

---

# Federal Health Policies in the United States: An Alternative Explanation

VICENTE NAVARRO

*Johns Hopkins University*

ONE OF THE MOST IMPORTANT CHARACTERISTICS of the policies of the current Republican federal administration has been an unprecedented (in peace time) growth of military expenditures and an equally unprecedented reduction of social (including health) expenditures. From 1980 to 1985, the federal military expenditures rose from 7.2 percent to 9.9 percent of the gross national product (GNP), with a projected rise to 10.5 percent of the GNP in 1988. By 1990, the United States government will have spent, during the period of 1980 to 1990, \$2,500 billion, which is more than the whole United States military expenditure from 1946 to 1980 (\$2,001 billion) (Melman 1985, 11). On the other hand, federal social expenditures (including Social Security) declined for the period of 1980 to 1985 from 11.2 percent to 10.4 percent of the GNP. Federal funds for health and medical programs have also been reduced from 44.9 percent of all social welfare expenditures in 1980 to 42.4 percent in 1983. And the rate of growth of federal health expenditures has fallen from 16.5 percent per year in 1980 to 10.1 percent in 1983. The U.S. Council of Economic Advisors in its 1984 report to the president refers to such shifts of federal resources as "absolutely unprecedented" (U.S. Council of Economic Advisors, 1984; see also *Social Security Bulletin* 1986 and *Health Care Financing Review* 1984).

---

The Milbank Quarterly, Vol. 65, No. 1, 1987  
© 1987 Milbank Memorial Fund

The explanations given for these federal policies are many. A widely held interpretation attributes these policies to a popular mandate received by the Republican administration in the 1980 and 1984 presidential and congressional elections. Instances of this interpretation in the health and medical care bibliography are many. For example, the leaders of the Robert Wood Johnson Foundation, in an article in the *New England Journal of Medicine*, referred to the 1980 election as a "powerful mandate to decrease taxes and non-defense expenditures" (Rogers, Blendon, and Maloney 1982). In the same issue, J.K. Iglehart (1982), reporting on a major conference attended by leading exponents of the medical establishment, wrote of a quasi-consensus among participants that cuts in federal health expenditures had to be made in response to a popular mandate.

That popular mandate was perceived to be a result of popular disenchantment with government, and a popular desire to reduce government intervention in the health sector. Again, examples of this interpretation of the popular-mandate argument in the medical care bibliography are many. For instance, Paul Starr (1984, 419) in his influential *The Social Transformation of American Medicine*, interprets the victory of Reagan in 1980 as a result of people's belief that the government was *the* problem (for a critique of Starr see Navarro 1984b). This popular belief was based on the perception that, as David Mechanic (1984) approvingly put it, "the heavy hand of government causes more problems than it solves." Consequently, and as indicated by the publisher (W.B. Walsh [1985]) and the editor (J.K. Iglehart [1985]) of *Health Affairs*, a major health policy forum in the United States, Americans wanted the size of their government reduced and its interventions in the health sector diminished. These are not solitary voices. Far from it. These are representative voices of prevalent interpretations of current federal health policies.

The accumulated evidence for all of these years does not, however, support this interpretation of a popular mandate for these federal health policies. Quite to the contrary, a survey of all major opinion polls from 1976 to the present shows that there has been a constant and undiminished support for an expansion rather than a reduction of health and social expenditures (and for keeping and/or strengthening government interventions to protect workers, consumers, and the environment). Similar evidence exists to show that the reduction of

social expenditures, as well as other domestic policies carried out by the current administration, such as the transfer of federal funds from the social to the military sector, are not popular policies (Navarro 1982, 1985b; see also Ferguson and Rogers 1986, 1–39). Even Senator Paul Laxalt, a close friend of President Reagan and the chairman of the Republican National Committee, has recently referred to “the strange phenomenon that most Americans express approval of Ronald Reagan, although they are opposed to much of what the President supports” (cited in Lipset 1985). Lipset (1983) and Ferguson and Rogers (1986, 1–39) have shown that the majority of Americans remain more liberal than the president on economics, defense, foreign policy, and social questions. A survey of popular opinion regarding federal health policies shows that the same is true for health questions (Navarro 1985b).

In light of this evidence, a question that needs to be raised and answered is why did people vote both in 1980 and in 1984 for a candidate whose commitment to carry out those unpopular policies was clearly stated? Indeed, a major assumption made by the authors who believe in the popular mandate as the force behind those federal social policies is that *electoral behavior and popular opinion are synonymous*. The answer to the question needs to be given at different levels. One explanation is that the overwhelming majority of United States presidents have been elected by a minority, not a majority, of potential voters. And President Reagan, elected by 32.3 percent of the potential electorate in 1984 and 27.2 percent in 1980, was no exception to this reality.

Still, the question may be asked again. How is it that so many people voted for candidate Reagan despite the fact that they did not support his social (including health) policies? The answer involves the nature of Western democracy and its limitations. The act of voting is based on a totalizing interpretation of policy. In other words, in the act of voting (except in referendums), people are asked to vote for totalities, not for sectional choices. One votes either Republican or Democratic. But one cannot vote selectively, i.e., one is not offered the chance of voting for the many components of those policies (such as education, health services, transport, and employment policies). The vote is everything or nothing. In Walter Lippman’s (1925, 56–57) words:

We call an election an expression of the popular will. But is it? We go into the polling booths and make a cross on a piece of paper for one or two or perhaps three or four names. Have we expressed our thoughts on the public policy of the United States? Presumably, we have a number of thoughts on this and that with many buts and ifs and sos. Surely the cross on a piece of paper has not expressed them.

Thus, representative democracy is insufficient. It does not measure, nor does it reflect, the popular will on the many dimensions of public life. *Electoral behavior and popular opinion are not synonymous*. Consequently, there is no contradiction or schizophrenia involved in Reagan's winning the election while the majority of the people (including his voters) have different and even opposite views on many and even the majority of Reagan's policies (for a debate on popular opinion see Blendon and Altman 1984; Navarro 1985a, 1985d; Altman 1985). The paradox of the last elections—that the majority of the electorate seemed to be in disagreement with many of the Reagan positions, yet still the majority of those who went to the polls voted for him—is not incomprehensible. Polls (including exit polls) in 1980 and in 1984 show that the majority of people were in disagreement with many of Reagan's social policies. This disagreement appears even among Reagan's voters. In 1980, voters preferred Reagan over Carter primarily because of Carter's perceived unpopularity, and in 1984, voters preferred Reagan over Mondale primarily because they identified the economic recovery (and primarily the decline of inflation) with his policies (Nelson 1985). Moreover, no incumbent president has been defeated when economic growth in the election year has exceeded 3.8 percent; in 1984 economic growth exceeded 6 percent (Quirk 1985).

In summary, there is no evidence to support the thesis that the current federal social (including health) policies respond to a popular mandate. Thus, the original question of why these policies remains. I postulate that in order to answer this question we have to analyze these policies within the social, political, and economic context in which they take place. In other words, in order to understand these federal health policies—the tree—we have to understand the actual distribution of social, economic, and political power in the United States today—the forest.

## Class as Explanatory Value in Health Policy

One of the most striking areas of silence in the analysis of health policy in the United States is the absence of class as a category of power. Class, in health care bibliography, seems to be an “un-American” category. In most of this bibliography, the citizens and residents of the United States are divided according to biological (e.g., gender, race) or cultural (e.g., Hispanic, ethnic) categories, but rarely, if ever, according to class categories. Thus, the United States is the only major country in the Western industrialized world in which health and social statistics are not recorded according to class. An elementary observation needs to be made, however. The United States has classes. This observation bears repeating in light of dominant discourse in which class as a category of analysis and bearer of power relations is rarely mentioned. Aside from references to the United States as a middle-class society (a society in which the majority of United States citizens are supposed to be in the middle, between the rich and the poor), the power category of class never, or very rarely, appears in the major media in general or in the medical literature in particular. This definition of the United States as a middle-class society takes place, incidentally, in spite of the fact that more United States citizens define themselves as members of the working class (48 percent) than of the middle class (43 percent) (*Public Opinion* 1984) (see Appendix note 1).

Actually, the size of the working class is even larger than that based on people’s self perception of themselves as part of the working class. Erik O. Wright (1985) has shown how the actual size of the working class is over 60 percent of the United States population. The middle class, which has always been smaller in size than the working class, has been further reduced in size recently owing to the changes in the occupational structure of the United States (Thurow 1985, 60–66). Most of the major media, however—including the medical media—never refer to the majority of the United States population as working class. Rather, they define it as middle class. Just as the members of the working class are never or rarely referred to as such, so those “on the top” are never presented, discussed, applauded, or denounced as the capitalist class, a term usually dismissed as “rhetorical” and/or “doctrinaire.” (Contrary to prevalent belief, United States academic discourse and United States culture are heavily ideological. It is sufficient

to use certain unacceptable terms in that discourse to trigger unresponsive, if not plainly hostile, responses.) Here, a second observation needs to be made. The United States capitalist class is the most powerful capitalist class in today's world. In a truly Gramscian fashion, the interests of this class have been presented (and accepted) as the universal interest. To be anticapitalist, for example, is to be perceived as anti-American. Indicative of the power of this class to define the dominant discourse is the fact that classes never appear in that discourse. The capitalist class, however, is the most class conscious of all classes in the United States. And the current leadership of the Republican administration represents the most "class conscious" stratum within that class. In the unrestrained pursuit of its interests, it has exhibited a clear class behavior. One of its most substantial class achievements has been the weakening of the base of government support for organized labor in its dealings with management. This has been accomplished through sharp reductions in unemployment insurance, through the dismantling of the public service job program, through the weakening of the Occupational Safety and Health Administration, through the appointment of persons hostile to organized labor both to the National Labor Relations Board and to the Department of Labor, and through the reduction of social (including health) expenditures (Edsall 1984, 229). Similarly, Reagan's tax and economic policies have benefited primarily the capitalist and upper middle classes and have hurt the lower middle and working classes (Bawden 1984; Moon and Sawhill 1984).

The effect of these policies has a clear class base. According to the *Economic Report of the President, 1985* the following changes have occurred between 1979 and 1984 (as I have indicated elsewhere [Navarro 1985b] some of the social policies of austerity started under the Carter administration in the 1979 and 1980 federal budgets): (1) before tax profits and interest (correcting for inflation) grew 3.6 percent per year; (2) real wages of nonsupervisory workers fell by 5 percent; and (3) net farm income fell by 36 percent (U.S. President 1985, table B2, 234). In 1983, employers' health payments as a percentage of the GNP declined for the first time in recent history (*Medical Benefits* 1986a). Also, and as reported by the U.S. Bureau of the Census, the median income of those in the bottom 40 percent—a largely Democratic constituency—fell by \$477 (from \$12,966 to \$12,489) between 1980 and 1984, in constant 1984 dollars, while the income of those in the

top 10 percent—a largely Republican constituency—rose by \$5,085 (from \$68,145 in 1980 to \$73,230 in 1984) (U.S. Bureau of the Census 1984). Similarly, the Congressional Budget Office has found that the net effect of spending and tax cuts has resulted in a loss of \$1,100 between 1983 and 1985 for those making less than \$10,000, while those making more than \$80,000 annually have gained \$24,200 as a result of government policy (U.S. Congressional Budget Office 1984). It is this class behavior that also explains the shift of federal resources from the social to the military areas. The reduction of social expenditures and interventions does weaken the working population in its bargaining with the class of employers (e.g., an unemployed worker without health and/or unemployment insurance is more likely to accept a low-paying job than if he or she had insurance). As David Stockman (a main spokesperson for the Reagan administration) indicated, a main purpose of the reduction of social expenditures was to discipline labor, a policy that has been largely successful. (David Stockman refers to that process of disciplining labor—that included increased unemployment in the years 1980 to 1983 and cuts of social expenditures—as “part of the cure, not the problem” [cited in Ferguson and Rogers 1986, 49].) The number of strikes reached a long-time low in 1982 and the rate of salary growth was the smallest ever.

The opposition party—the Democratic party—however, does not represent any form of class behavior in general or working class behavior in particular. Not even a semblance of class discourse appears. Actually, one of the most successful capitalist class interventions in the United States was to outlaw any form of class behavior on the part of its antagonists: the working class (see Appendix note 2). The Taft-Hartley Act forbade American labor to act as a class and forced it to function as just another “interest group” (Milton 1982, 159). The steel workers cannot strike in support of the coal miners, for example. They can only take care of their own. No other major Western capitalist country has faced this situation. This splitting of the working class into different interest groups dramatically redefined all elements of political, economic, and sociocultural behaviors and possibilities. Class has disappeared from reasonable discourse; terms such as “capitalist class,” “petit bourgeois,” and “working class” are dismissed as ideological. Instead, the new terms of political discourse are “the rich,” “the middle class,” and “the poor,” all defined in the area of consumption rather than in terms of the relation of people to the means of producing

wealth and income. Language, however, is not innocent. It does, indeed, reflect the power relations in society. The working class and the United States population have been redefined in terms of biological categories (black, white, women, men, the aged) and in terms of consumption (rich, middle, and poor). The political, economic, and social consequences of that redefinition of the working class into interest groups are enormous, as is their importance for understanding today's United States health policies. For example, United States health services are largely paid for by work-related health benefits achieved through a bargaining process in which each sector of labor tries to get as much as possible for its own constituency. As a result of this situation, we find that different sectors of the working population in the United States have different types of health coverage, with manufacturing having better coverage than other workers, and sales and service workers being the least protected (*Medical Benefits* 1985, table 1, 3; Root 1985, 101–18). Table 1 records the relation between health benefits coverage in two major sectors of employment in the United States. Even within the same sector of employment, the degree of coverage depends on the strength of labor via unionization (Black 1986).

The consequence of this “interest group” behavior is that, while the coverage is comprehensive for some sectors of the working population, the coverage for the whole class is rather limited. As an average,

TABLE 1  
Percentage of Workers Who Are Unionized in Certain Types of  
Employment and Percentage of Coverage in Specific Types  
of Health Insurance

Industry	Percentage unionized	Percentage uninsured all year	Dental services coverage	Vision or hearing
Manufacturing	46%	4.8%	30.9%	15.6%
Personal Services	13	16.0	17.0	5.0

Sources: Bureau of Labor Statistics, Unionization. Directory of National Unions and Employment Associations, 1975; and Employment Associations, 1975; and Employment and Earnings, January 1979, table 1: Coverage of the privately insured population less than age 65 for selected health services: percent insured by type of insurance and identity of primary insured in *Medical Benefits* 1985, table 3; Employment and Health Insurance Coverage in Monheit et al. 1985.



United States citizens still pay in out-of-pocket and in direct expenses larger percentages for health benefits than any other Western industrialized nation (Maxwell 1981, table 4.1). Another consequence of relating health benefits to employment (besides reinforcing the resource disparities arising from pay differentials) is that it weakens the popular demand for improving governmental programs. Thus, those who remain unprotected through the work place are more isolated politically, decreasing the popular pressure for government to meet their needs.

This focus on work-related benefits (assured by collective private bargaining) rather than benefits assured by the state (which may be paid through general revenues or payroll taxes) is the primary difference between the expansion of health services coverage in the United States and in western Europe (Navarro 1985c). While the working class in western Europe has conducted its struggle for expanding health services coverage primarily through the state, its counterpart in the United States has struggled (not as a class but as an interest group) primarily through the bargaining table at the work place. A major objective of the labor movements in western Europe has been to achieve the universalization of health benefits covering all the population. A main goal of these European health services (both in the national health service or in the national health insurance varieties) is that the health benefits received by the individual or citizen do not depend on the amount of payment he or she makes as a worker. The struggle for that goal has occurred not only in the collective-bargaining arenas but primarily in the forums of the state (Esping-Andersen 1985). In the United States, the "interest group" behavior (each segment of labor looking out for its own) rather than class behavior (labor struggling with class solidarity for all sectors of labor) explains the enormous diversity of health benefits within the working class and the population.

In describing this situation, there is a need for four clarifications. First, this situation in which labor acts as an interest group rather than class and in which health benefits are work related rather than state provided is not, as Starr (1984, 312-13) indicates, an outcome of labor's choice or American values. He assumes that whatever happens in the medical sector is, in the final analysis, an outcome of what the majority of Americans want. Empirical information shows that this is not the case (see Navarro 1984b). Rather, this "interest group" type of behavior has been imposed on labor as the outcome of enormous struggles in the 1950s when labor was forced by the Taft-Hartley

Act not to behave as a class. Prior to that act, sectors of labor could strike in support of other sectors. That power of class mobilization represented a clear threat to the dominant sectors of the business community or capitalist class. The dominant sector of that class (particularly the employers of the labor-intensive sectors of industry) was afraid that that possibility of acting as a class could threaten their own class interests. They could remember an instance of that class mobilization during the New Deal, a program that they strongly opposed. Consequently, an important component of the Cold War and the repressive regime known as McCarthyism was to purge labor unions of that segment of the leadership that emphasized class practices rather than interest group practices within labor. Thus, an enormous struggle was carried out at all economic, political, and ideological levels of American society aimed at weakening labor and forcing on it this "interest group" type of behavior. Labor, through its major federation, the AFL-CIO, has fought the Taft-Hartley Act since its very beginnings (Milton 1982, 159).

The second clarification is that the majority of the poor and the majority of the uninsured are members of the working class (workers, retired workers, potential workers, and their dependents) (Stallard, Ehrenreich, and Sklar 1983; Harrington 1984; Monheit et al. 1985). In this respect, the problems of the poor and uninsured (high costs and limited coverage) are not dissimilar to the problems of the majority of the working population; the differences are primarily in degree rather than substance. According to popular opinion polls, high costs and limited coverage are still among the major problems faced by the United States population. In 1984 the reduction of social—including health—expenditures was one of the top three issues in the country about which the majority of Americans expressed concern (Shriver 1984; Altman 1985). This clarification bears repeating in light of the existing "dichotomy" between the middle class and the poor. This dichotomy seems to indicate that the problems of the poor are of a different type than the problems of the middle class. They are not.

The third point of clarification is that this interest-group type of behavior weakens the whole of the class. Witness how vulnerable labor is today to the current antilabor avalanche from the class of employers usually referred to as the business community. One result of this weakness is that one of the most prevalent health-cost-control measures among employers has been to increase the coinsurance and deductibles

among employees, which is frequently accompanied by the establishment of two layers of benefits, one for the already employed and another for the newly employed (*Medical Benefits* 1986b). These two layers of benefits weaken considerably the class solidarity among workers.

The fourth point of clarification is that the institutional structures that have arisen in the implementation of work-related benefits have strengthened a set of private vested interests that present great resistance to change. For example, the growth of private work-related benefits among the employed population is partially responsible for the growing dependency of life insurance companies on health insurance premiums. As L. Root (1985, 114) has indicated:

The income of life insurance companies has become increasingly dependent upon health insurance premiums and, to a lesser extent, upon retirement funds. In 1960, life insurance premiums accounted for 52.2 percent of the income of the 1,441 life insurance companies then operating. At that time, health insurance represented less than 18 percent of income, and annuity considerations only 6 percent. Twenty years later, life insurance premiums were only 31 percent of income, while health insurance and annuities contributed 40 percent—22 percent and 18 percent, respectively.

The life insurance industry has been one of the major forces lobbying against the establishment of a national health program in the United States (Navarro 1976, 151).

## Class, Taxes, and Health Legislation

United States labor has not always followed corporatist or interest group practices. The most important elements of social legislation—the New Deal—responded to the class practices of American labor. The New Deal (e.g., Social Security) benefited, for the most part, the majority of the working population. It was an enormous working-class mobilization that forced the establishment of the New Deal (Milton 1982; see also Huberman 1947, 351). Needless to say, other sectors of the population, such as farmers and small entrepreneurs and even sectors of the capitalist class (particularly the supporters of capital intensive industries) also benefited from these New Deal programs. It bears repeating that the New Deal did benefit the whole of the

working class, rather than just one segment. The programs were the result of class pressure and the establishment of the New Deal strengthened that class (e.g., a worker can stand up to his or her employer better with unemployment insurance than without it).

The breaking of class into interest-group behavior (that occurred primarily in the 1950s) explains why social legislation after the 1950s took place as a response to sectors of the working class (the Great Society type of programs) rather than to the whole class. (The United States welfare state includes two types of social programs: (1) non-means test programs that benefit the majority of the working population [e.g., Social Security], and (2) means test programs that benefit specially vulnerable sectors of the population [e.g., Medicaid]. The majority of the New Deal programs correspond to the first type of programs while the majority of the Great Society programs correspond to the second type. Medicare corresponds more to a New Deal type of program than a Great Society one. It is non-means tested and benefits the majority of the working population since the majority will age and become elderly.)

During the last forty years the expansion of social expenditures has affected both types of programs, although the overwhelming growth of these expenditures has been in New Deal or non-means test types of programs. (Only 8 percent of all federal social expenditures are of the Great Society variety. Charles Murray in his *Losing Ground: Social Policy 1950–80*, refers to the assumed failures of the Great Society type of programs—a minority of social programs—to support his policy conclusion of eliminating the majority of social policy interventions by the federal government. For a detailed analysis of the success of the Great Society type of programs see Schwarz 1983.) As I have shown elsewhere, there has been undiminished popular support for both types of programs, although support for existing New Deal programs is higher (95 percent of the people) than for the Great Society programs (68 to 72 percent, depending on the program) (Navarro 1985b).

These programs are funded primarily with taxes paid by wage and salary earners. Table 2 records that while income taxes and, in particular, social security taxes (as a percentage of all taxes) increased during the period of 1960 to 1984, corporate taxes declined dramatically (and, in particular, during the Reagan administration, which halved them in its first four years).

TABLE 2  
Sources of Federal Revenues, by Percentage

Fiscal year	Individual income tax	Social insurance tax	Corporate income tax	Excise, state and other
1960	44.0%	15.9%	23.2%	16.8%
1965	41.8	19.1	21.8	17.4
1970	46.9	23.0	17.0	13.0
1975	43.9	30.3	14.6	11.3
1980	47.2	30.5	12.5	9.8
1984 (est.)	44.8	36.8	7.8	10.5

Source: Adapted from table 6.4 in Edsall 1984, 212.

The shift of revenues becomes even more significant when we analyze the increased differentials in taxes paid between wealthy and nonwealthy income earners (Kuttner 1984, 53):

Between 1953 and 1974, direct taxes paid by the average income family doubled, from 11.8% of income to 23.4% of income, while the tax burden of a family with four times the average income went from 20.2 percent to 29.5 percent, an increase of less than half. Between 1969 and 1980, social security taxes applied to only the first \$37,700 of wages; the major portion of this increase was on the non-wealthy. During the same period, corporate income tax collections fell 14 percent, and capital gains rates were cut by 20 percent.

This shift of fiscal responsibilities is justified by conservative forces by the need to stimulate capital investment. The benefits for the corporate class, it is claimed, will eventually trickle down to the rest of the population. Even on its own terrain, however, this argument does not hold much credibility. The United States was one of the low-performance economies in the 1970s in spite of very low tax burdens on capital (far lower than in Japan and West Germany, defined as good performance economies, which had the highest and second highest reliance on capital taxes) (Kuttner 1984, 187).

In summary, the point that needs to be emphasized is that federal expenditures (including health expenditures) are based on taxes coming from labor rather than from capital, i.e., the welfare state is paid for

to a very large degree by the working population. Here, it is important to clarify a much debated and misunderstood issue: the overall level of taxation. It is true that the total United States tax level is relatively low compared with other countries. In 1974 it was 27.5 percent of the GNP, placing the United States 14th out of 17 major industrial capitalist nations. Only Switzerland, Japan, and Australia had lower overall tax levels. But, if instead of looking at overall levels one focuses on levels of taxation by occupational groups, it then emerges that for an average production worker the United States ranked 8th highest in the tax burden (Kuttner 1984, 190). The American tax system is indeed highly regressive.

This regressiveness is further highlighted if we look at what the average citizen gets in return for his or her taxes. The average European gets more from government than does the United States citizen. For the most part, the European citizen gets free or almost free health care (very low out-of-pocket expenses), generous family allowances, and better unemployment insurance, pensions, and disabilities than his or her American counterpart, as well as many other social benefits that increase individual income. The United States welfare state is underdeveloped compared with western Europe. In the health sector, for example, the United States citizen still pays 27 percent in direct costs compared with 8 percent in Sweden, 5 percent in Great Britain, 12 percent in West Germany, and 19 percent in France (Maxwell 1981, table 4.1). And no other country among Western industrialized nations has 38 million inhabitants (representing 16 percent) uncovered by any kind of insurance (*Medical Care Review* 1984). Fifty-six million people under the age of 65 are either uninsured for health care during the entire year, uninsured for a part of the year, or significantly underinsured (Farley 1985). For the 30 million people over the age of 65, Medicare covers only 49 percent of total health care costs, costs which average \$4,200 per year (*Washington Report on Medicine and Health* 1985, 1986). The average American taxpayer gets comparatively little from his or her taxes. A large percentage of taxes goes for military expenditures that return very little economic benefit to the average citizen. In 1983, government health expenditures represented only 4.5 percent of the GNP in the United States, compared with 8.8 percent in Sweden, 6.6 percent in West Germany, 6.6 percent in France, 6.2 percent in Canada, and 5.5 percent in the United

Kingdom (OECD Directorate for Social Affairs 1985). In brief, the average American taxpayer pays more and gets less back than his or her counterpart in other developed industrialized countries.

This measure of regressiveness explains why the average citizen feels under a heavy tax burden and strongly opposes increasing taxes. People are against increasing taxes because they are not getting much in return. But (and it is an extremely important but), they are willing to pay higher taxes if they are assured that they will benefit from them. This explains why: (1) Social Security taxes (the taxes that have increased most rapidly in the last ten years) are the least unpopular taxes (Peretz 1982); (2) the majority of Americans would be willing to pay higher taxes if they could be assured that those revenues would pay for health services (such as a national and comprehensive health program) from which *all* citizens would benefit (Navarro 1982). People are not willing to increase taxes, however, to resolve the deficit problem. Their anti-tax sentiment is highly selective. Thus, it is wrong to state, as is frequently done, that people are against paying taxes. How people feel about paying taxes depends on what they will get in return. It is as simple and logical as that; and (3) there is more support for New Deal types of programs (aimed at the whole population) than for Great Society programs (aimed at specific populations).

In brief, the average United States citizen is getting less in return for his or her taxes than the average citizen in major western European countries, a situation that is in large degree explained by the highly skewed nature of the tax system of the United States (falling heavily on the middle- and low-income levels of the working population) and by the large proportion that military expenditures represent within federal government expenditures. Since social expenditures are, for the most part, financed by taxes imposed on the working population, these transfers of government funds have not had a redistributive effect from the capitalist class to the working class. Rather, there has been a redistributive effect within the working population, with some sectors of the working class paying for others. This situation explains why Great Society programs have been somewhat less popular than New Deal types of programs. They have frequently been used to divide the working class, pitting whites against blacks, men against women, young against old, the middle-income families against low-income families, and so on. The identification of the Democratic party

with the Great Society (e.g., Medicaid) rather than the New Deal (e.g., Medicare and Social Security) has contributed to the weakening of the popularity of the party. As Edsall (1984, 39) has written,

The two tiered structure of social programs has functioned in practice to divide the working class Democrats from poor Democrats. . . . The formulation of mechanisms to reduce the divisions between these two sets of programs, if not to integrate them, remains essential to the Democratic Party if it is to lessen this conflict within its own constituencies.

In summary, the electoral history of the United States shows that the Democratic party has been more popular in periods when it has been perceived as the party of the entire working population, not just the party of its different components or interest groups. (The main reason given by Democrats in the summer of 1985 to explain why “they considered themselves Democrats” was that “the Democratic Party is the party of the working people.” And 80 percent of voting Democrats who did not vote in 1984 for Mondale indicated that “if Mondale were more of a strong Democrat like JFK or FDR who’d fight for working people, I’d be more inclined to vote for him” [poll results quoted in Fingerhut 1985, 25, 23].) One of the most popular Democratic administrations in the United States was the New Deal administration. Under the New Deal, the working population fought for and won Social Security, the Work Projects Administration, the National Labor Relations Act, and an enactment of a system of progressive taxation (low for the working class and high for the wealthy)—all programs and interventions that actually or potentially benefited the whole working population. One of the missing pieces was a national health program, dropped by New Dealers because of opposition from the insurance industry and the medical profession. It bears repeating again that the Democratic party has been most popular when it has been perceived as committed to the expansion of social expenditures that would benefit the whole working population. (Contrary to widely held belief, Ferguson and Rogers [1986, 35–36] have shown that the weakening of the Democratic party’s commitment to the New Deal was partially responsible for their defeat in the 1980 and 1984 Presidential elections.) In brief, class practices with a demand for programs that benefit the majority of the population rather than interest group



practice is what has put Democrats in power. Let me stress here that this situation is not unique to the United States. Countries such as Finland and Sweden, where parties are perceived to have clear class practices, have higher rates of electoral involvement, higher voter turnout, and more extensive welfare states than countries that do not have these practices. Indeed, Edsall (1984, 146) and Korpi (1983, 39) have shown that societies (such as Sweden) in which the political and economic instruments of labor are perceived as class instruments have less income inequality between the top and the bottom layers, a higher percentage of the GNP allocated to social expenditures, and a higher level of overall progressive taxation than those countries where labor is weak and does not follow class practices (such as West Germany, France, and the United States). Similarly, the first group of countries has higher coverage for health services, a smaller for-profit sector in the health sector, and less out-of-pocket expenditures in the health sector than the second one (Navarro 1985c). Table 3 records this situation for two countries at opposite poles, Sweden and the United States. In Sweden, labor follows class practices, with (1) a central labor federation that defends the interests of all sectors of labor and bargains centrally and collectively, (2) 88 percent of the working population unionized, and (3) a major political party, the Social Democratic party, that sees itself primarily (but not exclusively) as a working-class party. In the United States, labor follows a corporatist practice with (1) each union defending the interests of its own constituency, (2) 18 percent of the working people unionized, and (3) no parties with congressional representation that define themselves as working-class parties.

It is in those countries in which class practices within the working class do not exist and in which labor operates as one more interest group (highly divided into different subgroups, each one looking out for its own), that we also find a depoliticization of the population, with low voter turnout and a fragmentation of politics (Edsall 1984, 197). This is precisely what is happening in the United States today.

The lack of polarization of American politics and the conventional wisdom that parties have to move to the center to attract the middle class are producing a depoliticization of American life, with increasing disenchantment toward the two major political parties. In 1980, between 60 and 70 percent of the population (depending on the problem area) indicated that it did not perceive much of a difference

TABLE 3  
The Consequences of Labor Practices in Social and Health Policy: Sweden and the U.S.

Labor practices	Average turnout in national elections 1965-80 (percentage)	Income inequity* (percentage)	Public social expenditures as percentage of GNP	Tax revenue as percentage of GDP	Uninsured population (percentage)	Size of for-profit sector** (percentage of total health expenditures)	Direct out-of-pocket (percentage of total expenditure)
Sweden	90%	28	33.8%	44.0%	0%	17%	8.4%
U.S.	56	38	14.2	31.5	16	44	27.1

\* The higher the number, the larger the disparity in income between the top 20% and the bottom 20% of the population. The index represents the difference between the proportion of income earned by the top 20% and the bottom 20%.

\*\* For-profit sector includes payments to physicians and others in private practice or working as independent contractors, to pharmaceutical companies, and to other medical and hospital suppliers. The figure for the U.S. is the lowest within a range estimated by R.J. Maxwell. Sources: Cameron 1981; Magasiner and Reich 1982; Maxwell 1981, tables 4-1 and 4-2; Organization for Economic Cooperation and Development Directorate for Social Affairs 1985; Korpi 1983, 56.

between the two major parties (Ladd 1985, 223). The weakening of the New Deal commitments in 1984 (e.g., the Democratic party did not include a commitment to establish a national health program) also led the *New York Times* (1984) to editorialize that the programmatic differences between the two parties were uncomfortably narrow. It is not surprising then that, in 1980, 40 percent of Americans defined themselves as Independent, followed by 37 percent as Democrats, and 24 percent as Republicans (Ladd 1985, 222), a considerable increase in the number of Independents and dramatic decline in both Democratic and Republican party adherents. A similar situation has been reported by T.J. Lowi (1985) for 1984 (also Zald 1985). More than a realignment, what we have seen in the United States is a dealignment from the two major parties. The similarity between the two parties has also led to an increase in the number abstaining from electoral politics. The United States has the highest abstention rate in the Western world (Manatos 1984); 50 million eligible citizens did not register in 1984 and 35 million of those who registered did not vote. Another characteristic of American politics is that the working class votes less than the other classes. In 1980, 77 percent of white-collar professionals voted compared with only 44 percent of blue-collar workers. This class abstention hurts the Democrats more than the Republicans (Edsall 1984, 184), since the working class tends to vote more Democratic than Republican, and nonvoters tend to be more progressive than voters. Workers support larger social expenditures in larger percentages than do employers (Wolfinger and Rosentone 1980, 109–10). The declassing of American politics and the absence of class polarization, together with the recycling of politics through interest groups, has thus led to depoliticization and abstention, particularly among the lower echelons of the working class that do not see much meaning in their electoral participation.

In the United States, union membership (an important but not exclusive component of class practice) climbed from 3.8 million in 1935 to 10.2 million in 1942 (the largest growth of union membership took place during the New Deal years) and continued growing until the late 1950s (Troy 1965, table 1; cited in Root 1985, 104). It was after the anti-working-class legislation (the Taft-Hartley Act) that union membership started declining, a process that has been further accelerated during the Reagan years. This decline is not unrelated to the “interest group” practices followed by labor, also responsible for

the decline of electoral participation that has occurred since the late 1950s in the United States. Since 1960 the percentage of nonvoters among the adult population has increased from 37 percent to 47 percent in 1980. During this period the level of popularity of the New Deal type of programs has not declined, not even during the Reagan years of 1981 to 1986. But the level of support of the Democratic party among its supporters has declined (Ferguson and Rogers 1986, 3–39; Abramson, Aldrich, and Rohde 1986, 122–24). This weakening of support is not unrelated to a weakening of that party's commitment to the New Deal.

As I indicated before, this relation between class practices and electoral participation is not unique to the United States. The international experience shows that political diversity and class polarization is a condition both for active democratic participation and expansion of the welfare state. The further expansion of the welfare state, centered around the New Deal, has as a prerequisite the political polarization of the Democratic party and the development of class practices.

### *An Example of a New Deal Program: A Comprehensive and Universal Tax-based Health Program*

Let me give an example of what I mean by this emphasis on a New Deal program. There is today a large problem in the health care sector of the United States. By whatever health indicator one can think of (infant mortality, low birth weight, life expectancy, etc.), indicators in the United States do not compare favorably with those in other developed industrialized countries. And the situation is deteriorating in many important areas. For example, the decline of infant mortality has slowed down since 1981 (Shapiro 1984). This is a result, among other factors, of the 1979 to 1982 recession and of the reduction of social expenditures, a reduction that affected primarily but not exclusively the low-income groups within the working class. Those cuts were carried out with bipartisan support, following a nonexistent popular mandate. This reduction of social expenditures further increased the number of people who did not have any form of private or public insurance coverage. This problem also affected the majority of the population that did have some form of coverage, since the most common form of coverage is not comprehensive and still requires substantial payments by the patient.

These major problems explain why people in the United States want to see changes in the health sector. In 1983, 50 percent of polled Americans indicated that “fundamental changes are needed to make the health care system work better” and another 25 percent felt that “the American health care system has so much wrong with it that we need to completely rebuild it.” These percentages increased in 1984 to 51 percent and 31 percent respectively (Louis Harris and Associates 1985; Schneider 1985).

If the United States does not have a national health program it is not, as Victor Fuchs (1986, 269) wrongly indicates, because Americans do not want it. Nor is it because, as Reinhardt has indicated (Reinhardt and Relman 1968, 8), we Americans face a moral crisis, “an apparent unwillingness of society’s will to pay for the economic and medical maintenance of the poor.” (Reinhardt assumes, as many others do, that whatever occurs in federal health policy is the outcome of people’s wishes. This assumption perceives the American political system as fully responsive to people’s wishes. This assumption ignores the accumulated evidence that shows that popular opinion is not always the determinant of federal executive and legislative behavior.) Actually, in a 1984 ABC News-*Washington Post* poll, an unprecedented 75 percent of the respondents indicated that “the government should institute and operate a national health program,” a demand preferred by the majority of the American population for the last fifteen years (Schneider 1985; Navarro 1982).

Nor is the absence of such a program due to lack of resources; the United States spends 10.8 percent of the GNP on health services (Gibson et al. 1984). The problem is in the channels (i.e., the institutions) through which those resources are being spent. Indeed, the problems of insufficient coverage and high costs are rooted in the private, for-profit character of American medicine. An international analysis of health services shows that those countries with government control of the funding and administration of health services have better coverage, lower costs, and better distribution of health resources than those countries that have large for-profit private sectors in the health services—such as the United States (Navarro 1985c).

Meanwhile, this unfinished business of the New Deal—the national health program—continues to be wanted by the majority of the population, to the extent, I repeat again, of their being willing to pay even higher taxes. The issue, however, is not higher taxes for the

working population. It is the fact that the majority of working people (the social group with a heavier tax burden) are willing to pay even higher taxes, which shows how much they want that program. Yet, the establishment of such a program should not be based on further taxation for that sector of the population. The funding of a comprehensive and universal health program could be based on different but highly popular interventions:

1. Changed priorities within the health sector, not only through incentives but also active government interventions. The current reliance on highly technological medicine is neither good medical care nor good health care. Although high-technology curative medicine has a role to play, it should not be the dominant form of intervention. For example, the state of North Carolina has about the same number of deliveries per year as Sweden, but twice as many low-birth-weight babies and neonatal deaths, due to poverty and malnutrition. In 1978 and 1979 there were only 30 ventilator-equipped neonatal intensive-care-unit beds in Sweden compared to 60 or so in North Carolina, where even further expansions are now proposed (David and Siegel 1983). It would be cheaper and more humane to provide food and other social services rather than curative technology. The *laissez-faire* approach to medical care enables and stimulates a sophisticated technological approach to medical problems, but does not serve well a broadly based preventive approach capable of diminishing both the problems and the need for expensive technology. In summary, there is a need to shift the priorities away from hospital, curative, personal, and highly technological medicine toward preventive, community, environmental, occupational, and social interventions. This shift of priorities will not occur by continuing reliance on the for-profit private sector; it requires an active government intervention and active popular participation.
2. A shift of resources within the public sector, away from the military and back to social expenditures, reversing a trend that threatens the survival of the United States population. According to the 1986 Reagan budget proposal, the military budget will have further increased by a staggering 239 percent over the 1980 level by the year 1990. These funds are spent, in official rhetoric, to make American children more "secure" from external

enemies. Meanwhile, from 1980 to 1985, during the Reagan administration, more American children died from poverty than the total number of American battle deaths in the Vietnam War. It is estimated that, until 1990, 22,000 American babies will die per year because of low birth weight. Poverty is the greatest child killer in 1985 in the affluent United States. None other than President Eisenhower indicated that "the problem in defense is how far you can go without destroying from within what you are trying to defend from without" (Children's Defense Fund 1985). Here again, we find that Americans do support the reversal of this trend, with the shifting of resources from military to social and health expenditures. The level of popular support for health and social expenditures is much, much higher than the level of support for military expenditures (*Washington Post-ABC News Poll* 1985).

3. Increases in the level of taxation of the corporate class and upper-middle class, a level that has declined dramatically and is even imperiling the functioning of the American economy. The overall size of tax cuts aimed at the corporate class was \$220 billion in 1984 (*UAW Washington Report* 1981). The entire federal cost of a comprehensive health program was estimated by the Carter administration to be \$20 billion for 1984, less than 10 percent of the revenues lost to the federal government because of tax cuts for the corporate class (U.S. Department of Health and Human Resources 1974). A comprehensive health program has to be redistributive, based on authentically progressive revenues. It should increasingly rely on general revenues rather than Social Security taxes, which would also allow for shifting revenues among sectors. This situation is particularly important in light of the demographic transition, which is usually presented as a major reason for the rise of health expenditures. To have more elderly means to have more health consumption. The absolute and percentage growth of the numbers of the elderly is presented as one of the reasons for the crisis in the Western systems of health care. Due to the repetitiveness of this argument, let me clarify two points. First, the enormous growth of expenditures in the federal program for the elderly—Medicare—for the period 1978 to 1982 was not caused primarily by an increase in the numbers of elderly. The major cause of that growth of expenditures

was price inflation, i.e., price inflation of hospital and medical services that benefits providers and suppliers but not the patients. Second, the same demographic transition leads to fewer young people, with a freeing up of public funds for education, transportation, and recreation that could be shifted to health services. For example, the Organization for Economic Cooperation and Development (1985) secretariat has shown that, in the seven major industrialized countries, the estimated saving for public education due to the demographic transition could ensure a 0.7 percent annual growth of real social expenditures until 1990, more than sufficient to cover the expanding demands of the elderly in health services.

4. Government funding and administration of the health care services and institutions, with active worker and community participation in the running of these institutions. Himmelstein and Woolhandler (1986) have documented the ideological biases of most cost-control measures that are being researched in the United States, and that are being implemented by the American government. A majority of these measures involved a cut of benefits to the working population. A progressive agenda will have to focus on cost controls that enlarge these health benefits and further empower the patient and potential patient population, i.e., the citizenry. These authors estimated that if the United States had had a national health insurance in 1983, it would have saved the population \$42.6 billion annually (\$29.2 billion in health administration and insurance overhead, \$4.9 billion in profits, \$3.9 billion in marketing, and \$4.6 billion in physicians' income). If the United States had had a national health service, the population would have saved \$65.8 billion (\$38.4 billion in health administration and insurance overhead, \$4.9 billion in profits, \$3.9 billion in marketing, and \$18.6 billion in physicians' income). Complete nationalization of the health services, with nationalization of the drug and supplies industries, would save \$85.3 billion (one third of all health expenditures). And most important, these savings would occur while expanding rather than reducing the health benefits for the whole population (Himmelstein and Woolhandler 1986).

All of the points presented in this article bear repeating in light



of current arguments about the “crisis” of the welfare state and the health and social austerity policies that are being followed, which attribute that crisis to the growth of public expenditures (assumed to be out of control), and which explain and justify those austerity policies as responding to a popular mandate. Evidence presented in this article questions each one of these positions. These policies of austerity respond to the correlation of forces, including class forces, that exists in the United States today. The resolution of the major health problems, such as insufficient coverage and high costs, requires a change in the political practices and assumptions of the two major parties, with further development of the New Deal by the establishment of a national health program. Contrary to what is widely reported, there is, indeed, evidence of popular support for this health policy intervention by the federal government. The creation of such a program depends not only on that popular support but on the practices of the political and economic instruments through which class interests are expressed.

### Appendix note 1

Class is an objective category defined by the position of the individual within the social relations of production. (For an analysis of competing definitions of class see Wright 1985, 17–30.) According to Wright the capitalist class includes those individuals who, by virtue of owning substantial quantities of the means of production need not themselves work. Capitalists own sufficient capital such that they are able to obtain at least the socially average standard of living without working at all—they are able to reproduce themselves and their families entirely on the labor of others. This does not imply that capitalists always refrain from work but simply that they need not work to obtain the socially average standard of living (Wright 1985, 149, 188). They represent 1.9 percent of the United States population. The working class includes the nonskilled wage earner plus the semicredentialed workers and the uncredentialed supervisor. It does represent 60 percent of the United States population. Besides these two polar classes there are other classes, including the class of small employers, the petty bourgeoisie, managers and supervisors, nonmanagerial experts (including professionals), and skilled employees (including school teachers and craft workers, sales persons, and clericals with college degrees and

whose jobs have real autonomy). Middle classes are the nonworking class wage earners (Wright 1985, 187). Regarding the class structure there are two points of clarification that need to be made. One is that this class structure responds to objective and not to subjective conditions. People who objectively are part of the working class may not *feel* part of that class. Another point is that most social (including health) statistics are not collected according to class. Rather, other indicators such as income and education are used as proxies for class. These indicators, however, are not the determinants of class; rather, they are the symptoms of class. Because of the absence of class statistics in the United States, I, too, use income as a proxy for class in this article, in spite of the inherent limitations of such an approach.

## Appendix note 2

I want to clarify that working-class behavior and anticapitalist behavior are two different things. Swedish labor follows class practices that are not anticapitalist (see Navarro 1984a for an expansion of this important distinction). Working-class practices appear when there is (1) one major union formation that unites labor and that sees itself as representing the whole class rather than specific sectors of that class, (2) a high degree of unionization among major sectors of employment, and (3) a major political party that represents labor. The opposite to class practice is “interest group” practice in which (1) each sector of labor defends its own specific interests independently of other sectors of that class and frequently in competition among themselves, and (2) there is not a political party that represents labor. Within the Western world, the northern European countries are the ones in which labor follows more closely class practices while the United States is the country in which labor follows interest group practices (for a further expansion of this point see Korpi 1980; 1983, 39). United States labor has historically followed interest group practices although there have been historical periods (like the New Deal) in which there have been elements of class practices in labor’s behavior, i.e., large sectors of labor were mobilized in support of working class interests and labor was strongly influential in the Democratic Party.

## References

- Abramson, P.R., J.H. Aldrich, and D.W. Rohde. 1986. *Change and Continuity in the 1984 Elections*. Washington: Congressional Quarterly Press.
- Altman, D.E. 1985. What Do Americans Really Want? *International Journal of Health Services* 15(3):514–15.
- Bawden, D.L. 1984. *The Social Contract Revisited: Aims and Outcomes of President Reagan's Social Welfare Policy*. Washington: Urban Institute.
- Black, J.T. 1986. Comments on "The Employed Uninsured and the Role of Public Policy." *Inquiry* 23(2):209–12.
- Blendon, R.T., and D.E. Altman. 1984. Special Report: Public Attitudes about Health Care Costs: A Lesson in National Schizophrenia. *New England Journal of Medicine* 311(9):613–16.
- Cameron, R.D. 1981. *Politics, Public Policy, and Economic Inequality: A Comparative Analysis*. Paper presented at a conference on the Role of Government in Shaping Economic Performance, University of Wisconsin, Madison.
- Children's Defense Fund. 1985. *A Children's Defense Budget: An Analysis of the President's FY 1986 Budget and Children*. Washington.
- David, R.J., and E. Siegel. 1983. Decline in Neonatal Mortality 1968–1977: Better Babies or Better Care. *Pediatrics* 71:531–40.
- Edsall, T.B. 1984. *The New Politics of Inequality*. New York: W.W. Norton.
- Esping-Andersen, G. 1985. Power and Distributional Regimes. *Politics and Society* 14(2):223–56.
- Farley, P. 1985. Who Are the Underinsured? *Milbank Memorial Fund Quarterly/Health and Society* 63(3):476–503.
- Ferguson, T., and J. Rogers. 1986. *The Decline of the Democrats and the Future of American Politics*. New York: Hill and Wang.
- Fingerhut, V. 1985. Misunderstanding the 1984 Presidential Elections: Myths About the Democrats. *Campaigns and Elections* 1:21–28.
- Fuchs, V. 1986. *The Health Economy*. Cambridge: Harvard University Press.
- Gibson, R.M., K.R. Levitt, H. Lazenby, and D.R. Waldo. 1984. National Health Expenditures, 1983. *Health Care Financing Review* 6(2):1–29.
- Harrington, M. 1984. *The New American Poverty*. New York: Holt, Rinehart, and Winston.
- Health Care Financing Review*. 1984. Aggregate and Per Capita National

- Health Expenditures by Source of Funds and of Gross National Product, Selected Years 1929–1983. 6(2):3, table 1.
- Himmelstein, D., and S. Woolhandler. 1986. Socialized Medicine: A Solution to the Cost Crisis in Health Care in the United States. *International Journal of Health Services* 16(3):339–54.
- Huberman, L. 1947. *We the People: The Dream of America*. New York: Monthly Review Press.
- Iglehart, J.K. 1982. Special Report: Report on the Duke University Medical Center Private Sector Conference. *New England Journal of Medicine* 307(1):68.
- . 1985. From the Editor. *Health Affairs* 4(2):4.
- Korpi, W. 1980. Strikes, Power, and Politics in the Western Nations, 1900–1976. In *Political Power and Social Theory*, ed. M. Zeitlin, volume 1, 301–34. New York: JAI Press.
- . 1983. *The Democratic Class Struggle*. Boston: Routledge and Kegan Paul.
- Kuttner, R. 1984. *The Economic Illusion*. Boston: Houghton Mifflin.
- Ladd, E.C. 1985. The Reagan Phenomenon and Public Attitudes toward Government: In *The Reagan Presidency*, ed. L.M. Salmon and M.S. Lund, 221–49. Washington: Urban Institute.
- Lippman, W. 1925. *The Phantom Public*. New York: Harcourt Brace.
- Lipset, S.M. 1983. The Economy, Elections, and Public Opinion. *Tocqueville Review* 21(1):432–71.
- . 1985. Feeling Better: Measuring the Nation's Confidence. *Public Opinion* 8(2):6–9.
- Louis Harris and Associates. 1985. 1983 Equitable Health Care Survey. Washington.
- Lowi, T.J. 1985. An Aligning Election: A Presidential Plebescite. In *The Elections of 1984*, ed. M. Nelson, 278–301. Washington: Congressional Quarterly, Inc.
- Magasiner, I.C., and R.B. Reich. 1982. *Minding America's Business*. New York: Harcourt Brace.
- Manatos, A. 1984. U.S. Voter Turnout: Now World's Worst. *New York Times*, December 1.
- Maxwell, R.J. 1981. *Health and Wealth. An International Survey of Health Care Spending*. Lexington, Mass.: Lexington Books.
- Mechanic, D. 1984. The Transformation of Health Providers. *Health Affairs* 3(1):65–75.
- Medical Benefits*. 1985. Coverage of the Privately Insured Population Less Than Age 65 for Selected Health Services: Percent Insured by Type of Insurance and Industry of Primary Insurance. U.S. 1977. 2(12):1–3.

- . 1986a. Employer Health Care Spending Drops as Percent of GNP for First Time. *3(4):4*.
- . 1986b. Survey of Cost Containment among 861 Corporations. *3(3):1–2*.
- Medical Care Review*. 1984. Number of Uninsured Americans Increases. *41(2):72–73*.
- Melman, S. 1985. *The Permanent War Economy*. New York: Simon and Schuster.
- Milton, D. 1982. *The Politics of U.S. Labor: From the Great Depression to the New Deal*. New York: Monthly Review Press.
- Monheit, A.C., M.M. Hagan, M.L. Berck, and P.J. Farley. 1985. The Employed Uninsured and the Role of Public Policy. *Inquiry* *22(4):348–64*.
- Moon, M., and I.V. Sawhill. 1984. Family Incomes: Gainers and Losers. In *The Reagan Record*, ed. J.L. Palmer and I.V. Sawhill, 317–46. Washington: Urban Institute.
- Navarro, V. 1976. *Medicine under Capitalism*. New York: Neale Watson.
- . 1982. Where is the Popular Mandate? *New England Journal of Medicine* *307:1516–18*.
- . 1984a. The Determinants of Health Policy: A Case Study: Regulating Health and Safety at the Workplace in Sweden. *Journal of Health Politics, Policy and Law* *9(1):137–66*.
- . 1984b. Medical History as Justification Rather Than Explanation: A Critique of Starr's "The Social Transformation of American Medicine." *International Journal of Health Services* *14(4):511–28*.
- . 1985a. In Defense of American People: Americans Are Not Schizophrenic. *International Journal of Health Services* *15(3):515–19*.
- . 1985b. The 1984 Presidential Elections and the New Deal: An Alternative Explanation. Part 1. *Social Policy* *15(4):3–10*.
- . 1985c. The Public/Private Mix in the Funding and Delivery of Health Services: An International Survey. *American Journal of Public Health* *75(11):1318–20*.
- . 1985d. A Response to Conventional Wisdom. *International Journal of Health Services* *15(3):511–13*.
- Nelson, M. 1985. *The Elections of 1984*. Washington: Congressional Quarterly Inc.
- New York Times*. 1984. Happy Days Are Here Again. August 26.
- Organization for Economic Cooperation and Development. 1985. *Social Expenditures 1960–1990. Problems of Growth and Control*. OECD Social Policy Studies. Paris.

- Organization for Economic Cooperation and Development. Directorate for Social Affairs. 1985. *Measuring Health Care 1960–1983*. Paris.
- Peretz, P. 1982. There Was No Tax Revolt. *Politics and Society* 11(2):231–49.
- Public Opinion*. 1984. Social Class. 8(7):21–22.
- Quirk, J.P. 1985. The Economy: Economists, Electoral Politics and Reagan Economics. In *The Elections of 1984*, ed. M. Nelson, 155–88. Washington: Congressional Quarterly Inc.
- Reinhardt, U.E., and A.S. Relman. 1968. Debating For-profit Health Care and the Ethics of Physicians. *Health Affairs* 5(2):8–31.
- Rogers, D.E., R.J. Blendon, and T.W. Maloney. 1982. Who Needs Medicaid? *New England Journal of Medicine* 307(1):13–18.
- Root, L.S. 1985. Employee Benefits and Social Welfare. *Annals of the American Academy of Political and Social Science* 479:101–18.
- Schneider, W. 1985. Public Ready for Real Change in Health Care. *National Journal* 3(3):664–65.
- Schwarz, T.E. 1983. *America's Hidden Success: A Reassessment of Twenty Years of Public Policy*. New York: W.W. Norton.
- Shapiro, S. 1984. Sociodemographic Risk Factors in Infant Mortality and Low Birth Weight. Health Policy Forum, Harvard University, October 15. (Unpublished.)
- Shriver, T. 1984. The Most Important Problem. *Gallup Report* 220–221:28–29.
- Social Security Bulletin*. 1986. Social Welfare Expenditures under Public Programs: Federal Funds as Percent of Total Expenditures, Selected Fiscal Years 1950–1963. 49(2):19, table 5.
- Stallard, K., B. Ehrenreich, and H. Sklar. 1983. *Poverty in the American Dream*. Boston: South End Press.
- Starr, P. 1984. *The Social Transformation of American Medicine*. Cambridge: Harvard University Press.
- Thurow, L.C. 1985. *The Zero Sum Solution: Building a World-Class American Economy*. New York: Simon and Schuster.
- Troy, L. 1965. *Trade Union Membership 1817–1962*. Occasional Papers 92. Washington: National Bureau of Economic Research.
- UAW Washington Report*. 1981. The Winners and the Losers under Reaganomics. 21(33):2–3.
- U.S. Bureau of the Census. 1984. *Money, Income and Poverty Status of Families and Persons in the U.S., 1984*. Washington.
- U.S. Congressional Budget Office. 1984. *Staff Memorandum: The Combined Effects of Major Changes in Federal Taxes and Spending Programs since 1981*. Washington.
- U.S. Council of Economic Advisors. 1984. *1984 Economic Report to the President of the Council of Economic Advisors*. Washington.

- U.S. Department of Health and Human Resources. 1974. National Health Insurance: Working Papers, Volumes I and II. Office of Assistant Secretary for Planning and Evaluation. Washington.
- U.S. President. 1985. *Economic Report of the President, 1985*. Washington.
- Walsh, W.B. 1985. Publisher's Letter. *Health Affairs* 4(2):3.
- Washington Post*. 1985. *Washington Post-ABC News Poll*. January 20.
- Washington Report on Medicine and Health*. 1985. July 22.
- . 1986. March 31.
- Wolfinger, R., and S. Rosentone. 1980. *Who Votes?* New Haven: Yale University Press.
- Wright, E.O. 1985. *Classes*. New York: Verso.
- Zald, N.M. 1985. Political Change, Citizens Rights, and the Welfare State. *Annals of the American Academy of Political and Social Science* 479:48–66.

---

*Address correspondence to:* Vicente Navarro, M.D., D.M.S.A., Dr. P.H., Professor of Health Policy, School of Hygiene and Public Health. The Johns Hopkins University, Hampton House, Fourth Floor, 624 North Broadway, Baltimore, MD 21205-1901.