A Tale of Two Editions: Marmor's *The Politics of Medicare* and the Study of Health Politics after Thirty Years

For a book that has earned the status of a classic in the health politics genre, *The Politics of Medicare* enjoyed a modest inception. First published as a slender British monograph in 1970, it was not released by an American publisher for another three years—and then by the small, Chicago-based academic press Aldine Publishing Company. Despite a favorable review of the British edition in the *Economist* (Slow to Heal 1970), the manuscript was turned down by Oxford University Press, which praised the book but predicted anemic sales.[1] Even after its Amer-

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1. For similar reasons, Atherton, Basic Books, Harcourt Brace Jovanovich, Viking, and Little, Brown also declined to publish the book. This list is based on phone conversations with Marmor, who also kindly supplied me with much of his written correspondence with the various editors of these presses between 1967 and 1972. What is clear from these letters is that trade presses were unwilling to take a chance on a book that might be of interest only to "a specialist academic market," as one editor put it.

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ican release and a strong initial print run, *The Politics of Medicare* received a muted response from academic journals in the United States. Although a laudatory appraisal appeared in the *Social Service Review* (Linford 1971), the book was not reviewed by the flagship journal of the American Political Science Association, the *American Political Science Review*, nor did it garner any major political science prizes.

Perhaps this should not be too surprising. *The Politics of Medicare* entered what was then a relatively crowded field of journalistic and academic analyses of the new Medicare legislation (e.g., Harris 1966; Feingold 1966; Somers and Somers 1967; Sundquist 1968). It was a case study at a time when the discipline was gravitating away from the case study approach. And it arrived amid a notable succession of "big" books that, like it, applied diverse conceptual perspectives to a singular event or striking feature of political life, the most notable being Graham T. Allison's 1971 study of the Cuban missile crisis, *Essence of Decision*. Above all, however, Marmor's trenchant analysis was initially a victim of the general indifference to public policy within American political science, a discipline still deeply in the thrall of the behaviorist revolution with its fixation on process and action. The fairly conventional methodology of the book notwithstanding, *The Politics of Medicare* was an unconventional work—an examination of the political construction of a crucial public program appearing at a time when the substantive content of public policies played little or no role in most political science scholarship.

And yet this slim book, which arrived with such stealth on American shores more than a quarter-century ago, is now widely recognized not only as the "standard political science study" of Medicare's passage (Moran 1999: 57) but also as one of the most important founding texts in the field of health politics. The first edition of the book has been in continuous print since 1973. It has sold more than 50,000 copies, making it undoubtedly one of Aldine's best acquisitions. It has become familiar in graduate and undergraduate courses on health policy and American politics, in part because its argument was the basis for a chapter by Marmor in the widely adopted 1969 case study collection *American Political Institutions and Public Policy* (Sindler 1969). It has been a valued resource for scholars in a range of disciplines, from political science to sociology to history to public administration. The political scientist Nelson W. Polsby, for example, drew heavily on Marmor's research to illustrate domestic policy gestation in his 1984 study *Innovation in American Politics*, and the book has served as the major source regarding Medicare's political origins for such eminent works of social and political his-

tory as Paul Starr's *The Social Transformation of American Medicine* (1982).

All this would not be true, of course, if *The Politics of Medicare* did not offer a cogent, compelling, and still largely uncontested account of the passage of America's largest and most politically salient government health program. In Marmor's interpretation, Medicare's enactment poses a dual analytic puzzle. First, how did a legislative proposal that ran afoul of powerful interest groups and America's notoriously antigovernment political culture change, in the course of a decade, from a "legislative impossibility" into a "legislative certainty" (23, 45), ultimately passing in a more ambitious form than even its proponents had dared advocate? Second, turning the question on its head, why was the Medicare legislation, expansive as it was, still so much more limited than comparable programs found in other nations and than the true ambitions of its advocates? In the process of addressing these twin questions, the book weaves a rich story that shows how bureaucratic activism, interest-group mobilization, congressional politics, and presidential leadership all combined to make Medicare—but not national health insurance—inevitable in 1965. And, in an analytic move quite rare at the time of its publication, *The Politics of Medicare* situates this narrative about U.S. politics in the larger context of the comparative development of the welfare state.

Still, the intrinsic strength of the account offered in *The Politics of Medicare* is not sufficient to explain the book's enduring influence. The true reason is more straightforward—and more telling: When the U.S. edition of *The Politics of Medicare* was published in 1973, it was one of the first serious works of political science to analyze the politics of American medical care. Other scholars, to be sure, had examined health politics. But Marmor was among the first to apply political science concepts and methods in a systematic fashion to the domain and, just as critical, to treat the area not as a backwater of health services research or medical sociology but as a central area of political conflict and policy making in mature industrial democracies. In many ways, therefore, the publication of the first edition of *The Politics of Medicare* marks the inauguration of the field of health politics as the vibrant and wide-ranging realm of political science that we know today. Since the subsequent history of the field is also in significant part the story of Marmor's intellectual development and influence, it is appropriate to reflect on how far the field has come—and on how far, in some respects, it still has to go—in the context of tracing the evolution of Marmor's pioneering book from first to second edition.

The First Edition

Although *The Politics of Medicare* was first published when Marmor was in his early thirties, it did not grow out of a doctoral dissertation as do so many early career works. (Marmor's dissertation, completed in 1965 and belatedly published in 1988, was in fact a historical analysis of the career of the great southern politician and philosopher John C. Calhoun.) The beginnings of *The Politics of Medicare* can instead be traced to a long seminar paper that Marmor wrote for the late V. O. Key Jr. in 1963 and then revised while a postdoctoral fellow at the Harvard School of Public Health in 1965 and 1966. Based in part on this initial draft, Marmor was given a stint as a special assistant to Medicare's principal architect, Health, Education, and Welfare (HEW) Secretary Wilbur Cohen, who provided his young aide with "extraordinary access to primary materials" (xxi) while Marmor helped with the implementation of the new program during the summer of 1966. The final manuscript was completed shortly thereafter, at a time when Marmor was at Essex and Oxford Universities (where study of the welfare state was much better regarded than in American universities). The book is thus very nearly a contemporary account, written by someone who was there on the ground floor after Medicare's passage and who quite obviously believes its enactment was a good thing. Much of its appeal—and much of the appeal of Marmor's entire oeuvre—lies in this synthesis of objective social science, active political experience, and clear but not cloying ideological commitment.

Again, however, the strength of the first edition ultimately lies in the persuasiveness and concision of the account that it offers. Tracing the Medicare effort through the failed campaigns for national health insurance of the 1910s, 1930s, and 1940s up to the passage and early implementation of the program itself, Marmor divides his account into three principal stages: the early doomed efforts for national health insurance that set the intellectual agenda and interest-group roster for the final Medicare battles; the legislative maneuverings of the early Kennedy years, when some form of federal health insurance for the aged might have squeezed through Congress but did not; and, finally, the passage of Wilbur Mills's famous "three-layer cake"—Medicare Part A, Medicare Part B, and Medicaid—in the transformed matrix of partisan and congressional power created by the landslide Democratic gains of 1964.

Marmor does not, of course, ignore the feature of the Medicare fight that has preoccupied most commentators: the vitriolic attacks of the American Medical Association (AMA) and other organized opponents of

"socialized medicine." The overall thrust of his narrative, however, is that this was merely an additional count against a legislative proposal whose realization depended almost entirely on the balance of ideological forces in Congress and, in particular, within the powerful House Committee on Ways and Means, Mills's fiefdom and a bastion of southern Democratic influence. Although Marmor does not use the term, his then is primarily an "institutional" explanation of Medicare's fate. Given the structure of Congress, with the disproportionate power it granted committee chairs and conservative Southern Democrats from safe one-party states, Medicare's fortunes hinged not on the severity of the plight of the aged, nor on the balance of interest-group pressure, nor even on the character of popular sentiments, but on the institutional structure of Congress as it interacted with the underlying ideological and partisan divide that expansive social legislation like Medicare inevitably created.

In the final chapter to the first edition, which examines Medicare's genesis through the three analytic lenses used in Allison's *Essence of Decision* (1971)—rational actor, organizational process, and bureaucratic politics—it becomes clear that Marmor envisions his story as a "crucial-case" study of the sort later outlined by Harry Eckstein (1975). In this method of analysis, theoretical claims are tested and refined through the in-depth examination of "cases that ought, or ought not, to invalidate or confirm theories if any cases can be expected to do so" (ibid.: 118). This is essentially Marmor's approach, and his main target is the then-popular theory of "pressure politics." Medicare, he argues, provides a prime example of Theodore Lowi's (1964) category of "redistributive" policy issues: a debate over the proper boundary of the public and private sectors that divided opponents and proponents into cohesive, highly ideological camps led by national peak associations. Yet despite such hyperactive interest-group mobilization, Marmor argues, the power of interest groups, including the legendarily effective AMA, was ultimately rooted in the institutional structures and routines of Congress as they mapped onto partisan and ideological divisions over which advocacy groups had only marginal control. Thus, even in a context in which organized interests might have been expected to be—and, in fact, were widely seen to be—of decisive importance, their true power was in Marmor's view surprisingly limited.

Marmor takes the same tack, though with less convincing results, in his assessment of the influence of public opinion. Despite enormous lobbying campaigns for and (especially) against the Medicare legislation—campaigns that were explicitly designed to shape public attitudes—the

tangible effect of public opinion on the legislative process seems to Marmor to have been slight. The Medicare debate, he states flatly, indicates the "comparative irrelevance of mass public opinion in federal policymaking" (75). In retrospect, this conclusion seems overdrawn. As Lawrence Jacobs (1993) would later emphasize, *The Politics of Medicare* fails to explore in any real depth the diffuse effects of public understandings on the strategies and goals of program advocates. Nor does Marmor investigate the way in which public attitudes toward national health insurance and more incremental legislative alternatives were shaped by the rapid spread of private health insurance in the years after World War II, a development heavily promoted by the very groups that opposed Medicare. The crucial-case approach, so well suited to questioning the received wisdom of the day regarding the power of organized interests, appears in this instance less capable of bearing the analytic weight that Marmor puts on it.

Nonetheless, Marmor's overarching claim still seems entirely correct. The contours of public opinion, the character of interest-group demands, the to-and-fro of congressional bargaining, the influence of presidential leadership—all were critical in shaping the agenda for action and determining the content of the final legislation. Yet they do not explain why Medicare passed when it did, or why Mills eventually saw it necessary to craft not merely a minimal compromise but a bill that added Republican and AMA proposals for physicians' insurance on top of the original hospital insurance bill. For that to occur, a political "big bang" (Leman 1977) or "window of opportunity" (Kingdon 1984) was needed, and the election of 1964 supplied such a moment, just as the Depression and the Democratic ascendance of the 1930s supplied one for the original Social Security Act. Once this legislative window opened, strategic maneuvering loomed large (witness Mills's crafty about-face, which showed greater political flexibility than did the continued commitment of Medicare advocates to a limited hospital plan). But Medicare's passage was only possible because of a major shift in the balance of power within an institutional framework otherwise inhospitable to major social reforms.

In sum, by examining a case in which interest group power would be expected to be absolute and showing instead that it was institutionally contingent, Marmor impugns a major conceptual perspective in a way that case studies rarely can. And by focusing on a debate representative of a larger class of "redistributive" issues, he is able to say something at once meaningful and general about the politics of social policy in the United States.

Because Marmor does what he does both well and with admirable brevity, it is easier to forgive him for what he does not do. The first edition has relatively little to say, for example, about the postwar spread of private health insurance among the working population, which was promoted ironically by federal tax and regulatory policy and by an alliance of convenience among labor unions and business and medical interests, groups that were otherwise consistently at odds over national policy. This development—the extension of social insurance under private rather than public auspices—was arguably more important than AMA opposition in constraining the ambitions of aspiring health care reformers, who increasingly saw it necessary to accommodate existing institutions of medical finance and concentrate on filling their most conspicuous gaps.

Relatedly, *The Politics of Medicare* pinpoints its analytic energies on the string of Democratic proposals that led up to Medicare: the Truman plan, the Forand bill, and the King-Anderson program. With the exception of the AMA's "eldercare" plan and the final Republican alternative sponsored by John Byrnes—the proposals that Mills so unexpectedly transformed into Medicare physicians' insurance—Marmor largely ignores conservative strategizing and proposals. Yet, from the waning of the failed Truman campaign onward, there were serious efforts under way by Republican moderates like Jacob Javits, Eisenhower's HEW Secretary Marion Folsom, and even Richard Nixon to craft legislation that would create publicly sponsored and financed private coverage for older Americans, much as the Eisenhower-supported Federal Employees Health Benefits Program extended private coverage to government workers. And while the AMA never broached such a compromise, these efforts had behind-the-scenes support from leading figures in the Blue Cross/Blue Shield movement and the American Hospital Association, who were always more receptive to federal legislation than the AMA was. Today commentators on the left frequently complain that Democrats settled for too little in 1965. But given conservative attempts to expand private insurance through coordinated industry action and favorable legislation, it is revealing to consider what the nation might have ended up with had the 1964 Democratic landslide *not* occurred (or, indeed, had Kennedy not been assassinated). Although Marmor mentions the missed chance of the Kennedy years, he largely fails to consider these "roads not taken" and thus emulates most scholarship on the welfare state by fixing attention on the liberal proponents of expanded public protections, to the detriment of a richer appreciation of the full range of proposals, policies, and protagonists that animated the development of American social provision.

But these are thorny questions of historiography, hardly amenable to extensive consideration in a study that, after all, had as its principal aspiration a convincing explanation of Medicare's passage. A more critical omission of *The Politics of Medicare*, especially for a book so original in its focus and concern, is the general absence of any conceptual justification for making health policy an important subject of political science research—which, as Marmor's life work has shown, was clearly a major aim of the first edition. Marmor drops hints here and there, of course, especially in the opening examination of the distinctive history of government involvement in American medical care. His main goal, however, is to use health policy to illustrate the American political process, not to explain the special characteristics, if any, of this previously understudied policy domain. This is unfortunate, if only because scholars who followed Marmor's lead would have benefited greatly from even a rough conceptual map to guide the study of health politics. As it was, Marmor's major ideas on the subject would trickle out in a series of essays published over the next decade, while Robert R. Alford's (1975) less subtle typology of "structural interests" would become the first widely used theoretical framework for political scientists interested in medical care.

Health Policy, Health Politics

Even so, it was Marmor who really opened up this fresh and exciting new area of study. And in the years after the publication of the first edition, it was Marmor who also helped craft it into a self-conscious field. He did this not just through his writing and teaching, and not just through his role in helping found APSA's Committee on Health Politics and editing the *Journal of Health Politics, Policy and Law*, but also through his education and guidance of a stream of young scholars who have been his students and coauthors.[2] If he cannot say he has made the field what it is today, he can at the very least claim a substantial share of the credit. When the first edition of *The Politics of Medicare* was published, the welfare state was a marginal concern in American political science. Today it is one of the most vibrant areas of research in the discipline. When the first edition appeared, health policy was an exotic species of government action studied only by a fringe of hard-core specialists. Today it is a sizable and expanding field of interest within political science and, increasingly, a separate area of its own. The questions of com-

2. In the interest of full disclosure, I should note that I am one such scholar.

parative health policy to which Marmor turned after *The Politics of Medicare* were once all but ignored. Now, as a string of recent works suggest (e.g., Immergut 1992; Altenstetter and Björkman 1997; Maioni 1998; Hacker 1998; Tuohy 1999), they are at the center of the health politics field. Attributing causation is never simple, but there can be no denying that Marmor has been at the forefront of the move to bring health and social policy into political science and to transform health politics into an identifiable and important area of scholarship.

Throughout, Marmor has aspired to integrate what others have viewed as discrete. From the first edition of *The Politics of Medicare* through the second, his work has examined both how policy is made *and* what it does, both why policies pass *and* whether they are good or bad, both America's peculiar health policy path *and* its larger comparative context, both the small details of legislation *and* the large features of political life. It is fair to say, however, that this ambition is not universally shared, certainly not within the discipline as a whole and, regrettably, not even within the field of health politics itself. Indeed, each of the three major areas of scholarship to which Marmor has contributed over the past three decades—welfare state research, policy analysis, and the study of health politics—has become ever more self-contained and self-referential and ever more divorced from explicit normative argumentation. In the case of health policy studies, the trend has also been toward greater technocracy, as social scientists with a general focus have given way to a growing horde of policy specialists steeped in the complex minutiae of national policy. Once an uncharted wilderness, then a sparsely populated homestead, the field now seems increasingly a gated community, with the price of admission being long years learning health policy acronyms and reading the fine print of thirteen-hundred-page bills.

This is understandable and to some extent unavoidable. Today's policy analysts are less concerned with programmatic beginnings, most of which have been picked over for decades at this point, than they are with the dimensions, evolution, and operation of sometimes controversial, sometimes internally dynamic, but generally quite stable domestic programs. With the maturation of the welfare state, the agenda for programmatic action and policy research alike has shifted from the activist rhetoric of major policy innovations to the bureaucratic language of rationalization and incremental change. To understand this complex arena of discourse and action seems to require an investment of time and energy that leaves little of either to spare for the years of study needed to gain basic political science skills. Nor does it help that political science

itself offers few rewards and little support for those who devote themselves to the challenge of becoming deeply acquainted with the specifics of a particular area of national policy. It is not surprising, therefore, that the average analyst of health politics today is found in a think tank or a school of public policy rather than a political science department—and, indeed, is more likely to be an economist or health services researcher than a political scientist.

Unsurprising as this may be, there are still good reasons to be concerned about it. In the early years of political science, policy analysis and political analysis were viewed as inseparable. It was simply taken for granted that one needed to understand how policies worked to evaluate politics and how politics worked to evaluate policies. As the craft of policy analysis has become the province of self-identified "policy experts" with intellectual roots in economics and decision theory rather than political science, policy analysis has had less that is interesting to say about the difficult questions of political feasibility and administrative design that a hard-headed science of politics forces us to confront. At the same time, a political science community shorn of its earlier commitment to policy analysis has seen fit to treat the political process as if it were a generic script enacted anew with each discrete policy episode, as if political action and outcomes could be extracted from the programmatic and historical context in which they take place. As a result, policy analysts complain that political science is abstract and impractical, while political scientists complain that policy analysis is naïve and impenetrable.

Within political science at least, this has started to change. In the past decade, a growing body of research has explored the way in which policies, once implemented, shape and reshape political institutions and behavior (Pierson 1993). Building on these studies of "policy feedback," scholars in a range of disciplines have developed new conceptual tools to explain how and why certain features of the political world—including, but not limited to, major public policies—proceed down self-reinforcing or "path-dependent" channels of historical development from which departure may be difficult (e.g., North 1990; Pierson 2000). And yet, not only has this recent theorizing filtered slowly into the political science mainstream, but it has also failed to set its analytic sights on the politics of health policy, a subject more suited than most to the conceptual tools it provides (but see Hacker 1998; Tuohy 1999). The simple reality is that the most important influence on the landscape of health policy today is the existing configuration of public and private social policies. Health policy analysts understand this, but they have only a sketchy appreciа-

tion of its political ramifications. Political scientists have begun to map out these ramifications, but they have continued to pay scant attention to health policy.

The Second Edition

It is in this light that the second edition of *The Politics of Medicare*—its strengths, its weaknesses, and its relationship to the first edition—needs to be understood. For the second edition, as Marmor explains in the preface, "tells a different kind of story" from the first (xi). Its main concern is not why Medicare passed but "what happened to Medicare politically as it turned from a legislative act in 1965–1966 to a major program of American government in the three decades since" (xi). Inevitably, therefore, the animating questions in the second edition are somewhat less clear than they were in the first. If the first edition addressed a simple dual puzzle, the second extracts three more loosely linked questions from the complicated postenactment history of the program. First, what accounts for the failure of the Medicare program to expand incrementally in the years after its passage, as its architects hoped it would? Second, why did Medicare become more interventionist and regulatory in its cost-control efforts during the early 1980s, years when Republicans controlled the White House and Senate and when "pro-competitive" approaches to health care reform were gaining popularity? Third, and finally, why did proposals for "managed competition" become the centerpiece of congressional Republicans' efforts to transform Medicare in the 1990s, shortly after the same congressional Republicans had savaged the approach when it was embodied in President Clinton's doomed Health Security plan? Each of these paradoxical outcomes highlights for Marmor the critical turning points of a program that was transformed from an entering wedge for national health insurance in the 1960s into a cash-hungry abettor of medical inflation in the 1970s, into a sophisticated payer in the 1980s, and into a outmoded entitlement requiring radical pro-competitive reform in the 1990s.

Conveniently, each of these three questions also highlights for Marmor one of the three major explanatory variables that he deploys in the second edition: the "structural" constraints on change created by America's fragmented political institutions; the "insider politics" of program administration and fiscal stewardship; and "the changing distributions of political power" within the federal government (173). Unlike the Allisonian lenses deployed in the first edition, these are not really conceptual frame-

works. Nor, however, are they precisely identified independent variables. Rather, they are broad sets of factors that Marmor sees as critical in explaining each of the three general puzzles that he outlines. Thus the structural constraints on policy change provide Marmor's chief explanation for why Medicare failed to expand significantly after 1965. The insider politics of the program—and particularly the coincidence of interests among diverse political forces when it came to cost control—were crucial in bringing about the payment reforms of the 1980s. And the unexpected Republican takeover of Congress in 1994, which sparked a major congressional drive to cut taxes and scale back domestic programs, helps explain why Medicare reform based on "managed competition" became the favored, if mostly failed, policy alternative in the mid- to late-1990s. In addressing each of these questions, Marmor shows his usual narrative skill, although of necessity he provides less specific detail about the history of the program after 1965 than he did about its political genesis in the first edition. Reflecting the influx of scholars into health policy studies, the second edition is also more reliant than the first on the research of other authors, particularly the work of Marmor's former graduate student Jonathan B. Oberlander (1995), whose dissertation on Medicare's postenactment politics provides much of the raw historical material for the analysis.

The principal aim of the second edition, however, is not to rewrite Medicare's history, but to offer a political guide for how to understand the program's development—and, perhaps more important, for how *not* to understand its development. If the first edition was at the time of its publication mainly addressed to political scientists whom Marmor felt should pay more attention to health policy, the second seems mainly addressed to health policy analysts whom Marmor feels should pay more attention to political science. The new chapters of the book represent a frontal assault on the kind of apolitical policy analysis that is so characteristic of contemporary health policy studies. Marmor challenges the "managed competition" ideal for failing to consider administrative and political feasibility and for embodying an internally inconsistent conception of government that both disdains and requires active state management. He criticizes claims that Medicare is "unaffordable" or a source of "generational inequity," noting that the program has since the early 1980s grown slower on average than private health insurance and that charges of unfairness could be rectified more easily by enacting universal health insurance than by cutting back Medicare. His overall message is not that Medicare is without flaws. It is that these flaws are far less the result of

bad policy design than they are of the political context in which Medicare arose. Moreover, Marmor makes clear that changing assessments of Medicare have substantially more to do with the shifting state of American medical care and the broader ideological and fiscal climate of the welfare state than they do with any specific design features of the program itself. In a programmatic environment polluted with bad political advice masquerading as neutral expertise, the simple reminder that policy analysis must inevitably confront political reality and ideological conflict is a welcome breath of fresh air.

Perhaps because Marmor wishes to bring political sensibility into health policy analysis, he spends little time examining the other side of the coin: how to bring the interest in substantive policy details evinced by policy analysis into the mainstream of American political science. The divide between political analysis and policy analysis, after all, is not simply the fault of policy analysts who fail to consider political and administrative feasibility. It also reflects the perception that political science offers few tools for understanding the complex and richly textured world of policy making that policy specialists make their lives understanding. What is too often missing from general political science accounts, such specialists frequently complain, is an appreciation of the deep specificity of a policy process driven by the routines and exigencies of existing public programs and government policies. To argue that policy analysts should be aware of the myriad ways in which political realities shape and constrain policy design is all well and good. Yet, by the same token, political scientists should be aware of the myriad ways in which the substantive features of programs shape and constrain politics, undermining facile generalizations about how "the American policy process" works.

The second edition of *The Politics of Medicare* represents a golden opportunity to respond to these complaints. In turning from program origins to postenactment evolution, Marmor also necessarily moves from a conception of policy as a *result* of political forces to a conception of policy as a *cause* of such forces. Furthermore, as just noted, the idea that "policies create politics" is already an important theme of recent political science research on public policy, although little of this work has examined health policy per se. By and large, however, Marmor does not seize the opportunity. Though he explains how the linkage of Medicare Part A to an earmarked trust fund has created periodic fiscal "crises" that have facilitated policy adjustments (an insight also made by Patashnik 2000 and Oberlander 1995), he has surprisingly little to say on the question of whether other features of the program have influenced Medicare's

ongoing political evolution. Marmor does not refer to any of the major writings on policy feedback by scholars such as Hugh Heclo (1974), Theda Skocpol (1992), and Paul Pierson (1993, 1994), nor does he examine in any detail the "insider politics" of program administration and fiscal management—the explanatory factor that seems to bear the most resemblance to policy-feedback arguments. Instead, most of the book's emphasis centers on the broader political and institutional environment within which Medicare has operated, what Marmor calls the "wider forces that framed [political] bargaining and shaped program operations after 1965" (94). But although these wider forces are clearly crucial for understanding the shifting agenda of Medicare politics, and in particular the rise of fiscal control as the preeminent concern of Medicare's administrators and overseers, it is less clear that they account for the actual path of programmatic change, which has largely exhibited a pattern of incremental response to the twin imperatives of budgetary cost-cutting and political blame-avoidance.

Indeed, viewed through the prism of recent scholarship on the path-dependent evolution of large-scale public policies, Medicare's relative stability—its failure to expand in the 1970s and its resistance to retrenchment in the 1990s—looks considerably less puzzling. Medicare, unlike the Social Security program that it aimed to emulate, covered all elderly Americans in one fell swoop. It thus offered no natural base for expansion: Coverage of new beneficiaries required a new program orientation and rationale. Thanks to Mills's intervention, Medicare also financed both hospital and physician services from the outset, thus foreclosing the Canadian route of expansion through the coverage of new service categories. And unlike Social Security, Medicare purchased services in the private sector and, in fact, relied on private fiscal intermediaries, so it was always subject to the inflationary tendencies of the private medical market. It surely did not help either that the segment of the population it covered was among the most expensive and difficult to insure, which of course had been the chief rationale for Medicare all along. Given all this, it is easy to understand why expansion of the program has proved a difficult political and fiscal challenge even without taking into account the structural constraints imposed by American political institutions or the harsh climate Medicare faced in the years after its enactment.

Retrenchment, however, has scarcely proved easier. As Medicare payments pulsed out into the health economy, the program became deeply interwoven into U.S. medical care and the American welfare state. It funneled money not only to beneficiaries themselves but also to hospitals,

doctors, Blue Cross administrators, graduate medical institutions, and a host of other powerful claimants. It shaped Americans' expectations about work and retirement. It conditioned employer and union benefit practices. And for millions of elderly Americans (and their children), it became a crucial ongoing source of financial protection when health was most fragile. It is a little-known feature of Medicare's history, unmentioned in Marmor's account, that the program's inadequate benefit package created the basis for widespread political mobilization of the elderly by allowing the American Association of Retired Persons to sell low-cost supplementary insurance as a means of attracting members. Although we tend to think of Medicare as a triumph of the "gray lobby," the powerful popular constituency that now supports the program is mostly its effect rather than its cause.

In light of Medicare's deeply embedded character and the widespread support that it enjoys, it is not surprising that there has never been a serious effort to eliminate the program—not during the "Reagan revolution" of the early 1980s, not during the Gingrich budget crusade of 1995, and certainly not today. Rather, the contractionary changes seriously considered have taken two forms: major structural alterations of Medicare's programmatic architecture (the introduction of vouchers for private insurance being the most extreme example) and measures primarily intended to bring about cost-containment (such as the prospective payment system for hospital services). As Marmor rightly argues, the former have had as their primary motivation a desire to scale back social insurance by shifting the risk of health costs back onto the elderly. The latter, by contrast, have been motivated mostly by budgetary exigencies, a particular problem for Medicare because of the historically rapid rate of medical inflation. The important point to note, however, is that with the possible exception of the 1997 balanced-budget reforms, the structural reforms have consistently failed while the budgetary reforms have only succeeded when their costs to beneficiaries have been obscured, usually by targeting cost reductions on providers. When all is said and done, the striking feature of Medicare's postenactment development is not the bitterness of the criticism directed against it or the volume of changes considered, but its essential stability and the consistent preference of policy makers for incremental adjustments imposing few immediate losses on beneficiaries. Medicare has changed, and not always for the better, but these changes have been surprisingly modest, especially when considered against the turbulent backdrop of American medicine.

None of this is to deny that Medicare has failed to expand to meet the

rising costs of medical care for the elderly or that the program does not face serious ongoing problems. Nor is it to insist that major structural changes are a political impossibility. But such changes would require a consolidation of political power and willingness to ignore electoral losses that have until now consistently eluded Medicare's opponents. They would probably require in fact the kind of rare political mandate that, as Marmor so skillfully shows, allowed the program to come into existence. The closest approximation of such an opportunity came (and went) in 1995, when an unusually unified Republican majority bet that a weakened President Clinton would accept a Medicare overhaul and lost. In the absence of an epochal shift of the 1964 variety, Medicare will likely continue to muddle through, responding to its environment in the slow and episodic fashion so characteristic of an established program, with changes mostly driven by budgetary and technical imperatives rather than the deep ideological disagreements that continue to divide Medicare's opponents and proponents. At this moment in fact the program seems on a course of modest *expansion* within its traditional structure, as a growing bevy of politicians insists that it cover a portion of pharmaceutical costs and that a share of the projected budget surplus be set aside to fund the looming influx of aging baby boomers.

Of course, major structural change might also occur through the self-reinforcing effects of relatively small and individually uncontroversial alterations in Medicare's programmatic architecture—a possibility, it must be said, that *The Politics of Medicare* does not consider. The practice of contracting with private health plans, for example, has been quite popular with the elderly, despite posing risks to vulnerable patients and the program as a whole. Beneficiaries who enroll in private plans obviously favor the policy. And why not? Because Medicare has historically paid private plans far in excess of the appropriate amount for these relatively healthy beneficiaries, enrollees in private plans have generally received broader benefits than have those who remain in the traditional program. At the same time, the costs to Medicare and, ultimately, to taxpayers and public sector beneficiaries, are relatively invisible and diffuse. With more than a seventh of Medicare beneficiaries now in private health plans, contracting surely represents a real change in Medicare. It also constitutes a real threat to the program, because private health plans may siphon off ever more healthy patients, driving up costs and undercutting Medicare's ability to pool risks and maintain a unified political constituency. To the extent, however, that these threats become widely apparent, there will be strong political pressures to prevent them from

being realized. Moreover, the same budgetary exigencies that drive reductions in payments to providers also push politicians to rein in payments to private health plans, as they did in 1997 by cutting the per capita allotments to health plans and mandating the use of risk-adjustment. Finally, however contracting is evaluated, it certainly does not represent the "dismantling" of Medicare. Nor, at least for now, can it even be criticized as an abandonment of Medicare's traditional commitment to a defined-benefit entitlement, since there is no financial penalty for remaining in traditional Medicare.[3]

If Medicare seems no longer at the crossroads, the same is not true of the health politics field. An impressive array of aspiring and established scholars committed themselves to the study of health policy making during the debate over the Clinton health plan, giving the field an infectious enthusiasm and topical relevance that it had rarely enjoyed before. Yet that sense of enthusiasm and relevance has already waned, as policy analysis and political analysis have continued along their separate tracks while much of political science has maintained its fascination with highly technical formal models whose conclusions are too often trivial or suspect. International relations theory offers a troubling precedent here. When the Cold War ended, dollars and scholars poured into international relations research, with researchers seeking to apply cutting-edge theory to the most pressing problems of foreign affairs. By the mid-1990s, however, both money and interest had begun to run dry, and any faith that analysis and action shared an essential connection had been sorely tested. It is too soon to say whether the same fate will befall the field of health politics, but it is surely soon enough to fear that an unprecedented opportunity to place the field on firmer disciplinary footing and invest it with a stronger theoretical core may be slipping irrevocably from our grasp.

The Politics of Medicare shows that good political science is not inimical to thoughtful analysis of national policy. It has been Marmor's greatest contribution to the discipline to emphasize that this is so and to demonstrate, in word and deed, that the rewards of the marriage are considerable. If the new edition of *The Politics of Medicare* does not entirely bridge the divide that now plagues the study of health politics, it nonetheless brings us closer to the goal, repeatedly and powerfully expressed by Marmor himself, of making the field a vibrant intellectual community

3. For more on these issues, see my review of Richard Kronick and Joy de Beyer's *Medicare HMOs: Making Them Work for the Chronically Ill* in Hacker 1999.

that merges broad theoretical aspirations with specific policy concerns. The next task for the field may well be to grapple with the questions that the first and second editions of *The Politics of Medicare* leave unanswered, questions about the distinctive political characteristics of the medical domain and the ongoing feedback effects of established health policies. If Marmor were to tackle these important areas of inquiry, he would no doubt help lure a new generation of scholars into the uncharted byways of health politics, just as he did with the first edition of *The Politics of Medicare* almost three decades ago.

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References

Alford, Robert R. 1975. *Health Care Politics: Ideological and Interest Group Barriers to Reform*. Chicago: University of Chicago Press.

Allison, Graham T. 1971. *Essence of Decision: Explaining the Cuban Missile Crisis*. Boston: Little, Brown.

Altenstetter, Christa, and James Warner Björkman, eds. 1997. *Health Policy Reform, National Variation, and Globalization*. New York: St. Martin's.

Eckstein, Harry. 1975. Case Study and Theory in Political Science. In *Handbook of Political Science*, ed. by Fred I. Greenstein and Nelson W. Polsby. Reading, MA: Addison-Wesley.

Feingold, Eugene. 1966. *Medicare: Policy and Politics*. San Francisco, CA: Chandler.

Hacker, Jacob S. 1998. The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy. *Studies in American Political Development* 12 (spring):57–130.

———. 1999. Review of *Medicare HMOs: Making Them Work for the Chronically Ill*, by Richard Kronick and Joy de Beyer. *Journal of Health Politics, Policy and Law* 24(5):1230–1237.

Harris, Richard. 1966. *A Sacred Trust*. New York: New American Library.

Heclo, Hugh. 1974. *Modern Social Politics in Britain and Sweden*. New Haven, CT: Yale University Press.

Immergut, Ellen. 1992. *Health Politics: Interests and Institutions in Western Europe*. New York: Cambridge University Press.

Jacobs, Lawrence. 1993. *The Health of Nations: Public Opinion and the Making of American and British Health Policy*. Ithaca, NY: Cornell University Press.

Kingdon, John W. 1984. *Agendas, Alternatives, and Public Policies*. New York: HarperCollins.

Leman, Christopher. 1977. Patterns of Policy Development: Social Security in the United States and Canada. *Public Policy* 25:261–291.

Linford, Alton A. 1971. Review of *The Politics of Medicare* by Theodore R. Marmor. *Social Service Review* (June):226–227.

Lowi, Theodore. 1964. American Business, Public Policy, Case Studies, and Political Theory. *World Politics* 16:677–715.

Maioni, Antonia. 1998. *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada*. Princeton, NJ: Princeton University Press.

Marmor, Theodore R. 1988. *The Career of John C. Calhoun: Politician, Social Critic, Philosopher*. New York: Garland.

Moran, Michael. 1999. *Governing the Health Care State: A Comparative Study of the United Kingdom, the United States, and Germany*. Manchester: Manchester University Press.

North, Douglass C. 1990. *Institutions, Institutional Change, and Economic Performance*. New York: Cambridge University Press.

Oberlander, Jonathan B. 1995. Medicare and the American State. Ph.D. diss., Yale University.

Patashnik, Eric. 2000. *Putting Trust in the U.S. Budget: Federal Trust Funds and the Politics of Commitment*. New York: Cambridge University Press.

Pierson, Paul. 1993. When Effect Becomes Cause: Policy Feedback and Political Change. *World Politics* 45:595–628.

———. 1994. *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment*. New York: Cambridge University Press.

———. 2000. Path Dependence and the Study of Politics. *American Political Science Review* 94(2):251–267.

Polsby, Nelson W. 1984. *Innovation in American Politics: The Politics of Policy Initiation*. New Haven, CT: Yale University Press.

Sindler, Allan P. 1969. *American Political Institutions and Public Policy: Five Contemporary Studies*. Boston: Little, Brown.

Skocpol, Theda. 1992. *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*. Cambridge: Harvard University Press.

Slow to Heal. 1970. Slow to Heal. *Economist*, 12 September, 57.

Somers, Herman, and Anne Somers. 1967. *Medicare and the Hospitals: Issues and Prospects*. Washington, DC: Brookings Institution.

Starr, Paul. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic.

Sundquist, James L. 1968. *Politics and Policy: The Eisenhower, Kennedy, and Johnson Years*. Washington, DC: Brookings Institution.

Tuohy, Carolyn Hughes. 1999. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. New York: Oxford University Press.