THE BROOKINGS INSTITUTION
THE BROOKINGS CAFETERIA: The biggest health care issues of the 2020 election
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(Music)

DEWS: Welcome to The Brookings Cafeteria – the podcast about ideas and the experts who have them. I'm Fred Dews. Polls show that health care is one of the top issues American voters care about, but ideas about controlling costs and expanding coverage are divided along partisan lines.

Today's episode features a deep dive into health care policy and what Democratic presidential candidates and Republican Party leaders are offering as their solutions. My guests are two of Brookings top health policy experts.

Christen Linke Young is a fellow in the USC Brookings Schafer Initiative for Health Policy. And among her many roles in public service, served in the White House as a senior policy adviser for Health. Matthew Fiedler is also a fellow with the Shafer Initiative and was previously chief economist of the Council of Economic Advisers in the White House where he oversaw the council's work on health care policy. Both Young and Fiedler have contributed explainer pieces on health policy as part of the Policy 2020 project here at Brookings. You'll hear me refer to these papers throughout the interview and you can find them at Brookings.edu/Policy2020. Also on today's show, meet Annelies Goger, a new Rubenstein fellow in the Metropolitan Policy Program. She shares some of her family history to explain how she became a scholar.

You can follow the Brookings Podcast Network on Twitter @policypodcasts to get information about and links to all of our shows, including Dollar & Sense, the Brookings trade podcast, The Current and our Events podcast. And now on with the interview.

Christen, Matt: Welcome back to the Brookings Cafeteria.

LINKE YOUNG: Great to be here.

FIEDLER: Thanks for having us.

DEWS: You all have authored or are the coauthors of a number of what we call Voter Vitals papers for the Policy 2020 project here at Brookings. We're going to talk about many of those in

detail. I do want to point out to listeners that these are all available on the website Brookings.edu/policy2020. So thanks for your contributions.

So we're going to talk about health care. Health care has been one of the top issues on voters' minds in recent elections. It was the top issue in the 2018 midterm elections, according to Gallup polling. Why do you all think that health care policies are receiving the attention they do?

LINKE YOUNG: Health care is an intensely personal issue. When you or a family member need medical care it is the most important thing in your life. For months at a time, sometimes for people with chronic illnesses, it's really the centerpiece of much of the way they organize their life. At the same time, it's a huge expense for families and also for the U.S. economy. So this is a major pocketbook issue as well.

I don't think it's really a new phenomenon, but there is a lot to talk about this year. There's a huge gulf between the parties in the way they view the problems in the health care system and the way they think about the policy direction we should be headed in health care. And even among Democrats, while there's agreement on the direction U.S. policy should be heading, there's a fair amount of disagreement about the tactics that we should pursue to get towards those outcomes. So, there's really a lot going on in this space that is intensely personal and economically significant.

DEWS: I'll point out to listeners that this episode is airing just before the next Democratic candidate debate. Again, I would encourage listeners to read your papers on Brookings.edu/Policy2020 to get up to speed on what the issues are.

Kind of abstracting from what the political issues are, maybe, Matt, you could take this one. What are the biggest issues in health care policy that need to be addressed?

FIEDLER: I think we can think about dividing issues in health care policy into two broad categories: issues affecting health insurance coverage and issues affecting health care costs. So coverage policy is about how people get health insurance, what that insurance covers, and who

pays for that coverage. I think as Christen alluded to these are often the issues at the center of political debates, in part because there's no clear agreement among policy makers about what problem we should be trying to solve. Policymakers on the left have often prioritized expanding how many people have coverage, even if that requires increasing what the federal government spends. By contrast, policymakers on the right of emphasized reducing what the federal government spends on coverage programs and limiting federal involvement in insurance markets – even if that means fewer people with health insurance.

I think the second main category of issues is about how we can reduce the underlying cost of health care which is the reason health insurance is so expensive. Policies in this space look at either reducing unit prices of health care services, price per doctor's visit or hospital stay, or the utilization of health care services – number of doctor visits or hospital stays people make in a year. I think there's more agreement here between left and right on what the goals of policy are, and even some agreement on what tools we should be using to achieve those goals. But even here, progress is often difficult because efforts to reduce spending translate into lower revenue for health care providers. So industry opposition to change can still be quite fierce.

DEWS: I want to dive a little deeper into these issues of insurance coverage and costs in a minute. But first, there's kind of a really big issue that's looming over all of this debate, and that is the effort to undo the Affordable Care Act in the courts. Christen, it's something that you've talked about before. Can you address what's going on with that case?

LINKE YOUNG: There always is a lawsuit when it comes to the Affordable Care Act. And the most recent one is an argument being made by Republican attorney generals, and the President, and the Department of Justice that the entire ACA should be struck down. Their argument begins with the Supreme Court's conclusion from 2012 that the individual mandate is only constitutional because it's a tax. They contend that when Congress eliminated the penalty for failing to maintain coverage, that made the mandate no longer a tax and therefore it had to be unconstitutional. And

they further argue that Congress must have wanted the whole law to be struck down if the mandate was unconstitutional. If that sounds crazy, it's because it basically is. Even conservative legal scholars generally agree that this is a pretty frivolous argument. At the same time, it has made it through the legal system and we are waiting for a decision from an appeals court any day now.

Almost everyone thinks that this case is ultimately headed to the Supreme Court. So whatever the fifth circuit decides in the coming days, ultimately this issue will be decided by the Supreme Court and nothing should change for people when it comes to the Affordable Care Act in the coming months. But it is out there.

I also want to note that it's useful to understand this lawsuit in the context that this is really another attempt to accomplish through the courts what Republicans were unable to achieve in Congress in 2017 in repealing the Affordable Care Act. And it's really a rehash of that same conversation.

DEWS: Let's just be clear. If for some reason the Affordable Care Act were to be struck down by any level of court – Supreme Court, most likely – if they made that decision, that would mean what? That insurance companies would be able to exclude people based on preexisting conditions...

LINKE YOUNG: It would have widespread ramifications throughout the health care system. So it would undo the insurance market reforms in the Affordable Care Act, like requiring insurance companies to cover people with preexisting conditions, requiring coverage of preventive services. It would also get rid of the entire federal financing infrastructure that's making coverage more affordable for millions of people. So it would eliminate the Affordable Care Act's financial assistance for people that buy coverage directly from insurance companies. It would end the Medicaid expansion that's helping states provide coverage to millions of people. It would mean big sweeping changes in how Medicare pays hospitals. It would even change components of our drug

regulatory regime, which were changed by the ACA. There would really be impacts throughout our health care system.

DEWS: I think you wrote in one of your Voter Vitals papers that some millions of people could lose health care coverage.

LINKE YOUNG: That's absolutely right. I think if the Supreme Court were to repeal the entirety of the Affordable Care Act, we would expect millions of people to lose coverage.

DEWS: Well, let's use that as a segue to talk about some of the specifics of where we are now in terms of how people get coverage, how many are uninsured, and how the Affordable Care Act affected those numbers.

LINKE YOUNG: Yes. So let's start with what things look like today. As we sit here today about 90 percent of Americans have health insurance coverage. Half have coverage through their family member or their own job. So employment-based coverage is the major way that people get coverage in the United States. Another 35 percent of people have coverage through a public program like Medicare or Medicaid. 5 percent of people buy coverage directly from an insurance company. And just under 10 percent of Americans are uninsured. The uninsured rate is near its historic low and it's down about 40 percent since passage of the ACA.

I do think it's important to keep in mind that some people who have coverage can still face very high spending burdens, either in the form of high premiums or high out-of-pocket costs like deductibles and other forms of cost sharing. So having an insurance card isn't the end of the story, but it definitely is an important one.

DEWS: And I understand that some segment of those uninsured are actually undocumented residents of this country. Right?

LINKE YOUNG: That's right. About 16 percent of people who are uninsured today are undocumented residents of this country. At the same time, about half of people who are

uninsured are eligible for coverage through one of our existing coverage programs. So there's a real mix in terms of what the uninsured look like today.

DEWS: Let's switch to some of the specific policy proposals that we've heard from the Democratic side in the last primary debate. There was some contention between some of the more moderate progressive candidates over their approaches to health care coverage and especially on what we now know as Medicare For All – and then how to pay for it is a really big issue. So are there significant differences between the plans that are being proposed on the Democratic side?

FIEDLER: So all of these proposals are focused on expanding coverage and making coverage more generous for some people who already have it, largely by committing additional federal resources to coverage programs, but they differ dramatically in their structure and their scope. So some proposals are aimed at filling gaps in the current system while limiting disruption to existing coverage arrangements. They do things like taking steps to ensure that people who are left uninsured by states that have not expanded Medicaid under the ACA get coverage, expanding subsidies available to people in the individual market, and creating mechanisms to ensure that people who are already eligible for subsidized coverage actually enroll in that coverage.

By contrast, the single payer proposals take a fairly different approach. They would create a new federal program to cover everyone in the country and thereby achieve universal coverage in sort of one fell swoop. These plans have the advantage that they offer a simpler system with lower administrative costs. The flip side of that is that they require a much larger investment of federal funds and by their very nature involve quite a bit more disruption to existing coverage. I think the other feature here is that if you think private insurers sometimes add value, you forego the opportunity to have them and that value in the context of a single payer system.

DEWS: Well I want to put a fine point on that disruption question, because as we talked about a few minutes ago, 50 percent of people have coverage through their employer, through

private insurance market, and in a single payer system, that large group of people who are currently covered would have to transition somehow out of their current plan into a single-payer plan. Have any of the candidates given thought to how that would actually transpire?

FIEDLER: I think one of the questions that has been left open is exactly what a transition would look like. I mean, I think it was interesting in Senator Warren's proposal last week that she referred to the need for a lengthy transition. And the fact that Medicare For All might be a long-term goal. I think exactly what that transition would look like once it's put out in in legislative language is the question that people have not delved into deeply at this point.

DEWS: There's another big question obviously around costs. And critics of these kind of plans say, well, you obviously have to raise taxes on everybody – it's just a tax increase. But then the counter argument would be, well, yeah, my taxes might go up, but the premium costs that I pay every month to insure myself, to insure my family, will go down more than the increased taxes. So, do you think that's a valid argument?

FIEDLER: I do. So the single payer plans being discussed likely wouldn't reduce the overall amount the United States spends on health care. They'd use the government's leverage to reduce the prices paid for health care services, but because more people would be covered and they'd have more generous coverage, people would use more services. So sort of overall spending would probably remain about the same. But these proposals do change who pays for health care.

So both the Warren and Sanders proposals envision financing a substantial fraction of the new single-payer system through taxes on higher income households, which would mean that those households would now bear a larger fraction of the overall health care burden in the United States. Which would mean that other households – those in the middle and potentially in some cases at the bottom of the income distribution – would bear less of health care spending burden than they do today.

DEWS: Let's move on to look more specifically at proposals that are supported by President Trump from Republicans in Congress. Now, looking beyond the lawsuits – that's one thing we've already addressed – your Voter Vital paper for the Policy 2020 project actually addresses some of the key elements of Republican health care proposals. Kind of in the affirmative, if you will. Christen, can you address what some of those elements are?

LINKE YOUNG: Absolutely. Republican proposals around health care coverage generally feature three parts. First, Republicans want to repeal the parts of the Affordable Care Act that have helped people gain coverage and made that coverage more affordable. So that means getting rid of the financial assistance to buy coverage in the individual market and eliminating the ACA is Medicaid expansion that is helping states cover more low-income people through the Medicaid program.

Second, they seek to reduce regulations on health insurance and insurance coverage so that not all insurance companies would be required to cover preexisting conditions. Insurance might have higher deductibles or cover fewer benefits that would reduce premiums for some people by making coverage less generous, but it could also increase premiums or increase out-of-pocket spending for others and so it's really a mixed bag here.

The third component of the formula is to change the federal government's mechanism for funding the Medicaid program so that the federal government would contribute less towards the program that states are using to provide coverage to low income people, including children and pregnant women, seniors, people with disabilities. States could respond to that reduced federal funding by spending more of their own money or by making other changes to the way they structure the program, or who gets covered, or what benefits people who have coverage are able to receive.

This suite of policy changes together is really about reducing the federal footprint in health care – less federal regulation and less federal financing, even if it means that fewer people are getting health care coverage.

DEWS: Let's turn now to health care costs. So we're talking a lot in the context of the race for president and what the two political parties advocate or oppose, but whether or not we're talking about politics, we still have to address the issue of health care costs. Today, health care costs families a lot of money. What are some strategies that policymakers have right now – again, absent politics – to address underlying health care costs?

FIEDLER: So I'm not sure we can ever fully get away from politics when we're thinking about ways to reduce health care costs, but broadly speaking, the cost of health care reflects the prices of the services we consume and how many of those services we consume. So, ultimately, the options have to target one of those two things. On the price side of the equation, I think there are sort of two broad paths that policymakers could think about.

One path would seek to make health care markets more competitive and drive down prices that way. So that type of path might feature stronger antitrust enforcement that would seek to block mergers between physician groups or hospitals that would render markets less competitive or police other types of anti-competitive behavior. Policymakers could also try to foster price competition in other ways like changing the way we subsidize employer coverage in the tax system. I think there's a question of whether those types of policies aimed at making markets more competitive are adequate to the task at hand. A lot of health care markets are already highly concentrated and reversing that concentration would be very difficult in practice.

DEWS: And what do you mean by highly concentrated?

FIEDLER: So a concentrated market is one where there are few people selling the service in question. So there are many markets in the country [that] have only a few hospitals or even only one or two hospitals serving that market. So I think given this market environment, policymakers

are also thinking about options that would more directly reduce the prices of health care services either by regulating those prices or by making greater use of public programs and delivering health insurance. So one of the things we know is that public programs tend to pay much lower prices for health care services than private insurance and so it's not a coincidence that on the Democratic side of the aisle you see proposals to expand that type of coverage either through the form of a single payer system, as in some of the proposals, or in the form of a public option that would compete alongside private insurers but pay prices more like public programs paid today.

That's the price side. On the utilization side, there are also options to try to discourage inefficient utilization of health care services. There's been a lot of effort in recent years to change how we pay health care providers to give them incentives to identify and eliminate unnecessary services by paying them based on the total costs their patients incur over the course of the year rather than paying them based on each individual service they deliver. I think there's some evidence that those efforts have been moderately successful in reducing unnecessary utilization without harming the quality of the care patients receive. And I think there's probably more to be done there, although I think we should be realistic about what we're likely to achieve. There are going to be no quick fixes there and no silver bullets.

DEWS: I think this is a good transition to this issue of costs, which comes in the form of the concept that you all have written another Voter Vitals paper on, which is about surprise billing for medical care. So, heaven forbid that I break my leg later. I get rushed to the emergency room. I'm not in a position to make any choices about my care. I'm going to get seen by the doctor, maybe a surgeon, and if it's really bad, other kinds of specialists. And then they present me a bill, but I'm not calling my insurance company to get pre-authorization. First of all, what is the phenomenon of surprise billing for medical care and how widespread is it? And, are policymakers looking at that particular aspect of the cost of medical care?

LINKE YOUNG: This is a major issue in U.S. politics right now and also in our health care system. So surprise medical bills arise when you receive care from an out of network health care provider under situations that you can't reasonably control. You are not able to choose which provider you're seeing, and so you're seeing an out of network doctor in a way that you couldn't avoid. A common situation is emergency care where you may not have a choice over which hospital you're taken to or you may go to an in-network hospital and see particular clinicians within the hospital that are out of network.

Another type of example, and in some ways the most egregious kinds of examples, arise when people go for a scheduled procedure at an in-network hospital. So they schedule a surgery or they schedule to deliver their baby at an in-network hospital. They're seeing an in network primary surgeon or an in network OBGYN, but it turns out that some of the other doctors that get involved in delivering their care are out of network. Unbeknownst to them, their anesthesiologist, or radiologist, or a consulting surgeon is out of network. And again, the patient had no ability to choose the specialist. They couldn't say, “I'm sorry, I'd like a different anesthesiologist” or “I want to run across town to find an in-network anesthesiologist.” That's not an option at all for these folks. You're stuck with the anesthesiologist that the hospital presents you with.

This is fundamentally a market failure. There is a group of providers that are exploiting the fact that you can't choose which doctor you're going to see in these circumstances to get the higher payment that they can receive by delivering out of network care.

It's actually fairly common. About 20 percent of emergency department admissions and 10 percent of inpatient stays involve some sort of care that could potentially lead to a surprise out of network bill. Half to two thirds of ambulance rides are out of network. So this is really widespread in pockets of the health care system.

It's useful to understand that the dynamic of surprise billing affects costs in two ways. It's really expensive for the people who get those surprise bills. They are hundreds or thousands or

tens of thousands of dollars in situations that, again, consumers just aren't predicting and didn't choose. So it's very, very expensive for the households that have to confront this. But it also leads to higher premiums for everybody else, because the group of specialties and providers that are involved in these potential out of network billing situations leverage the fact that they can threaten to send these surprise out of network bills to demand higher payment rates even when they do go in-network. And so that means all of us pay higher premiums because these providers can credibly threaten to stay out of network and surprise bill people.

So policymakers have a bunch of options to end this market failure and make it impossible for providers to threaten to send surprise bills and to send those bills when patients get care out of network.

It's actually been somewhat encouraging over the last few months here in Washington. In both the House and the Senate we've seen congressional committees refer out bills that would tackle this problem and really make meaningful progress in preventing surprise bills and regulating away this market failure. But I do think there's a reason to sound a note of caution about whether or not we're ultimately going to see Congress get something done for two reasons. The first is we are in the middle of an impeachment conversation, which is going to make it difficult to get things done here. And second, we've seen a lot of lobbying from provider groups and from hospitals that have really opposed the effort to take away their leverage here. And so that may make it more difficult to get bipartisan legislation.

DEWS: Let's wrap up the conversation by looking at the big picture. We've talked about a ton of health policy related issues, but are there other kinds of issues in health care policy that you think aren't getting enough attention or the attention they deserve at this point in the campaign?

FIEDLER: I think it's an issue we touched on, and this electoral cycle may actually be better than some past ones, but we really should be talking more about how to reduce the prices of health care services. You know, in a lot of health care policy debates insurers and pharmaceutical

companies are the standard bogeymen, and there's a plenty of waste in both areas that policymakers should be thinking about how to get at, but ultimately three quarters of what we spend on health care goes to providers of health care services. So doctors, hospitals, and the like. And, as I alluded to before, there's good reason to believe that the prices we are paying providers, particularly hospitals and physicians in certain specialties, are higher than they need to be to get care of the quality we want.

How to reduce those prices is a harder conversation politically because doctors and hospitals are much more sympathetic than insurers or drug manufacturers. And frankly, because hospitals are often one of the largest employers in any particular community. There's also plenty of room for disagreement about the best way to reduce prices, but if we're serious about reducing the underlying cost of health care this conversation about prices of health care services is one we just absolutely have to have.

LINKE YOUNG: I also want to remind people that quite apart from the election, open enrollment for coverage in the individual market is going on right now through December 15th. So if you are uninsured or you know folks who are uninsured, now's the time to go to healthcare.gov and check out your options. You may have a surprisingly affordable option to get covered.

DEWS: Well, Christen and Matt, I want to thank you both for taking the time today to talk about health care policy and remind listeners that you can find their Voter Vitals papers on our website www.Brookings.edu/Policy2020.

And now here's Annelies Goger talking about how she came to be a scholar, what she's working on now, and her recommended reading.

GOGER: My name is Annelies Goger and I'm a David M. Rubenstein fellow in the Metropolitan Policy Program at Brookings.

I grew up in rural northwest New Jersey, which used to be steel country but over time has become more of a feeder to the large metro areas and pharmaceutical companies. And when I

was a child, my mom cleaned houses and waited tables and my father worked in construction industry. He later started installing lightning rods on roofs. Neither of my parents have a college education and so we had a working-class experience and we lived in an old farmhouse with actually another family as a way to make ends meet.

My mom is also a Dutch immigrant and she came to the U.S. when she was 6. My grandparents lived under the Nazi occupation in Holland and survived the hunger winter of 1944-1945. And I've been thinking a lot about them recently because my grandmother just passed away at age 99. But my grandfather hid from the German army, which had tried to recruit young Dutch men at the time, and my grandmother hid him in the attic.

So when they moved here, my mom was 6 and they were trying to leave all those memories of the war behind them. And as the oldest child, I was also considered academically gifted in math and science and so I felt a lot of pressure to succeed and to go to a competitive college. But on the other hand, we didn't have a lot of money and we didn't have anyone in our family that had been through that process of trying to find financial aid and get into college. So I ended up really teaching myself a lot of that process, although I benefited from having really good schools and some other peers that were going through the same process and it was a lot of work to try to figure out how to get into college and how to succeed.

So I started college as a science and math person, as a premed student, and then I started taking sociology classes and started realizing a lot about the nature of poverty, the nature of the economy, and I had some mentors that really influence me and it inspired me to really start looking into questions around race and gender in society and how the economy affects society. Then later on I went to study city planning at UC Berkeley and started working and researching I.T. training programs and whether community-based models of training were better than government programs or agencies. And so that was my introduction to workforce development.

Since that time, I went back to school again to study economic geography. And what drove me to do that was I'd actually been studying the Trade Adjustment Assistance Program, which is for workers displaced from trade very carefully in local areas around the country. And I started thinking about globalization and economic transition and got really interested in the question of adjustment. And not only within the US where you had folks getting displaced, but also on the other side of supply chains in other countries. So I ended up studying the clothing industry and supply chains, supply chain governance in Sri Lanka and Europe.

All of that's to say that my interest in economic change and industrial transformation is really rooted in my own history and a deep understanding of the relationship between the economy and society.

So I think that we have two interrelated problems. One is an economic structure problem. So that has to do with economic change and the changing nature of work – the future of work. But also the legacies of trade liberalization and how that has structured our labor markets. A lot of poor-quality jobs that pay low wages. So those structural problems and also high concentration and many of our supply chains – monopolies or oligopolies.

On the other hand, you have these institutional problems. And basically, we have all these programs and funding streams that fund workforce education and training, but they're really fragmented and uncoordinated and underfunded, in my opinion. And there's not really an easy pathway either for workers to navigate when they're trying to make a career transition or for firms to try to figure out how to partner with government to identify and attract talent. And so, I'm really focused on that second problem, but I wanted to acknowledge that the underlying economic problems are also very real and people need to be thinking about them.

So right now I'm thinking about how we need a high-level redesign of our education and training systems in the United States. So, like I said a few minutes ago, this institutional structure was designed for a very different structure of economy. And so it doesn't really work for job

seekers or for students, and it doesn't really work for employers very well. So nobody wins in this situation except maybe folks are trying to sort of exploit the market failures.

So in redesigning that, I'm trying to do research that really highlights some of the things where I think we need to go. First of all, I think we need to go from a program mindset of "let me find a target population to design a program on" to a system mindset of how do we build something where you can start off in the insurance industry in an apprenticeship, but then you can decide after high school to get a college degree after getting network experience. It's not an either-or choice, but it's a both-and option. If I could have had a Google apprenticeship in my high school and then go to college with that, I think that would have been much better for me in so many ways, personally, because I would have gotten paid to get this opportunity, see what the workplace was like, and then use that to know what I wanted to do when I went to college. So I think that that's a compelling thing for us to think about.

Secondly, I think in designing this system we can build on other models around the world where they've already sort of addressed this problem. And so what they call that in the international world of OECD and ILO, International Labor Organization, is a qualifications framework from a policy side. So that's really kind of that underlying structure to help organize all of this stuff and it's not necessarily heavily structured. There's flexibility built into it and a state can flesh out what that means for each state, but it gives you a roadmap so that you can basically not have a totally different system in one state and then if you wanted to move to a different state you would be having to start all over. So it's that kind of continuity. You want to have a blend of flexibility in structure.

Then focusing a lot of research interested in getting inside the firm and figuring out how firms and companies can be learning organizations and how they are deploying technologies and what that all means. And I think there's kind of a black box right now as far as understanding how that actually looks at the organization level.

And then finally, human centered design. So, if you are a worker – an older worker – and you get laid off and you're trying to get a job, what resources are out there and what are your pain points when you're trying to make a career transition? And not into just a low wage job, but into a new career or something that will be sustaining for you. Or if you're incarcerated and you're coming back into society, what is your experience trying to use the system? Right now, frankly, I think it's just very confusing for everybody and nobody can really figure out, whether you're an employer or a worker, what is this. And so how can we make this experience a kind of draw from some of those methods in human centered-design to make this experience easy and simple.

So the other day I was rereading one of my favorite books from economic geography and one of my favorite scholars, Doreen Massey, she wrote a book in 1984 called "Spatial Divisions of Labor: Social Structures in the Geography of Production."

It was striking to me when I picked this book up that she's asking like a lot of the same questions that we're still starting with today about how industry is changing and how do we adapt as a society, which is fascinating in so many ways. Her central argument is that regions and the organization of production are not just a product of inexorable economic pressures. So it's not like we have technological determinism and the economy is just going to be what it is and we can't change it and whatever, but rather that those processes are really shaped by wider social, political, and ideological forces as well.

So I think we have a lot we could learn from her, basically. So, in other words, the economic level of society is formed and shaped through social processes. And then I think she also makes another really good point, which is that how we conceptualize things matters. So when we talk about terms like industry or employers or companies or training, the basic units of analysis that we use have to be meaningful. I think we have to rethink, with the fissuring of work, what does it mean to be an employer? Right. Those kinds of things I think we have to think carefully about as we try to design some new systems.

DEWS: The Brookings Cafeteria podcast is the product of an amazing team of colleagues, starting with audio engineer Gaston Reboredo, producer Christopher McKenna. Bill Finan, director of the Brookings Institution Press, does the book interviews, and Lisette Baylor and Eric Abalahin and provide design and web support. Our intern this fall is Eowyn Fain. Finally, my thanks to Camilo Ramirez and Emily Horne for their guidance and support.

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