore, broad application of the Parker-immunity doctrine would actually undermine the states’ ability to effectively delegate authority to specialized or local regulatory bodies by endowing these bodies with an antitrust immunity that state governments may have never meant to give them. “Neither federalism nor political responsibility is well-served by a rule that essential national policies are displaced by state regulations intended to achieve more limited ends.” Ticor, 504 U.S. at 636. The doctrine enables states to create regulatory subdivisions that do not interfere with the interest in preserving the benefits of competition. By “adhering in most cases to fundamental and accepted assumptions about the benefits of competition within the framework of the antitrust laws,” courts actually increase rather than diminish the states’ regulatory flexibility. Id. State legislatures may wish to make broad delegations of authority to their political subdivisions in order to maximize the benefits of the specialized governance those bodies offer— but that does not necessarily mean that state legislatures always want to give those entities the ability to violate the federal antitrust laws.

“When a state grants power to an inferior entity, it presumably grants the power to do the thing contemplated, but not to do so anticompetitively.” Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law ¶ 225a, at 131 (3d ed. 2006). Relying on the backdrop of the national policy favoring competition, states may enact such broad delegations that are nevertheless intended to create specific and narrow, rather than general and wide-reaching, regulatory schemes. Giving regulatory agencies state-action immunity too readily would undermine states’ ability to do so, creating the hazard that legislatures will inadvertently authorize anticompetitive conduct. State legislatures cannot possibly anticipate every potential anticompetitive consequence of these delegations of authority and explicitly disavow antitrust immunity for every one. “‘No legislature . . . can be expected to catalog all of the anticipated effects’ of a statute delegating authority to a substate governmental entity.” Phoebe Putney, 133 S. Ct. at 1012 (quoting Hallie, 471 U.S. at 43).

If a state intends a specific anticompetitive result, it may clearly articulate that result—or make it plainly foreseeable, see id. at 1011—giving voters the chance to oppose immunity-creating legislation before it becomes law and making it easier to hold legislators accountable. Otherwise, states would be impeded in their freedom of action because they would have to act “in the shadow of state-action immunity whenever they enter[ed] the realm of economic regulation.” Ticor, 504 U.S. at 636. The limited and careful application of the state-action immunity doctrine gives states the most freedom in delegating power and crafting regulatory entities, ensuring legislatures that they will not accidentally confer immunity and allow regulatory bodies to go rogue with anticompetitive conduct that deviates from the states’ interest of preserving robust marketplace competition for the benefit of their residents.

#### Biden’s XO empirically denies any FTC Parker links and more restrictions coming

Bulusu 21 [Siri Bulusu, Reporter Bloomberg Law, 7-12-2021 https://news.bloomberglaw.com/antitrust/worker-license-rules-emerge-as-ftc-competition-oversight-priority]

President Joe Biden’s order, signed Friday, calls on the Federal Trade Commission to boost labor market competition by writing new rules that limit “unnecessary, cumbersome” licensing requirements, often imposed by states’ regulatory boards and quasi-public organizations.

“Some overly restrictive occupational licensing requirements can impede workers’ ability to find jobs and to move between states,” according to the order. The order comes amid a flurry of lawsuits against state or state-backed licensing bodies that accuse them of violating antitrust law by imposing expensive fees or threatening to shut down out-of-state businesses. The text of the order didn’t include specific directions for federal antitrust agencies. But the FTC’s anticipated actions and possible rulemaking could lead to streamlined licensing requirements across states, eliminating demands for worker information unrelated to the job, enforcement of interstate commerce rules, and levying of punitive fines, market watchers say. Licenses are expensive and requirements vary among states, even in the same industry. Reining in the requirements could remove a significant employment barrier, particularly for military families and others who frequently move between states or offer services across state lines. But it also could shift states’ calculations in cracking down on frauds and impostors. Cosmetology licenses can cost up to $15,000 and sometimes years of study, said Dick Carpenter, a senior director of strategic research for the Institute for Justice. Other jobs, ranging from public health and safety positions to interior designers, barbers, and manicurists, also require licensing. “Without any kind of standardization of different licensing requirements—even if you have the same requirements in different jurisdictions—you still have to get a license for each jurisdiction, which impedes an employee’s ability to be mobile,” said Tracey Diamond, a partner at Troutman Pepper LLP’s labor and employment practice.

Potential FTC Moves

The FTC’s options include writing new rules

or heightening enforcement of interstate commerce rules in areas where they overlap with antitrust violations, labor market watchers say. Under this principle, restricting labor through onerous licensing requirements would be tantamount to limiting movement of services across borders.

“In the past, occupational licensing was a matter overseen by the Department of Labor, but they don’t quite have the teeth that the Federal Trade Commission has in terms of working in specific locations,” said Morris Kleiner, a University of Minnesota professor of labor policy.

The FTC could turn its limited resources toward scrutinizing occupational licensing programs that narrow the practice scope of a certain profession and limit competition, Kleiner said.

How the commission interprets which licensing requirements are “unnecessary” could be scrutinized. Those could include common requirements such as citizenship and a clean criminal record, said Bobby Chung, a postdoctoral research associate at the University of Illinois at Urbana-Champaign who focuses on licensing. .

“The required training, education and exams should confer the relevant skill sets,” Chung said. “If not, I would regard those requirements as unnecessary.” The agency also may impose specific guidelines that limit fees or frequency of license renewal, Kleiner said. “But more importantly, the FTC’s guidelines could be aimed specifically at states that have ratcheted up their requirements,” he said.

Gaining Attention

Burdensome licensing requirements have increasingly come under federal scrutiny as the labor market has shifted away from manufacturing jobs to service-oriented professions. States began imposing licensing requirements in order to protect consumers from bad actors and standardize services. “Licenses create a monopoly of workers who can provide a service,” Kleiner said. “But if you provide those services without a license, the police powers of the state can arrest and severely fine those individuals.” In 2020, roughly 23% of workers were required to have a license, according to the Bureau of Labor Statistics. Over the years, many states, including Arizona, Connecticut, Nebraska, and Tennessee, have modified their rules to lower what they considered to be burdensome barriers to obtaining licenses. Biden’s move is part of states’ broader push for changes, Carpenter said. “There is a momentum building to raise awareness to the issue.” Advocates for change also cite underemployment and unemployment stemming from the burdensome licensing requirements, as well as allegations that certain industries create occupational licensing to limit competition. Immigrants also can be affected by the licensing requirements, particularly if they hold foreign degrees but are performing lesser-skilled jobs in the U.S., according to a 2017 study by the Migration Policy Institute. Licensing particularly hurts foreign nationals with temporary work visas whose immigration status impedes them from seeking a license to work within their specialty, Chung said. That in turn impedes their path to permanent residency or citizenship, he said.

State Action

The FTC has struggled to rein in licensing practices with antitrust violations partly because public entities, like state-controlled licensing boards, can claim state action immunity. Such immunity authorizes a state to carry out certain legitimate government functions, often in regulated industries that require licensing.

“Many of these state certifications don’t violate antitrust law and that’s because of this doctrine that displaces antitrust law,” said Jesse Markham, a partner at Baker & Miller PLLC’s San Francisco office. “And that’s why these certification requirements exist with impunity.”

In 2015, the Supreme Court ruled in North Carolina State Board of Dental Examiners v. FTC that the state board was operated by market participants. Without active supervision from the state, the board couldn’t claim state action immunity from federal antitrust actions.

The ruling unleashed “dozens of lawsuits"—seeking antitrust treble damages—against individual members of licensing boards, according an October 2020 statement from Reps. Mike Conaway (R-Texas), Jamie Raskin (D-Md.), and David Cicilline (D-R.I.) in support of a bill they introduced to shield board members from such suits.

Qualifying for state action immunity largely depends on whether a board is a true government actor or a private market participant. But this delineation becomes more complex if there’s a blurred line between a state agency handling its own actions or a private group acting under state guidance.

How the FTC handles that blurred line will be one issue the agency tackles as it implements the president’s order.

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### 2ac – fw

#### Our FW’s is best for crafting resistance to neolib

Watts 21 [Galen Watts is Guest Professor with Special Appointment and Banting Postdoctoral Fellow, based at KU Leuven, “Are you a neoliberal subject? On the uses and abuses of a concept” 8-6-2021 Sage Journals]

a kind of cookie-cutter typification or explanation, a tendency to identify any programme with neo-liberal elements as essentially neo-liberal, and to proceed as if this subsumption of the particular under a more general category provides a sufficient account of its nature or explanation of its existence. (Rose et al., 2006, p. 98).1

Furthermore, it is critical to note that Rose, like Foucault, has long distanced himself from the kind of socio-critique implicit in neoliberalism (2). And the reason for this is that he seems to think, given that advanced liberalism is the regnant form of political rule, we are all subject to it in one way or another (Barry et al., 1996).

Where does this leave us? I would put it this way: If we accept that neoliberalism (1) has created socio-economic conditions that have forced individuals to adapt and thereby become, to some extent, self-responsible subjects, then it might well be that all of us, simply by virtue of inhabiting these social conditions, have become ‘neoliberal subjects’. Indeed, if we accept Rose’s claim that we are all subject to advanced liberal forms of rule, then this would seem a natural corollary. However, the difficulty with this conception of ‘neoliberal subject’ is that it is not clear what ‘neoliberal’ in this instance actually means. It is clearly not neoliberalism (2), since this would entail not just adaptation, but acquiescence such that we, as individuals, had accepted the basic tenets of neoliberal 14 European Journal of Social Theory XX(X) ideology. Nor is it clear that it entails neoliberalism (3), which entails having one’s subjectivity constituted by neoliberal reason. Thus, it seems to me far more accurate to say that we are all (or most us, anyway) liberal subjects – those who, in one way or another, conceive of ourselves as self-responsible, autonomous and self-realizing subjects. Though it goes without saying that such a claim is not all that illuminating.

Conclusion

Let me be clear: I do not doubt that, in some cases, neoliberalisms (1), (2) and (3) have led to the production of actual ‘neoliberal subjects’ – that is, living breathing homo oeconomicus. For instance, I would conjecture that the world of corporate finance is probably densely populated with such subjects (e.g. Neely, 2020). And indeed, in my own research, I have found that Charismatic Christians who subscribe to ‘prosperity gospel’ approximate the ‘enterprising self’ normalized in human capital theory (Watts, forthcoming). However, I am quite sceptical of the claim that neoliberal subjects populate each and every social sphere, as if we are all in the thralls of neoliberal ideology, or govern ourselves exclusively according to the dictates of neoliberal reason. That said, this obviously remains an urgent research question. But if we are to pursue it, we require a methodological approach that is sensitive to institutional specificities, the extent to which discourses are polyvalent, and the complexities involved in the production of psychic and embodied subjectivities, not just a loose discourse analysis of governmental texts.

Why? For both academic and political reasons. First, the academic: to the extent that neoliberalisms (1), (2) and (3) exist, it only muddies the water to overinterpret them. Indeed, we would do better to practice analytic precision when labelling something (or someone) ‘neoliberal’. This is especially the case when researching across national contexts: it is simply not accurate that every citizen of Western liberal democracies is equally ‘neoliberal’, either in the sense that they adhere to neoliberal ideology or that they live according to neoliberal reason. And as a growing number of scholars have maintained, it is misleading to interpret the subjective lives of citizens of East Asia and the Global South as wholly colonized by either neoliberalisms (2) or (3) (Ferguson, 2009; Parnell & Robinson, 2012). However, even within specific national contexts, we must make sure to recognize that identities and discourses are multiple, such that mere invocations of aspects of ‘neoliberal discourse’ should not be taken as evidence of a comprehensive ‘neoliberal subjectivity’. In short, if our aim as social scientists is to capture the complexity, richness and diversity of subjective life in the twenty-first century, then we ought to broaden the ‘repertoire of subjectivity’ (Green, 2010, p. 331) carried in our analytic toolboxes.

Second, the political: for those of us who find something abhorrent about neoliberalisms (1), (2) and (3), it may actually undermine our cause to repeatedly give the impression that one or either of these have seeped into the subjectivities of everyone presently living. One reason for this is that to the extent that we overlook, or dismiss, extant alternative social and moral forms, we may unwittingly serve to bolster neoliberal ideology and reason, aiding and abetting their spokespeople in their goal of global domination. Indeed, John Welsh (2020, p. 68) suggests that if we are to oppose neoliberalism in all of its forms, academics must begin to ‘introduce contingency back into the interstices of this seemingly impenetrable edifice’. Interestingly, this strategy actually aligns with the mature work of Foucault, for whom scholarship should seek to disrupt that which is taken for granted. Drawing on this Foucaultian legacy, Cornelissen (2018, p. 144) convincingly argues that ‘resistance should be given a more prominent analytical role in the critique of neoliberalism’, adding, ‘resistance is not secondary to the elaboration of alternatives; rather, moments of refusal must guide the formulation of alternative analyses’. Cornelissen concludes, ‘what is at stake politically is our capacity to imagine practices or resistance to neoliberalism and to take seriously those modalities of resistance that already exist’. I could not agree more. And for this reason, I think we should be far more careful when invoking the monolithic notion of a ‘neoliberal subject’.

### 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

#### 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.

#### 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.

#### 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.

### sustainability – long backline

#### It's sustainable---by every metric cap causes improvements

Schrager **‘**20 [Allison; Winter 2020; Ph.D. in Economics from Columbia University, Senior Fellow at the Manhattan Institute; "Why Socialism Won't Work," https://foreignpolicy.com/2020/01/15/socialism-wont-work-capitalism-still-best/]

WITH INCREASINGLY UBIQUITOUS IPHONES, internet, central air conditioning, flat-screen TVs, and indoor plumbing, few in the developed world would want to go back to life 100, 30, or even 10 years ago. Indeed, around the world, the last two centuries have brought vast improvements in material living standards; billions of people have been lifted from poverty, and life expectancy across income levels has broadly risen. Most of that progress came from capitalist economies.

Yet those economies are not without their problems. In the United States and the United Kingdom, the gap between the rich and poor has become intolerably large as business owners and highly educated workers in urban areas have become richer while workers' wages in rural areas have stagnated. In most rich countries, more trade has brought a bigger, better variety of goods, but it has also displaced many jobs.

With social instability in the form of mass protests, Brexit, the rise of populism, and deep polarization knocking at the capitalist economies' doors, much of the progress of the last several decades is in peril. For some pundits and policymakers, the solution is clear: socialism, which tends to be cited as a method for addressing everything from inequality and injustice to climate change.

Yet the very ills that socialists identify are best addressed through innovation, productivity gains, and better rationing of risk. And capitalism is still far and away the best, if not only, way to generate those outcomes.

TODAY'S SOCIALISM IS DIFFICULT TO DEFINE. Traditionally, the term meant total state ownership of capital, as in the Soviet Union, North Korea, or Maoist China. Nowadays, most people don't take such an extreme view. In Europe, social democracy means the nationalization of many industries and very generous welfare states. And today's rising socialists are rebranding the idea to mean an economic system that delivers all the best parts of capitalism (growth and rising living standards) without the bad (inequality, economic cycles).

But no perfect economic system exists; there are always trade-offs--in the most extreme form between total state ownership of capital and unfettered markets without any regulation or welfare state. Today, few would opt for either pole; what modern socialists and capitalists really disagree on is the right level of government intervention.

Modern socialists want more, but not complete, state ownership. They'd like to nationalize certain industries. In the United States, that's health care--a plan supported by Democratic presidential candidates Elizabeth Warren (who does not call herself a socialist) and Bernie Sanders (who wears the label proudly). In the United Kingdom, Labour Party leader Jeremy Corbyn, who was trounced at the polls in mid-December, has set his sights on a longer list of industries, including the water, energy, and internet providers.

Other items on the socialist wish list may include allowing the government to be the primary investor in the economy through massive infrastructure projects that aim to replace fossil fuels with renewables, as Green New Deal socialists have proposed. They've also floated plans that would make the government the employer of a majority of Americans by offering guaranteed well-paid jobs that people can't be fired from. And then there are more limited proposals, including installing more workers on the boards of private companies and instituting national rent controls and high minimum wages.

For their part, modern capitalists want some, but less, state intervention. They are skeptical of nationalization and price controls; they argue that today's economic problems are best addressed by harnessing private enterprise. In the United States, they've argued for more regulation and progressive taxation to help ease inequality, incentives to encourage private firms to use less carbon, and a more robust welfare state through tax credits. Over the past 15 years, meanwhile, capitalist Europeans have instituted reforms to improve labor market flexibility by making it easier to hire and fire people, and there have been attempts to reduce the size of pensions.

No economic system is perfect, and the exact right balance between markets and the state may never be found. But there are good reasons to believe that keeping capital in the hands of the private sector, and empowering its owners to make decisions in the pursuit of profit, is the best we've got.

ONE REASON TO TRUST MARKETS is that they are better at setting prices than people. If you set prices too high, many a socialist government has found, citizens will be needlessly deprived of goods. Set them too low, and there will be excessive demand and ensuing shortages. This is true for all goods, including health care and labor. And there is little reason to believe that the next batch of socialists in Washington or London would be any better at setting prices than their predecessors. In fact, government-run health care systems in Canada and European countries are plagued by long wait times. A 2018 Fraser Institute study cites a median wait time of 19.8 weeks to see a specialist physician in Canada. Socialists may argue that is a small price to pay for universal access, but a market-based approach can deliver both coverage and responsive service. A full government takeover isn't the only option, nor is it the best one.

Beyond that, markets are also good at rationing risk. Fundamentally, socialists would like to reduce risk--protect workers from any personal or economywide shock. That is a noble goal, and some reduction through better functioning safety nets is desirable. But getting rid of all uncertainty--as state ownership of most industries would imply--is a bad idea. Risk is what fuels growth. People who take more chances tend to reap bigger rewards; that's why the top nine names on the Forbes 400 list of the richest Americans are not heirs to family dynasties but are self-made entrepreneurs who took a leap to build new products and created many jobs in the process.

Some leftist economists like Mariana Mazzucato argue that governments might be able to step in and become laboratories for innovation. But that would be a historical anomaly; socialist-leaning governments have typically been less innovative than others. After all, bureaucrats and worker-corporate boards have little incentive to upset the status quo or compete to build a better widget. And even when government programs have spurred innovation--as in the case of the internet--it took the private sector to recognize the value and create a market.

And that brings us to a third reason to believe in markets; productivity. Some economists, such as Robert Gordon, have looked to today's economic problems and suggested that productivity growth--the engine that fueled so much of the progress of the last several decades--is over. In this telling, the resources, products, and systems that underpin the world's economy are all optimized, and little further progress is possible.

But that is hard to square with reality. Innovation helps economies do more with fewer resources--increasingly critical to addressing climate change, for example--which is a form of productivity growth. And likewise, many of the products and technologies people rely on every day did not exist a few years ago. These goods make inaccessible services more available and are changing the nature of work, often for the better. Such gains are made possible by capitalist systems that encourage invention and growing the pie, not by socialist systems that are more concerned with how the existing pie is cut. It is far too soon, in other words, to write off productivity.

#### Sustainable and the alt is try or die

King 21 (David King, Founder and Chair, Centre for Climate Repair at Cambridge, University of Cambridge; and Jane Lichtenstein, Associate, Centre for Climate Repair at Cambridge, University of Cambridge; “Surviving the next 50 years is an existential crisis – 3 things we must do now,” The Print, 8-14-2021, https://theprint.in/opinion/surviving-the-next-50-years-is-an-existential-crisis-3-things-we-must-do-now/715069/)

The challenge of surviving the next 50 years is now seen as a planet-wide existential crisis; we need to work together urgently, just to secure a short-term future for human civilisation. Global weather patterns are violently disrupted: Greece burns; the south of England floods; Texas has had its coldest weather ever, while California and Australia suffer apocalyptic wild fires. All of these violent, record-breaking events are a direct result of rapid heating in the Arctic – occurring faster than in the rest of the world. A warm Arctic triggers new ocean and air currents that change the weather for everyone. The only way to reverse some of these catastrophic patterns, and to regain a kind of stability in climate and weather systems, is “climate repair” – a strategy we call “reduce, remove, repair” – which demands that we make very rapid progress to net zero global emissions; that there is massive, active removal of greenhouse gases from the atmosphere; and, in the first instance, that we refreeze the Earth’s poles and glaciers to correct the wild weather patterns, slow down ice-melt, stabilise sea level, and break the feedback loops that relentlessly accelerate global warming. There are no either/or options. Reducing emissions About 70% of world economies have net zero emissions commitments over varying timescales, but this has come too late to restore climate stability. The IPCC has asked for accelerated progress on this trajectory, but whatever happens, current emission rates of atmospheric greenhouse gases imply global warming of 1.5℃ by 2030 and well over 2℃ above pre-industrial level by the end of the century – a devastating outcome. In particular, melting ice and thawing permafrost are considered inevitable even if rapid and deep CO2 emissions reductions are achieved, with sea-level rise to continue for centuries as a result. In every area of the world, climate events will become more severe and more frequent, whether flooding, heating, coastal erosion or fires. There are definitely important steps that can still reduce the scale of this devastation, including faster and deeper emissions reductions. However, this is not enough on its own to avert the worst. Together there is real evidence that the massive removal of greenhouse gases from the atmosphere and solutions such as repairing the Earth’s poles and glaciers could help humanity find a survivable way out of this crisis. Removing greenhouse gases Taking CO2 and equivalent greenhouse gases out of the atmosphere, with the aim of getting back to 350ppm (parts per million) by 2100, involves creating new CO2 “sinks” – long-term stores from which CO2 cannot escape. Sinks operate at many scales, with forest planting, mangrove restoration, wetland and peat preservation all crucially important. Very large projects, such as the restoration of the Loess Plateau in China demonstrate scalable CO2 removal, with multiple add-on benefits of food production, bio-diversity enhancement and weather stabilisation. Habitat restoration can also make economic sense. In the Philippines, mangrove is the focus of a cost-benefit analysis. Mangrove captures four times more carbon than the same area of rainforest, provides numerous ecosystem services and protects against flooding, conferring socio-economic benefits and significantly reducing the cost of dealing with extreme weather events. Big new carbon sinks must be created wherever safely possible, including in the oceans. Interventions that mimic natural processes, known to operate safely “in the wild”, are a workable starting point. Promotion of ocean pastures to restore ocean diversity and fish and whale stocks to the levels last seen 300 years ago is one such possibility – offering new sustainable food sources for humans, as well as contributing to climate ecosystem services and carbon sinks. In nature, sprinklings of iron-rich dust blow from deserts or volcanic eruptions, onto the surface of deep oceans, generating – in a matter of months – rich ocean pastures, teeming fish stocks and an array of marine wildlife. Studies of ocean kelp regeneration show the full range of real-life impacts, from increased protein sources for human consumption, to restoration of pre-industrial levels of ocean biodiversity and productivity, and extensive carbon sequestration. Extending the scale and number of ocean pastures could be achieved by systematically scattering iron-rich dust onto target areas in oceans around the world. The approach is intuitively scalable, and could sequester perhaps 30 billion tons per year of CO2 if 3% or so of the world’s deep oceans were to be treated annually. Large-scale carbon-sink creation of this kind is pivotal if the atmosphere is to return to pre-industrial CO2 levels. A billion tons per year of sequestration is the minimum threshold coordinated by the Centre for Climate Repair at Cambridge given the intensity of the climate crisis. While the scale of intervention is sometimes called “geoengineering”, the approach is closer to forest planting or mangrove restoration. The aim is to remove CO2 from the atmosphere using natural means, to return us to pre-industrial levels within a single generation. Repairing the planet The immediate challenge is to stabilise the planet, achieving a manageable equilibrium that gives a last chance to shift to renewable energy and towards a circular global economy, with new norms in urban, rural and ocean management. “Repairing” systematically seeks to draw the Earth back from climate tipping points (which, by definition, cannot happen without direct effort), providing a supporting framework in which “reduce” and “restore” can happen. Political and societal will is needed. The most urgent effort is to refreeze the Arctic, interrupting a bleak spiral of accelerating ice loss, sea-level rise – and the acceleration of climate change and violent global weather changes that they cause. Arctic temperatures have risen much faster (and increasingly so) than global average temperatures, when compared with pre-industrial levels. Figure 1 shows this clearly from 1850 to the present day. Melting Arctic ice embodies a powerful feedback force in climate change. White ice reflects the Sun’s energy away from the Earth before it can heat the surface. This is known as the albedo effect. As ice melts, dark-blue seawater absorbs increasing amounts of the Sun’s energy, warming increases, and ever-larger areas of ice disappear each summer, expanding the acceleration. Arctic temperatures govern winds, ocean currents and weather systems across the globe. A tipping point is passing: sea-ice loss is becoming permanent and accelerating; Greenland ice will follow and will eventually raise global sea-levels by over seven metres. Total loss may take centuries but, decade by decade, there will be relentless incremental impacts. By mid-century the melting will be irreversible, and sea-level rise alone will leave low-lying countries like Vietnam in desperate circumstances, with reductions to global rice production a certainty, many millions of climate refugees and no obvious pathway forward for such nations. Figure 1: comparison between average global temperature change, and change in the Arctic region from 1850 to present day. Provided by Nerilie Abram using IPCC data, ANU, Australia, 2021 The rapid Arctic temperature increase is matched by the rapid and accelerating loss in minimum (summer) sea-ice volume (Figure 2), which further accelerates the temperature rise in a spiral of reinforcing feedback loops. Figure 2: decline in annual minimum Arctic Sea ice volume 1980-2020. Provided by Nerilie Abram using IPCC data, ANU, Australia, 2021 It is vital to pivot the world back from this ice-melt tipping point, and to repair the Arctic as rapidly as possible. Marine cloud brightening in which floating solar-powered pumps spray salt upwards to brighten clouds and create a reflective barrier between the Sun and the ocean, is known to cool ocean surfaces and is a promising way to promote Arctic summer cooling. It mimics nature, and can be scaled up or down in a flexible way. Studies of marine cloud brightening, its climate impacts and interactions with human systems, are underway. As with promotion of ocean pastures, such solutions must be critically analysed, but there is no longer any doubt of their crucial importance. What we do in the next five years determines the viability of humanity’s future. Even if we narrow our aspirations to “survival”, fixing on a timescale of 50 years or so, the challenges are daunting. Humanity deserves better. We know what to do to be able to imagine thousands of years of human civilisation ahead, as well as behind us.

### Alt – rest

#### 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.

### Pornotroping – 2AC

#### ( ) The advantage creates productive grounding for action, not appropriation---rejecting cross-experiential understanding of violence is bad

-- prevents mutual understanding

-- places the sole onus for response on the oppressed

-- identities are contingent and socially constructed and can hence be remade (but this doesn’t mean we’re post-racial)

-- creates foundation for political action

-- the shared understanding (your cause is our cause – we are both hurt by this) militates against exclusion

Bhambra 10 – Dr. Gurminder K Bhambra, Professor of Sociology at the University of Warwick, and Victoria Margree, Principal Lecturer on the Humanities Programme at the University of Brighton, “Identity Politics and the Need for a ‘Tomorrow’”, http://eprints.brighton.ac.uk/12679/1/Identity\_politics.pdf

We suggest that alternative models of identity and community are required from those put forward by essentialist theories, and that these are offered by the work of two theorists, Satya Mohanty and Lynn Hankinson Nelson. Mohanty’s ([1993] 2000)post-positivist, realist theorisation of identity suggests a way through the impasses of essentialism, while avoiding the excesses of the postmodernism that Bramen, among others, derides as a proposed alternative to identity politics. For Mohanty ([1993]2000), identities must be understood as theoretical constructions that enable subjects to read the world in particular ways; as such, substantial claims about identity are, in fact, implicit explanations of the social world and its constitutive relations of power. Experience – that from which identity is usually thought to derive– is not something that simply occurs, or announces its meaning and signiﬁcance in a self-evident fashion: rather, experience is always a work of interpretation that is collectively produced (Scott 1991).

Mohanty’s work resonates with that of Nelson (1993), who similarly insists upon the communal nature of meaning or knowledge-making. Rejecting both foundationalist views of knowledge and the postmodern alternative which announces the “death of the subject” and the impossibility of epistemology, Nelson argues instead that, it is not individuals who are the agents of epistemology, but communities. Since it is not possible for an individual to know something that another individual could not also (possibly) know, it must be that the ability to make sense of the world proceeds from shared conceptual frameworks and practices. Thus, it is the community that is the generator and repository of knowledge. Bringing Mohanty’s work on identity as theoretical construction together with Nelson’s work on epistemological communities therefore suggests that, “identity” is one of the knowledges that is produced and enabled for and by individuals in the context of the communities within which they exist.

The post-positivist reformulation of “experience” is necessary here as it privileges understandings that emerge through the processing of experience in the context of negotiated premises about the world, over experience itself producing self-evident knowledge (self-evident, however, only to the one who has “had” the experience). This distinction is crucial for, if it is not the experience of, for example, sexual discrimination that “makes” one a feminist, but rather, the paradigm through which one attempts to understand acts of sexual discrimination, then it is not necessary to have actually had the experience oneself in order to make the identiﬁcation “feminist”. If being a “feminist” is not a given fact of a particular social (and/or biological) location – that is, being designated “female” – but is, in Mohanty’s terms, an “achievement” – that is, something worked towards through a process of analysis and interpretation – then two implications follow. First, that not all women are feminists. Second, that feminism is some-thing that is “achievable” by men. 3

While it is accepted that experiences are not merely theoretical or conceptual constructs which can be transferred from one person to another with transparency, we think that there is something politically self-defeating about insisting that one can only understand an experience (or then comment upon it) if one has actually had the experience oneself. As Rege (1998) argues, to privilege knowledge claims on the basis of direct experience, orthen on claims of authenticity, can lead to a narrow identity politics that limits the emancipatory potential of the movements or organisations making such claims. Further, if it is not possible to understand an experience one has not had, then what point is there in ~~listening to (~~reflecting upon) each other? Following Said, such a ~~view~~ (perspective) seems to authorise privileged groups to ignore the discourses of disadvantaged ones, or, we would add, to place exclusive responsibility for addressing injustice with the oppressed themselves. Indeed, as Rege suggests, reluctance to speak about the experience of others has led to an assumption on the part of some white feminists that “confronting racism is the sole responsibility of black feminists”, just as today “issues of caste become the sole responsibility of the dalit women’s organisations” (Rege 1998).Her argument for a dalit feminist standpoint, then, is not made in terms solely of the experiences of dalit women, but rather a call for others to “educate themselves about the histories, the preferred social relations and utopias and the struggles of the marginalised” (Rege 1998). This, she argues, allows “their cause” to become “our cause”, not as a form of appropriation of “their” struggle, but through the transformation of subjectivities that enables a recognition that “their” struggle is also “our” struggle. Following Rege, we suggest that social processes can facilitate the understanding of experiences, thus making those experiences the possible object of analysis and action for all, while recognising that they are not equally available or powerful for all subjects. 4 Understandings of identity as given and essential, then, we suggest, need to give way to understandings which accept them as socially constructed and contingent on the work of particular, overlapping, epistemological communities that agree that this or that is a viable and recognised identity. Such an understanding avoids what Bramen identiﬁes as the postmodern excesses of “post-racial” theory, where in this “world without borders (“racism is real, but race is not”) one can be anything one wants to be: a black kid in Harlem can be Croatian-American, if that is what he chooses, and a white kid from Iowa can be Korean-American”(2002: 6). Unconstrained choice is not possible to the extent that, as Nelson (1993) argues, the concept of the epistemological community requires any individual knowledge claim to sustain itself in relation to standards of evaluation that already exist and that are social. Any claim to identity, then, would have to be recognised by particular communities as valid in order to be successful. This further shifts the discussion beyond the limitations of essentialist accounts of identity by recognising that the communities that confer identity are constituted through their shared epistemological frameworks and not necessarily by shared characteristics of their members conceived of as irreducible. 5 Hence, the epistemological community that enables us to identify our-selves as feminists is one that is built up out of a broadly agreed upon paradigm for interpreting the world and the relations between the sexes: it is not one that is premised upon possessing the physical attribute of being a woman or upon sharing the same experiences. Since at least the 1970s, a key aspect of black and/or postcolonial feminism has been to identify the problems associated with such assumptions (see, for discussion, Rege 1998, 2000).

We believe that it is the identiﬁcation of injustice which calls forth action and thus allows for the construction of healthy solidarities. 6 While it is accepted that there may be important differences between those who recognise the injustice of disadvantage while being, in some respects, its beneﬁciary (for example, men, white people, brahmins), and those who recognise the injustice from the position of being at its effect (women, ethnic minorities, dalits), we would privilege the importance of a shared political commitment to equality as the basis for negotiating such differences. Our argument here is that thinking through identity claims from the basis of understanding them as epistemological communities militates against exclusionary politics (and its associated problems) since the emphasis comes to be on participation in a shared epistemological and political project as opposed to notions of ﬁxed characteristics – the focus is on the activities individuals participate in rather than the characteristics they are deemed to possess. Identity is thus deﬁned further as a function of activity located in particular social locations (understood as the complex of objective forces that inﬂuence the conditions in which one lives) rather than of nature or origin (Mohanty 1995:109-10). As such, the communities that enable identity should not be conceived of as “imagined” since they are produced by very real actions, practices and projects.

## T

### 2ac – t-private

#### We meet – the plan text specifies the application to the private sector

#### Parker immunity shields private entities in anticompetitive behavior – it’s not only when state is acting as sovereign

Safvati 16 [Sina Safvati, J.D., University of California, Los Angeles, School of Law, with honors, 2016 B.A., University of California, Los Angeles, summa cum laude, 2012 CLERKSHIPS U.S.C.A., 9th Circuit U.S.D.C., Southern District of Florida, https://www.uclalawreview.org/wp-content/uploads/2019/09/Safvati-63-4-update.pdf]

Based in part on the fear that States might “confer antitrust immunity on private persons by fiat,”24 the Supreme Court clarified in later decisions that the automatic exemption from federal antitrust law applies only when the state is acting as a sovereign—when the anticompetitive decision is expressly made by a state legislature or state supreme court.25 In the case of political subdivisions and private entities, the Parker immunity exemption applies only if the entity makes a sufficient showing that the anticompetitive decision was in fact one of the sovereign.26 Through its subsequent jurisprudence, the Court defined three distinct categories in the Parker-immunity inquiry.

The first category is reserved for cases in which the sovereign directly and expressly made the anticompetitive action, limited to actions of the state legislature or state supreme court.27 Parker immunity automatically applies in such cases.28 The second category (“quasi-public”)29 is reserved for cases in which a municipality or a “prototypical state agency”30 has engaged in anticompetitive conduct.31 When municipalities seek Parker immunity, the anticompetitive conduct must have been pursuant to a clearly articulated state policy to displace competition.32 The third category is reserved for instances in which private entities have engaged in anticompetitive conduct. When private entities seek Parker state-action immunity, they must show both that the challenged conduct was pursuant to a clearly articulated state policy and that it was actively supervised by the state itself.33 In the 2014–2015 term, the Supreme Court held in North Carolina Board of Dental Examiners v. FTC that a state occupational licensing board comprised of a “controlling number” of “active market participants” was private and subject to the active supervision requirement.34

[Footnote 33] E.g., Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc., 445 U.S. 97, 105–06 (1980) (holding that the private wine price-setting scheme could not benefit from Parker immunity because although the scheme was pursuant to a clearly articulated state policy, the state did not engage in any “pointed reexamination” of the program and thus did not satisfy the active state supervision prong); see also S. Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48, 56–57 (1985).

#### Private sector is not “controlled” by state

**JTP 21** (Java T Point, https://www.javatpoint.com/public-sector-vs-private-sector)

The **public sector** is the sector which includes both **public companies** and **services**. In other words, the public sector is the sector that is under government's control. The public sector includes agencies, enterprises, banks, companies, etc., that are controlled by the government. Some examples of the public sector include infrastructure, sewers, public transit, healthcare, goods, services, etc. The public sector is made of three parts, i.e., the judiciary, legislative, and executive. These three segments combine and make the private sector. One of the major aims of the public sector is to have a balance between economy and wealth. The public sector is under the state control. More or less, the companies and agencies under the public sector are owned by the state. Now, let us look at some contrasting points between these sectors.

Private Sector

The private sector is defined as the **sector** wherein the **economy** is controlled by **private groups**. In layman's terms, a **private sector** is the sector that is **not under the control of the state**. Private sectors are run by companies yielding profits. The private sector can also be called as the citizen sector. Examples of the private sector are ICICI Bank, ITC Limited, HDFC Bank, etc. Apart from the banks, the proprietors, businessmen, accountants, SMEs, etc., are some other examples of the private sector. The major objective of the private sector is to earn maximum profits and have sole ownership or control. The private banks have better management systems, due to which they are able to yield more profits. Some of the private companies include Vitol, Koch Industries, Huawei, etc.

#### We meet – Parker immunity shields private entities

#### It’s best---

#### Education---scope of state action immunity is vital question in antitrust enforcement---Crane & Sack

#### Aff flex---“expand the scope” massively constrains the aff---innovation prevents a sitting duck for PICs

#### Overlimits---they box out nuanced immunity debates and force repetitive, stale, giant innovation debates

#### Solves ground---stable direction of increasing prohibitions ensures links

#### Functional limits check---few advocates, advantages, and short list of “core” legislation

No link to effects impact – the direct result of the plan is increased prohibitions on private entities by limiting their immunity

They misread the phrase in context – the rez prohibits “practices” those are being done by the private sector even if they’re sanctioned by the public sector

#### Reasonability best – competing interps cause a race to the bottom and substance crowd-out

### Core Antitrust Laws – 2AC

#### We meet – expands reach of Sherman and FTCA

Crane 16 [Daniel A. Crane Frederick Paul Furth Sr. Professor of Law, University of Michigan Law School Adam Hester J.D., May 2016, University of Michigan Law School, 2016, State-Action Immunity and Section 5 of the FTC Act, 115 MICH. L. REV. 365, https://repository.law.umich.edu/cgi/viewcontent.cgi?article=1510&context=mlr]

This Article addresses the statutory prong—federal antitrust preemption of state law—in the wider context of constitutional and institutional history. In particular, it examines the assumed, but never decided, position that the United States Federal Trade Commission (“FTC”) lacks any preemptive power over anticompetitive state and local regulations, apart from the relatively light preemptive reach of the Sherman Act. It asserts, to the contrary, that the best historically informed and institutionally sound reading of Section 5 of the Federal Trade Commission Act suggests that the FTC should enjoy what the Supreme Court has hypothesized as “superior preemption authority” over state and local regulations that unduly restrict competition.12

As a matter of legal doctrine, the question of the FTC’s preemptive authority originates in the Supreme Court’s seminal 1943 decision in Parker v. Brown. 13 In Parker, the Court held that “[t]here is no suggestion of a purpose to restrain state action in the [Sherman] Act’s legislative history.”14 The resulting state-action immunity doctrine sharply limited any preemptive scope of the Sherman Act over anticompetitive state regulations.15 Parker also rejected a dormant commerce clause challenge to the state regulation at issue.16 The case thus showcased the Court’s uniform reluctance to permit any strand of federal law—constitutional or statutory—to revive Lochnerism.

## States

### Pandemics

#### Specifically, Parker immunity discourages effective pandemic response models

Sage 17 (William Sage, James R. Dougherty Chair for Faculty Excellence in the School of Law and Professor of Surgery and Perioperative Care in the Dell Medical School, University of Texas at Austin; and David Hyman Professor at Georgetown University School of Law, “Antitrust as Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?” Loyola University Chicago Law Journal, Pages 731-734, modified for ableist language indicated by strikethrough and [brackets])

Physicians possess this power for a simple reason: the body of doctrines and practices that we call “health law” systematically supports it. Laws protect the public from individuals and therapies not controlled by physicians, and discourage medical self-help. Laws fund physicians’ tools and assure their quality—though unfortunately not their value. Laws mandate and subsidize insurance coverage for the treatments physicians recommend. Laws insulate physicians from corporate structures and contractual norms. Laws mediate disputes between physicians and patients based on professional standards. Laws apply medical criteria to most ethical issues. Finally, laws such as those challenged in North Carolina State Board delegate substantial rule making and disciplinary authority to state licensing boards (i.e., to entities populated from, and controlled by, the medical profession). States typically justify this abdication of direct oversight in terms of physicians’ scientific expertise, and their ethical duty to heal, not harm, patients.

Both individually and collectively, these laws profoundly distort competition in health care and severely hamper the market’s ability to generate the benefits of competition that we see in other industries. Production remains fragmented. Prices are both inflated and arbitrary— and price competition is minimal (when it even exists at all). There are many barriers to competitive entry—even to deliver the most basic services. Geographic markets are needlessly small and are surprisingly concentrated. Supply bottlenecks are common, often to the mutual benefit of large health insurers and dominant health care providers. And innovation is limited to the sorts of inputs that fit into existing production processes—mainly drugs, diagnostics, and medical devices.

The result is that our health care system almost never trades in the types of consumer products that dominate other costly, complex, technologically sophisticated industries. Instead of fully assembled products accompanied by a strong performance warranty, patients are expected to pay for disaggregated professional process steps (including procedures and consultations) to which billing codes have been assigned, and for equally atomized inputs and complements to those professional processes (such as diagnostic tests and surgical supplies). Health insurance agglomerates these unstructured procedural steps and physical inputs into “covered benefits,” but it does not assemble them into actual, useful products—and only a few true Health Maintenance Organizations (“HMOs”) provide comprehensive prepaid care.

The past decade has witnessed growing agreement regarding both the necessary attributes of a high-performing health care system,17 and the managerial strategies for achieving them.18 Much less attention has been paid to the legal obstacles that have long hindered attempts to redesign acute and complex care—let alone to moving the locus of basic care “upstream,” where it can be communally or self-administered, rather than professionally controlled. As currently constituted, American health law presents concrete structural impediments to accomplishing these consensus health policy goals, and also creates opportunities for incumbent providers to delay or sabotage such efforts.

C. Anticompetitive Effects of Medical Licensing The deep legal architecture of health care strongly favors physician self-regulation, and furthers physicians’ professional insularity and self interest. Physician-controlled medical licensing boards have attracted criticism for decades. Milton Friedman famously wrote in 1962: I am . . . persuaded that [restrictive] licensure has reduced both the quantity and quality of medical practice; . . . that it has forced the public to pay more for less satisfactory medical service[;] and that it has ~~retarded~~ [slowed] technological development both in medicine itself and in the organization of medical practice.19

At the time he made it, Friedman’s harsh economic critique of occupational licensing was not widely shared (except among other libertarians). Professional elites were thought to represent a progressive, prosperous alternative to industrial commodification and the supposed exploitation of labor. To be sure, there was some recognition that the professions might use ethical codes to pursue their own economic selfinterest.20 But mainstream economists such as Kenneth Arrow still believed that collective professionalism improved the marketability of health care by fostering the trust needed to overcome medical uncertainty and informational asymmetry between physicians and patients.21 More recently, a wide array of voices have questioned the economics, and even the justice, of professional privilege.22 In 2015, the Obama Administration issued a report on occupational licensing, finding that “licensing can . . . reduce employment opportunities and lower wages for excluded workers, and increase costs for consumers,” and that “the costs of licensing fall disproportionately on certain populations.”23

To be sure, medical licensing laws are not solely to blame for health care’s competitive shortcomings. Other federal and state regulations and subsidies bear responsibility as well. Still, licensing boards set the tone for the rest of health law as gatekeepers into the health professions and arbiters of practice once admitted. These boards determine the permitted scope of practice, confer authority to write prescriptions, police departures from conventional patterns of care, respond to complaints by licensees about outsiders, and decide when (and, usually, when not) to take disciplinary action against a licensed professional.

From a health policy perspective, physician-imposed barriers to market entry and innovation—typically enforced by a professional licensing board—are the most pernicious practice. Licensing boards set standards for acceptability and impose discipline on licensees who violate their dictates. Unlicensed practice is a criminal act. These entry barriers not only deter novel approaches from new directions, such as telehealth and various “upstream” self-care modalities, but they also discourage existing competitors from adopting practices introduced to the market by disruptive innovators.

#### Extinction – innovative approaches vital to solve pandemics

Penn 21 (Michael Penn, Director of Communications, Marketing and Alumni Relations, Duke Global Health Initiative, citing William Pan, Ph.D., associate professor of global environmental health at Duke, Marco Marani, adjunct professor at Duke department of Global Health, where he previously was a professor of civil and environmental engineering and Anthony Parolari, Ph.D., of Marquette University, is a former Duke postdoctoral researcher, Gabriel Katul, Ph.D., the Theodore S. Coile Distinguished Professor of Hydrology and Micrometeorology at Duke, “Statistics Say Large Pandemics Are More Likely Than We Thought” Duke Global Health Institute, <https://globalhealth.duke.edu/news/statistics-say-large-pandemics-are-more-likely-we-thought>) CULTIV8

The COVID-19 pandemic may be the deadliest viral outbreak the world has seen in more than a century. But statistically, such extreme events aren’t as rare as we may think, asserts a new analysis of novel disease outbreaks over the past 400 years.

The study, appearing in the Proceedings of the National Academy of Sciences the week of Aug. 23, used a newly assembled record of past outbreaks to estimate the intensity of those events and the yearly probability of them recurring.

It found the probability of a pandemic with similar impact to COVID-19 is about 2% in any year, meaning that someone born in the year 2000 would have about a 38% chance of experiencing one by now. And that probability is only growing, which the authors say highlights the need to adjust perceptions of pandemic risks and expectations for preparedness.

“The most important takeaway is that large pandemics like COVID-19 and the Spanish flu are relatively likely,” said William Pan, Ph.D., associate professor of global environmental health at Duke and one of the paper’s co-authors. Understanding that pandemics aren’t so rare should raise the priority of efforts to prevent and control them in the future, he said.

The study, led by Marco Marani, Ph.D., of the University of Padua in Italy, used new statistical methods to measure the scale and frequency of disease outbreaks for which there was no immediate medical intervention over the past four centuries. Their analysis, which covered a murderer’s row of pathogens including plague, smallpox, cholera, typhus and novel influenza viruses, found considerable variability in the rate at which pandemics have occurred in the past. But they also identified patterns that allowed them to describe the probabilities of similar-scale events happening again.

In the case of the deadliest pandemic in modern history – the Spanish flu, which killed more than 30 million people between 1918 and 1920 -- the probability of a pandemic of similar magnitude occurring ranged from 0.3% to 1.9% per year over the time period studied. Taken another way, those figures mean it is statistically likely that a pandemic of such extreme scale would occur within the next 400 years.

“ The most important takeaway is that large pandemics like COVID-19 and the Spanish flu are relatively likely. WILLIAM PAN — ASSOCIATE PROFESSOR OF GLOBAL ENVIRONMENTAL HEALTH

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But the data also show the risk of intense outbreaks is growing rapidly. Based on the increasing rate at which novel pathogens such as SARS-CoV-2 have broken loose in human populations in the past 50 years, the study estimates that the probability of novel disease outbreaks will likely grow three-fold in the next few decades.

Using this increased risk factor, the researchers estimate that a pandemic similar in scale to COVID-19 is likely within a span of 59 years, a result they write is “much lower than intuitively expected.” Although not included in the PNAS paper, they also calculated the probability of a pandemic capable of eliminating all human life, finding it statistically likely within the next 12,000 years.

That is not to say we can count on a 59-year reprieve from a COVID-like pandemic, nor that we’re off the hook for a calamity on the scale of the Spanish flu for another 300 years. Such events are equally probable in any year during the span, said Gabriel Katul, Ph.D., the Theodore S. Coile Distinguished Professor of Hydrology and Micrometeorology at Duke and another of the paper’s authors.

“When a 100-year flood occurs today, one may erroneously presume that one can afford to wait another 100 years before experiencing another such event,” Katul says. “This impression is false. One can get another 100-year flood the next year.”

As an environmental health scientist, Pan can speculate on the reasons outbreaks are becoming more frequent, noting that population growth, changes in food systems, environmental degradation and more frequent contact between humans and disease-harboring animals all may be significant factors. He emphasizes the statistical analysis sought only to characterize the risks, not to explain what is driving them.

But at the same time, he hopes the study will spark deeper exploration of the factors that may be making devastating pandemics more likely – and how to counteract them.

“This points to the importance of early response to disease outbreaks and building capacity for pandemic surveillance at the local and global scales, as well as for setting a research agenda for understanding why large outbreaks are becoming more common,” Pan said.

## OS

### FTC OS – 2AC

#### No link – FTC capacity is high and already closely review state immunity cases

Crane 16 [Daniel A. Crane Frederick Paul Furth Sr. Professor of Law, University of Michigan Law School Adam Hester J.D., May 2016, University of Michigan Law School, 2016, State-Action Immunity and Section 5 of the FTC Act, 115 MICH. L. REV. 365, https://repository.law.umich.edu/cgi/viewcontent.cgi?article=1510&context=mlr]

B. Institutional Constraints and Capacities

Beyond the core concerns about the anti-democratic and pro-laissez faire tendencies of economic substantive due process, there lurk questions about institutional constraints and capacities. Allowing the Sherman Act to become an aggressive anti-regulatory charter would pose considerable risks of unwieldy and excessive challenges to state regulatory regimes and state sovereignty, since the Sherman Act is privately enforceable.251 Further, the federal courts may lack the expertise and fact-finding processes to make well-informed decisions over whether state regulatory decisions reflect exercises of police power in the public interest, or, rather, naked pork-barreling for the benefit of concentrated economic interests. On these scores, FTC enforcement under Section 5 of the FTC Act enjoys a considerable advantage over the Sherman Act.

First, Section 5 of the FTC Act is enforceable only by the FTC, not by private plaintiffs.252 Superior preemption under Section 5 would not lead to a flood of private challenges against state regulations, nor would it injure state interests by forcing the states to constantly defend anti-regulatory actions by private interests. (Recall that Parker itself involved a private challenge to state law, as have many of the important state-action immunity cases since).253 Rather, preemption of state law would depend on an administrative decision by a majority of the FTC commissioners to bring an action or otherwise declare a state law preempted. Preemption would not flow directly from the statute, but from a decision of the FTC to enforce the statute in a particular context. The burden of the intrusion on federalism interests and state sovereignty would therefore be considerably lower than if the Sherman Act were read to directly preempt anticompetitive state laws, permitting private plaintiffs to seek invalidation of state laws whenever the laws infringed on competition.

Second, and relatedly, the FTC enjoys a much greater capacity to evaluate the range of competing interests entailed by state regulations than does a federal court. Not only does the commission employ a large staff of expert economists,254 but it wields broad investigatory powers to investigate trade conditions through mandatory processes such as document requests and depositions.255 The FTC already serves the states in a consultative capacity, giving advice on proposed legislation and engaging in competition advocacy by issuing reports on various competition issues or intervening as amicus curiae in litigation.256 Unlike generalist federal courts, the FTC has the capacity to study the competitive effects and justifications for state regulatory schemes, consult formally or informally with state officials and other interested parties, and bring to bear its economic expertise in mediating competing claims about the effects of regulations on consumers or other interests.

#### Lots of thumpers

Zakrzewski 8-19 (Cat Zakrzewski, technology policy reporter at The Washington Post, covers antitrust, privacy and the debate over regulating social media companies, former reporter for Wall Street Journal Pro Venture Capital, BS Journalism, Northwestern University; **internally citing competition policy director at the consumer group Public Knowledge Charlotte Slaiman, and George Washington University professor and former FTC chair William Kovacic**; “Lina Khan’s first big test as FTC chief: Defining Facebook as a monopoly,” The Washington Post, 8-19-2021, https://www.washingtonpost.com/technology/2021/08/19/ftc-facebook-lawsuit-lina-khan-deadline/)

“There’s multiple signals that FTC is serious about doing their job of investigations and bringing these cases and fighting them hard,” said Charlotte Slaiman, competition policy director at the consumer group Public Knowledge.

Though the most significant, the Facebook case is but one of a wide range of issues on Khan’s plate. A month after she assumed office, the Biden administration issued a sweeping competition executive order, which called for her agency to take a tougher line on concentration throughout the economy.

So far, Khan has taken a series of steps to signal a shake-up has arrived at the FTC. She’s started hosting open meetings to open the agency’s business to the public, and she’s warned that greater scrutiny of mergers is on its way.

But the challenge will be for the agency to remain focused on the most important cases, including Facebook, Kovacic said. “She has a downpour of demands from both ends of the avenue,” he said.

And none of her other efforts will matter if she can’t show that she can win against companies, including Facebook, in court.

“The real measure to business decision-makers of your effectiveness and seriousness is your ability to prosecute and win cases,” Kovacic said.

#### Nextgen tech is emerging at an exponential rate – effective state regulatory experimentation avoids downsides and maximize the benefits of AI and nano

McGinnis 11 (John, George C. Dix Professor of Law, Northwestern Law School, “LAWS FOR LEARNING IN AN AGE OF ACCELERATION,” <http://scholarship.law.wm.edu/cgi/viewcontent.cgi?article=3404&context=wmlr>)

The twenty-first century’s information age has the potential to usher in a more harmonious and productive politics. People often disagree about what policies to adopt, but the cornucopia of data that modern technology generates can allow them to better update their beliefs about policy outcomes on the basis of shared facts. In the long run, convergence on the facts can lead incrementally to more consensus on better policies. More credible factual information should over time also help make for a less divisive society, because partisans cannot as easily stoke social tensions by relying on false facts or exaggerated claims to support conflicting positions. Thus, a central task of contemporary public law is to accelerate a politics of learning whereby democracy improves a public reason focused on evaluating policy consequences. Government should be shaped into an instrument that learns from the analysis of policy consequences made available from newly available technologies of information.1 Greater computer capacity is generating more empirical analysis.2 The Internet permits the rise of prediction markets that forecast policy results even before the policies are implemented.3 The Internet also creates a dispersed media that specializes in particular topics and methodologies, gathers diverse information, and funnels salient facts about policy to legislators and citizens.4 But a public reason focused on policy consequences will improve only if our laws facilitate it. For instance, constitutional federalism must be reinvigorated to permit greater experimentation across jurisdictions, because with the rise of empiricism, decentralization has more value for social learning today than ever before.5 Congress should include mandates for experiments within its own legislation making policy initiatives contain the platforms for their own selfimprovement.6 Creating a contemporary politics of democratic updating on the basis of facts is a matter both of great historical interest and of enormous importance to our future. In the historical sweep of ideas, a government more focused on learning from new information moves toward fulfilling the Enlightenment dream of a politics of reason—but a reason based not on the abstractions of the French Revolution, but instead on the hard facts of the more empirical tradition predominating in Britain. By displacing religion from the center of politics, the Enlightenment removed issues by their nature not susceptible to factual resolution, permitting a focus on policies that could be improved by information.7 The better democratic updating afforded by modern technology can similarly increase social harmony and prosperity by facilitating policies that actually deliver the goods. For the future, a more consequentially informed politics is an urgent necessity. The same technological acceleration that potentially creates a more information-rich politics also generates a wide range of technological innovation—from nanotechnology to biotechnology to [AI] artificial intelligence. Although these technologies offer unparalleled benefits to mankind, they may also create catastrophic risks, such as rapid environmental degradation and new weapons of mass destruction.8 Only a democracy able to rapidly assimilate the facts is likely to be able to avoid disaster and reap the benefits

inherent in the technology that is transforming our world at a faster pace than ever before. Every industry that touches on information—book publishing, newspapers, and college education to name just a few—is undergoing a continuous series of revolutionary changes as new technology permits delivery of more information more quickly at lower cost. The same changes that are creating innovation in such private industries can also quickly create innovation in social governance. But the difference between information-intensive private industries and political institutions is that the latter lack the strong competitive framework for these revolutions to occur spontaneously. This Essay thus attempts to set out a blueprint for reform to make better use of some available information technologies. Part I describes the reality of technology acceleration as the acceleration both creates the tools for democratic updating and prompts its necessity. Technological acceleration is the most important development of our time—more important even than globalization. Although technologists have described and discussed its significance, its implications for law and political structure have been barely noticed. Part II briefly discusses how better social knowledge can change political results. A premise of the claim is that some political disagreements revolve about facts, not simply values. As a result, better social knowledge can help democracies design policies to achieve widely shared goals. Social knowledge energizes citizens to act on those encompassing interests, like improved public education, because they come to better recognize the policy instruments to advance those interests. Better social knowledge provides better incentives for citizens to vote on these interests. Part III considers the mechanisms for creating a contemporary politics of democratic updating that begins to meet the needs of the age of accelerating technology. It focuses on two of the new resources that can have substantial synergies in improving social common knowledge and shows how an increase in common knowledge can systematically improve political results by providing better incentives for citizens to work for encompassing social goods. First, Part III considers the improvement in empirical analysis of social policy that flows from increasing computational capacity. It then discusses how specialized and innovative media does much more than disseminate opinions: it widely distributes facts and factual analysis. The combination of these technologies can better discipline experts and representatives, providing stronger incentives for them to update on the basis of new facts. Part IV discusses the information-eliciting rules that will maximize the impact of new technologies of information. These steps include a program of restoring, where possible, governmental structures that permit appropriate decentralization for experimentation, empirical testing, and learning. Congress and regulatory agencies should structure legislation and regulations to include social experiments when such experiments would help resolve disputed matters of policy. The Supreme Court should generally refrain from imposing new substantive rights for the nation so that it is easier to evaluate the consequences of different bundles of rights chosen by the states. But it should also protect the dispersed media, like blogs, from discriminatory laws, because this dispersed media plays a crucial role in modern policy evaluation. In short, the Supreme Court needs to emphasize a jurisprudence fostering social discovery and the political branches need to create frameworks for better social learning. Constitutive structures encouraging and evaluating experimentation become more valuable in an age where better evaluation of social experiments is possible. I. TECHNOLOGICAL ACCELERATION It is the premise of this Essay that technological acceleration is occurring and that our political system must adapt to the world it is creating. The case for technological acceleration rests on three mutually supporting kinds of evidence. First, from the longest-term perspective, epochal change has sped up: the transitions from hunter-gatherer society to agricultural society to the industrial age each took progressively less time to occur, and our transition to an information society is taking less time still. Second, from a technological perspective, computational power is increasing exponentially, and increasing computational power facilitates the growth of other society-changing technologies like biotechnology and nanotechnology. Third, even from our contemporary perspective, technology now changes the world on a yearly basis both in terms of hard data, like the amount of information created, and in terms of more subjective measures, like the social changes wrought by social media. From the longest-term perspective, it seems clear that technological change is accelerating and, with it, the basic shape of human society and culture is changing.9 Anthropologists suggest that for 100,000 years, members of the human species were hunter-gather- ers.10 About 10,000 years ago humans made a transition to agricultural society.11 With the advent of the Industrial Revolution, the West transformed itself into a society that thrived on manufacturing.12 Since 1950, the world has been rapidly entering the information age.13 Each of the completed epochs has been marked by a transition to substantially higher growth rates.14 The period between each epoch has become very substantially shorter.15 Thus, there is reason to extrapolate to even more and faster transitions in the future. This evolution is consistent with a more fine-grained evaluation of human development. Recently, the historian Ian Morris has rated societies in the last 15,000 years on their level of development through objective benchmarks, such as energy capture.16 The graph shows relatively steady, if modest, growth when plotted on a log linear scale, but in the last 100 years development has jumped to become sharply exponential.17 Morris concludes that these patterns suggest that there may be four times as much social development in the world in the next 100 years than there has been in the last 14,000.18 The inventor and engineer Ray Kurzweil has dubbed this phenomenon of faster transitions “the law of accelerating returns.”19 Seeking to strengthen the case for exponential change, he has looked back to the dawn of life to show that even evolution seems to make transitions to higher organisms ever faster.20 In a more granulated way, he has considered important events of the last 1000 years to show that the periods between extraordinary advances, such as great scientific discoveries and technological inventions, have decreased.21 Thus, both outside and within the great epochs of recorded human history, the story of acceleration is similar. The technology of computation provides the second perspective on accelerating change. The easiest way to grasp this perspective is to consider Moore’s Law. Moore’s Law—named after Gordon Moore, one of the founders of Intel—is the observation that the number of transistors that can be fitted onto a computer chip doubles every eighteen months to two years.22 This prediction, which has been approximately accurate for the last forty years,23 means that almost every aspect of the digital world—from computational calculation power to computer memory—is growing in density at a similarly exponential rate.24 Moore’s Law reflects the rapid rise of computers to become the fundamental engine of mankind in the late twentieth and early twenty-first centuries.25 The power of exponential growth is hard to overstate. As the economist Robert Lucas has said, once you start thinking about exponential growth, it is hard to think about anything else.26 The computational power in a cell phone today is a thousand times greater and a million times less expensive than all the computing power housed at MIT in 1965.27 Projecting forward, the computing power of computers twenty-five years from now is likely to prove a million times more powerful than computing power today. To be sure, many people have been predicting the imminent death of Moore’s Law for a substantial period now,29 but it has nevertheless continued. Intel—a company that has a substantial interest in accurately telling software makers what to expect—projects that Moore’s Law will continue at least until 2029.30 Ray Kurzweil shows that Moore’s Law is actually part of a more general exponential computation growth that has been gaining force for over a 100 years.31 Integrated circuits replaced transistors that previously replaced vacuum tubes that in their time had replaced electromechanical methods of computation.32 Through all of these changes in the mechanisms of computation, its power increased at an exponential rate.33 This perspective suggests that other methods under research—from carbon nanotechnology to optical computing to quantum computing—are likely to continue growing exponentially even when silicon-based computing reaches its physical limits.34 Focusing on the exponential increase in hardware capability may actually understate the acceleration in computational capacity in two ways. First, a study considering developments in a computer task using a benchmark for measuring computer speed over a fifteen-year period suggests that the improvements in software algorithms improved performance even more than the increase in hardware capability.35 Second, computers are interconnected more than ever before through the Internet, and these connections increase collective capacity, not only because of the increasing density among computer connections, but because of the increasing density of connections among humans made possible by computers. The salient feature of computers’ exponential growth is their tremendous range of application compared to previous improvements. Almost everything in the modern world can be improved by adding an independent source of computational power. That is why computational improvement has a far greater social effect than improvements in technologies of old. Energy, medicine, and communication are now being continually transformed by the increase in computational power.36 As I will discuss in Part II, even the formulation of new hypotheses in natural and social science will likely be aided by computers in the near future. The final perspective on accelerating technology is the experience that the contemporary world provides. Technology changes the whole tenor of life more rapidly than ever before. At the most basic level, technological products change faster.37 Repeated visits to a modern electronics store—or even a grocery store—reveal a whole new line of products within very few years. In contrast, someone visiting a store in 1910 and then again in 1920—let alone in 1810 and 1820—would not have noticed much difference. Even cultural generations move faster. Facebook, for instance, has changed the way college students relate in only a few years,38 whereas the tenor of college life would not have seemed very different to students in 1920 and 1960. Our current subjective sense of accelerating technology is also backed by more objective evidence from the contemporary world. Accelerating amounts of information are being generated.39 Information, of course, is a proxy for knowledge. Consistent with this general observation, we experience exponential growth in practical technical knowledge, as evidenced by the rise in patent applications.40 Thus, the combination of data from our present life, together with the more sweeping historical and technological perspectives, makes a compelling case that technological acceleration is occurring. It is this technological acceleration that creates both the capacity and the need for improving collective decision making. As technology accelerates, it creates new phenomena, from climate change to biotechnology to artificial intelligence of a human-like capacity. These technologies may themselves have very large positive or negative externalities and may require government decisions about their prohibition, regulation, or subsidization to forestall harms and capture their full benefits. They may also cause social dislocations, from unemployment to terrorism, that also require certain collective decisions. Society can best handle these crises not only by making better social policy to address them directly but by improving social policy more generally to create both more resources and more social harmony to endure them. Thus, society must deploy information technology in the service of democratic updating if it is to manage technological acceleration

## Politics

### Nord Stream 2 – 2AC

#### Not a DA – sanctions will never pass – and all of their cards, including the impact, were literally manufactured by a Ted Cruz election psyop and both sides are in on it

Kumar 12-22 (Natasha Kumar, reporter on the news desk, former legal affairs correspondent for the Metro desk, at The Times Hub, former staff writer at the Village Voice and freelancer for Newsday and The Wall Street Journal, “Quixoticism of the Republicans in the “fight” with the “Nord Stream-2”,” The Times Hub, 12-22-2021, <https://thetimeshub.in/quixoticism-of-the-republicans-in-the-fight-with-the-nord-stream-2>) \*replaced Unicode Decimal Codes in original with corresponding punctuation, added [Cruz]

According to the American edition “The Hill”, Democratic Majority Leader Chuck Schumer and Republican Senator Ted Cruz have agreed to put to a vote the issue of sanctions against the Nord Stream 2 gas pipeline, which may already pass in the coming weeks – until January 14.

During the negotiations, Republicans insisting on penalties against the pipeline operator of the pipeline “Nord Stream 2 AG” promised, in exchange for consideration of their initiative in the Senate, no longer delay the approval of dozens of candidates for the posts of ambassadors, which they had previously blocked, precisely because of the refusal of the administration of President Joe Biden to impose new sanctions against “SP-2”.

It would seem great news for Ukraine, for which the launch of a new gas pipeline bypassing Ukraine already in 2025 could mean a complete cessation of the transit of Russian gas through our GTS, which means annual losses for “Naftogaz” at least $ 1.5 billion. But even worse—turning it into a heap of scrap metal, because necessary for the functioning of the gas pressure in it after the termination of the transit of Russian gas “in the pipe” will not.

However, as they say, “the devil is in the details”. The thing is that for the adoption of the bill and the introduction of new sanctions, not the traditional simple majority of votes (51), but 60 will be required. Considering that the Republicans have 50 mandates in the Senate, they will need to win as many as 10 to their side for the introduction of new sanctions Democratic senators.

Which, of course, is extremely unlikely. Yes, among the Democrats there are indeed those who oppose the launch of “Nord Stream 2”. But it is highly unlikely that Democrats will allow as many as 20% of their representatives in the Upper House of Congress to move away from “party politics” and “substitute” Biden, for whom it was precisely the refusal to introduce new sanctions against the gas pipeline along the bottom of the Baltic Sea that became the cornerstone of the agreements with Merkel and Putin this summer.

After all, it was after meeting with him in Geneva that the Biden administration refused to impose sanctions against operator company “NS-2 AG”, announced back in April against the background of the previous threat of the invasion of Russian troops into Ukraine. After that, a deal was reached with German Chancellor Angela Merkel on “SP-2”, for which the Republicans also criticized the Biden administration.

And to follow the lead of the Republicans and significantly complicate relations not only with Putin, who has not yet decided to withdraw troops from our borders, but, most importantly, with Germany, France, the Netherlands and Austria, whose companies are taking part in the project, Biden is now definitely won't. Because it was precisely the lack of sanctions against the Russian gas pipeline, when it had not yet been completed, that was Germany's main requirement for mending relations after a significant aggravation during the Trump presidency.

In addition, the gas pipeline has already been completed and is awaiting certification, after which it can be put into operation. Yes, most likely this will not happen during this heating season. Although there are options here, if severe frosts come in Europe and there are not enough gas reserves in the storage facilities. And they are much less full than even last year. Putin, as expected, still refuses to increase pumping through the Ukrainian gas transportation system, thereby forcing the Europeans to speed up the certification of the gas pipeline.

Then why all this performance? The thing is that Ted Cruz represents Texas, the state-leader in shale gas production, in the Senate. The oil and gas sector is a traditional sponsor of the Republican Party and it is he who is interested in preventing the launch of a new gas pipeline from Russia to the EU, which will only increase dependence on Russian gas supplies. Trump imposed sanctions against “SP-2” and in parallel demanded to increase the supply of liquefied gas from the US to the EU, where thanks to the “shale revolution” gas production in some years exceeded gas production in the Russian Federation.

Naturally, Cruz uses the situation for his own personal gain, seeking to increase his support not only in Texas, but also among the supporters of the GOP in general. On the eve of the start of the 2016 US presidential campaign, he was almost the main candidate for the Republican nomination. But then, like “the hell out of a snuff box”, Trump appeared, smashing all his competitors in the primaries.

Now, when lawsuits against Trump's inner circle and himself continue to be considered in American courts, and the first verdicts have already been passed on the investigation of the storming of the Capitol in January 2021, there is a real possibility that the Democrats will be able to achieve their main goal. Namely—remove Trump from the presidential elections in 2024.

Accordingly, Trump's rivals in the Republican Party are starting to get a chance to run for the presidency. Indeed, during his presidential term, Trump substantially “cleaned” competitors, and none of them even dared to nominate themselves for the primaries in 2020. They simply weren't held among the Republicans.

The Democrats, by the way, are also interested in the growth of the popularity and weight of Cruise [Cruz] in the Republican Party as a competitor to Trump, while the issue of his removal from the right to participate in elections in the courts has not yet been resolved and there is no exact certainty on this issue. After all, Biden's representatives have already announced that he plans to run in the presidential elections in 2024. And based on how difficult it was for him to defeat Trump in 2020, and even more so with an eye on the current low ratings of support for his policy, today it will be extremely difficult for Biden to beat Trump in the next election. Today.

Ted Cruise [Cruz] has far less support among Republicans than Trump and is certainly a more convenient competitor for Biden.

Therefore, it seems to me, a similar compromise was reached between Republicans and Democrats in the Senate. Cruz will unblock the appointment of ambassadors in the Senate, and in January the Democrats will put to a vote a bill on sanctions against “Nord Stream 2”. As a result, and “wolves” will remain full, and “sheep” are intact.

That is, Cruz himself and the Republicans in general will receive electoral balls and the appearance that “bent” Democrats now even in a minority, and the Democrats in the end will be satisfied, because no new sanctions against “SP-2” they will not introduce it anyway.

By the way, this is probably the reason for another important news for Ukraine in the American media. CNN reported yesterday that, according to their sources in the Biden administration, the possibility of a Russian attack on Ukraine would remain for at least another month. That is, every time until the Senate vote on new sanctions against “Nord Stream -2”

Coincidence? I don't think so.

#### Doesn’t solve – the only sanctions that could pass would be reactive

McFall 12-18 (Caitlin McFall, digital reporter at Fox News Media, former video journalist at The Daily Caller, MA International Journalism, City University of London, “Sen. Cruz scores a future vote on Russian pipeline sanctions in deal with Democrats,” Fox News, 12-18-2021, https://www.foxnews.com/politics/sen-cruz-scores-vote-russian-pipeline-sanctions-deal-democrats)

Despite previous hesitation to implement sanctions on the pipeline, recent steps taken by Germany and comments made by the Biden administration suggest the tide could be turning on Nord Stream 2 sanctions.

Germany last month slowed progress on the pipeline when a German regulator suspended the certification process of the pipeline, due to a legal paperwork issue.

Additionally, Minister of Germany’s Economic Affairs and Climate Action, Robert Habeck, warned Russia of "severe consequences" and threatened to block the pipeline’s completion if the Kremlin attacked Ukraine, reported DW Saturday.

A similar tone was taken by U.S. National Security Advisor Jake Sullivan last week when he suggested the pipeline could be used as a bargaining chip to deter Russian aggression.

"The fact is that gas is not currently flowing through the Nord Stream 2 pipeline," he told reporters. "Which means that it is not operating.

"Indeed, it is leverage for the West because if Vladimir Putin wants to see gas flow through that pipeline, he may not want to take the risk and invade Ukraine," Sullivan added.

Republicans have long argued the pipeline would bolster the Kremlin and pose a greater threat to European energy security. But the argument on sanctions appears to have shifted and is no longer a debate on if, but when.

While Republicans on the Hill have advocated for preemptive sanctions, Democrats are expected to back implementing sanctions only if Russia invades Ukraine – a move Ukrainian President Volodymyr Zelenskyy has warned against.

"For us, it is important to have sanctions applied before, rather than after, the conflict would happen, because if they were applied after the conflict would happen, this would basically make them meaningless," Zelenskyy told reporters this week.

### PC – Link Turn – 2AC

#### Plan’s a win – boosts PC

Lincicome 20 (Scott Lincicome, senior visiting lecturer at Duke University Law School, senior fellow in economic studies at the Cato Institute, formerly spent two decades practicing international trade law at White & Case LLP, JD University of Virginia School of Law, BA political science, University of Virginia, “A COVID-19 Silver Lining That Could Be Even Shinier,” The Dispatch, 12-1-2020, https://www.cato.org/commentary/covid-19-silver-lining-could-be-even-shinier)

Fortunately, there’s some hope here. First and foremost, states like Arizona, Missouri, California, Iowa, Florida, and South Dakota have begun to act, either by enacting permanent reforms that recognize licenses from other states or by making it easier to get a license (including for people with criminal records). Governors across the country (and across party lines) have also voiced support for licensing reform, so hopefully more systemic reforms are on the way. COVID-19 has also caused many states to temporarily suspend “never needed” regulations to improve their pandemic response, including licensure requirements for not only health care workers (either expanding services that licensed nurse practitioners may provide or by recognizing out‐​of‐​state licenses) but also several other occupations. (A comprehensive list of these moves is available here.) These “emergency” exceptions should be made permanent.

Finally, there’s bipartisan support at the federal level for occupational licensing reform, which has been championed by the Obama administration, the Trump administration, and President‐​elect Biden. Although most licensing regulations are at the state level, there is an opportunity for federal action, for example the FTC’s work to educate the public on licensing rules and its specific antitrust actions against anti‐​competitive state licensing boards (as a result of the Supreme Court’s decision in North Carolina State Board of Dental Examiners v. Federal Trade Commission). Other legislative proposals, such as the “Restoring Board Immunity Act” (which piggybacks off the aforementioned case and encourages state licensing reform in exchange for antitrust immunity) should also be considered.

Regardless of the specific proposal, it’s clear that licensing reform is needed, has bipartisan support, and could help many American workers who lost a job due to COVID-19 and are now trying to set out on their own. They admirably adapted in the face of seismic changes to the U.S. economy—changes that could persist long after vaccines have been widely distributed—and many are now thriving in what could very well be the “new normal.” Governments should get out of their (and others’) way.

#### Biden claims credit BUT shifts blame

Selin 20 (Jennifer Selin, Kinder Institute Assistant Professor of Constitutional Democracy, Department of Political Science, University of Missouri, PhD Vanderbilt University, JD Wake Forest University, BA Lebanon Valley College, “How the Constitution’s federalist framework is being tested by COVID-19,” Brookings Institution, 6-8-2020, https://www.brookings.edu/blog/fixgov/2020/06/08/how-the-constitutions-federalist-framework-is-being-tested-by-covid-19/)

National politicians look to governors for partisan wins

Even with an expanded executive branch, the national government simply does not have the resources to do everything it wants. As a result, it increasingly turns to the states to carry out important governmental tasks. Such reliance further develops and strengthens executive branch actors at the state level. This is particularly true in healthcare, where lines between state and federal policy are quite blurred.

How politicians engage this complicated relationship between the state and federal government is strategic—federalism has become an important tool in political negotiations. National political figures enact vague policies that allow for variation in state implementation, claiming credit for acting on important issues while shifting the responsibility for figuring out the details to the states. Not only does this strategy allow for some states to take minimal efforts in implementing federal policy, but it can enhance partisan conflict. President Trump’s actions over the past few months illustrate this point. When his administration began to respond to the crisis, issuing guidelines and emergency use authorizations, he used his relationships with various governors for partisan gain. In one of his more colorful statements on the issue, Trump tweeted “Tell the Democrat Governors that ‘Mutiny On The Bounty’ was one of my all time favorite movies. A good old fashioned mutiny every now and then is an exciting and invigorating thing to watch, especially when the mutineers need so much from the Captain.” Such comments suggest that political competition may no longer flow through the separation of powers or federalist system, but rather through political parties.

#### He’ll shift the blame to courts – duh

# 1AR

## K – Healthcare

### Shell

#### The aff’s understanding of access as health is the cornerstone of modern capitalism.

McKee and Stuckler 12 – Martin McKee, London School of Hygiene and Tropical Medicine, and David Stuckler, University of Cambridge and London School of Hygiene and Tropical Medicine, UK, December 28th (“The Crisis of Capitalism and the Marketisation of Health Care: the Implications for Public Health Professionals”, NCBI, Available online at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4140370/>, Accessed 02-06-2022)

The lessons for health care

The corporate greed that underpinned the financial crisis has implications for health policy that are too easy to overlook. Some years ago, major corporations realised that they needed to move beyond the traditional means of making money, the production of goods that people would buy, to the provision of services. The problem was that many of the key services that people depended on, such as health, education, and social care, were being provided by the state, at least in Western Europe. The challenge they faced was to transform these services, which for 50 years had been funded by taxes, based on the ability of citizens to pay, and received on the basis of need. They were owned collectively by the people through the intermediary of the state, and people remained safe in the knowledge that they would be there when needed. They were not seen as an opportunity for private profit.

To change this, market elites first had to rewrite the rules in their favour, getting their client governments in North America and Europe to shape the General Agreement on Trade in Services to their advantage.13 Within the European Union, similar measures were adopted in relation to the provision of services.14 To get their hands on health and education services, seen as the main growth areas, the corporations needed to prise them away from government control. The anticipated rewards of privatisation were enormous, as they had realised in the United States where returns on investment in the health sector had been huge (now accounting for one-fifth of GDP, the highest worldwide). And health had another benefit. The demand was potentially unlimited, not least because those who supplied it could themselves stimulate demand.

Second, the market elites had to overcome resistance from a universal public system that had enduring popularity and public support. This involved creating popular discontent, drawing attention to any failings in the public system, and promoting choice as a value in itself, alongside effectiveness, efficiency, humanity and equity.15

However, in seeking to unleash a market in health care they faced some fundamental problems. Some fifty years ago, the Nobel Laureate Kenneth Arrow described why the market in health care fails.16 The reasons include the presence of externalities, whereby one person benefits from another receiving health care, especially if they have a contagious disease or a psychosis that may cause them to be violent. There is also information asymmetry, where the health professional offering care knows more about what the patient needs than they do themselves. But above all there is the problem that those who are in most need of care are the least able to afford it. In contrast, those who need care least have plenty of money. This was recognised in the 1920s in the United States when the insurers Blue Cross and Blue Shield were created by associations of doctors and hospitals, not because they were concerned about the ability of people to obtain care, but rather to ensure that they themselves would be paid for providing it. Given these well-known market failures, how can the private sector make the profits it sought from health care? The answer is to redefine health care, as shown in the next section.

A British general practitioner, Margaret McCartney has recently described what she terms the Patient Paradox.17 She describes her difficulties, even in the National Health Service in the United Kingdom, in getting appropriate care for her patients who really do have illnesses, and especially the most difficult group, those with mental illness, while at the same time being cajoled, encouraged, and incentivised to deliver services, such as ever increasing varieties of unevaluated screening, to those who are well. Put simply, those with real illnesses offer little scope for profit by those who have been contracted, in the British internal health care market, to provide care.

The problem is exemplified at an international level by neglected tropical diseases. They are neglected for a reason. The reason is that the pharmaceutical industry cannot see a way of making money out of them. If these diseases are to be cured, it will not be enough to rely on the capitalist market.18 Instead, there is a need for intervention by the state, or states, for example through advance market commitments, whereby governments agree to share the risk of development.19 However, they are simply symptoms of a wider problem.

The pharmaceutical industry now realises that it is running out of ideas that will make it the massive profits it was once used to. These profits were based on a model that found a common disease, ideally with its onset about middle age, which would require regular treatment for years. It found them. They included, among others, high blood pressure, chronic airways disease, diabetes, Parkinson’s Disease, and depression. But the problem now is that there are no more of these diseases to be found. There are perfectly good treatments for them and any new treatments can make, at most, a marginal contribution, and even that is frequently exaggerated by selective reporting and manipulation of clinical trial data.20 These firms could develop antibiotics, but the problem there is that resistance emerges before expiry of patent protection, so there is no money to be made.21 Then there is cancer, but it is not a single disease. The more scientists learn about it, the more they divide the market into smaller and smaller parts.22 Any new drug will be effective against tumours in a relatively small number of people. They will only take it for a short while. The cost per dose will be astronomical. Publicly funded health systems will be reluctant to pay, knowing that they will have to reduce existing care for others as a result.23 And the individual patient will, with rare exceptions, be able to pay. The same is true of drugs for children.24 Who will pay for the necessary testing knowing that the market will be tiny? Instead, the industry has focused on so-called lifestyle drugs. Anyone watching American television could be forgiven for thinking that the entire male population must have erectile dysfunction. The system of drug production, based on the free market, is as broken as the financial system and, just like it, it is far from clear how to fix it.

But it is not just pharmaceutical companies that face fundamental problems. So do those corporations moving into the delivery of health care. Their problems are illustrated by the ageing of populations. Older people can be very difficult to treat. They do not fit into convenient boxes with a single disease. They have multiple disorders, necessitating a complex combination of drugs, many of which may interact with each other.25 They may have varying degrees of organ failure, with their liver or kidney function influencing how those drugs are metabolised. They may have cognitive decline, so that they forget to take their tablets when they should, leading to unanticipated and potentially unnecessary admissions to hospital. Fundamentally, they are unpredictable and, as we are constantly told, markets hate uncertainty. Anyone running a health system for profit will see them as the last people they want to deal with. Instead, they want to design simple, protocol-driven packages for young people with single diseases, such as uncomplicated diabetes or asthma, that can be delivered by health workers with minimum training, or even better, by computerised systems that take the human touch out of care delivery altogether.

These examples illustrate the problems that corporations active in the health sector are facing. To respond, just as the financial sector did when it realised that its traditional sources of profit were no longer sufficiently lucrative, they must redefine the rules of the game. In the next section, we examine how they are doing this.

Back in the 1950s, Eisenhower warned about what he called the military industrial complex, whereby a powerful coalition of generals and chief executives conspired to talk up the threat from the Soviet Union, exaggerating the so-called ‘missile gap’ and seeing threats where none existed.26 The goal was not to protect the United States, but instead to transfer vast sums of money from the federal budget to the coffers of the corporations, and ultimately to those generals who would move seamlessly into their employment on retirement. This is a model that has since been widely emulated. There is the security industrial complex, whereby corporations and government officials, many also looking for a lucrative retirement home, have conspired to spend billions of euros and dollars on ineffective systems of airport security.27 This has resulted in countless people having their cosmetics, nail files and the like confiscated while the few people who actually had bombs sailed straight through, even when they have done everything possible to draw attention to themselves.28

But it is now the medical industrial complex that is setting the rules of the game, by redefining the goals of health care away from those in most need, such as those with tropical diseases or ageing populations with chronic disorders and towards those who are essentially well. If the general practitioner is unwilling to respond to these pressures and incentives, many others will. In particular, those who do respond are the many private providers who offer so-called screening services using ever more complex imaging technology to visualise every part of one’s body to find entirely harmless anomalies for which they can extract money for giving what they call ‘treatment’. McCartney catalogues many examples, such as the treatment of surrogate markers, such as cholesterol, even at levels far below where it might do any harm, the creation of new so-called diseases, such as pre-diabetes, and treatment of raised levels of prostate-specific antigen, even at the cost of often appalling side effects while giving no overall benefit.17 Yet at the same time as people are being encouraged to spend ever greater sums of money on interventions that are useless, corporations are telling everyone that the rise in health care expenditure is unaffordable and must be rationed. Moreover, those same corporations are funding lobby groups, often in a manner that is far from transparent, to persuade governments and the public that the European welfare state is unsustainable, using highly selective and frequently misleading evidence. In some cases, where governments view the economic crisis as a once in a lifetime opportunity to roll back the welfare state, they are pushing at an open door.29

#### Neolib sanctions relentless environmental damage.

Guerin 19 – Fred Guerin holds a Ph.D. in philosophy and teaches philosophy part-time at Vancouver Island University in Powell River, British Columbia, August 11th (“We Must End Neoliberalism, or Neoliberalism Will End Us”, Truthout, Available online at <https://truthout.org/articles/we-must-end-neoliberalism-or-neoliberalism-will-end-us/>, Accessed 07-08-2021)

Neoliberalism Versus the Climate

If there is one thing that history has made clear to us again and again, it is that no human construction is eternal, all-pervasive or invulnerable to change. Reality has a way of disrupting the status quo, messing up well-laid plans and invalidating conventional pieties.

In the last 20 years, reality has asserted itself in a way unprecedented in human history. For the first time, we are imminently threatened as a species because we have chosen an economic and political system that treats the planet as if it were no more than a means for infinite exploitation and individual wealth, rather than a limited Earth that only conditionally provides the possibility for all forms of life.

In an unprecedented way, what has come into focus today is both the limiting nature of instrumental reasoning and the life-destroying impact of neoliberal capitalism to which it is wedded. Climate disruption as a consequence of human-caused planetary warming has brought into sharp focus two stark and undeniable truths:

For the first time in human history, we have put more than a million different species at risk of extinction including our own.

The economic system of capitalism and its most recent neoliberal configuration is the principal cause of the present climate crisis that threatens human and other species’ survival.

The growing recognition of the above truths has pressed us to finally ask deeper questions about what we really value: the quality of life, the well-being of human and other forms of life, the health of our communities and food systems, and the safety and dignity of persons in the context of massive climate disruption.

For the first time, we are asking how is it that we have come to accept the kind of instrumental rationality and neoliberal economic and political system that not only dehumanizes us as individuals but will inevitably destroy life as we know it. Those who financially benefit from the system of neoliberal capitalism would have us believe that we cannot change or transform the world into a better, more equal, more caring, environmentally sustainable and responsible place. But the fact is there are individuals and groups emerging and multiplying around the world whose actions demonstrate the neoliberal capitalist worldview is no longer viable. They are doing unprecedented things: putting forth Green New Deals that forward new ways of thinking and doing economics and politics; investing in and building environmentally sustainable alternative energy systems and modes of transportation and agriculture; demanding food sovereignty; and promoting local forms of banking, governance and sustainable living.

What has become apparent to the rapidly growing numbers who are building alternative ways of living is that capitalism must end. Historically, critiques of capitalism focused on worker alienation and exploitation, imperialism, profound disparities of wealth, market instability and the erosion of democracy. However, all of the latter pale in comparison to the critique of capital based on the very foreseeable potential it has to completely destroy the very conditions of possibility for life itself.

For the first time in the history of humankind, we are forced to admit that gradualism, half-measures and tinkering will no longer suffice. We either completely break with capitalism and the neoliberal ideology that enables it, or we face extinction. Economic and political systems that destroy the Earth, gradually erode human freedom and undermine social, environmental and economic justice only appeared unstoppable because we once saw them as inevitable, necessary or absolute. With the rise of climate change consciousness, we now see them for what they have always been: contingent human choices and deliberate human constructions that we must not accede to any longer. That will require a revolution — not just in thinking and lifestyles but fundamentally in our politics and in our economics.

#### The alternative is a multi-paradigmatic disruption of homo economicus. That averts extinction.

Urbina and Ruiz-Villaverde 19 – Dante A. Urbina is a Professor at the University of Lima in Heterodox economics, Alberto Ruiz-Villaverde, Profesor Titular de Universidad, January 23rd (“A Critical Review of Homo Economicus from Five Approaches”, American Journal of Economics and Sociology, Volume 78, Issue 1, pp. 63-93, Available online via USC Libraries, Accessed 07-09-2021)

The neoclassical scheme of homo economicus is clearly inadequate and deficient in portraying the complexity of human behavior. We have used not one, but five approaches to criticize the notion of homo economicus, which underlies the entire framework of neoclassical economics.

From the study of psychology, behavioral economics has shown that there is no perfect rationality or criterion for optimization; on the contrary, our perceptions and decisions are systematically affected by biases and cognitive limitations.

From an analysis of the way behavior is shaped by social norms, institutional economics has established that we are not isolated subjects with given preferences but are constitutively formed by norms and social structures. Even our apparent individuality and preferences themselves are influenced by social factors.

From the perspective of social and power relationships, political economy finds that individuals do not exist separately and independently. Humans exist in social groups or classes within a hierarchical scheme. The self-interested nature of homo economicus is not universal; on the contrary, it is a social construction of capitalism itself.

From the historical study of cultural development, economic anthropology calls into question the universality of homo economicus by showing that, in pre-capitalist economies, schemes of social interaction based on cooperation and solidarity cannot be reduced to self-interested motivations. The complexity of motivation involves deeper and transcendental connotations.

Finally, from the broader vision of conceptualizing human beings as part of a large ecosystem, ecological economics considers the environment not as something exogenous that can be addressed as a subsidiary issue in economic theory. Conversely, it should be considered endogenous, as something that needs to be consistently addressed from a holistic perspective and not from the limited neoclassical scheme.

Despite these critical perspectives, the defense of homo economicus remains in force because it legitimizes and rationalizes the functioning of the current market society. A series of contradictions have emerged in market societies and reveal the pressing need to transcend the approach created by adherence to the logic of homo economicus.

The first contradiction involves the hedonistic principles of homo economicus, which tie happiness or well-being to consumption of goods and services. We seriously question the validity of that connection. As we have shown, the quality of life for the population may actually be declining in relation to food, clothing, and housing.

Second, the optimizing logic of production and consumption in an increasingly competitive environment of capitalist accumulation lowers the price of commodities. In neoclassical theory, this result is treated as an indicator of the success of capitalism. However, the logic of optimization has also caused the deterioration of working conditions and a reduction of the remuneration of the working class. The failure of neoclassical economics to address this trend reveals an enduring alliance between mainstream economics and the capitalist class.

Third, the model of market society in the industrial metropolis (the rich nations of the Global North) is not generalizable on a global scale. The level of production achieved in these metropolitan centers is built on the increasing use of energy and nonrenewable raw materials. That process can be sustained only through the appropriation of energy and the raw materials from countries of the Global South and through practices of ecological colonialism, such as operating the most polluting industries in their territory.

Finally, ecological economics shows us how the expansion of the current model of society and its growing dependence on the degradation of energy and nonrenewable raw materials has already met the limits offered by our small planet. Thus, it is becoming more urgent to keep in mind the relatively short deadlines for the exhaustion of a whole series of nonrenewable raw materials and the rupture of the basic ecological balances that make life on earth possible (Naredo 2015: 87).

The notion of homo economicus continues to dominate the thinking of mainstream economists and, by extension, of other agents of the capitalist economy. In order to obtain consistent and genuine progress toward a more just and sustainable economy, a multi-paradigmatic vision is required. We have sought to call attention to several types of paradigms that would need to be incorporated in this new perspective. More critical knowledge would enable us to construct an alternative economics and an alternative economy. We close with the inspiring thought of Pierre Bourdieu (1993: 944) that a new world is truly possible: “What the social world has done, it can, armed with this knowledge, undo.”

### Extinction

#### **Capitalism is unsustainable. Extinction by thermodynamics.**

Murphy 12 – Thomas Murphy is a PhD in General Relativity from Caltech, Professor in Physics at University of California San Diego, April 10th (“Exponential Economist Meets Finite Physicist”, *Do The Math*, Available online at <https://dothemath.ucsd.edu/2012/04/economist-meets-physicist/>, Accessed 01-18-2021, \*\*Excerpt from Chapter 2 of the *Energy and Human Ambitions on a Finite Planet*)

Cast of characters: Physicist, played by me; Economist, played by an established economics professor from a prestigious institution. Scene: banquet dinner, played in four acts (courses).

Note: because I have a better retention of my own thoughts than those of my conversational companion, this recreation is lopsided to represent my own points/words. So while it may look like a physicist-dominated conversation, this is more an artifact of my own recall capabilities. I also should say that the other people at our table were not paying attention to our conversation, so I don’t know what makes me think this will be interesting to readers if it wasn’t even interesting enough to others at the table! But here goes…

Act One: Bread and Butter

Physicist: Hi, I’m Tom. I’m a physicist.

Economist: Hi Tom, I’m [ahem..cough]. I’m an economist.

Physicist: Hey, that’s great. I’ve been thinking a bit about growth and want to run an idea by you. I claim that economic growth cannot continue indefinitely.

Economist: [chokes on bread crumb] Did I hear you right? Did you say that growth can not continue forever?

Physicist: That’s right. I think physical limits assert themselves.

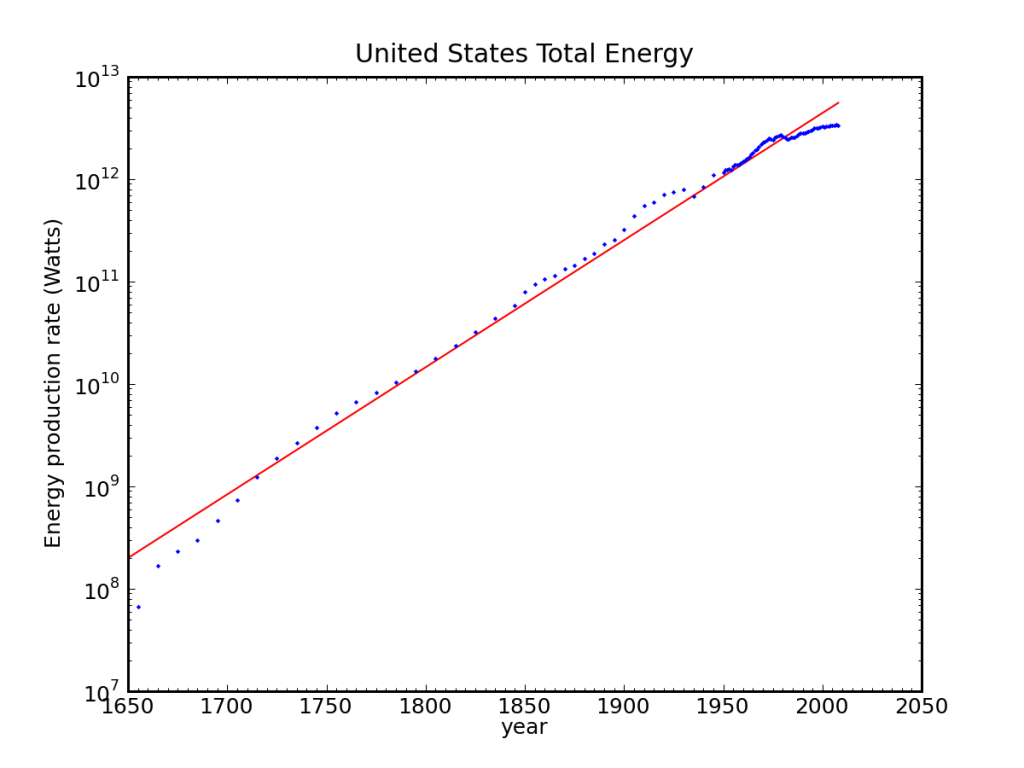
Economist: Well sure, nothing truly lasts forever. The sun, for instance, will not burn forever. On the billions-of-years timescale, things come to an end.

Physicist: Granted, but I’m talking about a more immediate timescale, here on Earth. Earth’s physical resources—particularly energy—are limited and may prohibit continued growth within centuries, or possibly much shorter depending on the choices we make. There are thermodynamic issues as well.

Economist: I don’t think energy will ever be a limiting factor to economic growth. Sure, conventional fossil fuels are finite. But we can substitute non-conventional resources like tar sands, oil shale, shale gas, etc. By the time these run out, we’ll likely have built up a renewable infrastructure of wind, solar, and geothermal energy—plus next-generation nuclear fission and potentially nuclear fusion. And there are likely energy technologies we cannot yet fathom in the farther future.

Physicist: Sure, those things could happen, and I hope they do at some non-trivial scale. But let’s look at the physical implications of the energy scale expanding into the future. So what’s a typical rate of annual energy growth over the last few centuries?

Economist: I would guess a few percent. Less than 5%, but at least 2%, I should think.



U.S. total energy 1650-present (logarithmic)

Total U.S. Energy consumption in all forms since 1650. The vertical scale is logarithmic, so that an exponential curve resulting from a constant growth rate appears as a straight line. The red line corresponds to an annual growth rate of 2.9%. Source: EIA.

Physicist: Right, if you plot the U.S. energy consumption in all forms from 1650 until now, you see a phenomenally faithful exponential at about 3% per year over that whole span. The situation for the whole world is similar. So how long do you think we might be able to continue this trend?

Economist: Well, let’s see. A 3% growth rate means a doubling time of something like 23 years. So each century might see something like a 15–20× increase. I see where you’re going. A few more centuries like that would perhaps be absurd. But don’t forget that population was increasing during centuries past—the period on which you base your growth rate. Population will stop growing before more centuries roll by.

Physicist: True enough. So we would likely agree that energy growth will not continue indefinitely. But two points before we continue: First, I’ll just mention that energy growth has far outstripped population growth, so that per-capita energy use has surged dramatically over time—our energy lives today are far richer than those of our great-great-grandparents a century ago [economist nods]. So even if population stabilizes, we are accustomed to per-capita energy growth: total energy would have to continue growing to maintain such a trend [another nod].

Second, thermodynamic limits impose a cap to energy growth lest we cook ourselves. I’m not talking about global warming, CO2 build-up, etc. I’m talking about radiating the spent energy into space. I assume you’re happy to confine our conversation to Earth, foregoing the spectre of an exodus to space, colonizing planets, living the Star Trek life, etc.

Economist: More than happy to keep our discussion grounded to Earth.

Physicist: [sigh of relief: not a space cadet] Alright, the Earth has only one mechanism for releasing heat to space, and that’s via (infrared) radiation. We understand the phenomenon perfectly well, and can predict the surface temperature of the planet as a function of how much energy the human race produces. The upshot is that at a 2.3% growth rate (conveniently chosen to represent a 10× increase every century), we would reach boiling temperature in about 400 years. [Pained expression from economist.] And this statement is independent of technology. Even if we don’t have a name for the energy source yet, as long as it obeys thermodynamics, we cook ourselves with perpetual energy increase.

Economist: That’s a striking result. Could not technology pipe or beam the heat elsewhere, rather than relying on thermal radiation?

Physicist: Well, we could (and do, somewhat) beam non-thermal radiation into space, like light, lasers, radio waves, etc. But the problem is that these “sources” are forms of high-grade, low-entropy energy. Instead, we’re talking about getting rid of the waste heat from all the processes by which we use energy. This energy is thermal in nature. We might be able to scoop up some of this to do useful “work,” but at very low thermodynamic efficiency. If you want to use high-grade energy in the first place, having high-entropy waste heat is pretty inescapable.

Economist: [furrowed brow] Okay, but I still think our path can easily accommodate at least a steady energy profile. We’ll use it more efficiently and for new pursuits that continue to support growth.

Physicist: Before we tackle that, we’re too close to an astounding point for me to leave it unspoken. At that 2.3% growth rate, we would be using energy at a rate corresponding to the total solar input striking Earth in a little over 400 years. We would consume something comparable to the entire sun in 1400 years from now. By 2500 years, we would use energy at the rate of the entire Milky Way galaxy—100 billion stars! I think you can see the absurdity of continued energy growth. 2500 years is not that long, from a historical perspective. We know what we were doing 2500 years ago. I think I know what we’re not going to be doing 2500 years hence.

Economist: That’s really remarkable—I appreciate the detour. You said about 1400 years to reach parity with solar output?

Physicist: Right. And you can see the thermodynamic point in this scenario as well. If we tried to generate energy at a rate commensurate with that of the Sun in 1400 years, and did this on Earth, physics demands that the surface of the Earth must be hotter than the (much larger) surface of the Sun. Just like 100 W from a light bulb results in a much hotter surface than the same 100 W you and I generate via metabolism, spread out across a much larger surface area.

Economist: I see. That does make sense.

Act Two: Salad

Economist: So I’m as convinced as I need to be that growth in raw energy use is a limited proposition—that we must one day at the very least stabilize to a roughly constant yearly expenditure. At least I’m willing to accept that as a starting point for discussing the long term prospects for economic growth. But coming back to your first statement, I don’t see that this threatens the indefinite continuance of economic growth.

For one thing, we can keep energy use fixed and still do more with it in each passing year via efficiency improvements. Innovations bring new ideas to the market, spurring investment, market demand, etc. These are things that will not run dry. We have plenty of examples of fundamentally important resources in decline, only to be substituted or rendered obsolete by innovations in another direction.

Physicist: Yes, all these things happen, and will continue at some level. But I am not convinced that they represent limitless resources.

Economist: Do you think ingenuity has a limit—that the human mind itself is only so capable? That could be true, but we can’t credibly predict how close we might be to such a limit.

Physicist: That’s not really what I have in mind. Let’s take efficiency first. It is true that, over time, cars get better mileage, refrigerators use less energy, buildings are built more smartly to conserve energy, etc. The best examples tend to see factor-of-two improvements on a 35 year timeframe, translating to 2% per year. But many things are already as efficient as we can expect them to be. Electric motors are a good example, at 90% efficiency. It will always take 4184 Joules to heat a liter of water one degree Celsius. In the middle range, we have giant consumers of energy—like power plants—improving much more slowly, at 1% per year or less. And these middling things tend to be something like 30% efficient. How many more “doublings” are possible? If many of our devices were 0.01% efficient, I would be more enthusiastic about centuries of efficiency-based growth ahead of us. But we may only have one more doubling in us, taking less than a century to realize.

Economist: Okay, point taken. But there is more to efficiency than incremental improvement. There are also game-changers. Tele-conferencing instead of air travel. Laptop replaces desktop; iPhone replaces laptop, etc.—each far more energy frugal than the last. The internet is an example of an enabling innovation that changes the way we use energy.

Physicist: These are important examples, and I do expect some continuation along this line, but we still need to eat, and no activity can get away from energy use entirely. [semi-reluctant nod/bobble] Sure, there are lower-intensity activities, but nothing of economic value is completely free of energy.

Economist: Some things can get awfully close. Consider virtualization. Imagine that in the future, we could all own virtual mansions and have our every need satisfied: all by stimulative neurological trickery. We would still need nutrition, but the energy required to experience a high-energy lifestyle would be relatively minor. This is an example of enabling technology that obviates the need to engage in energy-intensive activities. Want to spend the weekend in Paris? You can do it without getting out of your chair. [More like an IV-drip-equipped toilet than a chair, the physicist thinks.]

Physicist: I see. But this is still a finite expenditure of energy per person. Not only does it take energy to feed the person (today at a rate of 10 kilocalories of energy input per kilocalorie eaten, no less), but the virtual environment probably also requires a supercomputer—by today’s standards—for every virtual voyager. The supercomputer at UCSD consumes something like 5 MW of power. Granted, we can expect improvement on this end, but today’s supercomputer eats 50,000 times as much as a person does,

so there is a big gulf to cross. I’ll take some convincing. Plus, not everyone will want to live this virtual existence.

Economist: Really? Who could refuse it? All your needs met and an extravagant lifestyle—what’s not to like? I hope I can live like that myself someday.

Physicist: Not me. I suspect many would prefer the smell of real flowers—complete with aphids and sneezing; the feel of real wind messing up their hair; even real rain, real bee-stings, and all the rest. You might be able to simulate all these things, but not everyone will want to live an artificial life. And as long as there are any holdouts, the plan of squeezing energy requirements to some arbitrarily low level fails. Not to mention meeting fixed bio-energy needs.

Act Three: Main Course

Physicist: But let’s leave the Matrix, and cut to the chase. Let’s imagine a world of steady population and steady energy use. I think we’ve both agreed on these physically-imposed parameters. If the flow of energy is fixed, but we posit continued economic growth, then GDP continues to grow while energy remains at a fixed scale. This means that energy—a physically-constrained resource, mind—must become arbitrarily cheap as GDP continues to grow and leave energy in the dust.

Economist: Yes, I think energy plays a diminishing role in the economy and becomes too cheap to worry about.

Physicist: Wow. Do you really believe that? A physically limited resource (read scarcity) that is fundamental to every economic activity becomes arbitrarily cheap? [turns attention to food on the plate, somewhat stunned]

Economist: [after pause to consider] Yes, I do believe that.

Physicist: Okay, so let’s be clear that we’re talking about the same thing. Energy today is roughly 10% of GDP. Let’s say we cap the physical amount available each year at some level, but allow GDP to keep growing. We need to ignore inflation as a nuisance in this case: if my 10 units of energy this year costs $10,000 out of my $100,000 income; then next year that same amount of energy costs $11,000 and I make $110,000—I want to ignore such an effect as “meaningless” inflation: the GDP “growth” in this sense is not real growth, but just a re-scaling of the value of money.

Economist: Agreed.

Physicist: Then in order to have real GDP growth on top of flat energy, the fractional cost of energy goes down relative to the GDP as a whole.

Economist: Correct.

Physicist: How far do you imagine this can go? Will energy get to 1% of GDP? 0.1%? Is there a limit?

Economist: There does not need to be. Energy may become of secondary importance in the economy of the future—like in the virtual world I illustrated.

Physicist: But if energy became arbitrarily cheap, someone could buy all of it, and suddenly the activities that comprise the economy would grind to a halt. Food would stop arriving at the plate without energy for purchase, so people would pay attention to this. Someone would be willing to pay more for it. Everyone would. There will be a floor to how low energy prices can go as a fraction of GDP.

Economist: That floor may be very low: much lower than the 5–10% we pay today.

Physicist: But is there a floor? How low are you willing to take it? 5%? 2%? 1%?

Economist: Let’s say 1%.

Physicist: So once our fixed annual energy costs 1% of GDP, the 99% remaining will find itself stuck. If it tries to grow, energy prices must grow in proportion and we have monetary inflation, but no real growth.

Economist: Well, I wouldn’t go that far. You can still have growth without increasing GDP.

Physicist: But it seems that you are now sold on the notion that the cost of energy would not naturally sink to arbitrarily low levels.

Economist: Yes, I have to retract that statement. If energy is indeed capped at a steady annual amount, then it is important enough to other economic activities that it would not be allowed to slip into economic obscurity.

Physicist: Even early economists like Adam Smith foresaw economic growth as a temporary phase lasting maybe a few hundred years, ultimately limited by land (which is where energy was obtained in that day). If humans are successful in the long term, it is clear that a steady-state economic theory will far outlive the transient growth-based economic frameworks of today. Forget Smith, Keynes, Friedman, and that lot. The economists who devise a functioning steady-state economic system stand to be remembered for a longer eternity than the growth dudes. [Economist stares into the distance as he contemplates this alluring thought.]

Act Four: Dessert

Economist: But I have to object to the statement that growth must stop once energy amount/price saturates. There will always be innovations that people are willing to purchase that do not require additional energy.

Physicist: Things will certainly change. By “steady-state,” I don’t mean static. Fads and fashions will always be part of what we do—we’re not about to stop being human. But I’m thinking more of a zero-sum game here. Fads come and go. Some fraction of GDP will always go toward the fad/innovation/gizmo of the day, but while one fad grows, another fades and withers. Innovation therefore will maintain a certain flow in the economy, but not necessarily growth.

Economist: Ah, but the key question is whether life 400 years from now is undeniably of higher quality than life today. Even if energy is fixed, and GDP is fixed once the cost of energy saturates at the lower bound, will quality of life continue to improve in objectively agreed-upon ways?

Physicist: I don’t know how objective such an assessment can be. Many today yearn for days past. Maybe this is borne of ignorance or romanticism over the past (1950’s often comes up). It may be really exciting to imagine living in Renaissance Europe, until a bucket of nightsoil hurled from a window splatters off the cobblestone and onto your breeches. In any case, what kind of universal, objective improvements might you imagine?

Economist: Well, for instance, look at this dessert, with its decorative syrup swirls on the plate. It is marvelous to behold.

Physicist: And tasty.

Economist: We value such desserts more than plain, unadorned varieties. In fact, we can imagine an equivalent dessert with equivalent ingredients, but the decorative syrup unceremoniously pooled off to one side. We value the decorated version more. And the chefs will continue to innovate. Imagine a preparation/presentation 400 years from now that would blow your mind—you never thought dessert could be made to look so amazing and taste so delectably good. People would line the streets to get hold of such a creation. No more energy, no more ingredients, yet of increased value to society. That’s a form of quality of life improvement, requiring no additional resources, and perhaps costing the same fraction of GDP, or income.

Physicist: I’m smiling because this reminds me of a related story. I was observing at Palomar Observatory with an amazing instrumentation guru named Keith who taught me much. Keith’s night lunch—prepared in the evening by the observatory kitchen and placed in a brown bag—was a tuna-fish sandwich in two parts: bread slices in a plastic baggie, and the tuna salad in a small plastic container (so the tuna would not make the bread soggy after hours in the bag). Keith plopped the tuna onto the bread in an inverted container-shaped lump, then put the other piece of bread on top without first spreading the tuna. It looked like a snake had just eaten a rat. Perplexed, I asked if he intended to spread the tuna before eating it. He looked at me quizzically (like Morpheus in the Matrix: “You think that’s air you’re breathing? Hmm.”), and said—memorably, “It all goes in the same place.”

My point is that the stunning presentation of desserts will not have universal value to society. It all goes in the same place, after all. [I’ll share a little-known secret. It’s hard to beat a Hostess Ding Dong for dessert. At 5% the cost of fancy desserts, it’s not clear how much value the fancy things add.]

After-Dinner Contemplations

The evening’s after-dinner keynote speech began, so we had to shelve the conversation. Reflecting on it, I kept thinking, “This should not have happened. A prominent economist should not have to walk back statements about the fundamental nature of growth when talking to a scientist with no formal economics training.” But as the evening progressed, the original space in which the economist roamed got painted smaller and smaller.

First, he had to acknowledge that energy may see physical limits. I don’t think that was part of his initial virtual mansion.

Next, the efficiency argument had to shift away from straight-up improvements to transformational technologies. Virtual reality played a prominent role in this line of argument.

Finally, even having accepted the limits to energy growth, he initially believed this would prove to be of little consequence to the greater economy. But he had to ultimately admit to a floor on energy price and therefore an end to traditional growth in GDP—against a backdrop fixed energy.

I got the sense that this economist’s view on growth met some serious challenges during the course of the meal. Maybe he was not putting forth the most coherent arguments that he could have made. But he was very sharp and by all measures seemed to be at the top of his game. I choose to interpret the episode as illuminating a blind spot in traditional economic thinking. There is too little acknowledgement of physical limits, and even the non-compliant nature of humans, who may make choices we might think to be irrational—just to remain independent and unencumbered.

I recently was motivated to read a real economics textbook: one written by people who understand and respect physical limitations. The book, called Ecological Economics, by Herman Daly and Joshua Farley, states in its Note to Instructors:

…we do not share the view of many of our economics colleagues that growth will solve the economic problem, that narrow self-interest is the only dependable human motive, that technology will always find a substitute for any depleted resource, that the market can efficiently allocate all types of goods, that free markets always lead to an equilibrium balancing supply and demand, or that the laws of thermodynamics are irrelevant to economics.

This is a book for me!

Epilogue

The conversation recreated here did challenge my own understanding as well. I spent the rest of the evening pondering the question: “Under a model in which GDP is fixed—under conditions of stable energy, stable population, steady-state economy: if we accumulate knowledge, improve the quality of life, and thus create an unambiguously more desirable world within which to live, doesn’t this constitute a form of economic growth?”

I had to concede that yes—it does. This often falls under the title of “development” rather than “growth.” I ran into the economist the next day and we continued the conversation, wrapping up loose ends that were cut short by the keynote speech. I related to him my still-forming position that yes, we can continue tweaking quality of life under a steady regime. I don’t think I ever would have explicitly thought otherwise, but I did not consider this to be a form of economic growth. One way to frame it is by asking if future people living in a steady-state economy—yet separated by 400 years—would always make the same, obvious trades? Would the future life be objectively better, even for the same energy, same GDP, same income, etc.? If the answer is yes, then the far-future person gets more for their money: more for their energy outlay. Can this continue indefinitely (thousands of years)? Perhaps. Will it be at the 2% per year level (factor of ten better every 100 years)? I doubt that.

So I can twist my head into thinking of quality of life development in an otherwise steady-state as being a form of indefinite growth. But it’s not your father’s growth. It’s not growing GDP, growing energy use, interest on bank accounts, loans, fractional reserve money, investment. It’s a whole different ballgame, folks. Of that, I am convinced. Big changes await us. An unrecognizable economy. The main lesson for me is that growth is not a “good quantum number,” as physicists will say: it’s not an invariant of our world. Cling to it at your own peril.

### Apocalyptic Link

#### Apocalyptic pandemic reps bad.

Mannathukkaren 14

(Nissim Mannathukkaren, Dept. Chair and Associate Prof. of International Development Studies @ Dalhousie University, “Pandemics in the age of panic,” November 22, 2014, <http://www.thehindu.com/features/magazine/social-media-should-be-a-positive-force-and-public-health-systems-should-focus-on-prevention-of-epidemics/article6624674.ece>)

\*Evidence is edited to correct gendered language\*

If natural disasters induce panic, so do pandemics. In recent years, we have seen a series of pandemics: AIDS, avian influenza, SARS and H1N1. Now, we are in the midst of an epidemic, Ebola, which — according to experts — can acquire pandemic proportions. Natural disasters and pandemics have existed in the pre-modern era as well but what is remarkable is that, in the modern era, the attitudes towards hazards — both natural and man-made — have drastically changed. Panic is the order of the day, especially in sanitised spaces of the developed West. Medical scholars, Luc Bonneux and Wim Van Damme, term panic itself as a pandemic.

As they point out, in 1999, Belgium slaughtered seven million chicken and 60,000 pigs when dioxin, a cancer-causing chemical, entered animal feed. Not one person died from dioxin poisoning. In 2005, the chief avian flu coordinator of the UN predicted that 150 million people could be killed by the flu. However, in 10 years, it has killed less than 400 people. The same apocalyptic predictions were made about BSE/CJD, SARS, and H1N1 as well.

Media coverage and the responses of governments and people to Ebola and recent pandemics tell us an important and paradoxical truth: we might be living in an era that is the apogee of human scientific advancements but this has not necessarily mitigated our fears and panic about potential dangers. This has led theorists to argue that we live in a ‘risk society’, a society that generates a lot of risks precisely because it is obsessed with, as the sociologist Anthony Giddens puts it, “the aspiration to control and particularly with the idea of controlling the future.” Traditional cultures did not have a notion of risk as diseases and natural disasters were taken for granted and were attributed to God or fate.

Interestingly, many of the risks in the modern era, as Giddens elaborates, are manufactured by the “very progression in human development, especially by the progression of science and technology.” Diseases caused by industrial pollution, natural disasters caused by environmental destruction, man-made disasters like Bhopal gas tragedy, Chernobyl and Fukushima nuclear accidents, and latrogenesis — adverse effects caused by medical intervention and modern medicines — are examples of these manufactured risks. In the U.S., scholars estimate that 2,25,000 deaths annually are due to latrogenic causes, and is the third leading cause of death after heart disease and cancer! Thus, science and technology itself generates new uncertainties as it banishes old ones and fear of the unknown cannot be eliminated by further scientific progress.

We have to read the coverage of, and response to, Ebola in this wider context of a risk society. Politics of fear, panic, and scaremongering are inevitable outcomes of such a society. Look at the panic around Ebola in the U.S., where so far not one citizen has died of the disease. A nurse returning after treating Ebola patients in Sierra Leone has won a court order against a mandatory quarantine order imposed by the state. Australia and Canada have imposed visa ban on citizens travelling from the affected countries, violating WHO’s International Health Regulations.

Renowned journalist Simon Jenkins argues that “we have lost control of the language of proportion” in responding to Ebola and other pandemics. Similarly, other journalists have severely criticised the media’s coverage of Ebola. The scaremongering is seen in absurd and irresponsible statements like Ebola is ‘the ISIS of biological agents!’ One major responsibility of the mainstream media, other than providing detailed and proper information about the disease itself, is to enlighten the public about the socio-economic and political conditions that govern health and healthcare systems in various societies, which in turn impact the origin and spread of pandemics. Without educating the public about the root causes that condemn the poorer parts of the world to bear the brunt of global pandemics, the media becomes a ~~handmaiden~~ [servant] of the powers — developed countries and pharmaceutical corporations — that control global health.

This lack of knowledge about larger forces also adds to risks and the resultant panic. Thus, in the 2009 H1N1 pandemic, the media’s role in the investigation of allegations of whether it was a false pandemic was nothing to be proud of. The head of health at the Council of Europe had raised questions about the role of pharmaceutical corporations in the declaration of H1N1 as a pandemic. Later, an investigation by the British Medical Journal found that medical experts advising WHO on H1N1 had financial ties with pharmaceutical companies producing the vaccine for the pandemic. As all the developed countries stocked up on the vaccines, reportedly, the pharmaceutical companies made profits ranging from $ 7-10 billion.

In this context, the media’s role in the coverage of pandemics raises questions. Where are the stories in the media about the lack of vaccines for Ebola, 40 years after the disease emerged? Or about the drug firms now in the race to produce a vaccine (the share prices of one of the companies ahead in the race have shot up exponentially)?

While certain prominent Western media houses have definitely pushed the panic button with regard to Ebola, the hard data about the overall coverage as studied by the Foreign Policy magazine indicates that it is not the case. But this study is merely restricted to the English language coverage. Further, the mainstream media has failed miserably in countering the serious issue of the racialisation of Ebola (as with AIDS before) as an African disease caused and spread merely by its cultural practices.

In a risk society, we have to confront new unknowns too, like social media and its impact. One media source called Ebola ‘the first major outbreak in the era of social media’. But, in the coverage of the outbreak, social media has reportedly been a negative force spreading misinformation and rumours that, in some cases, even led to deaths due to dangerous treatments administered.

#### They can’t say no link—the aff has compartmentalized its benefit in terms of productivity gains.

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

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

### Federalism Link

#### Federalism espouses freedom from economic regulation. The aff’s belief in this constitutional doctrine perpetuates neoliberal violence.

Purdy 14 – Jedediah Purdy, Robinson O. Everett Professor at Duke Law School, June 10th (“Neoliberal Constitutionalism: Lochnerism for a New Economy, *Duke University Press*, Available online at <https://scholarship.law.duke.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=6015&context=faculty_scholarship>, Accessed 04-19-2019)

The second contribution of the Lochner-era comparison is to cast light on the connection between the jurisprudence of constitutional rights and that of constitutional structure, particularly federalism. Although these are, formally speaking, distinct principles, it is not accidental that the same Lochner-era courts that invalidated state economic regulations on equal-protection and due-process grounds also overturned federal economic regulations as exceeding the Constitution’s grant of power in the Commerce Clause.15 Nor is the link as simple as the fact that both kinds of rulings had the concrete effect of enabling employers to pay lower wages, hire child workers, and so forth. Rather, the areas of social life exempted from federal regulation were associated with specific values, the same that were protected by Fourteenth Amendment jurisprudence. So Justice Day wrote in 1918 that if Congress could forbid interstate shipment of goods produced in factories where children under 14 were employed or children under 16 worked more than 8 hours a day, “all freedom of commerce will be at an end.”16 The idealization of a certain version of laissez-faire economic relations as “freedom of commerce” lent charisma and cogency to both lines of cases. The parallel today is evident in the arguments against the 2010 Affordable Care Act’s individual insurance-purchase mandate that persuaded five justices that the requirement exceeded Congress’s power to regulate interstate commerce. Formally speaking, the judgment was purely structural, based in the extent of the Article I, Section 8 grant of legislative power to Congress. Near the heart of the Justices’ opinions rejecting the Commerce Power basis for the individual mandate, though, is the idea that the Constitution protects, even indirectly, the autonomy of the consumer deciding how to spend her money. The moral and political gravamen of the structural argument, that is, captured the present mood of laissez-faire for consumer capitalism, as Justice Day’s warning about the end of “freedom of commerce” did a century ago for the industrial economy The strangeness of the ACA ruling lies precisely in its use of a structural federalism argument to protect a substantive individual right. In legislating, Congress always faces two kinds of constitutional constraints. It cannot do some things because those things are forbidden by rights-protecting language like the First Amendment, and others because, although they are not prohibited, they are not authorized by the Constitution’s list of Congress’s powers. The five justices who found that the Commerce Clause could not support the individual mandate relied, of course, on the latter kind of constraint. The Court has, in general, given a famously broad interpretation of the power “to regulate commerce … among the several states” since the New Deal cases overruled Hammer v. Dagenhart and turned decisively away from other cases striking down federal economic regulation, such as Carter v. Carter Coal. Upholding the federal ban on home production of medical marijuana for personal use in the 2007 case of Gonzales v. Raich is only one recent, touchstone instance. The Justices reasoned that, although the medical marijuana in question was not intended to leave the state or enter any commercial flow, it might find its way into the market for illegal drugs, so prohibiting it counted as an integral part of a broader federal scheme of regulating (by prohibition) interstate traffic in marijuana. But in NFIB v. Sebelius, five Justices held that the Commerce Power does not authorize Congress to require people to make purchases in a field of economic life that they have not already voluntarily joined. Become a farmer, the argument goes, and you may be subject to all kinds of regulations, quotas, and so forth. The initial choice to enter the field means taking on its regulatory burdens. But a passive citizen, just by being, has done nothing to subject herself to the insurance mandate. Once she enters the field of health-care consumption, the Justices conceded, she could be required to buy insurance; but as long as, like Winnie-the-Pooh, she just is, Congress cannot reach her. This argument is strange because, although it formally addresses the limits of federal power, its rhetorical, moral, and political force comes from its appeal to the autonomy of the consumer and warnings that a runaway Congress might violate that autonomy. Lower federal courts overturning the individual mandate invoked dark fantasies of a paternalistic government requiring citizens to buy American cars, health- club memberships, or vegetables.17 The same dire warnings appeared in the Justices’ Sebelius opinions.18 The odd thing about this parade of nanny-state horribles is that, because the Commerce Clause concerns the powers of Congress, not the rights of individuals, a ruling that invalidates the individual mandate under the Commerce Clause simply means that only state governments, not the federal government, can pass such a law. Massachusetts had done just that in a piece of legislation that served as a templace for the ACA, to the discomfiture of former Massachusetts Governor and 2012 Republican presidential nominee Mitt Romney.

#### “Disruptive innovation” is a capitalist myth. Integrating competitive rationality into healthcare assimilates the world into the market.

Enstad 19 – Nan Enstad is the Robinson Edwards Professor of History at the University of Wisconsin, Madison, March 20th (“Debunking the Capitalist Cowboy”, Boston Review, Available online at <https://bostonreview.net/articles/boston-review-tk-cigarettes/>, Accessed 02-06-2022)

Capitalism, like the United States itself, has a mythology, and for five decades one of its central characters has been the nineteenth-century maverick cigarette entrepreneur, James B. Duke. Duke’s risk-taking investment in the newfangled machine-made cigarette, so the story goes, displaced the pricey, hand-rolled variety offered by his stodgy competitors. This, in turn, won Duke control of the national, and soon global, cigarette market. Repeated ad nauseam in business and history journals, high school and university curricula, popular magazines, and websites, the story has taught that disruptive innovation drives capitalist progress.

The problem? The Duke story is false: mid-century business historians fabricated it to accord with the theory of creative destruction, developed by libertarian economist Joseph Schumpeter. For generations, we have learned from this myth to fetishize entrepreneurial innovation as the engine of capitalism, while missing Duke’s instrumental role in rampant corporate empowerment.

For generations, we have learned to fetishize entrepreneurial innovation as the engine of capitalism.

Duke’s true “innovation” came not in the 1880s, when the cigarette machine transformed the production process, but in the 1890s, when business corporations shed the fetters of state regulation and radically redefined themselves. Duke’s American Tobacco Company (ATC) moved to the cutting edge of this process when it repelled legal challenges to its monopoly by drawing on new notions of corporate personhood in the wake of the Fourteenth Amendment. Passed during Reconstruction, the Fourteenth Amendment established federal protections of property and due process, rights previously controlled by state law, so that freed slaves would be able to claim full citizenship no matter where they resided. Though the amendment referred to “persons born or naturalized in the United States,” which suggests human persons, lawyers attempted to use the amendment to shield corporate “persons” from state regulations. With the ATC’s win in court, the corporation claimed an enhanced legal personhood, protection from states, and status as a private rather than public entity. Unrestrained, the ATC rapidly gobbled up companies across the United States and the globe, catapulting Duke to spectacular wealth and power. These changes in the corporation, though dramatic and unprecedented, came to seem so natural that they became nearly invisible. And what is natural and invisible is impervious to critique.

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The myth of Duke has enjoyed a decades-long career legitimating free-market capitalism. Born at the Harvard Business School in the years after World War II, the myth took shape in the Research Center in Entrepreneurial History. Established in 1948 with a grant from the Rockefeller Foundation, the interdisciplinary Research Center linked Harvard’s economics department with the business school and business historians. Joseph Schumpeter joined the faculty in the economics department in 1932 and was a founding member of the Research Center. Much like an urban legend, the Duke myth was not the result of conscious lies. Rather, the economically flush and ideologically siloed space of the Research Center led to a narrowing of critical debate and a cascading failure of rigorous historical methods.

The Fourteenth Amendment allowed corporations to claim legal personhood, protection from states, and status as a private rather than public entity.

Schumpeter eagerly used the Research Center to promote ideas on innovation that he had been developing since the 1930s. Schumpeter’s theory narrated a drama of capitalism in which the entrepreneur entered as hardnosed antihero, the driver of capitalist innovation and progress. Schumpeter gave the entrepreneur “glamour,” in the words of economist Arthur Smithies, by painting the entrepreneur as a prescient rogue. While most businessmen are “fenced in by social habits or conventions and the like,” the innovative entrepreneur, Schumpeter claimed, is “the most rational and the most egotistical of all.” He is “more self-centered than other types, because he relies less than they do on tradition and connection and because his characteristic task . . . consists precisely in breaking up old, and creating new, tradition.” In other words, if you see an antisocial, egotistical entrepreneur leaving a path of wreckage in his wake—destroyed markets, lost jobs, bloated monopolies—you should celebrate rather than lament, because this is how the capitalist market revitalizes itself. Schumpeter never referenced the cowboy explicitly, but his antihero entrepreneur markedly resembled a John Wayne character. (Incidentally, Schumpeter loved riding horses and often showed up to Harvard faculty meetings in his jodhpurs.)

Schumpeter’s third wife, Romaine Elizabeth Boody, whom he married in 1937, advised him on how to promote his ideas over those of his archrival, John Maynard Keynes, who advocated for government intervention and regulation. A respected economist in her own right, Boody urged Schumpeter to make his claims bigger and to coin his own term—“creative destruction”—which he did in his 1942 masterpiece Capitalism, Socialism and Democracy. In that volume, Schumpeter boldly declared that creative destruction defined capitalism itself: “This process of Creative Destruction is the essential fact about capitalism,” he wrote. “It is what capitalism consists in and what every capitalist concern has got to live in.” Here is the punch line: because the maverick entrepreneur is “the pivot on which everything turns,” he should be given free rein to act and not be hampered by regulation. Schumpeter’s ideal of the rogue entrepreneur conferred glamour on his own libertarian conservative views.

Business history emerged in the 1930s with the goal of defending the capitalist system, and like others at the Research Center, Schumpeter saw the field as a platform for the popularization of economic theory. He published a call for business students and historians to “test” his theory of creative destruction by examining “the already available secondary literature for data upon entrepreneurial characteristics and phenomena.” Advanced business and history students obliged by writing two articles for the Harvard Business Review that applied the theory of creative destruction to historical entrepreneurs, among them Duke.

‘Creative Destruction is the essential fact about capitalism. It is what every capitalist concern has got to live in.’

No surprise, the authors found that Duke exactly matched the Schumpeterian model of the entrepreneur. A 1963 article claimed that “Duke illustrates classically the Schumpeterian activities of innovation.” He was the “bold opportunist” who introduced the cigarette machine as a “new production technique.” His “cunning” allowed him to negotiate the lowest royalty rate for the machine. Because of his “tempermental difference . . . [from his] lethargic competitors,” Duke gained control of the market and forced the formation of the ATC monopoly “with Duke as president.” Another article argued that Duke displayed the personality traits of the Schumpeterian entrepreneur by being “vigorous,” “shrewd and tough,” “ambitious and fiercely competitive.” Duke’s “most significant innovation,” the introduction of the cigarette machine, allowed him to “revolutionize the entire industry.” Duke’s innovations “caught his competitors napping.” “By the time the other manufacturers saw the error of their ways,” the article went on, “Duke had stolen a long and quiet march on them.” Duke was first to see the potential of the cigarette and the first to market it abroad.

None of these points is accurate. Duke was not the first to use the cigarette machine; in fact, all of the major producers used it by 1887. Nor did he have the best royalty deal for the most efficient machine; that was held by the Lone Jack Tobacco Company. Duke was not the first U.S. entrepreneur to make a success with cigarettes or to find a foreign market for them; Lewis Ginter of Richmond, Virginia, achieved as much before Duke even began making cigarettes. Duke did not force his competitors to merge into the ATC, and he was not its first president. The five major producers formed the corporation in order to gain clout in negotiations for the foreign rights to the best cigarette machine, and Ginter was the first president. No one checked the story against primary sources. Even a look at New York Times articles from the 1880s would have revealed telling inconsistencies and errors.

The myth of Duke went viral when Alfred Chandler, long considered the doyen of U.S. business history, included it in his opus, The Visible Hand (1977). Chandler credited the Research Center as one of his most important influences, and his graduate student, Glenn Porter, had written one of the articles on Duke. The Visible Hand focused on the role of managers rather than entrepreneurs, but Chandler celebrated innovative firms that achieved vertical and horizontal integration, the ATC among them, and cast their entrepreneurs in Schumpeterian terms. The book won the Pulitzer Prize and became the single most influential business history text of the century, read by academics and general readers alike. The book shaped business-related curricula from grade school to business school. The Duke myth has remained unchallenged and unrevised in the forty years since.

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Duke was not the first entrepreneur to make a success with cigarettes. So how did he achieve his extraordinary power?

So how did Duke achieve his extraordinary power, if not through clever innovations with the cigarette machine? Three maneuvers gave him control of the ATC and transformed the corporation itself. The ATC’s opposition, ironically, supplied the first maneuver. The ATC originally incorporated in Virginia with Ginter, a Virginia resident, as president. But just days after approving the ATC’s charter, alarmed tobacco planters in the Virginia legislature launched a successful campaign to rescind it. They claimed they had read the bill they had just voted on, but fear of the impact of the new monopoly on tobacco leaf prices had spread like wildfire through the state, prompting their about-face. The five companies then turned to New Jersey for a corporate charter, and Duke, the second most powerful of the ATC entrepreneurs, assumed the presidency.

The move to New Jersey was profoundly consequential because lawyers there had just succeeded in radically weakening the state’s incorporation laws so that corporations could do virtually anything they wished. The Delaware of the nineteenth century, New Jersey drew the ire of other states because incorporators rushed to establish their charters there, and New Jersey raked in tax revenues. The ATC was one of the first.

When Duke proceeded to pursue controversial, monopolistic business practices, now perfectly legal in New Jersey, he faced pitched opposition from his fellow incorporators. Some objected to practices that they deemed unethical, while others believed Duke neglected the markets they had built in order to take over the pipe and chewing tobacco industry. But Duke made an alliance with financiers who wanted a piece of the action and forced the other entrepreneurs out of the corporation. Duke now enjoyed unchallenged authority over ATC decision-making.

The most significant maneuver, however, happened in the courts, when the ATC prevailed against lawsuits challenging its monopolistic practices and thereby solidified the corporation’s legal redefinition. The ATC’s lawyers drew on the Fourteenth Amendment to declare that the corporation should be treated “as if it were an individual carrying on the same business.” The corporation was not a public but a private entity, “owing no duty to the public or any part of it.”

New Jersey’s laws put virtually no limits on corporate activities and corporate law did not yet exist. It was the corporate version of the Wild West.

As a New Jersey corporation, the ATC freely used its monopoly over cigarettes to force previously independent distributors to carry its products exclusively. Distributors quickly lost their status as business owners and became dependent, contract employees of the ATC, with a dramatic decline in income. Competitors, meanwhile, could no longer get their products to retailers or consumers. Already the biggest cigarette firm in the country, the ATC got bigger still. Though common in today’s economy ruled by Amazon and Walmart, these business practices were highly controversial at the time because they stifled competition, believed to be necessary to a healthy economy.

Previously, business practices like these could be challenged legally by claiming a corporation had exceeded state incorporation laws as expressed in its charter—called an ultra vires (“beyond the powers”) complaint. But New Jersey’s new laws put virtually no limits on corporate activities and corporate law did not yet exist. It was the corporate version of the Wild West.

The ATC’s power grab won it many enemies, some of them in powerful places. A coalition quickly formed to bring creative legal challenges to the ATC’s practices—and by implication, the New Jersey laws—through linked cases in New Jersey (1893) and New York (1895). The coalition consisted of the National Cigarette and Tobacco Company (a company formed with the sole purpose of challenging the ATC in court), the attorneys general of both New York and New Jersey, and distributors. Duke saw these cases as serious threats: he paid the ATC’s top lawyer an annual salary of $50,000—roughly $1.3 million today—and prepared for war.

Both cases had the potential to stop the advance of the ATC and to put great pressure on New Jersey to revise its lax incorporation laws. The New Jersey case, brought in equity court, claimed that ATC business practices harmed trade and commerce in the state and demanded that the corporation be restrained from utilizing its charter. New Jersey state lawyer Benjamin F. Einstein argued that states chartered corporations for the public good and that states had the power to restrain corporations that caused public injury. Had this case succeeded, the ATC would have been forced to cease operations and New Jersey’s courts would have been at odds, likely carrying the case to the Supreme Court and forcing a national debate about the corporation’s expanding legal powers.

In New York, Attorney General Theodore E. Hancock had more distant jurisdiction but drew on a new anti-monopoly law that enabled him to charge the ATC in criminal court with “conspiring to stifle competition.” Hancock insisted that New York state had “sufficient jurisdiction” to restrain a corporation “from transacting an illegal business.” The ATC’s lawyers cleverly responded to the charge by arguing that two are needed to conspire and, because the ATC corporation should be considered a single individual, it was impossible for it to conspire. Had the ATC been found guilty, its New York state certificate would have been cancelled and its executives could have faced jail time. Since New York was the site of the company’s headquarters, its largest factories, and its largest market, a loss there would also have ground the company’s engine to a halt.

Both cases failed to stop the ATC. In New Jersey, Vice Chancellor Alfred Reed, the case’s judge, parroted ATC lawyers by accepting the equation between the corporation and a private individual, according them the “same authority” and protections under the law. He also scolded the plaintiffs for bringing the case in equity court rather than making an ultra vires complaint, even though such a complaint would be futile given the changes in New Jersey’s laws. Anyone wishing to challenge a New Jersey corporation after the ATC’s case faced a catch-22.

The Fourteenth Amendment was created to protect African Americans. Instead corporations immediately began using it to protect themselves.

In New York, the judge ridiculed the lawyers’ argument that the corporation was a single individual and therefore could not conspire, but the criminal court jury was hung and failed to bring a conviction. The ATC quickly patched its distributor contracts in New York to undermine the effectiveness of a retrial. With these wins, Duke’s ATC insulated itself from significant regulation for another fourteen years, until the 1911 Supreme Court busted the behemoth into four still-huge companies. In the meantime, the ATC expanded across the United States and the globe and Duke became the world’s most powerful tobacco executive.

With these cases, the ATC succeeded in using the Fourteenth Amendment to insist that the corporation not be seen as a public institution, chartered by a state for the public good, but as a private individual, deserving protection from the state. In the end, the ATC’s victory became part of the story of Reconstruction’s failures and unforeseen consequences: the Fourteenth Amendment had meant to create enhanced federal protections for individual private property rights in order to shield African Americans from state-level attacks after the close of the Civil War. Instead corporations immediately began using the Fourteenth Amendment to protect themselves from state-level regulations—and because corporations were chartered by states, all regulations at this time were at the level of the state.

The point was not whether corporations were persons, but what kind of persons they were, with what rights and protections. The common law basis of the U.S. and British legal systems is based on the individual as the unit of law. The form of the corporation developed as a way to legally render a collective as a singular entity, or legal person. States chartered such corporations as public persons with obligation to the public good. A wide variety of projects took corporate form, from public works projects, to schools, to businesses. The British East India Company and Virginia Company are two examples of British corporations chartered to pursue colonization for the good of England. As big business grew in the late nineteenth century, a conflict arose between the way states regulated large corporations such as the ATC and the legal standing of equally large companies that did not incorporate. The federal protections of the Fourteenth Amendment were a boon to lawyers looking for tools to free corporations from state-level controls.

The historically public nature of corporations could have become a way of legally construing and regulating the relationship of rapidly growing business corporations and other large companies to undeniably public resources such as water, land, infrastructures such as railroads and highways, and labor. Instead, business corporations became defined as private and their use of public resources became protected by laws historically designed to protect the privacy of white male individuals and their households, laws specifically strengthened by the Fourteenth Amendment. What does the corporation owe to the public? Duke’s lawyers were correct: if a corporation is a private “person,” it legally owes nothing whatsoever. This shift also set the ground for corporations’ successful claim in the twentieth and twenty-first centuries on liberty rights, such as the right to free speech, that originally had been intended for human individuals.

African Americans did not fare as well by these same legal changes. At the same time that crucial state-level attempts to limit corporate claims on the Fourteenth Amendment failed, states succeeded in passing Jim Crow laws, limiting access to jobs and other public resources, such as public transport. The federal government endorsed these restrictions in Plessy v. Ferguson in 1896, ushering in a half century of legal apartheid that lasted until the 1964 Civil Rights Act.

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This history shapes our collective imagination about capitalism as much as it shapes our reality. Though corporate law, regulations, and ideas of corporate responsibility surfaced in the twentieth century, the notion that so-called “private” businesses gain their power and wealth from public resources and therefore owe a duty to the public remains a difficult argument to make more than a century later. Instead we talk endlessly about innovation and the next brilliant (or despicable) entrepreneur.

Historians find in Duke’s inflated corporate power the roots of chronic inequality, economic instability, and the heedless promotion of a deadly product.

This brings us back to the Duke myth and its power to shape the present-day conversation about capitalism. Schumpeter’s economic theory battled with Keynes’s for decades, but were the two men still alive today, Schumpeter likely would be claiming the last laugh. Even Duke’s harshest critics repeat the Schumpeterian story and aid its circulation. Historians of labor and medicine find in Duke’s inflated corporate power the roots of chronic inequality, economic instability, and the heedless promotion of a deadly and addictive product. One such strident title in medical history, Robert N. Proctor’s Golden Holocaust (2012), jolts readers to recognize the scale of corporate crimes. But these historians, too, fail to check the story of how Duke gained his power, likely because the Schumpeterian mythos of the entrepreneur easily accommodates their outrage. Duke as a selfish and bombastic egotist who wrested power from calmer men while he raked in the cash? They concur and simply spin the story of innovation to the left rather than the right. Schumpeter made no secret of his conservative libertarian perspective, but his theory of creative destruction underpins many explicitly left-leaning interpretations of capitalist history.

Schumpeter’s influence has skyrocketed since the decline of Keynesian economics and the rise of neoliberal deregulation of free markets, but today the person most associated with the idea of the disruptive entrepreneur is Clayton M. Christiansen. A Harvard economist, Christiansen unveiled the theory of “disruptive innovation” in his 1997 book The Innovator’s Dilemma. Christiansen was heavily influenced by Schumpeter’s theory of creative destruction, but whereas Schumpeter focused on the entrepreneur, Christiansen elevated the startup—the innovative smaller company that catches its sleepy competition unaware. With fewer resources than its larger competitors, the small company or startup nonetheless disrupts established business practice by offering a cheaper, often inferior product, thereby capturing a new element of the market ignored by established companies. Think personal computers versus the old mainframes. When even established consumers switch to the cheaper product, forcing older companies to mimic the new business model, disruptive innovation has occurred.

As the words “big government” helped dismantle two generations of Keynesian social and economic policy, Schumpeter’s ideas of creative destruction finally triumphed over those of his old rival and found new life in destructive innovation. “Ever since The Innovator’s Dilemma,” historian Jill Lepore writes, “everyone is either disrupting or being disrupted.” As regulations fell and income inequality rose, a euphoric discourse of innovation reassured at least part of the public that society’s numerous ills were necessary—and inevitable—growing pains for a capitalist economy. Lepore’s scathing exposé of disruptive innovation reveals how the idea has enjoyed ridiculously wide uptake in contemporary life, from business to health care to higher education to media. The idea has become so popular, she argues, that it operates as a theory of history, shaping our view of the world and how it works. Lepore researched some of the “handpicked case studies” used to prove the theory in The Innovator’s Dilemma and found that Christiansen had selectively sifted and arranged historical facts with his theory in mind. Lepore also notes that Christiansen has faced very few challengers—a fact that may explain the outrage with which disruptive innovation’s true believers attacked her article.

Perhaps disruptive innovation seems so natural because the Duke myth has reigned in our school lessons and our public culture for so many decades. Corporations continue their barely restrained plunder of public resources, while “innovation” is the buzzword that keeps on buzzing.

#### Advantage turns this sheet.

Pueyo 18

(Salvador Pueyo, PhD in Biology and Ecology from University of Barcelona, Dept. Evolutionary Biology, Ecology, and Environmental Sciences, Universitat de Barcelona, “Growth, degrowth, and the challenge of artificial superintelligence,” *Journal of Cleaner Production 197*, 1731-1736)

We could be approaching a technological breakthrough with unparalleled impact on the lives of every reader of this paper, and on the whole biosphere. It might seem fanciful to suggest that, in a near future, artificial intelligence (AI) could vastly outperform human intelligence in most or all of its dimensions, thus becoming superintelligence. However, in the last few years, this position has been endorsed by a number of recognized scholars and key actors of the AI industry. Several research institutions have been created to explore the implications of superintelligence, for example at Oxford and Cambridge Universities. For details on how this idea emerged and is becoming established, see the chronological table in the Supplementary Material, and for a thorough understanding of the current discussions see Bostrom (2014) or Shanahan (2015). Artificial intelligence (AI) is defined as computational procedures for automated sensing, learn-ing, reasoning, and decision making (AAAI, 2009, p. 1). AIs can be programmed to pursue some given goals. For example, AIs programmed to win chess matches have been defeating human world champions since 1997 (Bostrom, 2014). Current AIs have narrow scopes, while a hypothetical superintelligence would be more effective than humans in pursuing virtually every goal. AI experts surveyed in 2012/13 assigned a probability of 0.1 to crossing the threshold of human-level intelligence by 2022, 0.5 by 2040 and 0.9 by 2075 (median estimates; Muller et al., 2016). The European Commission recently launched the e1 billion Human Brain Project with the intent of simulating a complete human brain as early as 2023, but its chances of success have been questioned (Nature Editors, 2015), and superintelligence is thought to be more easily attainable by engineering it from first principles than by emulating brains (Bostrom, 2014). Following Yudkowsky (2001), the current discussion on the implications of superintelligence (Bostrom, 2014; Shanahan, 2015) is framed around two possibilities: the first superintelligences to emerge will be either hostile or friendly (depending on their programmed goals). In most authors' views, these would result in either the worst or the best imaginable consequences for humanity, respectively1. Much subtler distinctions apply to weaker forms of AI, but it is argued that intermediate outcomes are less likely for an innovation as radical as superintelligence (Bostrom, 2014, p. 20). Hostile superintelligence is imagined as a result of failure to specify and program the desired goals properly, or of instability in the programmed goals, or less frequently as the creation of some illicit group. Therefore, it is framed as a technical rather than a political challenge. Most of the research is focused on ways to align the goals of a hypothetical superintelligence with the goals of its programmer (Sotala and Yampolskiy, 2015), without questioning the economic and political system in which AI is being developed. Kurzweil (2005, p. 420) is explicit in that an open free-market system maximizes the likelihood of aligning AI with human interests, and is leading a confluence of major corporations to advance an agenda of radical techno-social transformation based on this and other allied technologies (Supplementary Material). The benefits imagined from friendly superintelligence find an economic expression in rates of growth at an order of magnitude above the traditional ones or more (Hanson, 2001, 2008; Bostrom, 2014). This view is akin to that of some authors within sustainability science, who take seriously the environmental challenges posed by economic growth, technological innovation and the functioning of capitalist markets, but seek solutions based on these same elements. Opposed to this position is the idea of degrowth (D'Alisa et al., 2014). Degrowth advocates hold a diversity of views on technology (see the Introduction to this special issue), but agree that indefinite growth is not possible if measured in biophysical terms, and is not always desirable if measured as GDP, both for environmental and for social reasons. Also, they are critical of capitalist schemes: to foster a better life in a downsized economy, they would rather support redistribution, sharing, democracy and the promotion of non-materialistic and prosocial values. The challenges of sustainability and of superintelligence are not independent. The changing fluxes of energy, matter, and information can be interpreted as different faces of a general acceleration 2. More directly, it is argued below that superintelligence would deeply affect production technologies and also economic decisions, and could in turn be affected by the socioeconomic and ecological context in which it develops. Along the lines of Pueyo (2014, Sec. 5), this paper presents an approach that integrates these topics. It employs insights from a variety of sources, such as ecological theory and several schools of economic theory. The next section presents a thought experiment, in which superintelligence emerges after the technical aspects of goal alignment have been resolved, and this occurs specifically in a neoliberal scenario. Neoliberalism is a major force shaping current policies on a global level, which urges governments to assume as their main role the creation and support of capitalist markets, and to avoid interfering in their functioning (Mirowski, 2009). Neoliberal policies stand in sharp contrast to degrowth views: the first are largely rationalized as a way to enhance efficiency and production (Plehwe, 2009), and represent the maximum expression of capitalist values. The thought experiment illustrates how superintelligence perfectly aligned with capitalist markets could have very undesirable consequences for humanity and the whole biosphere. It also suggests that there is little reason to expect that the wealthiest and most powerful people would be exempt from these consequences, which, as argued below, gives reason for hope. Section 3 raises the possibility of a broad social consensus to respond to this challenge along the lines of degrowth, thus tackling major technological, environmental, and social problems simultaneously. The uncertainty involved in these scenarios is vast, but, if a non-negligible probability is assigned to these two futures, little room is left for either complacency or resignation. 2 Thought experiment: Superintelligence in a neoliberal scenario Neoliberalism is creating a very special breeding ground for superintelligence, because it strives to reduce the role of human agency in collective affairs. The neoliberal pioneer Friedrich Hayek argued that the spontaneous order of markets was preferable over conscious plans, because markets, he thought, have more capacity than humans to process information (Mirowski, 2009). Neoliberal policies are actively transferring decisions to markets (Mirowski, 2009), while firms' automated decision systems become an integral part of the market's information processing machinery (Davenport and Harris, 2005). Neoliberal globalization is locking governments in the role of mere players competing in the global market (Swank, 2016). Furthermore, automated governance is a foundational tenet of neoliberal ideology (Plehwe, 2009, p. 23). In the neoliberal scenario, most technological development can be expected to take place either in the context of firms or in support of firms3. A number of institutionalist (Galbraith, 1985), post-Keynesian (Lavoie, 2014; and references therein) and evolutionary (Metcalfe, 2008) economists concur that, in capitalist markets, firms tend to maximize their growth rates (this principle is related but not identical to the neoclassical assumption that firms maximize profits; Lavoie, 2014). Growth maximization might be interpreted as expressing the goals of people in key positions, but, from an evolutionary perspective, it is thought to result from a mechanism akin to natural selection (Metcalfe, 2008). The first interpretation is insufficient if we accept that: (1) in big corporations, the managerial bureaucracy is a coherent social-psychological system with motives and preferences of its own (Gordon, 1968, p. 639; for an insider view, see Nace, 2005, pp. 1-10), (2) this system is becoming techno-social-psychological with the progressive incorporation of decision-making algorithms and the increasing opacity of such algorithms (Danaher, 2016), and (3) human mentality and goals are partly shaped by firms themselves (Galbraith, 1985). The type of AI best suited to participate in firms' decisions in this context is described in a recent review in Science: AI researchers aim to construct a synthetic homo economicus, the mythical perfectly rational agent of neoclassical economics. We review progress toward creating this new species of machine, machina economicus (Parkes and Wellman, 2015, p. 267; a more orthodox denomination would be Machina oeconomica). Firm growth is thought to rely critically on retained earnings (Galbraith, 1985; Lavoie, 2014, p. 134-141). Therefore, economic selection can be generally expected to favor firms in which these are greater. The aggregate retained earnings4 RE of all firms in an economy can be expressed as: RE = FE(R;L;K) 􀀀 w   L 􀀀 (i + )   K 􀀀 g: (1) Bold symbols represent vectors (to indicate multidimensionality). F is an aggregate production function, relying on inputs of various types of natural resources R, labor L and capital K (including intelligent machines), and being affected by environmental factors5 E; w are wages, i are returns to capital (dividends, interests) paid to households, is depreciation and g are the net taxes paid to governments. Increases in retained earnings face constraints, such as trade-offs among different parameters of Eq. 1. The present thought experiment explores the consequences of economic selection in a scenario in which two sets of constraints are nearly absent: sociopolitical constraints on market dynamics are averted by a neoliberal institutional setting, while technical constraints are overcome by asymptotically advanced technology (with extreme AI allowing for extreme technological development also in other fields). The environmental and the social implications are discussed in turn. Note that this scenario is not defined by some contingent choice of AIs' goals by their programmers: The goals of maximizing each firm's growth and retained earnings are assumed to emerge from the collective dynamics of large sets of entities subject to capitalistic rules of interaction and, therefore, to economic selection. 2.1 Environment and resources Extreme technology would allow maximizing F in Eq. 1 for some given R and E, but would also alter the availability of resources R and the environment E indirectly. Would there still be relevant limits to growth? How would these transformations affect welfare? To address the first question, let us consider growth in different dimensions:   Energetic throughput: It is often thought that the source that could allow energy production (meaning tapping of exergy) to keep on increasing in the long term is nuclear fusion. This will depend on whether it is physically possible for controlled nuclear fusion to reach an energy return on energy investment EROI >> 1 (Hall, 2009). Even in this case, new limits would be eventually met, such as global warming due to the dissipated heat by-product (Berg et al., 2015). This same limit applies to other sources, such as space-based solar power. It is not known how global warming and other components of E would affect F in a superintelligent economy, or the potential for mitigation or adaptation with a bearable energetic cost. Whatever the sources of energy eventually used, the constraints on growth are likely to become less stringent right after the development of superintelligence, but this bonus could be exhausted soon if there is a substantial acceleration of growth. Other components of biophysical throughput: Economies use a variety of resources with different functions, subject to their own limits. However, extreme technological knowledge would allow collapsing the various resource constraints into a single energetic constraint, so energy could become a common numeraire. The mineral resources that have been dispersed into the environment can be recovered at an energetic cost (Bardi, 2010). Currently, many constraints on biological resources cannot be overcome by spending energy (e.g., the overexploitation of some given species), but this will change if future developments in nanotechnology, genetic engineering or other technologies are used to obtain goods reproducing the properties that create market demand for such resources.   Information processing: Information processing has a cost in terms of resources. Operating energy needs pose an obstacle to brain emulations with current computers (Sandberg, 2016), but the hardware requirements (Sandberg, 2016) could be met soon (Hsu, 2016), and other paths to superintelligence could be more efficient (Sandberg, 2016). However, current ICT relies on a variety of elements that are increasingly scarce (Ragnarsd ottir, 2008). In principle, closing their cycles once they are dispersed in the environment has an enormous energetic cost (Bardi, 2010). The resource needs of future intelligent devices are unknown, but could limit their proliferation. This does not have to be incompatible with a continued increase in their capabilities: When ecosystems reach their own environmental limits, biological production stagnates or declines, but, often, there is a succession of species with increasing capacity to process information (Margalef, 1980).   GDP: Potentially, it could continue to increase without need of growth in biophysical throughput, e.g., through trade in online services. It is argued in Sec. 2.2 that this could well happen without bene ting human welfare. Superintelligence holds the potential for extreme ecoefficiency: In the terms of Eq. 1, firms could not only increase F given R, but also decrease depreciation   (which, however, would only be viable for assets that do not need quick innovation because of competition). Increasing resource efficiency and decreasing turnover are common in maturing ecosystems (Margalef, 1980). However, ecoefficiency does not suffice to prevent impacts on the environment E (which does not only affect production but also the welfare of humans and other sentient beings). With firms maximizing their growth with few legal constraints (as corresponds to the type of society envisaged in Sec. 2.2), extreme resource efficiency could well entail an extreme rebound effect (Alcott, 2015), which is tantamount to generalized ecological disruption. 2.2 Society The literature on superintelligence foresees enormous benefits if superintelligent devices are aligned with market interests, including tremendous profits for the owners of capital (Hanson, 2001, 2008; Bostrom, 2014). By simple extrapolation of shorter-term prognoses (Frey and Osborne, 2013; see also van Est and Kool, 2015), this literature also anticipates huge technological unemployment, but Bostrom (2014, p. 162) claims that, with an astronomic GDP, the trickle down of even minute amounts in relative terms would result in fortunes in absolute terms. However, if there were astronomic growth (e.g., focused on the virtual sphere) while food or other essential goods remained subject to environmental constraints and competition between basic needs and other uses, resulting in mounting prices, a minute income in relative terms would be minute in its practical usefulness, and most people might not benefit from this growth, or even survive (think, e.g., of the role of biofuels in recent famines; Eide, 2009). In fact, there are even more basic aspects of the standard view that are debatable. This section presents a different view, building on the assumption that firms generally tend to maximize growth under environmental constraints. The following points discuss the resulting changes in each of the social parameters in Eq. 1, and relate them to broader changes in society:   L: A continuing trend toward L = 0 is plausible, but it could also be reversed because of resource scarcity. Following Sec. 2.1, energetic cost could be the main factor to decide between humans or machines in functions that do not need large physical or mental capacities. Humans are made up of elements that follow relatively closed cycles and are easily available, while most current machines use nonrenewable materials whose availability is declining irreversibly (Georgescu-Roegen, 1971). Intelligent devices could thus become quite costly (Sec. 2.1). A variety of responses are imaginable, from finding techniques to build machines with more sustainable materials to creating machine-biological hybrids or modified humans; yet, it cannot be taken for granted that human work would be discarded. Initially, one extra reason to use human workers would be the big stock available. Even if human labor persisted, some major changes would be foreseeable: (1) Pervasive rationalization maximizing the output extracted from labor inputs. Current experience with digital firms point to insidious techniques of labor management to the detriment of workers' interests (Mosco, 2016). (2) AIs replacing humans in important functions that need large mental capacities. These include the senior managers of big corporations and other key decision makers (as well as people devoted to economically relevant creative or intellectual tasks). A few unmanned companies already exist (Cruz, 2014).   w: Thus far, w and L seem to have been affected similarly by IT, via labor demand (Autor and Dorn, 2013). However, it is worth noting that firms also have an impact on human wants (Galbraith, 1985), and that this impact is being enhanced by AI. Every user of the Internet is already interacting daily with forerunners of Machina oeconomica that manage targeted advertising (Parkes and Wellman, 2015). Relational artifacts (Turkle, 2006) promise an even more sophisticated manipulation of human emotions. There is empirical evidence that, as it would be expected, the compulsion to consume induced by advertising results in longer working hours and depressed wages (Molinari and Turino, 2015). Furthermore, consumption is not the only motivation to work (Weber, 1904); e.g., some firms induce workers to identify with them (Galbraith, 1985). If these trends continued to the extreme, humanity would become extremely addicted to consumption and to work, and wages would drop to the minimum needed to survive and work (assuming that human labor remains competitive; otherwise, w would be reduced to the zero vector 0).   i: Like work, having capital invested in firms is not just motivated by the wish to consume (Weber, 1904). Procedures like inducing identification (Galbraith, 1985) could magnify the other motivations and reduce i. Consumption advertising acts in this case as a conflicting pressure (Molinari and Turino, 2015), but firms paying profits to households would probably be outcompeted by firms with no effective ownership (technically, nonprofits) or owned by other firms, which would allow reducing i to 0 (note that dividends and interests paid to other firms, including banks, cancel out because Eq. 1 refers to the aggregate of all firms). The owners of capital might currently have an economic function by allocating resources, but automated stock-trading systems have already determined between half and two thirds of U.S. equity trading in recent years (Karppi and Crawford, 2015), making human participation increasingly redundant.   Demand: This is not an explicit term in Eq. 1, but is implicit in F to the extent that production is addressed to the market. In an economy in which humans receive minimum wages and no profits, or in an economy without humans, demand would be basically reduced to firms' investment demand. This would serve no purpose, but would result from economic selection favoring firms with the greatest growth rate. Given the complex interactions mediated by demand, it is unclear whether or not a maximization of each firm's growth should translate to a maximization of aggregate growth.   g: For a strict neoliberal program, the main role of governments would be to serve markets, and this function would determine some g negotiated with firms. Directly or indirectly, governments would continue to exert functions of surveillance and coercion, aided by vast technological advances. Their decisions would be increasingly automated, whether or not they maintained some nominal power for human policy makers. Even elections are starting to be mediated by intelligent advertising (Mosco, 2016). Therefore, a range of negative impacts can be expected, and they are unlikely to spare senior managers or capital owners. Let us consider some moderate deviations from this political extreme. For example, these effectively selfish automated firms could coordinate to address shared problems such as resource limitations, but this does not mean that they would seek to benefit society, such as by ceding resources for people's use with no benefit for firms' growth. Or, before superintelligence is fully developed, governments could try to implement some model combining market competition as a force of technological innovation and wealth creation with economic and technological regulations to ensure that humans (in general, or some privileged groups) obtain some share of the wealth that is produced. However, this project would meet some formidable obstacles: 1. Ongoing neoliberal globalization is making it increasingly difficult to reverse the transfer of power to markets. A reversal will also be increasingly unlikely as computerization permeates and creates dependence in every sphere of life and the capacity of firms to shape human preferences increases. 2. The mere prohibition of some features in AIs poses technical problems that could prove intractable. In the words of Russell (interviewed by Bohannon, 2015): The regulation of nuclear weapons deals with objects and materials, whereas with AI it will be a bewildering variety of software that we cannot yet describe. I’m not aware of any large movement calling for regulation either inside or outside AI, because we don’t know how to write such regulation. 3. The objective role of humans obtaining profits from this type of firms would be parasitic. Parasites extract resources from organisms that surpass them in information and capacity of control (Margalef, 1980). In nature, parasites generally have high mortality rates, but persist by reproducing intensively. No equivalent strategy can be imagined in this case. The transfer of profits to humans would be an ecological anomaly, likely to be unstable in a competitive framework. A much more likely departure from strict neoliberalism would result from structural mutations that would carry the system even further from any human plan, in unpredictable manners. Such mutations were excluded from the definition of this scenario, but not because they should be unlikely. In particular, they could provide a path to forms of hostile superintelligence more similar to those in the literature. Marxists believe that societies dominated by one social class can be the breeding ground for newer hegemonic social classes. In this way bourgeois would have displaced aristocrats, and they expect proletarians to displace the bourgeois (Marx and Engels, 1888). However, the bourgeoisie represented an advance in information processing and control, unlike the proletariat. AIs are better positioned to become hegemonic entities (even if unconsciously). This would not be just a social transition, but a biospheric transition comparable to the displacement of RNA by DNA as the main store of genetic information. So far, there is nothing locking future superintelligences in the service of human welfare (or the welfare of other sentient beings). Whether and how this future world would be shaped by the type of society from which it emerges is extremely uncertain, but neoliberalism can be seen as a blueprint for a Kafkaesque order in which humans are either absent or exploited for no purpose, and ecosystems deeply disturbed. 3 Degrowth as a viable alternative Criticisms to the environmental and social impacts of the capitalist market are often answered with appeals to the gains in efficiency and long-term growth brought about by a free market. The above thought experiment shows how misleading it is to assume that efficiency and growth are intrinsically beneficial. The economic system as a whole may become larger and more efficient, but there is nothing in its spontaneous order guaranteeing that the whole will serve the interest of its human parts. This becomes even more evident when approaching the point in which humans could cease to be the most intelligent of the elements interacting in this complex system. Even though the thought experiment assumes neoliberal policies, as one of the purest expressions of pro-capitalist policies, Sec. 2.2 also lists some reasons to be skeptical of reformist solutions. Here, a response to this challenge is outlined. This involves, first of all, to disseminate it and integrate it into a general criticism of the logic of growth and a search for systemic alternatives, in contrast to the technocratic (sensu Kerschner and Ehlers, 2016) strategies to keep the management of this issue within limited circles (Supplementary Material). This awareness could initially permeate the social movements that originated in reaction to a variety of environmental and social problems caused by the current growth-oriented economy (including the incipient resistances to labor models introduced by digital firms; Mosco, 2016). This will not just be one more addition to a list of dire warnings like resource exhaustion, environmental degradation and social injustice: While the economic elites now have the means to protect themselves from all of these threats, it is shown above that intelligent devices could well end up replacing them in their roles, thus equating their future to that of the rest of humanity. This alters the nature of the action for system change. It means that, in fact, this action does not oppose the interests of the most influential segments of society. A new role for social movements is to help these elites (and the rest of humanity) understand which policies are really in their best interest. In the kind of alternatives outlined below, such elites will gradually lose their privileges, but they will gain a much better life than if the loss of privileges occurs in the way that Sec. 2 suggests. Initially, few in the elites will be ready for such a radical change in their worldview, but these few could start a snowball effect. This is a game-changer creating new, previously unimaginable opportunities. A key step will be to reform the process of international integration. Rather than democracy controlled by the global market, markets will need to be democratically controlled (there has been a long-standing search for alternatives, e.g., The Group of Green Economists, 1992). This will not necessarily have to be followed by a trajectory toward a fully planned economy: a lot of research needs to be done on new ways to benefit from democratically tamed self-organization processes (Pueyo, 2014). What does not suffice, however, is the old recipe of setting some minimum constraints with the expectation that, then, the forces of market competition will be harnessed for the general interest. If, as suggested in Sec. 2.2, there is no way for governments to control a mass of entities evolving in undesirable ways, an alternative is to deflect the forces that drive such evolution. This entails nothing less than moving from an economic system that promotes self-interest, competitiveness, and unlimited material ambitions in firms and individuals to a system that promotes altruism, collective responsibility, and sufficiency. In short, moving from the logic of growth to the logic of degrowth (see D'Alisa et al., 2014). Thus, besides regulations setting constraints of various types, there is a need for methods to align economic selection with the collective interests. The application of such methods would, for example, cause demand (which affects production F in Eq. 1) to become positively correlated with wages (i.e., with each firm's contribution to w), negatively correlated with resource use (R), and properly correlated with other more subtle parameters (not explicit in Eq. 1). The common good economy (Felber, 2015) is an approach worth considering because it aims explicitly to remove pressures that propel growth, and is already expanding with the involvement of many businesses. In this approach, a key tool is the common good balance sheet, a matrix of indicators of firms' social and environmental performance designed by participatory means, completed by the firms and (ideally) revised by independent auditors. Its function is to ease the application of ethical criteria by private and public agents interacting with firms in every stage of production and consumption. Felber (2015) envisions an advanced stage in which firms and the whole economy transcend their current nature (e.g., big firms would be democratized). While the common good balance sheet would serve mainly as an aid to change firms' general goals, it could also incorporate some explicit indicator of the perilousness of the software that these firms develop or use. Hopefully, changing values in firms, governments, and social movements will also ease the change in individual values. This will further reduce the risk of having people engaged in the development of undesirable forms of AI. Furthermore, for those still engaged in such activities, there will be an increased chance of others in their social networks detecting and interfering with their endeavor. This reorientation at all levels (from the individual to the international sphere) will also help to address forms of AI distinct but no less problematic than Machina oeconomica, such as autonomous weapons. Even with such transformations, it will not be easy to decide democratically the best level of development of AI, but the types of AI should become less challenging. (Also, these transformations could moderate the pace of technological change and make it more manageable, by relaxing the competitive pressure to innovate). However, they will only be viable if they take place before reaching a possible point of no return, which could occur well before superintelligence emerges (considering irreversibility, obstacle 1 in Sec. 2.2). 4 Conclusions There is little predictability to the consequences that superintelligence will have if it does emerge. However, the thought experiment in Sec. 2 suggests some special reasons for concern if this technology is to arise from an economy forged by neoliberal principles. While this experiment draws a disturbing future both environmentally and socially, it also opens the door to a much better future, in which not only the challenges of superintelligence but many other environmental and social problems are addressed. This pinch of optimism has two foundations: 1) The thought experiment suggests that nobody is immune to this threat, including the economically powerful, which makes it less likely that the action to address it gets stranded on a conflict of interests. 2) The neutralization of this threat could need systemic change altering the very motivations of economic action, which would ally the solution of this problem with the solution of many other obstacles to a sustainable and fair society, along the lines of degrowth. One of the main dangers now lies in our hubris, which makes it so difficult to conceive of anything ever defying human hegemony.

#### No disease impact.

Farquhar et al 17 – Sebastian Farquhar, Project Manager at FHI responsible for external relations, M.A in Physics and Philosophy, Oxford, John Halstead, Global Priorities Project, Owen Cotton-Barratt, Research Associate in the FHI at Oxford, Lecturer in Mathematics at St. Hugh’s College, Stefan Schubert, PhD in philosophy, Researcher at the Centre for Effective Altruism, Haydn Belfield, Academic Project Manager, Centre for the Study of Existential Risk, Cambridge., Andrew Snyder-Beattie, Director of Research at FHI. (“Existential Risk: Diplomacy and Governance.” *Future of Humanity Institute*. Oxford, Global Priorities Project, Available online at <https://www.fhi.ox.ac.uk/wp-content/uploads/Existential-Risks-2017-01-23.pdf>)

For most of human history, natural pandemics have posed the greatest risk of mass global fatalities.37 However, there are some reasons to believe that natural pandemics are very unlikely to cause human extinction. Analysis of the International Union for Conservation of Nature (IUCN) red list database has shown that of the 833 recorded plant and animal species extinctions known to have occurred since 1500, less than 4% (31 species) were ascribed to infectious disease.38 None of the mammals and amphibians on this list were globally dispersed, and other factors aside from infectious disease also contributed to their extinction. It therefore seems that our own species, which is very numerous, globally dispersed, and capable of a rational response to problems, is very unlikely to be killed off by a natural pandemic.

One underlying explanation for this is that highly lethal pathogens can kill their hosts before they have a chance to spread, so there is a selective pressure for pathogens not to be highly lethal. Therefore, pathogens are likely to co-evolve with their hosts rather than kill all possible hosts.39

## DA – Politics

### Sanctions

#### **US sanctions key to deter *Russian aggression* – absent *strict sanctions*, Russian military adventurism and US-Russia conflict are inevitable**

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(Nigel, International Relations at Mahidol University and an Associate Fellow at Chatham House, “Sanctions on Russia Are Working,” Foreign Affairs, August 22, 2018, <https://www.foreignaffairs.com/articles/russian-federation/2018-08-22/sanctions-russia-are-working> //)

This was also a landmark in sanctions history. No economy as big as Russia's has been subject to major sanctions in recent times. Only the restrictions imposed by the League of Nations on Italy, and by the United States on Japan, before World War II bear comparison. But unlike Italy and Japan back then, Russia is a key supplier of oil and gas to the rest of the world. An embargo on its major exports—a traditional sanctions tool—is all but unthinkable. Designing effective sanctions against such a hard target was a new challenge. How have the sanctions fared? Russia has not returned Crimea or withdrawn from Ukraine. Nor has its economy collapsed. But sanctions were never intended to achieve those things. Rather, they were designed for three goals: **first,** to deter Russia from escalating military aggression**; second,** to reaffirm international norms and condemn their violation**; and third,** to encourage Russia to reach a political settlement—specifically, to fully implement the Minsk agreements, which oblige it to observe a cease-fire, withdraw military equipment, and allow Ukraine to restore control over its borders—by increasing the costs of not doing so. Judged against those goals, sanctions have largely worked. There is strong evidence that at moments of intense fighting in 2014–15, the prospect of significant further sanctions curbed Russian escalation on the ground and, together with Ukrainian resilience, forced Russia to scale back its ambitions. **Sanctions have also powerfully reaffirmed the principles of international order that Russia violated.** Since sanctions create costs for the countries imposing them, they convey resolve better than verbal condemnation. The cohesion and purpose they instilled helped marshal an effective response to the Skripal poisoning. The unprecedented expulsion of 150 Russian intelligence officers from the United States and several Western allies was a diplomatic triumph that built on earlier coordination over sanctions. Sanctions have failed only in their most ambitious goal, to nudge Russia toward fulfillment of the Minsk agreements. Russia's routine violations of the agreements and its other actions, such as its recognition of identity documents issued by the Donetsk and Luhansk People's Republics within Ukraine, make reaching this goal less likely than ever. Russia is prepared to incur large costs to maintain its influence in Ukraine. Even so, **Russian sanctions have worked** much better than might have been expected. Indeed, it is rare for any foreign policy instrument to achieve all its goals. The most comprehensive study of sanctions, which draws on over 100 cases, finds they are most effective when imposed on democracies, on countries that can be isolated, and between states that previously enjoyed a close relationship. None of these correlates of success is present in the Russian case. Yet sanctions have been remarkably successful and have brought results over a shorter period than the years or even decades that sanctions usually require. Nor have sanctions proved counterproductive. Some have argued that sanctions play into Russian President Vladimir Putin's hands by stoking a "rally 'round the flag" mood in Russia. But the post-2014 spike in Putin's personal ratings was the result of the annexation of Crimea, not a reaction to sanctions. **Since Putin's reelection in March,** his ratings have fallen sharply to their pre-Crimea levels, even as sanctions have become more stringent. Others claim that by pressuring oligarchs to return assets to Russia, sanctions help Putin achieve his long-sought goal of "de-offshorization." But there is no sign that Russian oligarchs are repatriating large amounts of capital. **Capital outflows from Russia are** actually **rising. The most significant effects of sanctions lie ahead. By design,** their impact will intensify. In particular, measures that deprive the energy sector of foreign technology and finance will bite more deeply the longer they are applied. Russia's concerns are growing. In July, the government drew up its first comprehensive plan to combat sanctions. On August 3, Nikolai Patrushev, secretary of the Russian Security Council, noted that **sanctions were creating** "serious problems" in the energy sector. Not only economic liberals but siloviki, the security service officials who dominate key issues, are alarmed. The newest sanctions are the most potent. In April, the U.S. Treasury released a list of Russians it was cutting off from much of the global financial system. This has created unease among Russia's oligarchs, who wonder which of them will be next. Complementing this, the United Kingdom is now scrutinizing oligarchs and their wealth more stringently and raising transparency standards in its Overseas Territories, popular havens for anonymous Russian wealth. These new sanctions and standards are set to disrupt the Russian elite's ability to make money in Russia and send it abroad for safekeeping. By protecting oligarchs from a rapacious state, the West's financial and legal systems make it easier for Russia's economic elite to reconcile itself to the way power works in Russia. In this way, the West has helped stabilize Putin's rule. If a critical mass of oligarchs feels its core interests are harmed by Western responses to the Kremlin's behavior, it may begin to view Putin in a different light. The interests of political power and wealth in Russia will become less aligned than at any time since Putin asserted dominance over oligarchs in his first term, from 2000 to 2004. This will not lead to change today or tomorrow. But as the "2024 question" looms—will Putin leave office as the constitution mandates, and if so, who will succeed him?—tensions between power and money could create an important new force for change, not only on Russia's actions but also on its governance. Finally, some critics worry that sanctions are overused. If the West turns to sanctions too often, they fear, countries will figure out how to evade them. This is a legitimate concern in other cases, but not here, for three reasons. First, **the sanctions have escalated for good reason, as Russia's behavior** has only deteriorated **from annexing Crimea to intervening in the Donbas, downing Malaysian Airlines flight MH17, interfering in Western elections,** and using Novichok to carry out a political assassination abroad. Failing to match new outrages with new sanctions would undermine perceptions of Western resolve. Readiness to expand sanctions is also what makes them effective deterrents. It was the prospect of more costly measures, such as sanctions on Russian government debt or exclusion from international payment systems, that helped curb Russian ambitions in Ukraine. There is evidence, for example, that they deterred Russian forces from taking the strategic city of Mariupol in September 2014 and from pressing their advantage after their victory in Debaltseve five months later. Had the initial sanctions been more severe, and Western governments signaled their intent to escalate more clearly, the deterrent effects would likely have proved stronger. If anything, sanctions have been used too little, not too much. Second, Russia has struggled to find new ways to evade sanctions**. If anything, its efforts to adapt have created new problems.** Retaliatory import bans have failed to weaken Western political resolve and merely benefited Russia's domestic producers at the expense of Russian consumers by driving up food prices. Government rescues of sanctions-hit companies have expanded the state's importance (it now owns around 50 percent of the economy), exacerbating existing problems of inefficiency and corruption. And although Russia has hastened its search for new partners, it has found itself with fewer options and a weak hand. China, in particular, is now in a stronger position to shape the Sino-Russian relationship to serve its interests. Finally, critics of sanctions must explain how the United States and its allies can better achieve their security goals. No instrument is perfect. But **sanctions are** smart, low-cost, and nonlethal and play to the West's natural strengths**. In the past decade, Russia has carried out impressive military reform and waged effective information warfare.** Its resurgent power has surprised and disconcerted the West. But **Russia remains, as it has always been,** economically weaker than its rivals**. The West's biggest advantage lies in economic power. Sanctions exploit that fact**. Not all sanctions are good sanctions. Like any tool, they must be carefully designed to achieve defined goals while preserving unity among allies and limiting unintended consequences. To this end, restoring the U.S. State Department's Coordinator of Sanctions Policy Office, which was abolished in 2017, would be a sensible move. **Sanctions on Russia are** working better and faster than predicted against a difficult target**. They harness the West's biggest strength.** The longer they are applied, the more effective they will be**.** And as a new era of geoeconomic competition dawns, they offer valuable experience for future contests. **Judge them properly, use them wisely, but don't abandon them.**

### Uniqueness

#### **Russia sanctions pass now.**

Sprunt 2/2 – Barbara Sprunt, 2022 (“Senators make headway on Russia sanctions bill, but 2 sticking points remain”, NPR, Available online at https://www.npr.org/2022/02/02/1077589147/senators-make-headway-on-russia-sanctions-bill-but-two-sticking-points-remain)

As concerns mount over Russia's aggressive posture toward Ukraine, a bipartisan group of senators is negotiating legislation that would impose ~~crippling~~ sanctions on Russia to act as a deterrent.

There's broad support for the sanctions bill to get done but two sticking points remain: Nord Stream 2 and when the sanctions should kick in.

"We keep working to fine tune that to get to common ground," said Sen. Bob Menendez, D-N.J, who chairs the Senate Foreign Relations Committee. "I think we can and will, and I hope to get it done sooner rather than later."

Menendez is working on the legislative package with GOP Sen. James Risch of Idaho, ranking member of the committee.

Nord Stream 2 is a controversial natural gas pipeline from Russia to Germany that runs more than 750 miles.

The gas isn't flowing yet, but critics of the pipeline argue its existence gives Russia too much control over Europe's energy supply. Last month, Democrats blocked a bill sponsored by Sen. Ted Cruz, R-Texas, that would impose sanctions on the pipeline. The White House and Democratic lawmakers argued such sanctions could drive a wedge between the U.S. and key European allies.

"[Nord Stream 2 is] going to be the last 't' crossed 'i' dotted before we get the ball across the finish line," Risch told CNN Sunday.

The second unresolved issue is the timing of sanction imposition. Republican lawmakers have pushed for penalties to be implemented ahead of any further steps taken by Russia.

Senate Minority Leader Mitch McConnell on Wednesday threw his support behind the idea of some sanctions now "to confront a litany of Russian threats, including their use of energy as a geostrategic weapon. At the same time, let's make clear we are prepared to impose even more devastating costs should Russia continue its aggression."

Menendez said sanction timing could be an area of compromise, although he acknowledged the Biden administration isn't keen on imposing upfront sanctions.

"They're not enthralled with the idea," he said. "But I have suggested to them that a strong bipartisan response is something that strengthens their hand."

Sen. Rob Portman, R-Ohio, who led a congressional delegation to Ukraine last month, stressed the importance of sending a bipartisan message to Russia.

"What [getting a deal soon on the package] is tied to is just ensuring that here in Congress, we have a strong, bicameral and bipartisan message to the people of Ukraine, and to Vladimir Putin and the Russians, that one, we stand with Ukraine," he said. "What Russia is already doing is considered to be subject to sanctions now, and should they make a big mistake and actually invade Ukraine, the consequences would be devastating. So we agree with this on a bipartisan basis, bicameral basis, we need to express it clearly."

Senators have come to agreement on other aspects of the bill such as bolstering security assistance to Ukraine, possibly including a bill that would set up a lend-lease type program for the country, and helping counter Russian misinformation.

Sen. Chris Murphy, D-Conn., who was on the recent congressional trip to Ukraine, warned against downplaying the global significance — and potential ramifications — of Russia's actions.

"I don't know what we would use sanctions for, if not to punish a country from invading a sovereign neighbor," Murphy said. "This would be the most significant violation of the post-World War II order in Europe in our lifetime, and China is watching. If Russia gets away with this without any significant penalty, it'll just be a matter of time before China moves on Taiwan."

White House press secretary Jen Psaki told reporters Monday the administration is encouraged by the ongoing bipartisan talks on how to hold Russia accountable.

#### Passes now. It’s on the top of the docket.

Luscombe 1/30 – Richard Luscombe, 2022 (“US Senate panel close to approving ‘mother of all sanctions’ against Russia”, The Guardian, Available online at https://www.theguardian.com/world/2022/jan/30/ukraine-crisis-us-sanctions-russia-putin)

The leaders of the Senate foreign relations committee said on Sunday they were on the verge of approving “the mother of all sanctions” against Vladimir Putin, warning there would be no appeasement as the Russian president contemplates an invasion of Ukraine.

“We cannot have a Munich moment again,” the panel’s Democratic chair, Bob Menendez of New Jersey, told CNN’s State of the Union, referring to the 1938 agreement by which allies ceded parts of Czechoslovakia to Hitler, believing it would stave off war.

“Putin will not stop if he believes the west will not respond,” Menendez said. “We saw what he did in 2008 in Georgia, we saw what he did in 2014 in pursuit of Crimea. He will not stop.”

Menendez said he believed bipartisan negotiations for severe sanctions were “on the one-yard line”, despite disagreements with Republicans over whether measures should be imposed before or after any Russian invasion. The UK government promised to ramp up sanctions against Putin and his associates.

The negotiations come ahead of an expected UN security council meeting on Monday, at the request of the US, to give Russia the opportunity to explain its actions.

Linda Thomas-Greenfield, the US ambassador to the UN, said: “We’re going to go into the council prepared to listen to Russia’s security concerns, but we’re not going to be distracted by their propaganda.”

On Sunday, Kyiv urged Moscow to pull back its troops from Ukraine’s border and continue dialogue with the west if it was “serious” about de-escalating tensions that have soared amid fears of a Russian invasion. Canada moved its Ukraine-based military units westward on Sunday and announced the temporary withdrawal of all non-essential employees from its Kyiv embassy, citing ongoing Russian threats along the border.

“We will continue to take all precautions necessary to keep our Canadian Armed Forces safe and secure,” said Canada’s defense minister, Anita Anand, at a press conference in Kyiv. Canada has 900 military members supporting the Nato mission in Ukraine via “land, air and sea”, she said.

Meanwhile, Jens Stoltenberg, the head of Nato, said Europe needed to diversify its energy supplies, saying the situation “demonstrates the vulnerability of being too dependent on one supplier of natural gas”.

Tensions on the Ukraine border have continued to escalate, with Reuters reporting the Russian military buildup included supplies of blood in anticipation of casualties.

John Kirby, the Pentagon press secretary, told Fox News Sunday: “Putin has a lot of options available to him if he wants to further invade Ukraine, and he can execute some of those options imminently. It could happen really, honestly, at any time.”

Seeking to show bipartisan resolve, Menendez gave CNN a joint interview with his committee’s ranking Republican, James Risch of Idaho.

Menendez said: “There is an incredible bipartisan resolve for support of Ukraine, and an incredibly strong bipartisan resolve to have severe consequences for Russia if it invades, and in some cases for what it has already done.

“We are building on the legislation that both Senator Risch wrote independently, and I wrote, which I called the mother of all sanctions. It’s to include a variety of elements, massive sanctions against the most significant Russian banks, crippling to their economy, Russia sovereign debt. These are sanctions beyond any that we have ever levied before.”

Risch said talks had been a “24 hour-a-day effort for the last several days” in an attempt to reach agreement over sanctions timing and content, and that he was optimistic.

“That’s a work in progress,” Risch said, when pressed over discussions about pre-emptive sanctions or measures to be taken in the event of an invasion. “[But] I’m more than cautiously optimistic that when we get back to DC tomorrow that we’re going to be moving forward.”

Menendez said he believed western allies did not have to wait to start penalising Putin.

“There are some sanctions that could take place up front because of what Russia has already done, cyber-attacks on Ukraine, false flag operations, the efforts to undermine the Ukrainian government internally,” he said.

“But then the devastating sanctions that ultimately would crush Russia’s economy, and the continuing lethal aid that we are going to send, means Putin has to decide how many body bags of Russian sons are going to return to Russia.

“The sanctions we’re talking about would come later on if he invades, some sanctions would come up front for what has been done already, but the lethal aid will travel no matter what.”

Risch criticized the stance of several far-right figures, including the Fox News host Tucker Carlson and the Kentucky congressman Thomas Massie, who have questioned why the US is backing Ukraine and opposing Russia. Carlson said “it makes sense” that Putin “just wants to keep his western border secure” by opposing moves by Ukraine to join Nato.

“We side always with countries that are democracies, and certainly there isn’t going to be a truce committed in that regard,” Risch said.

“But the people who were saying that we shouldn’t be engaged in this at all are going to be singing a very different tune when they go to fill up their car with gas, if indeed there is an invasion. There are going to be sanctions that are going to be crippling to Russia, it is going to cripple their oil production. And as we all know, Russia is simply a gas station that is thinly disguised masquerading as a country. It is going to have a devastating effect on the economy around the world.”

On NBC’s Meet the Press, Dick Durbin, co-chair of the Senate Ukraine caucus, addressed concerns aired by President Volodymyr Zelenskiy on Friday that growing rhetoric over the crisis was causing panic and destabilising his country’s economy.

His comments followed a call with Joe Biden that Ukraine officials said “did not go well”.

“Any decision about the future of Ukraine will be made by Ukraine,” said Durbin, an Illinois Democrat. “It won’t be made in Moscow or in Washington, in the European Union or in Belarus. It’s their future and their fate and their decision as far as that is concerned.”

The caucus co-chair, Republican Rob Portman of Ohio, who is also on the foreign relations committee, told NBC he believed Putin had underestimated the unity of Nato and others.

“One thing Vladimir Putin has done successfully is he has strengthened the transatlantic alliance and countries around the world who are looking at this and saying, ‘We cannot let this stand, we cannot let this happen,’” Portman said.

“For the first time in nearly 80 years we could have a major and very bloody conflict in Europe unless we stand up together and push back, and so far so good.”

#### Details are under negotation.

Shalal and Gardener 1/26 – Andrea Shalal and Timothy Gardner, 2022 (“U.S. companies push Biden, Congress for caution on Russia sanctions”, Reuter, Available online at <https://www.reuters.com/world/us/us-companies-push-biden-congress-caution-russia-sanctions-2022-01-26/>)

WASHINGTON, Jan 26 (Reuters) - U.S. President Joe Biden has threatened to impose devastating sanctions on Russia if leader Vladimir Putin invades Ukraine, but some big companies and business groups are pushing the White House and lawmakers to be cautious.

A trade group representing Chevron, General Electric and other big U.S. corporations that do business in Russia is asking the White House to consider allowing companies to fulfill commitments and to weigh exempting products as it crafts any sanctions. At the same time, big energy companies are pushing Congress to limit their scope and time frame.

The Biden administration and Congress need to "get the details right in case they must follow through on the threat of sanctions," Jake Colvin, president of The National Foreign Trade Council, told Reuters Monday.

"Those details should include consideration of safe harbors or wind-down periods to enable companies to fulfill existing contracts and obligations, as well as carve-outs for lifesaving medicines and other humanitarian considerations consistent with longstanding U.S. policy," Colvin said.

Energy companies have also reached out directly to U.S. lawmakers to press for a "cool down" or "wind down" period so their assets are not seized if they are unable to fulfill business agreements in Russia, a congressional aide told Reuters.

The American Petroleum Institute, the largest U.S. lobbying organization for oil and gas drillers, has discussed sanctions on Russia with congressional offices. "Sanctions should be as targeted as possible in order to limit potential harm to the competitiveness of U.S. companies," an API spokesperson said.

Export sanctions are typically phased in, giving companies time to wind down their existing business, or ensure delivery arrivals, said William Reinsch, a former senior U.S. Commerce Department official.

But in this case, the sanctions are likely to be applied suddenly, in the middle of a crisis, making a "wind down" period more difficult to secure, he said.

The U.S. Treasury in the past has provided some mitigation measures on financial sanctions, such as granting licenses protecting senders of humanitarian aid and personal remittance flows to Afghanistan despite sanctions against the ruling Taliban.

A U.S. Treasury official declined to comment on any such measures regarding potential sanctions against Russia, but added: "We are prepared to deliver severe costs to the Russian economy while minimizing unwanted spillover."

CRIMEA SANCTIONS LEGACY

Oil companies felt the aftermath of the U.S. sanctions on some of Russia's more expensive drilling operations for years after Putin invaded Crimea in 2014.

The measures forced Exxon Mobil (XOM.N) out of Russia's Arctic and ended the company's collaboration with Russian state oil company Rosneft (ROSN.MM), with which it signed a $3.2 billion deal in 2011 to develop the region.

Exxon's argued the sanctions, which slowed work on a major discovery in the Kara Sea above the Arctic Circle, unfairly penalized U.S. companies while allowing foreign companies to operate in the country, one of the world's largest oil producers.

The 2014 sanctions hit the easiest targets in Russia's high-tech exploration

and gas projects in the Arctic, Siberian shale and deep sea.

New sanctions could be broader, but also tricky to pull off without damage to Western companies.

One possible "safe harbor" measure could protect companies from legal liability for sanctions violations if certain conditions were met, said Reinsch, such as showing that a shipment went to the sanctioned country without permission, perhaps from a third country.

Exxon did not immediately respond to a request for comment about any lobbying it is doing on the potential Russia sanctions.

A spokesman for the U.S. Chamber of Commerce, the largest lobbying group for American business, declined to comment on the topic.

U.S. goods and services trade with Russia totaled an estimated $34.9 billion in 2019, according to the U.S. Trade Representative's office.