

SMA “Take a Stand” Statement: Health Insurance Reform

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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 2012). Similar pressures have led Eastern European nations to adopt private sector reforms to their formerly socialist health care systems (Ahlin 2012; Mishtal 2012), while nations of western Europe are facing unprecedented challenges to their historic traditions of social insurance (Almeida 2012; Castañeda 2012; Larchanché 2012). 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 re-conceptualization of the varying responsibilities of the individual, the corporation, and the state.

It is against this backdrop that the US has undertaken the first major reform of its health care system in 45 years. Facing escalating health care expenditures as well as rising numbers of uninsured, the US is widely considered the most inefficient and inequitable health care system in the developed world (Reid 2010). Even as roughly 20 percent of Americans lack health insurance, health care expenditures currently consume about 17 percent of the US Gross Domestic Product—nearly twice the amount as in any other developed country. Despite the fact that the US spends more per capita on health care than any other country, its basic health indicators still fall far below its peers. The Patient Protection and Affordable Care Act of 2010—if fully enacted—aims to reduce the number of the uninsured through the simultaneous expansion of the private insurance industry and government-funded Medicaid. Yet critics charge that it will neither achieve universal health insurance nor significantly reduce rapidly rising health care costs (Relman 2011). While proponents argue that the reform is a move in the right direction, others fear that it largely leaves the nation’s inequitable, costly, and fragmented employer-based system intact.

The Aim of the Initiative and this Brief

The debate over health reform continues in the US—and a potential change in administration makes its future that much more uncertain. The current moment is characterized by such flux in the conceptualization of the social contract and in the organization of health care systems worldwide that critical medical anthropological attention is incumbent. The aim of this “Take a Stand” initiative is to stimulate critical dialogue about how health care can be delivered both equitably and efficiently—in the United States and across the globe.

The following general theoretical and empirical questions about insurance—and about the social contract in general—are ripe for medical anthropologists to discuss, analyze, and debate:

1. How has the notion of the public's "right to health"—as enshrined in many state constitutions and the United Nations' Universal Declaration of Human Rights—undergone transformation and questioning over the past 20 years? How have various actors defined the "right to health," and how have industry groups appropriated this notion? For example, citizens have mobilized the concept of a "right" to health care in opposition to reforms diminishing access and equity in Colombia (**Abadía 2012**), but—prompted by the pharmaceutical industry—they have also mobilized it in Brazil to claim the state's responsibility to provide pharmaceuticals for patient groups (Biehl 2007; **Iriart 2012**; Petryna 2009). As the notion of a "right to health" is in constant play at this particular moment, medical anthropologists must pay critical attention to how the notion of health as a fundamental "right" is variously asserted, contested, and co-opted.
2. Since the development of social insurance schemes in Europe and Latin America following World War Two, the rise of chronic diseases and an aging population have facilitated more recent neoliberal reforms emphasizing citizen responsibility for health. These run the gamut from taxes on unhealthy behaviors such as smoking and excessive sugar consumption, to the "individual mandate" to purchase health insurance, to rising copayments, out-of-pocket payments and deductibles for health care. In advanced liberal societies, the notion of individual responsibility for health has become enmeshed with the idea of responsible citizenship, as prudent individuals voluntarily undertake preventive health checks, genetic testing, and lifestyle changes. How have states—and various actors and subgroups within states—defined the notion of health as a personal responsibility, and how has this been wielded to undermine the notion of health as a public good?
3. In parts of the developing world with "failed" or "failing" states, to what extent *can* the provision of health care be the sole responsibility of the state? In such regions, how do non-state actors assume responsibility for service provision, financing and planning of health services? What roles have NGOs and global institutions played in the provision of health care? How does the influx of global actors in the provision of health care both impinge on state sovereignty and enable new forms of rights and belonging?
4. The past two decades have witnessed a growing role by the private sector in the payment and delivery of health care, as many states have privatized or partially privatized their health social security plans in an effort to reduce public sector spending. In many ways, 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. Yet to date, the evidence on the efficacy of privatization in improving health outcomes while reducing costs remains unconvincing (**Abadía 2012**; **Almeida 2012**; **Mishtal 2012**; **Mulligan 2012**). Moreover, the degree to which states involve the private sector—or adopt corporate sector strategies—varies greatly across the globe, as does the degree of state regulation of private sector involvement in health care delivery. Under what circumstances does the private sector become a legitimate or illegitimate means of delivering health care, and in what cases does the state retain its sovereignty while transferring its responsibilities to the private sector?
5. And 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? 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?

If medical anthropologists hope to affect how politicians, policymakers, public health officials, activists, and other key stakeholders think about and carry out health reform, the creation of an engaged task force on global health insurance reform is vital.

How Critical Medical Anthropologists Can Intervene

Intended as a complement to the Society for Medical Anthropology's task force on US health insurance reform, this initiative aims to draw lessons from across the globe to help inform the US' efforts. Medical anthropologists have long understood that health care systems reflect different cultural values and norms. Thus we contend that no other discipline is so well positioned to offer analysis and comparison of the assumptions underlying the US system. As an exercise in cultural critique, anthropology has long been useful in dispelling ethnocentrism and facilitating reflexivity by allowing the West, and the US—in particular—to hold a mirror to itself. An examination of the US health care delivery system from a global perspective helps reveal the peculiarities of the US system and open it to debate.

Therefore, we envision this initiative as comprising two complementary scholarly projects: 1) a critical discussion of the PPACA in light of anthropological insights regarding health insurance--and health care reform, more broadly--both within the US and globally; and 2) an appraisal of recent global developments in health care reform. We expect that discussion of each will inform and guide the other.

We suggest that medical anthropologists can make several useful interventions at this juncture:

1) *Empirical Analysis: On the Ground* First, an extensive body of anthropological literature exists on tactics of health care reform and how they reshape processes of care-giving and care-seeking. This literature is helpful in documenting reforms' unintended consequences on safety net institutions and on vulnerable populations. An equally vital literature exists on privatization and the neoliberal restructuring of the state. We must draw upon both literatures to help document the potential and actual effects of health reforms across the globe, empirically analyzing their impact and implementation.

2) *Empirical Analysis: Studying Up* Analysis of how the PPACA plays out on-the-ground must be complemented by "studying up"—by examining the financial side of health policy. As Mulligan argues (2011), we must devote efforts to "studying the balance sheets, market metaphors, and economic assumptions that constitute the financial side of health policy." While we have productively shed light on the clinical context of health care reform, it is time we turn ethnographic attention to the actuarial practices and administrative strategies through which health insurance companies make a profit on the nation's health.

3) *Exposing Ideological Investments: Shifting the Terms of the Debate* Even as delivering health care through for-profit health insurance companies has failed to improve health outcomes

while reducing costs, there remains significant ideological investment in the efficacy of market-based medicine. This poses a relevant question: How has for-profit medicine—despite its failures—maintained its cultural legitimacy (Mulligan 2011)? Not only must we expose the ideological foundations upon which market-based medicine is based, we must also examine how the inequities and inefficiencies of market-based medicine are naturalized. Anthropologists should spend as much time deconstructing market-based medicine—that is, dissecting the assumptions about health, risk, and responsibility that undergird the insurance industry as we do the public “common-sense.”

A critical analysis of ideological underpinnings of market-based medicine may point to ways anthropologists can intervene. Many of the terms bandied about during the town halls—“choice,” “competition,” “rationing,” and “socialized medicine”—have become empty rhetoric. How can anthropologists help shift the terms of the debate? For example, can we deconstruct the concept of “choice,” and can we sever its unproblematic association with “competition”? Does our current health care system offer those with chronic illnesses a “choice,” and has a purported “competition” between for-profit insurance plans truly expanded affordable options for working Americans? Why would competition between for-profit plans and a public plan *deny* Americans “choice?” The concept of “choice” itself has become a fetish; it bears a uniquely American connotation of unfettered free will and equal opportunity that is no longer suited to the contemporary realities of health care delivery. Can anthropologists help replace “choice” with a more transparent alternative that reflects both agency *and* structural constraints—that is, the inevitability of trade-offs in decision-making—a term like “options”?

4) *Contextualization*: Finally, the town halls leading up to the passage of the PPACA revealed many public misconceptions about health insurance systems worldwide, exposing an unreflective health jingoism that stifled constructive debate. Medicare recipients ironically decried “Canadian-style medicine,” even as a history of the US Medicare system reveals that it was inspired by Canada’s (Janes 2012). Rumors circulated about “death panels” and the perils of a “socialized” system. Concrete references to empirical analyses of patient satisfaction, health outcomes and health care inflation in other countries—and promising alternative models within the US’ health care system-- were notably absent.

Medical anthropological analyses can help provide a reality check and enrich the national debate. First, we can provide grounded analyses of the different modes of financing, organizing, and regulating health insurance worldwide, along with the relative strengths and weaknesses of each system. Second, we can help point the public to potential solutions—that is, existing models that address health needs in comprehensive and effective ways. For example, the Veterans’ Administration—which covers veterans for life—has found that investing heavily in prevention and primary care is the best means of minimizing future health expenses. Its health system stands as a stark counterpoint to the “choice” of competing plans in a health care marketplace, and yet consistently outperforms civilian health care programs on measures of patient satisfaction and management of chronic illnesses—all at significantly lower cost per capita for a relatively sicker population (Scandlyn 2012). A balanced and thoughtful discussion of such alternatives can help guide public debate and place the PPACA in context.

Health Care Reform in the US: the PPACA and Beyond

Currently, there are roughly 49 million Americans who lack insurance (KFF 2011). 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 US in 2007 were linked to medical bills (Himmelstein et al. 2009). Yet the US health insurance crisis is not only a crisis of the uninsured; 25 million Americans are estimated to be “under-insured” (that is, their out-of-pocket medical expenses amount to 10% or more of income) (Schoen et al. 2008). Rampant health care inflation has led to rising health care premiums and copayments for working families and to the increase of high-deductible plans that cover catastrophic illness and accident alone. Even for those with some form of insurance coverage, high deductibles, high co-pays, limited provider networks, and confusing plan rules are significant barriers to accessing care.

The PPACA aims to redress this situation through the expansion of employer-based insurance, the expansion of Medicaid eligibility to the near-poor and to eligible childless adults, and an “individual mandate” that the uninsured purchase private health insurance. In brief, the Act represents a compromise between the US government and the insurance industry. The Obama administration removed the “public option” from the 2010 Act due to insurance companies’ fear they could not compete, in effect handing over roughly 16 million soon-to-be-insured Americans to private insurance companies. 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” or cancellation of insurance policies due to accident or severe illness, and the denial of coverage on the basis of pre-existing conditions. Insurance companies will also now be required to spend 80-85% of premiums on medical care and to report how many claims they deny each year, although the Act imposes no significant regulation of companies’ claims administration process.

The US is the only country in the developed world that allows private insurance companies to make a profit off of basic health care. Although some European countries with lower rates of health care inflation *do* deliver basic health care through private insurance companies, they have imposed regulations preventing such plans from yielding great profit (Reid 2010). As anthropologists have shown, providing insurance through private entities adds an additional layer of bureaucracy and complexity to the provision of health care (Horton et al. 2001). While administrative costs under single-payer systems such as Medicare range from 3-5% of total health care expenditures, those in US private insurance companies consume 20-30 percent of every dollar devoted to health care (Waitzkin 2010). We contend that research has shown that without sufficient regulation, delivering health care through private insurance companies is one of the least efficient and most inequitable methods in the world.

Given that the Act is currently ensnared in judicial challenges, this is an opportune moment for anthropologists to intervene. Twenty eight states have mounted lawsuits challenging the constitutionality of PPACA’s individual mandate. Initially proposed by conservatives as a means of ensuring individual responsibility for health care, the individual mandate has ironically become a symbol of excessive government intrusion. The linchpin of the state’s compromise with the insurance industry, the individual mandate ensures the affordability of premiums by broadly pooling risk. The mandate avoids the pitfalls of “adverse selection;” it ensures that not only the sickest and most infirm participate in the health insurance marketplace. The Act’s future—and the affordability of health care premiums and curtailment of health care costs--remains uncertain if the individual mandate is struck down.

We suggest that, should the PPACA survive its judicial challenge, anthropologists should rigorously document the effects of the legislation in order to inform and help guide the public debate. We highlight here some questions of broad relevance to health care reform in the US, and suggest how previous anthropological studies help provide a context within which to analyze the PPACA and its potential effects.

Questions

1. Even as the PPACA theoretically expands access to health insurance, what concrete barriers to insurance do vulnerable populations continue to experience? Under the PPACA, certain populations are exempt from the individual mandate, while other low-income groups may receive state subsidies for care. Yet Massachusetts' experiment with the individual mandate revealed that the paperwork necessary to obtain an exemption or state subsidy may be prohibitive, leading to un-enrollment and fluctuating enrollment among the low-income—the very group most in need of insurance (**Shaw 2012**).
2. Will the PPACA's expansion of Medicaid eligibility actually lead to improved care for the newly-insured, or will the existing flaws in Medicaid preclude meaningful access and quality care? Anthropologists have long highlighted flaws in the Medicaid system that inhibit enrollment, access, and continuity of care. Detailed asset and income tests—combined with caseworkers' "work-shifting" to clients (Lamphere 2003)—often discourage enrollment (Horton 2004; Waitzkin et al. 2002). Onerous recertification requirements—and fluctuating income—often lead to fluctuating eligibility (**Shaw 2012**). Finally, Medicaid reimbursement rates for primary care—which the PPACA will only temporarily increase to Medicare levels—have long dampened provider participation in the program and precluded meaningful access for beneficiaries. If these flaws in the system are not resolved, this will compromise the quality of care for the 16 million Americans the PPACA plans to newly insure through Medicaid and the Children's Health Insurance Program (CHIP), and potentially exacerbate a two-tiered health insurance system.
3. The US' experience with attempts to expand enrollment of eligible low-income children in CHIP and in Medicaid may serve as a cautionary tale for PPACA (**Dao 2012**). Despite the expansion of such programs, more than half of the nation's 8.1 million uninsured children are eligible for state-funded insurance yet not enrolled (Keney et al. 2010). The barriers to eligible children's enrollment—including parents' immigration status—reflect persistent gaps in coverage that have not yet been addressed (**Dao 2012**). Ethnographic research on reasons for the gap between children's eligibility and enrollment—and ethnographically-grounded interventions to close such gaps—are essential.
4. What will be the effect of the PPACA's expansion of Medicaid on safety net clinics and providers? Analysis of the Massachusetts health care experiment—which served as a model for PPACA—suggests that safety net providers may bear a hefty administrative burden at the initial roll-out as they face the task of enrolling new patients in Medicaid in order to provide them care (**Shaw 2012**).
5. How will current disparities in access to care in rural and urban areas be addressed, and will the rural workforce keep pace with an expanded demand for services from the newly-insured? As health insurance expands, will this in fact translate into meaningful health care access?
6. At present, there is no universal standard for what constitutes "minimum essential coverage," and there is some indication that states will be granted considerable discretion

in defining it. How will dental care, mental health care, and complementary/alternative medicine (CAM) be incorporated—or not—into the standard of “minimum essential coverage”? Despite increasing evidence of their roles in preventive care and chronic disease management, a key priority of the Act, it remains to be seen whether these services—currently marginally covered by insurance plans and primarily paid out-of-pocket—will be incorporated into emergent health insurance schemes (**Thompson and Nichter 2012, Raskin 2012**).

7. What systems emerge to fill the gap in the provision of conventional biomedical health care services under PPACA? CAM and cross-border health care seeking have long served as a creative means by which Americans compensated for a lack of health care access (**Thompson and Nichter 2012, Horton 2011**). Once the Act is rolled out, will Americans continue to supplement their biomedical care for reasons beyond cost and/or access, or do they seek CAM and/or cross-border care in lieu of participating in health insurance? What alternative care models show promise in filling health care needs?
8. And finally, this analysis of how the reform is implemented on the ground must be complemented by a rigorous effort to “study up.” Medical anthropologists must document what strategies insurance companies use to subvert PPACA’s control of industry profits. PPACA aims to curtail the profits US insurance companies make on the public’s health by placing a ceiling on administrative costs at a maximum of 15-20% of premium income. This measure is intended to maximize the amount of premiums insurance companies devote to delivering health care services as opposed to lining their wallets. Yet ethnographic analyses of the inner workings of health insurance companies are cause for reservation. Mulligan’s research in managed care organizations in Puerto Rico has shown that companies use creative tactics to game government reimbursement systems and thereby increase premiums. How—as Mulligan puts it—do insurance companies attempt to “game the system,” and what measures, if any, might be implemented to prevent this?

Global Health Care Reform

Along with these specific questions regarding the implementation of the PPACA, we identify a number of questions below of broad relevance to health care reform—and the advance of privatization—in various regions of the globe.

1. As European countries with a long tradition of social insurance adopt neoliberal reforms reducing benefits and implementing new copayments, anthropologists must document how the quality of health is affected. While health economists, quality specialists, and epidemiologists measure the effects of reform through population based health indicators, anthropologists can broaden the evidence base by examining the effect of reform on the day-to-day functioning of health care institutions, the practice of accessing care, and patient experience.

2. How is the concept of social insurance further eroded by the new austerity programs recently implemented in countries such as Italy and Greece? As slashed public health care budgets are translated into hospital shortages, rising copayments, and lengthening waiting lists, how are austerity programs affecting the quality of health in these countries?

3. Even as market-based reforms have proven ineffective in many countries, there paradoxically remains great ideological investment in neoliberalism by patients, politicians, and

clinicians. Through what ideological work do for-profit insurance systems maintain their cultural legitimacy?

4. What are the impacts of neoliberal reforms on concepts of health citizenship, and on the notion of social solidarity? How do these reforms—and new austerity programs—lead to the generation of new categories of those “undeserving” of care? (**Larchanché 2012**)

5. While we have witnessed an active privatization of social insurance plans in parts of Europe and Latin America, other countries have faced a more gradual “passive privatization” through private individuals’ purchase of supplemental private insurance plans. To what extent does the growth of the private insurance market in many developed countries exist symbiotically with public insurance systems, and to what extent does it siphon off doctors and resources from the public insurance system?

6. In other countries, an even more covert privatization of health care has occurred through the partial privatization of the state—through the exchange of top officials between corporations and health ministries as well as through the co-optation of US politicians through campaign contributions (Navarro 2010). Yet these changes have not occurred without resistance. What kinds of resistance to such neoliberalism are occurring within civil society, and what kinds of collaboration have proven effective (Smith-Nonini 2010)?

7. A final “passive privatization” of health care systems is occurring through medical travel. How is medical travel—and the influx of private-paying patients into developing health care systems—transforming health care systems worldwide? To what extent is it pricing locals out of health care, and creating a two-tiered system in countries with universal health care systems such as Cuba and Costa Rica (**Lee 2012**)? In short, what is the relationship between the public health care sector and the medical tourism industry in developing countries?

8. Global financial institutions are increasingly favoring a new health reform in developing countries—Conditional Cash Transfers (CCTs) that involve cash payments contingent upon the poor’s engagement in behavioral reforms. To what extent do these new policies represent a neoliberal-statist hybrid? While quantitative analysis is charting the efficacy of these reforms, ethnographic research is needed to document the on-the-ground barriers to utilization and improved health outcomes (Timura 2011).

The Initiative’s Activities and How You Can Participate:

To achieve the goals of this initiative—that is, to spark dialogue among medical anthropologists about global transformations in health insurance and how we may intervene through scholarship, research, and debate—we have begun the following projects:

- We have compiled a working bibliography on health insurance reform—both in the US and around the globe—and posted it to the SMA/CAGH website. **Link** This will be complemented by a virtual repository of the sources that provides public access to references and abstracts. To add a source, please email frichard@msu.edu.
- We organized a panel at the 2011 AAAs, “Redefining Insurance, Redefining Governance: the US Patient Protection and Affordable Care Act in Global Perspective” (Sarah Horton and Fayana Richards, organizers). CAGH members are currently investigating the possibility of organizing a special issue of a journal on the topic. For

more information, contact Catherine Timura at catimura@gwu.edu or Amy Dao at amylm.dao@gmail.com.

- We are in the process of assembling a series of briefs on contemporary challenges to and transformations of health insurance systems world-wide and posting them to the SMA website. They are available at [Link](#). Based on these briefs, members are investigating the possibility of creating a handbook of case studies in health insurance reform. If interested in contributing to this part of the initiative, please email Sarah Raskin at: seraskin@email.arizona.edu.

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