How political science can help us solve global health care issues

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Credit: Massachusetts Institute of Technology

Andrea Campbell is the head of the Department of Political Science, and the Arthur and Ruth Sloan Professor of Political Science. Her research focuses on American politics, political behavior, public opinion, and

political inequality, particularly their intersection with critical political concerns such as social welfare policy, health policy, and tax policy. The author of "Trapped in America's Safety Net: One Family's Struggle" (University Press of Chicago, 2014), Campbell served on the National Academy of Sciences Commission on the Fiscal Future of the United States, and has contributed vigorously to the national public debate surrounding health care and insurance.

She is the author of "How Policies Make Citizens: Senior Citizen Activism and the American Welfare State" (Princeton, 2003) and, with Kimberly J. Morgan, "The Delegated Welfare State: Medicare, Markets, and the Governance of Social Provision" (Oxford, 2011). Her research has appeared in the *American Political Science Review*, *Political Behavior*, *Comparative Political Studies*, *Politics and Society*, *Studies in American Political Development*, and *Health Affairs*, among others. She holds an BA from Harvard University and a PhD from the University of California at Berkeley. Her research has been funded by the National Science Foundation, Robert Wood Johnson Foundation, and Russell Sage Foundation. She is a member of the National Academy of Social Insurance and served on the National Academy of Sciences Commission on the Fiscal Future of the United States.

Campbell shared her thoughts on innovation, health care, and equity.

Q: What has your extensive experience as a political scientist taught you that can help us leverage innovations in health care delivery and medical research to make care affordable and universally available? In particular, what kinds of social innovations might we need to support the successful implementation of any technical innovations in health

care?

A: I attended the 2015 MIT SOLVE conference session on leveraging information technology to increase [health](#) care productivity, and the experience raised some interesting questions for me. The speakers noted, as one example, the fact that currently we collect many health indicators only sporadically rather than constantly.

Patients with high blood pressure only have their blood pressure monitored when they happen to go to the doctor's office. Yet, ideal disease management would call for more frequent, even constant, monitoring—particularly if you were trying to detect the conditions under which someone's blood pressure spiked.

The session was a fascinating one from a technical standpoint—how to collect the data; how to manage the enormous amounts of data that would be generated by constant monitoring. But, as a political scientist, my thoughts immediately went to the political and legal challenges, which weren't the focus of the session.

Historically, it was imperative to keep one's health data confidential because of the way medical underwriting worked in the old individual and small-group insurance market: Insurers might deny you health coverage for a pre-existing condition if you applied as an individual; if you worked for a small employer, an insurer might bump premiums up to an unaffordable level for the entire company based on the risk profile of one expensive employee.

The Affordable Care Act bans individual underwriting, but privacy remains a concern. Medical information that is revealed publicly might damage an individual's reputation, or an employer might fire an employee who is battling an illness, fearing absenteeism or productivity loss. The challenge in a world of electronically gathered data is keeping

that data safe.

Q: What economic, sociopolitical, and/or cultural issues do you think need to be addressed to improve health care outcomes?

A: To my mind, any initiative to address health and health care goals must wrestle with and address the enormous disparities that exist in health coverage, access, and outcomes across racial and income groups in the United States. Of course there are huge disparities across the developed and developing worlds—the developing world experiences some 85 percent of the global disease burden, yet 85 percent of all [health care spending](link) takes place in the rich democracies of North America, Europe, and Asia.

This rich world/poor world disparity is relevant for any infectious disease initiative. But the degree of disparity within the United States is astonishingly large and highly relevant for the mental health and cancer initiatives.

Just this winter a group of economists confirmed a trend first detected in Social Security data a couple of years ago: that the disparity in longevity between Americans in the top 10 percent of the income spectrum and those in the bottom 10 percent has grown, from six years in the case of men born in 1920, to 14 years for men born in 1950.

Disparities by race are similarly enormous. Breast cancer survival rates for white and black women were nearly identical in the 1980s; since 1991, the gap has grown, as better screening and treatment became available—for some. It's as if poor or black Americans are living in a different country, and in terms of poverty, health insurance, and health-care access, effectively they are.

If MIT is to make meaningful contributions to cancer and mental health, we must do so in ways that will benefit all Americans, not just the rich and well-insured. This is a political and social problem as much as a technical one.

Q: What barriers do you see to multi-disciplinary, sociotechnical problem-solving collaborations, and how can we overcome them?

A: Political science has much to say about the kinds of economic and political disparities that undermine our ability to meet the great challenges of our time. We study which groups in society are organized, which have voice, and which are represented when it comes to policymaking. We examine the feedbacks between economic and political inequality: how economic inequality undermines the political voice of the poor, which in turn results in public policies that fail to raise them up.

We also study how groups with low levels of politically relevant resources—education, money, communication and organizational skills—can be mobilized to political activity despite these barriers. Hence political science, along with other social science disciplines, is key to understanding the context in which technical solutions are carried out.

I see two main barriers to multi-disciplinary collaboration, both of which I believe we can overcome. First, our disciplines are quite separate and siloed. Younger faculty, who often possess the most sophisticated and effective tools, face incentives to address narrow questions within their disciplines rather than engage in problem-solving across disciplines. We need to reward the latter type of work as well as the former. Second, researchers often have difficulty identifying scholars in other disciplines

with whom they might partner to solve such complex challenges.

Hence, the Department of Political Science is spearheading a new Public Policy at MIT initiative, an information portal that will list faculty and research groups by a searchable menu of public policy areas. The goal for this website—which will launch officially in the fall of 2016—is to help foster interdisciplinary partnerships across the Institute.

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