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VOL. II NO. 1

BAKER CENTER JOURNAL OF APPLIED PUBLIC POLICY

FALL 2008

BAKER CENTER JOURNAL OF APPLIED PUBLIC POLICY

Published by Howard H. Baker Jr. Center for Public Policy at the University of Tennessee, Knoxville

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Manuscript submission, books for review, and any correspondence regarding this journal should be addressed to Editorial Office, Howard H. Baker Jr. Center for Public Policy, 217 Hoskins Library, Knoxville, TN 37996-4014 (telephone: **865-974-0931**, fax: **865-974-8777,** e-mail: *bakercenter@utk.edu*, web site: *www.bakercenter.utk.edu*).

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Baker Center Journal of Applied Public Policy

Published by the UNIVERSITY OF TENNESSEE
Howard H. Baker Jr. Center for Public Policy
VOL. II NO. I FALL 2008

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Introduction to the Baker Center Journal of Applied Public Policy

Welcome to the second issue of the *Baker Center Journal of Applied Public Policy*. I am very proud of this publication for many reasons. First, it continues to fulfill the mission that I stated in our inaugural issue: the research and discussion of applied public policy issues. Second, it has been put together by a resourceful set of University of Tennessee students, aided by Baker Center guidance and by our national board of advisors. It is refreshing to witness their dedication and determination. Lastly, the Journal is central to our vision for the *Howard H. Baker Jr. Center for Public Policy* at the University of Tennessee. The Center has established itself over the past five years as a leader in discussing, researching, and teaching about critical public policy topics as well as encouraging civic awareness and engagement. I am very pleased with its success and happy that, as part of its mission, it oversees the creation of this excellent publication.

Howard Baker

Call to Action: *A Federal Assault on Health Inequity*

***Rita Sanders Geier**, University of Tennessee, Knoxville*

The Current Crisis

We all know the problem: the alarming disparities in American health care and health status is a crisis that has been well-documented and widely debated. Scholars, politicians, and health care professionals have long recognized the crippling reality and destructive impact of inequities in this most fundamental of human rights. It is a crisis that not only impacts the credibility of our national promise of life, liberty, and the pursuit of happiness, but a pervasive problem with many different faces: disparities based on race, ethnicity, geography, socio-economic status, gender, and sexual orientation. It has a spectrum of manifestations, from basic lack of access to health care and unequal quality of care, to disturbing differences in health outcomes.

Health inequity has compelling moral and ethical implications as well as clear economic and social impacts. The consequences of the status quo are unacceptable. This spring, as we celebrate the legacy of Dr. Martin Luther King, Jr., we would do well to recall his words, that "of all forms of inequity, injustice in health care is the most shocking and inhumane."

The concern about health inequity embraces two distinct, yet inseparable disparities: a concern for disparities in *health* and a concern for disparities in *health care*. The concepts of *health*, "[the] differences between two or more population groups in health outcomes and . . . the prevalence, incidence, or burden of disease, disability, injury, or death," and *health care*, "the differences between two or more population groups in health care access, coverage, and quality of care, including differences in preventative, diagnostic, and treatment services" are inextricably interrelated ("Minority Health"). Health care disparities are a major cause of disparities in health status, and it is generally agreed that the ultimate goal of eliminating health care disparities is to achieve equity in health status. While this paper primarily examines the magnitude and impact of health care disparities, it concludes that it is essential to address the causes of health disparities to achieve effective and lasting results.

Overwhelming evidence indicates that health inequity has devastating human, economic, and social consequences. The opportunities lost from poor health care begin at birth: infant mortality, premature births, and low birth weights almost always result from lack of prenatal health care and inadequate early nutrition. These problems are most prevalent among poor and minority populations, and the physical and developmental disabilities associated with these life beginnings result in lifelong burdens. Many children with such disabilities face educational difficulties, their life opportunities dimmed at an early age.

The impact of health inequity on human life and suffering make a compelling case for urgent action. Dr. David Satcher (2006, p. 3), a former U.S. Surgeon

General projected in the book *The Covenant with Black America* that if the United States had eliminated disparities in health and health insurance, "[t]here would have been 85,000 fewer black deaths in 2000, including 4,700 fewer black infant deaths in the first year of life, 22,000 fewer deaths from diabetes, and almost 2,000 fewer black women would have died from breast cancer." While the many causes of health disparities: socio-economic factors, behavioral factors, environmental factors, and even genetics, often appear intractable and beyond our control, we should not doubt that the crisis of health inequity can be changed, and it demands our most serious attention as a nation.

Racial and Ethnic Health Care Disparities

Racial and ethnic disparities in health care, whether in insurance coverage, health care access, or quality of care, produce inequity in health status. In the 2000 Census, 30% of the U.S. population identified themselves as belonging to a racial or ethnic minority group. In fact, the Census Bureau projects that by 2050, racial and ethnic minorities will account for almost half of the U.S. population (U.S. Department of Health and Human Services, p. 127). The states of California, Hawaii, New Mexico, Texas, and the District of Columbia already have majority-minority populations ("'Texas Becomes Nation's Newest 'Majority-Minority' State," 2005). In looking towards the future, current U.S. Census data and projections of future demographic changes illustrate the magnitude of the dilemma of disparities in health care. This has disturbing implications for a health care system that is plagued with pervasive racial and ethnic disparities.

A report issued by the Commonwealth Fund in August of 2006 details the impact of disparities on the quality of life for minorities (Doty). The report, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults*, reported the following:

- Hispanics are at a particularly high risk of disconnect from the health care system. This minority group often lacks a regular source of primary care and does not receive essential preventative care. In addition, 21% of uninsured Hispanic adults with a chronic condition, disability, or other health problem did not visit a health care provider in the past year, double the number of whites (p.3).
- The prevalence of chronic conditions for African Americans is also strikingly high. The report states that 45% of African American adults reported hypertension, heart disease, diabetes, or asthma. In contrast, 31% of white, and 20% of Hispanic adults reported any one of these conditions (p. 5).
- Low-income and minority populations are also more likely to require hospitalization for potentially preventable medical conditions, particularly complications resulting from chronic disease. In fact, "African American adults (35%) are more likely than white (20%) or Hispanic (17%) adults to report using the emergency room for conditions that could have been treated by a primary care doctor if one had been available" (p. 6).

The *2006 National Healthcare Disparities Report* observed that:

> For racial and ethnic minorities, some disparities in quality of care are improving and some are worsening. For the poor, most are worsening. Of disparities in quality experienced by Blacks, Asians, American Indians/Alaskan Natives (AI/ANs), and Hispanics, about a quarter were improving and about a third were worsening. Two-thirds of disparities in quality experienced by poor people were worsening (U.S. Department of Health and Human Services, 2006, p. 6).

The strongest predictor of health disparities is poverty. While racial and ethnic health disparities are extensive, individuals in poverty have worse health than the non-poor, regardless of their racial or ethnic group (The Henry S. Kaiser Family Foundation, 2007, p.8). Socio-economic data indicate that racial and ethnic minorities are still more likely than non-Hispanic whites to be poor or near poor. The data also indicates that, in general, racial and ethnic minorities experience both reduced access to health care and lower quality (U.S. Department of Health and Human Services, 2006, p. 6). These facts have grave implications for the elimination of health disparities.

The Uninsured: The Nexus of Race and Poverty

The key to health care access is insurance, and the poor and minorities make up the bulk of the uninsured. Health insurance makes a big difference in whether and when people get necessary medical care, where they get their care, and ultimately, the state of their health. The number of uninsured Americans is growing and passed 46 million in 2006. The uninsured are largely low-income adult workers for whom coverage is either unavailable or unaffordable. This situation has worsened in recent years. In 2005, 1.3 million people joined the ranks of the uninsured, 80% of whom were people living near or below the poverty line. This followed an increase of 6 million between 2000 and 2004, a rise driven primarily by a declining number of employer-sponsored health insurance plans. This lack of available insurance plans hit low-income workers and their families the hardest (The Kaiser Commission, 2007, pp. 6, 9, 109).

Racial and ethnic minorities are disproportionately poor and are much more likely to be uninsured than white Americans. A 2003 report noted that "Hispanics and African Americans were much more likely to be uninsured compared to white, non-Hispanic people. The percentage who were uninsured was 52.2 percent for Hispanic people and 39.3 percent for African American people, compared to 23.3 percent for white, non-Hispanic people" (FamiliesUSA, p. 7).

Being uninsured can impose tragic health risks. According to the federally chartered Institute of Medicine:

- In 2002, 18,000 deaths among those aged 25 to 64 could have been prevented had those individuals had insurance.
- Uninsured people are almost twice as likely as the insured to delay getting medical care (15.7% vs. 8.6%).
- Even when they have serious symptoms they think need attention, 30% of the uninsured report getting no care, compared with 14% of the insured.
- Cancer patients who don't have coverage die sooner than those with insurance, largely because of delayed diagnosis.
- 25% of adult diabetics who were uninsured for a year or more went two years without a checkup, compared to 5% of diabetics with insurance (Alliance for Health Reform, 2006, p. 7).

The financial consequences of having no insurance can be devastating. Whole families suffer the social and economic consequences of poverty when a sick breadwinner cannot work, but when that worker is uninsured, the result can be ruinous. The skyrocketing of consumer bankruptcy filings from 718,000 in 1990 to 1.6 million in 2004, with nearly 27% of the filings resulting primarily from medical debt, is evidence of the severe financial impact on individuals and families. Clearly, removing barriers to health insurance is essential to alleviating the enormous financial burdens of health care disparities on the poor, and minorities in particular.

Yet, health insurance alone is not a panacea for health disparities. In a recent article in the *Journal of the American Medical Association (JAMA)*, Dr. Nicole Lurie (2007) cautioned that "[t]he availability of health insurance does not guarantee access to care—and certainly does not guarantee access to high quality of care" (p. 1119). Quoting J.M. Eisenberg and E.J. Power in their article, *Transforming Insurance Health Coverage Into Quality Health Care*, also in *JAMA*, Dr. Lurie compares the challenges encountered in obtaining quality health care to "an electrical system in which a current passes through a series of resisters, encountering voltage drops as it travels through a series of resistors, encountering voltage drops as it travels along the circuit" (p. 1119). She went on to add that:

> Individuals must enroll in available insurance plans that cover needed services, must be able to choose a primary care clinician whom they see regularly and consistently, and must be able to receive appropriate specialty services and high quality of care. Even then, communication challenges such as language differences between patient and clinician, or low health literacy, can impair the effectiveness of that care (p. 1119).

The Cost of Health Care Disparities

The 2006 National Healthcare Disparities Report, published annually by the Department of Health and Human Services' Agency for Healthcare Research and

Quality, provides information on the total financial impact of health costs:

- The costs of early death and poor health among the uninsured total $65 billion to $130 billion per year (p. 102).
- Direct medical costs for cardiovascular disease amount to $257.6 billion per year. This amount increases to $403 billion per year when the indirect costs of morbidity and mortality are included (p. 45).
- Direct medical costs for cancer are $78.2 billion per year. The total cost for cancer is $206.3 billion per year (p. 36).
- Direct medical costs for diabetes amounts to $92 billion, with total costs of $132 billion per year (p. 39).

This report emphasizes that, among all health problems, these chronic diseases are the most pervasive, costly, and preventable. In fact, chronic disease is a cause of 7 out of 10 deaths in the U.S. each year and 1 out of 10 Americans face major limitations in activity because of these diseases. Five conditions—heart disease, pulmonary conditions such as asthma, mental disorders, cancer, and hypertension—accounted for 31% of the growth in health spending between 1987 and 2000. These chronic diseases are also where there are the greatest disparities in health care (U.S. Department of Health and Human Services, 2006).

The high cost of treating chronic disease is exacerbated by a lack of preventive care and delays in diagnosis and treatment, particularly for the poor and minorities. Factors such as these contribute significantly to the spiraling costs of health care. In 2004, total health spending in the nation rose to $1.88 trillion, the equivalent of $6,280 for each person in the U.S. This total was 7.9% higher than in 2003, well above the growth in the Gross Domestic Product (GDP). Reflecting the unabated rise of health costs, total health spending in 2006 was $2.16 trillion, the equivalent of $7,110 for each person in the U.S. Projected total health spending for 2015 is $4.03 trillion, with per capita expenditures soaring to $12,320 (Borger et al., pp. W61, W67).

In 2006, health spending was 4.5% of the GDP. However, the director of the Congressional Budget Office has estimated that if health care costs continue to rise at the same rate as in recent decades, federal spending on Medicare and Medicaid alone, the two largest federal health programs, would rise to 20% of the GDP by 2015—roughly the share of the economy now accounted for by the entire federal budget (Orszag, 2007). This relationship between the dramatic projected growth in health care spending and the higher treatment costs for chronic diseases provides an additional fiscal incentive for reducing disparities in health care.

The Federal Role in Health Care Disparities

The Largest Purchaser of Health Care

The federal government's involvement in health care is so pervasive and influential that it is almost always the beginning and end point of any discussion involving health care policies or practices. Accordingly, it bears a huge responsibility for the nation's

late start in addressing the crisis of health inequity. Either directly or indirectly, the federal government provides health care for a large number of Americans. It has an extremely pervasive role as a health care provider and it operates a large number of programs covering a wide array of Americans: Medicare, Medicaid, the State Children's Health Insurance Programs (SCHIP), the Department of Health and Human Services (HHS), Indian Health Service, the Department of Defense's Tricare, the Veterans Affairs health care system, and the Federal Employees Health Benefits Program. Thus, at a time when the U.S. is experiencing unprecedented budget deficits and slower growth in personal income, it is cause for concern that "the rate at which health care costs grow relative to income is the most important determinant of the long-term fiscal balance . . ." (Orszag, 2007). Consequently, it is clearly in the national interest for federal health care policy to aim at prevention and health maintenance for all Americans rather than continuing to pay the high costs of a broken health care system.

The Impact of Federal Health Care Policy

Not only is the federal government the largest purchaser of health care, through a vast labyrinth of federal agencies, programs, and initiatives, it is also the primary arbiter of health care policy affecting both the public and private sectors. Federal regulations govern eligibility for both consumers and providers in the health care system. Federal financing, payment, and reimbursement policies and procedures also drive the flow of money through the rapidly expanding health care industry and significantly affect market forces in that sector of the economy. In addition, the federal government engages in extensive medical research, both directly, through the National Institutes of Health and its affiliated organizations, and indirectly, through generous federal grant assistance to universities, hospitals, and research organizations. On the macro level, the federal government's influence in health care is broad and powerful. On the micro level, its effect on the health care of over 100 million individuals is especially controlling.

Not surprisingly, due to the reach of federal involvement in health care, it has become extremely diffuse and fragmented. The largest programs, in number and size, are located within HHS. The Medicare and Medicaid programs, the National Institutes of Health, and the Centers for Disease Control and Prevention are all administered from within HHS. HHS also administers many smaller but significant health care-related programs and offices, including the Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Services Administration (SAMHSA), the Public Health Service (PHS), Health Resources and Services Administration (HRSA), the Office of Rural Health Policy, the Office of Minority Health, and the Office of Minority Health Disparity Elimination. The Department of Defense administers Tricare for the military, and Veterans Affairs (VA) maintains a network of VA hospitals providing direct, lifelong medical care for veterans. The Federal Employee Health Benefits Program (FEHB) subsidizes health care for federal employees, their dependents, and retirees and participants

are able to choose from a wide variety of approved plans. Clearly, as purchaser and regulator of this enormous health care system, the federal government has tremendous influence on the health of the American health care system.

Such influence carries with it an opportunity to shape health care policies and practices in ways that address the dilemma of health care disparities. One laudable historic example of the exercise of federal authority to ensure equal access to health care, without regard to race or wealth, occurred at the inception of the Medicare program in 1966. The federal government required hospitals, particularly in the South, to desegregate their facilities and end widespread segregationist practices. This mandate required the hospitals to end the practice of racially segregated waiting rooms, hospital rooms, bathrooms, and other health care related facilities, all as a condition of participating in Medicare, the new government medical insurance program for the elderly. Despite initial grumbling and attempts to merely require "freedom of choice" as an option, President Lyndon Johnson and the Department of Health, Education, and Welfare required, under Part A of the new program, that everyone, regardless of race or income, be treated in the same hospitals receiving Medicare reimbursements. Probably no other single act did more to reduce health care disparities between the races. Amazingly, rather than a long, drawn out process, in most cases this monumental change in behavior was accomplished almost overnight.

Unfortunately, the desegregation of Medicare in the 1960s had a disappointing side as well, demonstrating the failure of the federal government to exercise power and achieve a consistent policy. The government's stunning achievement in ending segregation in hospitals contrasted with the government's unwillingness to prohibit racial discrimination by physicians and other health care providers under Part B of the Medicare program, the part of the program covering non-hospital treatment. The nondiscrimination policy also failed to include nursing homes, although they, like hospitals, are covered under Part A of the Medicare program. Today, these exclusions continue to be significant factors contributing to the persistence of disparities in health care (Eichner & Vladeck, 2005).

Medicaid, the means-tested, federally-subsidized state-run health care program, is another HHS policy that has contributed to disparities in minority participation. Physicians and health plans are not required to participate in Medicaid (although hospitals and nursing homes are). This difference has adverse effects on minorities because of their higher representation in the low income Medicaid-eligible population (Eichner & Vladeck, 2005).

In his article with Julie Eichner, Bruce Vladeck, a former administrator of the Centers for Medicare and Medicaid Services (CMS), identified other Medicare policies that may contribute to health care disparities. Two policies he identified are the local medical review process by Medicare contractors to determine if services are eligible for reimbursement under fee-for-service Medicare programs, and the utilization review process of Medicare Advantage (*i.e.*, managed care) plans. Vladeck states that:

> These review processes may disadvantage minorities to the extent that people engaged in the process are unaware of, or unsympathetic to, the special needs of minority beneficiaries, or because minority beneficiaries are less likely to have providers prepared to advocate strongly on their behalf (Eichner & Vladeck, 2005).

However, the largest single factor preventing full participation in Medicare by poor and minority beneficiaries is the requirement to pay premiums for participation in Medicare Part B, which reimburses beneficiaries for a wide range of outpatient physician and medical services. These are substantial out-of-pocket expenses that are barriers to the necessary preventative care and health maintenance for those who need it most. While some relief from payments is available for those who qualify, Vladek states that these eligibility requirements for the Medicare Savings Program and Medicaid pose a formidable barrier. These programs are designed to help qualified low income beneficiaries pay some or all of their Medicare premiums and deductibles; however, less than 50% of those eligible actually participate (Eichner & Vladeck, 2005). Lack of knowledge about the programs and intimidation caused by the extensive documentation required are likely factors as to why more people do not participate. Additionally, these factors disproportionately disadvantage minorities because they are also more likely to be eligible (Eichner & Vladeck, 2005).

On balance, it should be noted that federal health care policies have also had positive effects in instituting quality initiatives and standards throughout the major federal health programs. There is a strong recognition that improvement in the quality of services and care for diseases disproportionately affecting minorities is a powerful weapon against health care disparities. The 2001 Institute of Medicine report, *Crossing the Quality Chasm*, identified "equity" as one of the six dimensions of high quality health care, along with effectiveness, safety, timeliness, patient-centeredness, and efficiency (2001, pp. 2-3). Quality Improvement (QI) efforts had not previously been identified as critical to the elimination of disparities. It has been noted that "[t]his apparent oversight miss[ed] an important opportunity because many potential synergies exist between activities to reduce disparities and improve quality" (Moy et al., 2005, p. 383). Since 2005, CMS has been a leader in this regard by establishing Quality Improvement Organizations (QIOs) in each region. These QIOs are charged with reducing disparities in chronic illness care from within physicians' offices.

Another important and promising exercise of the federal government's leverage to reduce health care disparities has been in setting standards for the delivery of culturally competent service. Cultural competence describes "the ability of systems and providers to care for patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs. Improving cultural competence has the potential to . . . reduce disparities . . ." (Vladeck et al., 2006). The HHS Office of Minority Health (OMH) has been at the forefront in assuring that health care is delivered in a culturally competent manner regardless of racial, ethnic, or linguistic diversity. In 2000, national standards for Culturally and Linguistically Appropriate Services (CLAS) were issued. These standards include several tiers of compliance requirements: Medicare Part A providers are covered; Part B providers who receive only Medicare Part B payments are exempted; and those receiving other federal dollars, such as Medicaid or SCHIP, are required to comply with the guidance for all patients with limited English proficiency, including Medicare beneficiaries (Eichner & Vladeck, 2005, p. 375, n. 20).

As we have seen in other areas of civil rights enforcement, data collection has made a critical difference in the ability to analyze and detect discriminatory practices in housing and mortgage lending and racial profiling by police. Data collection and analysis are also essential to determining the magnitude and nature of disparities and are crucial to any effort to reduce health disparities. The federal government has taken the lead in setting uniform standards for the collection of racial, ethnic, and linguistic data by federal agencies. However, it has fallen short by failing to ensure that agencies actually collect the data and use it to evaluate the impact of their programs. Health plans are not required to collect race, ethnicity, and socio-economic status (SES) information on their enrollees, and, although HHS has the authority to require it, it has not done so (Perez, 2002, p. 650).

Thus, in ways that are both subtle and complex, but with glaring impacts, federal health policies have contributed to the racial, ethnic, and economic segregation of health care. After analyzing and documenting how "all the persistent, complex, and interrelated forms of segregation influence current patterns of disparity in treatment and health," David Barton Smith, Professor and Director of the Health Care Management Program at Temple University, reached these conclusions in his report, *Eliminating Disparities in Treatment and the Struggle to End Segregation* (2005):

- "In spite of progress in eliminating disparities, health care remains quite segregated and may be becoming more so" (p. 8). Smith cites outpatient and nursing home care as the most segregated health care sectors today. A survey of primary care physician showed, for instance, that 80% of the visits of black Medicare beneficiaries were accounted for by 22% of physicians and that the physicians providing these services were less likely to be board-certified and more likely to report difficulty in obtaining access for their patients to high-quality specialist and diagnostic services (p. 9).
- "How health care is regulated and financed shapes the degree of segregation and disparities in treatment" (p. 10). Smith points out that the removal of the federal requirement for regional planning for obtaining approval of certificates of need (CONs) to build or expand facilities and where to locate them allowed health care providers' investor's decisions to be dictated by profitability without considering their social impact (p. 10-11).

- "Segregation produces a health system that increases the cost and reduces the quality of care for everyone" (p. 11). Smith notes that the trend has been for providers to expand profitable services in predominantly white higher income areas and to reduce services in the predominantly minority, lower income inner city. This has tended to lower access to certain types of care to those who are most at risk (*e.g.*, inner city blacks are at higher risk for heart disease and cardiovascular conditions) while oversupplying more affluent areas and encouraging over-utilization of more costly procedures. Without the pressures for cost-effectiveness through regional planning, this results in higher costs and lower quality (p. 10-11).

Federal Enforcement of Health Care Law

As shown in the above discussion, federal government policies can have the unintended effect of increasing or perpetuating racial, ethnic, and economic segregation in health care. In addition to this impact of health policies on segregation in health care, is the continuation of actual discrimination. Under various federal statutes, the federal government has the primary role in investigating and prosecuting acts of discrimination pertaining to health care. These include Title VI of the Civil Rights Act of 1964, which prohibits discrimination based on race, color, or national origin in any program or activity receiving federal financial assistance; Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against people with disabilities in programs receiving federal financial assistance; and Title II of the Americans with Disabilities Act, which prohibits discrimination against persons with disabilities in public accommodations.

Title VI has the broadest scope of these civil rights statutes and has been the major weapon in fighting discrimination. Significantly, Title VI prohibits both intentional and unintentional discrimination. It addresses practices that have a "disparate impact" or "discriminatory effect" on minorities. However, as discriminatory practices become less overt, challenges arise in terms of the amount of time and resources needed to investigate and prove that certain policies or practices have the requisite "disparate impact" or "discriminatory effect" on minorities. As new civil rights issues have arisen with respect to access of immigrants to health care, and as the industry itself has shifted dramatically toward managed care, both the number and complexity of potential discrimination cases has increased. While the authority of the Office of Civil Rights in HHS has not changed, it has not received the resources needed for aggressive prosecution of discrimination in health care, nor has this been a policy priority.

The Responsibility of the Federal Government for Reducing Health Care Disparities is Fragmented and Ineffective

The causes and effects of health care disparities are many, complex, and interrelated. They are rooted not just in access to doctors and hospitals but in access to healthy air, water, and nutritious food. The factors that contribute to, or aggravate

health care disparities are not just medical, but are also socio-economic, environmental, and educational. The involvement of the federal government in each of these critical areas has an effect on health care disparities, and, by the same token, has the potential to reduce such disparities.

The first obstacle to activating that potential is for federal agencies to realize that the causes of health disparities are many and demand comprehensive and coordinated solutions (Drexler, 2005, p.11). It is widely recognized that "policies on the environment, transportation, labor, housing, and medical services have profoundly affected citizens' physical and mental well-being" (p. 11). The federal government is heavily involved in each of these areas and others, setting policies that directly affect health and health care. The Office of Management and Budget (OMB) acknowledges that there are no fewer than 184 federal agencies administering programs related to health and well-being ("Programs Related to Health and Well-Being"). Yet, in the 1990s, former Surgeon General Dr. David Satcher tells of bringing together the heads of all federal departments to talk about health policy, and, with the exception of those directly responsible, only one agency head understood that their agency's policies had anything to do with health.

This diffusion of federal agency responsibility for health reflects the haphazard development of health policy, a development resulting in redundancies, gaps, and inefficiencies. OMB, for instance, recently made the following observations in evaluating the effectiveness of key health care-related programs:

- The Rural Health program "is duplicative and redundant of other programs in the Department of Health and Human Services." There are more than 225 health and social services programs within the Department that address rural needs ("Rural Health Activities").
- The Office of the National Coordinator for Health Information Technology "does not have strategic goals" ("Office of the National Coordinator for Health Information Technology").
- The Veteran's Research and Development "projects focus on health issues unique to veterans, but can also address issues that impact everyone and yield findings used by other entities" ("Veterans Health Research and Development").
- Of the lead federal agency for coordinating minority health initiatives, the Office of Minority Health, OMB said "[m]any of its initiatives appear duplicative with other Federal agencies.... Efforts are needed to demonstrate the differences and individual contributions of each organization ("Office of Minority Health").

The results of this fragmentation of responsibility for health policy are lost opportunities to effectively combat disparities. This is illustrated with respect to health research and the important contribution it can make to the elimination of disparities. In 2001, the Secretary of HHS established the Research Coordinating Council (RCC) to coordinate the many health services research activities within HHS. Because of the related research undertaken by other agencies, and the ben-

efits of sharing information and coordinating efforts, it was a lost opportunity not to include representatives of other agencies in the RCC (AcademyHealth, 2005, p. 6). AcademyHealth concluded that "coordination across federal agencies is especially important given the complexity of the health care system and the issues that health services research addresses. Coordination of findings and some direction regarding research needs will help increase the efficiency with which research improves the clinical and economic outcomes of the health care system" (p.6). Recently, promising steps toward increased coordination have been taken, e.g., in disability research and health information technology, but there is much more to be gained from interagency and public/private sector collaboration.

Needed: A Comprehensive, Coordinated, and Strategic Federal Assault on Health Inequity

Given the multitude of factors—social, economic, environmental, behavioral—contributing to health inequity, and the policymaking role of federal agencies in each of these areas, the federal executive branch must face the challenge of eliminating health disparities by first acknowledging the heavy impact of its programs and policies. Awareness of the magnitude of health disparities led to the 1999 adoption, by HHS, of a set of goals called "Healthy People: 2010." These goals declared the elimination of health care disparities as one of two overarching goals and laid out many objectives designed to meet that goal (U.S. Department of Health and Human Services, 2000). This action was followed quickly by a Congressional mandate to the Institute of Medicine to do a study on health care disparities, to create the National Center on Minority Health and Health Disparities at NIH, and to require two annual reports issued by the AHQR reporting on the nation's progress in reducing health disparities and improving the quality of health care. These initiatives were critical in raising awareness of the issue of health disparities, in prompting examination of the impact of policies and programs by many federal agencies, and in spawning efforts at coordination among agencies having the most direct responsibility for health care policy. These early coordinating efforts were focused on bringing the activities of the various agencies and offices within HHS into alignment. The Office of Minority Health became the focal point for coordinating activities pertaining to health care disparities within HHS, taking the lead in developing standards for culturally competent service and CMS taking the lead in collection of racial and ethnic data and quality initiatives. However, while these efforts were essential and laudable, they fall far short of the comprehensive and strategic executive branch action that is required to address the crisis of health disparities.

A Broader Vision of Health Policy

Over a century ago, the noted African-American scholar Dr. W.E.B. DuBois studied the rate of disease and mortality among African-Americans and correctly

observed that health disparities were the results of low socio-economic status and a lack of access to quality health care, factors he called "conditions of life" (1906). Others have noted that health and health disparities are embedded in larger historical, geographic, socio-cultural, economic, and political contexts. Thus, changes in a broad range of public policies are likely to be central to effectively addressing racial disparities (Williams, 2005, p. 325). Today, for instance, we are keenly aware of the environmental causes of health disparities with studies finding:

> Race to be [the] most significant variable in differentiating between zip codes with treatment, storage, and disposal facilities .... Latinos and African Americans disproportionately represented in census tracts with Toxics Release Inventory facilities in Los Angeles .... blood lead levels disproportionate by race and income .... estimated 300,000 farm worker[s] suffer pesticide-related illnesses each year .... [and] African American women in South Bronx exposed to auto exhaust tended to have smaller babies with smaller head circumferences (Stinson, 2003).

Indeed, it has been known for some time that "[p]overty, joblessness, and discrimination take a heavy toll on the human body" (Drexler, 2005, p. 11). Nevertheless, "[d]espite centuries of evidence that poverty and social injustice harm health, only in the past decade has concern with social inequalities in health entered the mainstream public health agenda" (p. 6). Thus, these "conditions of life" are heavily influenced by public policy in many areas, not just by what we narrowly consider health *policy*.

While much of the current focus has been on elimination of disparities in health care, effective and long lasting results cannot be achieved without changing the "conditions of life" of the poor and minorities, those who suffer their greatest impact. Improvements in health care alone (*i.e.*, coverage and quality of care, prevention, diagnosis, and treatment) are crucial, and the need for them is urgent. However, unless socio-economic, environmental, educational, housing, and other circumstances are attacked with equal vigor, the benefits of any improvements will be short-lived.

The futility of some health care measures is obvious:

> Prescribing an antibiotic that requires refrigeration to treat a child's ear infection is not an option for individuals in a Navajo community without electricity. We cannot expect individuals to apply wet to dry dressings to burns four times a day if they have no running water and must haul water from several miles away (Stinson, 2003, p. 17).

While the preceding examples are seemingly obvious, the disconnect between sound health care and the circumstances of daily living that can frustrate and defeat their effectiveness is usually less apparent. You cannot expect a middle-aged grandmother with hypertension who is caring for preschool children to faithfully take her prescribed regimen of pills that cause drowsiness, or a waitress with vascular problems to be "off her feet" for regular intervals during her workday. In these cases and many others, practicing good health care is at odds with the need to survive.

There is a dawning realization of the need to rethink what we mean by health policy. In light of the broad factors shaping the health status of individuals and communities that are based in non-health policies, real and lasting advances against health disparities cannot be made with a unilateral approach. It is imperative that interagency, interdisciplinary, and intergovernmental collaboration be used to successfully attack this multi-faceted dilemma. *Healthy People 2010* is one group who recognized that a broad view of the factors involved in achieving a healthy public was necessary:

> Physical and social environments play major roles in the health of individuals and communities. The physical environment includes the air, water, and soil through which exposure to chemical, biological, and physical agents may occur. The social environment includes housing, transportation, urban development, land use, industry, and agriculture and results in exposures such as work-related stress, injury and violence (U.S. Department of Health and Human Services, 2000).

What is needed is a broader vision of health policy. Policymakers need to grasp the impact that environmental policy has on those who suffer from the worst health; how housing and zoning decisions affect the availability of safe shelter, green spaces, and fresh vegetables, and how educational policies affect the ability of individuals to learn about healthier lifestyles and avoid risky behavior. In short, what is needed is an integration of health policy with non-health policy. Under this vision, a threshold question for policymakers in all policy areas affecting the "conditions of life" would be: what is the impact of this policy on the health of individuals and groups, particularly those who have the least health care and worst health status?

In calling for reform, Senator William Frist, a physician and leading advocate for health care reform, stated:

> We must engage and leverage the entire federal health apparatus, including HHS, the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ), as well as the Departments of Veterans Affairs and Defense, to systematically address disparities wherever and whenever they may occur (Frist, 2005, p. 449).

We must also take an even broader, more collaborative approach. As Senator Edward Kennedy, another key proponent of health care legislation, has said:

> Health is inextricably tied to educational opportunities for children, job security and living wages for families, safe and affordable community housing, and pension stability and social security for seniors. Elimination of disparities in health depends in part on progress in each of these critical areas (Kennedy, 2005, p. 457).

The need for a vigorous and comprehensive approach in addressing health disparities is reflected in proposed legislation sponsored by leading representatives of minority groups. The TriCaucus, a collaborative of the Congressional Black Caucus (CBC), the Congressional Hispanic Caucus (CHC), the Congressional Asian Pacific American Caucus (CAPAC), and the Native American Caucus (NAC), is one such group. The TriCaucus collectively represents populations that suffer disproportionately from health disparities. It has sponsored legislation calling for a "comprehensive solution," noting that:

> Far too long we have nibbled around the edges in addressing racial and ethnic, as well as gender and geographic health disparities. The absence of health equity needs a comprehensive solution as it is a complicated, sensitive, and multi-faceted problem that . . . is not only rooted in inequities throughout the nation's healthcare system, but . . . is based—to varying degrees—on inequities in economic and educational opportunity, as well as environmental justice. It . . . warrants a comprehensive solution because it cuts across more than just our public health and healthcare infrastructure and capacity. (CBC Health Braintrust Policy Brief, The Health Inequity and Accountability Act of 2007, HR 3014, January, 2008)

Having recognized the scope and complexity of health disparities and its myriad causes and effects, we are faced with a challenge: how can public policy be galvanized to achieve health equity? While legislation will be needed to structure basic reforms in our health system to achieve health equity, there is much that can, and must be done to make the existing system work better for those that need it most. The vast policy levers in the executive branch of the federal government must be directed at the health disparities crisis, and the entire federal establishment must take ownership of this issue if we are to devise effective strategies to resolve it. The

American public demands that our national health crisis be addressed. In this election year, concerns about our national health system are consistently at the top of voters' priorities, along with concerns about the war, the economy, and education. This concern stems from the spiraling cost of health care as well as the lack of access and quality, where disparities are at critical levels for the low income and minorities.

Developing a Comprehensive Federal Strategic Plan

No crisis demands a comprehensive interagency approach more than the issue of health care. This must be recognized in the White House, where the authority and leadership of that office may be used to galvanize the vast intellectual, policy, and administrative capacity of the federal government for a unified assault on health disparities. The goal should be a comprehensive strategic plan to eliminate health disparities and promote health equity for all, regardless of race, ethnicity, geography, economic status, religion, education, language, age, gender, sexual orientation, or disability. Developing a comprehensive strategic plan in the executive branch will require a shared sense of accountability at the very highest level. Unless eliminating health disparities is declared a critical priority because of its devastating impact on the health of our nation, it will not be attacked with the seriousness that it requires, a seriousness equal to that with which we approach war.

The foundation for developing a comprehensive national strategy must first be laid. The executive branch must engage in extensive dialogue and self-examination. This process must be open, interdisciplinary, evidence-based, collaborative, and focused on results. The resulting foundation must, at a minimum, be based on the following:

- Awareness and understanding throughout the federal establishment of the scope and nature of the crisis and its debilitating impact on individuals, our cities, communities, businesses, and government at all levels.
- A 360-degree inventory of the policies, programs, and practices within the executive branch that affect health disparities in the broadest sense, with emphasis on the social determinants that may be their root causes.
- An assessment of how effective existing policies, programs, and practices affecting health disparities are in concept, design, and implementation. Also, whether they are accomplishing their mission, and what needs to happen for them to succeed.
- An analysis of how the various policies, programs, and practices are interrelated and the extent to which they coordinate, collaborate, avoid redundancies, and achieve efficiencies.
- An identification of the gaps and/or inconsistencies in existing policies, programs and practices, as well as who is falling between the cracks in health policy, and what preconditions are lacking for program effectiveness.
- An assessment of the level of program compliance and law enforcement in areas affecting health disparities.
- The extent to which federal programs are consistent, coordinated, and aligned with private sector, state, and local government programs and activities.
- Whether the federal organizational structure and administrative infrastructure imposes barriers or limitations on effectively addressing health disparities.

A Model for Executive Branch Action: The President's Identity Theft Taskforce

The assault of the federal executive branch on the national crisis of identity theft may serve as a model for mobilizing the federal government to attack health disparities. Similar to health disparities, identity theft has reached crisis proportions, striking approximately 9.9 million Americans every year and instilling fear and insecurity in all who are not direct victims ("FTC Releases Survey"). Also, like health disparities, its causes are broad and complex, ranging from individual behavior to industry practices, and it has detrimental effects both for families and the national economy. Another shared factor is the extent to which federal policies designed to regulate commercial and financial practices as well as protect consumers are involved.

Combating the identity theft crisis demanded a comprehensive federal strategy and the highest level of interagency collaboration and coordination. Key agencies that administer programs with direct responsibilities affecting identity theft, such as the Federal Trade Commission, the Social Security Administration, the Internal Revenue Service, and the Department of Justice, had long recognized the need for interagency communication and sharing of data, and they formed informal networks for that purpose. However, similar to existing agency collaborations in the area of health policy, these efforts were neither broad nor deep enough to provide an effective comprehensive federal strategy. Responding to the intensifying public and congressional demands for decisive federal action, the White House acted to mobilize the entire executive branch and to develop and implement a broad-based strategy to combat identity theft.

On May 10, 2006, by Executive Order 13402 titled *Strengthening Federal Efforts to Protect Against Identity Theft*, the President established the Identity Theft Task Force, declaring:

> It is the policy of the United States to use Federal resources effectively to deter, prevent, detect, investigate, proceed against, and prosecute unlawful use by persons of the identifying information of other persons, including through: increased aggressive law enforcement . . . improved public outreach by the Federal Government to . . . educate the public about identity

> theft and protective measures [that] address how the private sector can take appropriate steps to protect personal data and educate the public . . . and increased safeguards that Federal departments, agencies, and instrumentalities can implement to better secure government-held personal data (Exec. Order No. 13402, p. 27945).

The Attorney General and Chairman of the Federal Trade Commission were named co-chairs, and a core membership consisting of the Secretaries of Treasury, Commerce, Health and Human Services, Veterans Affairs, Homeland Security, the Director of Office of Management and Budget, Commissioner of Social Security, Chairman of the Board of Governors of the Federal Reserve System, Chairperson of the Federal Deposit Insurance Corporation, the Comptroller of the Currency, Director of the Office of Thrift Supervision, Chairman of the National Credit Union Administration Board and the Postmaster General was established (Exec. Order No. 13402, p. 27945).

The Task Force was charged with duties to:

(a) review the activities of executive branch departments, agencies, and instrumentalities relating to [combating identity theft], and building upon these prior activities, prepare and submit in writing to the President within 180 days . . . a coordinated strategic plan to further improve the effectiveness and efficiency of the Federal Government's activities in the areas of identity theft awareness, prevention, detection, and prosecution;

(b) coordinate, as appropriate . . . Federal Government efforts;

(c) obtain information and advice . . . from representatives of State, local, and tribal governments, private sector entities, and individuals;

(d) promote enhanced cooperation by Federal departments and agencies with State and local authorities . . . including through avoiding unnecessary duplication of effort and expenditure of resources;

(e) provide advice on the establishment, execution, and efficiency of policies and activities to implement the policy [combating identity theft] to the President in written reports from time to time, including recommendations for administrative action or proposals for legislation; and . . . to the heads of departments, agencies, and instrumentalities as appropriate from time to time within the discretion of the Chairman and Co-Chairman (Exec. Order No. 13402, p. 27946).

The Task Force enlarged the member agencies to include other key agency heads such as the Secretaries of the Departments of Defense and Education, the Small Business Administration, and the Office of Personnel Management. Not only was the breadth of its composition important, but its operational structure encouraged active interagency collaboration in developing the strategic plan. Working groups were formed around law enforcement, education and outreach, legislation and administrative action, regulatory activities, private sector roles, and state, local, and tribal government roles. Each was charged with assessing current activities and initiatives, identifying best practices and recommending actions to improve effectiveness in these areas. The Office of Management and Budget (OMB) played a crucial role in the development of the comprehensive strategy because of its overview of agency authorities and operations, its singular responsibility for setting government-wide standards and procedure, and its authority to ensure agency compliance. The pre-existing interagency functional groups that OMB had formed to coordinate and implement government-wide policies, such as the councils of Chief Human Resource Officers, Chief Information Officers, and Chief Privacy Officers were valuable adjunct bodies to the Working Groups and the Task Force ("Facts Sheet: The Work of the President's Identity Theft Task Force," 2006).

The Task Force functioned with a high level of energy and interest, maintaining the personal involvement of top agency officials and experts who were engaged in finding effective solutions to the identity theft crisis. An interim report in September 2006 announced a series of completed actions, including the issuance of draft government-wide standards by OMB to enhance data security and protocols for reporting and handling data breaches. The Task Force's final report recommended a comprehensive set of thirty-one actions and established implementing structures and processes with specified agency responsibilities ("Facts Sheet: The Work of the President's Identity Theft Task Force," 2006).

The Task Force can serve as a model for an aggressive federal assault on health disparities because it illustrates that it can be done effectively with clear leadership and direction from the President and active engagement of all of the top leadership of relevant federal agencies. A broad-based, intense, and time-limited interagency review, analysis, and assessment of the crisis may lead to a strategic set of actions and recommendations of what needs to be done. This could include legislative and administrative action, structural realignments, and resource allocations and needs. It is a necessary step forward on the way to ending health disparities and achieving health equity.

A Conceptual Framework for Developing a Strategic Plan

In view of the multitude of factors affecting health status—race and ethnicity, income, education, environment, geography and others—it is daunting to devise a rational, efficient, and productive conceptual framework for the development of a comprehensive federal strategic plan. What is needed is a way to collect and organize the many pieces of the health disparities puzzle and the multitude of players for a meaningful exploration of related functions and factors. However, this must also be done while maintaining interagency and interdisciplinary analysis and not losing sight of the total dimension of the crisis. Just as broad and multi-faceted as the causes and effects of health disparity, is its complexity and the futility of examining any single aspect in isolation. When tackling such a problem in the maze of federal agency missions, authorities, jurisdictions, and constituencies, an interagency and interdisciplinary framework is necessary to force participants to a

new awareness of the problem and to think "outside of their boxes," with a concern for finding the best solutions rather than protecting the narrower interests of their agencies. The right conceptual framework is, therefore, key to the success of the effort.

One such promising conceptual framework is offered by Kate Meyers of the Kaiser Permanente Institute for Health Policy in *Beyond Equal Care: How Health Systems Can Impact Racial and Ethnic Health Disparities*. Dr. Meyers proposes four major arenas for policy action that are likely to have the most significant impact on health disparities. They are as follows:

1) Individual socioeconomic circumstances.
2) Physical and cultural community environment.
3) Personal management of health.
4) Health care financing and delivery (pp. 75-76).

Under a broad view of health policy, an examination of the impact of individual socioeconomic circumstances and the development of strategies that would help eliminate health disparities would bring together agencies administering the federal income maintenance and entitlement programs, education policy and programs, labor, taxation, immigration, commerce, law enforcement, and others whose policy domains shape the education, work, and income circumstances of individuals. The focus of this grouping should be on the interrelatedness of their policies and programs, how they individually and as a whole contribute to health disparities, and how each individually and as a whole can be part of a strategic solution. Similarly, the arena of physical and cultural community environment would bring together agencies whose policy domains are housing, environment, transportation, safety, food access and nutrition, community development, social services, and recreation. The arena of personal management of health must be addressed by key agencies in both the socio-economic policy domains and the physical and cultural community environment domains. After all, the ability to make beneficial personal health choices most often depends on having the resources, education, and information about healthy alternatives. Personal health choices are also influenced by physical access to healthy activities such as exercise and healthy diet, as well as freedom from stress and low allostatic load. The fourth arena, healthcare financing and delivery, is perhaps the best understood and documented. Examination of health disparities in this arena will involve the agencies directly and indirectly responsible for health and health care policy and programs. This may include some that are less obvious, such as the Internal Revenue Service, with its responsibility for tax policy relating to employer and individual health insurance, the Departments of Labor and Education, the Pension Benefit Guaranty Board, and the Office of Personnel Management.

Conclusion

As this paper illustrates, America's historic promise of the opportunity for a good life is threatened by the lack of opportunity for good health for many of

its people. It is a complex problem with many non-health causes, thus any real and lasting solutions must be broad and interdisciplinary. The role of the federal government in health policy is pervasive, and it is in a unique position to address health disparities. Only a comprehensive strategic approach that treats the causes and effects of health disparities as a complex and multi-dimensional dilemma will achieve real and lasting results. The current emphasis on health care disparities alone will not suffice and will ultimately waste time and resources without addressing the broader crisis of health disparities. A federal assault on health disparities must encompass the important "conditions of life" which are the soil in which improvements in health care must flourish or wither like the proverbial "raisin in the sun." Educational policy, environmental policy, transportation, housing, and civil rights policies are all threads in the fabric of health policy, and they must ultimately be woven together into a strong fabric of health equity for all Americans if we are to continue to be the land of opportunity for a good and healthy life. The call for strategic federal action is imperative, it is urgent, and it is possible. §

Appendix

The Task Force Strategic Plan called for 1) decreased unnecessary use of the Social Security Number (SSN) by Federal, State and local governments; 2) develop a comprehensive record of private sector use of the SSN; 3)educate Federal agencies on how to protect their data and monitor compliance with existing guidance; 4)ensure effective risk-based responses to data breaches suffered by Federal agencies; 5) establish national standards extending data protection safeguards requirements and breach notification requirements; 6) better educate the private sector on safeguarding data; 7) initiate investigations of data security violations; 8) initiate a multi-year public awareness campaign; 9) develop an online clearinghouse for current educational resources; 10) develop reliable means of authentication with involvement of academics, industry, consumers and entrepreneurs; 11) provide specialized training about victim recovery to first responders and others directly assisting identity theft victims; 12) develop avenues for individualized assistance to victims of identity theft; 13) amend criminal restitution statutes to ensure that victims recover for the value of time spent in attempting to remediate the harms they suffered; 14) develop a national program for allowing identity theft victims to obtain an identification document for authentication purposes; 15) assess the efficacy of tools available to victims; 16) establish a national identity theft law enforcement center; 17) develop and promote acceptance of a universal identity theft report form; 18) enhance information sharing between law enforcement and private sector; 19) facilitate investigation and prosecution of international identity theft by encouraging other nations to accede to the Convention on Cybercrime, or to ensure that their laws and procedures are at least as comprehensive; 20) identify countries that have become safe havens for perpetrators of identity theft and target them for diplomatic and enforcement initiatives formulated to change their practices; 21) enhance the U.S. Government's ability to respond to appropriate foreign requests for evidence in criminal cases involving identity theft; 22) assist, train and support foreign law enforcement; 23) increase prosecutions of identity theft; 24) conduct targeted enforcement activities; 25) close gaps n Federal criminal statutes used to prosecute identity theft-related offenses to ensure increased Federal prosecution of these crimes; 26) ensure that an identity thief's sentence can be enhanced when the criminal conduct affects more than one victim; 27) enhance training for law enforcement officers and prosecutors; 28) enhance gathering of statistical data measuring the criminal justice system's response to identity theft.

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Policy Considerations for Long-Term Care: *Cost, Quality & Access*

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Introduction

This essay addresses the issues of cost, quality, and access as they relate to the past, current, and proposed future policies relating to long-term health care in the United States. The geographic focus here is the Midwest, in particular, Illinois; however, relevant federal policies and initiatives will also be addressed. Moreover, due to length constraints, this discussion is a narrow view of long-term care policies. Many related issues will be addressed only briefly, and indeed, some not mentioned at all. Section I begins by discussing the financing of long-term care. Section II addresses both implementation of the *Olmstead* decision and the Deficit Reduction Act grants, which focus on community-based rather than institutional care. Section III explores states' policies for providing long-term care and compares current and proposed Illinois policies to those of other states, notably those of Wisconsin and Minnesota.

Financing Long-Term Care

Long-term care is "[t]he sustained provision of medical and custodial services to individuals, who (through age, disability, or illness) are unable to provide for at least some of their own daily needs."[1] A person of any age may require long-term care, and the definition of long-term care includes care provided by family members and friends. As such, the total amount spent on long-term care in the United States is essentially unascertainable. The total amount spent for paid providers is consistently prodigious—in 2004, $193 billion were expended on long-term care.[2] The collaborative state and federal Medicaid program paid for 49%, or approximately $86 billion of that larger figure.[3] Private long-term care insurance covered only about 1%, and Medicare benefits and out-of-pocket expenditures accounted for the remaining 52%.

Moreover, the cost of long-term care is rising. Specifically, the costs of institutionalized care continue to rise by approximately 5% each year.[4] For example, in

1 Keith Bradoc Gallant, *Long Term Care Insurance: Planning and Paying for "Long Term Care,"* SM054 A.L.I.-A.B.A. 61, 63 (2006).

2 U.S. Government Accountability Office, Long-Term Care Insurance: Federal Program Has a Unique Profit Structure and Faced a Significant Marketing Challenge (2006), *available at* http://www.gao.gov/docsearch/abstract.php?rptno=GAO-07-202.

3 *National Clearinghouse for Long Term Care: Costs of Care?*, (Apr. 20, 2008), www.longtermcare.gov/LTC/Main_Site/Paying_LTC/ Costs_Of_Care/Costs_Of_Care.aspx.

4 This rise mirrors the national inflation rate. Bus. Wk A.L.I. SM054, http://www.aarp.org/bulletin/longterm/Articles/a2003-10-30-dailycost.html. *See also* http://www.businessweek.com/the_thread/wellspent/archives/2005/09/nursing_home_co.html.

2004, the average cost for a private room in a nursing home was $194 a day. By 2005, the cost had risen to $203 daily.[5] In 2006, the average private room in Illinois, excluding the cost of rehabilitation, medications, and therapy was $156 a day.[6]

Out-of-Pocket: Tax Incentives

In 2005, Americans spent nearly $38.5 billion out-of-pocket on long-term care expenses.[7] Although this only accounted for about 21% of the total expenditures on long-term care, this amount is clearly significant.[8] What is most appealing about out-of-pocket financing on long-term care is that it requires no previous planning, whereas both long-term care insurance and Medicaid does.[9] Thus, paying out-of-pocket is the default method of paying for long-term care for many Americans. Accordingly, the federal government has implemented several tax incentives to encourage long-term care consumers to pay expenses out-of-pocket.[10] For example, one federal tax incentive emerges as an allowable "medical expenses" deduction for taxpayers who itemize their deductions. Certain long-term care expenditures, such as some long-term care insurance premiums, are deductible "medical expenses."[11]

Although the aforementioned tax breaks do provide some motivation for people to pay for long-term care out-of-pocket, the pitfalls with such incentives are plenty. For instance, the incentives are short-lived. As noted above, private nursing home care can cost more than $73,000 annually. Indeed, few people could afford to spend such an amount every year for the duration of a loved one's nursing home tenure. Moreover, according to the Census Bureau, the highest average per-capita income in any state was $42,104, clearly below the necessary expenditure needed to maintain adequate nursing home care.[12] Perhaps more importantly, encouraging consumers to pay for long-term care out-of-pocket may be not be in their best interest. As noted above, this is the default method of payment resulting primarily from failure to plan for the future.

Long-Term Care Insurance

5 Bus. Wk ALI SM054, http://www.aarp.org/bulletin/longterm/Articles/a2003-10-30-dailycost.html, http://www.businessweek.com/the_thread/wellspent/archives/2005/09/nursing_home_co.html.

6 Average Daily Cost for Nursing Home Care by State, 2006, http://www.aarp.org/bulletin/longterm/Articles/a2003-10-30-dailycost.html.

7 *Supra note* 3.

8 *Id.*

9 By "Medicaid" the authors meant that individuals who have assets above the criteria for Medicaid, and could therefore conceivably cover the costs of long-term care, intentionally impoverish themselves to qualify for Medicaid. This will be discussed further in Section III.

10 26 C.F.R § 213 (2007).

11 *Id.* As with many allowable deductions, the Internal Revenue Service has issued stringent guidelines on what expenditures may be deducted. *See also* Internal Revenue Service, *What Medical Expenses are Includible?* (January 21, 2008),

12 U.S. Census Bureau, http://www.census.gov/statab/ranks/rank29.html.

As an alternative to out-of-pocket expenses, long-term care insurance has developed as a relatively new type of insurance aimed specifically at covering the costs of long-term care services, many of which are not covered by traditional health insurance providers or Medicare. Services covered by long-term care insurance include in-home services, such as assistance with activities of daily living[13] ("ADLs") as well as care provided in a variety of facility and community settings.[14]

An unfortunate characteristic of long-term care insurance is that it is not widely utilized. In fact, a study completed in 2000 estimated that only 10% of elders owned any long-term care insurance.[15] The causes of such the low utilization of long-term care insurance are not readily understood. Perhaps one reason is that long-term care insurance, like all other types of insurance, does not cover all types of care that may be required. For example, long-term care insurance policies do not generally cover services provided by the family, care that would be payable by Medicare or workers compensation, nor treatment for alcoholism or drug addiction. Also, many policies do not cover care or services that result from an attempted suicide or from intentionally inflicted injuries. This is particularly troublesome since elderly men suffer from high rates of depression and the highest rate of suicide of any population demographic.[16]

The government has tried to encourage more consumers purchasing long-term care insurance. In 2000, Congress passed the Long-Term Care Security Act, requiring that the federal government offer long-term care insurance to all federal employees.[17] Yet, many federal employees did not buy into the idea of purchasing long-term care insurance.[18] Thus, despite its benefits, the percentage of elders who obtain long-term care insurance remains low. Instead, the majority of elders use alternative financing mechanisms, such as Medicaid, and many default to paying out-of-pocket as they are able.

Medicare & Medicaid

Although Medicare is widely known as our nation's safety net for the elderly, Medicare does not cover the majority of costs of long-term care for Americans. Medicare only covers long-term care services in limited circumstances. Generally,

13 Activities of daily living include having the ability to independently perform functions such as: eating, bathing, dressing, toileting, and transferring. Instrumental activities of daily living include more complex tasks, such as paying one's bills.

14 *What is Long-term care insurance?*, http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/ Private_Programs/LTC_Insurance/index.aspx.

15 Jeffrey Brown, Norma Coe, & Amy Finkelstein, *Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey*, http://www.aeaweb.org/annual_mtg_papers/2007/0107_1300_0701.pdf.

16 *What does long-term care insurance not cover?*, http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/ Private_Programs/LTC_Insurance/index.aspx.

17 U.S. Government Accountability Office, *Long-Term Care Insurance: Federal Program Has a Unique Profit Structure and Faced a Significant Marketing Challenge* (2006), *available at* http://www.gao.gov/docsearch/abstract.php?rptno=GAO-07-202.

18 *Id.*

Medicare will pay for 100 days of long-term care so long as the beneficiary has first spent at least three days (excluding the day of discharge) in the hospital for the same illness and so long as the services needed by the beneficiary require the skilled assistance of a registered nurse or other skilled professional. Additionally, the services must, for practicality's sake, be provided on an in-patient basis.[19] For example, a beneficiary who requires daily wound care and physical therapy may not qualify, because both of those procedures may be performed at home.

Instead, Medicaid covers most of the cost of long-term care. In fact, in 2005, Medicaid paid for nearly half of long-term care.[20] Indeed, some people plan to have Medicaid cover the cost of long-term care. These individuals intentionally impoverish themselves to qualify for Medicaid through a process commonly referred to as "spend down."[21] Critics of this practice note that this allows relatively wealthy middle-class individuals to utilize the Medicaid system, which was established only to provide health care funding for the poor. Conversely, proponents point out that most middle-class individuals cannot afford to pay for long-term care out-of-pocket, and this practice merely allows for their inevitable self-impoverishment, while preserving an estate for their families.

Both Congress and the Clinton and Bush Administrations have clearly taken the side of "spend-down" critics. In § 217 of the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), Congress created criminal penalties for improper transfers of assets by Medicaid applicants. Subsequently, Congress eliminated the criminal penalties against persons transferring the assets but made it a crime for others to counsel a person to make such a transfer.[22] Just two years later, the United States District Court for the Northern District of New York and the United States Attorney General Janet Reno declared the law unconstitutional.[23]

Then, in February 2006, President Bush signed the Deficit Reduction Act ("DRA") into law. When signing the bill, the President stated, "[t]he bill tightens the loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits. Along with governors of both parties, we are sending a clear message: Medicaid will always provide for those in need, but we will never tolerate waste, fraud, or abuse." Thus, while a hotly debated ethical issue, "spend down" is not uncommon, and evidence suggests that its prevalence is actually increasing.[24]

19 Julie Stone, CRS Report, http://opencrs.cdt.org/rpts/RL33921_20070314.pdf.

20 *Id*. at 1.

21 An individual can do this in several ways. The two most prevalent means include by gifting and creating trusts, such as a Special Needs Trust or a Miller Trust. As I will describe below, Congressional efforts to curtail this practice are currently being implemented.

22 42 U.S.C. § 1320a-7b (2007).

23 *See* New York State Bar Ass'n v. Reno, 999 F. Supp. 710 (N.D.N.Y. 1998); Rainey v. Guardianship of Mackey, 773 So.2d 118, 120, n.4 (Fla. Ct. App. 2000).

24 Cynthia Gruman & Leslie Curry, *Spend-Down Patterns of Individuals Admitted to Nursing Homes in Connecticut -- Discussion Paper 11*, (1999), *available at* http://www.opm.state.ct.us/pdpd4/ltc/researcher/spendown.htm.

To combat the issue, state governors have also sustained various initiatives to revamp Medicaid for long-term care funding. For example, many governors have supported Congress as it works to create special programs enabling seniors to pre-pay for long-term care with guarantees that the state will pick up costs if policy benefits run out. Currently, only four states have the federal government's blessing to operate such plans. Moreover, some states have suggested their own plans to combat "spend down" that involve reverse mortgages and the like.[25]

Another problem that Medicaid faces arises in its deciding how to allocate its already limited funds. That is, should the funds be focused on institutional or home-based care? The following section addresses this issue in detail.

Delivery of Long-Term Care

Background

When the need for long-term care arises, in addition to issues of how long-term care will be financed, another concern that pervades a disabled or elderly person with particular poignancy is where such care will be provided and by whom.[26] A major debate exists concerning whether long-term care should be provided in institutional settings or instead in community and home based settings as they are available.

Disabled adults and older Americans who can no longer live independently have several options under the rubric of "long-term care," including home care, congregate living arrangements, and nursing homes.[27] Home care involves bringing assistance into the residence of an elderly or disabled person and may involve skilled nursing care, such as home health nurses or aides administering medications or performing medical procedures such as injections and insertion of feeding tubes, catheters, or breathing devices.[28] This option also includes personal care or homemaker services with no medical component, such as meal preparation, personal care housekeeping, home maintenance, and simple repairs.[29] Most home care is part-time, generally provided in segments of eight hours or less per day, and usually is not provided every day.[30] Another option, congregate living arrangements, includes assisted living facilities and board and care homes, which provide personal care and homemaker services, including assistance with bathing, laundry, cleaning, and cooking. If a more severe health problem arises, however, the individual will have to be transferred to a hospital or nursing home.[31]

25 Pamela M. Prah, *Governors Plot Revamping of Medicaid*, (Apr. 15, 2005), http://www.stateline.org/ live/ViewPage.action?siteNodeId=136&languageId=1&contentId=25726.

26 Richard L. Kaplan, *Cracking The Conundrum: Toward A Rational Financing Of Long-Term Care*, 1 U. ILL. L. REV. 47, 49 (2004).

27 *Id*. at 50.

28 *Id*.

29 *Id*.

30 *Id*. at 51.

31 *Id*.

Nursing homes are yet another option. Nursing homes are residential facilities that provide long-term care with a substantial medical component.[32] Some nursing homes offer very sophisticated medical treatment as well as common recuperative therapies, such as rehabilitation following certain surgeries. Others provide care for chronic conditions such as Alzheimer's disease and other mental illnesses.[33] Regardless of their specialty, nursing home personnel are on the premises and logically accessible at all times.[34]

Despite the array of available long-term care options, historically, Medicaid has only covered care in institutional settings.[35] Considering that Medicaid pays for almost half of all persons receiving long-term care, a large percentage of disabled adults and elderly do not have a choice concerning the delivery of their long-term care. Moreover, many disabled persons who need assistance with daily living but not the full medical complement of nursing homes are forced to reside in nursing homes, as the states did not provide them with a Medicaid covered alternative.

Drivers of Change: The Supreme Court's Ruling in Olmstead vs. L.C.

In 1999, the Supreme Court ruled in *Olmstead v. L.C.* that discrimination results under the American with Disabilities Act (ADA) when states fail to find community placements for individuals with disabilities, thereby causing them to remain in institutions.[36] The *Olmstead* case involved two women with mental illnesses who were Medicaid beneficiaries and who had been treated in institutions in Georgia. The women brought suit challenging their continued confinement and alleged that the state's failure to place them in community-based settings after their doctors determined that such placements were appropriate violated Title II of the American with Disabilities Act.

The Supreme Court found that unnecessary segregation of people with disabilities in institutions is discriminatory for two reasons. First, "institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[37] Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."[38] Thus, the Supreme Court held that states must place

32 *Id.* at 56.

33 *Id.*

34 *Id.*

35 Kaiser Commission on Medicaid and the Uninsured, *Olmstead v. L.C.: The Interaction Of The Americans With Disabilities Act And Medicaid,1*, 2 (June, 2004), *available at* http://www.kff.org/medicaid/upload/Olmstead-v-L-C-The-Interaction-of-the-Americans-with-Disabilities-Act-and-Medicaid.pdf

36 *Olmstead v. L.C.*, 527 U.S. 581 (1999).

37 *Id.* at 15.

38 *Id.* at 16.

persons with mental disabilities in community settings rather than institutions when "the state's treatment professionals have determined community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the individual, and placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."[39]

Implementing the *Olmstead* Decision

While finding state funds for long-term health care was already a formidable challenge, states face even greater demands on their budgets post-*Olmstead*. Under *Olmstead*, states are now required to make "reasonable modifications" in programs and activities. Modifications that would "fundamentally alter" the nature of services, programs, or activities are not required.[40] However, the federal government has encouraged states to plan for reforms not only in the health arena but also in the areas of transportation, housing, education, and other social supports to fully integrate people with disabilities into the least restrictive settings.[41]

The Centers for Medicare and Medicaid Services (CMS) has further stated that "*Olmstead* challenges states to prevent and correct inappropriate institutionalization and to review intake and admissions processes to assure that persons with disabilities are served in the most integrated setting appropriate."[42] Additionally, CMS has encouraged states to develop plans with the active involvement of persons with disabilities and their representatives in design, development, and implementation. CMS has provided some recommendations about key principles and practices for states to consider as they develop plans, but has largely left the decision to each respective state.[43]

Many states have begun *Olmstead* implementation by utilizing funds efficiently through home and community-based service (HCBS) waiver programs and by garnering contributions through federal grant programs. Waiver programs allow states to provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent. Forty-eight states are currently using some form of the HCBS waiver system. Also, most states are seeking to curb increasing costs for nursing homes. To cut costs and comply with *Olmstead*, states are expanding the range of home and community-based services that they offer to provide greater options for the elderly, people with

39 *Id.* at 1.

40 Barbara Coleman, *Wendy Fox-Grage & Donna Folkemer, State Long-Term Care: Recent Developments and Policy Directions, US Department of Health and Human Services*, (July, 2002), *available at* http://aspe.hhs.gov/daltcp/reports/stateltc.htm#chapI.

41 *Id.*

42 US Dept. of Health and Human Services, *Letter to State Medicaid Directors*, (January 14, 2000), *available at* http://www.hhs.gov/oct/olms0114.2.tm.

43 *Id.*

physical disabilities, people with mental retardation or developmental disabilities, and other diverse populations with disabilities.

Arguments in Favor of Implementation

Those in favor of implementation of an *Olmstead* plan argue that people with disabilities suffer discrimination when they are committed to institutions against their will.[44] Therefore, such a plan supports civil rights by giving people with disabilities, as well as the elderly, a right to choose between community-based services or nursing home care. Furthermore, pursuant to an *Olmstead* plan, the redistribution of services shall not have the effect of forcing any institutional resident to involuntarily accept community-based services or be involuntarily discharged from a nursing home.[45]

In addition, those in favor of implementation of the *Olmstead* plan argue that community-based services are fiscally responsible and save taxpayer dollars. In Illinois, for example, the state's Department of Human Services calculated that their community reintegration program, which assisted people with disabilities under age sixty to leave nursing homes and reside in the community with appropriate services, saved taxpayers in the state of Illinois more than $55.5 million between 1998 and 2005.[46] The cost savings per year were calculated by taking nursing home costs avoided less up front and home service program costs.

Arguments Against Implementation of the Olmstead *Decision*

Although HCB services have been proven to save taxpayer dollars in the long-term, overcoming the initial cost of implementing such services is a significant hurdle to implementation of the *Olmstead* decision, according to the National Council of State Legislators.[47] New state appropriations are needed to implement many of the community services, especially those related to increasing the number of waiver slots or residential settings that are available to people with disabilities, and stagnant state revenues along with budget shortfalls and an aging baby-boomer population continue to delay the implementation of the *Olmstead* plan.[48]

In addition to the cost of implementing community-based services, in many states, including Illinois, the strength of the nursing home lobbies serves as a barrier to implementation of the *Olmstead* plan. In Illinois, for example, the waiver programs and their advocates are not established enough to compete with the nursing

44 Illinois Olmstead Coalition, *Olmstead Implementation Act-The Time Is Now!, available at* http://home.comcast.net/~sltriano/ilolmsteadact.htm.

45 *Id.*

46 Illinois Department of Human Services Division of Rehabilitation Services, *Cost Savings Resulting From One Community Based Alternative: The Community Reintegration Program, available at* http://home.comcast.net/~sltriano/il.htm.

47 Wendy Fox George, Barbara Coleman, & Donna Folkemer, *The States' Response To The Olmstead Decision: A 2003 Update,*(February, 2004), *available at* http://www.ncsl.org/programs/health/forum/olmstead/2003/olms2003report.htm.

48 *Id.*

home industry as a politically influential industry.[49] Moreover, the nursing home industry and other opponents of the *Olmstead* plan argue that diverting funds from the nursing homes with the implementation of a "money follows the person program" will force nursing homes to either close or simply lack the resources to continue serving disabled persons who need nursing home care. Those opposed to increasing community-based services also argue that these services are more difficult to regulate than institutional services and thereby increase the risk of exploitation and abuse for people with disabilities.

Policies Adopted by State and Federal Governments to Implement *Olmstead*: Addressing Cost, Quality & Access

Federal Requirements

Currently, states are required to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services when: (a) the State's treatment professionals reasonably determine that such placement is appropriate; (b) the affected persons do not oppose such treatment; and (c) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others who are receiving state-supported disability services.[50] The Supreme Court cautioned in *Olmstead*, however, that nothing in the ADA condones termination of institutional settings for persons unable to handle or benefit from community settings. Moreover, the Supreme Court further stated that a state's responsibility, once it provides community-based treatment to qualified persons with disabilities, is not unlimited.[51]

*State by State Implementation: Model Behavior Post-*Olmstead*?*

Each state approached *Olmstead* in a different way. Some states developed specific strategies designed for implementation over a number of years, some identified key priorities for more immediate actions, and others set forth broad policy recommendations upon which to base future action. Meanwhile all states shared to goal of containing spending.[52]

As always, controlling costs has proved to be one of the largest barriers in implementing proper *Olmstead*-compliant policies. However, to facilitate change, CMS

49 Statewide Independent Living Council of Illinois, *The"Olmstead Opportunity" for Illinois, available at* http://www.silcofillinois.org/olmsteadop.htm.

50 US Dept. of Health & Human Services Administration for Children & Families, *The Olmstead Decision Fact Sheet: Assuring Access to Community Living for the Disabled, available at* http://www.acf.hhs.gov/programs/add/otherpublications/olmstead.html.

51 *Olmstead v. L.C.*, 527 U.S. 581 (1999).

52 Barbara Coleman, Wendy Fox-Grage & Donna Folkemer, *State Long-Term Care: Recent Developments and Policy Directions, US Department of Health and Human Services,* (July 2002), *available at* http://aspe.hhs.gov/daltcp/reports/stateltc.htm#chapI.

has awarded $240 million in Systems Change Grants for Community Living distributed throughout all fifty states, as well as two U.S. territories. In all, 287 grants have been awarded during those five funding cycles.[53] These grants are specifically intended to improve long-term care quality and access by helping states and others build the infrastructure that will result in effective and enduring improvements in community-integrated services in addition to structuring long-term support systems that enable individuals of all ages to live in the most integrated community setting suited to their needs, to have meaningful choices about their living arrangements, and to exercise more control over the services they receive.[54]

Further, following from the Deficit Reduction Act of 2005, the Money Follows the Person (MFP) Rebalancing Demonstration began as part of a comprehensive, coordinated strategy to assist states, in making widespread changes to their long-term care support systems to improve both quality and access to long-term care.[55] With the history and strength of the Systems Change grants as a foundation, this initiative is designed to assist states in their efforts to reduce reliance on institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities.[56]

Adoption of Medicaid Waivers

Medicaid can be an important resource to assist states in fulfilling their obligations under ADA and *Olmstead*. The HCBS waiver program in particular is a viable option for states to use to provide integrated community-based long-term care services and supports to qualified Medicaid eligible recipients.[57] As previously mentioned, forty-eight states have also decided to take advantage of the HCBS waiver programs. There is no federal requirement limiting the number of HCBS waiver programs a state may operate at any given time, and currently there are approximately 287 active HCBS waiver programs in operation throughout the country.[58]

Medicaid HBCS waivers are an attempt to provide services not originally dictated by federal law. Federal Medicaid rules originally required only nursing home coverage for eligible long-term care recipients and thereby did not allow for other long-term care options.[59] Rules do allow, however, for CMS to grant waivers from Medicaid nursing care. The waiver is a state plan approved by CMS to provide community services such as home care or assisted living to a certain number of

53 http://www.cms.hhs.gov/RealChoice/01_Overview.asp.

54 *Id.*

55 *See* supra note 53.

56 *Id.*

57 http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp.

58 *Id.*

59 Thomas Day, *About Medicaid Long Term Care, available at* http://www.longtermcarelink.net/eldercare/medicaid_long_term_care.htm#1.

qualifying people.[60] Eligibility for HCBS waivers is determined by each state and can vary even within a single state according to the type of waiver. Different waivers are designed for those who are aged or disabled, mentally retarded or developmentally disabled, children, AIDS infected, and mentally disturbed amongst others.[61] Additionally, federal rules require that waiver participants meet state Medicaid level of care eligibility rules for nursing homes and that the cost for waivers be neutral, meaning they cannot exceed equivalent nursing home costs.[62] Medicaid community waiver care is often a more desirable alternative to nursing homes, and generally those receiving care prefer to stay at home or use community programs, but access to such care is still widely restricted.

The Illinois Prerogative

Illinois institutionalizes its citizens with disabilities—both physical and mental—at one of the highest rates in the nation.[63] Illinois ranks forty-ninth out of fifty states and the District of Columbia for citizens with disabilities receiving residential care in settings of six or fewer persons, with only Arkansas and Mississippi ranking lower.[64] Almost 75% of long-term care dollars are spent on nursing home care.[65] Despite the bias towards institutional care in Illinois, 21% of nursing home residents expressed a preference to reside in their homes and return to the community.[66]

Current Medicaid Waiver Programs in Illinois

Presently, Illinois has nine HCBS Medicaid waiver programs: Children that are Technology Dependent/Medically Fragile; Persons with Disabilities; Persons with Brain Injuries; Adults with Developmental Disabilities; Persons who are Elderly; Persons with HIV or AIDS; Supportive Living Facilities; and Children and Young Adults with Developmental Disabilities.[67] In Illinois, all HCBS waiver programs are 1915(c) waivers and allow eligible individuals to either remain in their own homes or live in a community setting, instead of an institutional setting, such as a hospital, nursing home, or intermediate care facility for the developmen-

60 *Id.*

61 *Id.*

62 *Id.*

63 Access Living of Metropolitan Chicago, *". . . shunted aside, hidden, and ignored . . ." A Blueprint to Implement Olmstead v. L.C. and End the Unnecessary Institutionalization of People with Disabilities in Illinois, available at* http://home.comcast.net/~sltriano/Documents/ShuntedAside.pdf.

64 Illinois Olmstead Coalition, *How Is Illinois Complying (or rather Not complying) with the Olmstead Decision? available at* http://home.comcast.net/~sltriano/il.htm.

65 *Id.*

66 *Id.*

67 Illinois Department of Healthcare and Family Services, *Home and Community Based Waiver Programs, available at* http://www.hfs.illinois.gov/hcbswaivers.

tally disabled.[68] In order to be eligible, the individual must meet Medicaid financial eligibility criteria for the specific HCBS waiver program.[69] In addition, the individual must require institutional care in the absence of the HCBS waiver and the HCBS waiver service package must not exceed the cost of the comparable institutional services.[70]

State Policies Already Adopted: Disabilities Services Act and Older Adult Services Act

Disabilities Services Act of 2003 (Public Act 093-0638)

In response to the Supreme Court's *Olmstead* decision, Governor Rod Blagojevich signed the Disabilities Services Act of 2003 (Public Act 093-0638).[71] The Act seeks to provide the foundation for a wider range of community-based services and supports, including outpatient and residential options.[72] In order to assist in the design and implementation of the Disabilities Services Plan, the Act established a governor-appointed advisory committee called the Disabilities Services Advisory Committee (DSAC). The DSAC is comprised of persons with disabilities, the elderly, disability advocates, family members, and non-voting managers representing the State of Illinois's Departments of Aging, Public Health, Human Services, and Healthcare and Family Services and has been meeting regularly since February 2005 to develop recommendations on how to implement the *Olmstead* decision in the state.[73] However, at this time, none of their recommendations have been enacted.

Older Adult Services Act (Public Act 093-1031)

Later, in August 2004, Governor Blagojevich signed SB 2880, the Older Adult Services Act (Public Act 093-1031).[74] This law supports seniors who wish to stay in their homes by restructuring the delivery of services to include home-based services as well as institutional care.[75] The law requires the Department on Aging to begin the restructure no later than January 1, 2005, and the restructure shall include: the expansion of services to older adults and their family caregivers, subject to the availability of funds; development of rules to implement the law and an annual report of progress; and collaboration between the state Department of Aging, Department of Public Health, and Department of Healthcare and Family Services.[76] As the Governor himself stated in his press release accompanying the bill's signing, the law "responds to the desires of most of our elders who dearly wish

68 *Id.*

69 *Id.*

70 *Id.*

71 Rod R. Blagojevich, *Illinois Disabilities Service Plan Update*, (July 2006), *available at* http://www.dhs.state.il.us/onaNetLibrary/27897/documents/Initiatives/DSAC/DSAC7-06Update.pdf.

72 *Id.* at 2.

73 *Id.*

74 Illinois Department on Aging, "Older Adult Services Act," http://www.state.il.us/aging/1athome/oasa/oasa.htm.

75 *Id.*

76 *Id.*

to remain in communities near their friends and families."[77]

Pending Legislation: The Olmstead Implementation Act (SB 0470)

On February 8, 2007, Senator Maggie Crotty introduced SB 0470: the *Olmstead* Implementation Act of 2007.[78] The proposed law would implement the "money follows the person" system and provides that disabled persons have the right to the amount of public funds that are, or would have been, expended for their care in an institution transferred to pay for their community-based services. However, the legislation does not provide a date by when persons shall be integrated into the community nor does it establish a quota of how many people will be integrated per year. Proponents of the legislation emphasize that the law would increase the personal autonomy and dignity of persons with disabilities and senior citizens by allowing them to use community-based services rather than nursing home care if they so choose. However, opponents emphasize the cost of integrating persons with disabilities into the community. Despite disability advocates' efforts to meet with state legislators about the *Olmstead* Implementation Act on April 25, 2007, the legislation did not make it out of the Rules committee and has remained stalled.[79]

Minnesota

An examination of Minnesota's policies offers a different prospective on long-term care because Minnesota faces several unique challenges. Not only does it have the second longest life expectancy in the United States (surpassed only by Hawaii), but Minnesota also has one of the nation's highest proportions of persons age eighty-five and over.[80] Both of these facts signal a high current and future need for long-term care. This may be the reason that Minnesota has taken what is widely regarded as the most ambitious effort of all the states to reshape long-term care policy. Minnesota's efforts were lead by its Long-Term Care Task Force, which began meeting in 2000.[81] The Long-Term Care Task Force was not created specifically as a response to *Olmstead*, and Minnesota has enjoyed a head start by recognizing long-term care issues before they reached the national forefront; the

77 Office of the Governor, *Gov. Blagojevich Signs New Law Supporting Home-Based Care For Seniors*, (Aug. 27, 2004), *available at* http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=3343.

78 S. 0470, 95th Gen. Assem., Reg. Sess. (IL 2007), *available at* http://www.ilga.gov/legislation/BillStatus.asp?DocNum=470&GAID=9&DocTypeID=SB&LegId=28223&SessionID=51&GA=95.

79 Access Living, *People with Disabilities Deliver their Message to Springfield*, (Apr. 30, 2007), *available at* http://www.accessliving.org/SpringfieldRallyDayApril-2007.htm. *See also* Bill Status of SB 0470, (Jan. 21, 2008), *available at* http://ilga.gov/legislation/BillStatus.asp?DocNum=0470&GAID=9&DocTypeID=SB&LegID=28223&SessionID=51&SpecSess=&Session=&GA=95.

80 Joanne Binette, *Minnesota Long-term Care Survey: An AARP Survey of Minnesotans* (2002), *available at* http://www.aarp.org/research/reference/publicopinions/aresearch-import-64.html.

81 Barbara Coleman, Wendy Fox-Grage & Donna Folkemer, *State Long-Term Care: Recent Developments and Policy Directions, US Department of Health and Human Services*, (July, 2002), *available at* http://aspe.hhs.gov/daltcp/reports/stateltc.htm#chapI.

task force's policies are directed exclusively at the elderly population.

Minnesota has drastically increased spending devoted to expanding options in home and community-based services for the elderly. This spending has been partially offset by $44 million in savings from downsizing the state's nursing home industry by 5,100 beds.[82] Additionally, the Minnesota legislature has created a comprehensive framework for reshaping the state's long-term care system. Key components of the legislation include encouraging the voluntary closure of nursing homes and making information and assistance more readily available for people and their families who are seeking long-term care services.[83] Other legislative initiatives seek to improve the quality of nursing home care and promote a stable, long-term care workforce.[84]

Finally, Minnesota has successfully implemented the Minnesota Long Term Care Partnership, which aims to increase the number of Minnesotans with long-term care insurance and decrease the number of citizens who are transferring assets to qualify for Medicaid.[85] The State has estimated that this program will save its taxpayers between $120 and $154 million by 2030.[86]

Wisconsin

Wisconsin illustrates yet another approach to state long-term health care issues. Wisconsin state officials report that two of their highest priorities with regard to long-term care are expanding regulation of assisted living facilities and raising nursing home staff rations.[87] These priorities indicate Wisconsin's continued interest in providing quality institutional care. However, Wisconsin generally believes that money should follow the client and, accordingly, the state is working to restructure children's long-term care.[88]

Moreover, Wisconsin has been engaged for several years in developing the Family Care Program, which integrates long-term care services at the county level through local Aging and Disability Resource Centers.[89] The Family Care Program has been a great success thus far. Studies have shown that Family Care actually saves the state money.[90] Indeed, Wisconsin taxpayers save $452 per month for every individual enrolled in Family Care instead of a nursing home.[91] Regardless,

82 *Id.*

83 *Id.*

84 *Id.*

85 Minnesota Department of Human Services, *Minnesota Long-Term Care Partnership*, (Feb. 7, 2008), *available at* http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137036.

86 *Id.*

87 *Id.*

88 *Id.*

89 *Id.*

90 *See supra* note 86.

91 *Id.*

the goal of Family Care is not to save money. Instead, it is to provide Wisconsin residents with affordable long-term care choices that allow them to live independently with dignity.[92] This is an exemplary program that other states can adapt to meet their own needs as they strive toward *Olmstead* compliance and improved long-term care policies for their residents.

Conclusion

Medicaid remains the primary source of public financing of long-term care for people with disabilities, including the elderly. Although, historically, Medicaid only covered institutional care, as a result of the Supreme Court's *Olmstead* decision, the proportion of long-term care financing directed to community based services and the number of disabled adults and elderly residing in the community has increased. However, despite the Supreme Court's decision and disabled persons' preferences for community care, in many states, including Illinois, the majority of long-term care dollars continue to fund institutional care. Society's bias for institutional care and the cost of implementing community based care are the most significant barriers to implementing the *Olmstead* decision. §

92 *Id.*

"The Monster that Ate Nashville": *TennCare and the Future of Government Health Care*

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Introduction

In the summer of 2005, Democratic Tennessee Governor Phil Bredesen announced an agreement with Tennessee's Republican-led legislature on TennCare, the state's eleven-year-old attempt to replicate and improve upon Medicaid. The announcement was disappointing for many Tennesseans and devastating for others. Spiraling costs and out-of-control spending, the Governor announced, made it necessary to either cut benefits or cut beneficiaries from the TennCare system. Since the former option of cutting benefits had repeatedly been blocked by court action, Tennessee had no choice but to embrace the latter option of cutting beneficiaries from the system. Bredesen announced that some 170,000 people, more than 10% of the total number of TennCare patients, would see their coverage lapse at the end of the 2005 fiscal year. Two years later, many Tennesseans still measure time from these 2005 TennCare cuts. The cuts were a surprising (and for some, appalling) development in the TennCare story.

Rarely has a state-led public policy initiative been launched with more fervent hopes and more ardent believers than when former Democratic Governor Ned McWherter launched TennCare in 1994. At the time, the program seemed destined to not only improve the physical health of Tennesseans—while protecting the fiscal health of the state government—but also to serve as an example for other states. At the same time, in the political atmosphere of 1993, McWherter's Republican opponents also saw TennCare as a conservative, state-based alternative to "Hillarycare," the pejorative nickname for the Clinton Administration's attempt at building a national health care system.

In 1993, TennCare looked like the answer to every governor's prayers. It would provide health insurance to the poor and uninsurable while using private health care providers to keep administrative costs down. TennCare placed what its creators considered to be reasonable restrictions on eligibility and benefits. Through the remainder of the 1990s, TennCare succeeded beyond even these optimistic dreams. Tennessee had the lowest uninsured population in the U.S. and spent less per Medicaid enrollee than any other state. Moreover, TennCare attracted the attention of the large 1994 class of conservative Republican governors and governors-elect, who thought that they had found a prototype for winning back from Washington the power over health care policies and returning it to the states.

However, by 2005 the once lauded program was threatening to consume more than 40% of the state budget; care was deteriorating and lawsuits were multiplying. Bredesen, who had been the subject of Vice Presidential speculation in 2004,

found himself staring at what appeared be the end of his promising political career. Corruption was rampant in the system, prompting a federal investigation code-named "Tennessee Waltz." Ultimately, TennCare-related allegations of corruption reached into the office of Tennessee's most powerful legislators. Yet, by 2007, Bredesen's reputation was benefiting from his TennCare decisions, and four imaginative programs have risen from the ashes of the 2005 TennCare debacle.

This is the story of the rise and fall, and rise again, of TennCare. I will take a brief look at the program's origin, at its precipitous fall from grace starting in 2004, at its situation at the time of Bredesen's radical changes in 2005, and at the attempts by Tennessee to repair some of the damage. Through this discussion of TennCare, one of the first state-implemented programs of its kind, unmistakable parallels to the ongoing debate over national health care policies will appear. Any discussion of each should help to inform the other.

The Beginning of TennCare and Its Fall from Grace

Health care was probably the most frequently discussed political issue in 1994. The recent inauguration of President Bill Clinton, his promise during the 1992 campaign of major health care reform, and the somewhat novel situation of having the First Lady taking the lead on such a major policy issue all contributed to an atmosphere of change and experimentation in government health care. In Tennessee, Governor Ned McWherter brought a unique credibility to the health care discussion due to his experience as the owner of several nursing homes. Like Clinton, McWherter was from the centrist wing of the Democratic Party and, like many governors in both parties, was firmly convinced that national problems could and should be addressed at the state level.

McWherter was also eager to test the new administration's commitment to granting waivers to states whose leaders wished to experiment with government programs. Clinton had said repeatedly during his campaign that his experience as governor of Arkansas had convinced him that Washington did not hold all the answers and that he would be liberal in granting waivers to state governments wishing to temporarily avoid federal regulations in order to pursue new state programs.

The most significant change to health care that McWherter envisioned was a shift from the traditional Medicaid fee-for-service system to something closer to managed health care. In addition, McWherter broke new ground by insisting that the state program, dubbed TennCare, would not compete directly with private health insurance providers. Rather, the state would only provide insurance to "uninsurables," which TennCare defined as individuals with existing medical conditions or permanent financial difficulties that disqualified them from private health insurance.

At the start, TennCare had characteristics that gained strong support from many Tennessee Republicans. Some were attracted to the idea of states playing a

role in (if not completely taking over) a public policy area that had been increasingly perceived as amenable only to national solutions.[1] Other Republicans favored McWherter's decision to use private firms to manage paperwork, billing, and other administrative aspects of TennCare, which both Democrats and Republicans hoped would help control the program's costs. Finally, the Democratic governor promised to limit benefits and eligibility, making TennCare more of a last-resort safety net rather than a comprehensive program. Put differently, in 1994 most Tennesseans assumed that most other Tennesseans would not rely on TennCare for their health insurance.

Not all of Tennessee's political leaders were convinced of the wisdom of the TennCare approach. On the right, critics pointed to the vague eligibility requirements in the original proposal, and warned that costs for the program could easily rise quickly under the right circumstances. On the left, McWherter also had his critics who thought the program too limited, too stingy, or simply a quixotic attempt to use Tennessee's limited resources to address a problem that required federal involvement. In spite of critics on both sides, however, TennCare began with the best wishes of a broad spectrum of Tennessee's political leadership. Indeed, when the term-limited Democratic McWherter was replaced in 1994 by the conservative Republican Don Sundquist, elected in the Gingrich sweep of that year, the new governor promised to maintain Tennessee's commitment to TennCare.

Long-Term Difficulties Unaddressed

It may have been exactly these sincere, strong, and general feelings of good will toward TennCare that prevented policy makers in Nashville from addressing some glaring deficiencies in the original plan. For example, as early as 1999, after some managed care organizations (MCOs) went bankrupt waiting for their TennCare reimbursements for medical payments made on behalf of beneficiaries, Blue Cross-Blue Shield, the state's largest MCO, threatened to leave the TennCare program unless the state assumed all of the risk.[2]

In addition, it was not until 2004 that Tennessee law prohibited TennCare enrollees from accepting employer-provided private insurance at the same while enrolled in TennCare. A scandal uncovered that year revolved around thousands of Tennessee state employees who failed to inform their employer that they already had medical coverage through TennCare. Opting in some cases to take their private health insurance payments in cash, some workers spent the money on non-health related expenses.[3]

Until 2005, TennCare enrollees did not have to provide even nominal

1 For some Republicans, the general ideological preference for state-based public policy joined a specific hope that Hillary Clinton's national health care plan would fail, while state programs prospered. For some Democrats, TennCare was a real and present danger to the dream of a national, single-payer system.

2 The monster that ate Nashville. (2005, January 22). *The Economist*, *374*, 33.

3 Doniach, A. (2006, October 18). City council briefs. *The [Memphis] Commercial Appeal*, p. B5

co-payments for doctor visits or for other health care services. In addition, there were no limits on either the type or the number of prescription drugs for which TennCare covered. In 2004, each TennCare enrollee was receiving, on average, thirty prescriptions per year.[4] TennCare lacked an executive Inspector General until one was created by a 2005 law.[5] It was only earlier in 2005 that TennCare finally established a procedure for collecting unpaid debts from deceased patients.[6]

At the same time, a series of court cases in the late 1990s and the early part of this decade torpedoed efforts to rein in TennCare benefits. The lawsuits, all of them in federal court, were brought by a group called the Tennessee Justice Center. This liberal public advocacy organization argued that Tennessee had an obligation to provide at least as high a level of benefits to TennCare patients as they would receive if they were still part of the federal Medicaid program.[7] By use of the courts, the Tennessee Justice Center has had as much influence in making policy on health care in Tennessee as any elected official.

By 2005, TennCare costs were rising at the unsustainable rate of 18% per year, rising to a 24% increase in the original draft of the 2006-2007 Tennessee budget. These numbers prompted *The Economist* to devote a cover story to TennCare, aptly titled, "The Monster that Ate Nashville." Compounding this increasingly serious fiscal problem was a worsening political problem that threatened to derail basic reform of TennCare. The original presentation of TennCare to the people of Tennessee was, to put it mildly, overdone. Again, the general enthusiasm in Nashville prompted political leaders from both parties to promise, among other things, that a fully-implemented TennCare would mean no Tennesseans would go uninsured.[8] Expectations about cost and coverage control also proved to be overly optimistic.

The Crisis Comes to a Head

Thus, when Governor Phil Bredesen took over the statehouse in 2003, the seeds of a full-blown crisis had been sown. TennCare's appetite for tax money looked like it would compel state leaders to devote nearly half of the state budget to this single program.[9] The state's bond rating, as measured by Standard and Poor's, fell nearly to the B-range, a rating usually considered suitable only for junk bonds. Because of the political heritage of overselling, many Tennesseans were certain to

4 Ibid.

5 Cook, D. (2007, February 12). State targets TennCare fraud. *Chattanooga Times Free Press*, pp. B2, B4. As we will see below, legislative oversight of TennCare was complicated by some glaring conflicts of interests among the chief legislative overseer of the program.

6 Green, A. (2006, December 2006). A flap over recouping costs of Medicaid: States try harder to cover their losses. *The Christian Science Monitor*. Retrieved April 27, 2008, from http://www.csmonitor.com/2006/1226/p03s03-ussc.html.

7 Berry, E. (2006, November 21). State asks court to throw out health deal. *Chattanooga Times Free Press*, p. B2, B5. An extensive interview with Gordon Bonnyman, the Executive Director of the Tennessee Justice Center, appears in *Health Affairs*, 25 (2006): x217-w225 (published online 25 April 2006).

8 Connolly, D. (2007, February 17). AccessTN insurance begins enrolling. *The [Memphis] Commercial Appeal*, pp. C1-C2.

9 Bredesen would say of this demand for money, "It sort of takes all the air out of the room."

interpret any significant changes in TennCare as "cuts," even if the actual amount of spending on the program merely slowed down. At the same time, Bredesen and the Republican legislative leadership had both won their respective offices in 2002 largely on promises that they would not increase taxes.[10]

Moreover, by 2005 it had become increasingly clear that in some basic ways, TennCare was simply not doing its job. From 1999-2005, Tennessee had the second highest increase in the country of children under the age of 19 from poor families without health insurance.[11] TennCare was clearly failing in its fundamental mission of providing a health care safety net. With cuts in benefits still blocked by federal court decisions, Bredesen took the only alternative open to him: he made large cuts in the number of TennCare enrollees. After negotiations with the legislative leadership, Bredesen announced that an estimated 170,000 beneficiaries would receive letters informing them that their state-provided insurance would end with the close of the 2004-2005 fiscal year.[12]

While the reaction among Tennessee's creditors and bond raters was positive, the political fallout was extreme. Bredesen found himself portrayed as more heartless and insensitive than the most conservative Gingrich-era Republican governor. Criticism of his no-tax pledge was particularly strong, and Tennessee newspapers abounded with letters to the editor from self-identified working people whose lives were shattered by the cuts.[13]

Bredesen and the legislature attempted to soften the blow. Half of those who received the dreaded TennCare letter in 2005 also received a state-issued certificate that entitled them to require private insurance companies to offer them coverage comparable to what they had under TennCare, provided that they applied within a reasonable length of time.[14] However, if the governor and his fellow political leaders believed that these certificates would spare them political grief, they were soon proven wrong. In the first place, only about half of TennCare's ex-enrollees received these certificates, and the state did not make it clear on what basis some received creditable coverage and some did not. In the second place, the state did not make any arrangement with the private insurance companies to keep premiums down for new policy holders who had formerly been covered by TennCare.

Back from the Brink

In spite of the extremely negative publicity that surrounded the TennCare reforms of 2005, which prompted many predictions of Bredesen's forthcoming political demise in 2006, the governor actually began to benefit from his reforms for a number of reasons. First, as a Democrat, Bredesen was more insulated from

10 The sudden political demise of former Governor Don Sundquist was primarily due to his plan to raise taxes in 2002.

11 Flaum, D. (2007, September 13). Tennessee gets mixed CFED report card. *The [Memphis] Commercial Appeal.*

12 Connolly, D. (2007, June 14) $2.7B TennCare budget sails through. *The [Memphis] Commercial Appeal.*

13 Letters to the editor along these lines still make regular appearances on the op-ed pages in Tennessee.

14 Berry, E. (2006, November 25). State seeks offers to run AccessTN. *Chattanooga Times Free Press*, B1, B3.

charges of meanness and heartlessness, since most such charges came from people to his left and mostly within his own party. The only way for more liberal Tennessee Democrats to punish Bredesen was to run a liberal candidate against him for the gubernatorial nomination in 2006. Such a threat never materialized, and it would have had only a slim chance of success against an incumbent.

Second, Bredesen and his fellow political leaders benefited from the mounting legal troubles of Democratic Senator John Ford of Memphis. Ford spent much of 2005 fending off charges stemming from a federal investigation into fraud and influence peddling. As one of the central players in the FBI's "Tennessee Waltz" investigation, Ford found himself under indictment at the beginning of 2006 for taking $55,000 in bribes, on camera, from an FBI agent. The agent was posing as an executive trying to state contracts from the Tennessee government.[15]

The charges were only the latest in a long string of run-ins with the law for the legislator who described himself to federal officials (also on camera) as "the man who makes the deals." In the 1990s, Senator Ford had been charged with shooting at a truck driver on Interstate 40, taped while cursing at a state trooper who stopped him for speeding, and accused of shooting at utility workers. While being given a parking ticket at the Memphis airport, he allegedly shoved the ticket in the officer's chest and said, "You cannot do a damn thing to me and evidently you do not know who I am." Allegations and behaviors such as these prompted the federal investigation.

In the course of that investigation, Ford was accused of taking over $800,000 in consulting fees between 2002 and 2005 from two TennCare contractors. Doral Dental and OmniCare Health Plan both allegedly paid Ford to facilitate their dealings with state TennCare officials. At the time, Ford was a member of three Senate committees involved in the oversight of the TennCare program.[16] Such was Ford's power and influence in the state senate in 2005 that he was able at first to derail an investigation, and then to delay ethics law changes, simply by threatening to resign. The TennCare-related charges, combined with revelations that Ford's sister, although well-off financially, was a TennCare recipient, brought the program bad publicity at the very time that Bredesen and the legislature were making their radical enrollee-cutting changes.

Other stories of fraud and mismanagement at TennCare surfaced. Tennessee newspapers from 2005 are filled with reports of doctors, hospitals, and patients getting undeserved funds from TennCare fraud. One Jamestown dentist filed more than 500 false claims on dentures, caps, root canals, and other (mythical) procedures before his 2007 conviction.[17] A Nashville couple who said that they were mistakenly placed on TennCare in 2005 said they had trouble getting off the

15 "John Ford and the Law" (2007, April 28). *The Commercial Appeal*, p. A5.

16 Perrusquia, M. (2007, August 11). Ford wants to snip wiretap use in graft trial. *The Commercial Appeal.*

17 Dentist charged with defrauding TennCare. (2007, September 12). *The Knoxville News-Sentinel.*

program, while 170,000 others were being dropped against their will.[18]

At the same time, TennCare was compiling a horrible record of leaving doctors and hospitals with legitimate claims unpaid.[19] Indeed, one of the roots of the 2005 crisis was the growing number of physicians and health care maintenance organizations (HMOs) who were refusing to treat TennCare patients.[20] Finally, the unlimited prescription benefit of TennCare had an unexpected and unwanted consequence. From 1997-2005, consumption of prescription pain-killers rose in Tennessee by 206%, more than twice the national average.[21] It was not until 2007 that doctor-shopping for painkillers was finally made illegal for TennCare recipients. At least one TennCare patient admitted to selling and trading his prescription drugs out of his apartment. "There were eight or ten people in my apartment complex on TennCare," the man said. "That was the place to come if you needed drugs."[22] Front-page news stories painted a picture of TennCare as a wasteful, out-of-control program that favored the corrupt and routinely mismanaged taxpayers' dollars.

Again, the negative publicity assisted Bredesen in making the cuts politically palatable. In fact, although Bredesen continues to draw fire among writers of letters to the editor, the cuts actually turned out to be politically popular less than one year after they were enacted. In October 2006, a poll taken by the *Commercial Appeal* showed that 55% of Tennesseans approved of the TennCare reforms that Bredesen instituted, compared to 29% who disapproved.[23] The month after the poll, Bredesen firmly quieted critics of his TennCare cuts by scoring a decisive win in his try for a second term. The man whose political obituary appeared in 2005 trounced his opponent in 2006.[24]

The Return of TennCare—One Piece at a Time

In spite of his victory, Governor Bredesen was not immediately anxious to discuss his 2005 TennCare cuts. In his 2007 Inaugural Address, the governor made exactly one mention of TennCare.[25] Bredesen's website does not make mention of the TennCare cuts—only listing TennCare as one of a number of links to various agencies of the Tennessee government.[26] Instead, Bredesen spent much of 2007

18 Couple had trouble getting off TennCare. (2007, April 23). *Associated Press Newswire*.

19 Versel, N. (2001, January). TennCare troubles; Ailing program pushes forward despite new setbacks. *Modern Physician*, 5(3), 4. See also Lieberman, T. (2005, December 12). Mismanaged care. *The Nation*, p. 19.

20 Northeast Tennessee only region out of CoverTN health program. (2007, February 23). *Associated Press Newswire*.

21 On role models, painkillers. (2007, September 2). The Knoxville News-Sentinel. (Reprinted from *The [Nashville] Tennessean*. (2007, August 26).).

22 New law makes it a felony to deceive doctors for drugs. (2007, August 11). *Associated Press Newswire*.

23 Locker, R. (2006, October 3). Bredesen builds robust lead over Bryson. *The Commercial Appeal*.

24 It is worth noting that as a Democrat running in 2006, Bredesen had a built-in advantage. At the same time, Tennessee was the only state to elect a freshman Republican Senator, so vulnerability on TennCare might have hurt Bredesen.

25 The text of his address appears on the *Associated Press Newswire*, (2007, January 20).

26 Phil's priorities: Budget. (2007, September 28). Retrieved November 26, 2007, from http://www.tennesseeanytime.org/governor/Budget.do.

establishing, advertising, and promoting four new health care programs designed to restore much of the safety net that Bredesen tore down in 2005.

The first of these programs is CoverKids, launched in March 2007. This program is designed to provide basic medical care to children in families with lower-middle class incomes (a family of three qualifies for the program with a yearly income of $42,925, with four, an income of $51,625 or less).[27] CoverKids is intended to emphasize well-baby and well-child doctor visits as well as generally to improve Tennesseans' use of preventative medicine. The program also promised benefits for children with more urgent needs for medical care; CoverKids has no exclusion for pre-existing conditions. Bredesen inaugurated the program by handing an insurance card to a five-year-old boy at a capitol press conference.

For all of the dire anecdotal evidence of children being denied medical care since the 2005 TennCare cuts, CoverKids did not recieve a large influx of applications when it was unveiled in March of 2007. In fact, from March to August, only 4,000 (of an estimated 127,000 eligible) children were enrolled in the program. Seemingly without even considering the possibility that the program was not as urgently needed as advertised, Bredesen and his administration spent the summer practically demanding that children sign up for CoverKids if their families were eligible. "Giving our children quality health care is just as important as providing them with a quality education," Bredesen said in a statement. He continued, "We are blanketing the state with applications, resources and volunteers to make sure we do not miss any child who could possibly benefit from CoverKids."[28]

The governor traveled all over the state, stopping at schools, shopping malls, food stores and other gathering places to promote the CoverKids program. Outside a Wal-Mart south of Memphis, Bredesen used the sound bite: "At the top of the checklist for everybody this year ought to be health insurance for our children." At the start of the 2007 school year, Tennessee taxpayers paid to have 1,000,000 applications sent home with schoolchildren. The eight-page application included phone numbers for help in filling them out, with instructions in English, Arabic, Kurdish, Spanish and Vietnamese. Back in Nashville, House Democrats were recommending automatic renewal, relieving enrollees of even the burden of filling out a form each year.[29]

The second TennCare substitute program is CoverTN, intended to provide limited health insurance coverage to workers in small businesses that may not be able to provide insurance on their own. As with CoverKids, Bredesen launched the program with great fanfare and a statewide tour. Appearing outside small businesses from Knoxville to Memphis, the governor emphasized the program's promised benefits and introduced Tennesseans who, he said, would benefit from

27 Holden, B. (2007, September 4). The first years. *The[Memphis] Commercial Appeal*.

28 Connolly, D. (2007, July 25). Insurance program strives to cover kids. *The [Memphis] Commercial Appeal*.

29 Batiwalla, N. (2007, August 5). Bredesen campaigns for CoverKids. *The[Memphis] Commercial Appeal*. The day before, the *Chattanooga Times Free Press* quoted Bredesen giving the same speech outside a mall.

the program. After the initial blitz last Spring, Bredesen returned to Memphis in July, while TennCare's chief administrator chided businesspeople for "lagging behind" other parts of the state in applying for the program. Once again, Bredesen seemed almost to take it personally if too few people took advantage of one of his pet programs.

Small business owners have some reason to hesitate to getting involved with CoverTN, beyond the predictable problems of dealing with a new government bureaucracy. To qualify for CoverTN, businesses must have fewer than twenty-five employees, at least half of whom must earn less than $41,000 per year. In addition, businesses that already offer their employees private health care are required to drop it, and "go bare" for six months before any benefits from CoverTN begin.[30] Employers, employees, and the taxpayers each pay one-third of the premium cost. After complying with these requirements, workers at small businesses are eligible for only $25,000 in medical coverage, prompting David Goetz, the program's administrator, to recommend that workers buy catastrophic care insurance as a supplement.[31]

The third part of Bredesen's second-term health care package is CoverRx, which, as the name suggests, provides coverage for prescription drugs. By far, this was the most popular and most requested of the TennCare substitutes. The program had a maximum enrollment of 10,000 people, and this plateau was reached in February 2007, less than three months after CoverRx was unveiled.[32]

While the 10,000-person program cap was clearly a cost-saving measure, the creators of CoverRx may have failed to foresee other ways in which the program's price tag would rise out-of-control. According to the original plan, patients would be limited to five taxpayer-supplied prescriptions per month. However, the fine print of the CoverRx plan initially listed 400 drugs that were not subject to the cap, and the list was soon expanded to include another 600 drugs, provided a patient's doctor said such drugs were necessary.[33] Since the projected costs of CoverRx are in the range of only $3 million per year, Bredesen's aides may think there may be plenty of room for expanded benefits. Such thinking, of course, helped bring TennCare to its 2005 crisis.

Rounding out Bredesen's attempt to reweave the TennCare safety net was AccessTN, a program for adults whose pre-existing medical conditions made them ineligible for most private insurance plans. This group was the original target of TennCare back in 1994. The program carries a fee, and applies to only about one-tenth of the 60,000 seriously-ill Tennesseans dropped from TennCare

30 Flaum, D. (2007, March 22). CoverTN insurance plan falls short, critics say. *The [Memphis] Commercial Appeal.*

31 In spite of these drawbacks, the CoverTN program received praise from President George W. Bush in April 2007. Bush commended Bredesen at a health care roundtable in Chattanooga for being "on the leading edge" of health care reform. See Terhune, C. (2007, April 18). Guarded health: Covering the uninsured, but only up to $25,000. *The Wall Street Journal.*

32 Morris, S. (2007, March 17). Don't mistake CoverTN for health cure-all. *The [Memphis] Commercial Appeal.*

33 Daily briefing, (2006, December 21). *The [Memphis] Commercial Appeal.* See also TennCare relaxes drug limits for some patients. (2006, December 20). *Associated Press Newswire.*

in 2005. Interestingly, the AccessTN program did not receive the sort of high-publicity launch that the other three programs did. Administration officials (not Bredesen himself) somewhat defensively described the program as merely a start, and emphasized that 4,500 of the 6,000 reserved places would be held for those dropped from TennCare.[34] Officials also expressed the hope that federal matching dollars will permit Tennessee to increase the number of slots beyond the original 6,000.[35]

A final theme of Governor Bredesen's health care policy worth noting is the strong emphasis that he and his administration have given to various kinds of preventative medicine. In the wake of the TennCare disaster, Bredesen seems to have concluded that the best way to save money on taxpayer-supplied health care is to give Tennesseans incentives to stay healthy in the first place. This also brings political benefits to Bredesen and his party, since some of the preventative programs he has put in place have introduced more and more Tennesseans to the purported wonders of government-supplied health care.

One element of TennCare that survived the 2005 upheaval was the School Based Preventative Dental Program. A team of dentists and hygienists travel to schools around the state, offering basic dental checkups and cleanings to students whose parents have given permission. Here, as in other parts of the Tennessee health care system, especially pre-2005, there is no effort to distinguish between children whose parents cannot afford regular dentist visits and those for whom school-based dental care is simply more convenient. While each child's "free" care can cost the taxpayers up to $480, it would presumably take an unusually brave legislator to suggest curtailing a children's dental program.[36]

Other preventative measures are likely to generate more controversy. TennCare's proposed budget for 2007 included nearly $3 million to give away smoking cessation products, another $3 million for "smoking cessation counseling" for pregnant women, and nearly $2 million for Weight Watchers memberships for overweight enrollees. Although the overall TennCare budget is slated to grow at a much slower rate than pre-reform days, the agency will still get nearly 10% more money than a year ago (3% of that increase coming from Tennessee's budget).[37] At the same time, the long-term political support for TennCare is likely to rise by even more, since programs like Weight Watchers and nicotine patches will, like the child dental program, draw more Tennesseans into the TennCare program.

Lessons from Tennessee

Since the 2005 crisis, Bredesen has introduced a number of cost-cutting procedures to the operation of TennCare. A federal inspector general report in August

34 Newsbriefs from around Tennessee. (2006, November 14). *Associated Press Newswire.*

35 Connolly, D. (2007, February 17). AccessTN insurance begins enrolling. *The Commercial Appeal.*

36 Melvin, L. (2007, April 30). Traveling dentists visit area schools on a mission. *The Commercial Appeal*, pp. B1, B5.

37 Berry, E. (2006, December 6). TennCare lays out modest expansion. *Chattanooga Times Free Press*, pp. A1, A11

commended TennCare for making extensive use of technology to save money. As an example, the IG cited the e-Rx program, which saves on paperwork. In addition, all 1.2 million TennCare enrollees are part of the state's Shared Health electronic health record.

Of even greater impact was the decision to privatize many of the administrative duties of the agency. Earlier this year, a Virginia Beach-based company won a contract to handle billing and record keeping for TennCare. AmeriGroup will receive a fixed fee for these services, allowing legislators to better predict TennCare's overall costs, while prompting the private firm to find ways to trim these costs.

Earlier, a Chattanooga-based managed care organization agreed to change the way it did business with the state. Previously, the MCO had received a flat rate for paying claims to patients and providing related services. Now, it receives a monthly rate per patient to manage all aspects of the patient's state-provided health care, including paying for needed medical care. The goal is to provide the private agency with incentives to urge preventative care and keep TennCare enrollees healthy.

While such steps are likely to slow the rise in TennCare costs, and while it is unlikely that the program will spiral upward fast enough to bring about a repeat of the 2005 crisis, the upward pressure on state-provided health care in Tennessee is not relieved at all by Bredesen's initiatives. Quite the contrary is true, in fact. All four of the substitute programs (CoverKids, CoverTN, CoverRx, and AccessTN) have started out as small programs, with specific goals and limited eligibility. For exactly that reason, legislators may overlook them in the yearly search for budgetary savings in Nashville.

At the same time, the chances for incremental increases in the programs are high, and a slow (or not so slow) process of expanding eligibility seems almost inevitable. Given the fact that Tennessee's government has made itself a competitor with private insurance companies with three of the four programs (AccessTN being the exception), it is likely that the near future will see fewer private companies willing and able to do business in the state. This will eventuality in and of itself increase pressure on future governors and legislators to ease eligibility requirements for state-sponsored programs. Fewer private companies also means less competition, which leads to higher prices and less customer satisfaction. These processes also fuel enthusiasm for state-run alternatives. Finally, given the aggressive methods used by the Bredesen administration to sell the TennCare substitutes to the public, it seems clear that he intends to draw as many Tennesseans as possible away from private insurance. This has sown the seeds of another crisis down the road. §

Policy Salience and Voter Turnout: *An Analysis of Contemporary U.S. Presidential Elections*

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Introduction

Voting is both a right and a duty of every citizen in a democratic state. From its Greek roots, the concept of democracy implies people's participation in running affairs of the state. Campbell et al. (1980) observes that "in the contemporary world, the activity of voting is rivaled only by the market as a means of reaching collective decisions by individual choices." However, despite the significance of elections, not all eligible voters actually vote. In fact, the literature is filled with claims that the number of people turning out to vote in elections is rapidly decreasing even in advanced democracies like the United States. Callander and Wilson (2007) for example observe that "turnout in U.S. presidential elections averaged only 56% of the eligible voting population in the last decade." They note that, except where voting is compulsory, voter turnout is generally lower now in literally all established democracies, including the United States, than it was in the 1950s and 1960s.

There has been a vibrant scholarly debate on both voter motivation and means of accounting for variations in voter turnout. Myriads of explanations have been put forth to account for variations in voter turnout, including: the level of partisanship (Kaempfer & Lowenberg, 1993); candidates' campaign platforms (Callander & Wilson, 2007); economic heterogeneity (Oliver, 1999); timing of voting day (Franklin, 2004); partisan altruism (Fowler, 2006); balance between party-owned issues and issues viewed as salient by the citizens (Sides, 2007); voters' union membership (Leighley & Nagler, 2007); policy process (Franklin, 1999); and racial diversity (Hill & Leighley, 1999). This multiplicity of variables demonstrates the multidimensional complexity of voter turnout.

Against this background, this study seeks to examine the impact of policy salience on voter turnout. The decision to posit policy salience as an explanatory variable is reinforced by a number of factors. First, there is Lowi's (1972) proposition that policy determines politics, which essentially means that the factors that determine political events such as voter turnout are located in the policy sphere. Lowi's proposition is, however, helpful only to the extent that it suggests a causal link and direction of causality between policy and politics, but it leaves open the task of determining what aspect of policy determines voter behavior. Secondly, Wolf and Holian (2006) observe that scholars are increasingly focusing on how issue salience sways relationships in various political arenas. With regard to the Congress for example, much of the focus is put on how issues of national importance are viewed by the local constituency, and how this shapes the behavior of representatives (Bianco 1994). Judicial scholars have also tried to establish the extent to which issue salience influences assignment of cases to the Supreme Court justices

(Segal & Spaeth, 1993), as well as the amount of time justices spend bargaining among themselves regarding an issue's resolution (Epstein & Knight, 1998). Issue salience has also been used to explain international conflict. Brecher (1993) for example argues that the higher the salience of an issue under contention, the higher the stakes for the actors, and the greater the costs they will be willing to incur to protect their interests. George et al. (1971) argue that the asymmetry of issue salience explains the failure of coercive diplomacy or the nonmilitary tools and why some states are more willing to use military force than others.

Finally, Rabinowitz et al. (1982) observes that despite the wide consensus on the significance of issue salience, little research has focused on the effect of issue salience on attitudes or behavior and in the few cases where researchers have used issue importance in predictive models, the inclusion of salience does not seem to add value to the predictive power of those models. They note that the central theme in these studies is that an individual's political judgments are influenced more by the issues he/she views as important and that the importance attached to issues vary with context. They therefore conclude that, "the literature thus is ambiguous on the subject: salience is widely seen as having great importance in determining the influence of an issue on political decisions; yet, no evidence has been presented to show that the issues people identify as important to them have any more impact on their decisions than issues not so designated" (Rabinowitz et al., 1982, p. 42).

Thus, Lowi's (1972) grand idea that policy determines politics, the research trend observed by Wolf and Holian (2006), and the dilemma noted by Rabinowitz et al. (1982), provide a spring board for this study. It is puzzling indeed, why scholars converge on the fact that policy salience influence voter behavior yet they are unable to yield evidence to sustain this thesis.

Theoretical Perspectives on Policy Salience and Voter Turnout

Issue Salience Theory

The issue salience theory stems from the premise that a vote for party or candidate is often a vote for a given set of policies or salient issues (Carlin & Love, 2007). Because of this, candidates tend to focus on issues which voters consider most important, regardless of whether their party "owns" those issues. When a candidate's agenda stresses issues that voters already consider important, voters see them as responsive to the public. Conversely, when they ignore issues that are crucial to voters, candidates are seen as being out of touch (Sides, 2007). Franklin and Wlezien (1997) argue that people care and hold opinions about salient issues– thus making them politically important. It is these opinions about salient issues that shape voting behavior.

This study finds issue salience theory useful but insufficient. While it does offer a precise indicator of the direction in which our quest for causal drivers of voter turnout should proceed, it does not travel the entire distance. In light of this,

our study seeks to refine and extend the theory by suggesting that voters who view at least one candidate as responsive to their plight are more likely to vote than those who view all contestants as being out of touch.

This study postulates that the probability that an individual will vote increases as he/she becomes convinced that at least one of the parties or candidates is responsive. Conversely, the probability of voting diminishes as a voter becomes convinced that all the contestants are out of touch. Where more than one contestant appears responsive, the voters often use additional non-policy parameters like personal traits and social ties to decide whom to vote for.

Issue Ownership Theory of Voting

Issue Ownership Theory is associated with Budge and Farlie (1983) as well as Petrocik (1996). Its central thesis is that political parties tend to develop issue reputation on account of their stand on key policy issues. This way leaders do change but the party image largely remains intact. In the United States, for example, the Democratic Party has a reputation for being best able to effectively handle issues of education, civil rights, and welfare, while the Republican Party has a reputation for being more competent in dealing with foreign affairs, national defense, and crime (Petrocik 1996). To maintain credibility among voters, parties tend to stress issues they "own," which are consistent with their longstanding image (Alesina, 1988; Bowler, 1990). Individual voting decisions are based on their evaluation of the competence that each party has in handling specific issues. This theory has been used in several empirical studies in the United States (Petrocik et al., 2003; Holian, 2004; Kaufmann, 2004). In their modification of the theory, Bélanger and Meguid (2005) notes that the impact of issue reputation on individual vote choice is mediated by issue salience. That is, issue ownership only affects the decision of those voters who think that the issue in question is important. In this regard they pose the question, "why should knowing that the Democrats (or Labor in Britain, or the Liberals in Canada) are the owner of the health care issue matter for an individual's vote if she thinks that health care is irrelevant" (Bélanger & Meguid, 2005, p. 5)?

The Investor-Voter Model

This model was developed by Popkin et al. (1976). The model views a voter as an investor and designates each vote as an investment in one or more collective goods. The investment of a vote is made under conditions of uncertainty, characterized by costly and imperfect information. To begin with, the voter often has difficulty distinguishing between campaign rhetoric and actual position statements. In addition, the voter typically finds it difficult to interpret vague position statements or fill information gaps (Ang & Peksen, 2007). The decision to vote is thus a function of the voter's calculation of the individual stakes and costs involved in elections, including his/her issue concerns as well as his/her estimates of opportunity for participation. However, the large size of the electorate, the privacy of

the voting act, and the collective aspect of vote investment reduces the value of the vote and makes the expected returns from this investment small compared to their opportunity cost. This encourages free-rider.

Rational Choice Theory

When Mancur Olson (1965) raised the question about why individuals engage in collective action, he set the stage for the emergence of what came to be known as the paradox of voting. His position was that voting is irrational since its costs far outweigh its benefits. The paradox of voting has dominated the rational choice theory literature on voter behavior, deeply dividing many rational choice theorists. On the one hand, there are those who support Olson's position that voting is an irrational act, with some adding that a rational person cannot vote since the odds of one vote influencing electoral outcome are almost zero (Downs, 1957; Rae, 1971; Brunk, 1980; Aldrich, 1993; Lijphart, 1994). Aldrich (1993) notes that voting is a low-cost activity with low benefits and is therefore an irrational act. Lohmann (1993) adds that although the probability of an individual vote making a difference is high in finite-size society, voter turnout tends to zero in a large and poorly informed electorate. Likewise, Brunk (1980) notes that people vote not because they are rational but because they are deluded about the utility derived from voting. He hypothesizes that as people get more educated and have better grasp of the futility and irrationality of voting, voter turnout will decline.

The central thesis of this school of thought is that voting is irrational and deliberate abstention is rational. From this, it can be hypothesized that in any society, the majority of irrational people would always vote and the majority of rational people would always abstain. In this regard, voter turnout would essentially reflect the proportion of the population that is irrational. But how do we determine rationality or irrationality of the voter? In the policy context, a rational voter should identify a policy issue that best corresponds to his self-interest and vote for the party or candidate who guarantees actualization of the relevant policy. However, an irrational voter may support a specific policy but consciously support a party or candidate unlikely to implement the desired policy. In other words, he may make decisions and take actions that are ruinous to his desired outcomes. It is fairly clear from the foregoing discussion that the argument that voters are irrational actors cannot take us far in our quest to understand why people vote the way they do. This is more so because it is less likely that a voter can consciously vote for a party/candidate who is likely to block him from realizing his desired ends, when presented with an option that offers better prospects for realizing his desired ends.

As a result, I shift focus to the other side of the paradox of voting, which embraces voting as a rational act. Scholars like Uhlaner (1993), argue that the consumption benefits of voting make it rational. Others associate the decision to vote with a sense of civic duty (Riker & Ordeshook, 1968; Moon, 1992; Overbye, 1995) and still some view it as a habit (Green & Shachar, 2000; Franklin, 2004).

Similarly, Edlin (2007) argues that voting is rational since it is driven by the greater common good—the need to improve the welfare of others and society in general. Eldlin's argument blends well with James Fowler's (2006) "partisan altruism" model which suggests that turnout is a function of the extent to which each voter is concerned about the welfare of others. The model rests on the idea that, although the chances of a single vote swaying election results are slim, the number of people who enjoy benefits accruing from the victory of the favorite choice is large.

Although scholars like Converse (1964) argue that the average citizen is generally ignorant and irrational, several fairly recent studies indicate that the average citizen is more informed than usually assumed. While he may not be very knowledgeable about politics, an average citizen is able to make rational political choices. As Key (1966) famously put it, "voters are not fools." Page and Shapiro (1992) add that even in the face of individual ignorance, aggregate preferences often react sensibly to real-world trends. Wlezien (1995) compares public reaction to real-world issues and policy to a thermostat. The public adjusts its preference for more or less policy in reaction to current policy levels, favoring less policy when policy increases beyond some level and more when it decreases below a given level. Bueno (2000) concludes that citizens who weigh policy preferences heavily are politically knowledgeable or have specific policy interests.

Rational Choice and Policy Salience

In light of the foregoing discussions, I pursue the idea that when electoral contest elevates key policy issues to sufficient levels of salience, voter turnout is likely to increase. The underlying assumption is that voters are rational, driven by self interest, and have sufficient information on presented policy options and their effect on a voter's self interest. A voter's inclination toward promoting his own self interest motivates him to vote not only when policy issues at stake directly affect him, but also when he is convinced that at least one of the options presented to him during the election has the potential to address whatever he considers to be the greatest problem of the day. In this regard, he either votes because his party or candidate's proposals cater to his specific interests or because he strongly abhors any of the alternative proposals. Either way, he votes to preserve his self interest. It is also possible that while pursuing their self interest, voters often end up pursuing the common interest. This is hardly surprising in view of the classic invisible hand argument in which Adam Smith argued that market forces would always direct individuals purely driven by their own selfish interests to ultimately reach outcomes that result in the common good and maximized social utility.

Popkin observes that "voters actually do reason about parties, candidates, and issues. They have premises and use those premises to make inferences from their observations of the world around them. They think about whom and what political parties stand for; they think about the meaning of political endorsement; they think about what government can and should do. And the performance

of government, parties and candidates affect their assessment and preferences" (Popkin, 1991, p. 7).

Research Question, Hypothesis, and Variable Measurement

Despite the foregoing discussion, one fundamental question still persists, and will constitute the focus of this study: Does *policy salience* influence *voter turnout?* As a first attempt toward answering the question, this study is guided by the hypothesis that, *the higher the salience of key policy issues during elections, the higher the voter turnout*. In this study, the dependent variable is *Voter Turnout* and the independent variable is *Policy Salience*.

Voter Turnout

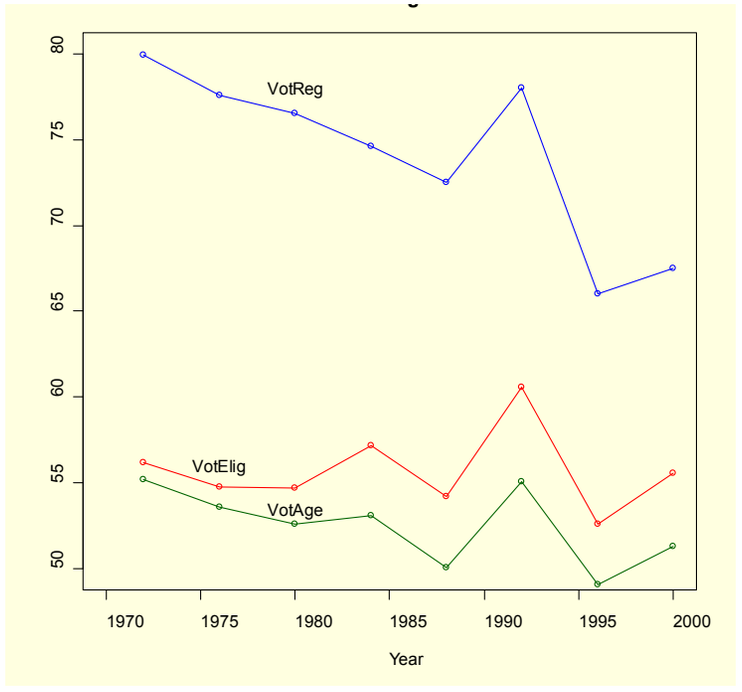
Franklin (2004) could not have been further from the truth when he referred to voter turnout as the *grand enchilada* of puzzles in political science, noting that almost everything about voter turnout is puzzling. Part of the puzzle is of course the meaning of voter turnout. Although scholars concur that voter turnout is about the number of voters who actually cast their vote during elections, there is considerable conceptual latitude with regard to whether the turnout denominator is the voting age population (VotAge), the registered voters (VotReg), or the voting eligible population (VotElig).[1] In reality, it does appear that the real contest is about who is eligible to vote. McDonald and Popkin (2001) argue that taking voter turnout rate as a proportion of the voting-age population is faulty since the VotAge in the United States and in many other democracies consists of all those aged eighteen years or older residing in the country. This includes ineligible felons and alien residents, but excludes eligible voters living overseas. Finally, such conceptualization is based on a mistaken assumption that age alone determines voting eligibility. However, other non-age factors like registration as a voter as well as certain forms of deviance or criminality are also relevant.

McDonald and Popkin (2001) argue that the best voter turnout over time and across states is what I refer to as *VotElig*. They note that the overdramatized decline in voter turnout is in fact an artifact of the way in which the concept is measured. Contrary to popular view, it is not that voter turnout is declining but rather, the number of those ineligible to vote has been increasing. They explain the so-called post-1971 decline in U.S. voter turnout by the fact that the non-citizen population of the U.S. in 1972 was less than 2% of the voting-age population (VotAge), but by 2004 it had risen to 8.5%. Interestingly, the U.S. *VotAge* and *VotElig* data for 1972 through 2000 remains very close as shown in Figure 1 due to the fact that there are very minor non-age barriers to voting eligibility in the U.S. However, there is a significant difference when it comes to VotReg largely because of the variations in

1 I am using the terms, *VotAge*, to refer to voter turnout as a percentage of the voting age population; *VotReg*, as the registered voters or the voting eligible population; and *VotElig* as

voting requirements. While some states require potential voters to register, others do not. The VotReg trends in Figure 1 probably show that when people register to vote, they are more committed and therefore more likely to turn out and vote.

Figure 1
Various U.S. Presidential ElectionTurnout Rates 1972-2000



Data Source: Data derived from various sources as shown in Appenix 2.

I take *voter turnout* to mean the total number of people who cast their votes as a proportion of all those who, according to the electoral laws as of the time of voting, are eligible to vote. It is not reasonable to count those ineligible to vote as part of those who did not turn out to vote. That is, voter turnout is a fraction of the voters, and voters are that fraction of the population which falls within certain parameters defined by law. If the law excludes certain groups of people from voting on account of age, social status, or any other legally ingrained voting qualifications, then such people are not part of the universe called voters of which a fraction turns out to vote.

Policy Salience

There seems to be no consensus on how to measure policy salience. For example, Eisner et. al. (1999) measure salience by counting the number of new stories in a given year that focus on a given policy, through a key word search of *The Readers' Guide to Periodic Literature*. However, as they rightly point out, this measurement

is limited since it does not account for the changing key word conventions in *The Readers' Guide* and the rising number of media outlets.

I take *policy salience* to mean the eminence accorded to a policy issue by both the general public and the political leaders. As a measure for the degree of policy salience, I took public response to the American National Election Studies' (ANES) poll question: *Which political party do you think would most likely get the government to do a better job in dealing with the most important problem facing the country today: Republicans, Democrats, or wouldn't there be much difference between them?* Although the precise wording of the question has slightly changed over the years, the above question nonetheless captures the essence of what the poll's question seeks to address.

It should be noted that this question is usually asked as a follow-up to the question about what is the most important problem facing the country today. After stating what they consider to be the most important problem, respondents are required to state the party which they believe has what it takes to fix the problem. First, I take responses to the question on the most important problem as statements about what respondents consider to be the most salient policy issue. I also assume that the decision about which party can best address the problem is rational and based on the policy campaign platforms of the various parties. I further assume that political parties, at least in the American context, are embodiments of ideas and that electoral contest is largely about policy issues. Given that voters are rational, it is unlikely that they would trust a party or politician without a clear policy agenda on the issue they regard as important. As such, it is reasonable to expect that the answer to the question about which political party is most important is an expression of a shared policy worldview with the party chosen. I therefore took the proportion of those interviewed who feel that at least some political party is capable of addressing their perceived problem as an indicator of the degree of policy salience between the citizens and the political leaders. In any case it is now clear that one of the fundamental principles of democratic government is that policy should be a function of opinion (Weale, 1999).

In essence, I created a policy salience scale of 1-100 scores. The salience score for each year was taken as the proportion of the respondents who stated that either the Democrats or the Republicans could address the most important problem. This was obtained by adding the proportion of those who felt that the Democrats can address the most important problem to those who vouched for the Republicans. These responses are found in Appendix B.

Some clarifications need to be made at this point. First, the study recognizes that the respondents may have tagged different policy issues as "the most important problem" and even recognized different political parties as capable of addressing them. This underlines the fact that voters regard different issues as important, and in some cases, have at least some vague ideas of how they would like the problem addressed. At the same time political parties make several policy proposals with varied degrees of appeal to various sections of their constituencies.

Secondly, although we have treated those who did not directly endorse either Democrats or Republicans as capable of effectively addressing the most important problem as though they lacked a stand, it is possible that some of them felt that both parties had equal capability of addressing the problem. However, two equally appealing policy positions advanced by two equally appealing parties/candidates cannot determine how one would vote in a "one-voter, one-vote system" since it would be difficult to vote for either of them. One of the parties or their policy positions must be preferable if policy were to be the basis for deciding for whom to vote. This explains why the study did not take into account those respondents who argued that the Democrats or the Republicans would not make much difference.

Some scholars argue that salient policy issues change over time. In fact, Best (1999) observes that each policy issue has tended to dominate particular time frames, creating well-defined policy eras. According to Best, racial policy issues were the most salient of domestic priorities in the United States from 1956 to 1969 with annual response average of 57% compared with 18% for other social issues. During the 1970s and 1980s, racial issues steadily become less salient as social policy issues gradually rose to prominence and from 1970 to 1975 social issues became more dominant, comprising 56% of responses annually compared with 13% for racial issues. Although the salience of social policy declined after 1975, concerns of social policy remained alive through the end of the 1980s. Best notes that beginning in 1962, budgetary issues became increasingly salient, eclipsing other policy concerns from 1975 to 1991, averaging 54% of annual responses, compared with 44% for social issues and 2% for racial concerns. It was in this light that Reagan campaigned in 1980, running on a platform of tax cuts, increased military spending, and reduced social spending.

These findings, however, do not negate this study since its focus is not on which specific policy is salient at any given time, but on the general degree of policy salience during an election. In any case, the change in salient policies seems to be very modest. Indeed, some scholars of the election-policy cycle like Isaacs (2004) argue that the key policy agenda for political leaders, the news media, and voters has changed little from successive U.S. presidential elections in the last five decades. Voters have been more concerned with the economy, followed by education, health care, social security, and to a lesser extent in some election years, the proper role of the U.S. in international and military affairs.

Correlating Policy Salience and Voter Turnout

Data Analysis

In order to determine whether there is any correlation between policy salience and voter turnout, we used both the Spearman Rank Order Correlation Coefficient and the Pearson's product-moment correlation. Essentially, these are two sides of the same coin, and as Verzani (2005) notes, "the Spearman rank correlation is the Pearson correlation coefficient computed with ranked data" (Verzani, 2005, p. 88).

Three reasons made Spearman rho very appealing for this analysis. First, due to variations in the measurement of voter turnout as already explained, the raw data relating to turnout tended to vary from one data source to the other. However, the data still retained quite stable ranks, hence the decision to use Spearman rank order correlation. Secondly, coefficient statistics are typically sensitive to the value of n and it has been suggested that the distribution of r is not normal when $n \leq 30$. Given that in this study $n = 8$, Spearman readily transforms itself into a test of the null hypothesis that there is no correlation, against an alternative hypothesis that there is a correlation. Thirdly, although the data as presented here is in ratio scale, it easily converts into ranks which can be analyzed using Spearman.

However, the stability of the ranks mentioned above also imply that the variations in the raw data are minimal, and hence it is still possible to get reliable results from Pearson product-moment correlation coefficient. Secondly, a tie in ranks reduces the accuracy Spearman and its p-value. Since two of the eight policy salience scores (or 25%) were tied scores, as shown in Table 1, it is useful to corroborate the findings using Pearson's Product Moment Correlation Coefficient which utilizes raw data instead of ranked scores. Finally, Pearson correlation requires that the scores are numerical values on an interval or ratio scale, and since the data is on ratio scale, it can corroborate the Spearman rho.

In using the Spearman Rank Order Correlation Coefficient, I began by creating a table with raw data for both voter turnout and policy salience. The voter turnout data was directly extracted from Macdonald and Popkin (2001) as shown in appendix 2. The data was then rank-ordered so that 1992, which is the year in which turnout was highest was ranked first, and 1984 which is the year with the second highest voter turnout was ranked second and so on.

The raw and ranked data on VEP voter turnout and the degrees of policy salience for each year, as extracted from Appendix A and B are shown in Table 1 .

Table 1
Data and Ranks for Policy Salience and Voter Turnout

Year	VEP Voter Turnout		Policy Salience	
	VEP Turnout%	Rank	Degree of Salience	Rank
1972	56.2%	3	49	4.5
1976	54.8%	5	46	6
1980	54.7%	6	50	3
1984	57.2%	2	55	1
1988	54.2%	7	44	7
1992	60.6%	2	52	2
1996	52.6%	8	43	8
2000	55.6%	4	49	4.5

Working with the ranks for voter turnout and policy salience, I got Spearman $r_s = 0.827$ and with $P < .05$. At the same time, working with raw data without ranks, I got Pearson $r = 0.763$ with $P < .05$.

Interpretation of Study Findings

As already pointed out, the Null Hypothesis (H_o) for this study is that there is no correlation between policy salience and voter turnout, while its Alternative Hypothesis (H_a) is that there is a correlation between policy salience and voter turnout. The critical value of Spearman r_s when $n = 8$ and $p = 0.05$ is 0.7143. This satisfies the equation: $-0.7143 \leq H_o \geq +0.7143$. In other words, the acceptance region for H_o lies between -0.7143 and +0.7143. This study yielded $r_s = 0.827$, which falls within the rejection region for H_o within 95% confidence level. We thus reject the Null hypothesis and take the Alternative Hypothesis that there is a correlation between policy salience and voter turnout.

Determining the significance of Pearson r proceeds in much the same way as Spearman. Rather than using the value of n, we use degrees of freedom (df), where $df = n-2$. Given that $n=8$, $df = 6$, the critical value of Pearson r when $p = 0.05$ is 0.707. This satisfies the equation: $-0.707 \leq H_o \geq +0.707$. The acceptance region for H_o is between -0.707 and +0.707. For this study, the computed Pearson $r = 0.763$ which lies within the rejection region for H_o. Once again we reject the Null hypothesis that there is no relationship and embrace the Alternative Hypothesis that there is a correlation between policy salience and voter turnout.

Since the value of both Spearman r_s and Pearson r ranges from -1 to +1, a coefficient of 0.827 for the former and 0.763 for the latter within .05 significance level show a very strong positive correlation between policy salience and voter turnout. This confirms, within the parameters of our study, our hypothesis that policy salience influences voter turnout. However, it should be noted that neither the Spearman r_s of 0.827 nor the Pearson r of 0.763 shows a perfect relationship, which in each case would be 1.000. This means that there could be other relatively mild factors that influence turnout besides policy salience. All the same, the two tests indicate that there is a very strong positive relationship between policy salience and turnout.

Conclusion

The findings of this study support our hypothesis that policy salience influences voter turnout. It shows that policy salience and voter rationality blend well in explaining voter turnout. If voters are not rational as some scholars have argued, policy salience would not matter to them since they would not be able to tell which policy options are in line with their self interest. In fact, even if they knew which policy is in their interest, it would not guide them in deciding whether or not to vote. However, in making a conscious decision to vote or not to vote, voters are

guided by their rational self interest calculations and have little time for issues that are unlikely to secure their self interest or to produce a significant impact in their lives. They would simply be unable to distinguish between party/candidate that is responsive and one that is out of touch. At the same time, if voters do not consider issues to be salient, they would not be psyched to vote.

In essence, Lippmann (1922) was right in noting that the voter has a picture of the world of politics in his mind which determines his voting behavior. This is made even more succinctly by Campbell, who notes that: "By casting a vote, the individual acts towards a political world towards whose objects he perceives and evaluates in some fashion; the view he has formed of the presidential candidates, of the two major parties, and of various political issues and of politically involved groups has a profound influence on his behavior" (Campbell et al., 1980, p. 39).

However, it should be noted that this study, from its very design, did not set out to show that policy salience is the sole explanatory variable responsible for voter turnout, nor does it purport to suggest that that is the case. What it does show is that there is a strong positive correlation between policy salience and voter turnout. This suggests that, to a very large extent, policy salience mobilizes voters and influences turnout.

There is need for a much broader study to include even more elections to further corroborate our findings, it may be important to test our hypothesis in congressional and state elections and also in other established democracies outside the U.S., especially in Western Europe. For now, we tentatively conclude that policy salience determines voter turnout in all democratic frameworks in which political contest revolve around issues. §

Appendix A

Data on ANES Poll Question: Which Party is Best Able to Handle the Most Important Problem?

Response Options	Presidential Election Year							
	1972	1976	1980	1984	1988	1992	1996	2000
Democrats	24%	34%	10%	24%	23%	39%	23%	27%
Not Much Difference	42%	46%	43%	43%	53%	47%	57%	46%
Republicans	25%	12%	40%	31%	21%	13%	20%	22%
Don't Know/ Others	10%	8%	7%	2%	3%	2%	0%	5%
N	1030	2224	1346	1830	1698	1990	741	863

Source: The American National Election Studies (ANES)

Appendix B

National Voter Turnout in US Presidential Elections: 1972–2000

Year	Voting Age Population	Registered Voters	Voter Turnout	Turnout as % of Voting Age Popula-tion*	Turnout as % of Eligible Voters**	Turnout as % of Regis-tered Voters
1972	140,776,000	97,328,541	77,718,554	55.2	56.2	79.9
1976	152,309,190	105,037,986	81,555,789	53.6	54.8	77.6
1980	164,597,000	113,043,734	86,515,221	52.6	54.7	76.5
1984	174,466,000	124,150,614	92,652,680	53.1	57.2	74.6
1988	182,778,000	126,379,628	91,594,693	50.1	54.2	72.5
1992	189,529,000	133,821,178	104,405,155	55.1	60.6	78.0
1996	196,511,000	146,211,960	96,456,345	49.1	52.6	66.0
2000	205,815,000	156,421,311	105,586,274	51.3	55.6	67.5

Source: Data derived from varied sources including Federal Election Commission, Congressional Research Service reports, Election Data Services Inc., Macdonald P. Michael and Samuel L. Popkin 2001 p.966 (as derived from http://www.census.gov/population/www/socdemo/ voting.html). Data include Washington, DC.

** Bureau of the Census estimate of people of voting age living within the United States.*
***The voting-agee population is an estimate of people who are eligible to vote in U.S. elections as determined by Macdonald P. Michael and Samuel L. Popkin (2001).*

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Public Policy and New Destination Latino Immigration

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Introduction

Keep, ancient lands, your storied pomp!" cries she
With silent lips. "Give me your tired, your poor,
Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore,
Send these, the homeless, tempest-tossed to me,
I lift my lamp beside the golden door!"

-from "The New Colossus" by Emma Lazarus. This sonnet, written in 1883, is engraved on a bronze plaque, on a wall in the base of the Statue of Liberty.

Overview

Migration has been an essential element of human existence throughout history. Human migration has shaped the epochs of history and has served as a driving force for the rise and fall of civilizations. Although the ability to migrate and seek a better habitat may simply seem like a natural component of human behavior, immigration between modern nation-states is one of the most contentious issues that frequently arises in American political discussions. In March 2005, following several years of steady growth, the number of undocumented persons in the United States reached an estimated 10.3 million. Approximately 6 million of these individuals are thought to be from Mexico. With 8.5 million undocumented immigrants from Latin American countries, the Latino population makes up the majority of undocumented persons in the United States (Passel, 2005). Before 1995, approximately three-fourths of the total immigrant population resided in just six states: California, Florida, Illinois, New Jersey, New York, and Texas. Just over ten years later, however, the total immigrant populace in these states has waned to about two-thirds, with other states experiencing a rapid increase in immigrant populations over the same time period (Anrig & Wang, 2006).

The sustained growth of the immigrant population of Tennessee is an example of this spread in immigration. According to data drawn from the 2005 U.S. Census, the Latino population of Tennessee had grown by 35% since 2000. This growth was not a demographic anomaly—even though the Latino population of Tennessee has been low by historic standards, that demographic has grown by 286% in the 1990s alone (Lamb, 2005). These numbers demonstrate the significant growth in the Hispanic population of the United States and a similar surge in the state of Tennessee. Rather than providing answers, this data leaves a plethora of public

policy questions unanswered.

The aim of this article is to investigate the complex policy issues surrounding Latino immigration, with an emphasis on how the exponential growth in the Latino community affects Latino immigrants, other residents of the state of Tennessee, and the enactment and enforcement of public policy. Though immigrants come to the United States and to Tennessee from countries throughout the world, I focused my examination on undocumented persons from Latin America. According to the March 2004 Current Population Survey conducted by the U.S. Census Bureau and the Department of Labor, these individuals represent about 81% of the undocumented population in the United States (See Appendix, Figure 3: Estimates for Size and Characteristics of Undocumented Population in the United States).

First, I will examine the growth of the immigrant population in the United States and document the shift of this demographic to "new destination" states that have previously had little experience in managing services and policies for immigrants. Next, I will investigate the means by which Latino immigrants enter the United States illegally and the reasons behind their willingness to subject themselves to the precarious existence of an undocumented person in this country. I will further discuss the obstacles that the undocumented Latino immigrant community faces in Tennessee, from assimilating into mainstream culture to fighting for access to public services and the protections of due process. Subsequently, I will analyze how the influx of Latino immigration affects the native-born residents of Tennessee, and the social attitudes and conceptualizations that native-born residents have of Latino immigrants. Finally, I will discuss the proposed and enacted public policy measures which have an effect on the rights of both Latino immigrants and current residents. I will conclude with my thoughts on how each of these elements influences social justice in the state of Tennessee and my recommendations for the policy measures to be taken to provide a comprehensive alternative to the current U.S. immigration system.

Distinguishing Terms

It is appropriate and necessary at this point to explain certain linguistic choices that I have made as the author.

Immigration/Emigration

Immigration and emigration, due to their homophonic similarities, are often misused or misunderstood by laypersons. Persons who are born in foreign countries and enter the United States for residence are immigrants to this country and are emigrants from their country of origin. Foreign-born and native-born residents of the United States who leave this country to seek legal residency in another country are emigrants from the United States and immigrants in their destination country. The difference between the number of people leaving the United States and the number of people entering the country is known as net migration. If the latter is larger than the former, net migration will be positive, and immigration will have contributed to the United States' population growth (Smith & Edmonston, 1997, p. 21).

Alien/Immigrant/Tourist

An "alien," in the context of the discussion of immigration, is a person from another country who does not have legal residency in this country, whereas an "immigrant" is a person who migrates to another country, typically seeking residence in that country. The connotative difference between these two terms makes the usage of "immigrant," in conjunction with a modifier to indicate documentation status, arguably more neutral than that of "alien," which promotes an image of "otherness" that many believe is an obstruction to an unbiased discussion of policy issues. Nevertheless, there is some use of the term "alien" in government documents, including but not limited to the text of the Immigration Reform and Control Act of 1986 (Library of Congress, 1986). The Immigration and Nationality Act of 1952 (INA), still the main statute governing federal immigration law, utilizes the term "alien," defined as "any person not a citizen or national of the United States" (United States Citizenship and Immigration Services). The INA further defines an immigrant as all "aliens" not within a subset of non-resident "aliens," such as students residing in the United States for the purpose of attending school and diplomatic personnel. Another distinction states that "aliens" who are in the United States on a permanent basis are immigrants, regardless of their legal status, according to "Act 101-Definitions," provided by United States Citizenship and Immigrations Services.

To avoid the implied negative connotations of "alien" while accommodating for its use in the context of legislation and other governmental practices and procedures, I will use quotations, as in the passage above. In my own discussion and analysis, I will use the less contentious term immigrant, following the appropriate modifier to designate legal status.

Visitors to the United States from other countries who are in the country as tourists fall within the technical categorization of "alien," but since this classification has no bearing on the discussion of immigration policy (unless such a person were to violate the terms of temporary legal admission to the country, becoming an undocumented immigrant), I find no need to include a corrective definition.

Illegal/Undocumented

The Associated Press (AP) Stylebook, which serves as the main style and usage guide for newspapers and magazines throughout the United States, suggests the use of the phrase "illegal immigrant" to describe "those who have entered the country illegally" (Goldstein, 2006). The AP Stylebook specifically advocates using "illegal immigrant" rather than "illegal alien" or "undocumented worker." Although

it is certainly against the law for such a person to enter and remain in the United States, pro-immigrant advocates argue that it is inaccurate and premature to use the "illegal" designation. Therefore, I will refer to the act of entering or being in the United States without valid credentials as illegal immigration. Those who have violated the letter of the law and are in the United States illegally are referred to in this work as undocumented persons/workers/immigrants.

According to Adversity.Net, a non-profit organization founded in 1997 to support the "victims of reverse discrimination," the term undocumented immigrant is "designed to deliberately gloss over the fact that such individuals have broken [federal] laws" ("Definitions: Alien, Immigrant, Illegal Alien, Undocumented Immigrant," 2002). Nevertheless, the connotation of terms such as "illegal" and "alien" are potent enough to warrant caution. I have concluded that the combination of the word immigrant, with the modifiers of legal or undocumented to specify authorized status in the United States is the most appropriate usage available.

Latino/Hispanic

The official use of the term Hispanic by the American government originated from the 1970 U.S. Census, where the Census Bureau endeavored to identify Hispanics by the use of the following criteria: people who self-identify Spanish descent or origin; people with Spanish heritage by location of birth or family name; Spanish speakers and people from a Spanish-speaking household (Gibson & Jung, 2002, p. 12). Conversely, the term Latino typically denotes a person who is from or has cultural origins in Latin America. This encompasses areas which were colonized by the countries of the Iberian Peninsula. Countries with inhabitants who do not primarily speak Spanish, such as Brazil, are excluded from the standard definition of Hispanic Americas (see Appendix, Figure 1: Map of the Hispanic World). Though the distinction between Hispanic and Latino is important to some, the White House Office of Management and Budget changed the categorization of "Hispanic" to "Hispanic or Latino," (Office of Management and Budget, 1997). The decision to use these two terms jointly was motivated by regional uses of Hispanic, which were employed more frequently in the eastern sections of the United States, and Latino, which was used more commonly in the western U.S. (Office of Management and Budget, 1997). In 2003, the U.S. Census Bureau further clarified that Hispanic is not a racial classification, as "people who are Hispanic may be of any race. People in each race group may be either Hispanic or Not Hispanic. Each person has two attributes, their race (or races) and whether or not they are Hispanic" (United States Census Bureau, 2003).

While the U.S. government uses Hispanic and Latino interchangeably, I find Latino more fitting for this discussion. Despite varying cultural and social preferences for one word or the other, I find Latino to be the most neutral and descriptive term to use in the discourse of public policy.

Riding America's Immigration Wave

> *"We have got to do something with this question of immigration."*
>
> -Minnesota Senator Cushman K. Davis, in 1894 (Zeidel, 2004, p. 7)

The United States is historically and contemporarily a nation of immigrants. In fact, net international migration in the U.S. adds one person every thirty one seconds to the total population, demonstrating that the United States accepts more legal immigrants as permanent residents than the rest of the world combined ("U.S. population hits 300 million," 2006). Despite this fact, debate on immigration policy rages on. Nearly every new immigrant group throughout American history has received at least some negative treatment or derisory attention from nativists. The effects of legislative and enforcement policies enacted during periods of increased immigration were typically dependent on the amount of political support each group of immigrants garnered. For example, the creation of laws which excluded Asian immigrants from 1882 to 1917 and the 1920s national origin quota systems disfavoring southern and eastern Europeans arguably occurred because of hostile political attitudes toward these immigrant groups. But these debates also resulted in more evenhanded immigration categories in 1965 and a limited amnesty program for undocumented immigrants in 1986 (Hing, 2006, p. 1).

The historical push and pull of U.S. immigration policy between restriction and progression has impacted the current status of the immigration system. Accordingly, a brief chronology of U.S. immigration legislation and policy decisions is included below.

- 1790: Congress established a two-year residency requirement for naturalization (Rubin & Melnick, 2007, p. 256). The Naturalization Act of 1790 limited U.S. citizenship to free white persons (Glenn, 2006, p. 293).
- 1882: The Chinese Exclusion Act prohibited Chinese laborers from entering the United States and denies naturalization to the Chinese in America. The law stood for ten years (Rubin & Melnick, 2007, p. 256).
- 1891: The Immigration Act of 1891 provided the first comprehensive set of immigration laws for the United States and directed the Immigration Bureau to deport "unlawful aliens" (Smith & Edmonston, 1997, p. 24).
- 1921: The Emergency Quota Act set an annual immigration ceiling of approximately 350,000. New nationality quotas were established, limiting admissions to 3% of each nationality living in the United States in the census of 1910 (Miller, 2003). The law was intended to restrict the flow of immigrants arriving from eastern and southern European nations (Rubin & Melnick, 2007, p. 258).
- 1924: The Immigration Act of 1924, also known as the Johnson-Reed

Act, reduced the annual immigration cap to 165,000. This revised quota lowered the admissions rate to 2% of the number of people from a country represented in the U.S. Census of 1890 (Trevor, 1924). This act denied entry to nearly all Asians (Rubin & Melnick, 2007, p. 258).

- 1924: Congress created the Border Patrol (Rubin & Melnick, 2007, p. 258).
- 1952: The Immigration and Nationality Act, also known as the McCarran-Walter Act, permitted immigration from South and East Asia, but limited each country to 100 immigrants (Rubin and Melnick, 2007, p. 261). This law also set a quota for immigrants with vocational skills needed in the United States (Smith & Edmonston, 1997, p. 24).
- 1954: Through Operation Wetback, the U.S. Immigration and Naturalization Service repatriated undocumented Mexican immigrants from the southwest region of the United States (Koestler).
- 1965: The Immigration and Nationality Act repealed the national-origin quota system that was established in 1924 (Rubin & Melnick, 2007, p. 263). It also established a visa system with seven categories intended to increase family unification. Additionally, the Act created a quota for immigration from the Western Hemisphere for the first time, while setting a country limit of 20,000 immigrants for the Eastern Hemisphere(Smith & Edmonston, 1997, p. 24).
- 1986: The Immigration Reform and Control Act (IRCA), signed by President Reagan and also known as the Simpson-Mazzoli Act, declared amnesty for all undocumented immigrants who could prove continuous residence in the United States since January 1, 1982 (Rubin & Melnick, 2007, p. 264). IRCA also increased border enforcement and began to penalize employers for knowingly hiring undocumented workers (Smith & Edmonston, 1997, p. 25).
- 1991: The North American Free Trade Agreement (NAFTA) was enacted. The Mexico-U.S. border saw a massive increase in immigrant population, as maquiladoras, or assembly plants, were built in the region (Rubin & Melnick, 2007, p. 265).
- 1994: Operation Gatekeeper was enacted, and a large wall was erected along the border with Mexico, in San Diego (Goerman, 2006, p. 29).
- 1996: The Illegal Immigration Reform and Immigrant Responsibility Act expanded restrictions for legal immigrants seeking access to welfare benefits (Smith & Edmonston, 1997, p. 25). This act made it possible for U.S. Border Patrol to refuse entry and/or deport immigrants without a guarantee of legal process (Rubin & Melnick, 2007, p. 265).
- 2005: The REAL ID Act placed more restrictions on political asylum and imposed federal restrictions on the forms of documentation that could be used to garner a state-issued driver's license (National Conference of State Legislatures, 2005).

American immigration policies have, in recent years, become increasingly restrictive, particularly toward Latino immigrants. Yet, in March 2004, the estimated number of undocumented Mexican immigrants totaled 5.9 million. These immigrants make up the largest proportion of undocumented persons in the United States and are the largest contribution to undocumented Latino immigration in Tennessee (See Appendix, Figure 5: Census 2000: Hispanic/Latino Population Breakdown for Tennessee). On average, the Mexican population living in America has grown by about half a million people per year over the past decade, with unauthorized migrants accounting for about 80% to 85% of this increase (Passel, 2005). The size and characteristics of the undocumented population are determined by subtracting the estimated legal-immigrant population from the total foreign-born population and treating the residual as a source of data on the unauthorized migrant population because neither the U.S. Census Bureau nor any other government agency counts the unauthorized migrant population in their data collection (Passel, Van Hook, & Bean, 2004).

Perhaps the explanation for the disparity between the statutory restriction of illegal immigration and the proliferation of the undocumented population lies in the federal government's pursuit of contradictory policies for North American integration. While the federal government has pushed for commercial assimilation through the North American Free Trade Agreement, it has conversely sought to curb the flow of laborers attempting to cross the U.S.-Mexico border (Massey, 2005).

Methods and Motivation for Illegal Immigration

Although undocumented immigrants are often thought to be a homogeneous amalgamation, there are three distinct ways in which a person can immigrate illegally. First, a person could stay beyond the sanctioned time period for his or her legal visit to the United States. A second way is to violate the terms of legal entry, such as when a foreign tourist accepts a job with a domestic employer. The third, and perhaps the most openly discussed method for becoming an undocumented immigrant is to enter the country illegally, without the proper inspection or documentation, or at some location other than a legal point of admission (Smith & Edmonston, 1997, p. 21). According to a May 2006 report from the Pew Hispanic Center, a little more than half of the unauthorized immigrant population illegally entered the United States by this method. The share of Mexican legal visitors who overstay is estimated to be 1.7%, which is lower than for Central American at 3.2%, or South American nationalities at 2.4%, because "it is easier for Mexicans to make illegal entries and harder for them to get visitor visas" (Pew Hispanic Center, 2006). However, the March 2005 Current Population Survey and Department of Homeland Security reports indicate that this was the case for only a small percentage of unauthorized immigrants, between 250,000 and 500,000. Some Mexicans

who live near the border entered the United States legally from Mexico using a "Border Crossing Card," a document that allows short visits limited to the border region, but then violated the terms of entry (Pew Hispanic Center, 2006).

The next line of inquiry concerns how these prohibited entrances continue to occur. According to the Pew Hispanic Center's study, "Modes of Entry for the Unauthorized Migrant Population," some undocumented immigrants have evaded customs and immigration inspectors at ports of entry by hiding in vehicles such as cargo trucks. Others have trekked through the Arizona desert, waded across the Rio Grande, or otherwise eluded the U.S. Border Patrol, which has jurisdiction over all the land areas away from the ports of entry on the borders with Mexico and Canada (Pew Hispanic Center, 2006). Policy changes that have heightened border enforcement have had the effect of pushing the flows of illegal immigration into more remote regions along the U.S.-Mexico border; as a result, the death rate at the border has tripled, while the rate of apprehension of undocumented immigrants at the boundary has taken a dramatic fall (Massey, 2005).

The risks incurred by immigrants attempting to cross the border illegally are certainly palpable. According to the U.S. Border Patrol, 1,954 people died crossing the United States-Mexico border between the years 1998-2004. Deaths due to exposure to extreme environmental conditions resulting in hypothermia, dehydration, or heat stroke, have risen sharply since the mid-1990s due to the redirection of migration paths along more treacherous terrain, following the tightening of border enforcement (Eschbach, Hagan, & Rodriguez, 2001, p. 3). But nature is not the only peril jeopardizing the lives and well-being of undocumented persons attempting the journey across the U.S.-Mexico border. For instance, in 2006 the number of immigrants killed in traffic accidents during illegal crossing was about fifty. In a single accident in the Yuma district on August 7, 2006, nine migrants perished in an automobile wreck when the driver of a Chevrolet Suburban lost control after crossing a Border Patrol spike strip at a high speed. There were twenty-one Mexican immigrants in that vehicle (Dobyns, 2006).

Despite the obvious perils faced when entering the United States illegally, undocumented immigrants are still willing to make the trek for economic, political, and personal reasons. A long-held explanation for the motive for much of the illegal immigration to the U.S. has been that people cannot find work in their country of origin. Yet, according to a 2005 study by the Pew Hispanic Center, only 5% of 4,836 Mexican immigrants in seven major U.S. cities who had been in the U.S. for two years were unemployed before they crossed the border. Higher paying job opportunities are the true lure; though the undocumented Mexican immigrants receive only a median income of $300 a week in the United States, the average weekly earnings in their country of origin is only $100 to $120 ("Illegal migrants had jobs back in Mexico, survey finds," 2005).

Another demonstrated impetus for illegal immigration is the desire to escape civil war or subjugation in one's country of origin. Though not as prevalent as the

economic motive, political strife has caused a sizeable portion of the Latino immigrant community in the United States to flee their native countries. For example, El Salvador sends more people per capita to the United States than any other nation (Snyder, 2007). The migration of Salvadorans from their country was due primarily to the civil war in which the Salvadoran government forces worked with mercenary death squads to murder and suppress suspected leftists. From 1980 to 1982, at the height of persecution, an average of 800 bodies were found each month. More than half of the refugees of the civil war immigrated to the United States—between 500,000 and one million (Castellanos). Similarly, a notable Colombian subset of the Latino immigrant population consists of people who fled Colombia as a result of decades of armed violence. As a result of the conflict, approximately one in ten Colombians now live abroad (Bérubé, 2005). Colombia is the fourth largest contributor to the undocumented resident population of the United States, due to the spurring force of political instability in that country (Office of Policy and Planning for the U.S. Immigration and Naturalization Service, p. 9).

Further motivation for illegal immigration is the desire to be reunited with family members or loved ones. In 2005, 6,460 illegal immigrants from Central America under the age of eighteen were detained in the United States while traveling without their parents and were subsequently sent to government shelters, a 35% increase from 2004. While many of these youths were trying to reach family members in the United States, some were drawn to cross the border illegally by the higher wages that have similarly been shown to attract adults (Aizenman, 2006). Another subset of immigrants who face little legal recourse for entering the United States is binational same sex couples. Although gay marriage is recognized in a few states, it is not recognized under federal law, which leads to couples having to decide between leaving the United States to avoid immigration hassles, having one partner in the country illegally, or spending time apart as "love exiles" (Delfín, 2007). The number of undocumented immigrants that are in the United States due to restrictions on legal acknowledgment of same sex unions is probably quite small; in fact, the results of the 2000 U.S. Census found that 6% of the reported 594,391 same sex partnerships included one U.S. citizen and a non-citizen. Nevertheless, for the purpose of the examination of social justice, it is noteworthy.

Tennessee as a New Immigration Frontier

In recent years, there has been a dramatic increase in Latino migration to and settlement in nontraditional areas in the United States (Massey, Durand, & Malone, 2002). Beginning in the 1980s, a number of new states in the Midwest and Southeast began to experience a boom in the growth of their Hispanic populations (Goerman, 2006, p. 2). These states include: Alabama, Arkansas, Georgia, Indiana, Iowa, Minnesota, Missouri, Nebraska, North Carolina, South Carolina, South Dakota, Tennessee, and Virginia (See Appendix, Figure 7. Percentage change in Hispanic population for new destination states, 1990 to 2000). Due to

the recent Latino immigrant population growth in new destination states, "there has been little extensive academic study to date on the living conditions and experiences of Latino immigrants in these new areas" (Goerman, 2006, p. 2), much less any examination of the public policy and governmental implications for this expanding demographic.

The Century Foundation, a non-profit public policy research institution, commissioned research into the experiences of five states that are experiencing new waves of Latino immigration: North Carolina, Iowa, Georgia, Minnesota, and Nebraska. Though there was a certain degree of variation between the states among the home countries of the immigrant populations, local economic factors, and the current state political atmosphere, there were nevertheless three prevailing themes between all five case studies:

1. All of the states began their approach to the arrival of the new immigrant community with an attitude that was open to alterations, sometimes even welcoming the immigrants and encouraging more to come to their state as a means of boosting their economies;
2. Each of the states in the case studies became increasingly ambivalent toward the immigrants within their borders over time, eventually adopting more aggressive policies that hindered the immigrants from being accepted into the mainstream culture;
3. None of the states in the case studies succeeded in creating effective solutions to the key public policy difficulties presented by immigration, particularly undocumented immigration (Anrig & Wang, 2006, p. 2).

Tennessee is certainly capable of falling into the pattern of behavior evidenced in the Century Foundation's case studies of new destination immigration states. According to the U.S. Census Bureau, the percentage growth in the Hispanic population of Tennessee was 278.2% between 1990 and 2000 (See Appendix, Figure 7. Percentage change in Hispanic population for new destination states, 1990 to 2000). Despite this exponential growth, the pattern of Latino migration in Tennessee has a limited concentration, meaning that most towns have been largely by-passed. Notably, the large, metropolitan areas are absent from a list of Tennessee cities with the highest percentage of Latinos, whereas an assortment of small- and medium-sized towns have been greatly affected by the migration wave (Drever, 2006, pp. 20-22). This high concentration of the new Latino immigrant population in towns like Bells and Morristown solidly supports an economic hypothesis for why Latino immigrants are choosing to come to Tennessee; almost all of the places for the most rapid expansion of the Latino community are also centers for agriculture, labor-intensive manufacturing, and food processing. In the last ten years demand for U.S. poultry products, both domestically and abroad, has grown swiftly to the point of exhausting the small labor force of the small towns where the processing plants are located (Drever, 2006, p. 22). This wave of Latino immigration was courted, in a way, as a means of filling the labor void in the food processing industry (Guthey, 2001).

Latino Community in the Cultural Climate of Tennessee

> *"I don't think I could base my will to struggle on cold economics or some political doctrine. I don't think that there would be enough to sustain me. For me, the base must be faith."*
>
> -César Chávez (Espinosa, Elizondo, & Miranda, 2005, p. 3)

The question of how a person acquires American citizenship has a complex response which, when stripped of the intimidating rhetoric and lengthy process, can be outlined in three basic ways. The most common path to citizenship is to simply be born in the United States, following the Anglo-American custom of jus soli or "right of the soil." The right of birthright citizenship is protected by the citizenship clause of the Fourteenth Amendment, which provides that "all persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside" (Schuck, 2007, pp. 44-45). The second path to U.S. citizenship is naturalization, which confers almost all of the rights of citizenship, including the right to vote and greater access to public programs (Smith & Edmonston, 1997, pp. 378-379). In order to be naturalized, a legal permanent resident must have resided in the United States for five years while maintaining that legal status. He or she must also demonstrate the ability to speak, read, and write English, command a basic knowledge of American government and history, and be of good moral character (Schuck, 2007, p. 45). The third route to obtaining citizenship is available to naturalized citizens who wish to sponsor immediate family members for immigration without a numerical cap (Smith & Edmonston, 1997, p. 379).

For those seeking entrance to the United States to pursue employment opportunities, the demand for labor in America does not always equal the number of visas that are available. For example, legal immigration fell by 34% between 2002 and 2003, a drop that was not due to a lethargic market, but more likely because of the tighter government control on entrance to the United States that was prompted by the terrorist attacks of September 11, 2001 (Kaushal, Reimers, & Reimers, 2007, pp. 179-180).

There is clearly an economic call for undocumented migrant workers in the United States. According to the March 2005 Current Population Survey, unauthorized workers accounted for about 4.9% of the civilian labor force, or about 7.2 million workers out of a labor force of 148 million, and in some industries, the

presence of undocumented workers is a much larger percentage. For example, the unauthorized laborers represent 21% of the workers in private household industries, and they make up between 12% and 14% of all the workers in food processing, farming, furniture manufacturing, construction, textiles, and food services (Passel, 2006).

The demand for undocumented immigrants in the American work force is evident, and the realities of the supply should not be surprising. Illegal immigration will continue to occur as people seize these economic opportunities, but what cultural and socio-political issues will the Latino immigrants face in the United States, in the South, or in Tennessee?

The Reality of Being an Immigrant

The variables that are most crucial in analyzing the Latino population in Tennessee and weighing the costs and benefits of having come to Tennessee are language ability, education, income, and the age and gender distribution of the Latino population.

In Tennessee, as in many new destination immigration states, the share of recent immigrants is significantly higher than in states or regions that are traditional areas for Latino immigration, such as California or New York. According to data from the U.S. Census, 20% of all Latinos in the United States were living along or near the nation's borders prior to 1995. In Tennessee, the proportion of recent migrants entering into the population is twice that and is 10% higher than the numbers for the South, as a region (Drever, 2006, p. 28). These "new-arrival" immigrants generally have limited English skills and come from low-income backgrounds (Anrig & Wang, 2006, p. 1). Although Latino movement to southern cities garners more mainstream attention, much of the Hispanic immigrant population is settling in the small towns of the regional South (Furuseth and Smith, 2006, p. 11). Tennessee ranked fourth, according to the U.S. Census Bureau, among the ten states that have the fastest growing non-metropolitan Hispanic population from 1990 to 2000, of which seven were southern states (Furuseth & Smith, 2006, p. 12). Consequently, as the new Latino immigrants make their homes in the towns of the Tennessee countryside, situated around centers of food processing and other forms of industry that have a high demand for undocumented workers, the demography of these small towns undergoes "tectonic shifts" (Drever, 2006, p. 22). These shifts create an area where Latino immigrants may find themselves at a disadvantage compared with their demographic counterparts in other regions of the United States, mainly because these intermediate-sized towns in rural areas do not have the necessary experience to provide public and social services to a growing Latino immigrant population that includes both documented and undocumented persons. The lack of English as a second language (ESL) teachers as well as government or health officials who speak Spanish is apparent in rural Tennessee towns, which were already struggling to provide some basic services before these immigration waves.

The new Latino population is hardly sitting complacently in the cultural and economic environment of Tennessee. Latino immigrants who are recent arrivals are more likely to be attached to Mexican and/or Central American foods, which has spawned the local proliferation of tiendas and tacquerias. Rising to meet the demand for these goods results in storefronts that are more reminiscent of a restaurant or shop in Mexico, and distinct cultural markers like the signs for a tienda add to the color and diversity of the many small southern towns of Tennessee (Drever, 2006, p. 29).

One area where the new Latino immigrant community of Tennessee is certainly at a disadvantage is in education. For 2005-2006, Tennessee schools were ranked forty-first in the nation, and though the state's school systems jumped up eleven rankings to be in thirtieth place for 2006-2007 (Quitno, 2007), the areas of greatest concern for the Tennessee school system, the rural areas, are where some of the larger pockets of Latino immigrants reside. Rural schools have higher drop-out rates and lower teacher pay than the state average, which compounds the worrisome fact that the nationwide Latino drop-out rate was already 29.9 % in 2000, according to the U.S. Department of Education (Drever, 2006, p. 30). The children of new Latino immigrants will face a difficult entry into the work force once they reach adulthood; having grown up in a different environment will probably lead them to be drawn more towards the career expectations of their Americans cohorts, not just those of their parents (Chinchilla, Hamilton, & Loucky, 1993, p. 69). It is unlikely that the children of Latino immigrants in Tennessee will be satisfied with the poor pay levels and the difficult work environment of the food processing industry and the other labor fields that are dominated by undocumented Latino laborers (Drever, 2006, p. 31). However, it is even less likely that these Latino children will have the opportunity to pursue a post-secondary education; immigrants of Hispanic origin are the least likely to have taken or received high scores on the SAT out of those immigrant groups which perform well academically because the schools they must attend do not, for the most part, adequately prepare them for college applications (Suárez-Orozco, C. & Suárez-Orozco, 2007, p. 250).

Though most Latinos have chosen to settle in the two largest cities of Tennessee, the areas experiencing the largest proportional change are the small- and medium-size towns that are centers for labor-intensive industry or food processing. In comparing the human capital of the Latino immigrants living in Tennessee with that of their peers throughout the South and the United States, it is evident that the Latinos in Tennessee are not significantly disadvantaged, even in the area of net earnings, despite the sharp influx of Latinos migrating to this state in 2005 (Drever, 2006, p. 33). Though the Latino community and particularly its undocumented members are still experiencing public policy fluctuations as local and state governments adjust to the changing demographics and political pressures, there is still ample room for hope that the cultural, political, and economic topography of

Tennessee will provide an environment for the Latino immigrant community to grow into their American dream.

Grassroots Organizations, Friends and Foes

In the tradition of American pluralism, first observed by Tocqueville, when a contentious public policy issue is to be contemplated and disputed, people will often organize in order to promote their interests. In addition to the societal and cultural impediments that Latino immigrants face in migrating not only to the United States but additionally to new destination states like Tennessee, there are numerous opposition groups promoting ideas and policies that counter the interests of the Latino immigrant community and its allies. Though many forms and categories of interest groups exist, including everything from corporate entities both for and against immigrant interests to the Chambers of Commerce, I have chosen to focus on member-based citizen groups. Some of these grassroots "foe" organizations that are within that criterion include the following.

The Minuteman Project

In the spring of 2005, California Governor Arnold Schwarzenegger praised the Minutemen Project on a radio show, declaring that the group, which bills itself as a form of "Neighborhood Watch" for the U.S.-Mexico border, had "done a terrific job" and that the "federal government is not doing their job" (Gorman, 2005). The Minuteman Project ended its armed patrols in Arizona the week before Schwarzenegger's comments, and deemed their operation successful, taking credit for a dip in illegal immigration through border-crossing into the United States. Despite the fact that there are approximately 1,700 agents of the Border Patrol assigned to the sixty-six miles from the coast to the Imperial County line, Minuteman Project co-founder Jim Gilchrist insisted that there were still areas uncovered (Gorman, 2005).

During April 2005, trucks with large state and American flags flying above lined the fence separating the United States and Mexico. Some Minutemen carried handguns, while others wore night-vision goggles. The Minutemen publicly claimed that their project resulted in the capture and detention of nearly 350 immigrants along the twenty-three miles of the Arizona border where the group patrolled, taking credit for the dip in illegal immigration to the United States during the period of their watch. Yet, Border Patrol officials said the decrease in crossings was more likely the result of the Minutemen's presence in addition to other factors, such as the intense media attention on both sides of the U.S.-Mexico border (Gorman, 2005).

The Minuteman Project has drawn criticism from an array of opponents, ranging from prominent political officials to university students to organizations like the American Civil Liberties Union (ACLU). One incident in particular drew the ire of the ACLU; on April 6, 2005, Border Patrol agents called in deputies

from the Cochise County Sheriff's office to report that an immigrant was detained by three men who had identified themselves as Minuteman volunteers. The men physically restrained the twenty-six-year-old Mexican man, forcing him to hold a shirt that read "Bryan Barton caught an illegal alien, and all I got was this T-shirt," while his picture was taken and he was videotaped ("ACLU of Arizona Denounces Unlawful Imprisonment of Immigrant by Minuteman Volunteer," 2005).

The Minuteman Project leadership is now under scrutiny by the members of its advisory board. Rev. Marvin Stewart and other members of the board are claiming control over the organization. In initiating the takeover, Rev. Stewart alleged "gross mismanagement" on the part of James Gilchrist, the chairman of the Minuteman Project, and others. Defending the board's assertion of control, Rev. Stewart claimed that Minuteman Project leaders had failed to account for $400,000 of the $750,000 that a direct-mail company helped raise last year for the organization. Gilchrist, the founder of the Minuteman Project, has vowed a court fight to prevent the advisory board from assuming control (Seper, 2007). As of now, there is no indication as to how the looming litigation will affect the activities of the Minuteman Project.

Regardless of their chances to maintain organizational momentum, the volunteer movement that began with the Minuteman Project has spread from its beginnings in Arizona along the U.S.-Mexico border to Appalachia. As of July 2005, at least forty anti-immigration groups had popped up nationally, all inspired by the Minuteman Project (Mansfield, 2005).

Friends of the Border Patrol (FOBP)

Founded in August 2004 by Andy Ramirez, the grandson of a Mexican immigrant, Friends of the Border Patrol (FOBP) is a non-profit corporation with the principle purpose of helping to "educate the public about the duties and responsibilities of immigration law enforcement agents and how they can assist such agents through trained observation and reporting actionable information" ("Frequently Asked Questions for Friends of the Border Patrol"). Energized by the praise the Minuteman Project received from high profile elected officials such as Governor Arnold Schwarzenegger, FOBP initiated the Border Watch program on the U.S.-Mexican border near San Diego during the summer of 2005. Volunteers with FOBP were instructed not to confront people crossing the border illegally, but rather to report their locations to the Border Patrol (Gorman, 2005).

The Tennessee Minutemen

Though they have no direct affiliation with the Minutemen Project, the Tennessee Minutemen share similar goals. Both groups seek to address what they perceive as a lack of adequate law enforcement in curtailing illegal immigration and in preventing undocumented persons from establishing residence in Tennessee. The Tennessee Minutemen, which has planned rallies in Memphis and Nashville

and, as of July 2005, has reputedly heard from at least 120 potential members statewide, insists that its members are neither vigilantes nor racists (Mansfield, 2005). However, certain combative charges made at meetings in Morristown, Tennessee, such as a call for the children of illegal immigrants to be kicked out of public schools, has caused the group to meet with outright opposition from Latino advocacy organizations throughout East Tennessee (Mitchell, 2005).

Tennesseans for Responsible Immigration Policies (TnRIP)

Founded in 2001, Tennesseans for Responsible Immigration Policies (TnRIP) is Tennessee's leading anti-immigration group (Moser, 2006). This non-profit, non-partisan coalition group opposes federal immigration policies that will "force mass U.S. population growth" and depress wages of "vulnerable" workers. The group's website[1] outlines a mission statement that includes a manifesto for its vision of immigration reform. Examples of TnRIP's vision include statements that: all "illegal aliens" should be deported, excluding the spouses of U.S. citizens; all "illegal aliens" should be left without all public services, excepting emergency medical care; and children born in the U.S. to parents who are "illegal aliens" should be denied automatic U.S. citizenship ("Tennesseans for Responsible Immigration Policies – Mission Statement," 2007).

These are just a few concise examples of the anti-immigration or "foe" groups that exist in the U.S. today. Nevertheless, the Latino immigrant community has an abundance of allied "friend" organizations and movements committed to promoting social justice and the well-being of all people, whether they are legal or undocumented residents. Some examples of these "friend" groups and movements include the following.

The "Sanctuary Movement"

In the 1980s, faith-based organizations, in conjunction with more than 200 churches and synagogues across the United States, combined efforts to provide refuge to tens of thousands of political refugees from Guatemala, El Salvador, and Nicaragua. These immigrants, who had crossed the U.S.-Mexico border illegally, sought sanctuary in the U.S. The leaders of this "sanctuary movement," those who provided support to the undocumented immigrants in direct violation of federal law, considered themselves members of a contemporary Underground Railroad (García, 2005, pp. 159-163). These activists took Latino immigrants into their homes, assisted them in their travels, hid them, and helped them find work (Castellano, 2002). There is a distinct possibility of a resurgence of this sanctuary movement due to the appearance since the 1990s of humanitarian and religious organizations like Humane Borders, an organization that provides border crossers with sealed gallons of water (García, 2005, p. 170).

1 http://www.tnrip.org/mission.htm

American Families United

American Families United is a non-profit organization that focuses on helping U.S. citizens who are married to undocumented immigrants. Through lobbying efforts, American Families United seeks to ensure that American immigration laws protect and preserve families. The organization is currently engaging in talks with policymakers to help resolve the issue of families divided by nationality and citizenship ("Love unites them," 2006). According to the organizational website for American Families United[2], the group is working with Morrison Public Affairs Group to approach several members of Congress with proposed amendments that would help members of the organization and many other Americans facing similar situations. Select proposals from American Families United include: lowering barriers to legal immigration for immediate family members of U.S. citizens; enforcing accountability within the immigration process; preventing government errors from causing any further separation of loved ones; and improving the availability of waivers of inadmissibility for spouses of U.S. citizens ("How are we working to help families of American citizens?" 2007).

Tennessee Immigrant and Refugee Rights Coalition (TIRRC)

Founded in January 2001, the Tennessee Immigrant and Refugee Rights Coalition (TIRRC) is a statewide immigrant and refugee-led alliance whose mission is to empower immigrants and refugees throughout the state of Tennessee. TIRRC encourages its members to develop a unified voice, defend their rights, and foster a social and cultural environment in which immigrants and refugees are viewed as positive contributors to the state. Coalition members include organizations and persons representing ethnic groups from countries across Latin America, Africa, Asia, the Middle East, and Europe.

TIRRC joins with other organizations at the local, state, and national level to promote social justice issues that are critical to advancing the security of the immigrant community. For example, on April 5, 2007, TIRRC joined with the Rights Working Group, a national coalition of more than 250 community-based policy organizations, to participate in an event called "The Night of 1,000 Conversations." During this event, small gatherings of people across the nation discussed due process and the need for comprehensive immigration reform ("Night of 1,000 Conversations," 2007). TIRRC also organizes lobbying ventures to the Tennessee political delegation in Washington, D.C. and to Tennessee state legislators in Nashville ("Please Attend the TN New American Day on the Hill," 2007).

2006: Triumph and Set-back for Immigration Reform

For the Latino immigrant community and its allies, 2006 was a year of tribulation in the community's interactions with both national legislative bodies and state and local governments, including those within the state of Tennessee. However,

2 http://www.americanfamiliesunited.org

despite these frustrations and impediments to reaching the Latino community's goal of comprehensive immigration reform at the federal level, 2006 also provided undocumented immigrants with the opportunity to test their ability to unite their voices in protest. Their progress has garnered national attention.

The instigation of the Latino community's mass discontent was the Border Protection, Antiterrorism, and Illegal Immigration Control Act of 2005, a piece of legislation originally introduced in the House of Representatives. This legislation, if passed, would have increased the punishments for taking part in illegal immigration and would have reclassified unauthorized immigrants and those who assisted them in entering or residing in the U.S. as felons. Other examples of the provisions in the legislation slated to be phased in over a period of several years, included: requiring up to 700 miles of additional fencing in the locations along the U.S.-Mexico border with the highest number of illegal entries; ordering that the Department of Homeland Security conduct a study to determine the potential effectiveness of fencing on the U.S-Canada border; increasing penalties for unauthorized immigrants accused of aggravated felonies and various frauds, including marriage and document fraud; and mandating that employers electronically verify the legal status of their workers (H.R. 4437, 2006).

On March 29, 2006, a multitude of about 5,000 immigrant protesters, demonstrating their disgust for H.R. 4437, marched in Nashville from the NFL football stadium to the Capitol (Rodgers, 2006). Following the success of that march, TIRRC organized rallies in Knoxville, Nashville, and Memphis on April 10, 2006. Across the nation, over a hundred similar events occurred on this day of national protest against H.R.4437--legislation the immigrant community regarded as extremely detrimental to their interests ("Tennessee Immigrants Rally Across the State in National Day of Action," 2006).

While H.R. 4437 was being considered, the Comprehensive Immigration Reform Act, or S. 2611, was introduced in the U.S. Senate on April 7, 2006. Regarding the paths to citizenship, this proposed legislation was in sharp contrast to the overly stringent modifications of H.R.4437. Through the process proposed in S.2611, an undocumented immigrant who had been in the U.S. for more than five years could apply for citizenship by paying fines and back taxes (S.2611, 2006). The legislation met with praise from many organizations that represent the immigrant populace. One such organization was the National Immigration Forum, a pro-immigration and advocacy organization. When S. 2611 passed in a Senate vote on May 25, 2006, Frank Sharry, the organization's Executive Director, issued a statement praising the legislation as "a historic bipartisan breakthrough in the Senate in favor of comprehensive immigration reform" (Sharry, 2006). Though S. 2611 passed the Senate with amendments, it never became law. Nevertheless, the legislation remains significant because it emerged immediately following the series of protests and rallies led by the U.S. immigrant community and its allies.

Immigrant and advocate protests continued at the local and national level

throughout the spring of 2006. One such nation-wide protest took place on May 1, 2006, a day-long protest dubbed "A Day Without Immigrants." Those who disagreed with more stringent restrictions on immigration, including immigrants themselves, were asked to boycott all aspects of commerce, including not going to school or to work, as a means of demonstrating the impact immigrants have on the U.S. economy. Chicago had one of the largest turnouts for the protest. On its "Day Without Immigrants" about 300,000 supporters of the protest marched through downtown Chicago. Despite these mass protests, the impact of the walkouts and protests on the economy was questionable, partly because the turnout nationwide was lower than what event organizers had expected. Furthermore, those partaking in the protests were likely to buy extra food and supplies before or after the day of the protest, and absent employees returned to their jobs the next day with extra work awaiting them ("Hundreds of thousands march for immigrant rights," 2006).

Concerns, Quandaries, and the Mentality of Tennessee Residents

> *"Sadly, I've gotten to where I can look at a row of houses now and say, 'They're legal--they're illegal.' Simply because the ones that are legal tend to have that pride of place. The illegals? They don't give a rat's hind end about fitting in or being a US citizen. They're here because they want money, and that's it. They brought their chickens-in-the-yard culture over here with them. You see ten cars parked in the front yard, where you used to see flower beds."*
>
> -Theresa Harmon, co-founder of Tennesseans for Responsible Immigration Policies (Moser, 2006)

Misunderstanding and antipathy between recent immigrant populations and native-born Americans often occurs because the two groups have had few opportunities to interact in the past. Hamblen County, Tennessee might be an ideal testing ground for the truth of this proposition. Within a ten-year span, the Latino population of Hamblen County jumped to represent 6% of the county's total residents. During this time, many white working-class residents were becoming disgruntled about outsourcing, the loss of local jobs to other countries. These white residents viewed the entry of Latino laborers into the community work force as yet another encroachment on their ability to earn a living.

Nevertheless, not all long-term residents of Hamblen County had a negative view of the growing Latino immigrant population. In January 2002, the Morristown-based chapter of the Ku Klux Klan planned a rally to protest the "flood of non-whites into their communities." While the Ku Klux Klan event attracted little

more than fifty attendees, the counterdemonstrations organized by the NAACP and other groups drew crowds of between 800 and 1,000 people (Hing, 2006, pp. 173-174).

The reaction of native born residents of Tennessee to the arrival of Latino immigrants is certainly not homogeneous, yet there are certain misconceptions about immigrants that permeate and obscure the dialogue surrounding immigration. These misconceptions impede the work of seeking just, comprehensive reforms to the U.S. immigration system and to public policies that provide basic services for immigrants.

Conceptualization of the Latino Community

Anti-immigrant sentiments have begun to build in the U.S., based on a growing perception that illegal immigration will substantially increase taxes as the large cost of funding social services required by undocumented immigrants will continue to grow (Frazier & Reisinger, 2006, p. 271). A number of these myths and stereotypes appear repeatedly in the discourse that has accompanied the rise in this country of anti-immigrant feeling. Several of these conceptualizations are presented and discussed below in order to illuminate some of their inaccuracies:

The U.S. immigration issues can be solved by putting more law enforcement officials on the U.S.-Mexico border. The U.S. government has, for the past two decades, pursued contradicting foreign policies. On the one hand, the U.S. government's implementation of NAFTA has opened up North America to economic integration. On the other hand, the government has simultaneously tried to unilaterally curtail the influx of undocumented laborers across the U.S.-Mexico border. These contradictory policies have only added to the complicated issues surrounding illegal immigration. The increased border enforcement at traditional and less dangerous crossings has only forced those trying to cross the border illegally to press into the border's more remote regions. This has led to a decreased apprehension rate, despite the added enforcement. The result has been increased costs which must be shouldered by U.S. taxpayers. Tellingly, the cost of making an arrest at the border went from $300 in 1992 to $1,700 in 2002, an increase of 476% over that ten year period (Massey, 2005).

Latino immigrants who are in the United States illegally pay no taxes, and then they pillage the social services systems for free, unearned benefits. According to a 2002 report from the Bureau of Economics and Business Research at the University of Florida, immigrants in the United States actually pay more in taxes than they receive in governmental services each year. Unfortunately, these excess funds usually flow to the federal government rather than to the local and state governments—the entities that bear a significant portion of the cost of immigrant services (Frazier & Reisinger, 2006, p. 273). In Tennessee, however, sales and property taxes, paid by mostly everyone, are required to fund state programs and services. Sales taxes, which are collected at store cash registers at the point of

purchase, are virtually impossible to evade if basic consumer staples and food are to be bought in the marketplace. As a result, some of this effect may be ameliorated in Tennessee.

Furthermore, undocumented Latino workers live in fear of deportation. They rarely seek social services or file income tax returns because they are wary of being discovered, detained, or even deported. Typically, the only exceptions are when immigrants seek emergency medical care and enroll their children in primary education programs, services that are regarded as too essential to forego (Frazier & Reisinger, 2006, p. 273).

Latino immigrants do not want to learn English. According to the U.S. Census from 2000, only 10% of American-born citizens speak mostly Spanish and cannot speak English well at all. However, the percent of foreign-born Spanish speakers in the U.S. who have poor or non-existent English language abilities is much higher, about 48%. According to the Pew Hispanic Center (2000), 72% of foreign-born Hispanics are Spanish language dominant, whereas another 24% are bilingual. If these language-dominance figures hold true, within the next generation the Spanish dominant category will disappear entirely (Frazier & Reisinger, 2006, pp. 273-274). This rise in the number of Hispanics who are able to speak English is furthered by increasing calls from the Latino immigrant community and its allies for public policy reforms that would provide more funding for English as a second language (ESL) programs.

Latino immigrants are lazy, and they have come to the United States to live on 'handouts' from the government. The desire to secure work is a highly motivating force for Latino immigrants. In fact, economic motivations such as the search for a higher paying job and the desire to earn a better quality of life are among the most common reasons a person chooses to immigrate to the U.S. A recent Latino Labor Report from the Pew Hispanic Center tracked the key labor market indicators for Hispanics and non-Hispanics from the first quarter of 2003 to the first quarter of 2004. The report presents evidence that strong increases in Latino employment played a crucial role in the revitalization of the U.S. labor market, even though some labor force indicators, such as the unemployment rate, have yet to return to pre-2001 levels, the period before the U.S. economy's most recent recession (Frazier & Reisinger, 2006, p. 271).

Undocumented immigrants account for about 6 million members, or 5%, of the U.S. labor force. The participation rate of undocumented male immigrants in the labor force is approximately 96%, a ratio that exceeds that of legal male immigrants or U.S. male citizens. Undocumented women are less likely to be in the labor force, but this absence is likely due to the fact that more undocumented women are of childbearing age, and, for a variety of socio-economic and cultural reasons, undocumented women are more likely to have children and remain at home than their U.S. citizen counterparts (Frazier & Reisinger, 2006, p. 272).

Undocumented immigrants just aren't willing to play by the rules and wait

for their turn to enter the U.S. legally. According to the Pew Hispanic Center, there are approximately 485,000 new, unskilled, and unauthorized migrants who come to the U.S. each year seeking work in the available jobs. However, the U.S. immigration system, as it currently stands, only allows for the issuance of 5,000 visas for low-skilled foreigners seeking year-round work. In testimony before the U.S. Senate Committee on the Judiciary on July 26, 2005, Tamar Jacoby, a senior fellow with the Manhattan Institute, presented the following example illustrating why this disparity between available visas and labor demand is a social injustice:

> A Mexican without family in the U.S. who wants to do something other than farm work has virtually no legal way to enter the country. And even a man with family here must wait from 6 to 22 years for a visa, depending on what kind of relatives he has and what their legal status is. (Jacoby, 2005)

Ejecting illegal immigrants from the U.S. labor force would generate higher wages for legal workers. Economists maintain that expelling undocumented immigrants from the workplace would mean higher wages for legal workers. However, this increase in wages would only be short term. In fact, some members of the construction profession, one of the industries that would be significantly affected by a drop in the number of available laborers, are concerned that removing undocumented workers would drive up home prices, thus driving down profits for the industry (McCombs, 2006).

"We don't come to take jobs that they already have," said Jorge Quintanilla, an undocumented insulation installer, speaking in Spanish during an interview with the Arizona Daily Star. "We don't come to substitute, either. We just come to fill a hole that the demand of the United States economy requires" (McCombs, 2006).

Overall, barring considerable immigration-induced economies or diseconomies of scale, immigration's most probable effect on the economy is modest. This includes the effect of immigration on the total Gross Domestic Product and the effect of immigration on those whom it benefits and, conversely, impacts negatively. However, as a result of immigration, the effect on the U.S. domestic economy might in fact be positive, increasing from $1 billion to $10 billion a year. When viewed in the context of the vastness of the U.S. economy, this amount may not seem sizable, but in absolute terms, it is a significant positive gain (Smith & Edmonston, 1997, p.153). There is considerable disagreement over what impact immigrants have on the economy and what the economic effects would be following their expulsion. Nevertheless, the distinct possibility that the removal of immigrant workers from the U.S. might have a detrimental effect on the U.S. economy warrants serious consideration.

Undocumented immigrants are criminals. Unlawful presence in the United States is a civil violation, not technically a crime. The U.S. House of Representatives

voted on the Border Protection, Anti-terrorism, and Illegal Immigration Control Act of 2005 in December 2005 to designate all undocumented immigrants as "aggravated felons" (H.R.4437, 2005). This bill never became law, but if it had, it would clearly have had an adverse effect on undocumented immigrants who are, as a demographic, predominantly law-biding, other than being an undocumented person. In actuality, immigrants represent the lowest rates of imprisonment for criminal convictions in American society (Rumbaut, Gonzales, Komaie, & Morgan, 2006). According to data from the U.S. Census Bureau, the population of foreign-born persons in Tennessee increased by 267% from the years 1990 to 2004. Yet as indicated by data from the Tennessee Bureau of Investigation, the overall crime rate has, in fact, decreased, and the rate of violent crime has lessened by more than 5%.

Immigration in the Media

The Associated Press Stylebook promulgating the use of the phrase "illegal immigrant" is only one example of how the media, both in broadcast and in print, have the ability to frame the dissemination of information about immigration and to influence the debate on immigration policy reform. In contemporary society, Americans are saturated with visual images, from television, billboards, magazines, and movies. Messages also travel quickly, crossing regional and cultural frontiers with ease, permeating the consciousness of millions of U.S. residents. In deference to the important role that various forms of media have in framing policy discussions and shaping public perception, this section probes into the perceptions that current residents have of Latino immigrants. This section will also discuss the means through which the long-term citizens absorb information about the emergent undocumented immigrant population.

Between 1990 and 2000, Nashville experienced phenomenal growth in its Latino communities. The trend began with a domestic migration of single, young, Mexican males, coming from cities in California and Texas in search of jobs in construction and landscaping, and this movement developed rapidly into an international migration with persons arriving from countries of origin through Latin America. Shortly after, employers from Nashville in the service sector realized that the Latino community presented a new workforce for fast-food restaurants, landscaping businesses, and other low income employment sectors (Winders, 2006, pp. 169-176).

As Nashville went through its rapid social transformations during the late 1990s, the newspaper coverage of Latino immigration and the changing communities of Nashville began to capture the manner in which the native born residents of Tennessee were adjusting to the rapid alteration of the area in a way that economic reports or U.S. Census data would fail to satisfy. Beginning in 1995, the first articles about Latinos began to break into the headlines of *The Tennessean*, but this coverage of the Hispanic community in Nashville was not particularly positive.

In fact, one of the initial articles from this period focused on an "illegal worker crackdown," and the article itself was not placed prominently in the layout of the newspaper, having been relegated to page 4B (Winders, 2006, p. 176).

By 1997, the coverage of the Latino community that appeared in *The Tennessean* accurately depicted the escalating tension in Nashville's Metro Council, which was calling regularly for "crackdowns on illegal aliens." These articles appeared in the foremost sections of the newsprint, typically on page 1B (Winders, 2006, p. 177). The use of phrases like "illegal alien," in such a visible medium as the front pages of the newspaper in this major city captures the building friction between the long-term residents of Nashville and the growing Latino immigrant population, through the new millennium.

In the early months of 2007, there was resurgence in the appearance of the social attitudes Nashville residents bear regarding the Latino immigrant community. Metro Councilman Eric Crafton sponsored legislation that would require Metro government to communicate in English except when federal law or "public health, safety or welfare" required. Though the council approved the measure by vote, Mayor Bill Purcell vetoed it, saying the measure was unnecessary and would make Nashville "less safe, less friendly and less successful" (Cass, 2007). The veto sparked a great deal of commentary in Nashville and beyond. In marked contrast to the Metro Council's attempts to "crack down" on "illegal aliens," the long-term residents of Nashville responded to the veto of Crafton's "English first" proposal, which was far more neutral in language than the vote taken by the Metro Council a decade earlier, with a wave of opinion pieces and editorials that supported Mayor Purcell's decision. Several of these submissions openly supported the Latino immigrant community in Nashville.

In the span of a little more than a decade, the Latino immigration population has blossomed in and around the city of Nashville. Meanwhile, the language used in the city's main newspaper has changed from writing contentious phrases like "illegal alien" to serving as a forum for current Nashville residents to openly praise governmental action that does not restrict or limit the rights to basic services and government functions. *The Tennessean*, from 1995 to today, can function as a barometer to gauge the social attitudes of Tennessee residents toward the Latino immigrant community.

Though reading the newspaper articles from a well-known Tennessee periodical helps to gain a clearer perspective of how the press handles the issues presented by Latino migration, there is ultimately very little that a journalist or an editor can do to affect public policy. However, in the fall of 2006, there was another presence in the media which presented images of the Latino immigrant community in a distinct context, in order to convey a deliberate message to the legal residents of Tennessee. During the 2006 midterm elections for U.S. Congress, U.S. Congressman Harold Ford, Jr. and the former Mayor of Chattanooga, Bob Corker, were both vying for the seat in the U.S. Senate that would be open upon Republican

Senator Bill Frist's retirement. The campaign would be marked with salvos and constant, personal disputes between the two candidates (Sher, 2007). In the wake of the advertisements from each candidate and his supporting organizations that punctuated the media, Ford and Corker left a legacy of depictions of immigration policy that will resonate with voters (and with the undocumented community), years after Ford conceded the election to Corker.

First, consider immigration policy and its position in the national debate for the 2006 mid-term elections. Though the immigration issue has relative importance, in the context of a campaign, the differences between the Republican and the Democrat stances verge on being negligible compared to other key issues. According to survey results from the Pew Research Center for the People and the Press conducted in March 2006, approximately half of Republicans, Democrats, and independents favored harsher employer sanctions to reduce illegal immigration. About the same percent of Republicans as Democrats also stated that undocumented immigrants should be returned to their countries of origin. Certainly, there are partisan and ideological distinctions between the two major parties; in a margin of 54% to 40%, Republicans are more likely than Democrats to think that today's immigrants resist change (Escobar, 2007, pp. 34-35).

Republicans and Democrats are more likely to be distinctly divided on issues like abortion or the war in Iraq, and since immigration is a less partisan policy matter, it is difficult to incorporate a clear, definitive campaign message focusing on immigration as a central topic. Despite this precarious nature of a political platform that ties into immigration reform, Ford and Corker seemed to find a common battleground in attempts to impeach the others' stance on the issue. An ad for Corker accused his Democratic opponent of sending mixed messages on immigration. The television spot, which aired statewide, featured an announcer who ridiculed Ford for claiming that he supported "the toughest legislation against illegal immigration" (Davis, 2006), despite the fact that he voted against House amendments to have the military help with border patrol and an amendment to increase the punishment for illegal immigrants caught moving drugs across the border. The Corker campaign simultaneously released an ad with Corker discussing his position on immigration, his stance against amnesty, and calling for a new immigration policy "that reflects America's values" (Davis, 2006). Ford was also quoted criticizing Corker for not commenting on the 1988 raid on his company's construction site in an article in the *Chattanooga Times Free Press*, saying "no amount of money can hide the fact that he hired illegal immigrants" (Davis, 2006).

Immigration political ads appeared on television, radio, and on the Internet during the campaign season preceding the 2006 midterm election, yet the Ford ad striking back at Corker presents imagery and language that is verging on the offensive, especially coming from a Democratic candidate (Moscoso, 2006). Ford attacked Corker for owning a construction company that used a subcontractor that was raided by federal immigration officers and found to have four "illegal"

immigrant employees. In the advertisement, which aired statewide, Ford could be seen walking in a construction site as he talked to the camera, following a scene in which two Latino actors, depicting undocumented workers, step over a barbed wire fence, symbolically immigrating to the United States illegally (See Appendix, Figure 8: Image of illegal immigration in political ad from 2006 Tennessee U.S. Senate Election).

Included below is an unofficial transcript of Rep. Ford's immigration political ad, which can be viewed online at: http://youtube.com/watch?v=a55NJFTz81k.

> *Announcer:* Bob Corker likes to talk tough about illegal immigration and how he made over $200 million in construction. What Bob Corker doesn't tell you is that when he was building these apartments, the INS raided his work site, found illegals working there, and arrested them. He looked the other way for cheap labor, and we're paying the price.
> *Rep. Ford:* I'm Harold Ford, Jr., and to get control on our borders, we've got to get tough on illegals. Let's also get tough on employers who break the law. Bob Corker disagrees, and that's why I approve this message.

When the announcer reads the line "he [Corker] looked the other way for cheap labor," the screen shows the image of two Latino men in tattered clothing stepping over the fence and easily entering the United States as "cheap labor." Yet, as has been established, entering the United States illegally is often an arduous journey that can result in death. The Ford ad is also contentious because it furthers the impression that undocumented workers are somehow having an adverse effect on the economy or that they are passing the "price" of being in the United States and using public services to the taxpayer; again, this is a fallacy.

The Ford ad that targets Corker and promotes these stereotypes and misconceptions is especially interesting when compared to another ad that the Republican National Committee ran against Ford. This televised advertisement featured people in pseudo man-on-the-street interviews in which they criticized Ford and his stance on national security. Controversy erupted over one of the people featured an eye-catching blonde white woman who claimed that she had met Ford at a Playboy party. The commercial ended with the woman looking into the camera and saying in a coquettish voice and with a wink "Harold, call me" (Toner, 2006).

Critics across the nation asserted that the ad was a clear effort to play to racial stereotypes and fears. The GOP pulled the ad after running it for less than a week (Toner, 2006). Yet, the racial stereotypes of "illegals" and stirring the xenophobic fears of undocumented workers somehow coming with a "cost" for legal residents in the Ford ad went largely unnoticed, save for perhaps the immigrant community and its allies.

Future of Public Policy and the Latino Community in Tennessee

> *"[T}here is good reason to be optimistic regarding the future for 'the new neighbors' and the communities to which they are migrating in Tennessee…not only because Latinos in Tennessee have levels of human capital comparable to the nation as a whole, but also because migration is a selective process- it is those with the most ambition who leave the security of home to pursue a new life elsewhere."* (Drever, 2006, p. 34).

In May 2006, following the nationwide protests over H.R.4437 and the division between the Republicans and Democrats, the immigration reform bills stalled in Congress ("Hundreds of thousands march for immigrant rights," 2006). As Congress remains deadlocked over comprehensive immigration reform, and as the nation heads into what promises to be a contentious presidential election in the fall, state and local governments are largely left to fend for themselves in answering the problems posed by the growing immigrant population.

I will now highlight legislation that is currently being discussed in the Tennessee General Assembly, with a particular focus on the bills that would, if enacted, have a detrimental effect on the Latino immigrant community. Then I will conclude my research report with my recommendations for what public policy measures should be taken to more adequately address the issue of illegal immigration in a way that would better preserve the basic rights of undocumented immigrants while protecting the interests of legal residents.

Proposed Ordinances and Legislation

Individual states lack the power and resources to make comprehensive immigration system reforms because, clearly, immigration is a national issue that cannot be adequately addressed at the state level. Tennessee, as a new destination immigration state, has followed the pattern of the other states that were included in the case studies from The Century Foundation publication, *Immigration's New Frontiers: Experiences from Gateway States* (Anrig & Wang, 2006). The job market attracted a wave of Latino immigrants to Tennessee, encouraged by employers in need of laborers to fill their vacancies in low-income jobs. Now the state is in the process of adopting a more combative stance and attempting to enact policies that would "discourage the acceptance [of immigrants] into mainstream society" (Anrig & Wang, 2006, p. 2).

The following pieces of legislation in the Tennessee General Assembly fall into the category of "combative policies" that would negatively affect the Latino immigrant community and its allies. The full texts for each of these bills are found on

the Tennessee General Assembly website. [3]

SB 886 by Ketron/HB 0366 by Rowland

The law as it now stands authorizes the Department of Safety to issue a certificate for driving to persons whose presence in the United States has been authorized by the federal government for a specific purpose and for a specified period of authorized stay. This bill calls for the elimination of the issuance of certificates of driving, and allowing issuance of a one-year driver license to persons whose presence in the United States has been authorized by the federal government.

SB 576 by Burks/HB 1216 by Fincher

This bill creates a plethora of provisions regarding immigration. It requires public employers to register and to verify information of all new employees, shifting the responsibility of the federal government to enforce immigration policies to individual state employees.

SB 193 by Burchett/HB 600 by Turner, M

The principle elements of this bill create a series of criminal offenses for transporting immigrants. It prohibits the transportation of "illegal aliens" into the state of Tennessee, imposes a fine of $1,000 for such violation, and allocates money received from such fines toward the costs associated with deportation of such "illegal aliens."

SB 1343 by Haynes/HB 70 by Turner M

This bill prohibits persons from engaging in the purchase, sale, or rental in real estate or business opportunity from doing business with individuals who have illegally entered the United States. If this bill is enacted, a real estate professional who rents, purchases, or sells property to an undocumented immigrant could have his or her real estate-related license revoked, and the Department of Revenue could order county clerks and city tax collectors to revoke that person's existing business license. This bill, if enacted, would place an undue burden on real estate professionals to familiarize themselves with the intricate categories of legal and unauthorized statuses in the United States.

SB 252 by Haynes/HB 66 by Turner

This bill creates a Class B misdemeanor offense for illegal aliens who knowingly receive compensation for working in this state unless they have been granted an exemption by the U.S. Department of Labor. It also specifies that any money derived from such unlawful employment is subject to the criminal forfeiture provisions of this state. This bill presents clear concerns that the immigrant community would be further exploited. The bill would allow unprincipled employers to subject

3 http://www.legislature.state.tn.us/

unauthorized workers to hostile or unsafe working conditions, knowing that if they resist, the wages that they have earned could be forfeited.

Conclusion and Recommendations

The swell of the Latino immigrant population has presented an assortment of positive economic and cultural influences, as well as the consequence of difficult policy questions. Tennessee, which has emerged as a new destination state for Latino immigration, is now faced with the task of trying to provide adequate public services for legal residents and undocumented persons, without knowing when or if the federal government will enact comprehensive reforms to adequately repair the U.S. immigration system.

Though such a stance will certainly draw criticism from some legal residents and constituents, I recommend that local and state government officials allow the federal government to make the ample and necessary changes to the immigration system. Enacting various individual pieces of legislation will only further complicate the policy questions at hand and create negative externalities that will affect legal residents, like real estate professionals who would have to learn how to determine and enforce another person's residential status in the United States. In 2006, following the protests against restrictive immigration reform and as legislation at the state-level was making its way to the General Assembly, Governor Phil Bredesen remarked, "I think our federal government's got to step up and deal with the issue" (Rodgers, 2006), and I agree.

In my opinion, critics who decry waiting for the federal government to end the partisan deadlock in Congress as something that is far from being an actuality are being needlessly pessimistic. A bi-partisan, comprehensive immigration reform bill has already been presented in the U.S. Congress. Representative Jeff Flake (R-AZ) and Representative Luis Gutierrez (D-IL) are sponsoring the Security Through Regularized Immigration and Vibrant Economy (STRIVE) Act. Though the STRIVE Act does include provisions for increasing border enforcement personnel, it also includes fundamental principles that would address some of the larger issues within the immigration system. Some of these areas of reform include: the creation of a new worker program which would provide certain immigrants (and their spouses and children) with an opportunity to apply for conditional permanent residency and eventual citizenship; an increase in the resources of the immigration court system; a mandate that the United States cooperate with Mexico to address border security, drug trafficking, and human trafficking; and inclusion of Title VI, the Development, Relief and Education for Alien Minors (DREAM) Act, a bipartisan bill that would provide a path to legal status for individuals who were brought to the United States illegally as children years ago who have stayed in school and maintained good behavior (H.R.1645, 2007).

Americans are impatient for government action to be taken, to move toward a resolution of the pressures presented by immigration. As the STRIVE Act makes

its way through the House Judiciary Subcommittee on Immigration, I recommend that Tennessee policy makers suspend the discussion of piecemeal legislation that, at the state level, will only convolute the path to definitive, federal immigration policies. Public officials, legal residents, and undocumented persons from across Tennessee are not left without recourse—they can urge the Tennessee congressional delegation in Washington, D.C. to move forward on immigration reform by supporting the STRIVE Act, before it hits the floor of the House of Representatives.

Immigration has been a topic of debate in the United States for over two hundred years, and it will continue to spur discussion and disagreement for years to come. In Tennessee, the influx of new immigrants, particularly of Latinos, over the last twenty years has made a dramatic impact on the state's social and cultural environment. Medium-sized towns, like Morristown, have seen significant, proportional jumps in the size of their Latino population. At times, the initial arrival of Latino immigrants into these small towns that historically had few to no Latino residents may have been met with skepticism and a wave of nativism. However, there appears to be a gradual move towards the acceptance of Latino immigrants into mainstream society. Meanwhile, legal and undocumented residents should be wary of many of the pieces of state legislation that attempt to address immigration issues in Tennessee. Other new destination immigration states have capitulated to the pressure of adopting combative attitudes and polices regarding immigrants, yet none of these states has created public policies that adequately address the issues of immigration for their state.

Comprehensive reform for the U.S. immigration system is needed, and it must occur at the federal level. §

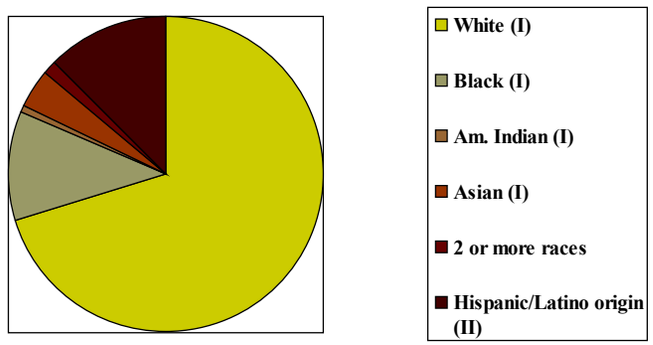
Appendix: Maps, Tables, and Charts

Figure 1
Map of Hispanic World



Original map from http://www.answers.com/topic/hispanic

Figure 2
U.S. Population At-a-Glance, 2005



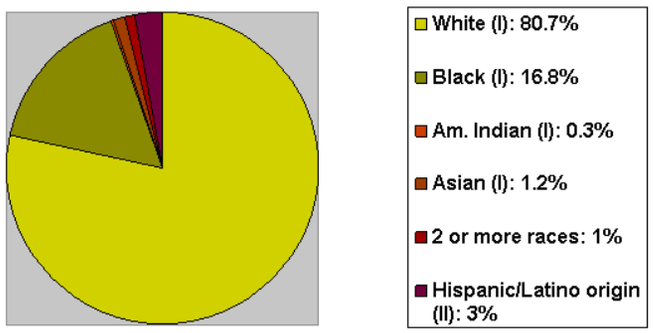
Notes:
I. Includes data from persons only reporting one race.
II. Hispanics/Latinos may be of any race and are also included in other applicable racial categories.
Data from U.S. Census Bureau

Figure 3
Estimates for Size and Characteristics of Undocumented Population in the United States

Country	Number of Persons	Percentage of Undocumented Immigrant Population
Mexico	6,840,000	56%
Latin and Central America	3,000,000	25%
Asia	1,080,000	9%
Europe and Canada	720,000	6%
Other	480,000	4%

This table uses data from the March 2004 Current Population Survey, conducted by the U.S. Census Bureau and the Department of Labor. (Passel, 2005).

Figure 4
Tennessee Population At-a-Glance, 2005



Data from U.S. Census Bureau: http://quickfacts.census.gov/qfd/states/47000.html.

Figure 5
Census 2000: Hispanic/Latino Population Breakdown for Tennessee

Hispanic or Latino and Race		
Total Population	5,689,289	100.0
Hispanic or Latino (of any race)	123,838	2.2
Mexican	77,372	1.4
Puerto Rican	10,303	0.2
Cuban	3,695	0.1
Other Hispanic or Latino	32,468	0.6

Data from U.S. Census Bureau: http://factfinder.census.gov/servlet/QTTable?_bm=n&_lang=en&qr_name=DEC_2000_SF1_U_DP1&ds_name=DEC_2000_SF1_U&geo_id=04000US47

Figure 6
Percentage change in Hispanic population for Southern states, 1990-1998

State	Percentage Change in Hispanic Population
Alabama	73%
Florida	42%
Georgia	102%
Kentucky	48%
Louisiana	25%
Mississippi	42%
North Carolina	110%
South Carolina	63%
Tennessee	***90%***
Virginia	56%
West Virginia	21%

Data from U.S. Census Bureau, (Pressley, 2000).

FIGURE 7
Percentage change in Hispanic population for new destination states, 1990 to 2000

State	Hispanic Population from 1990 Census	Hispanic Population from 2000 Census	Percentage Change from 1990 to 2000
Alabama	24,629	75,830	207.9%
Arkansas	19,876	86,866	337%
Georgia	108,922	435,227	299.6%
Indiana	98,788	214,536	117.2%
Iowa	32,647	82,473	152.6%
Minnesota	53,884	143,382	166.1%
Missouri	61,702	118,592	92.2%
Nebraska	36,969	94,425	155.4%
North Carolina	76,726	378,963	393.9%
South Carolina	30,551	95,076	211.2%
South Dakota	5,252	10,903	107.6%
Tennessee	***32,741***	***123,838***	***278.2%***
Virginia	160,288	329,540	105.6%

Data from US Census Bureau: http://www.census.gov/population/www/documentation/twps0075/tab01.pdf

Notes for table in Figure 7:
-For Census 2000, housing unit population and group quarters population are included.
-For Census 1990, housing unit population only.
-1990 totals do not include Puerto Rico because race and Hispanic Origin questions were first added to the Puerto Rican census form in Census 2000.

FIGURE 8
Image of illegal immigration in political ad from 2006 Tennessee U.S. Senate Election



This advertisement was approved by Harold Ford, Jr. and was paid for by Harold Ford, Jr. for Tennessee and the Tennessee Democratic Party.
Source: fordfortennessee.com/

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