It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America

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Abstract We argue that the United States does not have comprehensive national health insurance (NHI) because American political institutions are biased against this type of reform. The original design of a fragmented and federated national political system serving an increasingly large and diverse polity has been further fragmented by a series of political reforms beginning with the Progressive era and culminating with the congressional reforms of the mid-1970s. This institutional structure yields enormous power to intransigent interest groups and thus makes efforts by progressive reformers such as President Clinton (and previous reform-minded presidents before him) to mount a successful NHI campaign impossible. We show how this institutional structure has shaped political strategies and political outcomes related to NHI since Franklin D. Roosevelt. Finally, we argue that this institutional structure contributes to the antigovernment attitudes so often observed among Americans.

> American constitutionalism goes beyond the general idea of a government of laws. It includes specific modern concepts of limited government and, accordingly, specific kinds and techniques of limitation. It holds that these are essentially embodied in the written Constitution, which is the fundamental law that limits ordinary government (Diamond 1981: 100).

By the time this essay is published, both pundits and scholars will have analyzed and reanalyzed the failure of the Clinton health care plan. The most obvious explanations have already been offered. They blame Presi-

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dent Clinton, his plan, his advisors, his wife, the Democrats, the Republicans, the medical industry, and the American voters. Hundreds of knowledgeable scholars and journalists will offer their suggestions: "If they had only done this . . ." or "If only they had not done that . . . health reform would now be a reality." Furthermore, we are willing to predict today (10 November 1994) that the analysts will argue further that Clinton's missteps on health care explain the remarkable election results of 9 November 1994. They will argue that if Clinton had only been smarter, tougher, or more savvy, or if his plan somehow had been more "in tune" with America, the Democrats would have retained their control of Congress. Clearly, they will argue, Americans want comprehensive health care reform as much as the American economy needs it. If Clinton had not missed this golden opportunity, surely Congress would have finally passed what every other democratic legislature in the world passed long ago. Bill Clinton's burden must be heavy.

We argue that this line of analysis is wrong; instead we believe that America did not pass comprehensive national health care reform in 1994 for the same reason it could not pass it in 1948, 1965, 1974, and 1978. The United States is the only democratic country that does not have a comprehensive national health insurance system (NHI) because American political institutions are structurally biased against this kind of comprehensive reform.

This institutional bias begins with a political structure forged by America's founding fathers that was explicitly designed to pit faction against faction to protect minority factions from majority factions. Progressive reforms have exacerbated this bias by undermining strong political parties. Subsequently, several generations of congressional reforms unwittingly turned national politicians into independent political entrepreneurs. This institutional context explains (and could be used to predict) the failure of national health care reform in America—not flaws in the plan, the planners, or political strategy.

We offer a brief overview of the history of NHI politics through an institutionalist lens. It does not make sense to blame the Clinton administration for its inability to pass NHI yet forget the failures of the Roosevelt, Truman, Kennedy, Johnson, Nixon, Ford, and Carter administrations. We do not attempt a comprehensive history in these few pages, but instead focus on a few key junctures when NHI appeared to be close to passage. With this history we show how the structure of American political institutions shaped the political strategies of both proponents and opponents of reform and thereby explain the unique and often curious health

care reform policies that have passed in America. Finally, we suggest that the policies actually passed have confirmed the anti-statist "public understanding" (Jacobs 1993a) that is part of the American political culture.

Some Arguments for Reform's Failure

Culture

The most common explanation for the absence of NHI is that the United States is exceptional because of its unique political culture (Anderson 1972; Jacobs 1993; Rimlinger 1971). America has developed unique individualistic and anti-statist political values that have biased the polity against the welfare state. Of course, NHI would be a major step toward a more comprehensive welfare state and a major intervention of the public bureaucracy into the private market place.[1]

This logic has an intuitive appeal. The United States, a country founded by immigrants and those looking for freedom from the oppressive political chains of Europe, has a strong commitment to the values of individual responsibility, personal freedom, and anti-statist beliefs. Americans have never been so concerned with what government will do for the individual; rather they try to limit the power of government to control the individual through a system of clearly delineated rights, a standard against which all government legislation must be compared. In essence, Americans have tried to preserve the capacity for personal choice through a continued commitment to liberal values and market mechanisms. Anthony King (1974), in his often cited explanation for American exceptionalism, argues "The state plays a more limited role in America than anywhere else because Americans, more than any other people, want it to play a limited role" (see also Lipset 1991).

As intuitively appealing as this argument at first appears, flaws in both the logic and evidence that have been marshaled in its favor undermine its utility. First, and most obviously, public opinion polls have consistently shown that most Americans have favored some kind of comprehensive NHI system for most of the post-war era (see Table 1).

1. Lawrence Jacobs' recent book, *The Health of Nations*, is by far the most sophisticated of the culturalist analyses. In this tremendously interesting and well-documented book, Jacobs tries to show that Britain and America created radically different health care systems due to the differences in basic public preferences. We strongly recommend this book as the best counter-argument to our thesis. Although sympathetic to Jacobs' analytical aims, we believe he errs. In his attempt to show the policy relevance of public preferences, he overstates his case and, in the end, presents an overly static understanding of those preferences.

Table 1 Public Support for Greater Government Role in the Health Care Industry

Year	Percentage Expressing Support for Increasing Government Role in Health Care Delivery[a]
1937	80
1942	74
1961	67
1965	63
1976	66.7
1978	61.3
1992	75

a Data were taken from different polls that asked similar, but not identical, questions. See sources for exact questions.

Sources: Free and Cantril 1967: 10; Gallup 1961, 1965; *Fortune*: July 1942: 8–10; 12, 14, 18; *American Medical News* 1976, 1992: 27; What the Polls Show 1978: 20.

Second, even to the extent that Americans are highly individualistic, whether this general cultural predisposition translates into specific attitudes toward specific governmental programs is not clear. Political cultures, after all, contain various (and sometimes competing) political values (Page and Shapiro 1992; McClosky and Zaller 1984). Thus, although Americans do hold highly individualistic values, they are also profoundly egalitarian—especially with respect to the value of equal opportunity. American individualism did not prevent the U.S. government from developing a massive, comprehensive, publicly financed education system, nor did it stop the legislature from building one of the most generous social security systems in the world (Tomasson 1984; Derthick 1979; Weir et al. 1988). In each of these cases, reformers successfully argued that these programs reflected and were supported by American values. Of course, health care reformers have argued similarly. The real question is why, in this case, has the argument been less successful?

Third, a critical lacuna in the culturalist argument is the paucity of comparative historical evidence. The argument implies that Americans did not pass NHI but Europeans did because this program was demanded in Europe, whereas it was not in the United States. In truth, however, little evidence shows that NHI was the product of widespread public demand in other industrial democracies. Instead, the various comprehensive public health programs initiated throughout the world were, in fact, the product of governing elites' attempts to address pressing policy problems (Immer-

gut 1992; Heclo 1974). In many cases the public was generally frustrated by the costs and inaccessibility of health care, and they demanded that the government "do something" (Anderson 1972; Rimlinger 1971). But, as Table 1 indicates, this basic public preference has existed for some time in the United States as well. In short, if the culturalist argument was correct, we would expect to see compelling evidence that Europeans expressed higher levels of frustration with privatized health care financing and demanded specific reforms.[2] At issue is exactly what these different governments did when faced with the political and fiscal incentives to "do something" about the problems of cost and access to their nation's health care delivery system.

Finally, culturalist analyses tend to ignore or at least underemphasize the dynamic interactions between public preferences and public policy. For example, by striving to prove the stability and coherence of the "enduring social understandings and more immediate public preferences," Jacobs (1993a: 226) undermines his own comparative analysis. He notes that he is deeply concerned with institutional change and with the relationship between preferences and policy outputs, but he ignores the relationship between institutional change and public preferences. Clearly what governments do (or do not do) affect attitudes toward government. But the emphasis on the permanence of cultural preferences belies this point.

In the end, culturalists offer quite static explanations. What we need is a better understanding of the relationship between what people think about government and what government does (or does not do). Politics is an iterative process, not a one-off game. Thus if government does well, it builds support. If it fails to act in response to public pressure, or if it acts poorly, we should not be surprised that citizens lose faith in public institutions.

Although American political culture clearly is unique (just as Swedish, Japanese, or French political cultures are unique), far less clear is whether culture itself can provide an adequate explanation for any particular policy outcome, including the absence of comprehensive NHI in the United States.

2. Jacobs (1993) makes the most careful attempt to argue that differences in policy outcomes are a product of differences in public opinion. But even his very extensive comparative historical analyses of public opinion in Britain and America does not show that the British citizens demanded the National Health Service structure that the 1945 Labour government implemented. British citizens clearly believed the health care system needed reform at the end of the war, and they strongly believed that "everyone should be included." But although very interested, most citizens had only a hazy understanding of the details and the specific reforms they preferred (Jacobs 1993a: 13–14, 169–70, 173–75).

Interests

Many of the best political histories of the politics of health care reform in the United States either explicitly or implicitly advance what we call an "interest" explanation (Poen 1979; Alford 1975; Navarro 1976).[3] Although often explicitly sensitive to the peculiar cultural context of American politics, these analyses essentially argue that the United States has not developed an NHI scheme because of the determined opposition of powerful interest groups. In contrast to the culturalist argument, this thesis holds that the United States has not built an NHI system despite public support for it.

The interest explanation is substantially better grounded in empirical facts than is the culturalist alternative. Indeed, the evidence used to support this thesis in many ways is overwhelming. Any history of the politics of health care reform in the United States shows clearly that reformers in this country have faced an exceptionally well-organized and well-financed opposition, whereas the proponents of reform have been demonstrably less well organized and less well financed.

Still, as empirically satisfying as the interest explanation can be, we believe it has important analytic flaws. The first of these is similar to the critique of the traditional culturalist explanation: Although the explanation is comparative, little or no comparative evidence is generally provided. If the key explanation for the absence of NHI in the United States is that powerful interest groups fought the reform, then proponents of this argument should be able to show that countries that did pass NHI legislation did not have powerful interest groups opposing their reforms. However, studies of the politics of health care reform in other democratic polities clearly show that physicians, hospitals, insurance companies, business interests, and conservative political forces generally bitterly opposed NHI in every country in which national health care policies eventually emerged.[4] The important question is why the forces of opposition could

3. Of course, not all analysts of the development of the American health care system can be fit easily into these two categories. Indeed, two of the finest histories of the development of the American health care system, Paul Starr's *Transformation of American Medicine* and Theodore Marmor's *Politics of Medicare*, do not explicitly explain the particular policy outcomes they describe. In these cases, we can find evidence for, and inferences toward, both the culturalist and interest group explanations.

4. There are few genuinely comparative political histories of the politics of health care reform today. Two of the best are by Anderson (1972), who compares the politics of health care in Britain, Sweden, and the United States, and by Immergut (1992), who compares Sweden, Switzerland, and France, and Wilsford (1990) who compares France and the United States. Excellent single-country studies of health care politics written in English include: Ekstein (1960) and Klein (1983) (for Britain); and Heidenheimer (1980) (for Sweden).

stop some form of NHI in the United States but not in other democracies.

A second problem with the traditional interest explanation is that it cannot adequately explain why some policy reforms have been successful in the United States while others have not. The for-profit medical industry was opposed to the creation of Medicare and Medicaid in the early 1960s, just as they had opposed NHI in the 1940s and 1950s. They used many of the same tactics against this reform that they used successfully to prevent passage of earlier reforms. Why, if powerful interest groups can veto policies they oppose, did the Medicare/Medicaid legislation pass despite this opposition? The interest group analysis would, of course, argue that the different outcomes resulted from different political calculuses. In short, the outcome was different in 1964 than in 1948 because the times were different, the politics were different, or the policies in question were different. This explanation, while in some sense correct, is unsatisfying. The analytic model provided by this explanation forces us to look at each case separately and independently: A single issue can have different political and policy outcomes depending on the infinitely complex political context in which it happens to occur. Our problem is not simply one of social scientists trying to find analytic order where none exists. Instead, we argue that there have been patterns to the health policy outcomes in the United States (and in other policy arenas, for that matter). Each case is not unique. In fact, there is a structure to the mosaic of policy outcomes.

An interest group politics explanation, then, may be valuable to explain why Truman's plan failed, why Nixon's plan failed, or why Carter's plan failed, but it provides too little analytic leverage to understand why they all failed. (It does even less to help us understand why President Clinton could not bring his comprehensive plan to fruition.) Precisely because the interest explanation is focused on the minute details of the political struggle, it does not provide an adequate analytic mechanism to step back from the details and search for broader understandings of the policy process, political outcomes, or both.

Institutions

Recently, scholars working in various intellectual traditions have explored "the New Institutionalism."[5] We are particularly interested in several recent "historical institutionalist" studies that examine specific public policies and have explicitly tried to explain why different countries have fol-

5. See, for example, March and Olson (1989), Hall (1986), North (1990), Ikenberry et al. (1988), Weaver and Rockman (1992), Steinmo et al. (1992), and Weir (1992).

lowed different policy paths.[6] These authors have not tried to offer holistic theories of political history and behavior; instead they offer middle range explanations for distinctive policy patterns followed in different political regimes over time.

Two fundamental insights made by historical institutionalists are relevant. First, political institutions shape how interests organize themselves, how much access and power they are likely to have, and even the specific policy positions they are likely to take. Thus, as Ellen Immergut argues in her study of health care reform in Sweden, France, and Switzerland, "the analysis of policy making should focus more explicitly on the procedures for making policies and less exclusively on the demands themselves." She found that "[t]hese procedures do not simply represent the views of interest groups. They select the groups whose views will be represented and they shape demands by changing the strategic environment in which the demands of groups are formulated" (1992: xiii).

Second, institutions can critically affect preferences. This argument suggests first that what we want is structured in some fundamental ways by what we can imagine achieving. We do not normally desire things that we cannot imagine getting. Thus because institutions shape the rules and because institutions give priority to some interests and ideas rather than to others, they can also shape what we can imagine achieving. Furthermore, given that we are not, in reality, constantly recalculating, rational decision makers, but instead tend to be habitual, satisficing decisions makers (Simon 1985; Friedlander and Alford 1991; Powell and DiMaggio 1991), institutions shape how we lead our lives and thus can ultimately determine what we believe.

In the following history of the politics of health care reform in the United States, we show how institutions shape what people try to achieve and what they believe they can achieve. Political values, elite and public attitudes, and interest group behavior are central to our analysis. But rather than consider these variables givens, we explicitly examine them within the institutional context in which they were formed.

The Road toward Reform

For most industrialized democracies, the foundation for political battles for modern, comprehensive NHI systems was laid in the first decades of

6. See, for example, Dunlavy (1992), Hall (1986), Hattam (1993), Immergut (1992), Steinmo (1993), and Weir (1992).

the twentieth century. In most cases, the battle for protections against the ravages of industrial capitalism were bound up in the struggle for democratic participation. Social insurance (workers' compensation, health insurance, old-age pensions) were developed as important policies with which modernizing bureaucratic leaders hoped to satisfy worker discontent and important symbols that working and middle class parties used to mobilize support for extending the franchise (Rueschmeyer et al. 1992; Ashford 1986; Rimlinger 1971; Flora and Heidenheimer 1981; Heclo 1974).

But the United States was already in a unique position. Whereas in European states the lower and working classes had to fight for the right to vote, this right had been granted fait accompli in the United States. Thus the most fundamental institutional context within which the struggle for social insurance (including health insurance) was fought separated the United States from every other industrialized nation. The early extension of the franchise had enormous implications for the structure of political debate and reform in turn-of-the-century America. As several political historians have shown, the early extension of the franchise in the United States—combined with the post-Civil War division of power between the north and the south—allowed localized, one-party regimes to become dominant throughout the nation. Without genuine two-party competition, political parties often became patronage-oriented machines rather than true channels of democratic participation and control (Burnham 1970; Shefter 1978; Sundquist 1973). Political parties in America thus became objects of reform rather than agents of reform, as they were becoming in Europe. As a result, democratic reformers in the United States set their sights on dismantling entrenched parties and bureaucracies rather than building central political and administrative capacities to further working and middle class interests, as was done in Europe. Reformers in America passed a series of reforms at the state and national levels that, although designed to make government more honest and efficacious, actually fragmented political and administrative authority even further. Some of these reforms included the Australian ballot, referendums, initiatives, direct primary elections, and nonpartisan local government (Burnham 1970). In addition, the power of national party elites was taken away through congressional reforms (Polsby 1968). Finally, administrative reforms designed to make public administration less partisan and more efficient were also implemented (Skowronek 1982).

We must remember, however, that these reformers "were not anti-statist in their orientation" (Orloff 1988: 53). Indeed, despite the struc-

tural barriers to third parties in the American winner-take-all electoral process, Theodore Roosevelt's Progressive party garnered more than four million votes in the 1912 election (edging out the Republican Taft, but losing to the Democrat Wilson) on the platform of "the protection of home life against the hazards of sickness, irregular employment, and old age through the adoption of a system of social insurance adapted to American use" (Orloff 1988: 55).[7]

The Progressive impetus for reform did not, however, produce health care legislation. Roosevelt's defeat by Woodrow Wilson, along with the United States' entry into World War I, are widely cited reasons for the lack of progress on the issue. Although Wilson was a progressive Democrat, his agenda was international in outlook and had an entirely different focus than did those of the previous progressive reformers. Furthermore, as Paul Starr notes in *The Social Transformation of American Medicine*:

> In America, there was no comparable unification of political authority to compare with the power of Lloyd George (England) or Bismarck (Germany). Even if an American president had wanted health insurance, he would not have had the leverage to force the opposition to compromise. Only a more serious threat to political stability in America could have so changed the terms of debate as to force interest groups to work within the framework of reform instead of against it (1982: 257).

The Progressives could not push through health care policies they favored, but they did pass institutional reforms designed to usurp power from the entrenched conservative politicians. The long-term result they achieved was perhaps the opposite of what they had intended because political power was now further fragmented in the United States, thus making the policy reforms they favored even more difficult to pass. As Weir and Skocpol note:

> Moreover, the successes of Progressive administrative reformers were scattered and incomplete, and their partial successes combined with the weakening of party competition in the early twentieth-century United States to exacerbate tendencies toward dispersion of political authority

7. Socialist Eugene Debbs won another 900,000 votes in this election. Due to America's unique electoral college system for electing presidents, Roosevelt received only eighty-eight votes, Taft received eight votes, and Debbs won zero votes. Woodrow Wilson, however, who received less than 42 percent of the popular vote, won 435 electoral votes. It is interesting to ponder, in this context, the political and policy implications for American development, had the United States had a proportional representation electoral system such as is common in continental Europe.

> within the American state structure as a whole. Conflicts increased among presidents and congressional coalitions, and the various levels of government in the federal system became more decoupled from one another (1985: 135).

Whereas democratic political reforms brought a merging of executive and legislative authority and further centralization of local and national authority in early twentieth century Europe, in the United States forces favoring "democratization" won institutional reforms that further fragmented political power. This institutional reality has radically structured the political debate and strategic choices of health policy reformers and opponents alike.

The failure to implement the social policy reforms desired by Progressives in the early twentieth century also affected public attitudes about the proper realm of public authority. Although conservative European governments introduced these limited social policies to undercut support for working class parties, the extension of the state into these areas effectively legitimated state intervention. Once social policies were introduced, they established a new policy floor on which future political battles would be fought. To paraphrase Heclo from his study of early social welfare policies: New policies create new politics (Heclo 1974). Whereas in America the original battle over the expansion of the state into social welfare had yet to be won, in Europe it was already settled.

Where Was FDR?

These political and institutional realities form the basic framework that is necessary to make sense of the subsequent politics of health care reform in America. If we forget that the United States was a "social welfare state laggard" (Wilensky 1975) or if we forget the relative weakness of the executive branch in the American political system, we cannot explain why Franklin D. Roosevelt did not introduce NHI.

There is little doubt that Roosevelt had a wide mandate to promote progressive social reform. In addition, as many historians have shown, health care was a prime target for reformers of the era. But, despite the president's huge popularity and the clearly perceived mandate for social reform, Roosevelt and his advisors became convinced that bringing health care insurance into their reform package could "spell the defeat of the entire bill" (Witte 1962: 188, cited in Orloff 1962). This, however, was a strategic choice based on the fact that in America Congress, not the

president, writes law. The public clearly favored government-sponsored health protection (Schlitz 1970: 128–29), but Roosevelt and his advisors understood that the southern Democratic chairmen of key committees were hostile to the entire New Deal agenda. Adding the opposition of the hospital and insurance industries and the increasingly powerful American Medical Association (AMA)[8] might jeopardize the entire New Deal (Patterson 1967; Witte 1962; Orloff 1988).

We must remember that the Roosevelt administration was in effect starting from social welfare scratch. Whereas in Europe reformers of this era could build on, reform, or add to existing social policies, the New Deal administration had to confront the very legitimacy of state intervention into entirely new arenas. As Morone noted, reformers sacrificed health care reform so they could move other parts of their agenda through the congressional labyrinth:

> [S]imply ascribing medical dominance to interest-group power is to miss the underlying structure of American politics. The state's right to take on new tasks is always open to question. Moreover, through much of the twentieth century, political institutions—Congress and the presidency—were divided over social programs. The political pattern rarely varied: public officials (usually Northern Democrats) proposed a program like national health insurance; reformers cheered; as public opinion polls came into fashion (in the late 1940s), they generally indicated that the public concurred. However, other public officials (Southern Democrats, Republicans) opposed the extension of government authority. Health care reforms were sacrificed for other programs and the maintenance of political coalitions—a victim of the American system of checks and balances as much as of the dreaded AMA (Morone 1990b: 256).

Derthick (1979) and others have shown just how difficult it was for the administration to win the support of key congressional chairman, even without the explicit opposition of the medical industry. To add medical care reform to the plan and thus challenge one of the country's most powerful political forces would endanger the entire New Deal package. It simply did not seem worth the risk (Witte 1962). In short, despite the will to act, and despite popular support and Democratic majorities in the

8. The *New York Times* reported that already by the 1920s the AMA was perhaps "the most powerful [lobby] in the country." They further suggested that "the American Medical Association is the only organization in the country that could marshal 140 votes in Congress between sundown Friday night and noon on Monday" (cited in Morone 1990b: 256).

House, Senate, and executive branch, the fragmentation of authority in American political institutions forced FDR and his advisors to postpone their goals to reform health policy (Morone 1990b: 255–6).

The fact that medical interests opposed NHI was not unique to the United States at that time. In all industrialized states, these interests opposed government "intervention" (Immergut 1992; Heclo 1974; Rimlinger 1971; Ekstein 1960; Heidenheimer 1980; Klein 1983; Safran 1967). Immergut, for example, describes the French position in this way:

> The practice of medicine, it was argued, was a highly individual art that required a direct and private relationship between doctors and patients. . . . First, patients were to be free to choose their own doctor; second, the doctor-patient relationship was to be subject to the strictest secrecy; third, physicians required complete liberty with regard to the choice of medical treatment; and fourth, all financial matters ought to be decided by a "direct understanding" (entente directe) between doctors and their patients (Immergut 1992: 87).

Nor were French doctors unique in Europe at the time. "For the views of Swedish and Swiss [the two other countries Immergut's study covers] physicians, the liberal model of medicine was simply a codification of the defense of doctors' economic autonomy, common to elite physicians throughout Western Europe" (Immergut 1992: 87–8).

Ideological differences among physicians, nationally elected political reformers, or the public cannot account for FDR's failure to introduce an NHI plan. Instead the entrenched position and enormous political power yielded to economic interest groups and entrenched (southern) local elites forced FDR to conclude that "including health insurance in the proposed Economic Security Act was politically impossible" (Orloff 1988: 75). Roosevelt and his team believed that NHI could be brought forward in subsequent years. We now know, despite his continued national mandate for reform, that Roosevelt's entire progressive agenda was stymied after this time.

Truman Steps In

From the beginning of his presidency, Harry S. Truman strongly supported the idea of NHI. Reflecting the progressive sentiments of an earlier political generation, Truman believed that the key to a nation's strength lay in the health of its citizens, and that we must all be physically sound to participate in a democracy (Poen 1979). Truman's beliefs were echoed with public support. Indeed, a 1942 poll by *Fortune* magazine showed that

74.3 percent of Americans favored NHI (*Fortune* 1942).[9] At the time, the extension of government regulation into the health care industry seemed like a natural continuation of the process begun during Roosevelt's New Deal. War time requirements had acclimated American society to much regulation by the federal government (Weir et al. 1988). It was assumed that such regulation would continue after the war, because government assistance seemed necessary to sustain economic growth and avoid post-war depression. Thus, after Roosevelt's death, reformers had new confidence that progress would be made to pass NHI legislation.

Work on health insurance was delayed, however, by other political considerations in which the Truman administration became embroiled.[10] This delay appeared fatal. Difficulties in providing a smooth transition from a war-time economy made Americans believe that Truman was an ineffective president. Voicing their disapproval, they sent a Republican Congress to Washington in 1946. This mid-term election obviously precluded any serious discussion of health care. Truman was perceived as a lame duck, at best only a temporary occupant of the White House.

Oddly enough, Republican presidential hopeful Robert Taft's challenge against the Democrats on the national health care issue provided Truman the means to regain his political momentum and, ultimately, to win the next presidential election. Late in 1947, Senator Taft (R-OH) publicly challenged the Democrats to make health care reform a campaign issue. Unfortunately for Taft and the Republican party, the plan backfired. Truman seized the opportunity and made health care a centerpiece of his presidential campaign. The campaign targeted the Republican Congress precisely on the grounds that they opposed reform: "We worked out a painstaking plan for national medical care . . . It provided for new hospitals, clinics, health centers, research, and a system of national health insurance. Who killed it? The Republican 80th 'do-nothing Congress' " (Truman 1948). Truman campaigned on a platform promising to extend the New Deal in which NHI was the highest legislative priority (Poen 1979; Starr 1982).

Truman's strategy worked. The American voters gave their stamp of approval for a progressive vision for America. Not only did Truman win the election but the voters also elected a Congress that promised to extend the New Deal. Democrats gained seventy-five seats in the House, raising their majority to 263 seats, whereas the Republicans had only 171 seats.

9. A Gallup poll taken the next year showed continued support for the plan, with 59 percent of Americans still favoring the program.

10. Truman first voiced his support for NHI in 1945 (Poen 1979: 64).

Without question, the mass public supported changes in the nation's system of health care delivery. Public opinion polls taken in 1947 and 1948 were conclusive: 82 percent of the population believed the government should make it easier for all people to have access to medical care. Fifty-eight percent specifically endorsed NHI and were willing to pay for it with an increase in social security income deductions. Indeed, only 29 percent thought it was a "bad idea" to pursue NHI. Thus Truman came to office in 1949 armed with a clear mandate from the people to enact NHI.[11]

Of course Truman's mandate did not achieve NHI. The key to explain this curious failure lies in the unique character of the American institutional process. In the American electoral system, every legislator runs his or her own electoral campaign. Unlike the parliamentary systems found in other democracies, a win for the party does not necessarily mean that the party's electoral commitment will be passed.

NHI was not the only issue on Truman's legislative agenda. He also campaigned for the "Fair Deal," promising to extend various liberal programs and policies that the Democratic party had championed since Roosevelt. Civil rights legislation was high on this agenda. But unfortunately for Truman and NHI, the Democratic victory of 1948, which again was partly a product of Truman's coattails, worked to further entrench powerful southern Democrats in leadership positions on key congressional committees. Despite the Democratic party's numerical superiority in Congress, Truman could in no way command the Dixiecrats to pass his legislation. Instead, in retaliation for Truman's stand on social issues, these Dixiecrats blocked all of his legislative initiatives (Campion 1984: 153).

Truman's NHI failure did not reflect deep-seated cultural beliefs demanding personal responsibility and accountability. Given the American system of "committee government" developed in the context of the progressive reforms discussed earlier, power was given to committee chairmen, who were chosen based on their seniority (Polsby 1968). Committee government allowed Congress to protect itself against the increasing powers of the executive branch, but it also made it nearly impossible to pass legislation that was opposed by the most senior members, even when their ideology was widely out of step with the majority of the their party and even the nation as a whole.

In this system,

11. Public opinion data from *Hearings before a Subcommittee of the Committee on Labor and Public Welfare: The United States Senate*. Data were collected by the National Opinion Research Center, Denver, Colorado, and the Opinion Research Corporation, Princeton, New Jersey.

> . . . party leaders did not possess the power to discipline committee members who blocked party legislation. A committee's members, operating without accountability to a majority within either the House or the Senate, could top any legislation that fell within the committee's jurisdiction, no matter how widespread the support for the legislation in the Congress or the country (Dodd and Schott 1979: 75).

The Constitution directed that any legislation requiring revenue to be raised must originate in the House. Under the procedural rules in place in Congress in 1949, NHI legislation had to clear the House Ways and Means Committee. Despite the fact that the Democrats held a majority on that committee of fifteen to ten over the Republicans, disputes over civil rights assured a frosty reception for Truman's proposal. At that time, the committee was chaired by Robert L. Doughton from North Carolina. Also insulating the Ways and Means Committee from Truman's influence was the "closed rule" procedure used by the committee for all tax tariff and transfer bills. This rule meant that no additional amendments or changes could be added to the legislation that had been considered by Ways and Means.

Given the institutional rules in place at the time, if the committee (or its chairman) chose to kill legislation, neither the president nor the majority of the party could force the bill onto the floor in all but the most extreme circumstances. Although extensive committee hearings were held on Truman's NHI bills in 1948 and 1949, the committee did not forward any specific legislation for a full vote. This was also true in the Senate, where the sponsor of the Truman health care bill (S. 1679), Senator James Murray (D-MO), could not find enough votes to report the bill out of the Senate Finance Committee. Finally (in a tactic that will sound familiar to modern readers), to further confuse and diffuse the issue in the face of widespread public support of NHI, Republicans and southern Democrats sponsored their own versions of a health care reform bill. Of course there was no real intent to pass a conservative health care program, but Truman's opponents could lull voters into believing that a diligent Congress was working on a better plan than the one Truman had introduced (Poen 1979: 165). In the end, no substantive progress was made to enact NHI in 1949.

We could question, of course, whether ideology or political culture played an important, if not dominant, role in determining the outcome of Truman's health care policy initiatives in 1949. Clearly the ideology and values of the southern Democratic party elites was decisive. But

the peculiar institutional framework of American politics allowed these southern elites to block the programs endorsed by the majority of voting Americans. Despite the fact that Truman was the acknowledged leader of the Democratic party, despite the fact that his bid for re-election was defined around the legislation of NHI and other liberal reforms, and despite the fact that the American people voted their approval of Truman's vision, America's peculiar institutional structure allowed the expression of wholly geographic preferences at the expense of the entire nation. In no small part, in reaction to this fact, Americans soon became frustrated with the Democrats. In a pattern that would be followed many times in coming decades, they had made the mistake of raising public expectations and not delivering on their promises. As a consequence, suspicion that government is inefficient and untrustworthy was confirmed by the behavior of that government.

Toward Compromise

We will not describe in detail the politics of health care reform in the 1950s. The story of the massive mobilization of the AMA's "war chest" and its successful attempt to tarnish the idea of NHI as "socialized medicine" is too well known to be repeated here (Campion 1984; Marmor 1973; Poen 1979; Starr 1982). Instead we would highlight a few points. First, soon after the defeat of his health care plan, crises in foreign policy attracted Truman's attention (like many other presidents before and after him). Foreign affairs is an arena in which the president has a relatively high degree of authority and power. Second, the Truman administration's inability to deliver on its major domestic legislative promises also undermined public confidence in both the president and the presidency. Finally, the electoral battle between Truman and Eisenhower in 1952 was in no way a referendum on the welfare state or on the idea of NHI.

> Much was said subsequently about the personal nature of Eisenhower's victory. While the majority of Americans signified that they "liked Ike," they gave only a slight majority to Republican candidates for Congress. . . . Analysts would later suggest that the American people saw in his character and experience a reflection of their own ideals and aspirations (Richardson 1979: 21).

Rejecting the idea of national health care reform was not paramount in the minds of Americans when they cast their vote for Eisenhower, but

that was the result nonetheless. As a Republican, Eisenhower supported the antigovernment rhetoric of his party; national health reform became impossible for the next few years. But this did not stop the work of the Democratic party or of those in the health care reform camp.

Given the enormous political power mustered by forces against NHI and the fact that the Republican president would almost surely veto an NHI bill in the unlikely event that one should cross his desk, reformers adopted a new political strategy. Rather than focus on providing universal coverage for all Americans, they believed they would "get a foot in the door" by providing hospitalization coverage for the elderly. By the early 1950s, the Social Security system introduced by FDR had already gained massive public support. Clearly the reformers thought they could increase this support by offering the elderly protection against financial ruin caused by illness and eventually expand coverage to ever larger segments of the population. In short, the reformers accepted the political realities given the fragmentation of American political institutions and began working on a new plan that would do some good and begin to legitimate the state's participation in the health care sector (Morone 1990b).

Thus even when the Democrats retook the House of Representatives in 1954, senior Dixiecrats still controlled the key committees. Following their reductionist strategy, Ewing, Cohen, and Faulk worked to keep the idea of health care reform alive by focusing on hospital insurance for the elderly. A bill was introduced every year but was never given hearings in committee until 1958 (Marmor 1973: 30).

The new political strategy was neither a product of general public resistance to comprehensive NHI or of the reforming elite's understanding of what would be the best type of reform for America. Instead institutional obstacles to achieving comprehensive reforms forced reformers to choose what they believed to be a second-best incrementalist solution. In Europe, too, many argued that incremental reforms were better than broad, comprehensive solutions. But where majoritarian governments held power (as in Britain), reformers were not forced to choose second-best solutions and instead implemented health care reforms that were dramatic and universal (Ekstein 1960; Klein 1983). In countries with minority or coalition governments, reformers were forced to compromise with the elites of other parties. In these cases, they often had to make "side payments" to the political agendas of other elected political elites (Immergut 1992; Rothstein 1990). But in these cases, the institutionally defined strategies were unlike those facing reformers in America. In Europe, compromises could be made with elites who also had to face national elections. Thus the

political appeal of providing comprehensive and universal benefits was enormously powerful, and one that few national political elites could resist. Knowing this, reformers in Europe had every incentive to hold out and insist on universal and comprehensive programs, whatever the temporal opposition. In America, the political realities were different. Here, reformers faced enormously powerful opponents who never had to stand for national election.

These political realities, then, shaped the strategic choices of reformers on both continents. In America, reformers began to see the merit of taking half a loaf now and fighting for the other half later. As we shall see, this strategy had its own consequences for future reform. Although it was unclear whether this was the original intent of reformers in America, focusing benefits on a particular group clearly had the effect of changing the politics of health care reform to an approach more in tune with the structure of American political institutions: that is, to pit faction against faction.

Medicare Has Its Day

The assassination of President Kennedy did much to change American politics. Although Kennedy only won the presidential election by a slim margin, Lyndon Johnson won by a landslide. American voters sent him to Washington with an overwhelming liberal Democratic majority in both houses of Congress.[12] The issue of health care reform was never so important. Not only were the presidential candidates' views on the issues important but reform was a major issue in congressional races across the country as well. The Democrats elected that year were sent with the understanding that they would make Medicare their highest priority (Social Security Medicare Program Enacted 1966: 236). Johnson seized the momentum generated by the victory and, in his first special address to Congress in January, he focused exclusively on Medicare legislation, stating "With the sure knowledge of public support, the Congress should enact a hospital insurance program for the aged, in this way, the specter of catastrophic hospital bills can be lifted from the lives of older citizens" (Social Security Medicare Program Enacted 1966: 248).

Sensing the inevitability of reform and wanting to protect his institutional prerogatives, Chairman Mills engaged in one of the monumental

12. The Democrats increased their majority in the Senate to 68 vs. 32 and 295 vs. 140 in the House.

turnabouts in U.S. political history. On 2 March 1965, Mills made a suggestion that fundamentally altered the final structure of the Medicare program. He asked whether the Medicare proposal to provide hospital insurance for the elderly could be combined with a voluntary program of insurance similar to a Republican proposal that paid physician fees. Furthermore, he asked if a third component could be added that would cover the health care expenditures of poor Americans who were not included in the Medicare proposal. The Ways and Means Committee immediately began constructing a new bill to fit these expanded considerations. In one move, Mills had become the champion of the Medicare movement and had expanded the program's benefits beyond what anyone expected.[13]

Several important features of the Medicare story should be highlighted here. First, because of the institutional power vested in the chairman of the Ways and Means Committee, Mills could design the Medicare system in a way specifically intended to deflate the sails of future health care reforms. As Theodore Marmor noted, Mills's plan, in effect, "built a fence" around the social security program (1973: 79). Second, the system that was finally approved was passed in the most "American" of fashions: In the final analysis, everyone was bought off and no faction had its interests directly assaulted. As Morone points out:

> The liberal's long-sought triumph did not alter the traditional contours of American health care politics. Authority over the new programs was promptly ceded to the industry. The issue itself broke with legislative tradition: rather than promising everything to everybody, this law began by promising to change nothing. Its first three sections all denied the charges of government intrusion that had been repeated for five decades: "Nothing in this title shall be construed to authorize any federal official or employee to exercise any supervision or control over the practice of medicine." The next five passages embellished this theme, forbidding state control over medical personnel or compensation or organization or administration or choice of provider or selection of insurer . . . Indeed, Medicaid relieved the industry of much of its charity care, paying for indigents who had previously been able to pay little

13. The product reported by Mills's committee resembled a "three layer cake" of legislation. The original Medicare bill, or first layer, remained largely unchanged and became known as Medicare Part A. The second layer consisted of a voluntary program of insurance to cover physicians' services much in the same manner of the Republican proposal. The third layer was an expansion of the Kerr-Mills program designed specifically to administer to the needs of the poor. This final section became known as Medicaid and represented the most substantial expansion beyond the pro-reform group's original legislation. For a more comprehensive description of Medicare policy and politics, see Marmor 1973.

or nothing. In general, Medicaid paid the profession to continue doing what it had done in the past (1990b: 263–4).

The contrast to the politics in which the Labour government introduced the National Health Service in Britain nearly two decades earlier could scarcely be starker. Although, as Jacobs notes, in both cases the general preferences of the people were finally accommodated, in the British case once the government had decided to move it could manipulate the very institutional structure though which elite decisions needed to be passed.[14] "Labour's health legislation emerged from organized, ongoing bargaining among cabinet ministers and Ministry of Health officials; although continuing to weigh medical producers' claims, policy makers restructured the policy network to significantly curtail direct interest group participation" (Jacobs 1993a: 168). The most obvious consequence of essentially isolating the reformers from the opponents of reform is that the system they finally designed (including nationalizing British hospitals) emerged in clear and bold steps in which the planners and policy makers were not forced to make concessions to the multiple interest groups who would have preferred to help design the reform.[15]

Interestingly, the designers of the British National Health Service specifically argued that they should not make major concessions to interest groups on the grounds that these concessions might undermine the boldness of their reform. Providing free health care to all citizens, they correctly believed, would build confidence in public institutions. "It now seemed inconceivable to politicians and bureaucrats that they would be 'cowered by the threat of the medical profession to oppose [the government's proposal]' " (Interview with John Pater, cited in Jacobs 1993a: 175).

Addressing the Medicare Legacy

Medicare was both a "foot in the door" and an attempt to slam the door shut. Unsurprisingly, the foot became swollen and festered. Indeed, in many respects, the Medicare/Medicaid system contributed to the health care financing problems facing the United States today. By trying to ap-

14. Prime Minister Attlee faced a cabinet that was deeply divided over health care reform and, as a consequence, centralized control over the issue of an "inner inner" cabinet consisting of himself, Herbert Morrison, and well-know left-wing Minister Ernest Bevin (Jacobs 1993a: 173).

15. Indeed, "the crucial policy decisions on NHS were made before legislative consideration" (Jacobs 1993a: 173). When the bill was finally introduced to Parliament, strong party discipline ensured that there would be no changes to the legislation without the specific approval of the program's designers.

pease the medical industry's financial and ideological commitment to fee-for-service medicine, Medicare/Medicaid opened a revenue spigot from government to the medical industry. Soon, however, government officials realized that if this flood of red ink was not slowed other public programs ultimately would be drown. Indeed, one of the consequences of setting the government up as yet another third-party payer for health care has contributed to health care inflation generally. The Medicare/Medicaid compromise provided a public subsidy to the health care industry and protected that industry from more comprehensive NHI plans. By the early 1970s, the untenability of this fact was well understood by all health care policy participants. In July 1974, Alice Rivlin was just one of the many observers who believed that these forces would soon bring about comprehensive health care reform. She wrote in the *New York Times Magazine*: "That some form of national health insurance will be enacted in the next couple of years now seems virtually certain. In the years between Truman and Nixon, the argument has shifted from 'whether' to 'what kind.' Even organized medicine no longer quivers at the thought" (Rivlin 1974: 8).

This common understanding provided the impetus for the next major step toward serious consideration of NHI, which began in the fall of 1973 when Senator Russell Long (D-LA), chairman of the Senate Finance Committee, and Senator Abraham Ribbicoff (D-CT) presented a moderate health care reform bill that offered Americans federally subsidized protection from losses due to catastrophic illness and tried to restructure the administration of the Medicaid program. The potential political appeal of the Long-Ribbicoff catastrophic insurance plan motivated various actors on both the left and the right. Fearing that another partial health insurance reform measure would undercut political support for the universal single-payer system he favored, Senator Edward Kennedy, for example, began to consider scaling back his more ambitious proposal. Kennedy was ready to compromise, and the only question was when and with whom (Szaba 1973: 1860). We must remember, however, that Kennedy's new willingness to compromise did not imply that he favored a less comprehensive plan than the single-payer system his earlier proposals had advocated. Rather, he assessed the political situation and determined that now was an opportunity to at least achieve a plan that had universal coverage.

At the end of 1973, Nixon was also reconsidering his position on NHI. The Watergate scandal was becoming a serious issue and he needed something to refocus public attention and to relegitimize the presidency. Passing an ever-elusive system of NHI, the bane of all previous Democratic

administrations, stood out as the method by which he could achieve this goal.[16] In a speech to Congress on 5 February, Nixon stated: "Comprehensive health insurance is an idea whose time has come. I believe that some kind of program will be enacted in the year 1974" (Schmeck 1974: 16). Vice President Gerald Ford supported Nixon's plan: "Positive, fast action on this new health insurance program this session will mean lifting a tremendous burden of worry and concern for many Americans. That reassurance is long overdue. It would build national confidence" (Ford 1974: 29). Like Kennedy, Nixon was ready to deal on NHI.

The most important figure in Washington health care politics had yet to weigh in for the new push for NHI. Although Wilbur Mills was obviously no strong advocate of NHI, like Nixon he began to reconsider his ideas to shore up support for his institutional position at the center of the policy-making process. This authority had recently come under attack. In part due to the historical intransigence of the Ways and Means Committee in general and the conservatism of Congressman Mills in particular, the entire committee system was being scrutinized. As the legislative load of Congress became more demanding and the public perception of Congress's ability to produce quality legislation slipped, individual legislators had become very dissatisfied with the House committee system. This system was widely viewed, moreover, as placing Congress in a weakened position compared with the growing influence of the executive branch (Cotin 1974: 419; Dodd 1977: 269–307). Pressure began building to reform the system so as to tip the balance of power from the president back to Congress.

The Ways and Means Committee was singled out for particular attention. For example, Richard Bolling, chair of the "Committee on Committees" and a leading congressional reformer, argued for the creation of a new committee on commerce and health that would be responsible for defining benefits and policies for Medicare, Medicaid, and any future national health insurance legislation (Balz 1974: 913). Mills, not wanting to lose any of his or his committee's authority over health care issues, began a crusade to restore faith in the ability of the Ways and Means Com-

16. Nixon had also had a proposal on the table since 1971. But his National Health Insurance Partnership was not a comprehensive measure. It would have covered only employees through the use of employer mandates and provided group plans for small employers, the self-employed, and low-income groups. His 1974 Comprehensive Health Insurance Act was still to be administered through private insurance companies, but it provided a more liberal package of benefits to be offered by employers and it would have greatly expanded the Medicare program by offering the same set of benefits to low-income groups as well (Health Insurance: Hearings on New Proposals 1972; Health Insurance: No Action in 1974).

mittee to formulate the nation's health policy. Mills and his committee members knew that the best way to preserve their authority over health care was to produce important, high-quality legislation. The administration's renewed interest in NHI provided the perfect opportunity and the task was clear: produce a high-quality NHI bill. Veteran committee member Representative Charles A. Vanik (D-OH) described the pressure: "The committee has been under pressure to produce. To maintain our jurisdiction . . . [sic] [on health care legislation] we'll have to produce" (Balz 1974: 913). Thus, in an ironic twist of fate, Mills had taken up the cause of NHI and the stage was set for the most serious consideration of NHI in the history of the United States.

In April, a real breakthrough occurred. Kennedy and Mills had come together to produce a compromise plan of NHI that, while still preserving crucial differences from the administration's plan, took a large step in closing the distance between the Republican and Democratic proposals. Even better, the administration was ready to deal. Earlier in March, Casper Weinberger reported that the president had ordered him to use the Department of Health, Education, and Welfare's "full resources to secure passage of the Administrations health insurance legislation this year"(Iglehart 1974b: 381). By May, Nixon was pushing for action and calling the Kennedy-Mills compromise "constructive proposals which deserve consideration, we are not ruling out compromise" (Shabecoff 1974).

Wrenches in the Works

Of course, no NHI bill passed. The explanation for this can be found in the level of consensus required to move complex legislation through the American institutional labyrinth. In any other country, at any other time, a meeting of the minds such as had occurred over NHI legislation would have led to the enactment of some sort of legislation. But not in the United States. Despite the fact that the political leadership in both Congress and the administration wanted legislation, not all parties were satisfied. Our congressional system provided these dissatisfied players with ample opportunity to throw in a multitude of wrenches and force to a halt the entire legislative process.

Specifically, labor groups, which had for a long time been loyally represented by Kennedy, chose not to support his compromise with Mills. Sensing that Nixon was in lasting trouble over the Watergate scandal, they chose to withhold support for Kennedy's compromise and wait until the

fall elections, which would ensure a solid Democratic majority. Max W. Fine, executive director of the Committee for National Health Insurance, which also represented mainstream labor views, summarized his organization's strategy: "We will resist action this year because we need a Congress so Democratic that it will be able to override a presidential veto." Thus Kennedy's ability to influence votes had been undercut as his major base of political support abandoned him.

Another key to the lack of action is found in Russell B. Long's (D-LA) withdrawal of support for Kennedy and Mills in the Senate. Long was chairman of the Finance Committee, which was the leading committee with jurisdiction over health care legislation in the Senate. He had sponsored his own less aggressive, incremental approach to NHI. Although he promised not to impede the progress of any bill reported out of Ways and Means, he did not endorse the compromise efforts and chose instead to keep alive a chance at passing his own legislation (Iglehart 1974a: 527). Furthermore, Long's proposal was not the only alternative available to the members of the Ways and Means Committee. All told, the committee had to consider seven serious health care proposals emanating from every possible health care interest. In short, at the verge of compromise toward NHI, the left (Labor) protested because they thought they could get more and the right protested because they believed they could get less. Taking their cues from their most powerful constituents, members of the Ways and Means Committee defected as well. The more liberal members took Labor's side and waited for a better opportunity. Conservative members supported the incremental Long-Ribbicoff proposal. In short, despite the fact that most of the concerned leadership wanted legislation reported, they could not control the individual legislators on the committee.

Ford

In May 1974, Casper Weinberger provided a potent summation on the lack of progress on NHI in his plea to the members of Ways and Means to report a bill out of committee: "It would be callously cruel to delay action on something so vital to all the people just because a few had adopted a reckless attitude of rule or ruin, our plan or no plan" (Iglehart 1974a: 702). Needless to say, this is exactly what happened.

Soon Watergate dominated Congress' attention and further action on NHI appeared to be impossible. But by the beginning of August, Nixon had resigned, freeing space on the legislative docket, which otherwise would have been used for impeachment proceedings. Nixon's resignation

had a powerful effect on lawmakers throughout the capitol. The battle to remove the president was over, but now the politicians in Washington had to face the fallout of the scandal: the public perception that government was ineffective and could not be trusted. Our national political elite needed a legislative package that demonstrated the efficacy of their institution and their commitment to the people. Many believed that comprehensive health care reform could be used as an opportunity to rebuild the nation's confidence.

The new vice-president wasted no time voicing his intentions. Ford had argued that NHI was a means to boost falling national confidence in government back in February, and he restated his call for legislation in his inaugural address: "Why don't we write—and I ask this with the greatest spirit of cooperation—a good health bill . . . before Congress adjourns?" The day before on NBC's *Meet the Press*, all of the health care superstars, including Wilbur Mills, Edward Kennedy, Casper Weinberger, Martha Griffiths, Russell Long, and Russell Roth (President of the AMA), had gathered to discuss prospects of health care legislation. Most members, with the exclusion of the president of the AMA, suggested that compromise might be possible. This fueled prospects that some sort of bill might finally be reported out of committee (Campion 1984: 321). It seemed that, at last, all parties had been heard, clearing the way for Mills to construct another health care miracle, as he had done in 1965.

In pursuit of this goal, Mills agreed to another compromise. He introduced the new compromise, which also closely resembled the administration's plan. He immediately brought the bill to markup. Once again, however, the fragmenting forces of American political institutions undermined the reform effort. A series of close votes on the issues of financing and compulsory participation proved to Mills that he did not have the consensus required to report the bill out of committee. In the end, Mills conceded defeat. In late August he announced," I've never tried harder on anything in my life than to bring about a consensus on this bill, but we don't have it. I'm not going to go before the House with a national health insurance bill approved by any 13 to 12 vote" (Campion 1984: 323). Mills knew that for an NHI bill to have a chance to pass, his committee would have to show strong consensus.

Consensus in committee was necessary, he reasoned, because of the traditional absence of party discipline in this great federal republic. But the problem was exacerbated by the fact that the congressional reforms passed in 1974 undermined the Ways and Means Committee by taking away the "closed rule," which meant that now committee recommen-

dations could be reopened on the floor of the House. Without a strong show of support for the legislation from his committee and without the protection of a closed rule, Mills knew the bill would have been killed on the main floor of the House. Once again NHI was relegated to the congressional dustbin, a good idea but too controversial.

The lack of consensus in the committee itself was, of course, attributable to all of the factors that are endemic to the American political system. Neither Mills nor the party leaders could enforce party discipline among the members of the committee, let alone in the entire House. President Ford, despite the fact that he had been a powerful congressional player himself, was also powerless to force Republicans to tow the line. Labor was still holding out for something better, and the incremental proposal offered by Senator Long still harkened to the conservatives on Ways and Means as an easier option than passing a full program of NHI. Worse, public opinion on issues of health care reform had fallen into complacency.[17] The incremental strategies of the past had removed the immediate hardship of poor health coverage from most Americans. A crisis in financing was not a tangible reality that influenced public opinion.

If NHI ever had a realistic chance to pass, it was in 1974. Both the Republicans and the Democrats had a direct interest in passing some sort of bill. Key leaders in Congress desperately longed to pass something not only to shore up the authority of their committees but also to offer evidence for the effectiveness of Congress. In any other democratic government in any other industrialized country, such consensus would have guaranteed the passage of an NHI program. But barring a national emergency, it could not happen in the United States despite such overwhelming elite consensus.

The institutional consensus required to pass NHI had to be complete in the most absolute sense of the word. It was not enough to have the leaders of both parties and the executive branch committed to reform. It was not enough that they were willing to compromise on almost every aspect of the legislation. It was not enough that the country was facing a health care financing crisis. For NHI to pass, every possible interest had to be satisfied, every contingency accounted for. Alice Rivlin, who

17. Information was derived from Campion's book *The AMA and Health Policy Since 1940* and Stephan Strickland's *U.S. Health Care: What's Wrong and What's Right*. Polls done by *LIFE* magazine in the 1970s; the *Washington Post*; Continental Bank of Chicago; Black Opinion Survey of Washington, DC; Roper Reports; and the University of Michigan Institute for Social Research indicated that 70 to 85 percent of the population sampled were "satisfied" or "well satisfied" with the health care they received.

predicted the passage of NHI earlier in July, provided cogent insight into why such a plan might fail, with one key exception, when she wrote "If national health insurance fails to pass this Congress, it will not be because the idea is too radical, but because there are too many competing proposals. Furthermore, this is a bad year for hammering out legislative compromises" (Rivlin 1974: 8). She failed to account for the fact that when it comes to complex, inclusive legislative packages such as NHI, it is always a bad time for compromise.

One should not assume, however, that no health care legislation was passed during these years of political turmoil. Faced with their own commitment to "do something" about the increasing cost crisis, the Washington political establishment felt compelled to pass legislation that fit both American political logic. In 1973, a program promoting health maintenance organizations was passed with the hope that it would foster competition in the health care market place. Although the medical lobby certainly did not approve of this legislation, it feared it far less than the draconian measures put forth previously. Similarly, congressional conservatives had difficulty arguing against a program whose explicit goal was to avoid government intervention by encouraging market competition.

Second, because authorization for the Hill-Burton Act[18] expired in 1974, Congress was able to pass the National Health Planning and Resources Development Act. We will not examine this reform here but will point to some of its most obvious features. When viewed from afar, the Health Planning legislation appeared impressive. Its central goals were to rationalize the health care marketplace and to broaden public participation in community health care decision making. These were very admirable goals, but as Morone points out, "When the incoherent American state faces vexing problems, it reflexively musters up this hope of rationalization without fundamental change" (1990b: 272). In the end, the program passed was as incoherent as the community-based planning agencies were toothless. Health policy experts quickly and resoundingly criticized Congress' failure: "Impossibly flawed," wrote Marmor and Morone. "A fatuously implausible construct," judged Lawrence Brown. "We designed it backwards," said one official. "Upside down" wrote another. "The awesome list of goals," wrote Frank Thompson, "strained the limits of credibility."[19]

18. Hill-Burton was a massive piece of health care pork-barrel legislation written in the late 1950s that subsidized health care facilities nationwide. See Morone's (1990b: 258–84) excellent discussion of this issue for more details.

19. These quotes were taken from Morone (1990b: 275).

In the final analysis, Congress once again had done what it does best—attempted to deal with pressing national problems by placating powerful constituents. In passing the Health Planning Act, Congress could convince itself that it had moved toward regulation but could also show the industry that it had nothing to fear. The local health planning boards were given almost no real powers and would clearly be dominated by the medical industry at any rate. "Surely, this was the essence of pork-barrel politics," Morone summarized, "highly individualized choices about distributing benefits, each made without reference to any other, none of them taxing any fixed budget" (1990b: 278–9). This may have placated these powerful interest groups, but it certainly did not inspire Americans' confidence in their political institutions.

Carter

By the 1976 election, the budgetary fires were still flaming. Moreover, it was becoming increasingly obvious that large segments of the public were being left out of the health care system.[20] The Democrats once again seized on health care reform in an attempt to show the American public that theirs was the best party to solve national problems. Even the Republicans, acknowledging both the fiscal incentives for reform and the popular will to move in this direction, acknowledged that reform was inevitable and necessary. Thus when Jimmy Carter defeated incumbent Gerald Ford, and when the voters sent 292 Democrats and only 143 Republicans to the House, it was widely predicted—indeed assumed—that major health care reform was just around the corner.[21]

Unfortunately for Carter and proponents of health care reform, congressional reforms passed in the wake of Watergate made decisive action on controversial political issues such as health care reform less and not more likely to win approval. As noted previously, the congressional reforms

20. Federal health care expenditures had skyrocketed from $9.5 billion in 1965 to $41.5 billion in 1975. Moreover, a Department of Health, Education, and Welfare study estimated that twenty-four million Americans had no basic health care coverage and another nineteen million had inadequate coverage.

21. In no small part, due to the attention of national elites to the problems of cost of the health care system, the American public soon came to identify this issue as a key concern. Eighty-five percent of Americans believed that medical costs were increasing faster than costs for all other segments of the economy. In line with this perception, seventy percent believed that "the health care system is out of control and needs to be changed" (Harris 1978). Furthermore, many Americans believed the federal government should be involved in the change. When asked about federal involvement in the health care system, 65 percent responded that "the government should have a greater involvement in the country's medical and health care system" (Harris 1978).

passed in 1974 were intended to undermine the controlling power of conservative southern Democratic committee chairman (especially Wilbur Mills) and to redistribute that power to party elites and to more junior members of Congress. Several of these reforms are relevant for our analysis. First, participation in the Ways and Means Committee was dramatically expanded, thus making it more difficult to build consensus even within the committee. Second, jurisdiction over health care reform was now subdivided to four committees in Congress. (This way more legislators could become involved.) Finally, the "closed rule" was removed from House Ways and Means committee reports. Whereas before bills reported out of Ways and Means had to be considered as a whole on the floor (no amendments could be made), now anything that came out of the committee could be picked to death by individual legislators wishing to score points with particular constituencies at home.

This basic institutional context, combined with the increasing fiscal pressures on the federal government brought about by the Medicare/ Medicaid programs, encouraged the Carter administration to pursue a two-stage political strategy. Believing that they could face insurmountable institutional obstacles if they began with a comprehensive plan, the administration decided first to get cost-control legislation through Congress and then to move to broadening the net through a more comprehensive reform.

The administration first targeted hospitals in their efforts to control expanding medical costs. This choice was informed by several political considerations. First, hospital cost increases had outpaced other areas of the medical field for several years.[22] Thus hospitals were an obvious target for cost-control regulations. Moreover, everyone knew that the health planning legislation passed two years earlier would not have the cost-control effects that it was supposed to have. Second, Carter's advisors argued that our political system made it easier to divide and conquer, rather than to challenge the entire medical industry. This was especially important because the administration hoped to employ the plan quickly and make immediate gains in controlling costs. They believed this would help introduce an NHI program (Iglehart 1977: 685).

The proposal ran into immediate trouble. Sensing another "foot in the

22. In 1975, hospital costs increased at a rate of 15 percent, which was 2.5 times higher than all other price increases as rated by the consumer price index (*Congressional Quarterly Almanac* 1977: 500). Furthermore, the Department of Health, Education, and Welfare estimated that the cost of a one-night hospital stay has increased more than 1,000 percent since 1950.

door," every major medical lobby opposed the plan. Both the American Hospital Association (AHA) and the AMA launched lobbying campaigns against the president's proposal. Interestingly, the industry did not begin a massive public education campaign condemning "socialized medicine." Instead, the medical lobby used a strategy of focusing on the individual legislators, noting that "virtually every Member of Congress has a hospital in his or her district and these institutions effectively apply pressure on the legislators" (Iglehart 1977: 685).

It would be tempting to argue that it was simply the raw political power of the medical industry that defeated Carter's proposal. But such an analysis would gloss over the ways in which American political institutions shaped the strategies of the proponents and opponents of reform. Now there were even more legislators with a hand in health reform. Moreover, as Morone and Dunham (1985) noted, now there were even more interests who had a stake in the system. But in our view the increasing density of the health policy-making space made it even more difficult than before for reformers to impose costs on powerful groups.[23]

As more and more interests opposed the Carter plan, the legislature began to withdraw support from reform. A key to the frosty reception of Carter's reform legislation was the dissenting opinion of the chairman of the Senate Finance Committee, Herman Talmadge (D-GA). He chaired the fourth committee under which the administration's proposal fell. Talmadge disliked the short-term objectives of Carter's cost-containment legislation, preferring his own long-term plan that emphasized preserving the Medicare system (Hospital Cost Control Legislation Dies 1979: 619–25). Like Medicare, which had been blocked by Wilbur Mills in the hope of preserving the integrity of the Social Security program, Carter's cost-containment proposals were opposed by a senator who wanted to maintain the integrity of the Medicare program. Although Talmadge's lack of support for the bill did not constitute a veto of the program, his dissent fractured support for Carter's initiative. In the new post-reform Congress, no one chairman had enough influence to take responsibility for the bill because it required consensus from all four. This left the other legislators who sat on the four committees to their own devices. Thus the four committees disputed the form the bill should take, and each committee proceeded in its own direction. Thus health care was typical of congressional politics of the day:

23. For contrary views, see Morone and Dunham (1985), Morone (1990b), and Peterson (1993a).

> The new policy process is characterized by a proliferation of overlapping and competing policy subsystems, with legislative proposals spewing forth from hundreds of subsystems in an often conflicting and contradictory fashion. Because so many congressional actors have some degree of significant authority, the role of the central leaders is extremely difficult (Dodd and Schott 1979: 154).

This tangle of competing jurisdictions radically complicated the administration's task in promoting the bill. Despite an impressive list of congressional cosponsors,[24] Carter was never able to collect the necessary votes to move the bill out of committee. In the words of Representative Dante B. Fascell: "There is a whole new brand of politician in Congress, the seniority system is gone. Before, the President had a chain of command to work with and through, but it has disappeared. Now, no one can deliver the votes. Now you have to build whole new coalitions for each issue" (quoted in Bonafede 1977: 1759). The source of leadership that was once embedded in the House Ways and Means Committee (which acted as a double-edged sword) was no longer available. In the past, efforts to pass health care reform were frustrated by the strength of the seniority system and the partisan fractures in Congress (that is, the southern Democrats, the Republican Coalition). These two sources of conflict were no longer as relevant in the Congress serving under Carter. However, Carter's legislation had run into a new source of legislative block: extreme fragmentation of the "reformed" Congress.

This would set a pattern that would be repeated in each of the following years. The administration tried to push the program through Congress, only to be frustrated by the various attempts to reduce the bill's effectiveness to bypass the intransigency of the committee deadlock. The AHA and the AMA strenuously lobbied against the bill and, in the end, won an endorsement of the voluntary cost-control effort. This allowed Congress to make a symbolic declaration in favor of cost controls, without having to take any action on the issue. Congress walked away from the cost-control debacle still looking as though it had taken action, and thus soothed voter concerns. In reality, the cost-containment bill failed in 1977, 1978, and

24. In the House, the bill was cosponsored by Paul Rogers (D-FL), chairman of the Subcommittee on Health and the Environment, and by Dan Rostenkowski (D-IL), chairman of both the House Ways and Means Committee and the House Ways and Means Subcommittee on Health. In the Senate, the legislation was sponsored by Ted Kennedy (D-MA), chairman of the Senate Subcommittee on Health and Scientific research and a long-time advocate of NHI legislation (*National Journal* 1977).

1979, with no part of the cost-control proposal ever becoming law. By 1981, the voluntary effort by the hospitals was condemned as a failure, but no further action on behalf of hospital cost control was taken.

The failure to pass any sort of cost-containment legislation killed any chance for the president to promote an NHI plan successfully. Carter eventually developed a plan that was introduced on 12 June 1979. However, the proposal was dramatically reduced from the promises he had first made during the 1976 campaign (Iglehart 1978b). The bill was never taken seriously, and Edward Kennedy, the leading NHI advocate in the Senate, expressed a vote of no confidence by introducing his own competing legislation that addressed the concerns of labor more directly than did the Carter proposal. This marked the end of any attempts by the Carter administration to introduce health care reform as election concerns began to dominate the political landscape. Interestingly, public support for NHI remained high throughout the Carter administration. In 1978, public support for NHI was as high as 62 percent; by 1979 is had increased to 67 percent (Gallup Organization 1978, 1979).[25]

The American political system had once again defeated itself. Again the public's attention was focused on the need to reform the health care system by progressive reformers. Once again, our national political institutions proved unable to manage the very problems that they had brought to the public's attention. Unsurprisingly, citizen's confidence in those institutions dropped another notch. More than 60 percent of the American public believed they could not trust the government to do what was right most of the time. Having viewed the history of health care reform to this point, we must acknowledge that their skepticism was well justified.

National Health Reform Finally Comes of Age?

> A long-term crying need has developed into a national moral imperative and now into a pragmatic necessity as well . . . An aura of inevitability is upon us. It is no longer acceptable morally, ethically, or economically for so many of our people to be medically uninsured or seriously underinsured. We can solve this problem. We have the knowledge and resources, the skills, the time, and the moral prescience (Lundberg 1991).

25. The *American Medical News* reported a Gallup poll showing that 67 percent of Americans supported NHI and that 42% would support NHI even if it meant increasing their taxes (Kirn 1992).

With the election of Bill Clinton, almost all observers believed that comprehensive NHI would finally become a reality in America. There were many reasons to predict the success, and they are all familiar to our readers. Health care costs had clearly spun out of control. Now even traditionally powerful anti-state interests such as the corporate sector indicated their readiness to accept fundamental reform—even if that meant greater government involvement in the health care sector (Martin 1993). More than thirty million Americans without health insurance and tens of millions more were seriously worried about losing their insurance, and thus even the middle class saw a clear need for reform. Poll after poll indicated that 70 to 82 percent of the American public favored NHI (Roper Center for Public Opinion Research 1994b, 1994c). Bill Clinton also made NHI the keystone of his electoral campaign. Finally, as the previous quote indicates, even the provider community appeared to concede that health care reform was not only politically inevitable but also morally and economically necessary.

So what happened? Why were almost all predictions wrong? Why, given the fact that all of the cards appeared to be stacked in the direction of health care reform, did nothing pass? The answer, of course, is that reformers such as Bill Clinton are not playing on a level table. The game of politics in America is institutionally rigged against those who would use government—for good or evil. James Madison's system of checks and balances, the very size and diversity of the nation, the Progressive reforms that undermined strong and programmatic political parties, and the many generations of congressional reforms have all worked to fragment political power in America.

This fragmentation of political power—which has become more severe in the past twenty years—offered the opponents of reform many opportunities to attack Clinton's plan. This institutional bias, and not flaws in the plan or the political strategy pursued by the administration, once again killed plans for comprehensive NHI in America. A very brief overview of some of the new cards that are stacked against health reform is instructive. First, as both Peterson and Morone have suggested, American political institutions are not the same as they were twenty, thirty, or forty years ago. With the reforms of the 1970s "[t]he oligarchy had been changed into a remarkably decentralized institution. . . . Congress as a whole generally became a more permeable and less manageable institution than ever before" (Peterson 1993b: 418). Whereas policy making could at one time be characterized as "iron triangles," now it appeared to be dominated by "issue networks" (Heclo 1974). But whereas Peterson and Morone ap-

pear to believe that these changes make reform more likely than before,[26] we believe that the increased decentralization of institutional power makes meaningful reform less likely to pass today.[27]

Second, the 1990s is marked by "an entirely new type of policy community." According to Peterson, it "has lost its cohesiveness and its capacity to dominate health care politics and the course of policy change" (Peterson 1993b: 408, 411). Now that health care is one-seventh of the U.S. economy, even more interests have something to lose if meaningful comprehensive health care reform were to pass. The fact that there are so many more interests (factions) that now have a stake in the extant system (a system that is enormously profitable) does not suggest to us that reform is more likely in the 1990s. Quite the contrary: Reformers now have to battle a medical/industrial/insurance complex that has more than $800 billion a year at stake.[28]

Third, we must remember that the Clintons' bill needed support from *more than* 50 percent of the members of the House and 50 percent of the members of the Senate. Congressional rules (that is, institutions) in force in 1994 allowed a minority to block legislation as long as they could control just forty of one hundred votes in the Senate. No other democratic system in the world requires support of 60 percent of legislators to pass government policy. This institutional fact appears even more absurd when we remember that the Senate was so radically malapportioned.

Fourth, despite the fact that the 1990s was marked by the highest level of public support for government intervention in health care financing (Peterson 1993b: 406–7), the incredible $4,500,000,000,000+ debt

26. Both of these authors argue that reform is more likely today than it was in the past because of changes in the policy environment and policy community. Interestingly, however, they appear to argue that different types of reform are more likely. Peterson suggests that these "structural changes, in combination with the shift in politics and Clinton's election, have generated new opportunities for fundamental reform" (1993b: 396), whereas Morone suggests repeatedly that the new policy environment has become ever more dense and thus the state appears to be ineluctably drawn to even more interventions and thus, eventually, toward NHI (Morone and Dunham 1985; Morone 1990b). In sum, Peterson appears to believe that these changes offer new opportunities for a fundamental change and a dramatic NHI plan, whereas Morone appears to argue the opposite—that these changes offer the opportunity for "slouching" (to use Morone's term) or incremental change toward a system that will offer cost control and universal coverage. We think they are both wrong.

27. Whereas under the old rules health care reform had to pass through the Ways and Means and the Senate Finance Committees (no small task given the conservatism of these institutions), by the mid-1990s no less than five major congressional committees claimed authority over health care legislation. This meant that no matter how perfect, a bill would necessarily imply a compromise between the personalities (not to say egos) and the political predilections of five chairman and five committees. Five committees, moreover, meant five obvious "veto points" for opponents of reform.

28. For contrary views, see Peterson 1993a, Morone 1990a.

facing American taxpayers (most of which has been accumulated in the past fifteen years) make government financing of health care reform exceptionally unlikely indeed.[29]

Fifth, changes in the technology of electioneering have worked hand in hand with the increasing fragmentation of power in Congress to the point that members of Congress have become independent policy entrepreneurs. This means money. Between 1 January 1993 and 31 July 1994, candidates for the House and Senate received $38 million in campaign contributions from the health and insurance industries. The AMA had the most generous political action committee in the country, contributing more than $1,933,000 in 1993 and 1994 alone.[30] These figures do not include small donations made by local constituents, nor do they include donations from small business, another bitter foe of Clinton's health reform plans. "By the end of the year we expect that the health and insurance industries will have spent over $100 million to crush health care reform," reported the public interest research organization, Citizen Action. "They will have spent over $40 million in campaign contributions and another $60 million in advertising, public relations, organizing and lobbying. In addition, previous reports have identified over $13 million in campaign contributions from other opponents of comprehensive [health] reform" (*Citizen Action* 1994: 2).[31]

Sixth, the world around our political institutions has not remained static either.[32] Undoubtedly, the most important change in modern politics is the role of and importance of the media. The techniques available for marketing research and media delivery are radically more sophisticated today than they were only fifteen or twenty years ago. This point was not lost on the opponents of health care reform. The insurance industry, for example, spent more than $14 million on the famous "Harry and Louise"

29. Each comprehensive reform that was floated in Congress in 1994 crashed at the door of Robert Reischauer, director of the Congressional Budget Office, who was continually forced to give reformers the bad news: Comprehensive and universal coverage will cost money—at least in the short run.

30. Since 1979, the AMA has contributed more than $16.8 million to congressional campaign coffers. The American Dental Association contributed more than $7 million, and the National Association of Life Insurance Underwriters contributed more than $8.3 million since the last year President Carter was in office.

31. Unsurprisingly, members who held pivotal positions with respect to the health plan were particularly favored by the interests who had the most to lose. Interestingly, Jim Cooper, one of the key players whose "bipartisan" plan did much to deflate the Clinton plan's sails in August 1994, was the single largest recipient of health and insurance company money. They liked his proposals so much that they gave him more than $668,000 in less than two years.

32. See Steinmo 1993 for a fuller elaboration of the theme of the interaction of political institutions and the political and economic context in which they operate.

advertisement alone. Moreover, as Hamburger and colleagues note, the American media increasingly falls into a ratings game, thereby eschewing serious discussion and presentation of policy issues in favor of misleading headlines and horse race reportage (Hamburger et al. 1994).

Finally, the repeated failure of American political institutions to address the polity's problems—even when there has been clear public will for action—has worked to undermine dramatically the public's faith in their governmental institutions.

Health Care Reform and American Attitudes toward Their State

Conservatives and culturalists suggest that comprehensive health care reform cannot and will not win in America because Americans do not want it. Of course, public opinion data do not support this thesis. In fact, 68 percent of respondents to a CBS/*New York Times* poll taken in early September 1994 said that they were "disappointed" that Congress never passed health care reform. Only 25 percent said they would be pleased with this outcome. In the same poll, 73 percent said they think there is a "crisis" in health care today, and only 25 percent said they did not think there was a crisis today (Roper Center for Public Opinion Research 1994c). Moreover, Americans think fundamental reform is necessary. At the end of June 1994, only 19 percent believed that only minor changes were necessary, whereas 48 percent agreed with the following statement: "Our health care system has so much wrong with it that we need to completely rebuild it" (Roper Center for Public Opinion Research 1994c).[33]

We believe a relationship clearly exists between Americans' distrust of government and the government's inability to implement comprehensive and successful social policy reforms (Table 2). But, in contrast to those culturalists who appear to view the relationship between culture and public policy as a one-way street, we believe that the repeated failures of American national political institutions to adequately address the social problems facing Americans have fanned the fires of distrust within the American polity.

Once again, this problem has been dramatically exacerbated by the

33. In the fall of 1991, a Princeton survey poll found that 82 percent of Americans agreed that government should guarantee everyone health insurance coverage (only 16 percent disagreed). Moreover, as Jacobs noted, "polling results consistently indicate that the public's support for national health insurance is greatest when the reform promises to cover all Americans rather than target the uninsured and poor" (1993b: 632–2).

Table 2 Growing Distrust

Date of Poll	Government Is Run for a Few Big Interests (%)	Government Is Run for All the People (%)	Government Wastes a Lot (%)	Government Wastes Some (%)	Government Wastes Little (%)
March 1993	68	23	75	22	3
January 1994			83	16	1

Question 1. Do you think government is pretty much run by a few big interests looking out for themselves or that it is run for the benefit of all the people?

Question 2. Do you think the people in government waste a lot of money we pay in taxes, waste some of it, or don't waste very much of it?

Source: The Roper Center for Public Opinion Research 1994c.

election of a president who promised specific reforms that he could not deliver. As political analyst Stuart Rothenberg said the day after the November 1992 election, "Voters expected change. They believed they have voted for change. A year and a half later, they think they got more of the same" (Thomma 1994:8a). Public opinion polls confirm what many observers have noted. When asked "In general, do you approve or disapprove of the job Congress is doing in handling the issue of health care reform?" 26 percent approved, 65 percent disapproved, and 9 percent did not know. Moreover, by early September, 81 percent of Americans believed that Congress would be unable to pass a health care bill (Roper Center for Public Opinion 1994b). In short, citizens have increasingly come to believe that the system does not work. Given the performance of this system, it is difficult to disagree.

Opponents of reform, we should remember, have always been careful not to argue against any kind of health care reform. Instead, opponents of Clinton's plan did exactly what opponents of the Truman, Nixon, Ford and Carter health plans did: They said, "Oh yes, we *do* need reform. But there are particular things about *this* reform plan that we don't like." Then they slowed the reform inside the congressional labarynth. This left time for the media and the industry's public (dis)information campaigns to frighten voters and members of Congress about the details of the administration's plan. As Table 3 indicates, the enormous sums spent and the "gotcha" quality of the media coverage of the issue did finally swing public opinion against this specific administration proposal. (But it is even more remarkable, in our view, that even after one of the largest media campaigns in history, still more than 40 percent of Americans supported Clinton's specific plan.) *Now*, of course, there is evidence that a bare majority of Americans are opposed to Clinton's plan. But to argue that

Table 3 Decline in Support for Clinton's Health Plan

Date of Poll	Percentage Who Favor Clinton's Plan	Percentage Who Oppose Clinton's Plan	Percentage Who Think Congress Should Pass Clinton's Bill with No or Minor Changes	Percentage Who Think Major Changes Needed, or Congress Should not Pass Clinton's Bill
September 1993	59	33	57	33
November 1993	52	40	48	45
January 1994	57	38	47	45
March 1994	44	47	49	48
June 1994	42	50	42	53

Question 1. From everything you have heard about the plan so far, do you favor or oppose President Clinton's health reform plan?

Question 2. What do you think Congress should do with Clinton's health care plan: Pass it without any changes, pass it with minor changes, pass it but with major changes, or not pass any of it?

Source: The Roper Center for Public Opinion Research 1994a.

this plan failed because the majority of Americans did not want NHI is, simply, wrong.

It may be true, as Peterson suggests, that "[p]ublic sentiment can overpower private interests when its desire of change is unambiguous, when it is clear which policy alternative the public will accept, and when elected officials realize that the issue will affect votes" (1993b: 399). It is equally clear that these conditions are not now, and in our estimation never will be present with an issue as large as restructuring one-seventh of the American economy. This type of clear public consensus is especially unlikely around a particular policy proposal when there are powerful private factions whose interests are at stake. Finally, this type of consensus is not necessary in any other democratic polity. We are willing to venture, in fact, that if this level of public consensus around particular reform proposals had been necessary in other democracies, no country would have ever developed an NHI system.

Epilogue: Whither Reform?

We opened this essay predicting that, after the failure of Clinton's health care reform plan, pundits and scholars alike would blame the president,

his administration's policy team and their political strategy, the plan itself, interest groups' dirty campaign the media, and/or the American political culture for the failure of NHI in America. Once again, we think these analyses miss the point. The failure of the president's health care reform plan is neither a failure of this president nor a failure of his specific plan. Rather it is a failure of American political institutions with which he has been forced to work and through which the plan had to be passed.

This suggests to us that reformers who want real reform rather than a continuation of the pattern of buying off interests and avoiding making tough choices should focus their efforts on reforming American political institutions rather than designing ever more sophisticated reform strategies that might be able to squeak or "slouch" through the American political system. Our history tells us that even if these more politically palatable piecemeal solutions do pass in some future Congress, they are likely to throw fat on the inflationary fire—while at the same time deepen the alienation between the American people and their government.

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