

Social Determinants of Health Financial Determinants of Health Care: The Danger of a Single Story

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Introduction

Thank you very much for inviting me to give the lecture this evening to my esteemed colleagues including this year's inductees. I am honored and would like to dedicate my remarks to the memory of Dr. James Dumpson for his numerous contributions to social justice, social work, and social welfare.

Several months ago, I suggested to Rick Barth that my lecture this evening should focus on health policy since our meeting comes on the heels of one of the most contested presidential elections in which there were conflicting visions, choices, and directions proposed in health. The Affordable Care Act (U.S. Congress, 2010) albeit became law in 2010, was a central point of debate throughout the primaries and needed the Supreme Court to authenticate its constitutionality, and perhaps its morality, minimal impact on state and individual rights, and as agency of social justice (Roberts, 2012). The majority opinion of the Chief Justice in which he concluded that the mandate was a tax and thus within the purview of the congress was not expected nor accepted by various constituent groups who interpreted his views as antithetical to their interpretation of American values. Although he allowed the states the discretion to expand Medicaid, this did not prevent his vilification. A decision not to uphold the mandate was seen as lessening the reelection chances of President Obama. While this spirited debate was a health policy wonk's delight, you can imagine I have rewritten this presentation multiple times, based on the changing bellwether of the presidential, senatorial, house, and state governors' elections this past week. Were I Nate Silver (Silver, 2012) part of the complex task of statistical prediction of uncertain outcomes would have been easier and more accurate; but, then had more highly paid pundits heeded his predictions the course of this election and thus this paper would have been different. Far different.

Throughout the run-up to the election, I conceptualized that what was critical to the future of health care policy was the looming appointment of up to 4 new members to the Supreme court over the next 4 years; and, there was the potential for reversal of pivotal decisions

on PL 111-148, Roe v Wade, Social Security, Medicare, and the Civil Rights Act of 1964. Reversal of the latter act would relieve the southern states and a few others, with a sordid history of racially focused voter suppression, from further review by the US Department of Justice. Even without these new Supreme Court appointments, there is tension within the House of Representatives to free the states of the responsibility to insure that votes and voters are not suppressed – as has been the southern experience for decades. In my estimation, this was not a single issue election at all; the centrality of health care and its position in American government was as prominent as the economy albeit difficult obtaining traction since Romney had to petition against his singular gubernatorial achievement that mandated health care in Massachusetts. One must question why extending health care to the populace has met with such staunch opposition for over a hundred years and the extent to which it continues to be assailed as contrary to American values and states' rights as interpreted in the constitution. Can we assume that the states solidly opposed to expansion of health care would pass legislation and finance expanded care on their own?

I changed the focus of the lecture in the past few days to reflect not only the long-term complexity of the health care policy debate but to reflect the multiple articles, commentaries, lamentations, explanations, remorse, elation, and discussions immediately after the election. Neither the election nor the Supreme Court decision on mandated care appears to have quelled the angst in some quarters over the Affordable Care Act. This is due in part to the historical reality facing the electorate that health care policy tends to expand during democratic administrations [Roosevelt, Truman, Kennedy, Johnson, Carter, Clinton, and Obama] and contracts during the administration of republican presidents [Pierce, Roosevelt, Eisenhower, Nixon, Reagan, Bush, Bush]. Nixon's leadership in creating the HMO was based on a desire to curb not just health care cost but the role of the federal government. Nixon's policy position was the exception whereas Bush's support of Part D was a costly appeal to the pharmacy industry. Romney and other republican presidential aspirants, pledged to rescind the Affordable Care Act, despite a favorable Supreme Court decision and support for several of the provisions within the Act by the public. With the reelection of President Obama the Affordable Care Act's mandates remain in force with additional provisions to be implemented in 2014. Unless reversed by the courts, negated by the states, or financially hamstrung by the congress, President Obama will continue the trend established by prior democratic presidents by seeking to expand health care insurance reform and quality of health care.

The working title of my presentation this evening is Social Determinants of Health/Financial Determinants of Health Care: The danger of a single story. One aspect of the lengthy title stems from the work of Chimamanda Adichie the African novelist who wrote that “Our lives, our cultures, are composed of many overlapping stories.” Adichie warns that if we hear only a single story about another person or country, [or a policy] we risk a critical misunderstanding (Reference). She says that “The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story.”(Chimamanda, 2012). The single back story of national health care in the United States is that it has been labeled as socialized medicine, German in its origins, and represents an assault on American freedom, democracy, and constitutional guarantees. Those who oppose any

form of national health care allege that it puts governmental bureaucrats, principally at the federal level, in charge of our health status – controlling the way we are born, the quality of our lives, and when and how we die. This position begs the essential question of the notable contradictory roles of state governors and legislators in the Terry Shiavo case in Florida, the efforts by Governor Perry to require Gardasil vaccinations for cervical cancer, or the multiple pieces of legislation that have been introduced this past 4 years aimed at state involvement in reproductive health. In this view, socialized medicine wherever it is proposed should thus be avoided. The characterization of the Affordable Care Act as socialized medicine increased public hysteria and the chances that the policy would either fail to become law, would be reversed by the Supreme Court, or become an option exercised by the states. Franklin Roosevelt was castigated as a socialist for his initial proposal to have a national health care program within Social Security whereas LBJ is considered un-American for introduction of Medicaid and Medicare. My task this evening is to move beyond this single story and create a context for forecasting what the immediate future of policy in America will be in matters of health and mental health post these decisive and divisive elections.

The other conceptual driver of the paper is the belief that at the base of the ongoing health care policy dilemma in America is the presence of diametrically opposite views of health and the role of government versus the role of the individual circumscribed around efforts to obtain maximum profitability for corporate interests.

1. One view is of health and access to essential health care as a human right to be protected and enhanced through government policy, regulations, programs, and financing; the role of government in health care is seen as constitutionally sound and consistent with the nation's security; it is proposed that the complexity of disease and health and the absence of financial transparency increases the risk for the individual;
2. A second view is of health as just a commodity in the private sector or marketplace with no regulator role for government although access to governmental financing through fee for service processes is desirable; providers should be free to establish prices, provisions, and processes that increase their profits as with any other product or service;
3. A related view is that health is totally an individual, family, or community responsibility; and, there should not be any government policies, programs, financing, or entitlements. In this view, individuals are ultimately responsible for all aspects of their lives. Individuals and families have the responsibility to participate in an open market where health care is bought, traded, and sold.

I have tried to capture these tripartite perspectives by concluding that all health care is social; however, since 1900, health care has increasingly become a vast profit oriented industry competing for its share of the GDP and its potential for wealth accumulation for providers, hospitals, and insurers. The post WW II decision in the 1940s to tie health care to employers solidified it as a commodity, cost center, incentive, and employment benefit, subject to labor and management negotiations. Obviously, those without work were at risk of a loss of access to quality health care. Increasingly, the burden of health care on employers and goods and services has become an issue. In the past year, policies were proposed that would give employers the right to determine or allow certain health insurance provisions for their employees- particularly women [reference]. In addition, newer policies, managed health care for example, defined

benefit plans, and co-pays that would redistribute the risk of health care costs have been implemented.

The current narrow focus on individual responsibility for all life circumstances and the end of entitlements stems from the philosophy and conceptualization found in the Elizabethan Poor Law of 1601. We hear and see this single story orientation in the extensive comments before and 24 hours after the election:

1. On Tuesday, laws were passed in Wyoming, Montana, and Alabama barring individuals, government, and companies from being required to purchase health insurance – feeble
2. Governor Rick Perry immediately calls for the repeal of Obamacare – noting that it defiles democracy;
3. Mark Levin concludes that the US is doomed;
4. Bill O'Reilly says that “people want stuff” and that the election was determined by people who do not contribute but live for and by entitlements that he pays for;
5. Congressman Boehner indicates Obamacare is the law of the land and his party will not seek to repeal it as before; within several hours his press secretary contradicts his position and says that repeal remains an agenda item;
6. Governors in Florida, Georgia, South Carolina, Mississippi, Louisiana, Texas, and Virginia have indicated they will not set up insurance exchanges or expand Medicaid
7. Hospital stock prices have gone up within days of the elections.

Social/Cultural Determinants of Health

The need for a national health care policy was foreseen by social workers at the beginning of the 20th century; but, other stronger forces, [principally the AMA] based on their potential for personal financial gain, were aligned against the profession that at the time lacked voters, financing, and influence (Poer, 1979). With the introduction of health insurers, competition for the vast wealth in health care restricts the introduction of new policy directions that risk profits.

The earliest public appeals for compulsory national health insurance in the United States were initiated by organized social work advocates and reformers close to 110 years ago in northern urban communities. As early as 1902, these social work reformers – mostly affluent white women- petitioned Teddy Roosevelt's administration and the congress to include access to primary health care as basic constitutional rights of all American citizens, rather than as privileges based on the vagaries of income, race, gender, wealth, gainful employment, or social class. Their politically-based appeal was all the more remarkable because women - white or black- were not allowed to vote or hold elective office almost anywhere in the United States at the time they unapologetically advocated for compulsory national health insurance. And, it would be two decades later (1920-1922), before American women, although legal citizens acquired the right to vote under the XIX amendment to the U.S. Constitution. It would be decades more of intense political struggle before they obtained access to the potent financial resources that American politics requires from those intent on meaningful involvement in the struggle to control or change the status quo and secure rights ostensibly guaranteed by state and

federal law (Poen, 1979). The recent (2012) elections increased the number of women in the senate to 40%, the largest in history, although women are 52% of the population. The current Supreme Court, or at least the chief justice, upheld mandated coverage under the Affordable Care Act that was the centerpiece of legislation proposed by social workers as early as 1902.

In the early 1900s women advocates did not have excess political capital to offer, withhold, or withdraw in support of their appeal for compulsory national health insurance. The price of their un-involvement was that the health care issues of women, children, blacks, Native Americans, immigrants, and the poor were not given a priority in federal or state legislative policy until late in the 20th century. And, when considered were begrudgingly decided by an all male legislative club, described by Tina Fey as grey with \$2.00 haircuts (Fey, 2012). What these social work advocates offered were careful observations of the personal toll that had been taken on urban families and the community by joblessness, acute illness and longer term diseases; and, they pro-offered a strategy in which government-backed health care could be provided to all citizens as a human right. Although they lacked the power of the ballot or the seduction of the dollar at the time they initiated their appeal, they felt a compelling and pervasive sense of moral outrage and social injustice for the urban poor in the absence of a compulsory national health insurance plan. Today, the states where health care and the expansion of Medicaid are resisted have the highest proportion of uninsured and those in poverty: Texas, Arkansas, Mississippi, Georgia, Florida, SC, and NC. & Tennessee. The old South! Life spans there are shorter. Rates of diseases are higher!

Conceptually, social workers concluded that all health is social and cultural in both its origin and maintenance. Ill health or disease may originate in an individual but has immediate implications for their families, partners, communities, neighborhoods, co-workers, and friends. In this conceptualization maintaining or restoring health is infinitely social and cultural. The loss of population health or disparities is of such importance as to constitute a national security issue and a challenge to democracy. What undergirded the efforts to view health as social then and now are the philosophical differences between two major concepts or policy approaches: social determinants of health and its antithesis capitalistic/financial determinants of health care.

Social/cultural determinants of health are the recognition that the health of a nation, state, city, or a neighborhood is a collective responsibility and a major investment in the future of a nation, its security, and its ability to mount and maintain a viable population capable of participating in its economy and other vital societal functions. It is what we visualize when we think of the widespread impact of major diseases such as HIV/AIDS, TB, Schizophrenia, West Nile Virus, Swine Flu, depression, suicide, or Alzheimer's. These are not individualized personal problems but rather problems that have numerous direct and indirect costs for whole communities and populations.

This concept of social determinants of health care also proposes that individuals if offered the opportunity would not choose disease, ill health, injury, untreated disease, disability, or early mortality. All health care is both cultural and social is the bottom line. A physically unhealthy population is a national security risk in a world of uncertainty. This view suggests that health care is a human right not a bargaining chip in a low level Wall Street play on who can gain the most profit through providing the least amount of health care to the population. It is this

philosophical rupture that is at the heart of the American policy debate over health care that ignores the social, collective, collaborative character of health for the potential for profit.

Financial Determinants of Health Care

Social determinants are contrasted with the resurgence of an Elizabethan conceptualization of individual responsibility for all aspects of one's life including health and health care. The single back story of health care is as a commodity subject to the vagaries of the market place: demand, supply, pricing, location, risk aversion, availability, market saturation, advertising, sales, and growth. Under this view, health is the nature of the exchanges between individual responsibility and their standing in the health marketplace. As a commodity, health care is bought and sold on the common market not totally different from the way that oil and gasoline are managed. The aim is to produce profit for insurers, hospitals, clinics, physicians, managed care companies, pharmacies, pharmaceutical manufacturers, and stockholders. The message here is to buy stocks, become investors, owners, and recipients of a return on investment! The amount of funding for health care in the US is the largest in the world and invites numerous groups intent on obtaining a share (Frank & Glied, 2006). Federal government involvement is kept at a minimum to be congruent with conservative views not only on the role of government but as a means of keeping taxes low (Davis, 2008). Thus all programs considered as entitlements are at risk.

The United States Congress seemed to conclude that the concept of national health care policy, created in the cauldron of socialism, would of necessity be socialistic wherever it might have been implemented. A shift towards socialism would rupture the complex of tenuous individualistic values seen as the conceptual floor of American democracy. The frequent resort to labeling health care reform as socialistic also developed numerous political benefits as a means of preventing the introduction of new policies.

It seems as though the appeal for compulsory national health insurance was transfixed and determined to fail by a complex of historically negative sentiments towards the poor, dependency, women, blacks, and socialism as the boggy men. Despite their carefully drafted petitions and the extensive data and ideological stance used to support them, none of the policy initiatives proposed or supported by social work reformers, at the start of the twentieth century, were successful in creating a national system of health care in the United States.

Presidential efforts to change health care policy were consistently met by highly contentious charges of socialized medicine, oftentimes the political "kiss of death" for holding political office in the United States, party notwithstanding. If for no other reasons than to increase their political viability and longevity, the extent of changes in health care policy proposed by American presidents have been tempered by the level of risks inherent in the political environment in the last 50 years of the 20th century. The conflictual views on health care policy determined the outcome of the presidential election in many states and within key populations. Similarly, Obama's proposed policy was described as violating the constitution since it purportedly forced Americans to buy a product. Although the chief justice characterized it as a tax in his majority opinion it did not quell the opposition but was instrumental in the outcome of this election.

In 2012, the United States is the only industrial nation in the world that is attempting to manage such a complex labyrinth of overlapping and contradictory health care policies and values. The health care system in the United States is a hybrid amalgamation of all previous health care policy approaches with some structures under the aegis of federal and state control as well as free enterprise. However, despite the complex of policies and financing, the United States system does not compare favorably with other industrial nations on indices of health care quality for the populations.

Future Predictions

It is clear to me that the challenges to health care are not concluded. Prior to full implementation in 2014, I predict that the following major events will occur and will challenge the long-term position of social work on national or universal health care:

1. The House of Representatives will demand changes in the financing and programs in ACA as part of the debt crisis, tax reform, and sequestration negotiations. An ongoing effort will be made to force major reductions in the ACA through various congressional actions.
2. There will be a significant effort to reduce federal support of entitlement programs such as Medicaid and Medicare with less impact on Social Security; other entitlement programs will also encounter tremendous pressure to reductions and possibly extinction. I see this effort as reflecting the continued reemergence of Elizabethan thinking about individualism and individual responsibility and the emphasis on work as the sine qua non of existence, citizenship, and work.
3. Southern governors and legislators will not accept expanded Medicaid and will not develop insurance exchanges resulting in further deterioration of the health of their citizens; although the federal government will guarantee 90% of the initial costs, these states will continue to qualify their participation based on their views of states' rights and the size of federal government;
4. Male dominated legislative bodies will continue to introduce policies that impinge on the reproductive health status of women; the philosophical and moral arguments about abortion will remain unsettled and will be coupled with the sense of threat from gay marriage legislation; each of these areas constitute the sense that the republic is in jeopardy necessitating state efforts to maintain their sovereignty (Rothman).
5. Shortages in all areas of the workforce will place severe limits on the availability of services and the ability to carry out key provisions of health reform;
6. American companies will identify gaps and loopholes in the ACA that will allow them to shift the financial burden of health care to workers and to the federal government wherever possible.

There are actions that social workers in the mode of their sisters from the early 20th century must do:

1. Start the effort now to have a comprehensive White House Conference on Health as a Human right in 2014; insure that there is a focus on quality, disparities, and reproductive rights;
2. Build and provide the financial support for organizations that prepare and support women candidates for political office at the state and federal level with an immediate focus on the mid-term elections;
3. Support the discontinuation of the filibuster in the senate that disallows passage of legislation;
4. Start preparation now for the 2016 presidential election;
5. Recognize that the Affordable Care Act is but a partial victory in health care; numerous elements of a national health care policy were discarded or negotiated away in order to obtain passage of the bill that was found constitutional. There is a critical need to build on the current ACA as the basis of a more comprehensive future policy.

I want to thank Rick Barth and the American Academy of Social Work and Social Welfare for the opportunity to share these thoughts with you this evening. Although we have come far from the narrow health policy abyss that was the norm in 1902, much remains to be done lest we fall prey to a return to the sense of individualism so prominent in the Elizabeth era and the false characterization of health care as socialism as proposed throughout the 20th century.

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