CORPORATE PROFIT OR PUBLIC HEALTH?
THE AFFORDABLE CARE ACT’S INDIVIDUAL MANDATE IN THE CONTEXT
OF THE NEOLIBERAL PROJECT

by

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I. INTRODUCTION

For three decades efforts to reform the American Healthcare System have deteriorated in the face of partisan opposition and industry influence. The Patient Protection and Affordable Care Act of 2010 is accredited with being the first meaningful healthcare reform since the implementation of Medicare and Medicaid in 1965. The legislation passed at an apparently contradictory moment when neoliberalism, characterized by its proclivity for rhetoric damning social programs as bastardizations of free market function and individual responsibility, dominates public policy and discourse (Hartman 2005). “There is no such thing as society,” stated Margaret Thatcher, who is accredited with ascribing neoliberalism into the United Kingdom’s political sphere, in 1987. “There are individual men and women, and there are families. And no government can do anything except through people, and people must look to themselves first” (Margaret Thatcher Foundation). Under the rubric of antistatism typified by Thatcher, neoliberalism would seem to oppose key provisions under the Affordable Care Act (ACA): federal subsidies for primary care, regulations on private insurers, expansion of public health insurance programs and an “individual mandate” requiring all citizens to purchase health insurance. Yet a look at history suggests that the welfare state, including the healthcare system, sustains neoliberal political and economic function.

To understand the ACA, in terms of its content and its political debut in the neoliberal era, one first must recognize that the healthcare system is an arena for class struggle. I argue this based on the way in which reform to American health programs in the past three decades, manifest as the wholesale privatization and corporatization of care in the United States, has served the health industry in particular and private interests more broadly. While healthcare costs have climbed and entitlements have deteriorated, profit margins have increased for insurance companies, pharmaceutical manufacturers and health care corporation executives. The poor and working-class bear an increasingly disproportionate burden of disease as wealth concentrates in the hands of the health industry’s elite, surviving precariously between medical bankruptcy, untreated illness, and poverty (Stiehm, 2001). To talk about the effect of neoliberal policies on private profit and public health is to talk about a fundamental question of social justice in the United States - about the wealth of the business class versus the health of the public.

The relationship between class interests, neoliberal policy and the welfare state is the site of exploration for how healthcare reform pertains to the neoliberal project. This paper focuses on Section
Requirement to maintain minimum essential coverage. This so-called “individual mandate” was arguably the most contested of the ACA’s provisions, bearing substantial implications for the political and economic aspirations of organized labor, the health industry and the larger business class. Deconstructing this provision with regards to its content, stakeholder support, and surrounding discourse will shed light on how the legislation relates to the broader trajectory of the welfare state under neoliberalism. Doing so will answer the question, in what respects does the individual mandate of the Affordable Care Act serve neoliberal ideological and institutional dominance in the American health care system?

I. LITERATURE REVIEW

1. Neoliberalism and the Welfare State: What is neoliberalism, and how does it relate to the welfare state?

Theorist David Harvey states that “neoliberalism is in the first instance a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade” (2005, 2). In this respect neoliberalism can be taken as an economic utopian project intended to revive capitalism from stagnant markets and the effects of globalization in the late 1970s. Harvey concludes however that the rise of neoliberalism constituted opportunism on the part of the business elite who feared their economic and political interests threatened by socialism’s growing popularity. Private interests unified behind neoliberalism’s market principles, recruiting the Republican Party as its popular base. As a consequence of this coalition’s influence neoliberalism “has become incorporated into the commonsense way we interpret, live in, and understand the world” (2007, 23).

Neoliberalism as a theoretical framework is founded upon the sanctity of individual freedoms and the free market. According to Harvey, it rejects state intervention in society and the economy, except to create markets where there are none. Neoliberalism privileges a negative conception of rights such that “while personal and individual freedom in the marketplace is guaranteed, each individual is held responsible and accountable for his or her own actions and well-being” (2005, 65). According to this template neoliberalism is antagonistic to the welfare state because 1) the welfare state represents state intervention in society and the economy; 2) it is a poor substitute for the market in addressing inequalities; and 3) neoliberalism
interprets inequalities as the consequence of individual failings, which society is neither responsible for nor capable of addressing.

Harvey notes however that “when neoliberal principles clash with the need to restore or sustain elite power, then the principles are either abandoned or become so twisted as to be unrecognizable” (2007, 19). Neoliberalism normalizes antistatist rhetoric while simultaneously promoting state intervention sympathetic to private capital accumulation. The consequences of neoliberalism for the welfare state are twofold. First, what were entitlements under the Keynesian Welfare State are undermined by discourse asserting that “well-intentioned policies inevitably harm recipients by substituting perverse incentives in place of market mechanisms that teach the poor to work hard and exercise sexual restraint” (Hartman 2005, 67).

Second, the state systematically transfers provision of welfare services to the private domain, commodifying arenas previously exempt from market logic and funneling public funds through the private sector (Harvey 2007). While the Keynesian welfare state threatens business interests, challenges to private power and profit are neutralized within the liberal (as opposed to Social-Democratic or Christian-Democratic) model of the welfare state, according to theorist David Coburn (2000). The liberal welfare model is the least decommodifying; that is, it involves the greatest degree of market-based solutions compared to its alternatives (Coburn 2000). According to these arguments, corporations acting as providers come to dominate the neoliberal welfare state, using their significant resources to install policies that maximize profit. The tendency towards corporatization in turn results in restricted access to care for “unprofitable” Americans, as social benefits become contingent upon market principles.

Theorists Joe Soss, Richard Fording and Sanford Schram observe however that the welfare state does more than create new arenas for profit accumulation. It also acts as a tool to ensure that individual choices and behaviors match market function. The authors regard the welfare state as the grounds for convergence of neoliberal and paternalistic value systems. The first is “an effort to extend the reach of market logic, to apply it as an organizing principle for all social and political relations” (2009, 2). The second is a form of governmentality born out of neoconservative thought that depends on the state to align individual behaviors with the productive and moral aspirations of the liberal-democratic project. Despite their differences, neoliberal and paternalist rationalities converge on “a strong state-led effort to bring discipline to the lives of the poor so that they can become competent actors who (liberated from social disorder) recognize and
act on their interests as freely choosing agents of the market” (7). First and foremost this means work enforcement through welfare programs. Soss et al observe that neoliberalism, in a departure from its liberal and laissez-faire pedigree, explicitly endorses state intervention in the marketplace and society in order to manage disorderly populations. According to this neoliberal configuration, “functioning markets are not natural outcomes that emerge by default. Markets must be actively constructed; market behaviors must be learned; and once learned, they must be deliberatively extended to new arenas” (2011, 21).

Operationally this entails public policies that manage a compliant, flexible workforce through welfare programs. One example is Temporary Assistance for Needy Families (TANF), a cash assistance program for families where assistance is limited to a maximum of 60 months within one’s lifetime, and individuals are required to find employment within 2 years of receiving aid. Receipt of public housing aid and Food Stamps is similarly time-limited and contingent upon acceptance of suitable employment, participation in work-promotion programs, and a demonstrated effort to find work (17). Programs that tie aid to productive behaviors function alongside the rhetoric of personal responsibility to transform impoverished populations into “subjects who, under conditions of apparent autonomy, choose to act in ways that comply with market imperatives and political authorities” (2011, 28).

More broadly, paternalist and neoliberal ideologies of individual responsibility work together to sustain the ideological and institutional dominance of the market frame. “The conservative assault on the poor served as a symbolic vehicle for mobilizing opposition to the welfare state” in its decommodified form of “social entitlement and government support” (10), write the authors. Neoliberal paternalism’s ‘Personal responsibility Crusade’ “sought to undermine a wide array of collectivizing policies so that Americans would take greater ‘ownership’ of their risks and choices” (10). This paved the ground for a welfare model shaped around neoliberal aspirations of personal productivity and private markets.

Within the broader catalog of theories regarding how the welfare state reproduces neoliberal aspirations, theorists agree that state intervention under neoliberalism serves private interests. The mechanisms by which it does so remain contentious. The traditional Marxist perspective contends that the welfare state brings stability and legitimacy to the capitalist economic system. Incremental reforms legitimize the system to its discontents, dissolving popular movements and facilitating the next corporate attack on the welfare state. Theorist Howard Waitzkin makes this argument:
“The history of public health and welfare programs shows that state expenditure usually increases during periods of social protest and decreases as unrest diminishes…these incremental reforms, at least in part, reduce the legitimacy crisis of the capitalist system by restoring confidence that the system can meet the people’s basic needs” (1978, 268-9).

Incremental reforms preserve the system from “nonreformist reforms” which would “achieve true and lasting changes in the present system’s structures of power and finance” (Waitzkin 1978, 273).

Echoing the Marxist perspective, authors Piven and Cloward propose a theory for how institutional structures constrict the organization, mobilization and success of working-class movements. Their case study of the Welfare Right’s Movement in the 1960s leads them to conclude that legislative victories won through the formal organizing bodies of the working-class are contingent upon an historical context of institutional instability and a fractured economic elite. These victories are absorbed into the institutional framework in accordance with the market calculus. “Protestors win, if they win at all, what historical circumstances [have] already made ready to be conceded” (1977, 39) write the authors. The system’s elite will make economic concessions in order to maintain the “symbolic capital” of stability and legitimacy. Accordingly, reforms won by formal organizing bodies should be regarded in terms of their larger implications for the structure of the welfare state rather than as simply a victory for the poor or working-class. (The alternative route is “turbulence,” i.e. popular movements that are mobilized rather than just organized.)

Theorists agree that neoliberal policy has driven the reorganization and reorientation (rather than rollback) of the welfare state (Soss et al 2009 and 2011, Coburn 2000, Hartmann 2005). Discussion of the role of class interests in this transformation would be incomplete without first acknowledging divergent theories of the relationship between the state and class power. Some theorists define the state as an instrument of the dominant class to preserve the capitalist mode of production, and others as a neutral body mediating the competing public interests to which it is subordinate (Jessop 1982). Still others characterize the state as a self-serving entity “intent on its own expansion and aggrandizement” (McKinlay and Marceau 2000, 63). Engaging with the breadth of arguments regarding the nature and role of the state in class struggle is beyond the scope of my research. It is sufficient to acknowledge these theories, while drawing upon the definition provided by theorist Bob Jessop: The state is “the crystallization of political strategies,
as a specific political form which offers structural privileges to some but not all kinds of political strategy” (270). That is, the state reflects the balance of power in ongoing hegemonic struggles, while privileging certain forms of power over others, distributing influence over state change differentially between social groups. Regarding the state as terrain for power struggle rather than as a weapon in the hands of the capitalist class accounts for the dynamic forces influencing state change, with respect to the equally divided business and working classes. It allows for unabbreviated consideration of the ideological and institutional implications of welfare reform deliberations as they mold the way that we understand and seek to address endemic inequality and disease.

2. Labor’s Stake in the Privatized Welfare State: How has organized labor shaped the welfare state under neoliberalism?

As theorist Vincente Navarro (1993) observes, organized labor has historically been the strongest supporter of universal, government-sponsored health insurance. As a consequence, some theorists attribute the present privatized, corporatized welfare state to the inefficacy of a disorganized working class. According to Navarro, the working class has failed to realize its longstanding demands for comprehensive public health insurance because disorganization has rendered it impotent in the political arena.

Conversely, Marie Gottschalk (2000) argues that theorists like Navarro unfairly represent the policy solutions that have historically mobilized working-class support. In Gottschalk’s theory, the crystallization of the private welfare state co-opted labor’s organizational power, supplanting demands for a nationalized, single-payer system. Organized labor initially favored a national health insurance plan to replace commercial insurance, and was a tough opponent of an employer mandate first proposed by Richard Nixon in 1971. In the 1970s however, leading Democrats including President Carter moved away from the party’s longstanding support for a single-payer system. As market solutions gained ground, organized labor’s leaders struggled to preserve employer-sponsored benefits at the expense of the then-mainstream movement for a single-payer option. Labor’s leaders sought alignment with business interests, while its organized basis fractured between support of a private system and a single-payer system. The demise of Clintons’ Health Security Act in 1994 was telling moment: “Organized labor found itself implicitly or explicitly siding with large employers and insurers or sitting mute on the sidelines during some of the major skirmishes over health policy” (6). The privatization of labor’s agenda aided the narrow
terms of the healthcare debate, the dominance of neoliberal healthcare policy, and the precipitation of market-based ideology into the public sphere. “The debate over health-care reform was conducted in a vacuum, in which labor seldom raised broader issues about economic restructuring, the responsibilities of employers to their employees, and the role of insurance companies in the U.S. medical system” (154) states Gottschalk.

For critics of the healthcare system, the role of the working class in shaping healthcare reform is more complex than its proposed disunion at moments of institutional volatility. Some factions of organized labor have contributed to the present shape of the privatized healthcare system, leveraging explicit support for privatized healthcare as it relates to employer-sponsored insurance (ESI). Other factions have remained mute at critical moments of institutional change. The demands (or absence thereof) of the working-class are a crucial force shaping the American political imagination – that is, which solutions to a dysfunctional healthcare system are deemed appropriate and viable. Without a voice demanding alternatives to the privatized, corporatized system, the possible outcomes of reform are constrained within a narrow catalog of incremental fixes.

3. **Capital’s stake in the welfare state: How does the welfare state serve business interests?**

Harvey argues that the rise of neoliberalism is best understood as a concerted effort on the part of the business class to reshape public policy in accordance with market principles. Despite its cohesion behind the overall trajectory of neoliberal dominance, this paper seeks to deconstruct the hydra-headed approach taken by various industries to different social policies at different historical moments. Employers concerned with minimizing the cost of employer-sponsored health insurance will approach the healthcare debate differently than private insurers concerned with the commercial market. Jill Quadagno (2004) argues that the mix of public and private healthcare financing in the U.S. is a result of these divisions within the business class. She writes that the present healthcare system “was constructed through contentious struggles between reformers and powerful stakeholder groups who mobilized politically against national health insurance or any government programs that might compete with the private sector products or lead to government regulation of the market” (28). Take managed care as an example: Managed care expanded in the 1980s in response to public discontent with the inefficiency, inequality and cost of the healthcare system. According to Quadagno however the rise of managed care represents a victory for the insurance
industry. Managed care promised to control costs, a primary concern of health insurance companies. It was a substitute for a public health insurance alternative (the notorious “public option”) which would have devastated the private market. Managed care renders healthcare providers (including hospital complexes and the medical professions) subordinate to Managed Care Organizations (MCOs), which control the cost and type of services provided to enrolled patients. Organized subsets of the health industry such as the Health Insurance Association of America (HIAA) battled against physicians for public and policymaker support of MCOs. Quadagno suggests that even reforms such as Medicare and Medicaid constitute corporate victories, as they ensured that “private insurers retained a share of the market” so that “healthcare became a profitable enterprise for physicians, hospitals, and insurance companies” (33).

Quadagno’s argument has two important implications for the analysis that follows: First, the rise of managed care exemplifies how welfare state reform can open new markets in addition to preserving existing ones. Critics argue that MCO’s “very structure is designed for profit-making’ and provides the mechanism for corporate takeover of health services” (Rylko-Bauer and Farmer 2002, 478). Indeed, managed care has been ineffective at controlling healthcare costs but has produced exorbitant profits for MCOs (491). Second, managed care typifies how discordant business interests fracture the health industry and the larger capitalist class, creating a mix of healthcare financing and delivery that cannot be explained by undifferentiated business interests.

4. Theoretical Framework

What is the form and function of the welfare state under neoliberalism? Harvey argues that neoliberalism’s concern with sustaining elite power and profit has cultivated private markets within the welfare state. The retraction of entitlements under neoliberalism does not indicate a retraction of the welfare state; rather it is the consequence of the privatization of provision. This trend is congruent with Coburn’s observations regarding the liberal welfare regime as the least decommodifying model for provision – that is, one “designed to supplement market provision, to reflect participation in the market, or generally, to be targeted or means-tested rather than universal in application” (140).

Soss et al agree that the welfare state has been privatized and entitlements subjected to market fundamentalism. Subcontracting welfare provision however also allows private providers alongside the
The authors argue most fundamentally that the welfare state shapes “power, position and behavior in the political economy” (2009, 19). This argument raises questions of how the welfare state itself becomes a vehicle to maintain the market frame, most notably through policies and rhetoric framed around principles of individual responsibility for systemically produced ills.

Waiztkin argues for a very different understanding of how the welfare state operates to preserve market dominance. The state expands public programs in times of crisis to deter reforms that “achieve true and lasting changes in the present system’s structures of power and finance” (1978, 273). Piven and Cloward echo this view, observing that welfare expansions won through formal mechanisms of institutional change lend symbolic capital to present power formations. The welfare state according to these arguments is shaped to maximize fidelity to the market frame, and serves to circumvent reforms incongruous with the interests of the economic elite. These arguments are important because they distinguish between incremental (“reformist”) and radical (“nonreformist”) reforms. As Waitzkin states, “a reformist reform is one which subordinates objectives to the criteria of rationality and practicability of a given system and policy…it rejects those objectives and demands – however deep the need for them – which are incompatible with the preservation of the system” (1978, 273). Simply stated, these authors are arguing for the difference between reforms that highlight and attempt to address structural inequalities, and those that obscure these inequalities through efforts to preserve the present balance of power.

These two perspectives are limited however by the assumption that the state is a tool of the capitalist class that “acts generally to repress revolutionary social change or political action that threatens the present system in any fundamental way” (Waitzkin 1978, 298). I would argue that using this definition of the state limits our ability to understand the unique mix of public/private health policies produced in a system where commercial enterprise has historically crushed demands for government-sponsored health insurance. Particularly I am concerned with the role of organized labor under neoliberalism, which theorists Gottschalk and Navarro argue is one of the primary forces shaping the welfare state. Navarro on the one hand argues that labor has become so ineffective as a consequence of a disorganized working-class that it has been excluded from this struggle. Gottschalk on the other asserts that the working class, though fractured, has aided the privatization of healthcare. According to this argument, some factions of the
working class have propelled the privatization of care as it relates to ESI. Others have failed to provide the necessary opposition that would counterbalance the advancement of market fundamentalism within the healthcare system.

Healthcare reform has similarly splintered the business class according to Quadagno. She attributes the present form of the healthcare system to power leveraged by contingents within the business class attempting to augment their related markets. These reforms undermine the position of other business coalitions (e.g. physicians, in the case of managed care). The U.S.’s mix between federal, employer, and individually financed healthcare reflects the interests not of a unified corporate class but of alliances between splintered class coalitions, according to Gottschalk and Quadagno. While these coalitions have at times sought solidarity with public interests groups fighting for causes relevant to health industry interests, the health industry “ha[s] been able to defeat every effort to enact national health insurance across an entire century because they ha[ve] superior resources” (Quadagno 2004, 28).

These theorists agree that the reorganization of state authority under neoliberalism provides an opportunity for reform to be pursued in a neoliberal manner. The differences of opinion encountered here however point to the different ways that power operates within the arena of the state, and is manifest in healthcare institutions. Criteria for evaluating the individual mandate as it relates to these power formations are drawn from this project’s theoretical framework, which identifies the following key considerations: What problems does the mandate propose to address? What impact do the proposed solutions have on existing and potential markets within the health industry? How are key questions framed related to the distribution of entitlements, including the role of individual responsibility, social solidarity, and human rights? How has labor functioned with respect to healthcare reform – specifically, has labor continued to fight for employer sponsored insurance, backing private reform proposals at the expense of public alternatives? How do coalitions for and against reform represent divisions between classes and affiliations across classes? The arguments made by Waitzkin and Piven and Cloward concerning the role of popular movements in state reform raise additional questions: What types of popular protest do we observe leading up to healthcare reform initiatives? How were popular coalition situated with respect to the individual mandate? While these questions are beyond the scope of this paper, they nonetheless merit further research.
II. METHODOLOGY

Critics of healthcare reform have tended to attribute the ACA’s mix of healthcare financing to partisan politics. This approach is inadequate to reveal the mechanisms of power and profit shaping reform. Alternatively, a class-based analytical framework will elucidate the impact of these policies on public institutions and their corresponding markets. It can provide insight into our collective understanding of endemic social problems, and illuminate the ideological and institutional implications of the strange union between neoliberalism and the welfare state.

I used three sets of materials to assess the relationship between the mandate and the neoliberal project, including the mandate itself, Congressional Hearings on healthcare reform leading up to March 2010, and records of lobbying and campaign contributions directed at shaping the legislation. Criteria for evaluation are derived from the theoretical framework elucidated above.

I undertook a two-tiered analysis of “H.R. 3590, Section 1501: Requirement to maintain minimal essential coverage.” The key considerations above provided a guide to determining 1) the projected impact of the mandate on institutions of the healthcare system and 2) ideology reflected within its rhetorical elements.

As evidence of the discourse around the healthcare crisis, I used Congressional Hearings discussing the individual mandate leading up to the ACA’s passage into law on March 23, 2010. I retrieved hearing records of the 111th Congress (2007-2010) from the Government Printing Office’s Federal Digital System and searched for instances in which the terms “individual mandate” or individual responsibility” were mentioned. I analyzed a total of 16 hearings, spanning dates from January 22nd to November 3rd, 2009. Statements were made by congressional representatives in addition to representatives of large corporations, small business associations, health insurance companies and their affiliates, physicians’ organizing bodies, labor associations, and public interest groups. Using the aforementioned theoretical framework, I analyzed statements with respect to their ideological and institutional implications for the neoliberal project. Testimony from stakeholders also provided evidence for how stakeholders have influenced the legislative process. I analyzed these statements alongside records of lobbying and finance to deconstruct stakeholder support for and against reform from 2008 to 2010. Records of financial influence came primarily from the Center for Responsive Politics, a non-profit, non-partisan research group that collects and analyzes data.
from lobbying and campaign contributions. Given the fragmented approach both business and labor has taken to various reforms, these two sources will identify the position taken by factions within the business and working classes.

The theoretical framework laid out above identifies the role that neoliberalism has played in the transformation of the American healthcare system. The three aforementioned categories of materials can be analyzed to answer the questions that remain regarding the relationship between the individual mandate and the neoliberal project.

III. RESEARCH FINDINGS AND DISCUSSION

1. H.R. 3590, Section 1501: Requirement to maintain minimal essential coverage

According to the legislation, an individual mandate is a necessary part of reform in order to 1) prevent adverse selection, where individuals only purchase insurance when they anticipate they will need it and 2) achieve universal coverage. Section 1501 states,

"If there were no requirement, many individuals would wait to purchase health insurance until they needed it. By significantly increasing health insurance coverage, the requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold” (H.R. 3590 2010, 125).

Insurers previously addressed adverse selection by denying or rescinding coverage based on age or health status. Section 1201 of the ACA however imposes limitations on such underwriting. The mandate proposes to broaden the insurance risk pool to offset the effect of newly insured profit losers. In plain language this maintains a profitable consumer base to ensure persistence of the private insurance market. To understand how the mandate proposes to achieve this, note that the Act initially included a provision requiring states to expand Medicaid coverage to everyone living below 138% of the Federal Poverty Line (FPL) ($14,494 for an individual or $24,645 for a family of three in 2011) (Kaiser Family Foundation 2010). For those with income levels between 100% and 400% FPL participation in the private health insurance market is federally subsidized on a sliding scale. The mandate thus targets populations living above the FPL. Recognizing that health status is intimately related to income (Stiehm 2001), it is possible to conclude that
private insurers will capture the healthier contingent of those newly insured under the ACA. Indeed, insurance companies have based their support for the individual mandate on the argument that it will capture young, healthy “free riders” that otherwise would fail to pay into the insurance risk pool.

The mandate goes on to state that “the requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system” (125). It suggests that the goal of universal coverage can be achieved by addressing one of the primary barriers to care facing Americans, the high cost of insurance. In order to address this barrier, the provision proposes to “Add millions of new consumers to the health insurance market, increasing the supply of, and demand for, healthcare services…By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs” (126).

The bill is justified based upon its ability to lower health insurance premiums, create “economies of scale” and regulate supply and demand. It is considered in terms of its advantageous impact on “interstate commerce” (124). Precluding these justifications is the initial presumption that healthcare is a commodity, the appropriate distribution of which is best achieved through competitive markets. In reality, by allowing market principles to continue to determine who has access to care, the mandate leads to gaps in coverage especially for lower income Americans. Specifically, those for whom the mandate poses a financial hardship, i.e. if the “applicable individual’s required contribution…exceeds 8% of the individual’s household income” (H.R. 3590, 129), are exempt. The additional provision that would have required states to expand their Medicaid programs would have gone great distances to close gaps in coverage for exempt individuals. However, the 2012 Supreme Court ruling on National Federation of Independent Business v. Sebelius deemed the provision unconstitutional. As a consequence expansion of Medicaid programs is voluntary on a state-by-state basis. 14 states have opted out of expanding Medicaid and 3 have indicated that they intend to do the same (The Advisory Board Company 2013). For states that do not expand their Medicaid programs, eligibility is subject to a multiplicity of contingency tests. As of July 2012 for example, Medicaid eligibility for parents was limited to less than 100% FPL, and less than half FPL in 16
states. Nondisabled, parentless adults were ineligible for Medicaid regardless of income in 41 states (Kaiser Commission on Key Facts 2013). Eligibility will remain subject to the same contingency tests in states that choose not to expand their Medicaid programs. In states that don’t expand their Medicaid programs there will continue to be no health insurance safety net for those living below the poverty line.

The mandate’s relationship to the neoliberal project can be broken down as follows: First, the mandate preserves health industry markets through the expansion of the private health insurance market’s consumer base, and works alongside federal subsidies to transfer public funds to the private sector. The mandate corresponds to the neoliberal practice observed by Harvey and Coburn of using the state to stabilize existing markets and open new ones.

Second, the mandate privileges market solutions over policy alternatives, disregarding the inadequacy of the market frame to achieve the stated objective of universal coverage. Recalling Piven and Cloward and Waitzkin, this constitutes the kind of incremental reform that does not address the root causes of system dysfunction. Instead, it lends stability and legitimacy to corporatized healthcare without compromising its present system of healthcare finance.

Finally, the small improvements related to the individual mandate, such as federal subsidies of premiums, obscure the manner in which the system as whole contributes to the production of income-related health disparities. And while these subsidies will make coverage affordable to many, structuring social systems around corporate provision lends legitimacy to market frame as a solution to social ills, and influence to private providers as the distributors of social necessities. Recalling Waitzkin once again, this further entrenches market fundamentalism – specifically, healthcare as a commodity and markets as the best way to distribute care – into our commonsense understanding of social injustices and their appropriate solutions.

2. Stakeholder Mobilization: Congressional Hearings and Records of Lobbying and Finance

Despite opposition by Republicans in the 2009 to the individual mandate, conservatives initially favored the mandate as a free-market solution to reform. It was formulated as an alternative to an employer mandate, a public option and a national health insurance plan. “A group of economists and health policy people, market-oriented, sat down and said, ‘Let's see if we can come up with a health reform proposal that would preserve a role for markets but would also achieve universal coverage,” says Mark V. Pauly, a health
economist at the University of Pennsylvania and an adviser to the first Bush administration who has been accredited with originating the mandate in the 1980s (Rovner 2010).

The Health Industry

As Quadagno’s theory of stakeholder mobilization anticipates, health insurance companies have recognized that reform poses an opportunity to restructure their consumer basis in advantageous ways. As aging baby boomers reach 65 they will move from private insurance to Medicare, compounding the loss of consumers during the 2007 economic recession (Center for Responsive Politics 2010; Pear 2012). It follows that the insurance industry is adamantly opposed to a public option, which would place downward pressure on insurance prices and draw consumers away from the private market. The mandate on the other hand would bring in millions of new consumers without compromising the private basis of the insurance market. Like insurance companies, health product manufacturers (including pharmaceutical companies) opposed a public option, “fearful that private insurers would be marginalized and government price controls would limit what the industry can charge for its products” (Center for Responsive Politics 2010).

Insurance companies and health manufacturing giants were among the strongest champions of an individual mandate, strongest opponents of a public insurance option, and biggest spenders to influence reform. According to the Center for Responsive Politics, expenditure by pharmaceutical and health product manufacturers on lobbying eclipsed all other sectors of the economy in 2009 at $266.8 million (of which Pfizer, which is the world’s largest research-based pharmaceutical company, contributed over $43 million). This is the largest sum ever spent in a single year by a single industry. The health insurance industry on the other hand was the fourth largest lobbying spender in 2009, shelling out $164.2 million. Overall, the health sector, including all its health-related industries, spent close to $544 million on lobbying, a 12% increase from the previous year (Center for Responsive Politics 2010). The health sector also increased its campaign contributes by 88% in the 2008 election cycle compared to 2004, from $123.7 to $167.7 million (Center for Responsive Politics).

Of the money spent to sway legislators between 2003 and 2008, $4 million went to Senator Max Baucus (D-MT), chair of the Senate Finance Committee (2007-present) and a main instigator of reform (Center for Responsive Politics n.d.). Baucus’s role as chair of the Senate Finance Committee places him in a unique position with regards to healthcare reform, as the Committee is responsible for the nation’s largest
welfare programs including Medicaid and because healthcare reform legislation must pass through the Committee. One of the strongest voices for a “uniquely American solution” structured around private markets that excluded a public option, Baucus was also the author of the ACA’s precursor, “America’s Healthy Future Act.” His bill included an individual mandate but not a public insurance option. The same month that Baucus released his bill, Pharmaceutical Research and Manufacturer of America’s (PhRMA) instigated a $150 million advertising campaign in support of the Senator’s “Framework for Comprehensive Health Reform” (Center for Responsive Politics 2010). The ACA was released by Baucus, Majority Leader Harry Reid (D-Nev.) and Senator Chris Dodd (D-Conn.) one month later, representing a collaborative merger between the Baucus bill and a proposal by the Health Education Labor and Pensions Committee. The ACA passed the Senate on December 24, 2009 and the House on March 21, 2010 (Senate Committee on Finance).

Baucus was also responsible for organizing the “Coalition of the Willing,” a group of seven fellow Committee members opposed to the public option that together helped draft legislation that would win a bipartisan following. According to the Center for Responsive Politics, Coalition member Senator Orrin Hatch (R-UT) was the top recipient of pharmaceutical dollars, receiving $1.5 million since 1989. The other coalition members received a combined $1.5 million from pharmaceutical companies, $1.3 million from health insurers and $3 million from health professionals since 1989.

Baucus and his Coalition are but one example of the extent to which special interests sought to influence health reform through lobbying and campaign contributions. A group of nine Republicans from the Senate Finance Committee “have received $2.6 million from HMOs/health services and health and accident insurers to their candidate committees and leadership PACs since 1989” (Center for Responsive Politics 2010). The nine signers wrote a letter to President Obama in June 2009 that stated:

"Washington-run programs undermine market-based competition through their ability to impose price controls and shift costs to other purchasers. Forcing free market plans to compete with these government-run programs would create an unlevel playing field and inevitably doom true competition" (Center for Responsive Politics 2010).

For the health industry it was money well spent. A public insurance option to compete with private health insurance plans in the newly implemented Health Insurance Exchanges, on which Barack Obama
initially campaigned in his 2008 presidential bid, was excluded from the Affordable Care Act. Instead, the individual mandate was adopted to achieve universal coverage. Health care reform has been a staple of the liberal agenda for decades, and through reform proposals for government financing of care seemed to embody a commitment by liberals to the poor and working-class. That Baucus, a Democrat, was a primary instigator of this design suggests the extent to which neoliberal ideas and practice have come to shape the American political process. I don’t want to dismiss partisan ideology as a factor influencing reform. Rather, I am arguing that neoliberalism has aided the expanding influence of the private sector on American politics, which in turn has disseminated neoliberal practice across party lines. Ascribing the shape of the ACA to liberal/conservative ideological differences is unproductive in the face of the material private influence shaping reform.

The health industry sought to influence legislators on the Congressional floor, arguing that the mandate was a necessary counterweight to limitations set on underwriting. Specifically, testimony given by stakeholders at Congressional Hearings advocated a mandate to protect responsible consumers:

“It is said that thousands of the consumers are gaming Massachusetts’ 2006 health insurance law by buying insurance when they need it to cover pricey medical care and then dropping it after they have had their treatment. The typical monthly premium for these short-term members was $400, but their average claims exceeded $2,200” (Grace-Marie Turner, founder of the Galen Institute).¹

“I think the issue we have heard about young people not purchasing coverage is a real serious issue. I know I have a 23-year-old son, and he would rather buy fancy phones than his insurance. So they tend to feel invincible and we need to get them in the system to make sure that everything works best for everyone” (Alissa Fox, Senior Vice President of Blue Cross/Blue Shield).²

These statements displace responsibility for the high cost of care onto consumers, depicted as either young “invincibles” frivolously disregarding the impact of their choices on premiums or as opportunists failing to pay into the insurance pool until the need arises. In order to maintain the viability of an insurance market threatened by these “free-riders” the mandate must be strong and enforceable, another primary concern

voiced by the health industry among others. Janet Stokes-Trautwein, Executive Vice President of the National Association for Healthcare Underwriters (NAHU), stated:

“Concerning consequences of non-coverage, NAHU believes these penalties may not be sufficient to ensure adequate compliance. An individual mandate needs to be both effective and enforceable to make other market-reform ideas work. To improve this mandate’s chance of success, we believe the Federal reporting by individuals and insurers should be accompanied by measures at the State level, including enforcement through schools and drivers’ license bureaus, late enrollment penalties, and auto-enrollment requirement of proof of coverage through employers.”

An effective mandate entails an adequately heavy monetary penalty that, in the words of a prepared statement by the Alliance for Academic Internal Medicine, is “meaningful relative to premium levels.” Of course, concerns over free riders and enforceability are only meaningful within a private health insurance system, where insurers must now worry about covering more risky Americans. Hikes in health insurance premiums are a consequence of cost shifting by insurers following the abolishment of underwriting. While it might be logical to consider how copayments and premiums pose fundamental barriers to care in the present healthcare system, these discourses above direct attention towards individual (ir)responsibility rather than the overall structure of the healthcare system. I will explore the question of individual responsibility in more depth below, but for now want to note that the rhetoric of individual responsibility has traditionally accompanied efforts to replace universal benefits with market-based alternatives. As Soss et al argue, framing systemically-rooted ills as a product of individual responsibility leads to policy solutions that are, like the individual mandate, intended to reform individual choices and behaviors rather than the system itself.

Large and Small Business (Employers)

The position taken by business interests with respect to the mandate follows from a multiplicity of interest, including its impact on the cost of employer-sponsored insurance (ESI) and on uptake of ESI by employees. Additionally, the mandate has historically garnered support from businesses as an alternative to

3HELP, Healthcare Reform Roundtable (Part I), 111th Cong., 1st Sess., June 1 69.
the employer mandate. The ACA includes such a “pay or play” mandate, requiring businesses with 50 or more employees to subsidize the cost of insurance or pay a penalty. While the employer mandate is the primary reason that the business community is split over the ACA, the individual mandate is also a source of contention. Some of the strongest opponents of the mandate were small business associations, including the Small Business & Entrepreneurship Council, as well as the National Federation of Independent Businesses, which joined with 26 states to bring the lawsuit challenging the mandate’s constitutionality. Other coalitions supported the bill based on the individual mandate’s promise to reduce premiums (Pinckney 2010). Businesses that already offer employer-sponsored insurance benefit from the individual mandate which would lower health insurance premiums by increasing uptake of insurance.

Steve Burd, president and CEO of Safeway, Inc., supported the individual mandate. Burd spearheaded an initiative offering “Healthy Measures” insurance plans to Safeway employees, under which employees qualify for reduced premiums if they pass tests monitoring tobacco use, weight, blood pressure and cholesterol levels (Burd 2009). Burd is also the founder of the Coalition to Advance Healthcare Reform, an effort to promote similar healthcare plans by 61 businesses including PepsiCo, General Mills, Pacific Gas and Electric, and Blue Shield of California. Many of these corporations have made public statements at the 2009 Congressional Hearings supporting the individual mandate. Burd’s coalition has spent $200,000 since its inception to promote the interests outlined by Burd’s statement, “Reforming Health Care,” which states that “any lasting solution must be based on five core principles,” including free markets, the requirement that every American carry health insurance, and health plans designed to promote health behaviors (PNHP 2007). Burd made the following statement in support of the individual mandate, opposing the employer mandate and explaining his support for ESI:

“The reason most larger employers want to stay in this game is they believe that they get additional benefits and productivity from the wellness of their workforce…there’s no one in the Coalition to Advance Healthcare Reform of the 61 companies that are in it that want to get out of the insurance game because they believe that they can fundamentally affect behavior” (92).

On the one hand, ESI is costly for employers, who cover an average of 70% to 80% of the cost of employee premiums (Kaiser Family Foundation 2012). Employers that don’t already offer ESI balk at the “pay or play” mandate. On the other hand, Burd’s statement demonstrates that insurance not only may become less
expensive for employers under the individual mandate, but can also provide oversight of employee behaviors that impact productivity. According to the U.S. Department of Labor:

“...The Affordable Care Act creates new incentives and builds on existing wellness program policies to promote employer wellness programs and encourage opportunities to support healthier workplaces...These include, for example, programs that reimburse for the cost of membership in a fitness center; that provide a reward to employees for attending a monthly, no-cost health education seminar; or that provides a reward to employees who complete a health risk assessment” (2012).

These programs that use benefits to shape employee behaviors are reminiscent of Soss et al’s argument regarding the function of the welfare state under neoliberal paternalism. How these programs actually work merits close consideration. The authors focus on welfare programs targeting poor populations to cultivate an acquiescent, flexible, low-wage labor force. These wellness programs, and the requirement in general that individuals purchase insurance, operate very differently from TANF or food stamps. Unlike Neoliberal Paternalism’s welfare regime which is founded upon the “recurrent longing to reform the deviant poor” (2009, 6), the individual mandate is directed at those living above the poverty line. The ACA also does not include penalties that make healthcare coverage contingent upon workforce participation. Furthermore, Soss et al’s observation that welfare programs operate to keep recipients poor and available to the market at a low cost cannot be applied to the mandate. What can be said however is that the mandate installs a system of oversight and sanction of market-related choices that individuals are under-equipped to make alone. An enforceable mandate aligns consumer choices with health industry markets (by paying into the health insurance system from a young age). The ACA also expands on voluntary programs to manage health-related behaviors, while the individual mandate expands the reach of these programs by requiring individuals to obtain coverage. The government and employers become increasingly involved in individuals’ lifestyle choices, promising to produce both a healthier, more productive worker and a reliable consumer base for the health industry. Soss et al’s argument is most relevant to the theme of individual responsibility present in these policy implications, as well as in the language of testimonies and in the mandate itself. As Soss et al state:

“It would be a mistake…to imagine that the developments we have described matter only for poor people in the United States. As we have seen, the assault on poverty governance serves as the
visible face of a campaign that sought and achieved far broader changes. Arguments that were honed and legitimated by focusing attention on the disorderly poor provided the template for a broader “Personal Responsibility Crusade” that has left working Americans far more vulnerable to the predictable risks of social and economic life” (2009, 25).

Neoliberal policies directed at the broader American population turn individuals’ attention away from inequalities and hazards inherent in the market frame, and onto their own choices and behaviors. Reframing “collective policy questions as problems of individual choice…is not the muscular, supervisory brand of paternalism that poor people encounter in welfare and parole programs, but it applies a governing logic to all Americans that is cut from the same neoliberal-paternalistic cloth” (25). By encouraging individuals to bear full responsibility for their health (insurance) status, the mandate displaces responsibility for population health from the market – which produces socioeconomic health disparities through both the profit-based healthcare system and the broader capitalist mode of production – onto the individual. “There is, of course, nothing new about depoliticizing socially-produced harms by framing them as personal responsibilities” write Soss et al. “Under neoliberalism, however, this old dynamic is set in motion and given greater social reach through the broad application of a market frame” (2009, 4).

Organized Labor

The trajectory of the working-class’s position on health reform observed by Gottschalk anticipates the divisions seen in organized labor over the ACA’s different provisions, including the individual mandate, employer mandate, and absent public option. The working-class contingent that stood fast behind single-payer care was largely composed of healthcare worker unions. The California Nurses Association stated that the individual mandate and the ACA’s related provisions were insufficient given “insurance company pirates and their predatory pricing practices” (Guaranteed Healthcare). National Nurses United argued that the mandate cedes too much control to the insurance industry, entrenches the privatized basis of the health insurance system, and won’t lower rates of uninsured individuals (Huffington Post 2010). In contrast, Mary Kay Henry, president of Service Employees International Union (SEIU), stated that "working people won a resounding victory.” Dennis Van Roekal, president of the National Education Association, said that “millions of Americans can breathe a sigh of relief” (Knowlton 2012).
The nation’s two largest trade unions, the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) and Change to Win both positioned themselves with respect to the individual mandate as it related to employer sponsored insurance. The lobbying records indicate that these trade unions, alongside some of the nation’s largest labor unions including SEIU and the American Federation of State, County and Municipal Employees (AFSCME), were supportive of a public health insurance option but nonetheless rallied behind the ACA. Records also show that these trade and labor unions both lobbied on behalf of ESI in 2009 (Center for Responsive Politics 2010).

These splintered coalitions combined spent $53.6 million from 2008 to 2010 (Center for Responsive Politics 2010). Given that this amounts to just 14.5% of the that spent by health product manufacturers and 37% of that spent by insurance companies in the same time period, it is important to recognize that the influence of organized labor achieved greater significance within the context of cross-class coalitions informally mobilized behind the individual mandate. In accordance with Gottschalk’s argument, the fight for ESI continues to align labor with special interests that have been longstanding antagonists to the working-class’s more fundamental objectives for health reform. For example, AFL-CIO President Robert J. Haynes strongly opposed an individual mandate when it was proposed in 2006 in Massachusetts, on the grounds that the mandate undermined employer-sponsored insurance:

“This legislation leaves middle-income families dangling without a safety net, jeopardizes families who currently have employer-sponsored health care, and gives employers a free ride...We believe that workers have to participate in the solution to the problem, but this plan puts the entire burden on workers while letting employers off the hook” (Massachusetts AFL-CIO 2006).

Nonetheless, AFL-CIO indicated support for the mandate in 2012. This shift can be understood given the ACA’s promise that the individual mandate was not a substitute for an employer mandate. Celia Wcislo, executive board member of SEIU, stated her support for the individual mandate, the main reason being “the approach of shared responsibility that the House tri-committee bill adopts.” Wcislo went on to reference to Massachusetts’s own mandate:

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“I think it really is a shared responsibility. Everyone in our State understands we all have to be part of the solution. The employers did the right thing and are continuing to do the right thing. Individuals have bought and are continuing to do the right thing. And the government stepped up to subsidize for low-income people. Because we are all in it together, everyone is trying to make it work.”\textsuperscript{6}

Wcislo’s testimony indicates that, as Gottschalk and Quadagno argue has been the case for the past three decades, the coalition backing the individual mandate was informally comprised of factions from both the corporate and working classes. These authors both assert that these coalitions have produced a mixed bag of reforms that cannot be understood solely in terms of a single class interest. Some reforms have reflected working-class initiatives to expand federal or employer-sponsored care, as is the case with the ACA’s employer mandate and federal premium subsidies. Ultimately however, these initiatives are enmeshed in larger efforts directed against alternatives that would fundamentally challenge private healthcare. The individual mandate is the piece of the ACA that functions most effectively to stave off radical alternatives to privatized care. It proposes to address the healthcare crisis, which has undermined the stability and legitimacy of the healthcare system in its present form, without compromising existing markets.

The public option received very little attention once large contingents struggling to expand ESI broke from the working class’s single payer contingent. In order to fully account for the consequences of this shift in the healthcare debate for the policy outcome, I want to return to Wcislo’s comment that “we are all in it together.” I would argue that this kind of statement obstructs our ability to understand and interpret the true implications of the mandate for public health. The mandate fails to overcome the neoliberal impasse to social cohesion around collective wellbeing. Suggesting that the mandate is part of a larger solidarity project excludes evidence that it is much better designed to stilt up private health insurance markets than to provide insurance coverage for those who need it most. This is not to say that insurers and employers are interested in perpetuating poor health and medical bankruptcy for the poor and working-class. Rather, it is to say that these claims regarding social solidarity and human rights obscure the fact that, when corporate profit conflicted with public health when constructing the legislation, corporate interests predominated.

\textsuperscript{6}House Committee on Education and Labor, \textit{Tri-Committee}, 192.
Wcislo’s argument was echoed in testimonies made by academics from health policy organizations. In multiple instances these speakers interpreted the mandate even more broadly than Wcislo, making analogies between the mandate and healthcare as a human right:

“We would move towards a system of seamless coverage that would get us very close to covering all Americans and achieving Congressman Kucinich’s goal of healthcare as a human right” (Joe Hacker, Professor of Political Science, UC Berkeley).\(^7\)

“I think in its simplest form, an enforceable mandate is also an entitlement. People are entitled to coverage, and they are obligated to have it” (Karen Pollitz, Professor of Healthy Policy, at Georgetown University).\(^8\)

In sum, these statements suggest that the individual mandate is an appropriate substitute for guaranteed access to healthcare. The reality of course is that the mandate is an obligation to purchase insurance, not a right to healthcare, or even a right to health insurance. Echoing arguments made by Waitzkin and Piven and Cloward, the mandate threatens to dampen efforts on the part of coalitions traditionally fighting for universal and affordable coverage, including labor unions. These unsound conclusions, which conceal the actual inconstancies in coverage under the mandate, influence legislators who in turn shape public policy. This rhetoric similarly permeates the public mind, where the incremental reforms under the ACA threaten to curtail movements seeking radical system alternatives.

\(^7\)Ibid., 120.
\(^8\)HELP, *Roundtable Discussion*, 56.
IV. CONCLUSION

Situated at the present apex of welfare state transformation under neoliberalism, the individual mandate has much to reveal about neoliberal govern mentality as it is reflected within and through the appendages of the welfare state. When I argue that the mandate and its surrounding politics reflect the tendency of neoliberal reform to privilege profit over public wellbeing, I hope that the implications for the welfare state, and the healthcare system specifically, are understood with respect to their impact on the American poor and working-class, who shoulder the majority of the nation’s burden of disease.

The mandate can be characterized as part of a larger individual responsibility campaign that undermines our common ability to identify and address the systemic basis for endemic social ills. It is indicative of welfare programs that emphasize the role of individual behaviors and choices in jeopardizing the wellbeing of oneself and one’s community, effectively depoliticizing our understanding of inequality, poverty and disease and the systems that produce them. While previous neoliberal welfare programs may have shuttled the poor in and out of exploitative, low-wage market relations, the individual mandate is representative of an evolving form of welfare governmentality that leaves working-class Americans similarly susceptible to the hungers of capitalism. This phenomenon leads me to conclude that neoliberalism, in terms of its influence on American policies and political practice as a whole, has deeply compromised the ability of the welfare state to protect the wellbeing of its citizens.

This is true in the differential distribution of anti-statist logic under neoliberalism, illustrated in the 2012 Supreme Court case against the ACA. The court upheld the mandate despite the fact that it constituted state intervention into market freedoms, but ruled that Medicaid expansion was an overreach of federal authority and thus unconstitutional. Expanding public welfare entitlements is considered an impingement on states’ sovereignty. State intervention that serves to expand private markets however is deemed necessary based on its advantageous impact on interstate commerce. These inconsistencies in logic inevitably produce a welfare state most effective at profit making.

Looking forward, I am most concerned about what the individual mandate suggests about the capacity of groups fighting for the public interest, such as organized labor, to provide a strong counterweight to market fundamentalism. As the chosen policy option to achieve universal coverage, the individual mandate raises worries about how the neoliberal welfare state narrows our capacity to innovate
solutions to the hazards of social and economic life. The market frame of the welfare state threatens the American political imagination, across party lines and between classes, in terms of the way that we talk about and structure legitimate, viable policy solutions to social ills.

The informal cross-class coalition backing the ACA successfully brought about reforms that will bring healthcare coverage to large segments of the previously uninsured. Yet I would argue that the mandate’s history as an alternative to single-payer healthcare, its advantages for the health industry, its stated intent to achieve universal coverage without compromising health industry markets, and its surrounding politics that frame it as a public victory, reveal a larger policy framework designed to dispel meaningful reforms to present means of healthcare financing. The individual mandate is best understood as a policy designed to preserve power and profit for the health industry at the expense of government-sponsored alternatives. Were one to rationally design an approach with the intent of maximizing coverage and advancing health, a public insurance program for all would clearly be more efficient and equitable. Of course, such programs would place downward pressure on profit for health product manufacturers and hospitals, and would likely eliminate the private insurance market.

For such an approach to be realistic we as a collective have to be able to imagine a healthcare system where healthcare delivery is based foremost on need. I believe that the first radical healthcare reform is ideological rather than structural: that reworking the privatized, corporatized fundamentals of the healthcare system must be the product of an ideological shift, in which healthcare is recognized as a universal entitlement rather than a commodity.
Reference List


