The New Politics of U.S. Health Policy

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Abstract Following the demise of comprehensive health care reform in 1994, some reformers are seeking comfort in the successful "incremental" strategy for enacting Medicare that emerged out of President Harry Truman's failed campaign for national health insurance in 1948–50. But despite similarities between the Truman and Clinton health security efforts, overall contexts of government and politics are much less hospitable to governmentally funded reforms today than they were after Truman's defeat. Back then, market transformations and political dynamics were both pushing toward expanded access to health services and insurance coverage. Today, by contrast, both push in the opposite direction. The private insurance market is fragmenting, federal budgetary constraints stymie new programs, and the deficit dominates debate over existing programs. Equally important, a stable pro-reform coalition like that of Truman's day has yet to emerge, while a new and fiercely conservative corps of Republicans is championing coherent programmatic alternatives based on antigovernment premises. Although passage of the Kassebaum-Kennedy health insurance reform bill in 1996 unleashed a wave of enthusiasm about incremental health care reform, formidable political, fiscal, and technical obstacles continue to stand in the way of even relatively modest incremental solutions.

The rise and fall of health care reform is the oldest story in American health politics. Time and again in the twentieth century, reformers have unsuccessfully fought for expanded or universal health insurance. Then, in the aftermath of political defeats, private market actors have rapidly transformed patterns of health care financing and delivery. After World

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War II, this old story gained a new twist with the passage of federal legislation to augment the technological arsenal of American medicine. While proposals for national health insurance languished in Congress, the federal government pumped public funds into the medical industry, subsidizing private health insurance, hospital construction, and medical education and research, and generating new markets, profits, and political resources for major stakeholders in the one-seventh of the American economy now devoted to health care (Jacobs 1995).

Only in 1965, with the passage of Medicare and Medicaid, was the pattern of defeats followed by market transformations and incremental reforms momentarily broken. Yet that rare moment of victory for advocates of extended public financing of health care did not prove to be an entering wedge for universal health insurance through federal funding or mandates, as health reformers back then had hoped. By the 1970s, distrust of government, slow economic growth, and mounting fiscal constraints left reformers without much hope for achieving universal health insurance. Reformers found themselves struggling to protect existing public programs while advocating piecemeal regulations to control health care costs and narrow gaps in the private health insurance market.

The Health Security plan sponsored by President Bill Clinton during 1993 and 1994 aimed to break the political impasse facing post-1960s health reformers. With a "window of opportunity" for government-led reforms finally open (Kingdon 1995: 217–218; Hacker 1996), President Clinton sought to enact comprehensive federal rules that would, in theory, simultaneously control medical costs and ensure universal insurance coverage. The bold Health Security initiative was meant to give everyone what they wanted, delicately balancing competing ideas and claimants, deftly maneuvering between major factions in Congress, and helping to revive the political prospects of the Democratic Party in the process (Hacker 1997).

But, as everyone knows, the Health Security effort failed miserably (Skocpol 1996; Johnson and Broder 1996). And the electoral headway made by militant conservative Republicans in the wake of the Health Security debacle has threatened since 1994 to turn U.S. health politics entirely upside down. For more than a decade, congressional budget hawks and antigovernment conservatives have closed in on Medicare and Medicaid, two of the fastest growing items in the federal budget. During the 1980s, hard-core conservatives within the Republican Party gained influence and visibility while developing tough new strategies for achieving their goals. After the political reversals of 1994, the new Republican

majority advanced proposals to rein in the growth of Medicare and Medicaid, fundamentally restructure Medicare, and devolve responsibility for determining Medicaid eligibility and benefits to the states. Those proposals ultimately provided the opening for countermaneuvers by President Clinton, who used his veto to bury the Republicans' balanced-budget initiative and thereby position himself for victory in the 1996 presidential election. During the budget battle, however, both President Clinton and congressional Democrats committed themselves to balancing the federal budget in the very near future, a move that could have serious consequences for Medicare and Medicaid.

The demise of the Health Security plan was not, therefore, a mere setback for advocates of publicly guaranteed health insurance. It was, rather, a potentially decisive turning point in U.S. health politics—one that could set the terms of the debate over U.S. health policy for years and even decades to come. The Clinton reform effort of 1993–94 reflected a widespread recognition of the limits of the private health insurance market and of the corresponding need for an inclusive public framework for pooling health risks, containing medical costs, and subsidizing low-income workers. Its defeat, however, has strengthened an alternative view of the government's role in the medical sector, a philosophy premised on the notions that health care should be treated as much as possible like other market goods and that large insurance pools should be split up to encourage individual cost awareness and personal responsibility (see, e.g., Tanner 1993; Armey 1995). This ideological transformation has been helped along by the fiscal constraints created by the federal budget deficit, by the need for budgetary adjustments in the Medicare program, and by dramatic changes in the private health insurance market that are moving more Americans than ever into managed care. Chastened by the implosion of the Health Security campaign in 1994, President Clinton and congressional Democrats have also backed away from the reform agenda of the early 1990s and moved to embrace minimal incremental changes in the private insurance market, such as those contained in the Kassebaum-Kennedy health insurance bill passed by Congress with overwhelming support in 1996.

The new agenda of antigovernmentalism underscores the historic turn that American health politics may be taking. In the past, failures to achieve comprehensive health care reform were followed by incremental but substantial government measures that simultaneously built up the private medical industry and used tax funds to extend health care to vulnerable groups of citizens not already covered by employer-sponsored

health insurance. But in the aftermath of the Health Security debacle, reformers who favor a more active use of government face defeat without the confident expectation of future incremental victories. There may be no repeat of the detour toward Medicare and Medicaid that national health reformers took in the aftermath of President Harry Truman's failed effort to achieve national health insurance between 1948 and 1950.

Defeat and Its Aftermath, Then and Now

Like President Clinton's ill-fated Health Security effort, President Truman's failed campaign for "compulsory health insurance" in the late 1940s is remembered more for what did not happen than for what did. But although Truman's struggle for national health insurance ended in failure, it gave birth to a new political strategy and proreform coalition that would eventually result in the greatest triumph yet won by U.S. health reformers: the passage of Medicare and Medicaid in 1965. A brief glimpse back at the Truman campaign and its aftermath suggests that despite the similarities between the Truman and Clinton reform efforts, the current prospects for future victories on the order of Medicare and Medicaid are much lower today than they were in the wake of Truman's defeat.

Harry Truman took office in 1949 accompanied by a newly Democratic Congress and intent on pushing an ambitious legislative agenda that included national health insurance. Truman's surprise 1948 victory at the polls and the return of Congress to Democratic control galvanized New Deal Democrats, who for years had seen their unfinished domestic agenda stymied by events abroad and conservatism at home. The seeming propitiousness of the moment led many left-leaning commentators to drop their early distrust of Truman and express unguarded optimism about the future of progressive reform. A liberal columnist writing in 1949 opined that "the President can get most of his program, and without too much compromise if he constantly calls upon the great public support manifest for him in the election . . . and uses his political skill to organize the progressive forces" (Thomas L. Stokes, quoted in Hamby 1973: 311). Another journalist of the day (Samuel Grafton, also cited in Hamby 1973: 312) went so far as to declare that national health insurance was as good as enacted. All this bears an uncanny resemblance to the brief consensus among media pundits in 1993 that the Clinton administration was "certain" to put through some sort of comprehensive health care reform proposal in 1994.

But, of course, it was not any easier to enact comprehensive health reform in 1949 than it was in 1994. Although Democrats nominally controlled Congress, the "conservative coalition" of southern Democrats and northern Republicans dominated Capitol Hill. Nearly all southern Democrats were against Truman's proposal. With Republicans also opposed, the Senate backers of the plan had no hope of bringing a national health insurance bill to the floor. Instead, the Senate passed the politically popular distributive elements of the Truman-supported health bill—measures funding medical research, public health programs, and the construction of scores of hospitals spread generously across congressional districts—while burying the proposal for national health insurance. In the House, only hospital construction survived (Poen 1979: chap. 6).

Although the health reformers of the Clinton administration did not face the conservative lineup of Truman's era, they did run into a surprisingly fierce counteroffensive against their proposed reforms—an offensive orchestrated nationally and in many congressional districts by small businesses, commercial insurance companies, and members of the Christian Coalition and other right-wing advocacy groups (Skocpol 1996: chap. 5; Johnson and Broder 1996). Back in 1949–50, the players were not exactly the same; but a similarly fierce attack unfolded. A massive public relations campaign launched by the American Medical Association (AMA)—then the key market actor with a stake in defeating national health insurance—linked Truman's proposal to growing public fears about socialism. Deploying more than $100 million on everything from national advertising to alarming pamphlets in doctors' waiting rooms, the AMA lobbying campaign was the most expensive and sophisticated in American political history (Poen 1979; Marmor 1973; Starr 1982).

The final blow to both Truman's and Clinton's health security campaigns was the midterm elections. Although Democrats in 1950 did not experience anything like the drubbing that befell Democrats after the failure of President Clinton's health plan, they did suffer substantial losses. The ranks of Truman's committed supporters in Congress were trimmed considerably, and among the electoral casualties were two cosponsors of the omnibus health bill that contained national health insurance (Poen 1979: 187). After 1950, Democratic proposals for universal government-guaranteed health insurance vanished from the political agenda for two decades. Today's Democrats appear similarly unwilling to revisit the ambitious reform proposals that opened the door for their defeat in the 1994 elections.

The two years since the demise of Clinton's Health Security effort have been marked by huge transformations in the private insurance and health care delivery systems—changes largely in the direction of cost cutting through managed care (Wines and Pear 1996). Despite the very different market arrangements of the late 1940s, the failure of the Truman reform effort also furthered major market changes. With the threat of national health insurance still vivid, private insurance companies teamed up with doctors and many large employers to expand employer-provided private health insurance. The big CIO unions made bargaining for worker health coverage a priority, and employers enjoyed tax advantages if they offered health benefits (Stevens 1988). For many full-time employed Americans, access to health insurance after 1950 came not through government-guaranteed health coverage, but through employer-provided private insurance, encouraged by subsidies in the federal tax code.

The political dynamics of the 1950s were also pushing toward expanded coverage and spending. Before the end of Truman's presidency in 1952, Congress passed important amendments to the Social Security Act funding state medical programs for recipients of public assistance. Truman's Republican successor, Dwight Eisenhower, oversaw the addition of disability insurance to Social Security, the extension of public medical provision to dependents of military personnel, the growth of government assistance for medical research, and the enactment of the 1960 Kerr-Mills program to help states pay for medical care for the elderly poor.

Meanwhile, a broader strategy was emerging among committed health reformers. Following the 1950 elections, Truman bowed to administration advisers who urged him to pursue a scaled-down reform proposal calling for federal hospital insurance for the elderly under Social Security (Poen 1979; Marmor 1973). Although Truman was not to see the fruits of this "incremental" strategy during his presidency, the proposal was kept alive into the 1960s by officials in the Social Security Administration (SSA) and by Democrats and their allies in organized labor. Year after year, Democratic advocates of public hospital insurance introduced bills in Congress and agitated quixotically on their behalf. This determined insurgent movement gained additional momentum in 1957 with the introduction of a revised old-age insurance bill strongly supported by the AFL-CIO. After the landslide Democratic victories of 1964, both federal hospital insurance and coverage for physician services were enacted as Medicare. At the same time, Congress replaced the Kerr-Mills program with a joint federal-state program for the poor known as Medicaid (Marmor 1973).

The New Politics of Reform

Will contemporary proponents of universal health coverage be able to follow the path blazed by reform advocates in the 1950s and turn successfully toward major incrementalist steps to expanded coverage? Perhaps, but probably not. The surface similarities between the Truman and Clinton episodes should not obscure the fundamental differences in government and politics between then and now. Harsh and bitter as the battle over Truman's proposal was, it ended in a fiscal and political climate that would be scarcely recognizable today. American medical care was expanding rapidly as government support increased and private health insurance spread. The feared postwar recession never materialized, and the American economy continued to grow at an unprecedented pace through the 1960s. The fiscal picture was also rosy: The huge deficits run up during the war were replaced with balanced and even surplus budgets in the following decades. Although Republicans and southern Democrats remained opposed to major new social insurance programs, they were quite willing to move partway toward reformers' positions and support scaled-down forms of government assistance, particularly when money was sprinkled widely across congressional districts. President Eisenhower and congressional conservatives tried to hold the line on New Deal programs. They did not try to roll them back.

Furthermore, the coalition in support of old-age insurance that formed in the wake of Truman's defeat was stable, cohesive, and united behind President Truman and his aims (Marmor 1973; Derthick 1979). Advocates of publicly guaranteed health insurance almost universally agreed that federal hospital insurance for the aged was the appropriate first step toward their larger goals. They had a strong base of administrative support within the SSA, and enjoyed close ties with leading congressional liberals and organized labor. They also benefited from high levels of public trust and confidence in government—and in the popular Social Security program in particular. Throughout the 1950s, and well into the 1970s, Social Security steadily expanded under bipartisan pressure, with sizable benefit increases in election years (Derthick 1979).

By the mid-1970s, however, this stable expansionary pattern of politics had been eclipsed by rising medical costs, growing budget deficits, and the worsening state of the American economy. Perhaps the most telling change was the reversal of the steady postwar increase in the prevalence of health insurance. From the 1940s on, the share of Americans with private or public health insurance moved constantly upward,

leveling off in the 1970s at approximately 85 percent. Since at least 1980, the proportion has dropped steadily, and the free fall shows no sign of stopping. Indeed, the decline in insurance coverage during the 1980s would have been even greater were it not for the significant Medicaid expansions enacted late in the decade (Levit, Olin, and Letsch 1992).

Yet the postwar expansion of private insurance was not the only trend that came to an end in the 1970s. In the troubled economic climate of the 1970s, government health programs collided with the costly medical sector they had helped construct, creating a volatile political mix. As federal health care spending exploded in the years after Medicare's passage, as the motive force of American health policy shifted from expansion to rationalization. Federal policy makers sought (with consistently limited success) to restrain the costs of the scattered set of public programs passed in the 1950s and 1960s (Brown 1983), while paying less and less heed to the lonely voices on the left still calling for expansionary reforms. The 1980s brought calls for full-scale retrenchment in the face of a burgeoning budget deficit and growing attacks on "out-of-control" entitlement programs like Medicare. Aided by the budget reconciliation process, Congress in 1982 and again in 1989 passed legislation to clamp down on Medicare payments to medical providers. These measures represented a sharp break with the open-ended spending and deference to professional authority that had characterized U.S. health policy in the past.

The shift from programmatic expansion to budgetary control may be the most important change in American health politics in the last two decades. Although budgetary constraints have certainly not halted the growth of public health insurance programs (which is in any case largely driven by general medical inflation), they have made such programs a central target of deficit-reduction efforts and strengthened the cause of those who wish to scale them back. Nearly every budget deal since 1981 has included sizable changes in the Medicare program designed to slow the program's growth. Medicaid has been the target of fewer retrenchment efforts, in part because the program's benefits eroded in the 1970s and were cut substantially in 1981 (Pierson 1994: 136–139). Indeed, notable expansions of Medicaid were enacted in every year between 1984 and 1990, though even with these expansions the ranks of the uninsured continued to grow. Still, Medicare and Medicaid now pay providers at rates below prevailing market levels, and the degree of financial protection offered by Medicare has declined markedly.

But if the budget deficit has not precipitated the dismantling of existing programs, it has placed a daunting barrier in the path of new pro-

grams, particularly since the introduction of new budget procedures in 1990. Under current budget rules, special procedural restrictions apply to legislative initiatives that the Congressional Budget Office (CBO) estimates will increase the deficit in any year subsequent to passage. President Clinton ran headlong into this harsh new fiscal reality when he began his reform effort in 1993 (White 1995).

More critical, perhaps, than the deficit itself have been the changes it has spurred in the strategies of conservative opponents of publicly funded health insurance. From the 1940s through the 1970s, opponents of government-led reforms could be counted on to offer private sector alternatives to national insurance proposals, and to work around the margins of existing public programs. By the end of the Truman administration, in fact, something of a reform consensus had emerged, not behind universal health insurance, of course, but behind incremental spending measures to expand the medical system and fill its most glaring gaps. Despite enduring differences, both reformers and their opponents agreed that medical care was not like other market goods, and that government had a responsibility to subsidize—and, when necessary, supplement—voluntary health insurance (Anderson 1968: 124–129).

This postwar consensus eroded in two stages. In the first, opponents of government-funded health insurance began to attack public programs indirectly as unrestrained budget busters that were spiraling out of fiscal control and imposing ever-larger tax burdens on the American public. Although President Ronald Reagan tiptoed around Medicare and Social Security in 1981, Medicaid was hit hard (Starr 1986). As the decade wore on and tax revenues failed to keep pace with rising spending on mandatory entitlement programs, the budget deficit emerged as the paramount domestic policy issue in American politics. In this austere fiscal climate, Medicare, Medicaid, and other nondiscretionary programs came under increasing attack as spendthrift entitlements that endangered America's productive capacity and threatened to bankrupt future generations. These complaints were voiced not just by conservatives opposed in principle to the welfare state, but also by moderate Democrats and Republicans who saw the deficit as a sign of political failure. And these sentiments were echoed by elites in the media, academia, and private think tanks who insistently asked why politicians did not take the "responsible" course of curbing runaway programs (White and Wildavsky 1989: 426–428).

The emergence of the deficit as a focal point for attacks on existing programs was only the prelude, however, to a far more portentous transformation of conservative strategy and rhetoric. In the years leading up

to the Republican victories of 1994, critics of the welfare state moved beyond indirect attacks on government programs as unrestrained entitlements to frontal assaults on the programs themselves. Deficit reduction was no longer an end in itself, but a means to creating a smaller, less intrusive, less costly government. As Paul Pierson emphasizes, the Republican budget of 1995 aimed less at fiscal redistribution than at structural reform of government's role and purpose. Republican leaders "sought nothing less than a radical reduction in the political capacities of the federal government" (Pierson in press).

The budget battle of 1995 also demonstrated that conservatives were no longer willing to accept the rationale and structure of existing government programs, cutting here and there but leaving basic principles intact. Far from trimming around the edges of the current social policy thicket, the 1995 Republican budget presented coherent, integrated alternatives to existing programs that rejected wholesale previous philosophical and programmatic foundations. First, and most straightforwardly, Republicans sought to reduce spending on existing programs and put in place policy changes—such as large reductions in future tax revenues—that would prevent spending from rising again. Central to this strategy was the enactment of a balanced budget amendment to the Constitution, which failed by a single vote in the Senate in 1995 and failed again in early 1997.

Second, where programs were jointly run by the federal government and the states, Republicans sought to move key elements of fiscal and programmatic authority to the state level, while retaining sufficient federal control to mandate requirements for benefits and eligibility. Third, wherever possible, Republicans attempted to put in place programmatic mechanisms that allowed beneficiaries of programs to use public funds to purchase private alternatives to government-provided services. The primary goal of these privatization mechanisms was not budgetary savings, but the movement of most Americans out of social insurance programs and into private plans.

All three elements of the Republican budget strategy were on display in the congressional leadership's 1995 proposals to restructure Medicare and Medicaid. On Medicare, the Republican plan aimed to achieve $270 billion in savings by 2002, an amount that significantly exceeded the funds needed to place Medicare's hospital insurance trust fund on firmer long-term footing (and that bore a politically crippling resemblance to the $245 billion in tax cuts contained in the Republican seven-year bud-

get plan). Yet the most important aspect of the Republican Medicare proposal was not the budget savings it proposed, but rather the profound structural changes in Medicare it envisioned. These changes included the broadening of the Medicare HMO option to include a range of managed care plans, the replacement of a guaranteed level of coverage with a fixed federal contribution to public and private policies, and the creation of tax-protected medical savings accounts (MSAs)—IRA-style accounts for the purchase of medical care (or, with a penalty, other goods), which are generally coupled with high-deductible insurance policies.

Although these features of the Republican proposal accounted for only a small share of the plan's $270 billion in total budgetary savings (the MSAs would in fact have *cost* $2 billion over seven years, according to the CBO), they posed a much more serious threat to the stability of the Medicare program than the proposal's reductions in payments to providers, which provided the bulk of the total savings. This is because spending on Medicare beneficiaries is extremely skewed: 10 percent of beneficiaries account for approximately 70 percent of program expenditures (see the discussion by Jonathan Oberlander in this issue). Because MSAs and other private options are most attractive to the healthiest of older Americans, the Republican proposal threatened to set off a vicious cycle of adverse selection, saddling Medicare's traditional fee-for-service component with the sickest and most expensive of Medicare beneficiaries while siphoning Medicare spending into private plans whose healthy subscribers currently cost Medicare close to nothing. If this scenario had come to pass, it would no doubt have strengthened Republican claims about the unsustainability of Medicare's fee-for-service program.

On Medicaid, the Republican goals were in many ways even more ambitious. Not only did Republican leaders seek to eliminate the federal entitlement to Medicaid, they also proposed converting the program into various "block grants" and devolving most of the authority to determine eligibility and program structure to the states. The Republican sweep of 1994 had installed a large new coterie of Republican state governors who were eager to exchange reduced federal funding for greater control over their Medicaid programs. Throwing Medicaid to the states promised, moreover, to spare Republicans from some of the political fallout major programmatic retrenchment might otherwise entail. Most important, Republicans expected that the states would relentlessly contain future program growth, lopping people off the Medicaid rolls and speedily mov-

ing program beneficiaries into private managed care plans. In fierce competition with one another for capital and skilled labor, states would be sharply constrained in their ability to finance programs for the needy and disadvantaged (Peterson 1995).

A New Breed of Republicans

Behind these ambitious proposals lies a historic transformation of Republican leadership and strategy. From the ashes of the 1992 defeat of George Bush, the conservative elements of the Republican Party forged a new and much more aggressive party agenda (Balz and Brownstein 1996). The political battles between congressional Republicans and President Clinton in 1993–94, particularly over the president's Health Security plan, vividly demonstrated to Republicans the power of denouncing taxation and government as the source of public anxiety and discontent. More than that, it provided the opening for activists within the party who ridiculed the mealy-mouthed Republican opposition of the past, symbolized among conservative Republicans by Bush's decision to abandon his no-new-taxes pledge during the 1990 budget summit. For more than a decade, the conservative wing of the Republican Party, led by House Republican Newt Gingrich, had been reaching out to like-minded lobbies and think tanks and setting up its own private organizations to disseminate ideas and recruit conservative congressional candidates. With the party in disarray after 1992, these allied forces became the backbone of a crusading movement within the party to capture the organs of national political power and inaugurate a new era of activist conservative governance.

The ascendance of Gingrich Republicanism was in equal parts a generational, regional, and ideological transformation. During the Truman administration, the South was still solidly Democratic, and the largest Republican contingents came from northern states like Pennsylvania, Illinois, and Ohio. Today, almost the opposite is true. After the 1994 elections, Republicans controlled the majority of southern seats in Congress, and the Republican Party itself was dominated by fiercely conservative southern Republicans (Elving 1996; Lind 1995). Although Republicans lost congressional seats nationwide in 1996, they continued to make strides in the South. Looking just at the House results, Republicans picked up a net total of thirty seats between the 1992 elections and the present: two in special elections, sixteen in the 1994 elections, four through conversions, and eight more in the 1996 elections. Over this

same period, Democrats gained no southern House seats, although they did lose and then regain four.

Gone also are most of the moderate midwestern and northeastern stalwarts of the Republican Party who had been content to work around the edges of the New Deal and Great Society. In the House after 1992, the Republican leadership was composed almost entirely of southern Gingrich acolytes, the only exception being minority leader Bob Michel, who announced he would retire at the end of 1994. House Republicans removed moderate Californian Jerry Lewis from the chairmanship of the Republican House Conference and replaced him with the brash and fiercely ideological Texan Dick Armey, a former college economics professor with an almost religious antigovernment fervor. Armey ascended to the majority leadership in 1994 and was joined by minority whip Tom DeLay, another Texan and an equally tough-minded conservative. In the Senate, Kansas Republican Bob Dole's continued presence as majority leader prevented a southern capture of the leadership in 1995. But Dole's departure from the Senate permitted the elevation of Mississippian Trent Lott to the majority leadership and of Oklahoman Don Nickles to the number-two spot. This solid southern lineup was "without precedent," displaying not only the South's "extraordinary domination of the top jobs in both chambers" (Elving 1996: 1730), but also the emergence of a new generation of conservative southern politicians with national perspectives and ambitions.

Ideologically, too, the current crop of Republicans is a very different breed from their counterparts of even a decade ago. In the 1960s and 1970s, and even through much of the 1980s, Republicans were satisfied to let Democrats set the social policy agenda, to slow rather than halt the expansion of the welfare state, and to strike compromise deals inside Washington with their Democratic colleagues. Today's Republicans are much more conservative and much more hostile to inside-the-Beltway bargains. They are also much more skilled in the tools of modern mass media politics: polls, focus groups, political advertising, talk radio, and targeted media appeals. And they are able to link such tactics to grassroots mobilization through the Christian Coalition, the National Federation of Independent Business, the National Rifle Association, and other conservative advocacy groups with a strong presence in congressional jurisdictions. Republicans fought the health care reform debate of 1994 and the budget battle of 1995 using all the weapons of contemporary political warfare, taking their message to the public with rhetoric carefully crafted through public opinion research, and mobilizing local pres-

sures on Congress throughout the South and West (Balz and Brownstein 1996).

Despite the tenacity with which Republican leaders have formulated their public pronouncements and the willingness they have shown to take on their opponents in the battle for public support, the contours of American public opinion may be the greatest barrier to the kinds of changes in public policy that the new Republican leadership envisions. A decade of experience with retrenchment initiatives both here and abroad suggests one unassailable truth about the politics of such reforms: The most popular proposals for deficit reduction are those that are never implemented. Americans may support a balanced budget in principle. They may see government as bloated, wasteful, and ineffective. But like citizens in all advanced industrial democracies, they express strong support for the universal social programs that make up the programmatic and fiscal core of the American welfare state. As a policy goal, budget balance has a weak and diffuse public constituency, whereas cuts in social programs impose direct and immediate losses to which service recipients and providers can easily respond. Every previous attempt at serious deficit reduction in the United States—in 1985, 1990, and 1993—has resulted in political losses for budget cutters (Pierson in press).

This was the dilemma Republican leaders faced in 1995. To unite deficit hawks and enthusiasts of tax cutting within the Republican Party, Republican leaders advanced a budget package with large tax cuts and correspondingly large reductions in future government spending. Some of these reductions could be obscured by phasing them in over a period of years, "backloading" them in the later years of the Republicans' seven-year plan, or focusing them on service providers like doctors and hospitals. The bulk of them, however, had to come directly from popular social programs, most notably Medicare. Although Republicans tried to concentrate these remaining cutbacks on core Democratic constituencies, particularly the poor, their proposals were inevitably quite threatening to the working poor and lower-middle-class Americans who had defected to the Republicans in droves in 1994 (Teixeira and Rogers 1995). President Clinton and congressional Democrats seized on these cuts in their politically devastating portrayal of Republicans as heartless plutocrats robbing from average Americans and senior citizens to give tax breaks to the rich (Drew 1996). After scores of Clinton vetoes and two government shutdowns, the Republican budget package was fatally wounded by early 1996, and Republicans were frantically trying to pass measures that would improve their dismal public standing. A telling sign of the effec-

tiveness of Democratic attacks was the decision by flagging Republican presidential candidate Bob Dole to embrace a supply-side tax reduction plan and pick Reaganite true believer Jack Kemp as his vice presidential running mate, thus effectively jettisoning his emphasis on a balanced budget during the home stretch of the 1996 presidential campaign.

The new terrain of U.S. health politics does not, therefore, guarantee conservative ascendance. Given the difficulties of moving bold new initiatives through the American legislative gauntlet and the fragility of public support for such proposals, proponents as well as opponents of comprehensive reform remain poised to block policy changes they dislike. Yet the tables are now far more tilted against reformers than they were in the wake of Truman's defeat. Whether today's health reformers can build the programmatic rationales and political coalitions necessary to return from the defeats of 1994 is the perhaps the most pressing question of the moment.

The Road Ahead

Five times in this century—during the Progressive Era, the New Deal, the 1940s, the 1970s, and the early 1990s—health reformers saw government-funded health insurance for working- and middle-class Americans slip from their grasp. Legislative campaigns that began with optimistic predictions about the inevitable enactment of national health insurance ended in despair. The reasons for special optimism in the early 1990s were numerous: a deteriorating health insurance market that increasingly hurt middle-income Americans, interest group dissatisfaction with the status quo, long-term institutional changes in Congress that decreased the power of conservative committee chairs, and, not least, the election of a unified Democratic government after twelve years of Republican presidential ascendancy (Peterson 1994). But these favorable conditions were not enough to overcome America's fragmented constitutional structure or the budgetary constraints and antigovernment sentiments that have come to characterize contemporary U.S. politics. Once again, reformers convinced that the United States would embark on the rational international path ran headlong into ideologically charged attacks, interest group opposition, and public skepticism about the capacities of government.

In the aftermath of defeat, it is tempting to conclude that the conditions for an incremental reform strategy are actually more propitious than they were when the Truman administration turned to the elderly in the

wake of the 1950 elections. After all, the negative trends in U.S. medical care that first prompted political concern are still with us, and the public continues to believe that health care reform should be a top policy priority (Wines and Pear 1996). President Clinton and congressional Democrats have rebounded from the depths of 1994, largely because of their impassioned defense of Medicare and other government programs. They have also been able to secure real, if modest, victories on traditional Democratic policy issues like the minimum wage, and they seem determined to continue moving incrementally forward on these fronts. In addition, the ongoing transformation of the private insurance market toward highly restrictive forms of managed care seems poised eventually to spark public demands for a reinvigorated government role in health care financing. Such a backlash has already emerged at the state level, and recently surfaced in national politics with the passage of federal legislation requiring insurers to provide at least two days of hospital coverage to women who have just given birth. President Clinton's recently christened advisory commission on the quality of health care, comically denounced by Republican leaders as a reincarnation of Clinton's vilified 1993 task force, is just one sign of the gathering political response to middle-class fears about managed care.

Yet consider the contrasts between Truman's day and the present. Then, health insurance was just beginning its long postwar expansion, American medical care was comparatively inexpensive, and the economy was growing at a rate far in excess of the anemic growth of the past two decades. Although there was a large wartime debt to retire, the budget deficit was hardly a concern, and politicians eagerly larded up bills with "particularized benefits" for their constituents back home (Mayhew 1974). President Truman faced stiff resistance from Republicans and southern Democrats, but by the end of the 1940s, neither camp was willing to challenge the programmatic legacy of the New Deal (Hamby 1973). Now, however, politicians with reformist intentions must confront an enormously costly medical system and the easily ignited fears of the more than eight in ten Americans with some form of health insurance. And they must do this in a fiscal and economic climate characterized by slow economic growth and persistent budgetary strain.

The political opposition to reform is also more formidable than ever. Today's leading Republicans advance initiatives to scale back government that, as Dick Armey proudly notes in his book *The Freedom Revolution*, "would have been dismissed as impractical" (Armey 1995: 285) even during the Reagan years. In the two years since 1994, conservatives

have shifted the terms of national political debate much farther to the right than their record of legislative accomplishment would suggest. Even if Democrats control Congress, the White House, or both in coming years, conservative Republicans will remain a formidable force in national politics by virtue of their strong southern base, their ties to grassroots conservative groups, and their willingness to use the Senate filibuster. Although forces of the left may make a comeback, American politics is likely to be driven by the Republican agenda of the last few years for some time to come.

Back in Truman's day, moreover, reformers occupied stable positions within the executive branch and worked in tandem with a labor movement at the zenith of its power. They largely agreed on the goals they were pursuing and the strategic means to achieve them. None of this is true today. President Clinton's discredited White House task force symbolized the long-term decline of administrative agencies as a source of policy initiatives (although, to be sure, executive branch officials did participate extensively in the Clinton working groups). Administrators of federal social programs have ceased to be the zealous program advocates that the SSA's heads were in the 1950s, when program executives allied with outside advocates to push for the expansion of Social Security and the creation of Medicare (Derthick 1979). Organized labor's share of the workforce has dropped precipitously since the 1940s and 1950s, especially within the private sector, and today's labor leaders face an uphill battle to rebuild the movement and protect the gains of the past, while formulating broader alliances on behalf of progressive economic and social programs.

Nor is there much agreement among the fragmented array of foundations, think tanks, and citizen groups that might make up an updated proreform coalition. As President Clinton's failed efforts at alliance formation in 1993 and 1994 painfully suggest, many of the groups that might be enlisted to support progressive reform proposals are mass-mailing organizations with limited grassroots presence and limited inclination to commit themselves fully to particular legislative initiatives (Skocpol 1996: chap. 3). These groups can be expected to coalesce in opposition to cutbacks in existing programs and to flex their muscles in Washington politics when their policy priorities are threatened. But they find it much more difficult to display the kind of unified front in support of positive goals that characterized the reform alliance of the 1950s and 1960s, much less to work at the local level to build stable majority coalitions from the ground up.

Perhaps the closest analogue to the Medicare strategy that exists today is represented by so-called kiddie-care proposals for covering all children. These proposals briefly appeared during the final hours of the Health Security plan's messy death in Congress, when they were endorsed by the *New York Times* and Senate liberals like Tom Harkin as a down payment toward the broader aims of reform. In the 105th Congress, Democratic leaders in both the House and the Senate have placed a high priority on the passage of some kind of kiddie-care scheme. President Clinton has also declared his support for expanded health insurance coverage for children, but his proposal to extend coverage to half of the ten million children who lack insurance falls short of what some Democratic congressional leaders would like to enact.

The kiddie-care approach quite consciously follows the Medicare strategy, focusing on a target population for which sympathy and concern can easily be raised. Today, nearly a quarter of the uninsured are children, a proportion that would be higher were it not for recent Medicaid expansions. Twenty percent of children are already insured by Medicaid, and the number is rising as private employers drop dependent coverage (U.S. General Accounting Office 1995). Children are also relatively inexpensive to insure, making them an ideal target group in today's straitened fiscal circumstances.

To hold down budgetary costs, however, most kiddie-care proposals attempt to target only uninsured children without affecting those who are currently insured by Medicaid or employment-based insurance arrangements. But fitting in a new federal initiative without modifying existing programs or employment-based insurance would be no small task. Moreover, the low medical expense of children notwithstanding, covering even a fraction of them would still require new federal budgetary commitments that have little chance of passage in the present antitax, antideficit climate on Capitol Hill. In the 1996 campaign, Democrats touted what they called a "families first" agenda, which included a proposal to require private insurers to offer kids-only policies that could not be discontinued when families moved or children became sick. Yet this initiative, like the rest of the families first agenda, was a modest mix of exhortations and regulatory gestures that steered well clear of promising new governmental resources for expanded insurance coverage.

A second incremental strategy—perhaps the most popular among those who still harbor hopes for comprehensive health care reform—turns away from the federal government and toward the states (Mashaw

1993–94). Although only Hawaii has come close to universal coverage, state-level insurance regulations and coverage expansions could allow some movement toward reform while national efforts remain stalled. Even if state efforts were modest, they would help many Americans who cannot currently obtain or afford health insurance, and they might even prod national employers and insurance conglomerates to demand encompassing federal standards.

But the political upheavals that brought Republicans into the congressional majority in 1994 also decisively moved the states into the Republican fold. Republicans now control nearly twice as many governorships as Democrats do—the highest ratio in the postwar era. At the state legislative level, Republicans made "striking" gains (Fiorina 1996: 139) in 1994 and suffered only minor losses in 1996 (Verhovek 1997). The states also face special barriers that the federal government does not, including limited resources, Employee Retirement Income Security Act (ERISA) restrictions, and fears of business outmigration. Finally, the experience at the state level so far has not been encouraging: Incremental movement toward coverage of the uninsured by states like Minnesota and Tennessee has been matched by dramatic backtracking by previous reform leaders like Washington State (Sparer 1996).

Health reformers at the federal level seem to have been left with one residual strategy: supporting modest insurance market reforms such as those contained in the Kassebaum-Kennedy bill, which was introduced in 1995 by Senators Nancy Kassebaum and Ted Kennedy. The original bill aimed to remove some of the barriers to insurance portability and continuity by limiting the use of preexisting medical condition exclusions and requiring insurers to continue covering workers even when they lose or change jobs. House Republicans, however, added several provisions that were more controversial—most notably tax-free MSAs, which could have the effect of undermining large private or public insurance pools, should they begin to spread in the U.S. health economy. The bill that was ultimately signed into law by President Clinton in 1996 included MSAs, but on an experimental basis and on a much smaller initial scale than Republicans had hoped.

It is easy to see why reform advocates would latch onto these minimal insurance regulations. After the stunning debacle of 1994, the only thing that advocates of reform appear to be able to agree on is that Democrats made a major mistake in not pushing for incremental steps toward universal coverage. Politicians find it irresistible to use regulations when tax revenues are unavailable, and the Kassebaum-Kennedy rules are delib-

erately designed to step ever so lightly on the toes of powerful stakeholders in the medical economy. Modest as these new regulations are, they have considerable public appeal and could ease the fears of millions of Americans who already have private insurance (Nadel 1995).

More hopes may be raised than met, however. Whatever the merits of insurance reforms, they will not do much for the uninsured, nor will they contain rising health care costs. Indeed, by forcing insurers to cover more people or more services, they could actually raise rates and cause low-income and young people to drop out of the insurance market altogether. Contrary to the claims of its supporters, the Kassebaum-Kennedy bill does not guarantee that workers will be able to retain health insurance when they lose or change jobs, for it does nothing to ensure that the jobless can afford coverage. Recognizing this, President Clinton has proposed a modest new initiative to fund state efforts to finance continuing coverage for the unemployed and their children. Attacked by Republicans as a risky new entitlement the costs of which could skyrocket during a recession, Clinton's proposal has also provoked worries among Democratic leaders in Congress, some of whom fear that health insurance for the unemployed could displace coverage for children on the increasingly crowded incremental reform agenda.

As a policy prescription, incrementalism has received little critical scrutiny. In policy discussions today, the term is used so loosely that it has come to encompass everything from minimal insurance market reforms to major steps toward universal coverage. If incrementalism is understood in the latter sense, as a steady step-by-step movement toward universal health insurance, perhaps there were crucial interim initiatives that President Clinton and his allies could have sponsored in 1993–94 instead of their unwieldy 1,342–page bill. But if incrementalism is understood, as it usually is, as marginal regulatory adjustments, then the argument that President Clinton should have embraced incremental reforms when he entered office in 1993 is both historically myopic and politically naive. The Clinton reform effort was launched with broad public support for universal coverage and a widespread perception among political insiders and the public that a major policy breakthrough was finally possible and desirable. President Clinton simply would not have been able to gain Democratic support in 1993 for small fixes in the insurance market to make life better mainly for already covered, middle-class employees. Even if he had received such support, he risked squandering a historic opportunity to do something substantial for millions of low-wage working Americans without health coverage. In 1993, there was a real possi-

bility, however slim, that middle-class concerns and the needs of many low-wage workers could be addressed simultaneously. This was an opportunity that Clinton and congressional Democrats were understandably reluctant to let pass.

Perhaps enlarged opportunities for comprehensive reform will emerge again. Popular commentators have proclaimed the coming of a new wave of progressivism in American political life, as the public reacts against a Republican policy agenda that many Americans see as divisive, mean-spirited, and tilted toward the well-off (Dionne 1996; Lind 1996). Although the economy is by most measures fairly healthy, Americans remain worried about their economic future and the continuing replacement of stable, full-time jobs with part-time and contingent positions that offer few fringe benefits. By most measures, Americans are as concerned about the availability of affordable health insurance today as they were before President Clinton launched his reform effort (Wines and Pear 1996). They also have new concerns about the practices and procedures of managed care plans. It is very possible that over the next couple of decades there will be repeated waves of public calls for regulatory reforms, fueled by middle-class anger about insurance company practices and managed care.

But these trends will not by themselves revive the extension of coverage to the growing ranks of the uninsured as a compelling political issue. Real movement toward universal coverage and systemic cost containment will require not only the recognition of problems and the support of a receptive public, but also the ascendance of reform-minded political majorities with the strategic acumen and organizational infrastructure to build public support for a particular policy remedy. In this regard, the results of the 1996 elections augur poorly for reformers. Despite delivering a chastening blow to conservative House Republicans (a blow that has been magnified by Speaker Gingrich's well-publicized ethical troubles), the elections do not suggest that the deep political dissensus on health care reform will disappear soon. If anything, the distance between the two parties has grown in the past four years, as old-style congressional moderates have retired or been defeated (Binder 1996). Although Republicans only narrowly retained their majority in the House, they enlarged their seat share to fifty-five in the Senate and are virtually assured of augmenting their House and Senate majorities in the 1998 midterm elections. Bipartisan celebration of incrementalism notwithstanding, there is little guarantee that the vast differences between the two parties on health care will be bridged in this context. If a health pol-

icy breakthrough does occur in the coming decades, it will occur because advocates of reform have rebuilt the case for government action more generally, confronting head-on the negative policy and political legacies reformers in 1993–94 were forced to surmount.

The immediate challenge for American health reformers is more straightforward: to safeguard and maintain existing public efforts in health care. In the 1950s and 1960s, reformers had little to lose. Few health policy programs existed, none with the reach and scope of Medicare and Medicaid. Today, popular and successful programs exist, but they are under increasing challenge. If reformers are to rebuild momentum toward universal coverage, they will need to invest political energy and capital in the reconstruction and improvement of such programs. Equally important, they will have to work with like-minded organizations and movements to construct an institutional infrastructure and public philosophy of government on which a renewed campaign for insurance reform could rest. Without this broader effort, sentiments in favor of comprehensive reform might resurface. But there would be little reason to expect movement in the direction of universal health insurance.

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