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Critical Anthropology of Global Health “Takes a Stand” Statement: A Critical Medical Anthropological Approach to the U.S.’s Affordable Care Act

The Affordable Care Act (ACA) of 2010—the U.S.’s first major health care reform in over half a century—has sparked new debates in the United States about individual responsibility, the collective good, and the social contract. Although the ACA aims to reduce the number of the uninsured through the simultaneous expansion of the private insurance industry and government-funded Medicaid, critics charge it merely expands rather than reforms the existing fragmented and costly employer-based health care system. Focusing in particular on the ACA’s individual mandate and its planned Medicaid expansion, this statement charts a course for ethnographic contributions to the on-the-ground impact of the ACA while showcasing ways critical medical anthropologists can join the debate. We conclude with ways that anthropologists may use critiques of the ACA as a platform from which to denaturalize assumptions of “cost” and “profit” that underpin the global spread of market-based medicine more broadly. [Affordable Care Act, critical medical anthropology, health insurance, neoliberalism, Medicaid]

The last two decades have witnessed fundamental changes in health insurance systems worldwide. In Latin America, pressure from global financial institutions has led to the introduction of managed care and the privatization of social security funds in Chile and Colombia (Abadía-Barrero 2012). Similar pressures have led Eastern European nations to adopt private sector reforms to their formerly socialist health care systems (Ahlin 2012a; Mishtal 2012), while nations of Western Europe are facing unprecedented challenges to their historic traditions of social insurance (Almeida 2012; Castañeda 2012; Larchanché 2012).

Even as developing nations have begun implementing social health insurance plans with the aim of increasing health equity (Ahlin 2012b; Dao 2012a), the close of the past century witnessed a retreat from this notion among those industrialized nations that coined it. Across the globe, notions of health as the “right” of the population—only enshrined in international conventions in the middle of the past century—have been challenged by the conversion of health into a privately purchased commodity. These reforms entail a neoliberal transformation of the concept of governance itself, a resurgence of the role of the private

sector in the public provision of health, and a reconceptualization of the varying responsibilities of the individual, the corporation, and the state.

It is against this backdrop that the United States has undertaken the first major reform of its health care system in 45 years. Facing escalating health care expenditures and rising numbers of uninsured, the United States is widely considered the most inefficient and inequitable health care system in the developed world (Reid 2010). Even as roughly 20% of Americans lack health insurance, health care expenditures currently consume about 17% of the U.S. Gross Domestic Product (GDP)—nearly twice the amount of any other developed country (Oberlander and Marmon 2010). Although the United States spends more per capita on health care than any other country, its basic health indicators still fall far below its peers (Reid 2010). The Affordable Care Act (ACA) of 2010 aims to reduce the number of the uninsured through the simultaneous expansion of the private insurance industry and government-funded Medicaid. However, critics charge that it will neither achieve universal health insurance nor significantly reduce rapidly rising health care costs (Oberlander and Marmon 2010; Relman 2011), leaving the nation's inequitable, costly, and fragmented employer-based system intact.

As an exercise in cultural critique, anthropology has long been useful in dispelling ethnocentrism and facilitating reflexivity—allowing the West, and the United States in particular, to hold a mirror to itself. Thus, an examination of the U.S. health care delivery system from a global perspective helps reveal the peculiarities of the U.S. system and open it to debate. Within the space of this statement, we provide: (1) an appraisal of recent global developments in the “social contract of health”; (2) a critical discussion of the ACA in light of a brief historical overview of the U.S. health care system; and (3) a discussion of how critical medical anthropologists may use analysis of the ACA as a platform from which to challenge the global spread of market-based medicine more broadly.¹

Global Concerns: Transformations in the Social Contract of Health

Around the globe and across contexts, key theoretical and empirical questions about the conceptualization and commodification of health and health care—indexing shifts in the social contract in general—are ripe for medical anthropologists to discuss, analyze, and debate.

The notion of the public's “right to health”—as enshrined in many state constitutions and the U.N.'s Universal Declaration of Human Rights—has undergone extensive transformation and questioning over the past 20 years. For example, Colombian citizens have mobilized the concept of a “right” to health care in opposition to reforms diminishing access and equity (Abadía-Barrero 2012), while Brazilians—prompted by the pharmaceutical industry—have mobilized this notion to claim the state's responsibility to provide pharmaceuticals for patient groups (Biehl 2007; Iriart et al. 2012; Petryna 2009). In advanced liberal societies, the notion of individual responsibility for health has become enmeshed with the idea of responsible citizenship, as prudent individuals voluntarily purchase health insurance plans and undertake preventive health checks, genetic testing, and lifestyle changes (O'Malley 1992; Rose 1999, 2007).

In the U.S. context, the right to health has been reconfigured as a right to consumer choice—in terms of health insurance plans, physicians, and pharmaceuticals. And, in an interesting turn of events, the ACA's individual mandate has become a pawn in this debate, with the right to health insurance becoming the stand-in for health itself, and with opponents to the mandate arguing that the fundamental right is not to health but rather a (deeply stratified) consumer freedom: the right *not* to purchase health insurance. Anthropologists must pay critical attention to how the notion of health as a fundamental right is asserted,

contested, and co-opted, and how states—and various actors and subgroups within states—have defined the notion of health as a personal responsibility versus a public good.

With failed and failing states in the developing world depending on NGOs and global institutions for the provision of health services, and Western states outsourcing and privatizing health services in an effort to reduce public sector spending (Ahlin 2012a), we are witnessing an era characterized by regimes of “corporate governance” (Sunder Rajan 2006:80), in which corporations have taken on state responsibilities and the state itself has been partially corporatized. Advocates of privatization promise that the private sector can more efficiently and effectively spend states’ health care budgets. Yet, to date, the evidence on the efficacy of privatization in improving health outcomes while reducing costs remains unconvincing (Abadía-Barrero 2012; Almeida 2012; Mishal 2012; Mulligan 2012; Ugalde and Homedes 2012).

Anthropologists must investigate how the private sector becomes a legitimate or illegitimate means of delivering health care and what assumptions underlie the transfer of power to the private sector. What is the responsibility of the state for the provision of health services? How does the transfer of responsibilities to the private sector affect state sovereignty? Finally, if the corporation has entered into—and, in fact, mediated—the social contract between state and citizen, what responsibilities do corporations have for the public’s health (Porter 2008)? How has the idea of corporate responsibility been defined, asserted, and mobilized by citizens and states in opposition to neoliberal reforms, and what promising regulatory measures exist to enforce this? We use this discussion of overarching global transformations in the social contract to situate our examination of key issues related to health reform in the United States.

Health Care Reform in the United States: The History of For-Profit Health Care

The U.S.’s current fragmented and costly employer-based health care system must be understood in comparative and historical context. The divergence in the organization of the health care delivery system in the United States and in Europe can be explained in part by examining the growing sovereignty and power of the medical industry in the United States over the course of the 19th and 20th centuries (Jacobs and Skocpol 2010; Starr 1982a, 1982b; Weiss 1997).

The power of the health care industry to constrain the development of alternative modes of financing and delivering health care in the United States began with the emergence of physicians as a sovereign profession during the 19th century through the restriction of medical licensure—a weapon repeatedly invoked against challengers to their authority (Starr 1982a, 1982b). During the Progressive era, physicians—in coalition with other interests—used their political, economic, and cultural influence to resist repeated attempts to pass a tax-financed system of compulsory health insurance. This was a critical juncture when the United States could have embarked on a trajectory similar to its European counterparts by creating a government program to protect the public and socialize risk. Instead, due to the defeat of such reforms, no institutional structure existed for the development of social health insurance when medical insecurity first struck the middle class during the Great Depression (Starr 1982a:331).

Professional groups like the American Medical Association (AMA) repeatedly blocked attempts at implementing universal health insurance during the 20th century, yielding the current disjointed, for-profit, employer-based system. Charity and government programs for the elderly, disabled, veterans, and poor children fill some of the system’s gaps, but in a largely uncoordinated and inefficient fashion. Thus, hospitals and physicians developed health insurance in the United States, and, unsurprisingly, insurance was closely

aligned with their interests. The nation's medical societies—the American Hospital Association (AHA) and, later, the AMA—devised new provider-controlled insurance plans that were only nominally nonprofits. The AHA offered insurance for hospitalization (Blue Cross, founded 1929), and the AMA offered insurance for medical expenses (Blue Shield, founded 1939).

Blue Cross and Blue Shield soon had to compete with insurance plans offered by employers. Two main developments during the 1940s helped foster the spread of employer-based insurance. First, in 1942, the War Labor Board decreed that benefits up to 5% of wages were allowable; facing a labor shortage, employers increasingly began offering health insurance as a benefit. Second, when Congress declined to add health insurance to Social Security—due, in part, to the lobbying of AMA—unions began bargaining with employers for the “health security” that the government had failed to provide.

By the end of the war, commercial plans boasted more subscribers than either Blue Cross or Blue Shield (Starr 1982b:617). In contrast to the uniform community rate that Blue Cross and Blue Shield charged a group of subscribers, commercial plans calculated premiums based their group premiums on “experience-rating”—that is, they charged employers a lower rate on healthy, low-risk employees. Experience-rating favors the healthy and the financially advantaged, but it also drives costs higher by segmenting the population into small risk pools and leaving relatively older and sicker individuals in risk pools that are not employer based. By the mid-20th century, competition between the Blues and the commercial plans led the Blues to adopt experience-rating (Starr 1982b:620). The current employer-based system of insurance plans based on experience-rating alone had emerged.

One reason the U.S. employer-based insurance system is so entrenched is because it serves particular class and industry interests. The tax exemption employers receive to offer insurance subsidizes premiums for the middle class. By automatically deducting health care premiums from workers' paychecks, the health care industry is insulated from recession, and employees remain oblivious to rising health care expenditures. Meanwhile, those without insurance bear the full brunt of the inflationary effect on the cost of health care and the lack of third-party regulation.

Because the United States—unlike other industrialized nations—did not adopt universal insurance at a time when health care consumed a small share of the GDP, the health industry has expanded and has effectively prevented major reforms of its financing and organization. As Starr writes:

The basic tautology of health economics is that health care spending equals health-care incomes, and any serious proposal to control spending is, by its nature, a proposal to limit the incomes drawn out of health care. There is no way to change health-care finance without putting immense interests at risk. [2008:8]

The industry's control of the market—rather than differences in disease profiles or use of services—explains why the United States spends a higher proportion of its GDP on health care than any other country (Starr 2011:5). Indeed, the past half century has shown the ability of the medical industry to repeatedly avert comprehensive reform. During the cold war, the AMA organized political action committees to block proposals for universal coverage (Weiss 1997), and PhRMA (the Pharmaceutical Research and Manufacturers of America) and the AMA later helped defeat the Clinton health reform plan in 1994.

The AMA departed from this historical legacy when it—along with many other industry organizations—endorsed the ACA in 2009.² PhRMA even ran advertisements supporting the legislation. Policy analysts attribute industry's support for reform to the Obama administration's partial accommodation of industry demands. In the end, industry stood to benefit because reform will bring new, paying customers into the for-profit insurance

system; the reform ultimately expands, rather than restructures, the health insurance system in the United States.

The ACA: An Uneasy Compromise with the Insurance Industry

As of 2011, nearly 48 million Americans lacked health insurance (KFF 2012a). The U.S. health insurance crisis is not only a crisis of the uninsured; roughly 25 million Americans are under-insured (i.e., their out-of-pocket medical expenses amount to 10% or more of their income) (Schoen et al. 2008). Rampant health care inflation has led to rising premiums and copayments for working families and to the increase of high deductible plans and plans that cover catastrophic illness and accident alone. Even for those with some form of insurance, high deductibles, prohibitive co-pays, limited provider networks, and confusing plan rules present significant barriers to accessing care. Forty percent of Americans in terminal stages of illness report worrying about paying medical bills (Navarro 2010), and nearly two-thirds of all bankruptcies in the United States in 2007 were linked to medical bills (Himmelstein et al. 2009).

The ACA seeks to redress this situation through the expansion of employer-based insurance, the extension of Medicaid eligibility to the near-poor and to eligible childless adults, and an “individual mandate” that requires most Americans to obtain health insurance. Yet the ACA represents an uneasy compromise between the U.S. government and the insurance industry. Important concessions were made to the health care industry to secure their support for reform: A single-payer system was not even considered, a public insurance option was taken off the table, and the government agreed not to negotiate pharmaceutical prices in Medicare (Oberlander 2010). In exchange, insurance companies have agreed to prohibitions on a number of previously common practices—such as the imposition of annual or lifetime coverage limits, the “rescission” (cancellation) of insurance policies due to accident or severe illness, and the denial of coverage on the basis of preexisting conditions.³ Further, insurance companies are now required to spend 80–85% of premiums on medical care and to report how many claims they deny each year, although the ACA imposes no significant regulation on companies’ claims administration process.

To address existing inequalities in the system, the ACA has established guidelines to ensure that those buying coverage through the open market receive a basic minimum set of benefits, including preventive services at little or no out-of-pocket cost. However, the specific set of required benefits will vary nationally because the Department of Health and Human Services has granted the states considerable discretion in determining what constitutes minimum essential coverage (Cassidy 2012). Furthermore, despite increasing evidence of their roles in preventive care and chronic disease management, another key priority of the ACA, it remains unclear how health services such as dental and vision care, mental health services, and complementary and alternative medicine—currently marginally covered by insurance plans and primarily paid out of pocket—will be incorporated into insurance packages.

The ACA aims to redress systemic inequalities in access to care, but not all populations will benefit equally. For example, women—routinely disenfranchised in the insurance marketplace—will now be protected from higher premiums and lifetime and preexisting condition limits and will have access to an expanded set of basic women’s health services, including contraception. For these reasons, women’s health advocates have called the act “the single biggest advancement in women’s health in a generation” (Planned Parenthood 2012). However, new restrictions on abortion funding will impact poor women most acutely. Those living with HIV-AIDS—who are uninsured at much higher rates than the general population—will likely benefit from limits on exclusions to preexisting conditions.

Yet, beyond allowing one to search for plans that cover a same sex partner and funding cultural competency programs, the ACA does little specifically for LGBT people.

The ACA's Medicaid expansion and individual mandate have been the most controversial elements of the reform and beg the most immediate anthropological exploration. Below, we discuss the contested history of each and identify major areas of analysis that anthropologists should undertake to document the effects of the legislation and help guide public debate. Moreover, we suggest how previous anthropological studies help provide a context within which to analyze the ACA and its potential effects.

The Medicaid Expansion

As originally proposed, the ACA would have expanded Medicaid eligibility to a uniform floor of 133% of the poverty level, reducing existing disparities in eligibility across states (KFF 2012b). The federal government would cover the Medicaid expansion for the first three years, gradually increasing states' share of costs to 10% by 2020. The law obligated states to expand program eligibility to the new income threshold or forfeit all federal funding for Medicaid.

On June 28, 2012, the U.S. Supreme Court ruled that the ACA's restriction of Medicaid funding only to those states that comply with its planned Medicaid expansion was unconstitutional. Calling on a reinvigorated "new federalist" tradition of resistance to centralized government initiatives, the Supreme Court ruled that the ACA's allocation of Medicaid funds only to states that expand their eligibility requirements for Medicaid beneficiaries would have constituted a form of "economic dragooning" (NYT 2012). As the Medicaid expansion would have accounted for half the ACA's expansion of the insured, the Supreme Court's decision will dilute the ACA's impact. Moreover, the ruling greatly circumscribes the scope of federal powers in expanding the joint federal-state partnership in Medicaid, leaving the program vulnerable to the whims of state legislators and economic downturns.

Anthropologists must undertake analyses of the on-the-ground effects of the ACA's Medicaid reforms and the ideological role that the backlash against Medicaid plays in the debate. First, we should document the impact of the loss of new Medicaid funds on the health care safety net and on the uninsured in states that refuse expanded federal funding for Medicaid. Second, in states that choose to expand Medicaid eligibility, we must examine whether preexisting flaws in Medicaid preclude meaningful access to the newly insurable. Finally, anthropologists can reveal the discursive work through which Medicaid has been made a symbol of the waste and excess of the welfare state, exposing transformations in popular ideas of the role of the state in public governance.

Examining the Effect of Opting Out on the Health Care Safety Net. Anthropologists must devote renewed attention to how the ACA affects safety net institutions, providers, and patients in states that opt out of the Medicaid expansion. Historically, Medicaid has served as the workhorse of the nation's health care safety net; its revenues allowed safety net institutions to offset the costs of providing care to the uninsured (Cunningham et al. 1999). Yet the administration plans to cut Medicaid "disproportionate share" payments to hospitals—funds traditionally used to compensate institutions serving a disproportionate share of the low-income population—under the assumption that the Medicaid expansion will make this funding stream redundant (Coughlin et al. 2012). If states choose not to accept the ACA's funds for expanding Medicaid, safety net hospitals will face a double loss: They will lose out on the prospect of newly insured patients even as they face restricted—not stagnant—Medicaid funding.

How will these safety net institutions struggle to remain financially viable? Anthropologists have documented a number of strategies institutions adopt in response to restricted funding, such as charging the indigent higher fees and excluding the undocumented from programs charged with caring for county residents (Horton 2004; Horton and Lamphere 2006; Horton et al. 2001). Restricted safety net funding may also lead institutions to impose productivity quotas on providers, encouraging providers to engage in shortcuts—treating individuals as mass categories—to meet institutional requirements. This suggests that a climate of restricted funding will ultimately translate into increased disparities in treatment of minority and “difficult-to-serve” patients (Horton 2006).

Anthropologists must continue to document the material effects of changes in the safety net on providers and on vulnerable patients. Moreover, we must examine how institution and provider strategies to stay afloat are legitimated by new ideologies of patient “deservingness.” Will financial imperatives lead to the creation of new classes of “undeserving” and “difficult” patients?

Finally, “opting in” poses challenges to traditional safety net institutions as well, as they face the challenge of competing with private hospitals for newly insured Medicaid patients. If these institutions attempt to mainstream their services to attract the newly insured, will this compromise their mission to care for the indigent? Moreover, how will increased federal oversight affect providers? Given increasing requirements that institutions receiving federal funding document their performance—measured in units of provider “productivity” (see Horton 2006)—will participation in the Medicaid expansion prioritize efficiency over quality? Will opting in saddle physicians with heightened administrative burdens and cause burn-out?

Documenting Barriers to Enrollment and Access. Anthropologists have long used ethnography to highlight flaws in the Medicaid system that inhibit eligibility and enrollment. Beneficiary recertification requirements and fluctuations in recipients’ income often lead to fluctuating eligibility (Shaw 2012). In the past, detailed asset and income tests—combined with Medicaid caseworkers’ high caseloads and reduced autonomy—led to gate-keeping practices that discouraged enrollment (see Lamphere 2005). Will the ACA’s expansion of Medicaid eligibility to the formerly uninsured provide meaningful insurance, or will obstacles to eligibility and enrollment preclude access and continuity of care?

The ACA asks Medicaid patients to take over the work of enrolling themselves in an insurance plan and navigating a complex bureaucracy. It therefore involves the “labor-shifting” common in the postindustrial restructuring of service bureaucracies (Lamphere 2005:8), in which the beneficiary is transformed from customer to part-time employee. Further, the ACA mandates that states create a state-run website to ensure streamlined application and renewal procedures, deliver real-time eligibility decisions, and enable “seamless transitions” between Medicaid, the Children’s Health Insurance Program (CHIP), and state subsidies (KFF 2010a). But how these reforms play out in practice remain to be seen. Will low-income beneficiaries be able to navigate the new online state health insurance exchanges, or will lack of bureaucratic literacy lead to disenfranchisement?

Evidence suggests that safety net staff may absorb the cost of the reform’s initial roll-out as they attempt to provide continuity of care amid bureaucratic changes. A study of the implementation of Medicaid managed care suggests that although the reform was designed to shift more responsibility to patients, mid-level professionals and clerical workers instead bore its brunt as they attempted to buffer its impact on patients (Lamphere 2005; Waitzkin et al. 2002). Analysis of the Massachusetts health care experiment—which served as a model for the ACA—also shows that safety net providers shouldered a hefty administrative burden at the initial roll-out as they faced the task of enrolling new patients in Medicaid (Shaw 2012).

Ethnography can reveal how these reforms play out on-the-ground, documenting the steady down-shifting of responsibility to patients and safety net providers for ensuring access.

Moreover, will the ACA ensure the enrollment of underserved populations in Medicaid as intended? Previous attempts to expand the enrollment of eligible low-income children in CHIP and Medicaid—and the fact that more than half of the nation’s 8.1 million uninsured children are eligible yet not enrolled—serve as cautionary tales (Dao 2012b). Research suggests that one barrier to eligible children’s enrollment includes parents’ immigration status (Acevedo-Garcia and Stone 2008), yet the full range of reasons for such gaps in coverage have been inadequately explored and redressed.

The ACA appropriates funds to conduct outreach to underserved populations (KFF 2010b), but such efforts stand at cross-purposes with recent anti-immigrant legislation such as the 2005 Deficit Reduction Act requiring Medicaid applicants—even newborns—to document their U.S. citizenship (Sommers 2010). Ethnographic research in communities with low rates of children’s enrollment—among immigrant and mixed-status families in particular—can contribute by documenting such contradictions and examining parents’ attitudes toward Medicaid and the state.

Although barriers to eligibility and enrollment may hamper the potential of Medicaid expansion, low rates of provider participation have long precluded meaningful access for beneficiaries. Only 56% of U.S. physicians reported accepting new Medicaid patients, while 74% accepted new Medicare patients (Boukus et al. 2009). The ACA will temporarily raise primary care providers’ Medicaid reimbursement rates to Medicare levels in 2013 and 2014, yet low fees are one among several reasons impeding physician participation. The increased administrative burden imposed by managed care appears to be an equally important reason for physicians’ failure to participate in Medicaid (Boukus et al. 2009; Cunningham and Nichols 2005). If these flaws in Medicaid are not resolved, this will compromise care for millions of Americans the ACA plans to newly insure and potentially create, if not exacerbate, a two-tiered health insurance system.

Unpacking the Discursive Transformation of Medicaid. Since Congress unveiled the initial proposals that would later become the ACA, there has been renewed ideological investment in making Medicaid the stalking horse for the inefficiencies and bloat of government-provided insurance. Critics decry the longer waits facing Medicaid beneficiaries as opposed to privately insured patients and the lower number of providers accepting new patients. Despite serious and well-documented barriers to Medicaid’s effectiveness, states that have expanded eligibility for Medicaid have also seen significant improvements in adult health status, including decreases in mortality rates (Sommers et al. 2012). A history of the dismantling of the Medicaid program due to devolution and managed care can help provide a political-economic corrective to the stigmatization of the program as necessarily offering substandard care.⁴

When Congress established the Great Society programs in 1965, it set uniform national standards for eligibility and benefits for Medicare, a program supported by a vocal and politically powerful constituency. Yet it left the scope and breadth of Medicaid—stigmatized due to its association with the poor—to state discretion. The ACA’s imposition of a uniform Medicaid eligibility income threshold would have eliminated state-by-state disparities in eligibility (KFF 2010a), but the Supreme Court’s ruling has again left the program’s reach vulnerable to the whims of state legislators. The vitriol reserved for Medicaid is especially ironic since the program accounts for a disproportionately small amount of the national health care budget. Medicaid currently serves one-fifth of the nation’s population yet accounts for only 15% of health care spending—despite providing care for higher-need populations such as the poor, elderly, and disabled (MACPAC 2011:1). Indeed,

64% of Medicaid spending is devoted to long-term care for the elderly, even as low-income children and families comprise 77% of enrollees (NYT 2012). Anthropologists can help deconstruct the discursive work through which Medicaid has been made to symbolize the wastefulness and futility of government-run insurance schemes in general.

Meanwhile, the voices of Medicaid recipients—and their own perceptions of both the program and of the insurance debate in general—have been noticeably absent from the debate. How do formerly uninsured users of Medicaid view the program? Does their change in insurance status affect their access to preventive care, their continuity of care, and their financial well-being? How does the extension of Medicaid to the formerly uninsured affect their sense of “health citizenship”—that is, does their inclusion in a public insurance plan increase their sense of political and social inclusion as well? Medicaid advocates suggest that the ACA’s expansion provides a rare opportunity to mainstream Medicaid as part of an emerging “culture of coverage in the U.S.” and to “convey that it (like private insurance) is health coverage for working individuals and families” (KFF 2010a:1). Anthropologists can help document changing representations of Medicaid and its recipients and whether this reframing mitigates the stigma formerly associated with the program.

The Individual Mandate

After the ACA’s passage, 28 states mounted lawsuits challenging the constitutionality of the individual mandate to obtain health insurance, charging it represented excessive government intrusion into individual liberties. In its 2012 ruling, the U.S. Supreme Court upheld the individual mandate on the basis that it represented a tax rather than a penalty on individuals who chose not to undertake an economic activity. The individual mandate—requiring that most individuals enroll in insurance plans that provide certain minimum essential benefits—served as the linchpin of the state’s compromise with the insurance industry. The ACA’s future would have been uncertain if the mandate—aimed at ensuring premium affordability by broadly pooling risk—had been struck down. Thus, the discursive work that went into the transformation of the individual mandate from a conservative reform encouraging individual responsibility to a symbol of state intrusion is an issue ripe for anthropological deconstruction.

A genealogy of the individual mandate reveals that it originated among mostly conservative thinkers in the late 1980s, some stationed at prominent think tanks like the Heritage Foundation (see Bovbjerg and Kopit 1986; Butler 1989; Pauly et al. 1991). Early versions of the mandate were intended to reduce the burden uncompensated care placed on health care institutions and state and local governments. For example, in a 1991 article in *Health Affairs*, Pauly and colleagues outlined a plan for a “Responsible National Health Insurance” that aimed for efficiency and equity by requiring individuals to obtain coverage, subsidizing the low-income, utilizing “competitive markets,” and limiting government intervention (Pauly et al. 1991:8). They argued that citizens should be obligated to purchase health insurance because not having it imposes costs on others when uncompensated and charity care increase premiums for the insured (especially when young and healthy people opt out of insurance risk pools). In other words, the individual mandate was initially proposed as a solution to the “free rider” problem (i.e., the lack of perceived responsibility among the uninsured). Pauly et al. contend: “Permitting individuals to remain uninsured results in inefficient use of medical care, inequity in the incidence of costs of uncompensated care, and tax-related distortions” (1991:8).

The individual mandate surfaced in a variety of Republican health care proposals over the past two decades. In 1993, a limited individual mandate was included in legislation put forward by John Chafee (R-Rhode Island) as a Republican alternative to the Clinton

administration's plan—and particularly in opposition to Clinton's employer mandate. The Chafee legislation was co-sponsored by 20 Republicans in the Senate, including Bob Dole (Starr 2011:80). Meanwhile, in 2005, Governor Mitt Romney brokered a bipartisan compromise in Massachusetts that included an individual mandate. In discussions among Romney and his advisors regarding whether the mandate upheld Republican principles, Romney determined that the mandate was conservative because "it was appropriate to insist on 'personal responsibility'" (Starr 2011:169). During the debates leading up to the passage of the ACA, however, Republicans decried the individual mandate as unconstitutional, socialist, and a symbol of excessive government intrusion.

Anthropologists can advance understanding of the ideological underpinnings of health reform by analyzing the discursive work that has gone into transforming the individual mandate from a Republican solution to "free-riders" into a "socialist" ploy to revoke individual liberty. Obama's embrace of the mandate without including a public insurance option speaks to the astonishing success that neoliberal ideas have enjoyed in the United States. The mandate's approach to universal coverage revolves around individual responsibility—rather than socializing risk or safeguarding a public commitment to provide care—and further entrenches an atomized, individualized approach to public policy. In the ACA, health care is neither a social good, nor a part of the commons (Smith-Nonini 2006); it is an individual's responsibility to purchase coverage in the marketplace.

Anthropologists are well positioned to reveal how ordinary Americans themselves understand the mandate. Poll data have shown that the individual mandate is the least popular provision of health reform (KFF 2012c). Anthropologists are particularly well suited to drill into this statistical artifact and elucidate: What do people understand the individual mandate to mean, and how do they think it will affect them? What are the broader social and economic contexts in which individuals and families make decisions regarding health insurance coverage and utilization? How do they imagine the role of insurance, of being insured, and their part in protecting their own health? Do the uninsured view themselves as free riders? Do people experience a social responsibility to buy insurance, or is it primarily understood as an individual economic concern?

It is also essential that anthropologists document how the individual mandate rolls out in practice. Under the ACA, certain populations are exempt from the individual mandate; this includes prisoners, undocumented immigrants, those who do not have to file taxes because their income is too low, people who would pay more than 8% of their income on insurance premiums, and members of certain religious groups and Native American tribes. Individuals at or below 400% of the poverty line and certain small employers will also be eligible for subsidies in the form of tax credits to purchase insurance through "exchanges" (KFF 2012c). Massachusetts's experiment with the individual mandate revealed that the paperwork necessary to obtain an exemption or state subsidy may be prohibitive, leading to unenrollment and fluctuating enrollment among low-income people—the very group most in need of insurance (Shaw 2012). Even as the ACA theoretically expands access to health insurance, what concrete barriers to insurance and continuity of care will the low-income population continue to experience?

Finally, despite efforts to expand access to Medicaid and subsidies for individuals to purchase private insurance plans, experts project that nearly 23 million people in the United States will remain uninsured (Buettgens and Hall 2011). As states opt out of the Medicaid expansion, this number will only grow. Although the ACA is expected to reduce existing racial disparities in coverage, African Americans and Latinos will continue to be overrepresented among this group (Clemans-Cope et al. 2012). Meanwhile, the ACA's exclusion of the undocumented from both Medicaid expansion and participation in the health exchanges will make this group a growing proportion of the uninsured (Zuckerman et al.

2011). Emergency room use, cross-border health care seeking, and complementary and alternative medicine have long served as creative means by which the uninsured and underinsured compensate for a lack of access (Horton n.d.; Thompson and Nichter 2011). Anthropologists must examine what systems and negotiations emerge to fill the gap in the provision of services for those who remain uninsured or experience barriers to care.

Challenging Market-Based Medicine

As anthropologists intervene in the public debate surrounding the ACA, we can help highlight—and perhaps decenter—uniquely American ideas about individual responsibility, health care, and the public good. We can also use our analyses of the ACA to challenge the global spread of market-based medicine more broadly. We propose that critical medical anthropologists can help denaturalize the evolving health care market through five analytical strategies: (1) demystifying the “making up of costs”; (2) deconstructing the “standard of care”; (3) examining how insurance companies manipulate the system to maximize profit; (4) revealing the current shape of “corporate governance” (Sunder Rajan 2006); and (5) examining health care reform as part of the capitalist accumulation crisis.

1. Demystifying the “Making Up of Costs”

Critical medical anthropological analysis can expose the negotiations behind establishing costs and premiums, demystifying and unmasking the social dynamics of numbers (Guyer et al. 2010; Porter 1995; Sangaramoorthy and Benton 2012). First, inquiry into the making up of costs can denaturalize our taken-for-granted assumptions about health care’s expense, revealing how varied sectors of the health care industry construct the cost of specific services (e.g., surgical procedures and insurance premiums) and goods (e.g., drugs or medical devices). Anthropologists should also critically examine how the health industry has been “financialized,” as finance capital and publicly traded health care conglomerates increasingly dictate how health care is paid for and administered (Mulligan 2012). These strategies can reveal how the making up of costs is a social strategy to hide profit margins. Moreover, anthropologists should examine how cost works as an ideology of value such that health care treatments are unquestionably presented as “expensive” and “unaffordable,” thereby foreclosing public discussions of health care as a right or a public good.

2. Deconstructing the “Standard of Care”

A significant driver of health care costs in the United States is the “technological imperative”—the social processes that encourage the adoption of new medical technologies as the “standard of care,” regardless of clinical efficacy. Koenig (1988) shows that as new medical technologies are “routinized”—that is, defined as the standard of care rather than “experimental”—clinicians then perceive a “moral imperative” to provide them to patients. As private and government insurances reimburse for procedures accepted as the standard of care, the social processes underpinning routinization have powerful economic consequences. Indeed, Kaufman’s research suggests that “evidence-based medicine” itself often contributes to the rapid adoption of advanced technologies in end-of-life care, as the marginal improvements in life expectancy offered by new medical technologies overshadow their risks and social and economic costs (Kaufman 2009; Kaufman and Fjord 2011). The ACA currently contains no significant oversight mechanism to discourage the profligate adoption of new medical technology as standard procedure (Relman 2011). Anthropologists can

provide a corrective by helping reveal the social processes by which treatments become defined as the standard of care.

3. Examining Whether Insurance Companies Attempt to Manipulate the System to Maximize Profit

Providing insurance through private entities adds an additional layer of bureaucracy and complexity to the provision of health care (Abadía-Barrero and Oviedo Manrique 2009; Horton et al. 2001; Rylko-Bauer and Farmer 2002). While administrative costs under single-payer systems such as Medicare range from 3 to 5% of total health care expenditures, those in U.S. private insurance companies consume 20–30% of every dollar devoted to health care (Waitzkin 2010).

In a measure intended to maximize the proportion of premiums insurance companies devote to delivering health care services as opposed to maximizing profit, the ACA places a ceiling on administrative costs at a maximum of 15–20% of premium income. Nevertheless, ethnographic analyses of the inner workings of health insurance companies give cause for reservation. Mulligan’s research in managed care organizations in Puerto Rico demonstrates that companies use creative tactics to game government reimbursement systems and thereby increase premiums. Thus, any analysis of how the ACA is implemented on the ground must be complemented by “studying up”—that is, examining how insurance companies attempt to subvert the ACA’s control of industry profits (Mulligan n.d.). Similarly, it is essential to examine the influence of various stakeholders in the fine tuning of ACA regulations—including what preventive services are fully covered, how states determine what constitutes minimum essential health benefits, and how employer-based plans use grandfathering and arguments of religious freedom to exempt themselves from various provisions.

4. Documenting the Current Shape of Corporate Governance

Ethnographic studies of economic negotiations in an open market of competing oligopolies—provider groups, health care institutions, the pharmaceutical and biotechnological industries, and private insurance companies—can help illuminate the current shape of corporate governance in which the health care industry itself represents a significant corporate interest. This analysis should involve tracing the strategies through which multiple for-profit sectors compete to protect their economic interests in an internal market of around U.S. \$3 trillion (Loeppky 2009:40). Critical medical anthropologists can help reveal how professional associations, hospitals, pharmaceutical and biomedical/biotech companies, insurance companies, and health maintenance organizations have transformed health care delivery to favor their interests, jockeyed to control health care profits, and financed media campaigns, lobbyists and legislators—from local community representatives to U.S. presidential campaigns.

5. Analyzing Health Care Reform as Part of the Crisis in Capitalist Accumulation

Finally, using a critical political economy perspective, we must examine the health sector as part of the capitalist economy and its inherent cyclical crises. Not only do Marxist scholars argue for understanding the development of medicine and health care systems as part of the development of capitalism, but “the history of public health and welfare programs shows that state expenditures usually increase during periods of social protest and decrease as unrest becomes less widespread” (see Piven and Cloward [1971] and Sigerist [1956] in Waitzkin, 1978:268). One can see the apparently competing political positions for and against the ACA

as comprising two sides of the same capitalist coin. On one side, support for the ACA's expansion of welfare may help control social unrest as it ameliorates the suffering caused by a financial crisis that pushed millions into unemployment and poverty. On the other side, the ACA represents a boon for the very forces of capitalist accumulation currently in "crisis." In the end, the ACA leaves the nation's Goliath of a health care industry intact, imposing only mild regulations on insurance and pharmaceutical companies' leveraging of profits.

Conclusion

The current moment is characterized by flux in the conceptualization of the social contract and the organization of health care systems worldwide such that critical medical anthropological attention is incumbent. At this juncture, we suggest that medical anthropologists can make important contributions to public debate and policy at multiple levels:

1. Empirical Analysis: On the Ground

We call for ongoing ethnographic attention and critical analysis of the tactics of health care reform and how they reshape processes of care-giving and -seeking. This work must continue to document the privatization and the neoliberal restructuring of the state and critically examine the ACA's unintended consequences on safety net institutions, providers, and staff and the vulnerable populations they serve. We must be especially attentive to how health reform intersects with, reinforces, and at times challenges the existing inequalities in access and outcomes that make the U.S. health care system the most unequal in the industrialized world.

2. Empirical Analysis: "Studying Up"

Analysis of how the ACA plays out on-the-ground must be complemented by "studying up"—examining the financial side of health policy. Anthropologists must devote efforts to "studying the balance sheets, market metaphors, and economic assumptions that constitute the financial side of health policy" (Mulligan n.d.). Anthropologists have productively shed light on the clinical context of health care reform, now we must equally turn ethnographic attention to the actuarial practices and administrative strategies through which health insurance companies profit from the nation's health.

3. Challenging the Cultural Legitimacy of Market-Based Medicine

Anthropologists must deconstruct market-based medicine by dissecting assumptions about health, risk, choice, value, and responsibility that undergird the insurance industry—determining how the inequities and inefficiencies of market-based medicine are naturalized and reproduced. With the implementation of the ACA comes the need to examine how old and new inequalities are enacted and embodied. We must evaluate how policy initiatives aimed at leveling inequalities heed or ignore social determinants of health, and whether they legitimize unequal care on the basis of "cultural reasoning" (Briggs 2001). Moreover, not all groups subscribe to neoliberal ideas about individual responsibility and public governance. By examining how diverse groups respond to neoliberal expectations, anthropologists can help denaturalize market-based medicine and challenge the system's cultural legitimacy.

4. Historicization: Situating the ACA within the Crisis in Capitalism

Given the longstanding power of the health care industry to squelch any reform that threatened its financial and professional sovereignty, anthropologists must historicize the emergence and unfolding of the ACA at local, state, and national levels—situating both the U.S. health care crisis and its proposed remedy within the context of the crisis in capitalism.

5. Contextualization

Anthropologists must help situate the ACA and its provisions within a global context. Attention must be paid to biocommunicability (Briggs and Hallin 2007) in the debate around health care reform, and we must attend to the relationship between political rhetoric, media representations, and lay perceptions of the ACA and of other health insurance systems worldwide.

In sum, as the United States embarks on its first major experiment in health reform in nearly half a century, critical medical anthropological deconstruction of the reform's impact and the debate's ideological assumptions is incumbent. Such analysis has the potential to be of relevance not only to the United States. As market-based medicine spreads across the globe, anthropologists may use new critical approaches to the ACA as a springboard from which to denaturalize assumptions of cost and profit and reveal the inner workings of the health care market.

Notes

1. This statement emerges from the Critical Anthropology of Global Health (CAGH) Working Group on Health Insurance Reform, established at the 2010 meeting of the American Anthropological Association in New Orleans. Intended as a complement to the Society for Medical Anthropology's (SMA) task force on U.S. health insurance reform, the working group aims to draw lessons from across the globe, to situate the U.S.'s reform against this backdrop, and to reinvigorate critical anthropological attention to transformations in health care systems worldwide. A bibliography of sources on global health insurance reform, complementing the U.S. bibliography compiled by the SMA Policy Committee, is available at: <http://www.medanthro.net/stand/insurancebibliography.html>. In addition, mini-statements from scholars working on topics related to global health reform are available at: <http://medanthro.net/research/cagh/insurancestatements/>.
2. The national lobbying group for the insurance industry, America's Health Insurance Plans (AHIP), publicly supported reform, but secretly tried to undermine it. Over a span of 15 months, AHIP secretly gave \$102.4 million to the U.S. Chamber of Commerce to fund anti-health reform campaigns (Ungar 2012).
3. Other important concessions include insurance companies' coverage of preventive services with no co-pay and extending coverage to young adults up to age 26 on their parents' health plans.
4. It should be noted that although the brunt of the critique of federal programs has centered on Medicaid, Medicare has also been increasingly privatized through the Medicare Advantage program and its prescription drug benefit. Nevertheless, privatization has advanced less steadily in Medicare, while all 50 states currently have converted their Medicaid programs to managed care, the reach of which is expected to expand under the new ACA (Iglehart 2011).

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