

States, Power, and Societies



POLITICAL SOCIOLOGY SECTION
American Sociological Association

In this Issue

Symposium on the Politics of Health Care	1
Comments from the Section Chair	2
Graduate Horizons	9
Book & Article Abstracts	10
Announcements	11
Call for Submissions	11
Symposium References	12

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Symposium on the Politics of Health Care

Why is the political process of health care reform so contentious? Perhaps it was unreasonable to ask our contributors to offer commentary in the midst of the deliberations. They generously agreed to contribute. Despite writing when the fate of the reform legislation was unclear, the commentaries of Immergut, Quadagno, Skocpol, and Stephens demonstrate the clarifying power of the comparative political sociology perspective. Immergut is persuaded that it was not a flaw in the reform plan itself, or in Pres. Obama's communication about the plan, but the political institutions. Quadagno reviews the role of

vested interests over time to highlight the distinctness of the 2010 political configuration. Skocpol reminds us that Obama's agenda encounters obstructionism; not because it proposes new federal spending, but because it proposes to redirect spending from previously privileged groups; groups that have leverage with all party leaders. Stephens' 30-year intellectual journey through the terrain of comparative social policy reexamines the explanations for the likelihood of nations successfully fashioning social policies. (Schwartzman)

The Rise of the Phoenix: Health Care Reform 2010

Jill Quadagno
Florida State University

As a candidate for president, Barack Obama promised to make health care reform his number one domestic priority. To some critics this promise seemed like folly. After all, there were numerous other pressing national needs – wars

in Iraq and Afghanistan, the largest budget deficit in history, historic levels of unemployment, and billions lost in pension savings and housing wealth. Yet poor economic conditions and wars have not deterred other presidents from embarking on ambitious social initiatives. The crowning
(Continued on page 3)

Turning the Ship of State: Why Obama is Having Such a Hard Time

Theda Skocpol
Harvard University

When Barack Obama won the 2008 election even as larger majorities of Democrats took office in the House and Senate, many observers believed the country might be on the verge of a "New New Deal," as TIME magazine put it in a

post-election cover story. Obama and the surging Democrats would take office with Americans of all parties turning sour on Bush and the Republicans, and amidst a deepening economic downturn. Obama had campaigned on using government powers actively to encourage "bottom up" economic growth and
(Continued on page 4)

The Politics of the Obama Health Reform, or, It's the Veto Points!

Ellen M. Immergut
Humboldt University Berlin

The Obama health reform places many of the perennial issues of the American welfare state on the table, once again. Is the American welfare state doomed to be an 'exceptional,' welfare state 'laggard'? Is there a separate or 'hidden' American welfare state? Is American politics anathema to any form of social democratic social policy?

President Obama has been criticized for not communicating the benefits of his health plan to the American public. This criticism is in my view misplaced, for several reasons. First, looking at the dynamics of American health politics from a comparative, historical perspective, we don't find much evidence from abroad of citizens actively pushing for national health insurance, or being educated by political leaders to support such public plans. Instead, many national health plans date from pre-democratic

periods or authoritarian regimes; some examples are: Germany at the end of the 19th century; Spain under Franco; Italy under Mussolini, and occupied Belgium and the Netherlands. Furthermore, most democratically-enacted plans were generally introduced by a top down political process, rather than as a reaction to an outpouring of public support for national health insurance. Both the British National Insurance legislation of 1911 and the introduction of the NHS in 1946 entailed high-level party politics and negotiations with medical interests, and the involvement of the general public can in no way be compared to the polls, focus groups and 'tea parties' that characterize democratic politics today. In other countries, 'the public' was represented by fairly hierarchically-run interest associations, such as centralized union movements in Scandinavia. Finally, in the cases in which the general public *was* involved the drafting of national health insurance plans, this involvement has generally been counter-productive. In the heyday of the enactment of the Swedish welfare state, for example, health insurance was delayed just

(Continued on page 5)

Comments from the Chair: Obama's Health Care Plan and Theories in Comparative Social Policy

John D. Stephens
University of North Carolina at Chapel Hill

The political processes of the past year in the United States have clearly illustrated the accumulated knowledge of the past 30 years in the sub-field of comparative social policy, one of my main areas of specialization. I am known as a Sweden or Nordic specialist or more broadly as a comparativist, but in any case not a specialist in American social policy, but my original motivation for studying Sweden was to learn something about solutions for American social problems, particularly poverty and inequality. In the heady days of the late sixties' student movement, it seemed like everyone was interested in social change and my take on it was decidedly reformist: I was a social democrat (yes, you heard it right, I was for demobilizing the working class!). So, I began to study Sweden, that Mecca of social democracy. After I finished my undergraduate work, I spent a year there in 1970-71 and then focused my graduate studies on social democracy in general, and Sweden in particular, spending two more summers and an academic year in Sweden during my graduate studies. I was politically active in DSOC (DSA's forerunner) in this period, organizing a coalition for health care reform, in support of the Kennedy-Griffiths bill (better than the current Obama

plan in my view!) in Connecticut.

At this point in time, the dominant theories in comparative social policy were the logic of industrialism theory (Wilensky 1975), and Hecló's (1974) political learning/social technician approach. Wilensky was very explicit that the logic of industrialism did not explain differences between industrial societies, so Hecló became the point of departure for many of us, but most obviously me, because his 1974 book was a study of social policy development in Sweden and Britain, two countries which I knew very well. Hecló argued that bureaucrats and administrators are most consistently important for policy because they identify problems and frame concrete policies to respond to them. Policies come from "innovators and reformers of new social techniques" (social technicians) "imbedded in a new era of empirical studies and political investigations of social conditions." He explicitly rejected the influence of societal interests and elections. Comparatively, this did not make sense to me (even for the two cases he was studying). I thought that it was not plausible to attribute US policy outcomes to the failures of our bureaucrats and administrators. There must be a deeper explanation.

(Continued on page 6)

Quadagno: The Rise of the Phoenix (continued)

achievement of the New Deal, the Social Security Act of 1935, was enacted in the midst of a deep economic crisis. In the 1960s Lyndon Johnson waged a War on Poverty and enacted Medicare, a program of health insurance for the aged, despite a budgetary crisis and an escalating war in Vietnam (Quadagno 2005). What 2010 has in common with these earlier eras is an acceptance of the role of government as a major actor, a strong emphasis on planning, and a president elected with a wide popular mandate and a commitment to social reform (Lipset 1996).

In the fall of 2009, both the House and the Senate passed bills that to move the U.S. closer to universal coverage. Yet what seemed a certainly in October unraveled in January, when the Democrats lost a special election held in Massachusetts to fill the seat of Senator Ted Kennedy. Ironically, the untimely death of this lifelong champion of health care reform robbed the Democrats of their Senate majority. Then, like a phoenix rising from the ashes, the House Democrats passed the Senate bill, which the President signed into law on March 23, achieving a feat that had stymied other presidents since the 1930s.

Why has it taken nearly one hundred years for major health care reform to succeed and what explains the victory in 2010? Although the Democratic majority in Congress is the proximal cause, the more fundamental causes lie deeper—in American politics, in the structure of the health care system and in U.S. welfare state institutions. A central sociological premise is that policies are not only the product of political conflict but also produce their own politics by creating constituencies with a vested interest in a particular program. In Massachusetts, people 65 and older voted overwhelmingly against the Democratic candidate. In this case, senior citizens feared what proposed cuts to Medicare would mean for them. Their concerns made it easy for opponents of health care reform to convince them that they would lose benefits, even though the bill contained a new long term care benefit. The bill that was signed into law not only provides some financing for long term care but also includes a more generous prescription drug benefit that is likely to dampen opposition among seniors.

What also undermined public support across the nation was the war waged by the biggest opponent of reform, the private insurance industry. Insurers vehemently opposed a public option, which would offer an alternative that could out-compete private insurance on price and quality (Harwood 2009). The insurance industry launched a campaign on Capitol Hill against it, grounded in a study published by the Lewin Group, a health policy consulting firm that is owned by one of the largest insurers, UnitedHealth Group. Leading insurers, including UnitedHealth, urged their employees around the country to speak out. Company "advocacy hot line" operations and sample letters and statements were made available to an army of industry employ-

ees in nearly every congressional district. When members of Congress home for the August recess held town hall meetings, boisterous critics mobilized attacks on the as yet unspecified plan, reinforced by conservative radio talk show hosts. Some insurers supplemented the effort with local advertising, often designed to put pressure on specific members of Congress (Hamburger and Geiger 2009). These attacks undermined public support and sowed confusion. What insurance companies were willing to accept was increased regulation including a ban on pre-existing condition exclusions and lifetime benefit caps. The kicker was that regulation would be acceptable only *if* an individual mandate was included. The mandate coupled with government subsidies would create a vast new market of young, healthy customers. The final bill included stringent regulations on insurers, an individual mandate and no public option.

In 1965 LBJ had little trouble winning Medicare less than six months after he took office because a bill had been in the works since the 1950s, there was little competition in the private sector (private insurers don't want to cover people who might actually get sick) and everyone agreed that senior citizens were a deserving population. In 2010, by contrast, there were numerous groups with a vested interest in existing benefits including states with their vast and expensive Medicaid programs, liberal physician groups that would be satisfied with nothing other than a single payer program like Medicare, the private insurance industry with its deep pockets, workers already covered by an employer plan and Medicare beneficiaries worried about their coverage. Each had its own agenda and its own message. Now the Democratic Party faces the task of explaining to the public what health care reform means to them and winning back its independent supporters. And the benefits to be explained are significant, for President Obama's health care reform means a massive expansion of coverage for low income people -- more than 94% of American citizens will have health insurance coverage. Further, the new regulations will hold the insurance industry accountable for practices that have allowed them to callously refuse to cover people with any health risk. So finally, the U.S. can join the ranks of all the other western, industrialized nations that believe that health care is a right and that every citizen deserves to be insured against the risk of being sick. ■

Skocpol: Turning the Ship of State (continued)

offer greater opportunity and security to the middle class and the poor. He would pay for this in part by asking the wealthy to pay a higher share of taxes.

It took hardly any time at all after the Inauguration for partisan obstruction to take hold. Republicans were shocked and demoralized after the election, but extremist activists set out to delegitimize a popular president, the nation's first African American Chief Executive. And Republican Congressional leaders decided on a course of "just say no," hoping to gum up the works of legislation, prevent Democratic achievements in Washington, and ride popular disgruntlement to victory in 2010 if unemployment remained high. Ideologically, right-wingers attacked Obama as a "socialist" promoting "government take over" of the economy and health care.

Obama chose to forge ahead with both economic recovery efforts and the fifty-year-long Democratic priority of comprehensive health reform. But he kept trying to reach out to Republicans. He and his economic advisors also felt they had to take unpopular economic steps, bailing out Wall Street and the Detroit auto industry—even as they did not spend enough on Main Street to prevent unemployment from rising at an alarming rate. Bravely, Obama decided to proceed with comprehensive health reform, but he did little to explain his efforts to the public and left the legislative definition to slow-moving Congressional committees.

All of this meant that Obama could not and would not draw sharp political lines, even as Republicans vilified and obstructed. The media grabbed hold of a narrative that suggested it was pro-government liberalism versus free-market conservatism.

Meanwhile, though, big government versus the market was not at all what was at issue in the legislative and interest group trenches. The United States long ago committed itself to pervasive and expensive federal intervention in the economy, and so-called "conservatives" in recent years have been just as likely to increase federal spending and use federal regulations and tax breaks as Democrats have been. (They do this while cutting taxes on the rich.) What Obama aimed to do—and it was clearly outlined in his first budget message—was to REDIRECT spending and regulations and tax burdens. In one key area after another, he proposed to withdraw subsidies or tax breaks for privileged business and wealthy interests and redirect the resources toward programs supporting the middle class and lower-

income Americans.

In higher education policy, for example, Obama proposes to withdraw profit subsidies for banks that make loans to college students, substitute more efficient and less costly direct federal loans, and use the major savings to expand Pell Grants to low-income college students. In health care, he proposes to trim tax breaks for generous employer-provided health benefits, and take back profit subsidies to private Medicare insurers, and use those resources to help pay for expansions in Medicaid for the poor and for subsidies to help lower middle income working families buy insurance.

These shifts sound simple enough—and much less apocalyptic than the hue and cry about "socialism" versus the "free market." In a way, that ruckus, promoted by Republican leaders and activists, is beside the point. But what Obama is proposing to do in many key policy areas nevertheless is extremely difficult—above

all because key Democrats in the House and the Senate are thoroughly beholden to the various groups and private interests that have a stake in the old kinds of government interventions.

The groups Obama wants to help tend to be poorer, less educated, younger, and less attuned to politics than the powerful business and wealthy interests, and the vigilant trade unions, that Obama is asking to give up regulatory advantages, tax breaks, or profit subsidies. All those asked to give up existing privileges from interventionist government are able to lobby and spend—they get the attention of conservative Democrats in the House and the Senate. This is especially true in the Senate, where super-majority rules require only a few Democrats to oppose a presidential initiative to block it altogether. Ben Nelson has higher education loan companies in his state; Lieberman and Bayh listen to what private insurers want in health care. And so on.

The President's effort to redirect government therefore gets blocked as much by his own party as by the all-out Republican opposition. Voters see that Washington D.C. is "broken," yet the Democrats appear to be in charge, so who will they blame? Mid-term elections rarely inspire high turnout by the young or the poor or people of color—and these reluctant groups are the ones less likely to see promised benefits when Obama's agenda is blocked.

The story is not yet over for 2010 and beyond. After Scott Brown won the Senate seat in Massachusetts, Democrats in Congress and in the White House finally had to face the fact

(Continued on page 7)

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Immergut: The Politics of the Obama Health Reform (continued)

slightly enough to become embroiled in a 1948 electoral campaign, in which opposition to ‘socialized medicine’ was a key issue. Similarly, in Switzerland, the public opportunity to veto national health insurance legislation through a national referendum, gave way to a vitriolic campaign against socialized medicine, explicitly modeled on the American Medical Association’s campaign against the Truman plan in 1948. Thus, the ability of the political opposition to galvanize opposition to national health insurance seems widespread in health politics: plans go through when the politics are top down; once the electoral arena is engaged, opposition seems to escalate.

Second, public opposition is relatively easy to mobilize because, in the end, national health programs represent forced taxation to include the uninsured. This may indeed be a very good idea in terms of health policy. Universal coverage is solidaristic, giving all citizens’ (or, in some countries, even denizens) access to health care, regardless of employment status, age or pre-existing conditions. Universal coverage puts an end to the ability of insurance carriers to exclude bad risks, as all are covered. And universal coverage is an important step to monopsony or a ‘single payer’ situation, which is most effective for containing costs. In the short term, however, it is not that surprising that persons that now have health insurance coverage—and may have paid quite a lot for their insurance in the form of sacrificed wage increases or years of Medicare contributions—can be mobilized to protest against paying for persons that have not provided for themselves. For the uninsured or underinsured, compulsory insurance means an obligation to pay for insurance that may not be affordable. And healthy, younger persons certainly pay more under national health insurance than under private plans. Thus, once national health insurance politics ‘go public’ it is not easy for organizations representing these interests—the AARP, unions, anti-poverty groups and the like—to defend the compromises made at the elite level to get such a massive piece of legislation through. Indeed, the case of Nebraskans protesting their special Medicaid rebate shows how package deals made in more closed arenas unravel when broader publics are involved.

This means that the combination of political institutions and the majorities in them are critical ‘switchmen’ for health politics. As long as the Democratic Party held a majority in the House and a ‘supermajority’ in the senate, neither the House nor the Senate was a veto point. With the bungled Massachusetts election, the supermajority was lost, and the Senate is now a veto point. We can see very clearly how the tenor of the entire health care debate has shifted dramatically between December 25th

2009, when the Senate voted on the bill, and after January 19th when the Kennedy seat was lost to Republican Scott Brown. After the December Senate vote, passage of a health care bill—even if flawed—appeared to be a sure thing. After the loss of the Senate supermajority, the probability of reform has been called into question, and power has shifted to the Senate. Now the Senate plan is the basis for any possible compromise, and the greater weight of private insurance interests in the Senate will leave its mark on the legislation. With this new window of opportunity, Republican opposition is getting stronger, as is ‘public’ opposition.

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Why do I feel it is the political-institutional situation and not the flaws in the Obama plan that is generating the opposition? There are certainly flaws, to be sure. Nevertheless, there is no easy way to ‘fix’ health politics—whether in the United states or even in other countries that have decades of experience with national health insurance.

In order to provide health care to all, either huge sums of money must be spent on health or restrictions must be placed on patients and doctors. None of these options are popular, and it is thus inevitable that those asked to pay the immediate, real cost of reform will protest. The potential benefits lie in the future, and it is well known that voters and interest groups mobilize more rapidly when faced with costs than potential benefits. Unfortunately, health reform has been delayed so long in the United States that the cost of reform is indeed prohibitive and solutions hard to find. Health inflation has raised the price of health services to incredibly high levels by international standards. The rates charged by voluntary, nonprofit plans such as BlueCross and BlueShield are so high as to place them out of the running as the ‘natural’ carrier for a ‘public option’ as was the case in Western Europe. (Contrary to what many Americans believe, most European health plans are not single-payer and are not governmental; instead voluntary non-profit insurance was often used as the basis for public programs carried by private insurance agencies—a bit like the now notorious ‘health alliances’ of the Clinton plan.)

The flaw in the Obama administration’s health plan was not a lack of communication but a lack of speed. Comprehensive health reform is possible only at rare moments within American political institutions. Lyndon Johnson used such an opportunity to pass Medicare and Medicaid (68 seats in the Senate, a solid majority in the House). Bill Clinton did not enjoy the same opportunity, as the Democrats held only 56 seats in the Senate, despite a majority in the House, and thus failed to produce health reform. Now that the window of opportunity for radical reform has been closed, the most should be made of the

(Continued on page 7)

Stephens: Obama's Health Care Plan and Theories in Comparative Social Policy (continued)

In the course of my studies in the 1970s, what did I think I learned about comparative social policy? First, I thought the comparative evidence argued that US social problems were soluble. In American public policy circles, one view, I would say the dominant view, was that US social problems, poverty, lack of educational opportunity for the poor and minorities, and so on, were intractable problems that we were all concerned about but which we had no (easy) solutions to. I thought the comparative evidence showed conclusively that this was not true. Rather, the problem was the political will to do it. Why did we lack that? That was the second lesson I thought I had learned: Because union organization was weak and social democracy non-existent in the United States. Skocpol remarks somewhere that innovators of this theory (what became known as power resources theory - Walter Korpi's term) were all scholars who had studied Nordic, mostly Swedish, politics and that the theory was an attempt to generalize from the Swedish case. That was certainly true in my case, or rather I was trying to generalize from the cases I knew well; Sweden, Britain, and the United States.

The problem for me was that my scholarly conclusions came at the expense of my political aspirations. My theory said that the prospects for social reform were not very good in the United States. So I was open to alternatives. The first one to enter the scholarly debate at this time were a set of arguments by Theda Skocpol and her students (e.g. Ed Amenta, Margaret Wier, Ann Orloff) as part of a broader project by Skocpol and her SSRC funded States and Social Structure group to "bring the state back" into political sociology. They broadened Heclö's bureaucratic autonomy into state autonomy and added state capacity and the "Tocquevillian" effects of state structure, that is, the effects of state structure in shaping outcomes independent of state action. It is particularly the last that had a large effect on our (as I was now working with Evelyne Huber) thinking on comparative social policy (at least of OECD countries, for us, state autonomy and state capacity are quite important for social policy in Latin America, our other region of study). Here we were above all influenced by the work of Ellen Immergut on the development of health care policy in Sweden, France (4th and 5th republic analyzed as separate cases), and Switzerland. Immergut argues that the number of "veto points" in the policy making process retards reform and empowers minority interest groups, like the medical profession, intent on blocking reform. She argues convincingly that the strength and political position of the organized medical profession did not vary across the cases. Rather the veto points in the Swiss political process – passage

The satisfactory scholarly explanations of cross national variation in social policy came at the expense of our political aspirations for reform in the United States

through two chambers with different political composition and then a referendum in which the legislation had to get not only a majority of the voters but also a majority of the cantons – made it possible for the opponents of reform to block it. By contrast in Sweden with the social democrats and the communists with a consistent majority in both houses, a series of reforms culminating in the introduction of publicly delivered health care in the late 1960s passed easily. This argument rings true, of course, for the United States, and Evelyne and I were not surprised that we could demonstrate that a measure of veto points we developed proved to be an important determinant of a number of measures welfare state effort in quantitative analyses we carried out in the 1990s. But, again the satisfactory scholarly result came at the expense of our political aspirations for reform in the United States.

The veto points argument seemed to imply that if the same party or coalition of parties control both chambers, then the veto points could be overcome, and this is in fact what happens in other strongly federal bi-cameral systems, such as Canada, Australia, or Germany. The fate of Clinton's health care plan reminds us that this is not true in the United States. Part of the reason is the super majority requirement in the Senate (another veto point!), but Skocpol and others have argued that it is also due to the absence of disciplined parties in the United States, which they link in turn to presidential rather than parliamentary government. For health care reform, this has been demonstrated most elegantly by Antonia Maioni (1998) in her analysis of health care reform in the 1960s United States and Canada. Like Immergut, she argues that the difference in the outcome cannot be explained by differences in organizational strength or political posture of the medical care profession as these were similar across the two countries. Rather the lack of party discipline in the United States meant that Democratic congresspersons were open to lobbying, political pressure, and financial contributions from the medical profession. By contrast, once the Liberal Party took a position on health care, the individual members of Parliament were not at liberty to vote any other way. What is going on now is just déjà vu except that it is the health insurance industry and not the medical profession. In general terms, Amenta (1998) makes a very similar argument about the effect of lack of party discipline on New Deal and post New Deal reform in the United States. So yet a third time, the satisfactory scholarly explanations of cross national variation in social policy came at the expense of our political aspirations for reform in the United States. ■

Skocpol: Turning the Ship of State (continued)

that they must move some key legislation with bare, partisan majorities in both houses, using "reconciliation" in the Senate wherever possible and writing off many conservative Democratic votes as well as Republican votes. This may let Democrats gain the nerve to shove through some crucial redirections of government effort—toward greater help for the middle class. But privileged interests will use all the media and Congressional levers at their disposal every day from now until November 2010, working above all to keep conservative and moderate Democratic legislators from supporting Obama's priorities.

Will Republicans and entrenched interests succeed in blocking

every major change and send the feckless Democrats to massive defeats, with young and liberal voters staying home while older and conservative voters turn out in record numbers? Stay tuned. It will be a battle for months to come. Whatever happens, the Democrats will lose margins in the House and Senate after November—so whatever they get done soon is likely to be the high point of their achievements in redirecting government in the Obama era. They must do it now, or likely never. ■

Immergut: The Politics of the Obama Health Reform (continued)

majorities that still exist, and the possibility of non-radical reform should not be belittled. Given the tremendous growth in the private for-profit health insurance industry, single-payer and public insurance are unrealistic as goals, and as mentioned, many countries with good public health insurance programs aren't public or single-payer, anyway. Anything that increases universalism is a step in the right direction, as is anything that caps the profits of private insurance and slows the entry of money into the health sector. Many of the plans now under debate—even the Senate version—contain some provisions that would be steps in the right direction. Mandated coverage, expanded access to Medicaid and Medicare coverage, broader options for small businesses and individuals seeking health insurance—including non-profit plans offered by private insurers—all would help. Increasing Medicare contributions for the

wealthy and taxing "Cadillac" health plans can be seen as a sort of 'difference' principle that would allow some inequality in health as long as it benefitted the worst off (by providing tax revenues that could be used for improving their health insurance coverage). A bigger step would be simply phasing out tax deductibility for health insurance—or at least limiting this indirect government subsidy to non-profit plans. This would provide funds for health coverage for the uninsured and slow health inflation. But, at this point, so much momentum for health reform has been lost, that it is hard to say what is now politically possible. No matter how much communication is made to the public, when push comes to shove, what counts are the votes in Congress, and with mid-term elections coming up, these votes are going to be harder to get. ■

Immergut: Post-Passage Reflections

In the aftermath of the House vote on the Obama plan, I would like to take the opportunity to add two short comments to my previous remarks. First, veto points theory does not state that an open veto point makes it impossible to pass social legislation. It simply says that it is difficult, and that because the votes at the veto point are needed, interests relevant to the politicians at the veto point can get concessions in the legislation. Thus, the opening up of the Senate as a veto point after the Massachusetts Senatorial election did not make it impossible to pass legislation. As the Senate had already voted on the legislation, the House bypassed the need for a re-vote in the Senate by accepting the (more conservative) Senate plan. In fact, even if a vote would be needed in the Senate, the veto points theory does not say that the senate would not vote for such a plan, but simply that a) it would be unlikely and b) in order to get the necessary majority, concessions would need to be made to the Senators whose votes were needed. After passage of the bill, the appeal to the Supreme Court by several States is an example of interests—in this case Republican Governors, I assume—attempting to use another veto point to block the legislation.

However, despite my argument that the veto points approach fits the dynamics of the Obama health reform politics quite well, I have also realized that this process demonstrates the merits of other approaches that I did not adequately take into account while writing *Health Politics*. First, as discussed by Evelyne Huber, John Stephens, and Antonia Maioni, the American electoral system with its single member districts puts Congressional representatives under severe electoral pressure. Second, although I called health care a “boundary issue” of the welfare state, I underestimated the emotions that this issue raises in American political culture. I don’t agree with Larry Jacobs that public opinion is the ultimate predictor of health politics, but I do think I did not sufficiently analyse shifts in public opinion or traditions of political culture, along the lines stressed by Odin Anderson, so long ago. Third, as Jacob Hacker has pointed out, the failure to pass health insurance in the past has resulted in such substantial growth of the private insurance industry that insurance opposition in the United States today cannot really be compared to that in Western Europe or even Canada in earlier decades. At the same time, the cost to industry of the fringe benefits that became popular after the failure of the Truman plan may have been a force for corporate support for health reform. Finally, although *Health Politics* was written from an historical

institutionalist perspective, which includes attention to historical contingency and historical context, Carolyn Tuohy is right to point to the importance of contingency in social policy-making. In this case, it appears that without the persistence and commitment of Nancy Pelosi, the strategy of just passing the Senate bill and the marshalling of the votes in the House would never have come to pass. I hope that this political commitment will continue to be string, for with the passage of a health insurance bill, health politics has not ended, but is in a sense just beginning. As we know from the politics of countries with national health insurance systems the politics of health entail continual struggles about the provision of health services, the containment of costs and the distribution of the economic burdens of providing all citizens with access to health services. ■

Graduate Horizons

Sociology within the Political Process: Q&A with Dr. Tomás Jiménez

Welcome to the inaugural installment of Graduate Horizons! The purpose of this section is to introduce aspiring political sociologists to promising new research areas and novel modes of engagement with the polity and the public sphere. We welcome suggestions for future content of interest to graduate students.

We begin with a Q&A session entitled "Sociology within the Political Process" featuring Tomás Jiménez, Assistant Professor of Sociology at Stanford University and Irvine Fellow at the New America Foundation. In 2005, Dr. Jimenez was the American Sociological Association Congressional Fellow in the office of Rep. Michael Honda (D-CA), where he served as a legislative aide for immigration, veterans' affairs, housing, and election reform. Dr. Jiménez's scholarly writings have appeared in outlets such as the American Journal of Sociology, the Annual Review of Sociology, Racial and Ethnic Studies, and Social Science Quarterly, and he has penned editorials for the Los Angeles Times, the San Francisco Chronicle and The San Diego Union-Tribune (GAS).

Graduate Horizons: How did you become interested in communicating sociological knowledge to policymakers and the reading public?

Tomás Jiménez: This is something that I've always been interested in, but I became a lot more familiar with how to do it when I was an ASA Congressional Fellow in the office of US Rep. Michael Honda (CA). I was in charge of, among other things, advising the Congressman on immigration. What was great about the position was that Congressman Honda and his Chief of Staff gave me a lot of autonomy. I took the opportunity to get to know people at major think tanks and other staffers working on immigration reform. That experience taught me how to connect my academic research with policy. The most important lesson that I learned is that academic research may have its biggest influence on policy by generating *ideas*. We often think that generating specific empirical findings will change how policy makers see things. But I think that empirically informed *ideas* about how to approach a particular social problem go a lot further in influencing policy than specific empirical findings. Of course, policy is not just made in Washington. There are lots of ways that academics can influence state and local policies that have a significant impact on people's lives.

Graduate Horizons: How do you select op/ed topics? What do editors look for in an op/ed?

Tomás Jiménez: It's not easy. Most of the op-ed I write are tagged to things that are in the news. I write about immigration, which has been off the news radar, and so I haven't written as much lately. However, some editors will accept pieces that speak to issues of broad public interest, even if these issues are not terribly "newsy." Editors want pieces that are punchy and that express a very specific opinion about something. Writing 700-800 word op-eds does not leave a lot of room for nuance, and editors generally like authors to take a firm stance.

Graduate Horizons: What sort of opportunities are there in the think tank and legislative worlds for sociologists?

Tomás Jiménez: There are lots of opportunities. There is a think tanks for just about every issue out there, and they need researchers. I was amazing at how many PhDs I met during my time in Washington. These people are very smart, and they are always connecting their research to policy issues. The downside is that they don't necessarily get to choose their research questions. The ASA Congressional Fellowship provide an opportunity to see what this world is like. The American Association for the Advancement of Science also has a fellowship for which sociologists can apply.

Graduate Horizons: How have your experiences as a legislative aide and a public commentator influenced your research agenda?

Tomás Jiménez: I like to think that my public commentary is really a translation of social science research - both theory and empirical findings - for a public audience. Much of the time I draw on other people's research to inform my commentary. I think being involved in debates about immigration more publicly has made me think more carefully about how to do research that is relevant to both academics and a larger public. ■

Abstracts

RECENT BOOKS

Gay Seidman. 2009 (2007). *Beyond the Boycott: Labor Rights, Human Rights, and Transnational Activism*. New York: Russell Sage Foundation.

Through a detailed comparison of transnational campaigns in South Africa, India and Guatemala, the study suggests that voluntary corporate codes of conduct and independent monitoring—even when backed by the threat of broad consumer boycotts—may prove a more problematic approach to protecting citizens at work than advocates of 'stateless regulation' might predict.

**Honorable Mention from the ASA's Labor Section in 2008, now in paperback.*

Alberto Testa and Gary Armstrong. 2010. *Football, Fascism and Fandom: The UltraS of Italian Football*. London: A&C Black Publishers.

The Italian soccer *curve* (terraces) including those of the capital city of Rome represent in the 21st century Italy the epicenter of a football supporter subculture inspired by Italian fascism. That a place breathtaking in its beauty and referred to by many commentators as "The Eternal City" is centrally involved in these dynamics should not come as surprise; Rome as the bureaucratic capital of the Italian state was re-born during the years of Mussolini and was to provide the most spectacular backdrop in the celebrations of the fascist regime. Such celebrations are evident today albeit on a lesser scale and mainly in the city's Olympic Stadium which hosts the city's two biggest football clubs AS Roma and SS Lazio. The protagonist of such sentiment and display are known as UltraS, the capital 'S' being our neologism for the neo-fascist oriented fan which differentiates them from the wider hard-core football supporter gatherings which we refer to as ultra.

Despite their presence for some 15 years on the curve the UltraS have been the subject of very limited ethnographic research. This book evaluates the UltraS phenomenon through ethnographic research among two nationally renowned UltraS groups located in Rome – the Boys of AS Roma and the Irriducibili of SS Lazio. Through an understanding of political history, to testimonies of privileged observers and analysis of iconic material artifacts produced by the groups studied, the reasons for the persistence and the transformations that affect this subcultural universe are explored. The logics of their action and their communicative channels are also explored in detail.

The book is essential reading for those interested in both the contemporary attraction of the ideologies of neo-fascism and

the unfinished project that is the pursuit of parliamentary democracy and the modern nation state.

RECENT ARTICLES

Matthias vom Hau. 2009. "Unpacking the School: Textbooks, Teachers, and the Construction of Nationhood in Mexico, Argentina, and Peru." *Latin American Research Review* 44:127-154

This article examines trajectories of nationalism in twentieth-century Argentina, Mexico, and Peru through the analytical lens of schooling. I argue that textbooks reveal state-sponsored conceptions of nationhood. In turn, the outlooks and practices of teachers provide a window for understanding how state ideologies were received, translated, and reworked within society. During the late nineteenth century, textbooks in Mexico, Argentina, and Peru conceived of the nation as a political community, emphasized civilization for having achieved national unity, and viewed elites as driving national history. During the twentieth century, textbooks eventually advanced a cultural understanding of the nation, envisioned national unity to be achieved through assimilation into a homogeneous national identity, and assigned historical agency to the masses. Yet teacher responses to the textbooks varied. In Mexico, under Lázaro Cárdenas (1934-1940), teachers predominantly embraced textbooks that promoted a popular national culture. Teachers in Argentina under Juan Perón (1946-1955) and in Peru and Juan Velasco (1968-1975) largely opposed the texts.

Announcements

CALL FOR PROPOSALS TO ADD QUESTIONS TO THE 2012 GSS

NOTE: We are very sorry for the lateness of this announcement. We delayed this issue because of the health-reform debate (SPS Editors).

The General Social Survey is a nationally representative survey of non-institutionalized adults in the United States, conducted primarily via face-to-face interviews. GSS data are collected every two years, and made available to the research community and the public as soon as possible after data collection is complete. For additional information about the GSS and its study design, please consult the NORC/GSS website: <http://www.norc.org/GSS+Website/>.

Beginning in 2010, the NSF grant that funds the core GSS survey provides support for costs of collecting data for some user-contributed survey items. This represents a departure from the GSS practice (1998-2006) of adding topical modules only if they were accompanied by funding from other sources. Such outside-funded proposals remain welcome, and investigators interested in initiating proposals for outside-funded items should contact Tom W. Smith, the Principal Investigator and Director of the GSS at NORC (smitht@norc.uchicago.edu; phone 773-256-6288).

Proposals submitted in response to this call may advocate inclusion of supplementary GSS content that varies in length, from as little as a single survey question to as much as a topical module of interrelated questions that might require 5 minutes of interview time. Proposals should articulate the scientific objectives that would be met and the specific research issues that the proposer would seek to address using them. Ideally, proposals will include the specific wording of survey items, documentation of their past use and performance in other surveys, and evidence bearing on the quality of data (validity, reliability, item non-response, etc.) they elicit. Demonstrating that items have proved fruitful in past published work, or that their inclusion would contribute to better understanding in key social science domains, can strengthen all proposals. In some cases, however, users may be able only to suggest a general topic area and examples of the topics and types of items that are of interest. Items that have synergies with existing GSS content, or that promise to be of interest to a large number of GSS users, will be of interest.

Proposals submitted in response to this call should be roughly 2-5 pages in length, and should address the following points:

1. The background and the scientific, theoretical, or methodological motivation for inclusion of the topic in the GSS. Proposals for repeated/panel content should

- address the gains to be realized by obtaining data on within-individual change on the subject;
2. The specific topics, and ideally the specific items or questions, that would be included in the GSS, together with any evidence of the quality of the data they elicit;
3. Previous knowledge about the inclusion and use of the items, or items on similar topics, in the GSS or other surveys;
4. The appropriateness of the GSS for the proposed items, and any synergies they may involve with GSS project objectives or existing GSS items; and
5. If questions about multiple topics are proposed, a proposal should indicate the priority assigned to measuring the different topics in the GSS; likewise, if a proposal advocates using multiple items to measure a given topic, it should indicate which of those items are of higher and lower priority for inclusion on the GSS.

The Board and PIs will review and discuss proposals, and notify investigators as to whether or not their proposals were selected for further development. At that point, the Board and PIs may request that investigators provide additional information, and may suggest that separate groups of proposers with interest in similar topics collaborate as part of working groups to develop a topical module. The Board regrets that it can not provide detailed critiques of unsuccessful proposals.

To reiterate, proposals responding to this call should be submitted to Tom W. Smith at NORC (smitht@norc.uchicago.edu) no later than *April 2, 2010*.

Call for Submissions

States, Power, and Societies invites your suggestions and submissions. We would like to publish abstracts of recently published books, articles, or completed dissertations. We also invite your commentaries and suggestions for the symposia. This issue was devoted to commentaries on health policies, but we welcome additional commentaries that might be of interest to our members. We also invite input for our new column "Graduate Horizons." Its purpose is to create a space within the pages of SPS for interests and concerns specific to graduate students.

Please send your comments and submissions to Kathleen C. Schwartzman (polsoasa@email.arizona.edu)

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