Chapter 11
Work as Health: Tensions of Imposing Work Requirements to Medicaid Patients in the United States

Elaine Hsieh and Eric Kramer

Economic and political systems are reflections of dominant culture: its values, beliefs, expectations, motivations, and practices. Culture is expressed as an operant worldview. In the modern world, healthcare has shifted from being an expression of *religiō* to increasingly an economic-technological complex with political overtones. It may seem that issues of ethics and values have been reduced to the quantification of actuaries and accounting systems. But such calculations are means to other ends. Judgment is as pronounced as ever even as it has a veneer of objectivity. As individualism increases, the utilitarian ethics of hedonic calculus (I want to feel "good") and of mass averaging (economies of scale) constitute a rhetoric to justify decision-making and judgments. We wish to look behind the justifications to expose the values and motives at work.

This paper seeks to expose the true motives behind healthcare policy rhetoric and policy. We want to call attention not to argumentation per se but how arguments are being used (Toulmin, 1958). A pragmatism is in effect that cynically exploits and directs logic and argumentation turning philosophical analytics itself into a mere tool of mytho-ideological purpose that itself remains largely implied. The making of philosophical analytics into a mere means in the service of pursuing ulterior goals also functions to whitewash motives and obscure genuine purposes and goals. Effective arguing can make motives and goals appear "innocent" and even inevitable, objective, and natural. By implication contrary arguments are made to appear unnatural, subjective, contingent ("political"), and uselessly deluded. This process of this paper is to turn the logic of values upside down and recognize the value of logic as use-value employed for irrational means (Kramer & Kim, 2009). Argumentation, specific to this paper, arguments against universal access to

E. Hsieh (✉) · E. Kramer
University of Oklahoma, Norman, OK, USA
e-mail: ehishe@ou.edu

S. L. Arxer, J. W. Murphy (eds.), *Community-Based Health Interventions in an Institutional Context*, International Perspectives on Social Policy, Administration, and Practice, https://doi.org/10.1007/978-3-030-24654-9_11

healthcare, involves exploitation of analytical techniques and moral traditions to promote interests that have nothing to do with reason, logic, natural law (instinct), or classical morality. If effective, this critique should offer a path for a rhetoric of exposure, a process that would uncover the motives behind the arguments and the tropes they deploy and also expose the hypocrisy of those tropes. If effective, this will also suggest a means of defeating arguments by turning their axiomatic antecedents against them. Hence, arguments against universal access to healthcare are self-contradicting. But to show this, the gambit must be launched using the same traditions and language exploited by those seeking to justify denial of coverage individually and categorically.

Healthcare Cost Trends

Medicaid represents a public health insurance program that involves collaborations between the federal and state governments to provide "health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disability" (Centers for Medicare & Medicaid Services, n.d.-a). As of November 2018, 66 million Americans were enrolled in Medicaid and nearly 6.6 million children are enrolled in Children's Health Insurance Program (CHIP; Centers for Medicare & Medicaid Services, n.d.-b). In total, more than 35.4 million children are enrolled in CHIP or Medicaid, representing 50.6% of total Medicaid and CHIP enrollment (Rudowitz & Garfield, 2018). Medicaid covers one in five Americans and plays a critical role for certain populations, covering "nearly half of all births in the typical state; 76% of poor children; 48% of children with special health care needs and 45% of nonelderly adults with disabilities (such as physical disabilities, developmental disabilities such as autism, traumatic brain injury, serious mental illness, and Alzheimer's disease); and more than six in ten nursing home residents" (Rudowitz & Garfield, 2018).

One of the primary objectives of Medicaid is to enable each State to furnish "medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and costs are insufficient to meet the costs of medically necessary services" ("Social Security Act," 2019). Medicaid represents the ideals of American federalism through which state and federal governments collaborate to provide health services to states' poorest, elderly, and disabled citizens. Simply put, Medicaid is an essential social safety net for many marginalized and vulnerable populations to access services that are critical to maintaining their health (Hahn, 2018).

Medicaid represents a significant portion of federal and state budgets. In 2017, the total Medicaid spending reached $582 billion, accounting for 17% of the total national health expenditure (Centers for Medicare & Medicaid Services, 2018b). In 2010, the Affordable Care Act enabled states to opt-in Medicaid expansion, providing states significant incentives to expand Medicaid coverage to more people with low incomes. In particular, the federal government would pay 100% of the cost

of Medical expansion during 2014–2016, and the state portion will gradually phase in, capping at 10% of the total Medicaid expansion budget by 2020. Despite the strong federal incentives, only 32 states in the United States have adopted Medicaid expansion as of February 2019 (Centers for Medicare & Medicaid Services, n.d.-b). This is because Medicaid already represents a significant portion of state budgets. While the percentage of Medicaid in state budget can vary significantly (from 26% in Missouri to 7% in Oregon), 21 states reported that Medicaid accounts for at least 15% of their total state budget (Kaiser Family Foundation, 2019a). In addition, Medicaid is projected to grow 5.8% per year in spending in 2017–2026 due to the increasing number of aged and disabled enrollees. As a result, many worried that any increase in Medicaid expenditure can pose substantial pressure to states' already strained financial status. "Ten percent of $5 billion is a lot of money," said one state representative (Leonard, 2015). Despite the immediate benefits of providing health access to individuals who otherwise would not have health access due to low income, states' reluctance highlights their concerns of limited resources and other priorities (e.g., education and infrastructures). The commitment to provide health access to "as many people as possible" may not be a sustainable goal to states who already face budgetary concerns.

Reducing Access Through Work Requirements

Because health spending is projected to grow 1 percentage point faster than gross domestic product and that state Medicaid budget increases due to Medicaid expansion, both the federal and state governments have proposed creative strategies to limit health expenditures. One of the strategies proposed is Medicaid work requirement. In January 2018, the Centers for Medicare and Medicaid Services (CMS) issued new guidance for state Medicaid waiver proposals that incorporates requirements in Medicaid as a condition of eligibility. When eligible individuals fail to meet the Medicaid work requirements set by the state, they are disenrolled from the Medicaid and barred from reenrolling for a certain period (e.g., usually a few months) even when they are otherwise eligible for Medicaid. As of February 2019, Arizona becomes the seventh state to receive approval from CMS to impose a work requirement: state citizens have to have a job and get employment training or community service to be eligible for Medicaid (The Commonwealth Fund, 2019). Another eight states have work requirement proposals currently under review by CMS (Kaiser Family Foundation, 2019b; The Commonwealth Fund, 2019).

Requiring welfare recipients to work as an eligibility requirement to participate in welfare programs is not new. Imposing a work requirement is consistent with the celebrated virtues of self-reliance and self-sufficiency (e.g., "God help those who help themselves") in western, capitalistic, individualistic societies (Greene, 2008). The famed "Protestant work ethic," a myth spread by social science as well as civic and religious leaders throughout the twentieth century, undergirds the ideology justifying work requirements. Harboring racist and ethnocentric biases, this myth

expresses the notion of the White Man's burden to teach Others the value of work as a pseudo-religious virtue. Salvation comes from labor. This construct implies that Others (the poor) are lazy, stupid, and deceitful. This trope also expresses social Darwinian notions that poverty and the poor are a burden to the larger community. Labor is thus seen as little more than the largest cost to doing business, a necessary evil that can be minimized with consolidation, automation, and export of work. Otherwise, labor is nothing but a liability to the overall economic system. Of course most labor is accomplished by poor and working-class individuals who must sell their labor to those who can profit from it so that everything labor produces costs more than they are paid to produce it making the economic cycle of production/consumption a process by which labor loses value with each transaction.

As a result of the 1996 welfare reform law and debates in the 2000s, federal cash assistance (i.e., Temporary Assistance for Needy Families [TANF]), nutrition assistance (i.e., Supplemental Nutrition Assistance Program [SNAP], also known as food stamps), and some housing assistance agencies currently incorporate work-related requirements of some kind (such as that the recipient be engaged in a job search, job training, or employment and community engagement activities) as a condition of program eligibility (Falk, McCarty, & Aussenberg, 2016). The rationale for imposing work requirements involves four primary goals: "offsetting work disincentives inherent in social assistance programs; promoting a culture of work rather than one of dependency; rationing scarce taxpayer dollars to the truly needy; and combating poverty" (Falk et al., 2016, p. 2). Work requirements in these welfare programs have been carefully investigated with irrefutable findings (see also Hahn et al., 2017): (1) work requirements carry high administrative costs (Hahn, Kenny, Allen, Burton, & Waxman, 2018), and (2) the complex administration yields high error rates that deny otherwise eligible individuals benefits, including individuals living with disabilities and chronic illnesses (USDA Office of Inspector General, 2016). Previous studies also have demonstrated that some states would attempt to maximize the work participation rate by closing cases rather than helping welfare recipients find and maintain steady work (Kauff & Derr, 2008).

Work requirements for Medicaid recipients, however, are much more complicated than other welfare programs. For one, Medicaid is designed to ensure healthcare access for the most vulnerable and marginalized citizens of a state, whose health (and access to healthcare) is often faced with significant barriers (e.g., health status, old age, and poverty). In other words, modifications to existing Medicaid programs must not create barriers to achieve its legislative mandates and objectives. CMS argued that the work requirements, including community engagement such as job training and public service, can "strengthen" Medicaid programs by helping "non-disabled, working-age Medicaid beneficiaries" to "improve health and well-being and achieve economic self-sufficiency" (Centers for Medicare & Medicaid Services, 2018a). By reframing the meanings and functions of work, CMS further argued that "[t]his policy is anchored in historic CMS principles that emphasize work to promote health and well-being." Many of the state proposals have highlighted similar emphasis, noting how requiring individuals to engage with the soci-

ety through work, job training, or public services can enhance their psychological well-being and social awareness.

Work requirements for Medicaid recipients are an intriguing proposal for another reason: the policy targets an extremely small number of participants. A large percentage of the nonelderly, non-dual, non-SSI Medicaid recipients are already working (i.e., 60%; 42% working full time and 18% working part time), at school (6%), or unable to work due to illness or disability (14%) (Musumeci, Garfield, & Rudowitz, 2018). Another 11% are not working due to caregiving responsibilities (e.g., single mothers with young children), which is often included as an exempted category in state proposals (Garfield, Rudowitz, & Musumeci, 2018). This leaves roughly 6% of the population to be subjected to the Medicaid work requirements. It is intriguing that stage governments are willing to design and implement complex reporting systems to implement Medicaid work requirements despite the anticipated high administration costs and the small percentage of targeted population. So much ado about 6% of the population indicates that this is a political, more than serious substantive, gambit.

Those within the effected population are being used by conservatives to demonstrate their bona fides as responsible budget hawks. A dichotomy is suggested between irrational, emotional sentimentality, the bleeding heart liberal who is increasingly presented as a weak individual, and the rational, mature, and responsible manager of scarce resources, presented as the strong "adult-in-the-room" who is capable of making "hard choices" for the greater good of all. Two issues are presumed by this trope: first that resources are scarce and second that, therefore, choices must be made that ration access to healthcare. The rationing process demands criteria of those who deserve healthcare and those who do not. And according to the work ethic, to deserve something means to have earned it through work.

As a wedge issue, it purports to pit the hardworking good citizen against the lazy welfare cheat. Two wedges are at work: one that separates hardworking good people from lazy thieves and one that separates the vulnerable from the robust. The conservative rallying against such "theft" is thus presented as not merely a responsible steward of public funds but as a heroic leader of virtuous principle in accordance with the Protestant work ethic. In public pronouncements they, being good Christians, concede that vulnerable people, so long as they are citizens, must be helped. As during the 2016 presidential campaign, Trump stated that we cannot let people "die in the streets." A moral imperative to help the weak while punishing the wicked is promoted. But this is a double façade.

The puzzle gets more complicated when one realizes that for some states, their proposed Medicaid work requirements not only seek to punish the sins of sloth, envy, and greed but to also sacrifice to save the deserving too weak to fend for themselves, to be "my brother's keeper." While punishing the sinful who would take what they do not deserve is presented as noble, a lie is also revealed. For in fact some states do not promote these vulnerable populations' health or health access at all.

An analysis from Kaiser Family Foundation found that in Kansas and Mississippi, due to their Medicaid income-eligibility requirement, "meeting Medicaid work requirements through 20 hours of work per week at minimum wage could lead to loss of Medicaid eligibility. In addition, these jobs are unlikely to have health benefits" (Musumeci et al., 2018). In these states, individuals who are subject to work requirements are put in an impossible situation: "Damned if you do, damned if you don't" – If they do not meet the work requirements, they lose their Medicaid eligibility and access to health care; if they meet the minimum standard of work requirements, they will lose Medicaid eligibility, have no health insurance, and stuck with an income that barely supports basic cost of living, let alone health access. It would seem that such policy designs were not about "emphasiz[ing] work to promote health and well-being," as suggested by CMS, but about driving people out of Medicaid programs.

Insights into this puzzle are illuminated when one considers that as a health policy, Medicaid work requirements may simply be the pretext to minimize the financial burdens of Medicaid programs. Kentucky, the first state to receive CMS's approval to incorporate work requirement, projects that the policy will save the state and the federal government $2.2 billion over a 5-year period with an initial 3% decline in adult Medicaid enrollment in year 1 growing to 15% by year 5. By year 5, it's anticipated that nearly 100,000 will lose coverage (Meier, 2017; Solomon, 2018). In anticipation of the increasing costs of healthcare expenditure in Medicaid and the high administration costs for enforcing work requirements, large coverage losses allow the states' Medicaid programs limit state's expenses while maintaining budget neutrality (i.e., the cost to the federal government is not greater than the costs before incorporating work requirement; Hill, 2018), a necessary condition for CMS to approve states' Medicaid work requirement proposals. In other words, reducing the number of enrollees is essential to the cost-control elements *and the success* of the proposed Medicaid work requirement programs.

The experiences from Arkansas' Medicaid program, Arkansas Works, can provide some insight into the individuals who lose their Medicaid eligibility. Arkansas implemented its Medicaid work requirement in June 2018. By the end of October 2018, a total number of 15,081 individuals lose their Medicaid coverage, among whom only 3815 were due to noncompliance with work requirements (Arkansas Department of Human Services, 2018). However, work requirements are likely to be the reasons for many others to lose their Medicaid eligibility. For example, 28% of the participants lose their eligibility because they "failed to return requested information," another 25% were caused by "unable to locate client or moved out-of-state," 5% of enrollees requested to leave Medicaid, and 5% were listed as noncompliance. In contrast, only 13% listed their household increased income as the reason for becoming ineligible for Medicaid. While "churn" in Medicaid (i.e., individuals entering and leaving a welfare program) is normal, Arkansas experienced a larger percentage decrease of enrollees than any other state that expanded Medicaid (Hardy, 2018). To satisfy Medicaid work require-

ments, eligible Arkansans not only need to work at least 80 hours a month but also have to report their work activities monthly online, detailing hours spent in different eligible activities (e.g., working, education, volunteering, job training, or job search hours) (Arkansas Department of Human Services, n.d.). Given that Medicaid recipients who are subject to work requirements are individuals with low income, their lack of Internet access and technological literacy are likely to impose additional barriers to their ability and willingness to participate in *reporting* their work activities in order to remain in Medicaid. From this perspective, Medicaid work requirements is an over-inclusive policy, resulting in loss of eligible participants beyond the targeted population. This is not new, however. "[TANF] cash assistance program and from SNAP (food stamps) shows that considerable numbers of people who were working or should have qualified for exemptions from work requirements lost benefits because they didn't complete required paperwork or couldn't document their eligibility for exemptions" (Solomon, 2018).

By imposing work requirements, the state Medicaid programs can expect that more participants will leave the program than the actual number of people are targeted by the work requirements policy. For example, Kentucky anticipates "individuals with little to no claims activity choose to leave [Medicaid] rather than pay premiums" when they were not able to meet the work requirements. In a recent analysis, Kaiser Family Foundation explained, "Work requirements in Medicaid will *primarily affect people already working or exempt non-workers* by imposing new reporting requirements to document either their compliance or exemption with the rules regarding work [italics added]" (Garfield et al., 2018). Because the majority of Medicaid adults are already working or exempted, they will constitute the majority of people who are disenrolled under the Medicaid work requirements "even if they may lose coverage at a lower rate than those who are not already working but subject to work requirements" (Garfield et al., 2018). Depending on the different projected scenarios, Kaiser Family Foundation expected that between 1.4 and 4 million people may be disenrolled from Medicaid due to work requirements, among whom 77–91% are expected to be people who remain eligible but lose coverage due to new administrative burdens (e.g., not reporting work activities or exemption) (Garfield et al., 2018). By reducing the number of people covered by Medicaid and adopting a facially neutral yet over-inclusive-as applied policy, state governments can successfully control health expenditures while allowing the most vulnerable, marginalized citizens to "voluntarily disenroll" from Medicaid.

Unlike other welfare program that offers direct support (e.g., cash or food) to everyday life, Medicaid is ultimately a health insurance that provides access to healthcare – a recipient does not benefit from the welfare program until he or she utilizes healthcare services (i.e., Medicaid has no value to a person until one is ill or requires preventive care).

A New Rhetoric of Exposure

Our goal is to expose the motives behind the arguments. This paper presents a set of arguments based on common belief (culture), not moral principle or scientific fact, that must be acknowledged if policy change is to be successful. Deploying economic arguments against moral arguments, for instance, is mixing apples with oranges or, more accurately, competing in an apple-juice contest by using orange juice and expecting to win. We propose using apple-juice but in a different way. Headway in progressive healthcare reform must come from the grassroots.

We argue that one should make no mistake. Work requirements for medical aid are based on the Protestant work ethic and a common belief system that lies deeper than this contingent cultural-historical ideology. In this paper, we are not interested in arcane academic discussions of ethics and morality but rather the rhetorical sphere common to public communication and understanding. Thus, to understand the public sentiment about such policies, we must directly confront the cultural antecedents that motivate efforts to justify and demand rationing of healthcare. To do this we must directly access the mythological/cultural presumptions underlying such justifications. Hence, we recall the ideological complex variously canonized as the seven deadly sins and seven virtues presumed but rarely overtly stated that are the justifications for the policies discussed herein. But this ideological complex may emerge from and intertwine with an even deeper set of motives.

Ultimately, behind the value judgments and policy positions that limit access to healthcare is the belief that those who take what they do not deserve are selfish and being selfish encompasses all the capital vices (or cardinal sins). A concept of self is presumed and with it a construct of merit. Those with merit should be given aid. Merit involves the perceived worth of a person. The overall debate also presumes a zero-sum game. What I take is gone forever and is not available to you for sharing. It assumes a winner-takes-all hedonic calculus rooted in a particular cultural version of the self as a consumer.

Curiously, the United States and its people feel it necessary for the State to provide legal expertise to those who cannot afford it and who are charged with a crime, but this generosity does not extend to healthcare. Access to medical expertise for those who suffer an accident or disease is not similarly guaranteed. Why? Why do we choose to assure expert aid in one case but not the other?

Because, from the early US State's position, illness was beyond human interference. But a court could render great harm to a citizen through corruption. The Sixth Amendment thus provides for a jury of one's peers. This and other assumptions are obsolete and challenged herein.

It is true that the accused criminal is facing the power of the State for purported malicious actions against private or public goods, while the ill person faces the fates, often, in fact typically, without malign intent. Their illness may even be a just punishment by supernatural forces. Consequently, the State, *logically and justly*, has presumed that it has no role in health, illness, and healthcare. One would do better to throw oneself on the mercy of the fates or gods than the State. But this basic

presumption no longer holds. In both cases the government has a hand in managing responses, and healthcare has become a very powerful economic and technological complex that demands regulation.

This divergence between care for the accused criminal and care for the patient is rooted in a fragmentation and divergence of the world splitting into what is morally good and what is legal, what is sacred and what is secular power, and what is right and what is economical. The shaman was both a healer and lawgiver. But these poles have diverged to the point of becoming competing spheres of interests. The modern secular State sees its dominion over human affairs and law, not nature or supernatural domains. This allows State actors to claim innocence with regard to moral and ethical issues. They deal only with legalities. Certainly, justice is inherent in law, but many legal experts will argue that unjust laws exist and that it is not the role of courts, judges, and juries to define law but to follow it. If you have a problem with a law, take it up with the legislative branch of government which has the power to make law. So, it is here, among the elected, that morality and ethics are exposed in the formulation of law. Too often underlying issues of what is right are brought up in courts where they are dismissed.

Therefore, the State (that saw itself as separate from the interests and purview of religion) seeks to limit its own power in the case of legal prosecution. The citizen must be protected from State power, and the State should have no influence over natural and supernatural domains. However, this dichotomy is increasingly erased as illness increasingly becomes an issue of science and economics: human pursuits where regulation is called for. Furthermore, what is natural is increasingly recognized as a matter of conceptualization; in other words "nature" has become recognized as a cultural artifact conceived as a resource base for technological manipulation, ownership, and management. Genetics is a prime example.

The argument is that the natural laws of market forces should determine access. State failure to recognize the need for regulation of healthcare access, or more to our point herein, State failure to be responsible stewards of public needs, belies a failure to recognize that illness is not an issue of religion or the fates but rather highly correlated with social and economic processes within the purview of secular power and administration. Being ill is less and less regarded as a function of god's will or luck. And yet this dichotomy persists. Consequently citizens facing State power in the courts are deemed to be deserving of attention and worthy of expert counsel, while citizens facing the random fates of accident or illness are not. Furthermore, when citizens are in the control of the State, such as incarceration, they are then afforded access to healthcare as a function of administrative responsibility.

Essentially, one ideology has dominated the regulatory process which insists that government is not responsible for the health and well-being of its citizens unless they are "wards of the State." We suggest a set of arguments based on the comparison between legal aid and healthcare aid. As noted, we argue that this incongruity is rooted in common beliefs and perhaps deeper motives. There are a few possible explanations. The distinction between the two, that one is the domain of State power while the other is the rightful domain of market forces and divine intervention, must be collapsed because this distinction is the structure that justifies denial of State

power to "interfere" in healthcare. The call to "keep nanny government out of our lives" surrenders healthcare administration to the predatory practices of market forces and/or God's preordained plan (fatalism). Government, essentially, is the instrument of free humans to exercise agency over their own lives rather than passively submit to the cliché "that's just business," as if no other possibilities exist.

Instinct as Justification for Limiting Access to Healthcare

We propose that one explanation for the divergent appeal for aid between the criminal and the patient is social Darwinian. The US policy states that a person, citizen, or noncitizen should not be compelled to engage in forensic defense without the aid of legal counsel. But the US policy does not extend medical aid to those who cannot afford it and who are in need of it. This is rooted in a cultural proclivity to see weakness in others as not worthy of support. It may even be an instinctual response and part of evolutionary psychology. Weakness is not seen as having any merit. The daring criminal is more esteemed than the sick worker. Going to prison generates "street cred." But going to the hospital may, at most, generate empathy or pity. In the former case status is elevated. Some prisoners become celebrities. No one becomes a celebrity for being a patient. In the latter, the ill person is regarded as weak and passive. They may even be vilified if it is believed that they seek attention by faking illness. On the other hand, the criminal is perhaps misguided but bold and enterprising. I may secretly understand that what separates me from the thug is my own lack of courage and strength. I appeal to the police to fight my battles for me. Being a member of the sheep herd, I need the guard dog to fight the wolf for me. The wolf may be many things, but he is not weak or cowardly. The wolf's story is entertaining. The sheep's story is not interesting. The savior is willing to stand up to the bully. The greatest sin of all is of being weak, passive, and inert – uninteresting as Nietzsche (1987 Ger./1974 Eng.) put it. Criminal activity "makes the news." Unless you are already a celebrity, illness does not.

Maligning and attacking such perceived weakness may even be part of evolutionary biology. We fear the illness that may be contagious and hence the contagious person. A sick army is a weak army. One must respect the power of the corrupt king but not of the sick king. I may respect the tenacity, daring, and intellect of my enemies but I fear, pity, or disregard the sick. History books are filled with the nefarious activities of powerful people, but their illnesses are barely mentioned unless they impact the overall story or take on a scale, such as a plague, as to pique the interest of the writer. Becoming ill is never a strategy for "success." Illness and frailty are not paths to fame and fortune.

Hence, it may be that support for the sick is not nearly as sexy as tacit support if not adulation for the courageous and "genius" criminal. The deeds of the organized crime boss make "good copy." The more heinous, the more popular. But his illnesses do not make the cut. Illness, to the contrary, is mundane. The criminal mastermind pits herself against the wits of the law. The antiauthoritarian in us secretly, or even

openly, cheers for the criminal, especially if her rebellious actions are seen as just. We enjoy the drama of a "worthy opponent." The sick are not worthy. The sick resist no one. The sick compete with no one. Illness does not project agency or bravado. Who will "outlive" who is part of the larger evolutionary game of success? People take pride in the longevity of their "good genes." We want to live longer and longer but only if in robust health. Aging as the frailty of mind and limb is regarded as an illness too, and so there is a constant tension between committing resources to the young, to the future, or to the old, to past glories (Kramer & Hsieh, 2012).

The rhetoric of instinct is a naturalizing language that implies inherent permanence. It is debunked already by modern biology that recognizes the interaction between environment and genetic *predispositions* or tendencies (not predetermination). In lay rhetoric, instinct is used as a pseudoscientific synonym for fatalism. It is hopeless to suggest we can change our nature. Throwing money at certain defective persons is simply a waste of resources. In short, it is hopeless. This rhetoric can be intercepted by basic arguments from the very humanism that modern industrialists and capitalists claim as their procreant cradle. While religion may not offer strong cross-examination, humanism itself does. Here the rhetoric can be challenged by the trope of free will that capitalists espouse. Their rhetoric can be used against them. And it is not difficult to see a tropic landscape where such a battle can be waged. Furthermore, rewards and punishments are meted out in a belief that behavior can be modified. So the threat of withholding healthcare is expected to motivate people to work. Clearly, then, according to capitalists themselves, things are not preordained, genetically or spiritually.

Medical science is focused on extending human longevity. From the earliest magic to the most modern and complex technical treatments, healthcare has always been a process of confronting and attempting to defeat natural and supernatural forces. Healthcare is the application of human agency and ingenuity to defeat those forces that would threaten our desired quality and quantity of life. So to punt, to surrender to an argument from "instinct," is a direct contradiction of the rhetoric of free will and enterprise so central to capitalist mytho-ideology.

Mytho-ideology

As myth takes the form of written canon, it becomes disputative and ideological. Another aspect of the dichotomy between the worthy criminal and the unworthy patient has to do with Protestant (Calvanist) *ethics* as an evolution of older Catholic morality (themselves in part borrowed from Plato and Aristotle's *Nicomachean Ethics* via Thomism). Aristotle's modernistic take on ethics involved the introduction of an analytical mindset presenting "the good" as a strategic necessity for social stability. Rather than stating a virtue or vice without context as an absolute, Aristotle and later Kant, following in his mode, asked a more social question. What if everyone else acted in the same way? Thus, pragmatics via social stability enters into an ethical and moral judgment. Ethics becomes an issue of reliable consistency.

"The good" is not "in itself" sui generis, but a matter edging toward quantification: moral calculus. The hedonic characterization of this calculus would be added later with the utilitarianism of the Benthamites who shifted focus from collectivistic to individualistic reckoning. It violates its own attempts at generalized truth by elevating personal desires to the status of ultimate criteria. Thus, the calculus changes fundamentally and what is good, what is rational pivots on personal wants and needs rather than group wants and needs. What is rational becomes synonymous with what is the most efficient means to achieve personal wants and needs. This then is linked to the "greater good for the greater number" by means of production and identification of the self with the group via economic common ground, a sort of inescapable membership. Membership suggests personal choice like selecting one's church or religion, a process basically impossible in earlier times. As individualism and free will emerge with modernization, identities proliferate. Religious affiliations multiply. Sectarianism and fragmentation increase. But what all have in common is the growing market economics and labor.

As production became the dominant organizing structure of society (industrial society), the needs of the self become identified with the needs of one's firm or corporation – even nation. Fortunes rise and fall together. The unfortunate are those who have no affiliation and are typically careerless/homeless (literally and figuratively). They wander among us as people with no country (Kramer & Hsieh, 2019). While presented as an objective Darwinian process, the outcomes are utterly personal and strike at the core of character assessment and identity. Those "outside the system" are labeled "aimless." As burdens on the system, moral judgment follows with repercussions such as denial of access to systemic healthcare. Debtor's prisons have been replaced by even more inescapable economic profiles, credit ratings, job histories, criminal records, educational attainments, and so forth. The virtual person is more permanent and believable (consequential) than the actual one. And its identity is more economic, spiritual, social, or psychological.

Being unemployed is the most common crack through which individuals fall. Without a "safety net," they languish in a purgatory, present yet denied entrance into the shelter of civil society. This includes access, or the lack thereof, to basic healthcare. This is not seen as immoral but quite the contrary. Such denial of the unproductive is expressly justified by moral criteria. The only way to combat this situation is to recognize the rhetoric and implied morality and confront it at that level of judgment and in those terms. Only then can inconsistency, hypocrisy, and contradiction be clearly drawn. This is what we call the rhetoric of exposure. It is more than a rhetoric of values or motives (Burke, 1969). And it is more than mere storytelling as ontogenesis (Fisher, 1984; Kramer, 2013). It is the use of analytical skills to demonstrate the hypocrisy of an argument over time. Within the dialectic one finds the contradicting logic that decenters such claims to ultimate validity such as instinct, exposing a field for free will and innovation. It disrupts the orderly "coordination" of meaning. Healthcare for all is hardly a hopeless pipedream as some claim based on various warrants and claims.

The Presumed Criteria: The Linguistic Ground Staked Out and Where Disputation Must Engage

The seven deadly sins are *Luxuria* (Lust), *Gula* (Gluttony), *Avaritia* (Greed), *Acedia* (Sloth), *Ira* (Wrath), *Indvidia* (Envy), and *Superbia* (Pride). The seven corresponding virtues are *Castitas* (Chastity), *Moderatio* (Temperance), *Caritas Liberalitas* (Charity – Generosity), *Industria* (Diligence), *Patientia* (Patience), *Gratia* (Gratitude), and *Humilitas* (Humility). As this paper unfolds, you will see how these fundamental cultural presumptions are operant in justifying rationing access to healthcare. Because they are fundamental and only tangentially exposed in public pronouncements, they are very powerful antecedents to policy debates. They are powerful because they are uncritically presumed. Three such "sins" strongly influence policy justifications: greed, envy, and sloth. These are attacked in policies that ration access to healthcare. Concurrently and implicitly, those who attack such sins also present themselves as champions of the corresponding virtues of charity, diligence, and gratitude. Those who are not deserving of healthcare are portrayed as lazy greedy cheats. Those who warrant such help are presented as "vulnerable" and therefore deserving of charity given from the industrious, charity that should be received with humility and gratitude. This is the basic structure of the values-discussion underpinning policy debates and ultimately justifying selective access to healthcare.

In previous times health included cosmic balance involving ritualized respect for the sacred, what Cicero called *Cultum deorum*, "the proper performance of rites in veneration of the gods" (Cicero, 1933, p. 28.). Health had much to do with notions of balance and harmony between the temporal and the timeless, and in collectivistic societies, it was a community-wide condition. With secularization and increasing individualism, *religiō* became, as Max Weber put it, disenchanted and a new system for meaning- and value-creation emerged, namely, science. But as the larger rationalization and mathematical reduction of all things deconstructed all previous sources of meaning and value-creation, they themselves offered no unifying principles but rather an endless fragmentation of incompatible value spheres. All truths are destined to become obsolete as antithesis counters thesis in an endless process, an absurd process of progress with no final goal.

Science was not the answer. Rather, what came to be the answer to the traditional human questions of existence increasingly were answered by labor. The human as philosopher died along with the great existential questions, and the human as producer/consumer was born. Order no longer came from transcending criteria but from increased calls for self-discipline. The modern sees herself as an instrument of production. Use-value came to dominate industrial culture so that people could come to be seen as "useless" and "useful." A simple positivism emerged. You were either measurably profitable to the firm or you were not. The body came to be seen less as the receptacle of an eternal soul and more as an instrument of contingent production. "What have you accomplished for me lately" is the new measure of value. The grand durée has been supplanted by "time famine" and a chronic sense

of urgency (Kramer, 1992, 2013; Levine, 1997). Even capitalism is suffering as day-trading has accelerated to algorithmic automatic nanosecond trading, making entrepreneurial planning increasingly difficult. The system is characterized by a "time famine" (Levine, 1997) and "temporal anxiety" (Gebser, 1985), distressing all involved.

The Body as Material Production

Maintenance of the body is now driven so that athletes can keep "producing stats" and workers can keep laboring through illness and injury. Measurable performance is the ultimate truth. Pain management is a relatively new idea. It emerges with the modern individual and industrial warfare and production. The idea that pain can and should be managed if not elevated entirely is one of the goals of modern healthcare. It is almost presumed without question. It is so different from the concept of righteous suffering previously dominant in religious tropes that religious institutions are grappling with the role of suffering within God's plan. Designed suffering from penance to self-flagellation is seen as quaint if not bizarre practice of a bygone world and abandoned moral practice. Modernity has promised convenience and a guilt-free and pain-free existence. But for the Buddhist, this means abandoning life itself. For the Christian it means abandoning identification with Christ and His suffering. The idea that happiness is a goal in life is relatively new, an essential goal of modern positivism. Only recent Christian doctrines have argued that leading a Christian life should not necessarily lead to more suffering. To the contrary, contemporary Evangelical doctrine suggests the opposite, which an appeal of Christian conversion is the material as well as spiritual rewards God will bestow. In either case, work must be done and performance efficiency must increase. True evil is that which threatens production.

Endless work without pain is the goal. Insofar as illness and pain slow the pace of production, they must be managed. Since inherent value has become a myth, value exists only in exchange. Thus, according to use-value, we become alienated from our own bodies as useless unless they can be pressed into productive labor. Being healthy is valuable not in itself but as a precursor to being productive. Performance evaluation marks the status of the individual within administrative logic. Illness and injury no longer threaten the quality of life directly but also indirectly through career attenuation and termination. In a highly individualistic cultural environment, poverty is the "just punishment" for being unproductive. "Missing work" is a constant threat to the modern worker's very livelihood. Reliable, cheap labor and fast exchanges constitute the "good" in the industrial world. The show is alienated from the players. The show must go on even as the players falter. The show is no longer the players in a systemic coordinated process. The process of production (in a play or factory) is separated from the hands that operationalize the logistics (Horkheimer & Adorno, 1987). The producers are interchangeable with each other, and it is the production process that must not pause or cease. This is why

robotics is so valued and pursued because robots are better workers. They do not complain, they do not get sick, they do not unionize, and their output is highly predictable (consistent).

Just as actors are interchangeable but the play "is the thing," so too workers have become supplemental to work. Work and worker are separated. Producer and product are separated. Profit and salary diverge. The constant threat to the worker is that they are easily replaced. They are insignificant in and of themselves. Hence the other side of the coin of modern individualism is aggregation on a mass scale. The individual is meaningless, useless, unless they can be pressed into performing the tasks assigned by the logic of the production process. Illness and injury become existential and perpetual threats. Hence, debate over healthcare policy and practice rages. Why spend a great deal to repair a broken worker when they can be easily replaced? Even when workers spend a lifetime and go into debt to educate and train themselves for the workforce, still investing in a robot is more profitable in the long run. Robots are easily reprogrammable. And fixing them is relatively simple compared with a worker healing from an injury or illness. From the perspective of profit/logic, it makes no sense to waste resources on unproductive people. Consequently, where this ideology is more pronounced, the United States, "entitlements" are constantly debated even when they are paid for by workers' taxes. In this ideological milieu, the very word "entitlement" is pejorative even when it literally means something already earned. The word itself has fallen victim to the logic of undeserved or unearned privilege. And expenditures for warehousing the unproductive in child and senior daycares are systematically repressed (Kramer, 2004).

Evaluations reduce individuals to single numbers. Resumes and vitae constitute the modern portrait. Even in an environment of near-full employment, employers are so inundated by resumes that they increasingly are turning to standardized forms and algorithms to handle the sorting. The persona with a "preexisting condition" is flagged. Life as suffering, the ultimate preexisting condition, is itself deemed untenable according to the logic of production.

Everything including health, justice, and ethics became increasingly conceived as a balance sheet in modern parlance. It may have begun with Pauline epistles to the Corinthian traders he sought to convert. Paul's language is one of business exchange. Christ pays for your sins. Balance and objectivity dominate discourse. Hence, life satisfaction must be earned, and thus the Puritan ethic of "innerworldly asceticism (*innerweltliche Askese*)" converts the soul to a record of accomplishments (Weber, 1992). Control finally wedded to the modern self, and systematic synchronicity as the binding principle of productivity gives birth to rigorous self-control and self-discipline without need for gods. Internalized governance, self-control, and conscience are the subroutines of culture. A subroutine is a set of presumed rules that govern cognition and behavior and are replicable. The "stable" "mature" person is consistent and reliable. The good person is the productive one. Work is no longer seen as a means to other ends, to leisure and the pursuit of the liberal arts (innovation), but instead as an end in itself (Hunnicutt, 2013), indeed as the only real end. Routinized patterns of thought and action are "programmed"

through acculturation and enculturation (communication patterns) to assure "quality control." Feedback and control is the major type of communication between superordinate and subordinate. In fact, "personal" contact is increasingly outlawed.

According to this subroutine that justified cultural patterning itself, what one deserves is what one earns through sacrifice and self-discipline within the rationalization of administrative systemization, the organization of egoism that leads to the "iron cage" domicile of the assembly-line worker and salaryman. Modern rules of finance determine the credit rating of each person. The irony that one has what one earns, the self-made human, presumes the structures of production and administrative rationality. Agency in the making of the system is eliminated. Consequently, democratic modes of comportment and public sphere are increasingly seen as friction within the system. Education, critical assessment, and a free press are "enemies" of the system. They cause the system pain. Systems operate most efficiently without exogenous interference such as democratic institutions that may disrupt operation and reevaluate their founding purpose. Since value is no longer an inherent quality, to be of value is nothing other than a measurement of performance outcome. To be of value is to demonstrate utility within a system of production/consumption. No other value is recognized (Kramer, 2004). In fact, nothing, such as a rain forest, has value, until and unless it can be assimilated into the system, processed, and commodified. The value of the forest is calculated in board feet and current market demand (Kramer, 2004). Otherwise it is useless, valueless. Value and meaning are reduced to use: utility.

Domestication, the convergence of nature into an artifact of culture, is the first move of control (Kramer, Adkins, Kim, & Miller, 2014). The dominant ideas are the ideas of the dominant class, and it is the dominant class that establishes what counts as valid (not even valued) goals and purposes of life. Management posits a goal and since profit is actualized with each unity "moved," time becomes the dominant factor in production and the accumulation of wealth/power. Taylorism is but one expression of the modern utilitarian view with its presumption of objective rationality, but not a rationality based in a transcending principle but rooted in subjective desires and needs. Confronted with a profound expansion of empty, dead space, the modern becomes "encapsulated," isolated and must strive to be adequate. Modernity is thus characterized with endless confrontations. Encapsulated ego sees nothing but alterity and Otherness. Time is compartmentalized and schedules dominate life (Kramer, 1997a, 1997b). Time-rooms (boxes on calendars, subdivided down to minutes) dictate appropriateness. And timing "is everything." The good person is the reliable one, the one that is "just like clockwork." As time and space rigidify, the self responds, and identity becomes of paramount concern. Privacy of property and information intensifies. And increasingly production has nothing to do with democratic comportment except when regulation is suggested and then the relationship is adversarial. Thus access to healthcare is defined as a liability, especially when the worker's body is no longer necessary.

Robotics, artificial intelligence, algorithmic pattern recognition, and other innovations are meant to eliminate the worker's body and with it needs for its maintenance or nurturance. Work achieves increased efficiency by not just dissociating

from the worker but by eliminating the worker's body entirely and along with it democratic institutions because without a body there is no perspective on issue including healthcare policy itself. Eliminating workers and their unions eliminates the need for regulation and social support. Thus domestication, the essence of production, reflexively applies to itself, doubling down. It thus rids itself of the last element that may resist control or offer an ulterior perspective. The worker that once conceived of the product and the mode of production is domesticated and reproduced. Mortal aspects are replaced by robotic action. The work ethic is fulfilled. Sin is eliminated with the elimination of the sinner.

References

Arkansas Department of Human Services. (2018). *Arkansas Works program*. Arkansas Department of Human Services. Retrieved from https://humanservices.arkansas.gov/images/uploads/newsroom/111518_AWreport.pdf

Arkansas Department of Human Services. (n.d.). *AR Works Information*. Retrieved from https://ardhs.sharepointsite.net/ARWorks/default.aspx

Burke, K. (1969). *A rhetoric of motives*. Berkeley, CA: University of California Press.

Centers for Medicare & Medicaid Services. (2018a, January 11). *1115 community engagement initiative*. Retrieved from https://www.medicaid.gov/medicaid/section-1115-demo/community-engagement/index.html

Centers for Medicare & Medicaid Services. (2018b). *NHE fact sheet*. Retrieved from https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

Centers for Medicare & Medicaid Services. (n.d.-a). *Medicaid*. Retrieved from https://www.medicaid.gov/medicaid/index.html

Centers for Medicare & Medicaid Services. (n.d.-b). *November 2018 Medicaid & CHIP enrollment data highlights*. Retrieved from https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

Cicero. (1933). *De natura deorum, Academica* (R. H. Rackham, Trans.). Cambridge, MA: Harvard University Press.

Falk, G., McCarty, M., & Aussenberg, R. A. (2016). *Work requirements, time limits, and work incentives in TANF, SNAP, and housing assistance*. (7-5700). Washington, DC: Congressional Research Service. Retrieved from https://greenbook-waysandmeans.house.gov/sites/greenbook.waysandmeans.house.gov/files/R43400%20-%20Work%20Requirements,%20Time%20Limits,%20and%20Work%20Incentives%20in%20TANF,%20SNAP,%20and%20Housing%20Assistance_0.pdf

Fisher, W. (1984). Narration as a human communication paradigm: The case of public moral argument. *Communication Monographs, 51*, 6.

Garfield, R., Rudowitz, R., & Musumeci, M. (2018). *Implications of a Medicaid work requirement: National estimates of potential coverage loss*. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/

Gebser, J. (1985). *The ever-present origin* (N. Barstad & A. Mickunas, Trans.). Athens, OH: Ohio University Press.

Greene, T. W. (2008). Three ideologies of individualism: Toward assimilating a theory of individualisms and their consequences. *Critical Sociology, 34*, 117–137.

Hahn, H. (2018). *Work requirements in safety net programs: Lessons for Medicaid from TANF and SNAP*. Retrieved from https://www.urban.org/sites/default/files/publication/98086/work_requirements_in_safety_net_programs_0.pdf

Hahn, H., Kenny, G. M., Allen, E., Burton, R., & Waxman, E. (2018, January 12). *Guidance on Medicaid work and community engagement requirements raises many important questions*. Retrieved from https://www.urban.org/sites/default/files/publication/95846/2018.1.12.questions_final_for_pdf_v1_0.pdf

Hahn, H., Pratt, E., Allen, E. H., Kenny, G. M., Levy, D. K., & Waxman, E. (2017, December 22). *Work requirements in social safety net programs: A status report of work requirements in TANF, SNAP, Housing Assistance, and Medicaid*. Retrieved from https://www.urban.org/research/publication/work-requirements-social-safety-net-programs-status-report-work-requirements-tanf-snap-housing-assistance-and-medicaid

Hardy, B. (2018, August 9). *Scrubbed from the system: Why Medicaid enrollment has dropped almost 60,000 in 18 months*. Retrieved from https://www.arktimes.com/arkansas/scrubbed-from-the-system/Content?oid=21285998

Hill, T. B. (2018). *Beduge neutrality policies for Section 1115(a) Medicaid demonstration projects*. Centers for Medicare & Medicaid Services. Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf

Horkheimer, M., & Adorno, T. (1987). *Dialectic of enlightenment* (E. Jephcott, Trans.). Stanford, CA: Stanford University Press.

Hunnicutt, B. (2013). *Free time: The forgotten American dream*. Philidelphia, PA: Temple University Press.

Kaiser Family Foundation. (2019a). *Federal and state share of Medicaid spending*. Retrieved from https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/

Kaiser Family Foundation. (2019b, January 23). *Medicaid waiver tracker: Approved and pending section 1115 waivers by state*. Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

Kauff, J., & Derr, M. K. (2008, December). *Achieving higher TANF work participation rates: Case studies from Maryland and Utah*. Retrieved from https://aspe.hhs.gov/system/files/pdf/75606/report.pdf

Kramer, E. M. (1992). Gebser and culture. In E. M. Kramer (Ed.), Consciousness and culture: An introduction to the thought of Jean Gebser (pp. 1-60). Westport, CT: Greenwood.

Kramer, E. M. (2004). Vanishing meaning, the ideology of value-addition, and the diffusion of broadband information technology. In J. M. Choi, J. W. Murphy, & M. J. Caro (Eds.). Globalization with a human face. Westport, CT: Praeger, 87-108.

Kramer, E. (2013). Dimensional accrual and dissociation: An introduction. In J. Grace & E. M. Kramer (Eds.), *Communication, comparative cultures, and civilizations* (Vol. 3, pp. 123–184). New York, NY: Hampton.

Kramer, E. (1997a). *Modern/Postmodern*. Westport, CT: Praeger.

Kramer, E. (1997b). In J. M. Choi, J. W. Murphy, & M. J. Caro (Eds.),. Globalization with a human face *Vanishing meaning, the ideology of value-addition, and the diffusion of broadband information technology* (pp. 87–108). Westport, CT: Praeger.

Kramer, E., Adkins, G., Kim, S., & Miller, G. (2014). *Environmental communication and the extinction vortex*. New York, NY: Hampton Press.

Kramer, E. M., & Hsieh, E. (2012). Anti-culture and aging. In S. L. Arxer & J. W. Murphy (Eds.), *The symbolism of globalization, development, and aging* (pp. 135–156). New York, NY: Springer.

Kramer, E. M., & Hsieh, E. (2019). Gaze as embodied ethics: Homelessness, the Other, and humanity). In M. J. Dutta & D. B. Zapata (Eds.), *Communicating for social change: Meaning, power, and resistance* (pp. 33–62). Singapore: Palgrave Macmillan.

Kramer, E. M., & Kim, T. (2009). The global network of players. In J. M. Choi & J. W. Murphy (Eds.), *Globalization and the prospects for critical reflection* (pp. 183–211). Delhi, India: Aakar.

Levine, R. (1997). A geography of time. New York: Basic Books.
Leonard, K. (2015). *Opposing Medicaid expansion*. U.S. News. Retrieved from https://www.usnews.com/news/the-report/articles/2015/12/04/opposing-medicaid-expansion
Meier, A. (2017). *Kentucky HEALTH §1115 demonstration modification request*. Retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa2.pdf
Musumeci, M., Garfield, R., & Rudowitz, R. (2018). *Medicaid and work requirements: New Guidance, state waiver details, and key issues*. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements-new-guidance-state-waiver-details-and-key-issues/
Nietzsche, F. (1974). *The gay science* (W. Kaufmann, Trans.). New York: Vintage.
Rudowitz, R., & Garfield, R. (2018). *10 things to know about Medicaid: Setting the facts straight*. Kaiser Family Foundation. Retrieved from https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/
Social Security Act, 42 U.S.C.A. § 1396-1 (2019).
Solomon, J. (2018). *Administration's re-approval of Kentucky's Medicaid waiver again ignores harm to beneficiaries. Center on Budget and Policy Priorities*. Retrieved from https://www.cbpp.org/blog/administrations-re-approval-of-kentuckys-medicaid-waiver-again-ignores-harm-to-beneficiaries
The Commonwealth Fund. (2019). *Status of Medicaid expansion and work requirement waivers*. Retrieved from https://www.commonwealthfund.org/publications/maps-and-interactives/2019/feb/status-medicaid-expansion-and-work-requirement-waivers
Toulmin, S. (1958). *The uses of argument*. Cambridge, UK: Cambridge University Press.
USDA Office of Inspector General. (2016, September). *FNS controls over SNAP benefits for able-bodied adults without dependents*. Retrieved from https://www.usda.gov/oig/webdocs/27601-0002-31.pdf
Weber, M. (1992). *The Protestant ethic and the spirit of capitalism* (T. Parsons, Trans.). London, UK: Routledge.