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Reassessing the Conventional Wisdom: Entitlements from the Inside

Abstract: A family tragedy enables a social policy scholar to examine how American social assistance works from the recipient perspective. The experience results in a reexamination of conventional wisdom around US social policy. In contrast to the revisionist account, meager social assistance programs are still pretty meager. Despite the bifurcation between deserving and undeserving beneficiaries, some deserving populations are swept into catch-all means-tested programs and fare badly. Finally, the experience forces a new look at research approaches to social policy. More qualitative and ethnographic work is needed, as well as examinations of the interactions among multiple programs and their complicated and often contradictory rules.

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Introduction

As a political scientist who has written and taught about American social policy for years, I have recently had the eye-opening and humbling experience of learning how these programs really work. When my sister-in-law was in a car accident that left her a quadriplegic, I thought I would be a great help to her in navigating the complex web of social assistance upon which she now relies. What I quickly discovered was how distant my academic “expertise” is from recipients’ everyday experience (Campbell 2014).

I also discovered that several aspects of the scholarly conventional wisdom about American social policy – even aspects of the revised conventional wisdom – do not ring quite true. Of course we cannot abandon large-N studies or macro-level examinations of program functioning. But looking at social programs from the inside – from the perspective of the lived experience of recipients – yields important findings that these other methods miss. Such a perspective enriches our knowledge of what these programs do and how they shape recipients’ lives, in some instances overturning accepted truths.

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Here I reflect on three aspects of the received wisdom around American social policy. I challenge the new conventional wisdom about the proper way to characterize the American welfare state. This new view says that the line between the generous upper tier of social insurance and the meager bottom tier of social assistance is more blurred than the traditional view suggests. Furthermore, revisionists argue, the lower tier of means-tested programs is fairly robust and generous. I disagree. Although aspects of this new characterization are correct, from the recipient perspective the bad lower tier programs are still pretty bad. Second, I contest the notion that “deserving” beneficiaries are treated better by American social policy than the undeserving. In truth, because means-tested programs tend to be catch-alls serving widely disparate populations, some deserving groups face Draconian program limits and other stringencies meant for the undeserving. Finally, I move beyond these theoretical points to examine how we social policy scholars go about our business. We tend to specialize in specific programs, but what matters from the recipient perspective is the interaction among the web of programs in which they are enrolled. Recommendations for policy change will be more effective if we adopt a multi-program perspective.

Thus we should continue to do the work we do and to capitalize on new data and new research designs and statistical techniques. But we should also regularly look under the hood of these programs and assess them from the recipient perspective. More qualitative and ethnographic work is needed to complement our more technically sophisticated approaches. Pursuing such work will increase our understanding of the programs and better arm us to assess the politics of entitlements and to fight back against some of the more egregious extant proposals for change.

A Revision to the Revision: The Tiers of the Welfare State

Traditionally, scholars have characterized the American welfare state as having two tiers (for examples, see Howard 2007, pp. 27–28). The “upper” tier consists of the social insurance programs, most conspicuously Social Security and Medicare. These programs are typically described as universal, generous, and free of stigma because their benefits are earned by worker and employer contributions, which finance the programs. The “lower” tier consists of the social assistance programs such as cash welfare (AFDC/TANF), Medicaid, food stamps, housing assistance, and so on. These programs target low-income individuals, provide smaller benefits than the social insurance programs, and suffer from stigma driven both by their financing (“unearned” benefits paid out of general tax revenues) and by
their clienteles, who are perceived as blameworthy and personally responsible for their neediness.

**Howard’s critique**

Chris Howard (2007) offers an important critique of this dichotomy, arguing that the line between the upper and lower tiers is considerably more blurred than previous analyses would suggest. Not all of the upper tier programs are so “universal” and generous: most American workers do not qualify for Unemployment Insurance, for example, and the benefits are modest. Nor is funding of the upper tier entirely contributory and “earned”: significant portions of Medicare are funded by general tax dollars, just like “welfare” programs. The recipients of some upper tier programs – particularly Social Security Disability Insurance, which has grown significantly in recent years – are regarded with suspicion, despite the fact that they ostensibly earned their benefits through their payroll tax contributions.

Furthermore, Howard argues, social assistance programs are not necessarily as small and meager as the “lower tier” designation would suggest. The Earned Income Tax Credit, food stamps (SNAP) and other food assistance, and Medicaid have grown tremendously over time in enrollment and total spending. The EITC has proven popular with politicians on both sides of the aisle, a way to supplement the wages of the working poor unobtrusively through the tax code (Howard 1997, 2007). In 1975, just over 6 million tax filers claimed the EITC, rising to nearly 28 million in 2011 (Congressional Research Service 2014, pp. 8–9). The proportion of Americans receiving food stamps increased from 5% in 1972 to 14% in 2011, with a big eligibility expansion during the George W. Bush administration (Congressional Budget Office 2013, p. 17). The majority of public school children now receive free- and reduced- school lunch, thanks to increasing eligibility and schools with high poverty levels simply offering free breakfast and lunch to all students (Southern Education Foundation 2015). Medicaid expanded its reach as well, even before the Affordable Care Act, with state governments and hospitals clamoring for insurance coverage for low-income patients whose care they had to pay for anyway (Rose 2013). Medicaid now enrolls more Americans than Medicare (Centers for Medicare and Medicaid Services 2013; Department of Health and Human Services 2013). It also provides more comprehensive insurance than either Medicare or private health insurance, covering long-term care for the disabled and elderly, and providing vision and dental benefits, depending on the state, which Medicare does not cover. For certain vulnerable groups there is no cost-sharing either (Centers for Medicare and Medicaid Services 2015), whereas cost-sharing is substantial in both private health insurance and Medicare.
Howard’s argument that the bright line between the tiers of the welfare state is not so bright after all is well taken. The lower tier programs are not always small or shrinking; programs for the poor are not always poor programs. Nor are the upper tier programs always universal or robust. These distinctions may apply to Social Security versus AFDC/TANF, but they are less accurate with regard to other social programs.

Means-Tested Programs from the Recipient Perspective

However, my family’s experience shows that although means-tested programs may be faring well on macro-level measures such as overall spending and may be “better” than the traditional description suggests, from the recipient perspective they can be pretty awful. Compared to the social insurance experience, you do not want to be in a means-tested program. Wait lists in some programs and the arbitrariness of provision in others mean that recipients often cannot get what they need even if they are ostensibly eligible. Recipients must constantly re-apply to programs and are subject to monitoring and sometimes reprisal. The income and asset limits that define eligibility impose financial precariousness on the very recipients they are supposedly helping. And family members cannot pitch in financially without rendering their relative ineligible. The experience of recipients with Social Security and Medicare is imperfect, but far better.

One way to evaluate programs is in their adequacy in meeting recipient needs. Although some means-tested programs have grown in size, such as Medicaid and food stamps, others are wait-listed so that “eligible” individuals cannot access them. For example, housing assistance is wait-listed, with public housing projects being bulldozed and only one-quarter of low-income households receiving rental subsidization (Center on Budget and Policy Priorities 2013). The Transitional Assistance for Needy Families program (TANF) covers a shrinking number of the poor, and the program is wait-listed in many states. The federal TANF block grants to the states are set at their 1996 level, not adjusted for inflation. In addition, states have increasingly used these shrinking funds for purposes other than cash benefits, such as marriage promotion programs. The 1996 reform also established time limits on TANF receipt. As a result, cash benefits are unavailable to many of the poor. In the early 1970s, four in five children living in poverty received cash welfare; now four in five do not (U.S. House Ways and Means Committee 2011, Table 7–9). The fact that welfare rolls continued to fall during the Great Recession demonstrates the program’s shrinking relevance.

Beyond basic access, there are other ways in which means-tested programs can be inadequate in meeting recipient needs, which only an on-the-ground
perspective reveals. For example, although Medicaid spending and enrollment are up over time, and despite the fact that it provides more comprehensive insurance than Medicare or private health insurance, it can still fall short when it comes to particularly needy recipients such as my sister-in-law Marcella. Medicaid is the only source, public or private, for the decades’ worth of personal care assistance Marcella needs as a quadriplegic. We are extremely grateful for its existence. Nonetheless, the program has some dramatic shortcomings.

Medicaid provided Marcella with an electric wheelchair, but has refused to supply her with a fully reclining one, even though her physician wrote a request to the program. Thus instead of being able to be catheterized wherever she is, now she must go home every four to five hours to lie flat in bed for catheterization. Medicaid took away the pressure-relieving mattress topper she had when first discharged from rehabilitation, claiming that “she didn’t have enough bed sores” to justify it (now Medicaid will have to pay for the surgical repair of bed sores she gets from the flimsy replacement). Medicaid will pay for catheters, but 30 fewer per month than she needs. Every month she must file a request with her caseworker for the extras; if the request does not get processed in time, she has to pay for them out of pocket. In her state, Medicaid will only cover six prescriptions per month; the others she pays for. One of her prescriptions is in a drug class where the medication available on the Medicaid formulary would be dangerous to her heart; hence she must pay for the alternative out of pocket as well. She must meet all of these extra expenses on the poverty-level income required for Medicaid eligibility. Indeed, when Marcella and my brother Dave moved back into their house after friends and family worked for 2 years to renovate it for wheelchair accessibility (a huge undertaking for which there is no public help whatsoever), her Supplemental Security Income (SSI) cash benefit was actually cut because she and Dave were now under the same roof.

Beyond these benefit limitations is the degrading and time-consuming process of re-proving eligibility for each program. For Supplemental Security Income, Medicaid, two personal caregiver programs (state and county), WIC, and a child care subsidy, Marcella has to re-apply and re-prove her eligibility. This requires marshaling Social Security numbers, birth certificates, my brother’s paycheck stubs, their bank statements, and other documents at intervals ranging from once per year to every 3 months, depending on the program.

Perhaps worst is the financial precariousness that means-tested programs impose on recipients. Because of the Medicaid asset limit in their state (beyond their home and wheelchair van, they can only own $3150 in assets), my brother and sister-in-law cannot have an emergency fund, cannot save for retirement, and cannot save for college using a 529 fund. Every little thing that happens now is a quandary: how to fix the wheelchair van’s ramp, which stopped working? The
repair cost $3000, nearly the sum of their allowed assets (fortunately their tax refund had come in and went straight back out to pay for the repair).

The income and asset caps have plunged the entire family into poverty. Raising a son on a poverty-level income was not really what they had in mind (Marcella was pregnant at the time of the accident; fortunately the baby survived and is unharmed). Nor will Dave ever be able to retire; not only is he disallowed from having an Individual Retirement Account or other personal retirement savings, but also his Social Security benefits are going to be much lower, because he had to reduce his work hours to get his income under Marcella’s Medicaid eligibility level.

For someone like me watching from the sidelines, the cruelest stipulation is that family members are not allowed to help financially. And goodness knows Marcella and Dave need help. The disabled have a variety of higher expenses than the able-bodied (National Council on Disability 2008), and public programs cover them incompletely, not to mention the needs for which there is no public help at all. And yet because the supports the disabled require (particularly personal care) only come in means-tested form in the United States, family members are not allowed to cover the gaps with their own contributions, without that money being counted as income for the recipient and rendering her ineligible for the public programs.

The contrast with our mother’s situation is stark. She is enrolled in the major social insurance programs for older Americans, Social Security and Medicare. She never has to reapply. Social Security is designed to give her the maximum benefit, not the minimum: while our father was alive, she qualified for half of his benefit, which was higher than the benefit based on her own work history; when he died, she got his full benefit. Medicare does not cover everything, but beneficiaries can buy private Medigap insurance plans to meet the cost-sharing and benefit gaps. And most importantly, because these are social insurance programs for all workers rather than social assistance programs for those deemed poor enough, family members are allowed to assist financially. I can help my mother pay her Medigap premiums or household expenses without endangering her program eligibility. But if I were to do the same for my sister-in-law, whose needs are far greater, I could get her kicked out the programs that are so essential.

My family’s experience has taught me that although the old two-tiered dichotomy is not entirely accurate, neither is Howard’s challenge. Yes, spending on means-tested programs has grown over time. Yes, some of these programs provide relatively broad benefits. But my brother and sister-in-law’s trials show the suffering induced by these programs’ strictures. Dave and Marcella would like to have more income – because of their significant extra spending due to her disability, because of the hardships of raising a child at the poverty level – but they
cannot. They would certainly like to have the asset cap lifted, as it leaves them in a perpetual state of financial instability, not to mention an inability to plan ahead, ensure a secure retirement, or save for their child’s education. I would like to be able to help overtly, but I cannot. It’s one thing to look at facts and figures. It’s quite another to witness firsthand what these programs do to people’s lives and spirit.

Thus the lived experience of poverty reveals what the macro-level statistics and figures cannot: that people’s lives are severely compromised by these program restrictions. As social scientists we tend to analyze what can be measured, such as enrollment and spending. I would urge that such macro-level figures must be accompanied by measures of adequacy. Can eligible individuals enroll in programs or are they deterred by wait lists or by caseworkers imposing arbitrary restrictions? Do cash assistance programs bring their incomes above the poverty line? Do health insurance programs provide sufficient access to physicians and hospitals? Do food programs actually relieve their hunger? Assessing adequacy requires us to examine what’s actually happening to the recipients of the programs we study. The combination of quantitative and qualitative assessments will enhance the verisimilitude of our program analyses.

Social Security and Medicare: Worse Than You Think

One established piece of the conventional wisdom is that the big social insurance programs for the elderly, Social Security and Medicare, are universal and generous and meet seniors’ needs well. Perhaps a little too well, in critics’ eyes: they have attracted the attention of reformers worried about the long-term fiscal obligations of the federal government. Hence proposals to change these programs’ structures to save money are a recurring feature of American politics: proposals to shave future Social Security benefits or to privatize a portion of the payroll tax to obscure cuts in defined benefits; proposals to voucherize Medicare and thus limit the government’s liability. Even in Chris Howard’s revisionist account, his challenge to the two-tier bifurcation mostly points to Unemployment Insurance and Workers Compensation as the exceptions to the traditional top tier. And it is true that although these latter two are insurance programs, they do not share the generous benefits or universal coverage that characterizes the upper tier in the traditional typology (benefits are modest and vary by state; many workers are not eligible for the programs; Howard 2007).

However, Social Security and Medicare have their limitations as well. If Marcella had been a socially insured worker – had paid into Social Security and Medicare enough quarters (which she had not, having gone back to school) – she
would have qualified for the Social Security Disability Insurance and Medicare social insurance programs rather than for the Supplemental Security Income and Medicaid means-tested programs. If she were in the social insurance programs, family members could help her without penalty. Depending on her earned income, her SSDI benefit probably would have been higher than her below-poverty SSI benefit.

However, social insurance has its limits – and they are pronounced for the disabled. SSDI payments have a 5-month delay from the onset of disability. For Medicare the wait is even longer – 29 months (a 5-month wait for SSDI, and an additional 24-month waiting period for Medicare). The Medicare waiting period was instituted to save money – the early months of disability are the most expensive – and to prevent people from seeking disability benefits merely to get health insurance. But the gap leaves millions of the disabled without health insurance precisely when they need it the most; many end up on Medicaid in the meantime. Moreover, the disabled are barred from buying private medigap plans to cover Medicare’s high out-of-pocket costs. And because Medicare does not cover long-term supports and services, such as personal care attendants, many of the disabled are forced to go on Medicaid even if qualified for Medicare.

Perhaps more shocking are the inadequacies of Medicare and Social Security for the elderly. Medicare’s shortcomings as health insurance are legion: it requires sizable monthly premiums for doctors’ visit and prescription drug coverage (Parts B and D); substantial deductibles and cost-sharing in the hospital portion (Part A); and it does not cover major needs at all (vision, hearing, dental, long-term care). Altogether, Medicare only covers half of senior citizens’ health care costs. And seniors’ Medicare-related out-of-pocket costs are swallowing an increasing share of their Social Security checks: increasing from 10% in 1990 to 29% in 2007, projected to reach 53% by 2040 (Munnell 2007).

Social Security, the pinnacle of the American welfare state, has its shortcomings as well. Compared to the public pension programs in other rich democracies, the replacement rate – the proportion of earnings Social Security benefits represents – is lower in the United States (OECD 2013). There is no minimum Social Security benefit, so seniors with weak work histories often live in poverty. Indeed, although the senior poverty rate is half that of children in the United States, it is the highest among peer nations (Stepan and Linz 2011).

Medicare and Social Security are the most expensive domestic programs. They invite the ire of conservative politicians and the attention of would-be budget cutters. They are the most generous social programs in the American welfare state. But even they measure poorly in cross-national comparison. Thus the conventional wisdom that seniors and their programs are faring well requires some adjustment.
The Deservingness Dragnet

Another piece of conventional wisdom that my family’s experience blows apart is the concept of differential treatment of deserving and undeserving beneficiaries. There’s a long-standing notion that the “deserving” needy are treated fairly well by the American social policy regime. Some are deemed deserving because they have paid into a social insurance system, as Social Security and Medicare recipients have. That one cannot help growing older is another source of deservingness. Certain others are held blameless for their plight as well, such as poor children. The problem, however, is that those children are attached to poor adults, who we do hold responsible for their plights. Thus benefits that can be focused on the children without helping their scurrilous parents are relatively generous and conferred in a way which is not too demeaning, for example school lunch (relatively simple application process; given to all children in schools with high proportions of eligible children) and the Children’s Health Insurance Program (no asset test in most states; federal bonuses that encourage states to maximize enrollment, resulting in some of the highest take-up rates among means-tested programs).

We might imagine that the disabled would fall into the deserving camp as well. The disabled are a diverse group, including disabled former workers, the cognitively disabled, the nonelderly physically disabled, and the elderly disabled, just to name some of the subgroups. Each group, even each individual, qualifies for a slightly different configuration of programs and services. Each program poses different barriers and difficulties. In the face of high unemployment and low wages, and in the absence of other supports for displaced workers, Social Security Disability Insurance rolls have grown and invited criticism in recent years (Peterson 2015), particularly now that the SSDI trust fund is projected to run out of money by the end of 2016 (with no change, incoming DI revenues would only cover 81% of scheduled benefits at that point; OASDI Board of Trustees 2014, pp. 2–3). Children born with cognitive or physical disabilities can typically qualify for social programs through their parents’ work histories, but families often have to fight hard for needed benefits and supports.

I want to focus, however, on two populations that are ostensibly deserving, yet are treated poorly by the current social policy system, repudiating the notion that the deserving fare well: the elderly disabled and the nonelderly physically disabled.

Although the inevitability of aging is acknowledged in the universal and non-stigmatizing designs of Social Security and Medicare, the near-inevitability of disability in old age and need for long-term care often results in a plunge into social assistance. At age 65, the likelihood of needing nursing home care at some point during the remainder of one’s life is 49%, and is 72% for home health care
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(Friedland 2002). And yet only Medicaid covers such long-term care, not Medicare. Thus the elderly disabled needing institutional care or those whose families cannot (or can no longer) perform home health care must spend down their assets to the poverty level to come under Medicaid’s income and asset caps. Despite provisions to protect the community-living spouse, sometimes married elders get divorced to ensure that protection. Thus even though the elderly are perceived as deserving with regard to some social benefits, such as public pensions and health insurance, when it comes to long-term care, existing policy requires impoverishment. There is a tiny market of private long-term care insurance policies, but these policies are typically expensive and of dubious value, with time limits, low daily benefits, and overall benefit caps. Only 6% of Americans over age 45 even own such policies, and they fund just 1% of all long-term care (SCAN Foundation 2013; SCAN Foundation 2015). The number of insurers selling LTC products has shrunk from 100 to less than a dozen over the past decade (Greene and Scism 2013). Private long-term-care insurance is clearly a market failure, crying out for a social insurance solution, yet public provision remains confined to the poverty program.1

The physically disabled nonelderly such as my sister-in-law confront much the same public policy landscape. Marcella was rendered a quadriplegic by a hit-and-run automobile accident. I suppose some could disagree, but I think she would qualify as blameless for her condition. And yet the only source of the long-term supports and services she needs is Medicaid. So like elderly patients going into a nursing home, she had to shed her assets down to the poverty level to qualify. She and my brother must keep their income at the poverty level as well. Most nonelderly physically disabled people live in poverty, precisely because the supports they need are found only in Medicaid (Turkewitz and Linderman 2012).

The Affordable Care Act of 2010 added a cruel twist for the disabled living under Medicaid’s strictures. Originally eligibility for Medicaid was based on both income and categorical criteria: one had both to be poor and to be a member of an eligibility group (such as a child or a pregnant woman or a disabled person on SSI). Other low-income people, such as poor singles, were excluded from Medicaid in many states. The ACA expanded Medicaid eligibility to all low-income people (although the Supreme Court’s 2012 ruling in NFIB v. Sibelius made the Medicaid expansion optional for states). The cruel twist is this: low-income

1 The Affordable Care Act originally contained a social insurance provision for long-term care. The CLASS Act would have provided a daily cash benefit to participants who became disabled who had paid a payroll tax into the system for 5 years. The CLASS Act had a flawed design however: it was a voluntary program subject to adverse selection (those most likely to need the benefits would have been most likely to enroll), not a mandatory program maximizing the risk pool. The Secretary of Health and Human Services declared it actuarially unsustainable, and Congress later repealed the provision.
Americans who are newly eligible for Medicaid in the expansion states do not face an asset test, but Medicaid recipients in the original eligibility categories – such as the disabled – still do, if their state imposes one. Thus post-ACA, Marcella and Dave must keep their assets under their state’s cap, while a newly eligible low-income individual faces no asset limit.

Although few would blame Marcella or a frail older person for their conditions, we shunt such individuals into social assistance, where they are subject to all the strictures such programs impose on the blameworthy poor. Because the United States does not have social insurance for long-term care and supports and services, the disabled get caught in the dragnet for the poor. It is a callous system that illogically sweeps many different populations under one Draconian policy, even if it is a terrible fit for many of them. Being blameless is no guarantee of being treated well in the American welfare state.

The Scope of Our Inquiry

A final lesson arising from my family’s experience with the American safety net challenges not the conclusions of existing social policy research but the ways in which social policy scholars typically go about their work. Understandably, we tend to specialize in one area or one set of programs, some of us becoming experts on health policy, others on cash welfare, some on public housing, while others study child care policy. Given the complexity of these programs and the academic incentives for precision and depth, specialization is a perfectly logical response to the environment we researchers confront. However, analyzing program areas separately undermines important aspects of the scholarly endeavor. In examining programs individually, we fail to recognize the strategic environment that recipients face, and how the interaction of these programs and their rules shape client behaviors and outcomes.

For example, it appears that the best way for Dave and Marcella to gain some additional financial security would be for her to try to re-enroll in Medicaid (Medi-Cal in her state) through the California Working Disabled Program. CWD rules stipulate that as long as she is engaged in some kind of formal work for pay, she could save her earnings in a separate bank account that does not count against the asset limit; she could even open an Individual Retirement Account with the proceeds. And their income could rise somewhat without threatening her Medicaid eligibility. CWD is emblematic of programs designed in recent years to try to relieve the disabled of the stark choice they otherwise face between work and Medicaid. However, there is a problem: if Dave and Marcella’s income were to
rise, they would lose their childcare subsidy, the very benefit that enables them to work. Thus until their son is school age, they are stuck in a Catch-22 created by inconsistencies and conflicting rules across programs.

The failure to consider constellations of programs as a whole can result in recommendations for policy change that fall short. In its Fiscal Year 2011 budget, the Obama administration proposed raising the asset limit for federal means-tested programs such as food stamps and Supplemental Security Income to $10,000 (Hiatt and Newcomer 2010). This is a wonderful reform idea, except for one major problem: for individuals and families who are also enrolled in other, state-run means-tested programs with lower asset limits, the more generous federal limit is moot. If one is enrolled in Medicaid in a state with a $2000 asset limit, the fact that one’s food stamp asset limit rises to $10,000 is irrelevant.

Thus to understand truly how means-tested programs work, we must examine them in tandem, not just individually. We must study how their rules – some federal, some state – interact. This requires a new orientation, looking at the whole elephant, not just one part at a time. When I presented my work at his department, Texas A&M political economist Quan Li said that he was reminded of the type of research that business school scholars do for corporations. While a scholar of international political economy might provide insight on one aspect of the challenges a corporation faces, what businesses often want is to understand their strategic environment as a whole, not merely individual pieces. Recipients of means-tested programs face a similar multi-faceted set of incentives, barriers, and conditions. Analyzing the totality of their situations could lead us to understand better how programs work together and the true implications of individual program parameters.

Conclusion

Observing how social programs work from the inside has been quite an education. I am personally very sorry to have been in a position to do so, but as a scholar I have learned a tremendous amount. In particular, I have realized that many truisms about American social policy are not so true after all.

Armed with knowledge of the inner workings of American social policy, we scholars can be better positioned to engage the politics of entitlements and other forms of social spending. We can more readily see the disastrous consequences of Medicaid block granting and other means of curtailing spending on means-tested programs. We can see the shortcomings that exist even in the relatively generous Social Security and Medicare programs, and what Medicare voucherization
and other policy changes would mean for recipients. Behind the facts and figures are real, needy people whose interests must always be at the forefront of our endeavors.

References


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