

## **THE TIME IS NEVER RIPE**

The Repeated Defeat of Universal Health Insurance in the 20th  
Century United States

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## *The Time is Never Ripe*

Theda Skocpol

### *Introduction*

My presentation for today's Geary Lecture uses a recent episode in US politics – President Bill Clinton's 1993 Health Security proposal for comprehensive health insurance reform, and the subsequent conservative political backlash against it – as a window into the history of attempts to create universal health insurance in the United States. This episode also reveals much about the present and probable future of social-welfare politics in the United States.

On September 22, 1993, President Bill Clinton gave a stirring speech calling for "America to fix a health care system that is badly broken ... giving every American health security – health care that's always there, health care that can never be taken away".<sup>1</sup> Millions listened to the President, and polls taken right after the speech and over the next few weeks registered strong support.<sup>2</sup> THE CLINTON PLAN IS ALIVE ON ARRIVAL trumpeted the *New York Times*, as moderate Republicans and leaders of groups with a stake in the health care system promised to co-operate in working out reforms.<sup>3</sup>

Historic themes resonated as the Clinton plan was unveiled. Its very title "Health Security" harkened back to the Social Security Act of 1935, the charter legislation for America's version of the modern welfare state. And the "Health Security card" that the President said every American would receive was obviously meant to encourage a sense of safe and honourable entitlement such as Americans feel they have in Social

<sup>1</sup> From the prepared text, as reprinted in Erik Eckholm, (ed.) 1993. *Solving America's Health-Care Crisis* (New York: Times Books, pp. 301-314.

<sup>2</sup> Paul Starr, "What Happened to Health Care Reform?", *The American Prospect*, No. 20, Winter 1995, p. 20; and Lawrence R. Jacobs and Robert Y. Shapiro, "Don't Blame the Public for Failed Health Care Reform", *Journal of Health Politics, Policy and Law*, Vol. 20, No. 2, Summer 1995, p. 418.

<sup>3</sup> Adam Clymer, "The Clinton Plan is Alive on Arrival", *New York Times*, Sunday, October 3, 1993, p. E3.

Security. This contributory social insurance programme for the elderly is the closest the United States has to a universal social policy, and it is very popular across lines of class and partisan division.

How ironic, then, that just a bit over one year later both the Clinton Health Security plan and the Democratic party – the legatee of the very New Deal whose achievements President Clinton had hoped to imitate and extend – lay in a shambles. Voters went to the polls in November, 1994, and registered widespread victories for Republicans, not only those running for statehouses, governorships, and the US Senate, but also those running for the House of Representatives, which changed partisan hands for the first time in four decades. Many of the Republicans who won in 1994 are ideologically hostile to governmental social provision, and their "Contract With America" calls for dismantling social programmes and hobbling the federal government.<sup>4</sup> The New Deal tradition is dead, post-election commentators have declared.

To understand why the 1993-94 attempt at comprehensive health reform failed, we need to put this attempt at comprehensive health reform into historical perspective. We also need to understand why President Clinton devised a plan that was not only defeated in Congress but also inadvertently helped to fuel a massive political upheaval. Only against the backdrop of the upheaval, moreover, can we make sense of possibilities for the future of US politics.

#### *Earlier Attempts to Expand Health Insurance in the United States*

Repeatedly during the twentieth century, reformers in the United States have been certain that the time had come to enact broad, publicly financed or regulated health insurance. Such confidence especially bubbled up in the late 1910s, again during the 1930s and 1940s, and yet again during the 1960s. In 1964-65 there was a partial success, when

<sup>4</sup> *Contract With America: The Bold Plan by Rep. Newt Gingrich, Rep. Dick Armey and the House of Representatives to Change the Nation*, edited by Ed Gillespie and Bob Shellhas (New York Times Books, Random House, 1994). For the outlook from which current initiatives flow, see Newt Gingrich, *Window of Opportunity: A Blueprint for the Future* New York: Tom Doherty Associates, 1984, especially Chapters 4-6.

Medicare was enacted for the elderly and Medicaid to provide health coverage to the very poor. At other times, however, reformers sought general health coverage for working Americans, and their efforts ended in failure, as well as in political backlash. The hopes of advocates of one or another form of public health insurance were dashed on the shoals of the US political institutions, and against the rocks of fervent conservative opposition against "bureaucratic" governmental intervention.

From 1916 through 1920, the American Association for Labour Legislation (AALL) campaigned for public "sickness insurance" to cover American workingmen and their dependants.<sup>5</sup> Founded in 1906 and devoted to the use of social science research to promote various kinds of "labour legislation" in the United States, the AALL was a small association of reform-minded professionals, mostly university professors, labour statisticians, and social workers. As dozens of US states enacted regulations requiring businesses to provide industrial accident insurance, the experts of the AALL decided that health insurance would be "the next great step" in the march toward comprehensive social insurance. AALL members believed that there would be inevitable progress toward the enactment of public social insurance in all civilised industrialising nations; and the United States would have to be part of this worldwide movement. Reformers in the Progressive Era argued that sickness insurance – to be funded jointly by contributions from business, wage-earners, and government tax revenues – would help to prevent poverty among wage-earners. Health insurance would also promote economic and social "efficiency", because it would encourage employers, employees, and citizens alike to promote healthful conditions at work and in communities.

To the experts of the AALL, the logical case for the US states to enact health insurance was so obviously rational, and the worldwide

<sup>5</sup> Ronald L. Numbers, *Almost Persuaded: American Physicians and Compulsory Health Insurance, 1912-1920* (Baltimore, MD: Johns Hopkins University Press, 1978; Paul Starr, *The Social Transformation of American Medicine* New York: Basic Books, 1982, pp. 237-257; and Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, MA: The Belknap Press of Harvard University Press, 1992), Chapter 3.

course of "social progress" so clearly inevitable, that they were hardly prepared for the spread of ideologically impassioned opposition to their legislative proposals. Yet there were plenty of potential opponents. Private insurance companies opposed the death benefits that were to be included in health insurance as designed by the AALL. Business associations such as the National Association of Manufacturers looked askance at the new taxes that health insurance would entail. Private physicians and various state and local units of the American Medical Association worried about the imposition of governmental regulation. And certain labour leaders opposed all forms of public social insurance as an intrusion on union autonomy. As the United States entered World War I, ideologues opposed to health insurance highlighted the bogey of German statism, using opposition to "bureaucracy" as an effective rallying cry for the various forces potentially opposed to health insurance. Health insurance was labelled "un-American". What is more, the increasingly hysterical claims of the enemies of health insurance fell upon the ears of a middle-class public that were already skeptical about governmental efficiency and honesty, not to mention wary of new taxes. US government at the turn of the twentieth century had developed few bureaucratic capacities, and many elite and middle-class people did not trust government to administer social programmes effectively.

The normally cumbersome operations of US governmental institutions – which required reformers of the early 1900s to move proposals, state by state, through two legislative houses, past potential vetos by governors, and around potential constitutional and judicial obstacles – insured that opponents to health insurance would have plenty of time to build coalitions, and many institutional points at which to register opposition.<sup>6</sup> By 1920, the AALL-sponsored campaigns for health insurance had been deflected altogether in most US states, and defeated in pitched battles in California and New York. The progress that had seemed so "inevitable" a few years earlier was stopped dead in

<sup>6</sup> David Brian Robertson, "The Bias of American Federalism: The Limits of Welfare-State Development in the Progressive Era", *Journal of Policy History* Vol. 1, No. 3 (1989): pp. 261-291; and Skocpol, *Protecting Soldiers and Mothers*, Chapter 4.

its tracks; and the AALL itself permanently lost momentum after the nation-wide defeat of its all-out campaign for health insurance.

During the 1930s and 1940s, efforts to promote public health insurance – now for middle-class as well as working-class Americans – were pursued by various groups of intellectuals and officials located in and around the various administrations of President Franklin Delano Roosevelt and President Harry Truman.<sup>7</sup> At first, reform proposals called for federal incentives for optional state-level health insurance, but during and after World War II reformers' hopes shifted toward a comprehensive, national system of health insurance, modelled on contributory old-age insurance. Echoing the faith of the progressives of the 1910s, many New Dealers were confident that the United States would inevitably "complete" what the Social Security Act of 1935 had begun, building a comprehensive welfare state that would include national employment assurance, unemployment benefits, and health insurance coverage for all Americans.

President Roosevelt never gave full backing to health insurance proposals during the 1930s; and they were left out of the legislation for Social Security because of fears that opposition from the American Medical Association might sink the entire bill if health insurance was included. Nevertheless, the hopes of advocates of national health insurance looked as if they might be realised in the 1940s, particularly when Harry Truman featured this reform in his ultimately victorious bid for re-election in 1948.

Once again, reformists hopes were shattered. Throughout the 1930s and 1940s, all proposals for public health insurance were strenuously opposed by the formidable American Medical Association, which from the 1920s had become truly a peak association of private fee-for-service doctors in thousands of local communities and all the states of the United States. By the 1940s, moreover, private insurance companies had developed an interest in offering health insurance to the middle class.

<sup>7</sup> Daniel S. Hirshfield, *The Lost Reform* (Cambridge, MA: Harvard University Press, 1970); Monte M. Poen, *Harry S. Truman and the Medical Lobby* (Columbia, MO: University of Missouri Press, 1979); and Starr, *Social Transformation*, pp. 275-289.

During and right after World War II, major industrial employers were encouraged by wartime controls and provisions of the federal tax code to start offering health insurance as a "fringe benefit" to workers.<sup>8</sup> Thus, not only were industrialists opposed to paying taxes for public health insurance; many of them also become committed to their nascent private systems of health benefits – which had been used as bargaining chips in lieu of higher wages, and which did not seem so costly at that phase of history.

Just as ideological rallying cries against "German statism" brought together potential opponents of workingmen's health insurance during the late 1910s, the various forces ready to weigh in against Truman's plans for national health insurance were brought together in late 1940s by cries of opposition to "Communism" and "socialised medicine." The Cold War was emerging, as the United States shifted from its World War II alliance with the beleaguered Russians against the Nazis, toward global super-power rivalry with an imperial Soviet Union. Within the United States, witch hunts were launched against actually or allegedly pro-Communist public officials and labour union leaders. At this conjuncture, it was simple for opponents of national health insurance to label it "socialist", rapidly shifting public opinion away from public financing of health care costs. Reformers who had thought they were furthering a logical extension of the New Deal and Social Security, suddenly found themselves in an ideologically uncomfortable position – appearing to support something un-American, even "subversive". To be sure, the newly powerful CIO unions initially preferred to support Truman's plan for national health insurance. But many CIO leaders were themselves victims of anti-Communist crusades. And strong industrial unions were able, when necessary, to fall back on contract bargaining for employer-provided health insurance coverage. From the 1950s through the 1970s, that is exactly what they did, enabling many

<sup>8</sup> Beth Stevens, "Blurring the Boundaries: How the Federal Government Has Influenced Welfare Benefits in the Private Sector", pp. 123-148 in *The Politics of Social Policy in the United States*, edited by Margaret Weir, Ann Shola Orloff, and Theda Skocpol (Princeton, NJ: Princeton University Press, 1988).



unionised workers to enjoy very generous health benefits even in the absence of national health insurance.

We see, in short, that both during the 1910s and again during the 1930s and 1940s, experts and reformers relied upon rational analysis and arguments about how to solve problems of efficiency or access. Reformers were confident that time was on their side, and that public health insurance (of one sort or another) would "inevitably" be enacted in the United States. But each time, not only were there powerful opponents to reform, debates also quickly took a bitterly ideological turn. Such ideological turns were not anticipated by the rationally minded experts, yet they led to defeats for proposals that might well have gained broad citizen support, had they been more calmly discussed – or effectively dramatised – in the national political process. In each historical episode, locally rooted opponents of national governmental authority gained leverage through state legislatures or Congress to defeat attempts at comprehensive health reform in America. Following the policy defeats came a more general backlash against governmental intervention in US economic and social life.

#### *Why Prospects for Health Reform Looked Better in the 1990s*

If past battles over health insurance for the United States turned out to be very ideological, leaving the rational reformers mystified and demoralised, by the early 1990s it seemed that the time was finally ripe for the United States to move toward universal health insurance. Many US corporations were ready to support governmentally led efforts at health reform. Costs to employers who insured their workers had skyrocketed during the 1970s and 1980s, and many large businesses were experiencing extra costs shifted to them from other businesses who employed their employees' family members, but did not help to pay for health coverage. Physicians were no longer as big an obstacle as in the past. The American Medical Association (AMA), historically the bitterest of all enemies of governmentally sponsored health reforms, no longer represented as high a proportion of doctors as in the past. The

AMA had also moderated its stance, coming up with its own plan for legislation to guarantee health insurance to all Americans.<sup>9</sup>

By 1990, US public support for national health reform was at a 40 year high in public opinion polls, and Americans overwhelmingly felt that insurance coverage should be available to everyone.<sup>10</sup> In the fall of 1991, Democrat Harris Wofford's improbable triumph in a special senatorial election in Pennsylvania suddenly brought the issue of health care reform to the front burner in Washington D.C.<sup>11</sup> The financing of health care had become a middle-class issue as well as a problem for the working near-poor, whose jobs often do not carry health benefits. Middle-class concerns focused on "dramatic increases in health care costs", as more and more employers shifted expenses toward covered employees, and on "fear of losing all or part of their health care benefits in our employment-based system of health insurance", particularly during a period of extensive corporate down-sizing.<sup>12</sup>

Most Americans looked to the federal government for action and believed that Democrats were more likely than Republicans to promote needed health care reforms.<sup>13</sup> Not surprisingly, the leading Democratic presidential candidates in 1992, including Bill Clinton of Arkansas, committed themselves to pursue national health care reform if elected. Health care reform, after all, looked like an excellent priority for 1990s

<sup>9</sup> American Medical Association, *Health Access America: The AMA Proposal to Improve Access to Affordable, Quality Health Care* (Chicago, IL: AMA, 1990); and James S. Todd, S.V. Seekins, J.A. Krichbaum, and L.K. Harvey, "Health Access America - Strengthening the US Health Care System", *Journal of the American Medical Association*, Vol. 265, No. 19 (1991), pp. 2503-2506.

<sup>10</sup> Robert J. Blendon and Karen Donelan, "Public Opinion and Efforts to Reform the US Health Care System: Confronting Issues of Cost-Containment and Access to Care", *Stanford Law and Policy Review* (Fall 1991), p. 146.

<sup>11</sup> Dale Russakoff, "How Wofford Rode Health Care to Washington", *Washington Post National Weekly Edition*, November 25 - December 1, 1991, pp. 14-15; and Robert J. Blendon, Ulrike S. Szalay, Drew E. Altman, and Gerald Chervinsky, "The 1991 Pennsylvania Senate Race and National Health Insurance", *Journal of American Health Policy* (January-February 1992), pp. 21-24.

<sup>12</sup> Blendon and Donelan, "Public Opinion and Efforts to Reform", p. 147.

<sup>13</sup> Lawrence R. Jacobs and Robert Y. Shapiro, "Public Opinion's Tilt Against Private Enterprise," *Health Affairs* (Spring 1) (1994), pp. 285-298.

Democrats. The party needed to overcome racial divisions over intractable issues such as welfare reform and affirmative action; it had to highlight issues that could unite more and less privileged Americans. Successful sponsorship of national health care reform could revive the electoral fortunes of the Democratic party, provided that ways could be found to extend insurance to low-wage working families while simultaneously making coverage for the middle class more secure and less costly.

The Clinton administration has been accused of championing a "liberal", "government-takeover" approach to health reform. On the contrary, during the 1992 presidential campaign, Bill Clinton gravitated toward "competition within a budget" as an approach to national health care reform explicitly distinct from previously defined liberal as well as conservative alternatives. Once he found this middle way, Clinton never wavered from it.

Back in 1991 and 1992, the major visible alternatives in the simmering national debate over health care reform were three, and it was clear that Bill Clinton would not accept two that appeared to be on the right and left. "Market-oriented" reforms not aiming for universal coverage or cost controls were identified with the Republicans, and they had very little appeal for Democrats (and little backing from health policy experts, for that matter).<sup>14</sup> Apparently at the other end of the partisan spectrum were various sorts of Canadian-style "single payer" schemes calling for taxes to displace private health insurance. These were favoured by a few health policy experts, by various advocacy groups, by a sizeable group of Congressional Democrats, including a presidential hopeful, Senator Robert Kerrey.<sup>15</sup>

<sup>14</sup> Republican incremental proposals, and criticisms of them, are discussed in Richard A. Knox, "Health Care Leaps to Top of Political Agenda", *Boston Globe*, Sunday December 29, 1991, pp. 1, 16.

<sup>15</sup> For versions of single-payer, see: K. Grumbach, T. Bodenheimer, D.U. Himmelstein and S. Woolhandler, "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal", *Journal of the American Medical Association*, Vol. 265 (1991), pp. 2549-2554; and Robert Kerrey, *Health USA Act of 1991* (Washington DC: US Senate, 1991), which is explained in Robert Kerrey, "Why America Will Adopt Comprehensive Health Care Reform", *The American Prospect*,

An excellent technical case could be made that a single-payer approach could save more than enough on simplified administrative costs to cover all of the uninsured; and the Canadian experience after the 1970s suggested that it could also significantly reduce the rate of increase of national health care expenditures, while maximising the day-to-day autonomy of patients and health providers.<sup>16</sup> Nevertheless, most US politicians feared to endorse single-payer, because it would necessitate switching from employer-provided insurance and private insurance premiums toward explicit general or payroll taxation. Frank talk about raising taxes was considered the kiss of death. Walter Mondale had apparently shot himself in the foot with such talk in 1984; and George Bush was in trouble during the 1992 presidential campaign for having broken his "read my lips" pledge never to raise taxes. Not surprisingly, Bill Clinton rejected the single-payer approach. Determined to win middle-class votes for the Democratic ticket, Clinton was running a moderate campaign based on promises to reduce taxes on everyone except the very rich.

The third major alternative in 1991-92 was "play or pay", so labelled because it would require all employers either to offer and partially pay for health insurance for all employees, or else pay a kind of "quit tax" to help subsidise expanded governmental coverage for all Americans not employed and insured by their employers. This approach had come to seem the most "pragmatic" road to national health insurance by the start of the 1992 presidential campaign.<sup>17</sup> Key Democratic Senators were sponsoring legislation embodying play or pay.<sup>18</sup> It had

No. 6 (Summer 1991), pp. 81-90.

<sup>16</sup> Theodore R. Marmor and Jerry L. Mashaw, "Canada's Health Insurance and Ours: The Real Lessons, the Big Choices", *The American Prospect*, No. 3 (Fall 1990, pp. 18-29).

<sup>17</sup> For a cogent explication of the approach and its practical rationale, see Ronald Pollack and Phyllis Torda, "The Pragmatic Road Toward National Health Insurance", *The American Prospect*, No. 6 (Summer 1991), pp. 92-100.

<sup>18</sup> Mark A. Peterson, "Momentum Toward Health Reform in the US Senate", *Journal of Health Politics, Policy and Law*, Vol. 17, No. 3 1992, pp. 553-573.

also been endorsed in 1990 by the Pepper Commission and by the National Leadership Coalition of big employers and unions.<sup>19</sup>

As Clinton sparred during the presidential primaries with Senators Robert Kerrey and Paul Tsongas, he found he had to go beyond a general promise and outline what he would actually do about national health reform. Clinton's first move in January 1992 dallied with play or pay.<sup>20</sup> But this proved transitory. As President Bush attacked the payroll taxes and alleged anti-business thrust of play or pay proposals identified with Congressional Democrats, Clinton pulled back from that approach.

An intellectual conversion also occurred during the spring and summer, as Clinton talked with such advisers as John Garamendi, the Insurance Commissioner of California, Walter Zelman, and Paul Starr.<sup>21</sup> Building upon and modifying ideas from the economist Alain Enthoven, these advisers convinced Clinton that it would be possible to use regional insurance purchasing agencies along with very modest new tax subsidies to push the employed-based US health care system simultaneously toward cost-efficiency and universal coverage.

This approach, dubbed "competition within a budget", was just what Bill Clinton was looking for! It promised, at once, to satisfy the public's

<sup>19</sup> The Pepper Commission, *A Call for Action: Final Report* (Washington DC: US Bipartisan Commission on Comprehensive Health Care, 1990), as explained in J.D. Rockefeller, IV, "A Call for Action: The Pepper Commission's Blueprint for Health Care Reform", *Journal of the American Medical Association*, Vol. 265, No. 19 (1991), pp. 2507-2510, and in Judith Feder, "The Pepper Commission's Proposals", *Social Insurance Issues for the Nineties*, Proceedings of the Third Conference of the National Academy of Social Insurance, edited by Paul N. Van de Water (Dubuque, IA: Kendall/Hunt, 1992), pp. 53-58. On the National Leadership Coalition, see Susan B. Garland, "Already, Big Business' Health Plan Isn't Feeling So Hot", *Business Week* (November 18, 1991), p. 48.

<sup>20</sup> Bill Clinton for President Committee, "Bill Clinton's American Health Care Plan: National Insurance Reform to Cut Costs and Cover Everybody" (typescript, Little Rock, Arkansas, January 1992), p. 7.

<sup>21</sup> For overviews of the relevant ideas, see: Alain Enthoven and Richard Knonick, "A Consumer Choice Plan for the 1990s", *New England Journal of Medicine*, 320 (January 5, 1989); John Garamendi, "California Health Care in the 21st Century: A Vision for Reform", Department of Insurance, State of California, February 1992; and Paul Starr and Walter Zelman, "A Bridge to Compromise: Competition Within A Budget", *Health Affairs* (Supplement 1993), pp. 7-23.

desire for affordable universal coverage, and to further the cost reductions so favoured by powerful elites.<sup>22</sup> Managed competition would please big employers and large insurance companies, allowing the would-be president to court and work with these powerful interests, just as moderate southern Democratic governors have always done. This approach could presumably also be sold both to mainstream Democrats who care primarily about universal coverage and to "New Democrats" in the Democratic Leadership Council who want market-oriented reforms that minimise taxes and public spending.

Indeed, Clinton was especially attracted to the public finance features of managed competition within a budget. If he were to be elected president after a campaign promising deficit reduction and avoidance of taxes, he was going to have to devise a health care reform plan that did not include huge new taxes – and a plan with sufficient regulatory teeth to persuade Congressional Budget Office officials that future cost-reductions would be forthcoming in Medicaid and Medicare. Competition within a budget might enable a new Clinton administration to do all of this, while still promising universal health security. The budgetary logic of the approach was irresistible to a moderate Democrat who wanted both to cut the deficit and free resources for new public investments.

In November 1992 Bill Clinton was elected President of the United States with 43 per cent of the popular vote (and a much more commanding margin in the electoral college). The new President soon turned to working on economic reforms and budget cutting. Meanwhile, he convened a Health Reform Task Force under the leadership of his longtime friend, business consultant Ira Magaziner, and the First Lady, Hillary Rodham Clinton.<sup>23</sup> Most of the work of the Task Force took

<sup>22</sup> Ordinary Americans care most about attaining secure protection and keeping their own insurance payments low, while experts and institutional leaders such as employers and politicians are obsessed with spending less overall, and having each major organisational sector spend less on health care. On this, see Robert J. Blendon, Tracey Stelzer Hyams, and John M. Benson, "Bridging the Gap Between Expert and Public Views on Health Care Reform", *Journal of the American Medical Association*, Vol. 269, No. 19 (May 19, 1993), pp. 2573-2578.

<sup>23</sup> On Magaziner, See Robert Pear, "An Idealist's New Task: To Revamp Health

place in a few frantic months from January to May of 1993, but its report could not be finalised until after President Clinton got his first budget through the contentious Congress at the end of the summer.

During its life, the Clinton Task Force mobilised at least part-time participation from hundreds of governmental officials, health policy experts on loan to government, plus Congressional staffers and some state-level officials. Groups with a stake in the current US health care system were not officially represented, but the Task Force did hold many hearings, and consulted with hundreds of representatives of stakeholder groups. The purpose of such consultations was not political bargaining; rather Task Force members tried to discover ideas and concerns that they could take into account as the President's overall approach to health reform was fleshed out in detail.

When the Clinton administration's policy planners finished their work in the late summer of 1993, they had fleshed out a plan very much along the ideas about "managed competition within a budget" that Bill Clinton had outlined while he was running for president. The plan encouraged competition among private health plans. It used governmental regulations rather than tax revenues. And it emphasised cost containment as well as the spread of insurance coverage to all citizens. Briefly, it looked as if almost everyone in the United States – except a few small insurance companies – had reason to accept the Health Security plan that President Clinton so successfully launched on September 23, 1993 as a good start toward comprehensive reform. Although no one believed that the President's proposals would move through Congress without significant modification, it was widely believed in the fall of 1993 that the United States was "certain" to enact some sort of comprehensive health financing reforms during the coming months.

### *Democrats and Health Reformers in Disarray*

By a year later, however, the Clinton Health Security plan was dead and buried, and no substitute measures had been enacted either. When and why did this apparently promising effort at comprehensive health

Care", *The New York Times* (Friday, February 26, 1993), p. A14.

reform fail? Analysts have placed the fatal wounding of comprehensive health reform in 1993-94 at various points in time, ranging from the earliest months of the Clinton administration when the Task Force did its work, to the end of the summer of 1994 when the US Congress at last gave up trying to fashion a "mainstream" compromise preserving some elements of what the President aimed to achieve. In my view, the critical period was from the time of the President's late September speech through March 1994 - by which point concerted partisan campaigns against universal health reform had locked into place, and the support of elite and middle-class Americans for ambitious health reforms had begun to slide inexorably downhill. From then on, momentum toward inclusive reform was irretrievably lost.

By the early 1990s, the faith of Americans in the federal government to "do what is right" (either "always" or "most of the time") was at an extremely low point; less than one-fifth of Americans had that level of trust in Washington DC.<sup>24</sup> Against this backdrop, it is remarkable that for a time Americans were open to the idea that the federal government might be able to ensure health security for everyone. Given general skepticism about the contemporary US national government's capabilities, surely the President and his advisers should have realised that they had to follow up the introductory September speech with a convincing vision of *how* new governmental regulations would actually work to deliver on the overall goals the President had articulated. They also had to unite an array of groups and politicians in and around the Democratic party in support of the Health Security proposal. But during the fall of 1993 and the winter of 1994 the Clinton administration and its political allies did *not* wage a successful campaign on behalf of their proposed legislation.

There were some good reasons why the Clinton health reformers failed to do enough to sustain public support and deepen public

<sup>24</sup> A time-line of the percentage of Americans, from 1958 to 1994, answering "always" or "most of the time" to the question "How much of the time can you trust the government in Washington to do what is right?" has been put together by my colleague Robert Putnam from National Election Studies (1958-1990) and Gallup Polls (1992-1994).



understanding. The first reason flows from something political scientists know well: chief executive officers do not control their own agendas.<sup>25</sup> Soon after President Clinton introduced his health reform plan, he got diverted into dealing with the Somalia crisis, and then into the protracted public and Congressional campaign to pass the North American Free Trade Act (NAFTA), an international treaty initiative that had been passed down to him from previous presidents.

Looking at the situation more broadly, there was also the problem of the weakness of the institutionally given means of political communication and mobilisation open to Democrats and other progressive political forces in the United States of the 1990s. The Democratic party no longer has a nationally widespread, locally rooted infrastructure of loyal local organisations and allied groups (such as labour unions) through which concerted grass-roots political campaigns can be run.<sup>26</sup> The US conservative right now has such an infrastructure, in the form of grass-roots small business and Christian fundamentalist groups and Rush Limbaugh-style talk radio stations. But Democratic politicians, including a Democratic president, depend on pollsters, media consultants, and television to get messages out to the citizenry.

Given the way the national media operates, the President of the United States cannot be sure of getting television coverage. Had President Clinton asked for more airtime, perhaps the networks would have refused to cover additional explanatory speeches soon after his September 1993 Health Security address. There is also the matter of how US television and newspapers cover complicated and controversial policy issues. As various observers have argued, the media tend to focus not on the substance and adequacy of proposals, but on the "horse races" among conflicting politicians and interest groups.<sup>27</sup> They look at who is

<sup>25</sup> Charles O. Jones, *The Presidency in a Separated System* (Washington DC: the Brookings Institution, 1994), Chapter 5.

<sup>26</sup> David R. Mayhew, *Placing Parties in American Politics: Organisation, Electoral Settings, and Government Activity in the Twentieth Century* (Princeton, NJ: Princeton University Press, 1986), Chapter 11; and Marshall Ganz, "Voters in the Crosshairs: How Technology and the Market are Destroying Politics", *The American Prospect*, No. 16 (Winter 1994), pp. 100-109.

<sup>27</sup> Kathleen Hall Jamieson and Joseph Cappella, "Newspaper and Television

arguing with whom, giving perhaps the most weight (and certainly equal weight) to outrageous or extreme claims, while doing very little to help the public see the details of proposals or the validity of claims about them. To the degree that President Clinton had to rely only on media coverage to get his plan across to the American people, he was certain to face an erosion of sympathy and a steady increase of public disillusionment.

Throughout 1993-94, moreover, reform-minded politicians and groups in and around the Democratic party were never able to unite in wholehearted support of the Health Security proposal. Clinton's plan for health reform was not based on the major alternatives to which Democrats had been loyal before 1993, and the new President did not attract most Democrats to his specific approach. Democrats treated the President's bill as grist for protracted bargaining over this or that provision, and as fodder for infinitely complicated legislative manoeuvrings in five different House and Senate committees.<sup>28</sup> Continuing policy disagreements greatly undercut not only the explicability and credibility of Clinton's plan once it was officially announced, but also the possibilities for any compromise to be brokered in the Congress.

### *A Proposal that Was Never Explained*

There were also problems inherent in the Clinton plan itself. The plan was intricate, and called for daring leaps of innovative organisation-building. At the same time, its supports were ambivalent

Coverage of the Health Care Reform Debate, January 16 - July 25, 1994", a report by the Annenberg Public Policy Centre, funded by the Robert Wood Johnson Foundation (Philadelphia, PA, August 12, 1994); and Joseph N. Cappella and Kathleen Hall Jamieson. "Public Cynicism and News Coverage in Campaigns and Policy Debates", paper presented at the Annual Meeting of the American Political Science Association, New York City, September 4, 1994.

<sup>28</sup> An excellent account of Congressional manoeuvrings appears in Allen Schick, "How a Bill didn't Become a Law", in *How Congress Shapes Health Policy*, edited by Thomas E. Mann and Norman J. Ornstein (Washington DC: Brookings Institution, 1995).

about explicitly discussing the governmental mechanisms that would be involved in implementing the new arrangements.

Many commentators have condemned the Clinton plan for its "complexity", much of which was actually inherent in the existing private/public arrangements that the President wanted to modify, not revolutionise. In any event, sheer complexity was not the major difficulty. When the Medicare programme of health insurance for the elderly was debated and enacted in the mid-1960s, the legislation was very complicated, but its sponsors had the advantage of being able to build on widespread public understanding of and affection for the by-then well-established Social Security programme of contributory retirement insurance.<sup>29</sup> The core of public support was built on an analogy to a well-regarded earlier federal government programme. The elderly, and many others in American society, appreciated the universal and non-means-tested nature of Social Security; and they had an operational image of how earmarked payroll taxes worked to fund federally administered benefits for individual elderly people.

When he introduced his 1993 Health Security bill, President Clinton tried to invoke the Social Security precedent once again. This time, however, the analogy was purely rhetorical; it held only for the goal of universal, secure coverage. There was no relevant analogy to Social Security with regard to how governmental mechanisms in the proposed Clinton Health Security system would actually work.

The key mechanism in the new Health Security plan was the mandatory purchasing co-operative, something the Clintonites decided to label the "health care alliance". One or more of these new governmental institutions would be established in each state, and they would have all sorts of revenue-channelling, data-collecting, information-disbursing, and legal powers in relation to employers, insurance companies, and individual citizens. Supporters seeking to explain the proposed Clinton health plan never found any consistent examples of pre-existing organisations that health alliances could be said to resemble. Sometimes alliances were said to resemble food co-ops or grain co-ops for farmers.

<sup>29</sup> Lawrence R. Jacobs, *The Health of Nations and the Making of American and British Health Policy* (Ithaca, NY: Cornell University Press, 1993), Chapter 9.

Although one or another of these analogies may have resonated for particular audiences, there was no clear, convincing, well-understood, and popular federal programme precedent – nothing that could serve as Social Security did for Medicare. Citizens were left to imagine the health alliances arising out of nowhere. Not surprisingly, in a poll taken in February 1994, only one in four Americans claimed to know what a "health alliance" might be.<sup>30</sup>

Because Bill Clinton was trying to be a "New Democrat" rather than a "tax and spend", "traditional liberal Democrat", the promoters of his Health Security plan tried to avoid discussing the alliances as new sorts of *governmental* organisations. Instead of telling Americans as simply and clearly as possible why this kind of governmental endeavour would be effective and desirable, instead of explaining how the new regulations would work, their accommodation to the public's distrust of government was to pretend that President Clinton was proposing a virtually government-free national health security plan. Alliances were portrayed as if they were giant voluntary groups.<sup>31</sup> Promoters operated like advertisers, using images of voluntarism and words about choice to prevent, or calm, Americans' fears about government takeovers or bungling in the health care system. Arguably, however, vague and evasive explanations of the new system merely left Americans open to alternative descriptions purveyed by the plan's fiercest opponents. A portrayal of the Clinton plan as a vast set of voluntary associations simply was not plausible. If that was all the President had in mind, why did he need to ask Congress to enact a 1,342-page bill?

<sup>30</sup> Blendon, Hyams, and Benson, "American Public and Critical Choices", p. 1543.

<sup>31</sup> As, for example, in the explanatory pamphlet "Health Security: the President's Health Care Plan," which was distributed by the Clinton Administration starting in the fall of 1993. Pages 8 and 9 of the pamphlet discuss "The System After Reform", describing health alliances as "groups of individuals, families, and local businesses who use their combined purchasing power to negotiate for high quality, affordable health care." The word CHOICE appears like a mantra throughout the pamphlet. We are assured that "the President specifically rejected a government-run health care system and broad based taxes" and that the "US Government will create a framework for reform and then get out of the way". We do not learn *how* the framework will be created.

### *An Ideal Foil for Anti-Government Countermobilisation*

While US supporters of comprehensive health reform faltered in late 1993 and early 1994, opponents swung into action without delay or ambivalence. Many groups with an occupational or financial stake in the present US health care system had already mobilised to present concerns to the Clinton Task Force. The minute the Clinton plan officially appeared, all of those groups could quickly decide how disappointed or angry they were with each relevant detail of the vast plan. Their leaders and staffs could immediately gear up to notify their own members across the country about threatening features of the plan, to run press conferences, and to lobby in Congress for changes. Well-endowed and vitally threatened groups (like the Health Insurance Association of America, the association of smaller insurers who might have been put out of business had the Clinton plan passed) could also fund public relations campaigns designed to influence public opinion against the Clinton overhaul. In the end, according to a study by the Washington DC-based Centre for Public Integrity, health care reform would become "the most heavily lobbied legislative initiative in recent US history". During 1993 and 1994, "hundreds of special interests cumulatively ... [spent] in excess of \$100 million to influence the outcome of this public policy issues".<sup>32</sup>

At first, neither public opinion nor political observers were much influenced by complaints of the many groups that had a stake in the existing health care system. These were understood to be opening gambits in bargaining over the details of legislation to be hammered out in Congress. President Clinton himself kept saying that he was not wedded to all the details of his proposal, that he was prepared to make changes. Most early critiques of the Clinton plan were accompanied by disclaimers that their sponsors joined the President in wanting comprehensive reforms of some sort.

From very early on, however, there were hints of a much more hard-edged, total, and sincerely ideological opposition to comprehensive, governmentally sponsored health reform. Toward the end of 1993,

<sup>32</sup> Centre for Public Integrity, *Well-Heated: Inside Lobbying for Health Care Reform* (Washington DC, July 1994).

right-wing Republicans realised that their ideological fortunes within their own party, as well as the Republican partisan interest in weakening the Democrats as a prelude to winning control of Congress and the presidency, could be splendidly served by first demonising and then totally defeating the Clinton plan. William Kristol of the recently founded "Project for the Republican Future" started to issue a steady stream of strategy memos urging all-out partisan warfare.

Public support for the Clinton plan had begun to erode since September, Kristol pointed out, and "an aggressive and uncompromising counter-strategy" by the Republicans could ultimately kill the plan, if it convinced middle-class Americans that there really was not a national health care crisis, after all. Noting that polls showed most Americans to be satisfied with their personal health care, Kristol argued that Republicans should "insistently convey the message that mandatory health alliances and government price controls will destroy the character, quality, and inventiveness of American medical care".<sup>33</sup>

During 1994 the hard-line conservative attack on Clinton's Health Security plan brought together more and more allies, and channelled resources and support toward anti-government conservatives within the Republican Party. Ideologues and think tanks launched lurid attacks on Clinton's health reform plan.<sup>34</sup> Small business people in the National Federation of Independent Businesses and other associations mobilised against the proposed "employer mandate".<sup>35</sup> Portrayals of the Clinton plan as a bureaucratic takeover by welfare-state liberals were regular grist for Rush Limbaugh and other right-wing hosts of hundreds

<sup>33</sup> William Kristol, "Defeating President Clinton's Health Care Proposal", Washington DC: Project for the Republican Future, December 2, 1993 (in typescript), pp. 1-4. See also "Kristol Ball: William Kristol Looks at the Future of the GOP", *Policy Review*, No. 67 (Winter 1993), p. 15.

<sup>34</sup> For the Heritage Foundation's attack, see Robert E. Moffit, "Clinton's Frankenstein: The Gory Details of the President's Health Plan", *Policy Review*, No. 67 (Winter 1993), pp. 4-12. See also "No Exit", *The New Republic* (February 7, 1994), pp. 21-25, by Manhattan Institute intellectual Elizabeth McCaughey, who was soon to run for Lieutenant Governor in New York on the Republican ticket.

<sup>35</sup> Cathie Jo Martin, "Mandating Social Change: The Struggle Within Corporate America Over National Health Reform", paper presented at the Annual Meeting of the American Political Science Association, New York City, September 1-4, 1994.

news-talk radio programmes that reach tens of millions of listeners (indeed more than half of voters surveyed at polling places in the November 1994 election said they tuned to such shows, and the most frequent listeners voted Republican by a 3 to 1 ratio).<sup>36</sup> Similarly, Christian Coalition groups, already attacking Bill and Hillary Clinton on cultural issues, began to devote substantial resources to the anti-health reform crusade. On February 15, 1994 the Coalition's Executive Director Ralph Reed "announced a \$1.4 million campaign to build grass-roots opposition to the Clinton plan", with tactics to "include 30 million postcards to Congress distributed to 60,000 churches; radio commercials in 40 Congressional districts and print advertisements in 30 newspapers".<sup>37</sup>

Moderate Republicans who had initially been inclined to work out some sort of compromise began to back-pedal in the face of such anti-reform pressures from within their own party. And interest groups whose leaders had been prepared to bargain over reforms soon were pressured by constituents and Republican leaders to back off from co-operation with the Clinton administration or Congressional Democrats.<sup>38</sup> Both the US Chamber of Commerce, a leading business association, and the American Medical Association, the major physicians' organisation, backed away from initial willingness to negotiate over comprehensive health insurance reforms under pressure from conservatives determined to defeat any kind of reform.

<sup>36</sup> These facts come from Timothy Egan, "Triumph Leaves No Targets for Conservative Talk shows", *New York Times*, Sunday, January 1, 1995, pp. 1 and 22. For a sense of how Rush Limbaugh discussed the Clinton plan, see his *See, I Told You So* (New York: Pocket Star Books, 1993), especially pp. 167-174, where ridicule of Hillary Rodham Clinton is a running theme.

<sup>37</sup> Robin Toner, "Hillary Clinton Opens Campaign to Answer Critics of Health Plan", *New York Times*, Wednesday, February 16, 1994, p. A11.

<sup>38</sup> Such pressures are discussed in Martin, "Mandating Social Change", and in Graham K. Wilson, "Interest Groups in the Health Care Debate", paper prepared for the Conference on "Health Reform: Past and Present", Brookings Institution, Washington DC, January 23-24, 1994.

*From Social Security in 1935 to Health Security in 1994?*

Despite all the resources – of money, moral commitment, and grass roots communications networks – that the conservative US right could mobilise, the question remains why such attacks proved as influential as they did over the course of 1994. Middle-class Americans were (and remain) concerned about both the security of their access to affordable health care and the overall state of the nation's health financing system. As we have seen, centrist Democrat Bill Clinton had done his best to define a market-oriented, minimally disruptive approach to national health care reform; and his plan was initially well received. Nevertheless, by mid-summer 1994, and on through the November election, many middle-class citizens – not members of far-right groups, but Independents, moderate Democrats and Republicans, and former Perot voters – had come to perceive the Clinton plan as a misconceived "big government" effort that might threaten the quality of US health care for people like themselves.

Of course, 1994 is hardly the first time when US political conservatives and business groups have used lurid anti-statist rhetoric to attack Democrat-sponsored social programmes. For example, back in 1934-35 conservatives argued that the American way of life would come to an end if Social Security was enacted. Congress passed it anyway. But the overall governmental situation that Franklin Roosevelt and the Democrats faced in debating Social Security in the mid-1930s was instructively very different from the context in which President Clinton fashioned and fought for his Health Security programme. It is not just that Democrats enjoyed much greater electoral and Congressional majorities in 1935 (after all, many Democrats back then were Southern conservatives who often opposed federal government initiatives). The more important differences between Social Security and Health Security have to do with the *kinds* of governmental activities they called for, and how their respective programme designs related to pre-existing stakeholders in the given policy area.

Some officials and experts involved in planning the Social Security legislation introduced in 1934 wanted to include a provision for health insurance, but President Roosevelt and his advisers wisely decided to set



that aside. Because physicians and the American Medical Association were ideologically opposed to governmental social provision, and were organisationally present in every Congressional district, Roosevelt feared that they might sink the entire Social Security bill if health insurance were included.<sup>39</sup> Instead, Social Security focused on unemployment and old-age insurance and public assistance

Parts of Social Security called for new payroll taxes, yet these taxes were tiny, and came at a time when most US employees paid few taxes and were mainly worried not about taxes, but about getting or holding onto jobs. Of course, business leaders hated the new taxes; but in the midst of the Great Depression business opposition carried little weight with public opinion or elected officials, and could be overridden. Beyond promising employed citizens new insurance protections, Social Security also offered federal subsidies to public assistance and health programmes that already existed, or were being enacted, by most of the states. Roosevelt administration policymakers wanted to accompany the new subsidies with a modicum of national administrative supervision, but Congress stripped most such prerogatives out of the bill before it became law. In the end, the Social Security Act mostly promised to distribute money. Citizens (and state and local governments) were wooed with promised benefits, and not threatened with the reorganisation of services to which they already felt accustomed.<sup>40</sup>

Think of the contrast between Social Security and President Clinton's Health Security proposal. Clinton's plan was formulated during the "post-Reagan" political and governmental era, when taxes are electorally anathema and public budgeting is extraordinarily tight. Thus the proposed Health Security legislation was deliberately designed to

<sup>39</sup> Daniel S. Hirshfield, *The Lost Reform: the Campaign for Compulsory Health Insurance in the United States from 1932 to 1943* (Cambridge, MA: Harvard University Press, 1970), Chapter 2.

<sup>40</sup> The one new national programme enacted in 1935, contributory retirement insurance, came in an area where state governments had not previously legislated. What is more, the few corporate pensions plans that had developed during the 1920s mostly collapsed during the Depression. What we today call "social security" was thus fashioned on uncluttered terrain.

offer little new federal revenue to most people or groups.<sup>41</sup> What is more, it was put forward in the midst of a US health care system already crowded with many institutional stakeholders, and where most middle-class employees already had health insurance coverage of some sort. Although the Clinton plan offered new coverage to millions of uninsured, and promised new levels of security to the already-insured, it also entailed a lot of new regulations that would push and prod insurance companies, health care providers, employers, and state governments. These new regulations were designed in an intricate and fairly tight way precisely in order to ensure that rising private and public health care costs really would come down.

Historically, Americans have been perfectly happy to benefit from federal government spending, and even to pay taxes to finance spending that is generous and benefits the privileged groups and citizens, not just the poor.<sup>42</sup> Such benefits are especially appealing if they flow in administratively streamlined and relatively automatic ways. But Americans dislike federal government regulations not accompanied by generous monetary pay-offs. Ironically, precisely because Bill Clinton, a reformist Democrat, was working so hard to save money, he inadvertently ended up designing a health reform plan that appeared to promise lots of new regulations without widespread pay-offs. Established participants in the current US health care system became increasingly worried that the Clinton plan might squeeze or recognise the

<sup>41</sup> It is true that the Task Force incorporated certain sweeteners for key interests into the Health Security bill. The elderly on Medicare were to get additional prescription drug and long-term care benefits; and General Motors and other large corporations with generous health plans were to get government subsidisation of early retirees. But these sweeteners were fairly minor in the overall scheme, and even their intended beneficiaries doubted that they would survive Congressional deliberations. Fiscal constraints operated on Congress as well as the President, making it difficult for any group to be given – or reliably promised – federal subsidies.

<sup>42</sup> This argument is developed in Theda Skocpol, "Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States", in *The Urban Underclass*, edited by Christopher Jencks and Paul E. Peterson (Washington DC: Brookings Institution, 1981), pp. 411-436; also reprinted as Chapter 8 in Theda Skocpol, *Social Policy in the United States: Future Possibilities in Historical Perspective* (Princeton, NJ: Princeton University Press, 1995).

way they were accustomed to delivering, financing, or receiving health care. The right-wing critique of meddling governmental "bureaucracy" resonated so widely because it focused such worries.

From a broad historical perspective, in sum, Clinton's Health Security plan had many strikes against it from the start. The very societal and governmental contexts that originally made it quite rational for a centrist Democratic President to choose a reform approach emphasising firmly regulated "competition within a budget" simultaneously made that approach ideal for political counter-mobilisation by anti-governmental conservatives. The President and his allies could have done a better job than they did at explaining the regulatory mechanisms in their plan. But even if the Clinton administration had communicated more effectively, the Health Security plan launched so propitiously in September 1993 might still have gone down to a defeat that backfired badly against the Democrats. The bedrock fact is that the Clinton plan promised too much cost-cutting regulation and not enough pay-offs to organised groups and middle-class citizens pleasantly ensconced in the existing US health system.

#### *What Happens Next for the US Social Security State?*

Although they repudiated many incumbent Congressional Democrats, Americans who voted in the 1994 mid-term elections continued to care deeply about governmentally sponsored health care reform.<sup>43</sup> Hefty majorities of voters told pollsters that they favoured definite steps toward covering the currently uninsured, especially children and low-income people. Most also opposed any cuts in government spending on Medicare for the elderly and Medicaid for the poor, as well opposing cuts in the enduringly popular Social Security programme.

But such US citizen expectations have not determined what has happened in recent US politics. Following their November 1994 triumph, anti-welfare-state Republicans treated their "Contract with America" as a blueprint for governing. The Contract had nothing to say about health care reform, yet it emphasised welfare cuts, destruction of

<sup>43</sup> See note "National Election Night Survey", referenced in note 6 above.

federal regulations, and huge tax cuts disproportionately targeted on business and the top income quintiles. In order to achieve the order of tax and spending cuts they promised, Congressional Republicans have moved during 1995 to slash funding for the existing public health insurance programmes, Medicaid and Medicare.

Overall, conservative Republicans have in mind abolishing Medicare in favour of tax-subsidised vouchers or individual medical savings accounts, combined with efforts to encourage the elderly to enroll in for-profit managed care plans.<sup>44</sup> Their basic goal is to break up the universal coverage of publicly sponsored health insurance for the elderly, shifting the healthier and wealthier into subsidised private coverage, while severely shrinking the funding available to those who remain in the public part of Medicare. As Medicare becomes increasingly a "welfare programme" for the less privileged, tax funding for it can then be further cut, as funding for Medicaid is now being cut. Republicans are also trying to remove federal guarantees of coverage for the poor from Medicaid, turning it into a purely state-run programme. If Republicans win the US presidency in 1996 while holding controls of Congress, they will continue to cut back on America's public-sector health spending. They can also be expected to undertake fundamental reorganisations of the very popular Social Security programme. Their overall goal is to greatly shrink the domestic, social-welfare role of government in the United States, in favour of private market "solutions" to social problems.

Health insurance reform remains potentially a good issue for the US Democratic party, because the numbers of uninsured people, mostly in low-wage working families, continue to rise. And Republican-sponsored changes are sure to prove unpopular. But the Democrats are in deep electoral and intellectual disarray, and are not likely to achieve credibility on health care or other problems until they come to terms with the overall political challenges they face. Defending Medicare may help

<sup>44</sup> Robin Toner, "Gingrich Promises Medicare Tough Look, Bottom to Top", *New York Times*, Tuesday, January 31, 1995, pp. 1 and A14. Of course this is highly ironic, given that conservatives attacked the Clinton Health Security plan for allegedly aiming to drive Americans into managed care plans!

the Democrats politically over the near term, but such defence alone will not address the broader issues of cost and coverage that inspired President Clinton's 1993 effort in the first place. Nor will a defence of Medicare alone succeed in re-legitimizing the role of the US national government as a guarantor of citizens' welfare.

Very possibly, Americans who favour governmentally mediated universal health insurance have just had – and lost – their last opportunity for achieving it. Repeatedly over the course of the twentieth century, reform-minded US professionals pushed for government financing of health care for all, or large categories, of Americans. Again and again comprehensive plans for "rational" and "cost-efficient" reforms were drawn up, amidst considerable or great optimism that at last "the time was ripe" for the United States to join the rest of the civilised democratic-industrial world in providing broad health care coverage for its citizens. Most such attempts were defeated by locally entrenched groups who were able to work through Congress to defeat an attempt to extend national government intervention in health markets and in doctor-patient relationships. Only once did such efforts succeed, during mid-1960s when Medicare and Medicaid were enacted at the height of the Great Society.<sup>45</sup>

Not only did that single success come at a juncture when liberal Democrats, very briefly, enjoyed the kind of ideological élan and Congressional leverage that conservative Republicans enjoy in 1994. The mid-1960s was also a time when Americans overwhelmingly trusted the federal government to do good and effective things, when Americans even briefly thought that the federal government might wage a winning "war on poverty". Perhaps even more important, this was a time when Social Security, a universal social insurance programme could serve as a positive model for *how* the federal government could extend non-demeaning health security to all of the elderly.

Health reformers searching for optimistic historical analogies often take heart in the example of President Harry Truman. After his campaign for universal health insurance was defeated in 1948-50,

<sup>45</sup> Jacobs, *Health of Nations*, Chapter 9; and Theodore R. Marmor, *The Politics of Medicare* (Chicago, IL: Aldine, 1973).

Truman and his allies devised an "incremental" strategy that eventually led to the enactment of Medicare in 1965.<sup>46</sup> Reformers dream of doing this again, perhaps pushing forward toward universal health insurance by next focusing on extending coverage to all American children.<sup>47</sup> But today the policy legacies and governmental conditions are not so favourable as they were in the wake of Truman's presidency. Now a fully mature programme, Social Security has become since the 1980s an object of persistent criticism by fiscal conservatives in the Concord Coalition and beyond who consider its universalism to be "too expensive" for the federal government to preserve in the future.<sup>48</sup> Current (and likely near-future) struggles in Washington focus on how to cut taxes and federal spending, not on their gradual expansion, as was the case under moderate Republicans and Democrats during the 1950s and early 1960s. Democrats may look back wistfully to Harry Truman, cherishing his improbable electoral triumphs and the progressive legacies that grew even out of his policy failures. But Truman and his post-war era of US governance are truly dead and gone.

Even an issue like health security – central as it is for many Americans – will not, in itself, bring about a political revival for Democrats or a resurgence of faith in the social-welfare role of the US national government. As the failure of President Clinton's Health Security effort shows, the future of inclusive social policymaking in the United States depends on Americans' coming to believe that government can offer minimally intrusive solutions to the heartfelt needs of individuals and families. If progressives are actually to achieve universal health care coverage in America's future, it will be because new rationales for the role of government, and new majority political alliances, have been achieved first.

<sup>46</sup> Monte M. Poen, *Harry S. Truman Versus the Medical Lobby: The Genesis of Medicare* (Columbia, MO: University of Missouri Press, 1979).

<sup>47</sup> See the call for such an approach by the Editorial Board of the *New York Times* in "Anybody Home?", *New York Times*, Sunday, January 8, 1995, p. E18.

<sup>48</sup> See Peter G. Peterson, *Facing Up* (New York: Simon and Schuster, 1993). I discuss the attacks on "entitlements" in "Remaking US Social Policies for the 21st Century", the conclusion to *Social Policy in the United States*.

American progressives seeking centre-left electoral majorities will have to travel a long road to regeneration, much as Britain's Labour Party has done over the last generation. At present, however, the way forward for US progressives is barely discernible. Much work remains to be done, both intellectual and political.