National Health Care Reform: An Idea Whose Time Came and Went

Jacob Hacker
Yale University

Abstract Despite extensive commentary on the failure of health care reform, little systematic analysis has addressed the question of why reform became a national political issue in the early 1990s. Drawing on studies of agenda setting and examining opinion surveys, media coverage, and various measures of congressional activity, I identify the major factors that pushed health care reform onto the government agenda and explore the relationships among them. These factors fall into three categories: the underlying structural changes in Congress and the interest group community that created a receptive climate for addressing health care reform; more immediate changes in the medical system, public opinion, media coverage, and the budgetary and political environments that increased attention to the issue; and a crucial political catalyst that thrust the issue to the top of the government agenda—-the 1991 victory of Harris Wofford in a special Senate race in Pennsylvania. A content analysis of media coverage of that election reveals that journalists and politicians rapidly interpreted Wofford's triumph as a sign of broad-based public support for reform. This widely shared interpretation redefined the political risks and benefits of health care reform, creating an opportunity for legislative action. Partly because of the way reform reached the government agenda, however, this window of opportunity was more fragile than many believed. My argument thus has implications not

Journal of Health Politics, Policy and Law, Vol. 21, No. 4, Winter 1996.

A modified version of this article appears as chapter 1 in my book *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security*, to be published by Princeton University Press in January 1997.

For helpful comments on the manuscript, I am grateful to Frank Baumgartner, Andrew Martin, David Mayhew, Theodore Marmor, James Morone, Mark Peterson, Theda Skocpol, Peter Stern, and two anonymous reviewers. I owe a special debt to my wife, Oona Hathaway, for her assistance, support, and boundless patience. Finally, I thank the Robert Wood Johnson Foundation, the Thomas Temple Hoopes Prize Fund, the Harvard Institute of Politics, and the Ford Foundation for providing research funds.

only for agenda-setting research but also for the failure of national health legislation and the future possibilities for reform.

In September 1994, Senate Majority Leader George Mitchell announced to the nation what most close observers of the health care reform debate already knew: Comprehensive health care reform was dead—-for the 103d Congress and probably for years to come. Any remaining doubts about the fate of reform were decisively laid to rest by the 1994 midterm election. Republicans swept state and federal races nationwide, capturing not only the Senate but also, for the first time in forty years, the House. Far from being punished for challenging President Bill Clinton's ambitious proposal for national health care reform, the Republicans did not lose a single congressional seat. Meanwhile, Harris Wofford—the Pennsylvania Democratic senator whose unlikely victory in a 1991 special Senate race became a symbol for the health reform movement—was defeated by a brash young conservative who asked voters to ensure that Wofford's "health care reform plan, now dead, be buried permanently" (quoted in Russakoff 1994: 12). National postelection polls showed widespread disenchantment with Washington, with President Clinton, and, among an important minority of voters, with the president's "big government solution" to the problems in health care (Skocpol 1995: 67). After the election, gleeful House Republicans vowed to spend the first one hundred days of the new Congress enacting their "Contract with America," a campaign manifesto that makes no reference to the issue of health care reform (Gillespie and Shellhas 1994).

In the wake of this dramatic reversal, a throng of journalists and scholars is sifting through the historical rubble to try to explain why another seemingly promising attempt at national health care reform failed so quickly and completely. Yet the recent health care debate raises another question, one that seems particularly relevant in light of the dismal fate that the president's reform proposal and all competing proposals have met: Why did health care reform appear on the national political agenda in the early 1990s? After all, even the most casual observer of the recent debate must have wondered why, given the chilly reception that the president's proposal received on Capitol Hill, any politician would have staked his or her reputation, much less the presidency, on the achievement of substantial reform. But the puzzle goes even deeper. For not only Bill Clinton but every Democratic candidate, as well as former President George Bush, advocated health care reform during the 1992 presidential campaign. Indeed, by early 1992 comprehensive health care reform was

an idea whose political time had seemingly come. Now that its time has past, at least for the foreseeable future, it is worth understanding how and why it reached the national political agenda in the first place.

To some, of course, this question may appear too obvious to require examination. Opponents of health care reform are convinced that liberal do-gooders in the White House, Congress, and the major media outlets forced health care reform onto the national agenda by conjuring up a false crisis (Kristol 1993; Stelzer 1994). To them, the demise of the Clinton plan offers ringing proof that the health care crisis was a fiction promulgated by liberal elites and that most of the American public never really wanted fundamental reform.

Proponents of health care reform, on the other hand, are equally certain they know why reform became a national issue in the early 1990s: Americans from all walks of life grew increasingly dissatisfied with a medical system that was daily becoming more expensive, unreliable, and inhumane, and they rose up and demanded change. This has also been the answer favored by academics and policy experts, who have widely attributed the rise of health care reform to the deterioration of American medical care and to the attendant amplification of public discontent (see, for example, Aaron 1991; Jacobs 1994: 386–388; Kingdon 1995: 217–218).

Yet neither of these obvious explanations for the rise of health care reform will suffice. Contrary to the claim that advocates of health care reform deviously manipulated the public, overwhelming evidence indicates that public support for health care reform increased markedly during the 1980s in response to very real problems in the medical system. Indeed, public support increased before either the news media or national policy makers began to address the subject in earnest. The evidence is far more congruent with the second argument—that the problems in American medicine and the resulting public discontent forced policy makers to address the subject. Even so, this explanation does not account for the timing of the government response. Most of the negative trends in American medicine—health care costs rising faster than inflation, declining rates of insurance coverage—are long-standing and did not accelerate substantially in the late 1980s or early 1990s. The real growth in per capita health care costs was slightly greater in 1991 than in previous years, but the difference was hardly a blip in historical terms (calculated from data reported in Congressional Budget Office [CBO] 1993). The number of insured Americans increased almost monotonically throughout the decade, with the fastest growth apparently occurring in the early

years of the Reagan administration, when no one believed that universal health insurance was possible.[1] And although public support for health care reform clearly increased in the late 1980s, the question remains why that increase became politically consequential in the 1990s.

Several decades of research on agenda setting suggest why a "problem-driven" account of health care reform's rise on the government agenda is insufficient.[2] According to agenda-setting theorists, adverse conditions in society do not inherently become the subject of government attention. Not only must they be recognized by government officials but, as Deborah Stone (1989) argues, they also must be understood as problems that are amenable to human action. Even when problems are widely recognized, however, government officials may not try to address them. Problems may not be seen as the proper responsibility of government, or they may not be seen as sufficiently urgent or politically rewarding to displace the many other issues that capture policy makers' attention. In short, problems are not self-evident, and their elevation on the government agenda depends as much on policy interpretations and political opportunities as on their "objective" severity.

My aim is to explain why interpretations and opportunities conducive to a legislative effort on health care reform came together in the early 1990s to push the issue to the forefront of the national political agenda. The answer is complex, involving multiple interactions among the public, the media, and national policy makers. Nonetheless, we can separate the underlying factors that created a receptive climate for addressing health care reform from the proximate factors that pushed the issue to

1. I say "apparently" because estimates of the number of uninsured Americans differ and the wording of the relevant questions on the Current Population Survey changed in 1988. Excluding the children who were counted as insured because of the 1988 addition of new "cover sheet" questions eliminates some of the inconsistencies between the earlier and later survey results. Calculated thus, the number of uninsured increased by 6.5 percent between 1982 and 1983 and by 7.1 percent between 1983 and 1984, but only by 3.3 percent between 1989 and 1990 and by 4.2 percent between 1990 and 1991. (Calculated from data in Levit et al. 1992 and Employee Benefit Research Institute 1993.) See also Swartz 1994 and Employee Benefit Research Institute 1993.

2. Notable studies of agenda setting include Kingdon 1984, 1995; Baumgartner and Jones 1991, 1993; Baumgartner 1989; Stone 1989; Nelson 1984; Polsby 1984; Cobb and Elder 1983; Walker 1977; and Downs 1972. Public choice theorists such as Riker (1986, 1993) have also analyzed agenda setting, although they generally explore how manipulation of the alternatives affects social choices, not how issues and alternatives emerge in the first place. In addition, a large body of literature examines media agenda setting—the effect of the news media on the issue priorities of the mass public. Good reviews of this literature can be found in Iyengar and Kinder 1987 and McCombs and Shaw 1993. Throughout this article, I use the terms *government agenda, political agenda*, and *national political agenda* interchangeably to refer to "the list of subjects to which governmental officials and those around them are paying serious attention" (Kingdon 1984: 4).

the political foreground. And it is also possible to separate both these sets of factors from the crucial "focusing event" (Kingdon 1984) that redefined the issue and thrust it to the top of the national political agenda—the 1991 victory of the pro-reform Democrat Harris Wofford in a special Senate election in Pennsylvania. Many observers have recognized the importance of this election in raising political interest in health care reform (see, for example, Skocpol 1994: 67–68; Marmor 1994; Peterson 1992b). I go beyond these accounts by tracing the political and media response to the election to show how Wofford's triumph came to be seen as a symbol of broad-based public support for national health care reform.

I begin by describing Wofford's unexpected victory in Pennsylvania's special Senate race. I then travel back in time to examine the key changes that occurred in the medical sector during the 1980s and the effects those changes had on public opinion about health care. In this context, I explore the role the news media played in focusing public and political attention on health care reform and conclude that the media accelerated the political momentum toward reform but did not create it. Next, I amass as much evidence as possible to trace the movement of health care reform onto the congressional agenda in the 1980s and early 1990s. The evidence suggests two trends: a gravitation toward issues surrounding health policy beginning in the late 1980s and a sudden increase in attention to national health care reform in 1991 and 1992. With this empirical baseline established, I offer explanations for these dual trends, first highlighting the short- and long-term factors that increased congressional attention to health care reform and then focusing on the interpretations of the Wofford election that appeared in the news media. Finally, I draw out some of the broader lessons of my account for our understanding of the failure of health care reform and the future possibilities for reform.

The Pennsylvania Phenomenon

In many ways, the blossoming of the recent debate about health care reform can be linked to a fateful decision made in the summer of 1991. In early August, Harris Wofford's advisers gathered in Philadelphia to discuss the future of his senatorial campaign. The special election, only three months away, promised almost certain defeat for the little-known Democratic senator—and certain victory for his seasoned Republican opponent, former Pennsylvania Governor and former U.S. Attorney General Richard Thornburgh. Just months earlier, Wofford had been

appointed to the Senate by Governor Robert Casey after the untimely death of the Republican incumbent, John Heinz. At this point, surveys of the Pennsylvania electorate showed the liberal intellectual approximately 40 percentage points behind Thornburgh, validating the prevailing consensus that Wofford's brief tenure in the Senate would soon end.

To those meeting in Philadelphia, however, the race was far from over. In addition to Wofford, the conference room contained the two principal architects of the campaign, James Carville and Paul Begala; the campaign's pollster, Mike Donilan; and several other campaign aides. Donilan distributed the findings of a two-question survey he had conducted to assess voters' feelings about national health insurance, a policy issue that Wofford had been emphasizing in his campaign. The two questions were nearly identical. Each asked respondents to choose between Wofford and Thornburgh on the basis of a brief list of each candidate's qualifications. The second question, however, included a single caveat: Wofford wanted to enact national health insurance; Thornburgh did not. By more than a three-to-one ratio, voters asked the first question preferred Thornburgh. When national health insurance was mentioned, however, the relative position of the two candidates dramatically reversed, with Wofford skyrocketing from more than a forty-point deficit in the polls to nearly a ten-point lead. As Begala would later tell reporters, national health care reform was the policy issue that could "turn goat spit into gasoline" (quoted in Reynolds 1992).

The importance of Donilan's poll was not lost on Carville, who argued vigorously for making national health care reform the central theme of the campaign. As one participant in the meeting recounted, Carville saw the issue as the only real way to recapture the race: "Carville said, 'I don't think we can win this election any other way. We don't have a hope in hell against [Thornburgh] with the time we have, the name recognition we have, and the money we have. [National health care reform] is what we have, and it's definitely the long bomb, the hail Mary. But it's a pretty damn good hail Mary' " (Gabe Kaplan, interview with author, 17 August 1993).

The others in attendance agreed. Wofford would campaign on national health care reform.

Wofford won the Senate race with a startling 55 percent of the vote, a landslide by Pennsylvania standards. But it was how he won that was truly remarkable. Seemingly overnight, health care reform was an issue that captured votes. Postelection polls revealed that for one-half of Pennsylvania's voters "national health insurance" was among the two most

pressing concerns reflected in their voting decision; for almost one-quarter of voters it was the primary concern (Blendon et al. 1992). Although national health insurance was expected to appeal to the low-income residents of the Rust Belt and Appalachian portions of the state, Wofford also defeated Thornburgh in Philadelphia's suburban counties, where no fewer than two-thirds of the residents were registered Republicans. Furthermore, he performed much better than expected in the overwhelmingly Republican regions of northeastern Pennsylvania and made sizable inroads among the state's most loyal Republicans, the Pennsylvania Germans (Lewis 1992). The message of the election seemed clear: No candidate could afford to appear indifferent to an issue of such broad public concern.

The Pennsylvania election was not the first instance when this issue surfaced on the American political agenda. Comprehensive health care reform received widespread attention at many other points in American history: during the Progressive Era and the New Deal; under Presidents Truman, Kennedy, and Johnson; and in the 1970s. In none of these periods, however, did public pressure for reform play a critical role in spurring political leaders to action. In the Progressive Era, reformers looked not to the public for inspiration but to the social policies of Germany and Britain. During the New Deal, the Truman years, and the 1960s, the impetus for reform largely came from within the executive branch. And although attention to health care reform was more widespread in the 1970s, it was still primarily the province of national political leaders, labor unions, and interest groups.

Viewed in this light, the public discontent manifested in the Pennsylvania election begs an explanation. Why was Wofford's campaign strategy so effective? To answer this question, we must understand how a medical system that once muted middle-class concerns became the source of widespread public dissatisfaction.

Things Fall Apart

With the massive growth in private insurance coverage after World War II and the passage of Medicare and Medicaid in 1965, the task of mobilizing broad popular support for universal health insurance became deeply problematic. Most Americans were now covered by private and public health insurance, and most were largely unaware of its true cost because they paid for it through discreet tax increases and slower real-wage growth. Beginning in the early 1970s, however, the rate of increase

in real wages decelerated and inflation in the medical sector accelerated. As a result, premiums for employer-provided health insurance began to absorb a higher percentage of the growth in real wages. Indeed, from 1973 to 1989, health insurance premiums paid by employers accounted for more than one-half the increase in real total compensation per full-time employee (CBO 1992: 5).

The cost of health insurance to working Americans also became more visible. Starting in the late 1970s, many corporations tried to transfer the growing burden of medical spending to workers. This shift first took the form of insurance deductibles: Between 1979 and 1984, the percentage of large corporations requiring their employees to pay deductibles increased almost four times, from 14 to 52 percent (Bergthold 1990: 34). Shifting costs from employers to workers provided only temporary relief, however, and business began to search for new ways to moderate medical inflation. The simplest solution, of course, was to stop offering insurance altogether, which many new entrants and small firms did, especially in the growing service and retail sectors of the economy. For larger employers, eliminating or reducing dependent coverage became more attractive. Many larger firms also began to pay employee claims themselves, thus limiting the extent to which they subsidized the health expenses of other firms' employees. Under the terms of the 1974 Employee Retirement Income Security Act, self-insurance held the additional attraction of exempting firms from state taxes on insurance premiums and state-mandated medical benefits.

The increasing cost sensitivity of employers also further encouraged, sometimes inadvertently, a whole series of trends already under way in insurance marketing and claims management. First among them was the new vigor with which private insurers were seeking employer groups with lower-than-average health costs. Until the end of World War II, subscribers in a given geographic region generally paid the same "community" rate for group policies. This was the prevailing practice, for example, among the nonprofit Blue Cross/Blue Shield plans that dominated the group insurance market until the 1950s. In the early postwar period, however, smaller commercial insurers began to enter the insurance market, undercutting the Blues by offering low-risk groups less-expensive policies. By matching premiums to the expected actuarial risk of subscribers, a practice known as "experience rating," commercial insurers eliminated many of the cross-subsidies—from healthy to ill and from young to old—inherent in community rating. Soon the Blues were experience rating, too.

Experience rating runs counter to the goal of social insurance, which is

to spread risk across the whole of society (Stone 1993). Taken to its natural extreme, the logic of experience rating would have left many persons with greater health risks unable to afford insurance at all. Yet the early effect of experience rating was moderated by two factors: Health insurance was for most firms still an incidental expense, and insurers could not predict actuarial risk with any real accuracy. Beginning in the 1970s, however, all that changed. Strapped by rising medical costs, employers began to seek less-expensive insurance policies, and, responding to their pleas, private insurers refined their methods for rating employer groups and avoiding persons with the greatest health risks.

As more firms self-insured, moreover, the market for private insurance began to shrink. By 1988, most of the financial risk of insuring employees had shifted from insurance companies to employers (Thorpe 1992). In general, firms that failed to self-insure did not have enough employees to pool the risk of illness or injury. Compared with large employers, these firms were characterized by higher levels of employee turnover, more variable workforce health, and lower rates of insurance coverage. As the insurance market contracted and fragmented, therefore, rates of coverage among employer groups grew more uneven and the degree of uncertainty surrounding the health and tenure of employees increased. In this environment, the ability of insurers to accurately predict the cost of potential subscribers became crucial. If insurers had accepted all firms on an equal basis, firms that expected to incur higher than average health costs would have been more likely to purchase coverage than would those that did not. To prevent such "adverse selection," insurers resorted to increasingly sophisticated forms of underwriting to screen or limit the coverage of costly, high-risk applicants.

A final important trend that was encouraged by employers in the 1980s was the movement by insurers away from traditional indemnity plans and toward managed care. Before the passage of the Health Maintenance Organization (HMO) Act of 1973, the Nixon administration predicted that sixteen hundred new health maintenance organizations would be created by 1980, with 20 percent of the public enrolled (Starr 1976). Even accounting for the contradictory design of the HMO legislation, these expectations were wildly unrealistic. Indeed, when federal start-up grants for HMOs were curtailed in 1981, the actual number of HMOs fell far short of the Nixon administration's goal. If the 1970s was a decade of unrealized expectations, however, the 1980s brought unprecedented growth. By 1991, more than five hundred HMOs were operating in the United States, with a total enrollment of nearly 40 million persons (Merlis 1993).

Proliferating even more rapidly were more loosely organized systems of managed care, such as preferred provider organizations and point-of-service plans. With employers demanding lower premiums, even fee-for-service insurance plans rushed to adopt the cost-management mechanisms pioneered by managed care. Utilization review techniques, such as the requirement that patients receive an insurer's authorization before being admitted to a hospital, quickly became part of the standard operating procedure of claims management. Although physicians complained loudly about the growing encroachments on their clinical autonomy, utilization review held out the promise of one-time cost savings, a prospect that few employers could pass up. By 1990, only 5 percent of workers in the United States remained in plans with no utilization management, a decrease from more than 40 percent in 1987 (Starr 1992).

Partly as a result of these trends, and partly due to cutbacks in Medicaid, the number of uninsured persons increased steeply during the 1980s, leaving an estimated thirty-six million Americans without health insurance in 1991 (Employee Benefit Research Institute 1993). Among the poor, the decline in coverage reversed somewhat in the late 1980s when Medicaid was expanded under federal legislation. Nonetheless, the uninsured still came predominantly from low-income families. The majority of these families were headed by workers, who were generally self-employed or worked for small companies. In a political sense, however, the uninsured hardly formed a group at all. They were faceless and quiescent, without common ties or identification, and more than one-quarter were children. So the growing number of uninsured could not by itself be expected to spur political leaders to action. Something more was needed to create substantial public pressure for national health care reform. As it turned out, that something was the intrusion of rising health care costs into the medical security of the middle class.

The Middle Class and National Health Reform

In the summer of 1991, as Harris Wofford climbed back from his early deficit in the polls, James Carville read an article in *Harper's* magazine that immediately caught his attention. Its author was Paul Starr, a Princeton sociologist and author of the Pulitzer prize-winning book, *The Social Transformation of American Medicine*. Entitled "The Middle Class and National Health Reform," the article was a reprint of a short

piece that Starr had written for *The American Prospect*, the liberal journal he coedits.

For years Starr had lamented that reformers in the United States would never be able to overcome the formidable roadblocks to national health insurance. Now, however, he saw new possibilities. Although serious political obstacles remained, "the underlying pressures for the adoption of national health care reform in the 1990s" were stronger than they had been "for decades" (1991: 7). The reason, claimed Starr, was the "increasing jeopardy of the middle class" (p. 8).

In the past, Starr argued, "advocates of universal insurance, like advocates of so many other liberal policies since the 1960s, found themselves. . . appealing to middle-class voters to support change, not for their own good, but for the benefit of a minority—and a hazily defined, politically inaudible minority at that. . . . To the middle-class taxpayer, even the family of the unionized worker, or the elderly protected by Medicare, national health insurance seemed to promise too little for too much" (p. 8).

This was no longer the case, Starr claimed. The efforts of employers to control costs and of insurers to exclude persons with greater health risks were "undoing some of the middle-class insulation from health costs that made it so difficult to construct an alliance for health insurance reform across class lines." Thus health care reform could become the Democrats' "best campaign issue in the nineties" (1991: 9–10).

For obvious reasons, Carville found Starr's thesis persuasive. He called one of Wofford's legislative assistants and ordered him to "get Wofford together with this guy." In early October, Wofford and Starr met at the senator's home in Pennsylvania, and for most of the day they drifted through the house together, chatting about health care reform and its role in the campaign. According to one campaign aide, "They both saw very much eye to eye" (Gabe Kaplan, interview with author, 17 August 1993).

Starr and Wofford were not mind readers of the middle class. It was no secret that public discontent with the cost of health care and the vagaries of insurance coverage was substantial and growing. The percentage of Americans who believed that American health care needed to be fundamentally changed or completely rebuilt increased steadily in the late 1980s, exceeding 90 percent in November 1991 (Thomas 1992). What Starr and Wofford recognized, however, was a subtle but important shift in the character of public opinion. This shift involved not only an increase in overall public support for reform but also a growing conver-

gence of opinion among Americans of diverse viewpoints, circumstances, and characteristics.

Like public opinion about other major policy issues, general public sentiments about health care have remained relatively constant in the last half-century (Page and Shapiro 1992). Support for medical spending and for the government to "do more" on health care, for example, has been consistently high, with large majorities (60 to 80 percent) favoring increased government spending and assistance. Along with public support for other government initiatives, enthusiasm for government spending on medical care reached a low point between the mid-1970s and the early 1980s, as the economy soured and antigovernment sentiments prevailed. Unlike other domestic programs, however, health care programs rapidly regained public support during the 1980s. By 1987, they were even slightly more popular than they had been in the mid-1970s. Interestingly, neither programs targeted to the poor nor general domestic programs regained the levels of public support they had enjoyed in the 1970s. Indeed, after examining national polling data collected between 1975 and 1989, Mark Schlesinger and Taeku Lee conclude that "only for health care have Americans become distinctly more supportive of government in the late-1980s than in the mid-1970s" (1994: 315).

Why did government involvement in health care become more popular relative to other government initiatives? The most probable answer is that health care, compared with other domestic policy priorities, became less socially divisive between the mid-1970s and the late 1980s. Although support for government involvement in medical care varies by a person's income, age, education, gender, race, and degree of political involvement, these differences are substantially smaller for health care than for other types of government policy and may, in fact, have narrowed slightly in the past fifteen years. More important, federal health initiatives do not evoke the same negative public association as do other redistributive policies, such as antipoverty programs. They are not strongly identified with racial minorities or with the economically disadvantaged, and federal involvement in health care does not appear to be linked in the public's mind to a wider role for government in other areas of American society (Schlesinger and Lee 1994: 315–317).

As Figure 1 shows, the convergence of public opinion during the 1980s was accompanied by a sharp increase in public dissatisfaction with existing health care arrangements. The rise was particularly swift after 1989, presumably because of the economic downturn that began that year and

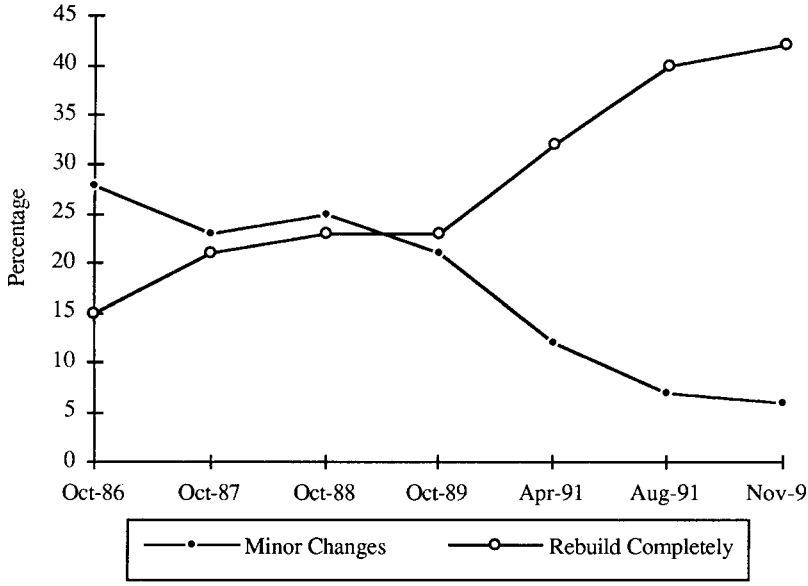

Figure 1 The percentage of Americans who said the American health care system needs to be completely rebuilt versus the percentage who said only minor changes are needed, for the years 1986 to 1991. Source: Thomas 1992: 10.

continued into the early 1990s.[3] In the two years between October 1989 and November 1991, for example, the percentage of Americans who believed the system needed complete restructuring increased from 23 to 42 percent, while the percentage advocating minor changes decreased from 21 to 6 percent. All told, by November 1991 more than 90 percent of Americans believed the health care system needed to be fundamentally changed or completely rebuilt—approximately 20 percent more than had felt that way two years earlier.

Although these figures are impressive, it is not entirely clear what they

3. I am aware that economists locate the official beginning of the national economic recession, defined as six months or more of contracting domestic economic output, between June and September 1990. Yet sluggish economic growth began before 1990, and in many regions of the country, including Pennsylvania, the economic downturn started earlier and accelerated faster than it did at the national level (Uchitelle 1990). I know of no studies that try to explain the sharp rise in public discontent reflected in polls in the late 1980s. But according to the public opinion data assembled by Schlesinger and Lee (1994: 364), all the factors associated with economic slumps—unemployment, disenchantment with the business community, and economic anxiety—tend to increase public support for government involvement in health care, both in absolute terms and relative to other domestic initiatives.

mean in programmatic terms. Certainly they indicate widespread public discontent and general support for policy change. But other survey evidence reveals greater public ambivalence. For example, although Americans expressed dissatisfaction with the medical system as a whole, they remained overwhelmingly satisfied with the quality and accessibility—if not the cost—of the medical care they and their families received. In addition, the extent to which Americans were willing to sacrifice to enable reform remained unclear. Although most Americans supported an expansion of coverage to the uninsured, opinion surveys showed limited public support for restrictions on personal medical care decisions or increased taxation to fund reform (Blendon et al. 1994; Jacobs and Shapiro 1994b). Moreover, the public remained ambivalent about the proper role for government in a reformed system: Polls indicated that Americans were convinced that government had to be part of the solution but at the same time were fearful that it would botch the effort (Jacobs 1994: 376–383).

Finally, public dissatisfaction with the status quo did not embody anything approaching a latent public consensus about the direction reform should take. In opinion surveys, many Americans appeared ready to embrace any alternative to present insurance arrangements, including a national health insurance system funded through taxes. But when respondents were asked to choose among competing reform approaches, support tended to split fairly evenly among the alternatives, with levels of support varying greatly with the wording of the survey question.

In sum, although many Americans were anxious about the security of their

health care arrangements, few understood the major options for reform being considered by policy makers or the trade-offs those options might entail. What emerged in the late 1980s and found expression in Wofford's stunning upset victory was a negative "public judgment" about a system of health care finance that most Americans found badly wanting (Yankelovich 1991). A corresponding positive judgment about the direction reform should take would prove far more difficult for policy makers and the public to reach.

Media Coverage of Health Care Reform

What role did the media play in drawing public and political attention to health care reform? Since Maxwell McCombs and Donald Shaw (1972) first examined the "agenda-setting function of mass media" in the 1968

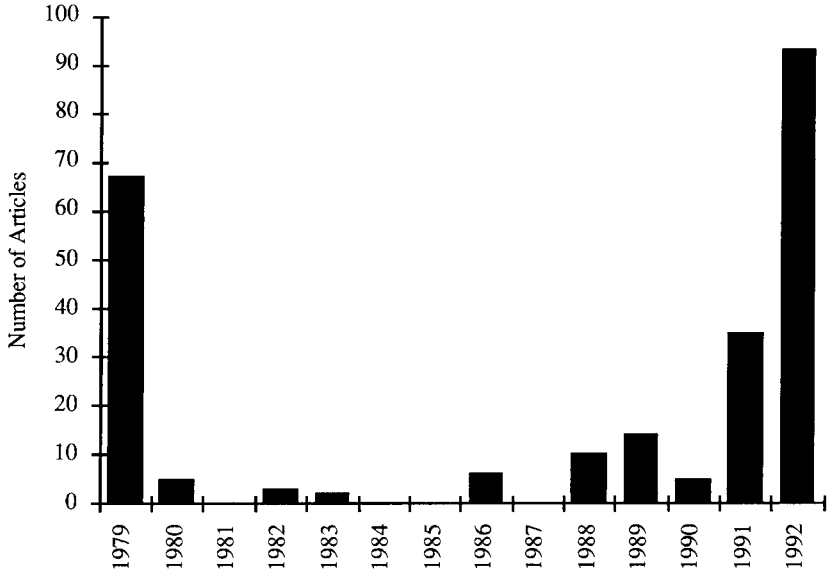

Figure 2 The number of articles in the *Christian Science Monitor*, the *New York Times*, and the *Wall Street Journal* that mentioned "health/medical care reform" or "national health insurance," for the years 1979 to 1992.

presidential campaign, communications researchers have demonstrated conclusively that the media affect citizens' perceptions of issue importance (Iyengar and Kinder 1987; McCombs and Shaw 1993). There is also reason to believe that policy makers rely on the media for their assessment of public concerns (Cook et al. 1983). Whether the media amplify the effects of other political actors or actively try to set the government agenda themselves, they can play an important role in raising public awareness about policy issues.

Media coverage of health care reform was almost nonexistent through the 1980s. Between 1980 and 1990, for example, three of the most widely read national newspapers—the *Christian Science Monitor*, the *New York Times*, and the *Wall Street Journal*—published a total of forty stories on health care reform or national health insurance. In not one of these years were more than fourteen stories printed, and in four years—1981, 1984, 1985, and 1987–there was no coverage of the issue at all. These figures stand in stark contrast to the last year of reform activity, 1979, when nearly seventy articles appeared in these three newspapers. As Figure 2

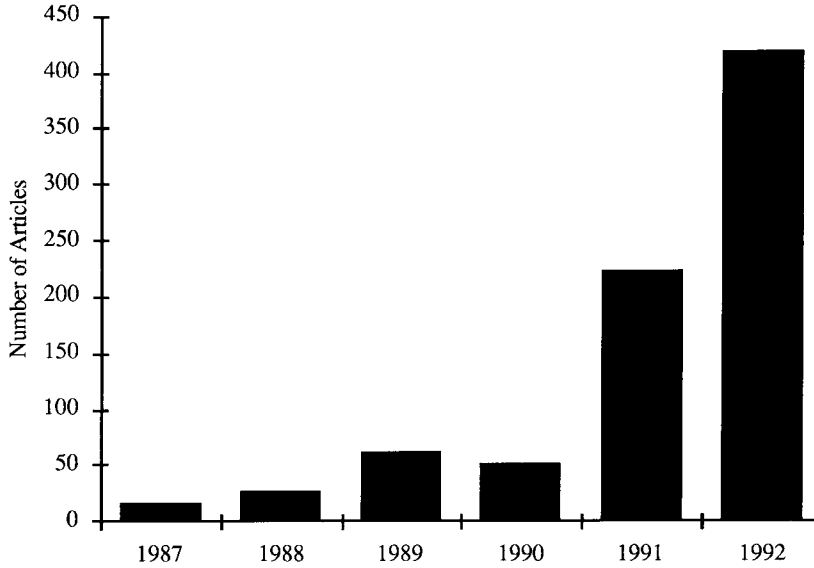

Figure 3 The number of articles in the *Atlanta Constitution/Journal*, the *Boston Globe*, the *Chicago Tribune*, the *Christian Science Monitor*, the *Los Angeles Times*, the *New York Times*, the *Wall Street Journal*, and the *Washington Post* that mentioned "health/medical care reform," for the years 1987 to 1992.

shows, the total number of articles increased slightly in the latter half of the 1980s, but the real expansion occurred in 1991, as the total number of articles increased from five to thirty-five, only to be followed by another more dramatic rise in 1992 as the number of articles totaled ninety-three.

These trends become clearer when we focus on the six years between 1987 and 1993 and expand the pool of newspapers. Figure 3 shows the number of articles mentioning health care reform that appeared in eight widely read newspapers between 1987 and 1992. As before, print media attention decreased slightly in 1990, followed by surges of coverage in 1991 and 1992.

Juxtaposed with the public opinion data presented in the last section and Wofford's victory in 1991, these trends suggest that the press was reacting to political events and that the increase in public discontent predated the rise in media coverage. On the other hand, public recognition of health care as a national problem clearly responded to the proliferation of media coverage. The ranking of health care on the Gallup Organization's "most important problem" list climbed sharply in the early

1990s. Although Gallup has asked this question since 1935, the first time health care appeared on the list was 1990, when 1 percent of Americans cited it as the most important problem facing the country. This proportion increased to 6 percent in 1991, to 12 percent in 1992, and to 28 percent in 1993 (Gallup 1991, 1992, 1993, 1994).

Identifying the exact causal process at work here is difficult because public

opinion, media coverage, and policy making influence one another. The concept of media agenda setting implies a one-way causal process whereby media coverage (the independent variable) changes public issue priorities (the dependent variable). Yet, as Everett Rogers and James Dearing (1988) argue, "there is undoubtedly a two-way, mutually dependent relationship between the public agenda and the media agenda in the agenda-setting process" (p. 571). Similarly, there is clearly an interactive relationship between journalists and policy makers. The great bulk of domestic news stories focus on people in government (Gans 1979), and media outlets are an important vehicle by which policy makers draw public attention to new policy issues (Walker 1977). At the same time, because people in government demand timely political feedback, journalists often become "stand-ins" for the national constituency (Gans 1979: 292), shaping policy makers' perceptions of the prevailing "national mood" (Kingdon 1984: 153–157).

The multiple paths of influence that connect the public, news media, and policy makers can make tracing an instance of agenda setting to its ultimate causal source difficult, if not impossible. In this case at least, the rise in public support for health care reform appears to have been a precursor to the increase in news media coverage, whereas public awareness of reform as a national policy issue followed media attention. But what seems most important is that public opinion, media coverage, and political events all closely tracked one another. The sudden emergence of health care reform on the national political agenda thus appears to be an example of an "amplifying feedback loop" (Smith 1991: 52) in which the public, news media, and national policy makers all responded to the cues of the others, creating a rapid cascade of attention to the issue. To substantiate this claim, however, we need to develop a fuller picture of what national politicians were doing in the years leading up to the Pennsylvania election.

Health Care Reform and the Congressional Agenda

In 1991, Congress faced a growing number of health care reform proposals. Yet policy makers remained cautious about addressing the issue. The federal government's last great foray into the wilderness of health care reform, the Medicare Catastrophic Coverage Act (MCCA), was passed in 1988 and then repealed the next year, after outraged upper-income senior citizens revolted against the progressive taxes the act levied on Medicare beneficiaries. Also ill-fated was the Bipartisan Commission on Comprehensive Health Care (the Pepper Commission). Authorized by the MCCA to develop a series of recommendations for health care reform, the commission quickly descended into partisan bickering. Its final recommendations, released in 1990, were greeted with little fanfare.

Noticeably absent from the debate about health care reform was Republican President George Bush. In his 1990 State of the Union address, Bush called on Secretary of Health and Human Services Louis Sullivan to craft a response to the issue. But dissension within the administration and between Bush and congressional Republicans over the appropriate character of that response had left the White House on the sidelines and Republican members of Congress bereft of executive leadership.

One way to estimate changes in the level of congressional attention to health care is to count the number of hearings that were held on the topic by congressional committees and subcommittees.[4] Yet hearings have their shortcomings as a measure of agenda status. Many hearings on health care are concerned with routine or ongoing issues surrounding existing health programs, including the periodic reauthorization of programs. Many others concern topics only tangentially related to health care reform, such as medical research or the process by which new drugs are approved. As Figure 4 reveals, the total number of congressional hearings on health care remained consistently high from 1980 through 1991, exceeding one hundred hearings per year after 1983 and topping 150 hearings annually in 1987 and 1991.[5] Although the number of hear-

4. I am not claiming here that committee hearings are a cause of the congressional agenda, only that there is a correlation between the agenda of Congress and that of committee hearings. For a theoretical exploration of the ways in which committees set the congressional agenda, see Sinclair 1986.

5. These figures on congressional hearings and all that follow were provided by Frank R. Baumgartner, Bryan D. Jones, and Jeffery C. Talbert, who compiled them as part of their

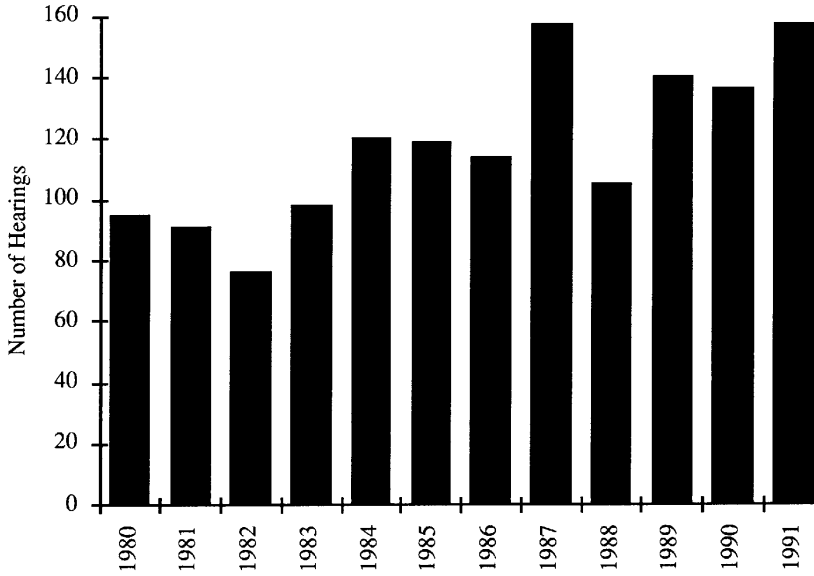

Figure 4 The number of congressional hearings on health care, for the years 1980 to 1991.

ings generally increased during this twelve-year period, the level of congressional attention remained remarkably high throughout. In every year from 1980 through 1991, Congress appears to have paid a considerable amount of attention to topics surrounding health policy.[6]

The picture looks somewhat different, however, if we consider only those congressional hearings that focused on medical costs or the uninsured.[7] Figure 5 shows the total number of congressional hearings that

---

exhaustive ongoing study of all congressional hearings from 1945 to 1993. All of the data are from National Science Foundation project number SBR-9320922, Frank R. Baumgartner and Bryan D. Jones, Principal Investigators.

6. Indeed, health care was the fifth most frequent topic of congressional hearings during this period, with 1,408 hearings in total. Foreign affairs and foreign aid was the fourth with 1,491 hearings; banking, finance, and domestic commerce was the third with 1, 757; defense was the second with 1,909; and government operations was the first with 2,490 hearings. In contrast, the total number of hearings on education during the same twelve-year period was 669 (Baumgartner et al. 1994).

7. The health care subtopics eliminated from consideration include the National Institutes of Health, Medicare/Medicaid, drugs and the Food and Drug Administration, medical facilities and nursing homes, medical education, mental illness, fraud and malpractice, long-term care and the elderly, women's health, abortion, veterans' and military health, research and development, the acquired immunodeficiency syndrome, cancer, heart and lung disease, Alzheimer disease, and various other diseases.

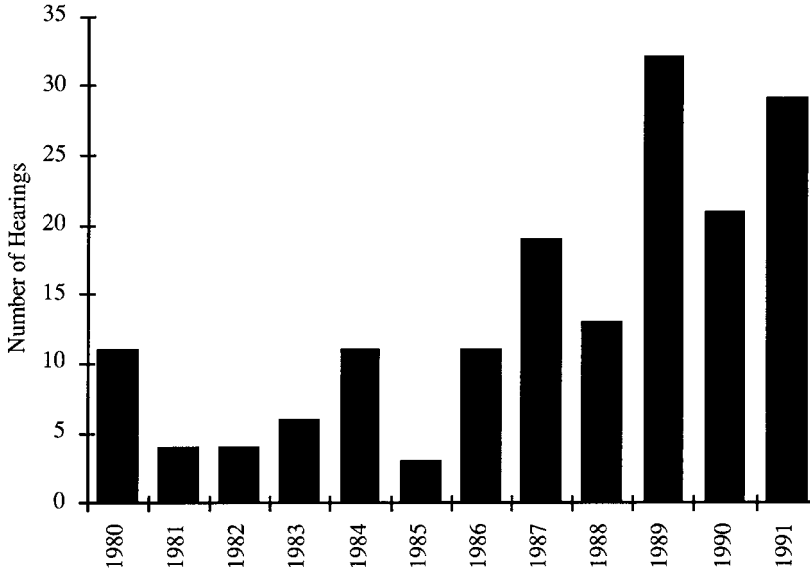

Figure 5 The number of congressional hearings on health care costs of the uninsured, for the years 1980 to 1991.

were held annually on these topics during the same twelve-year period. The volume of hearings is smaller in this case, and it increases more dramatically between 1980 and 1991. The number of hearings rises erratically through the mid-1980s, jumps sharply in 1989, falls back in 1990, and then increases again in 1991.

A similar but more dramatic increase occurred in another indicator of legislative activity, the volume of legislation introduced in Congress.[8] Figure 6 shows the total number of bills on the subject of national health care introduced in each Congress from the 96th (1979 and 1980) through the 102d (1991 and 1992).[9] The number of bills remains fairly meager

8. As with congressional hearings, the number of bills introduced in Congress does not provide a precise measure of legislative activity, but it can reveal general trends in an issue's agenda status. Legislative introductions have special problems as an indicator, however, because of increases in the number of noncontroversial "commemorative" resolutions introduced in Congress, changes in the rules of cosponsorship in the House, and increasing recourse to the budget reconciliation process, where many separate policy decisions are packaged together in mammoth omnibus measures.

9. I assembled these figures through computerized searches on the Legi-Slate database using preset subject codes. For the 96th and 97th Congresses, the subject code was "national health care." For all others, it was "national health (insurance) care." I chose to eliminate commemorative resolutions from the figures, but including them does not appreciably change the results.

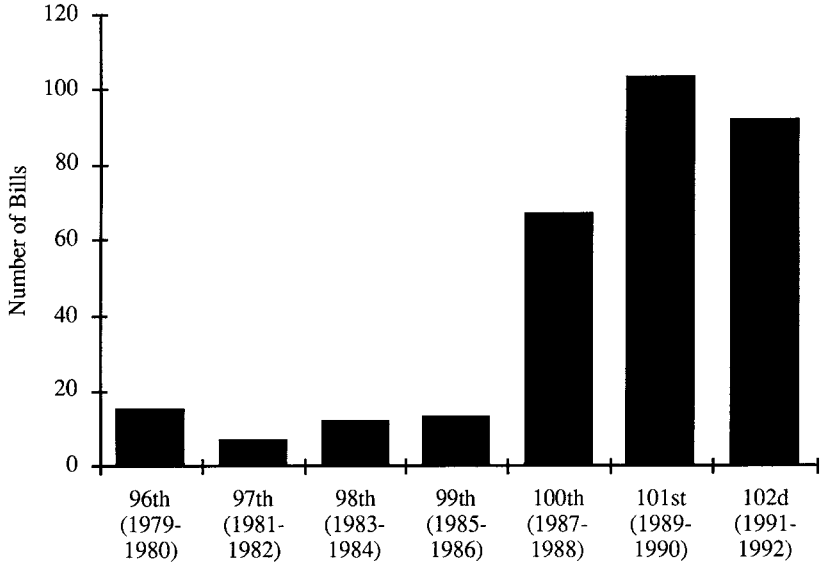

Figure 6 The number of bills introduced in Congress related to "national health care" or "national health insurance," for the years 1979 to 1992. *Source*: Computerized search on the Legi-Slate database using preset subject codes.

until the 100th Congress (1987 and 1988) and then rises precipitously, from thirteen bills in the 99th Congress (1985 and 1986) to sixty-three in the 100th Congress, to approximately one hundred in both the 101st (1989 and 1990) and 102d Congresses. Perhaps most surprising is the considerable legislative activity that surfaced in the 101st Congress, well before the Pennsylvania election. Indeed, the number of bills actually decreased slightly in the 102d Congress, from one hundred three to ninety-two. However, this reflects the large amount of legislation pertaining to the MCCA that was introduced between 1987 and 1989. When tabulated using a more narrow definition of health care reform, the number of bills in the 100th Congress showed no increase and the number in the 101st Congress rose only modestly.[10] By this narrower definition, as Figure 7 shows, the real increase in legislative activity occurred in the

10. I first eliminated from the totals all bills that dealt with the MCCA, except for the original legislation and the bill that repealed it. I then eliminated all bills that solely addressed specific programs (for example, the Indian Health Service or Medicare). Finally, I eliminated all bills that addressed only medical research. As in my earlier tabulations, I did not include commemorative resolutions.

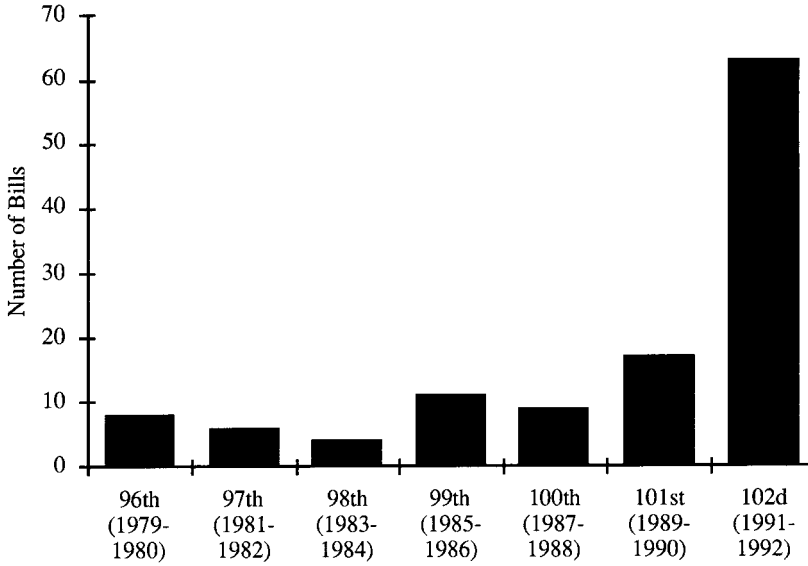

Figure 7 The number of bills introduced in Congress related to "national health care" or "national health insurance," for the years 1979 to 1992, narrow definition. *Source*: Computerized search on the Legi-Slate database using preset subject codes and excluding bills

102d Congress, when the number of bills rose from seventeen to sixty-three. About two-thirds of these bills, forty-one of the sixty-three, were introduced after the Pennsylvania election.

Taken as a whole, the pattern of congressional hearings and legislative introductions suggests two basic trends in congressional attention to health care reform. First, there was clearly a considerable degree of congressional attention to health care reform even before the Pennsylvania election, with the subject beginning to move steeply upward on the congressional agenda in the late 1980s. Second, like both public support for and media coverage of reform, congressional attention to the subject appears to have increased sharply in the 102d Congress (1991 and 1992) in the run-up to and the immediate aftermath of the Pennsylvania election.

Momentum toward Reform in Congress

What explains the momentum toward health care reform in Congress in the years immediately preceding the Pennsylvania election? We have already surveyed some of the proximate causes—deteriorating condi-

tions in American medicine, mounting public anxiety, and a sharp economic downturn—but three others seem comparably important. The first was the increasing pressure public health programs were placing on state and federal budgets. By the late 1980s, the escalating cost of the two largest federal health programs, Medicare and Medicaid, was generating widespread unease in Congress. In 1982, Congress passed legislation requiring the Health Care Financing Administration to develop new methods to pay hospitals under Medicare. By the Pennsylvania election, Congress had also enacted legislation creating fee schedules for physicians serving Medicare beneficiaries. Despite these measures, however, the cost of public health programs continued to rise rapidly.[11]

A second proximate cause of health care reform's enhanced stature on the congressional agenda was the emergence in the late 1980s of a revitalized Democratic leadership in the House. A key reflection of the Democratic Party's stronger leadership style was the aggressive legislative activism of the new Speaker of the House, Jim Wright of Texas, who entered office in 1987 with an ambitious list of legislative goals that included catastrophic health insurance. Although President Reagan first drew national attention to catastrophic health insurance with some offhand comments at a presidential news conference in January 1986, leading members of Congress quickly made the issue part of their own more far-reaching health policy agendas.[12] The return of the Senate to Democratic control in the 1986 election placed both houses of Congress in Democratic hands, and shortly thereafter Reagan's standing was further weakened by the Iran-Contra scandal. Wright and other Democratic leaders took advantage of Reagan's faltering stance, coupled with more than a decade of growth in the power of the Speaker and the Democratic Caucus, to pursue a partisan agenda more forcefully than the House leadership had since the beginning of Reagan's presidency. In the end, neither Wright, who resigned under a cloud of ethics violations in 1989, nor catastrophic health insurance, which was repealed the same year, proved to

11. In 1990 and 1991, for example, federal Medicaid spending increased by 21 percent and 29 percent, respectively. In 1992, the Congressional Budget Office estimated that without measures to check medical inflation, spending for Medicare and Medicaid would account for nearly a quarter of the federal budget by the turn of the century (CBO 1992: 6, 41, 45).

12. The sudden emergence of catastrophic health insurance as a policy issue in 1986 illustrates well the instability of the government agenda. As Beth Fuchs and John Hoadley observed in 1987, "The new drive by the administration and Congress to fill this particular gap in health care coverage is more an accident of politics than the product of any new-found consensus about unmet national needs" (p. 213). Indeed, Reagan's rambling comments about a possible administration proposal were in response to a question almost completely unrelated to catastrophic health insurance for the elderly.

have much lasting impact. Yet the new assertiveness of the Democratic leadership on catastrophic health insurance and other policy issues marked the arrival of congressional leaders more willing to define their policy commitments and use their expanded leadership prerogatives to achieve them, even in the face of presidential opposition (Rohde 1991; Dodd and Oppenheimer 1989: 39–64; Davidson 1988).

Finally, increased congressional attention to health care reform had a third important proximate cause: the growing demand for reform voiced by the major stakeholders in the health policy domain. By the time of the Pennsylvania election, many of the organized interests in health care had expressed support for some kind of reform. Even the American Medical Association, the most vociferous opponent of past reforms, had proposed an employment-based plan to improve access to medical care (Todd et al. 1991). Other provider groups, such as the American College of Physicians and the American Academy of Family Physicians, appeared willing to accept even more comprehensive reforms. Business was also beginning to countenance a greater federal role in the financing of medical care, after more than a decade of futile attempts to control costs on its own.

At first glance, this chorus of interest group support for reform appears puzzling. As Lawrence D. Brown asks, "If a formidable phalanx of powerful groups throttled change in the 1980s, why did they seemingly cease to do so in the early 1990s?" (1994: 199). Part of the answer, paradoxically, is that the seeds of interest group discontent were sown by the very success of these powerful stakeholders in preventing substantial policy change, not only in the 1980s but during most of this century. By the 1970s, continued cost increases were driving both the government and private employers to take more active steps to check medical inflation. In the 1980s, these efforts began to produce results, although not exactly those their architects had desired. Federal cost containment initiatives were shifting costs to the private sector, the growing microregulation of clinical decisions by insurers was irritating providers and patients alike, and corporate America's quest for lower insurance premiums was further segmenting the insurance market and lowering coverage rates among individuals and small firms. In the past, when the nation's capacity to absorb rising medical spending appeared limitless, stakeholders had seen little reason to challenge one another over the exact division of the spoils of medical progress. But now these same stakeholders saw the conflict as zero-sum—one group's gain came at the expense of another—and each believed that it was uniquely disadvantaged relative to its antagonists.

Accordingly, medical providers, insurers, and business began to advance proposals for reform that they believed would restore the proper balance.

If the new aggressiveness of Democratic leaders and the changing stance of powerful stakeholders were important proximate causes of the increased congressional attention to health care reform, they also reflected a broader transformation in the structure of American health politics. This transformation can be viewed as the deep or underlying cause of increased congressional attention to reform, for it greatly increased the probability of a renewed legislative push for national health care reform.

Mark Peterson (1994) describes this transformation as a shift from an "iron triangle," in which powerful private interests had privileged access to an oligarchically organized Congress, to a more open "policy network" in which power was widely dispersed among interest groups and individual legislators. The point of departure for Peterson's analysis is the early postwar period, when the medical lobby and a cross-party conservative coalition in Congress effectively blocked consideration of President Harry Truman's proposal for national health insurance. Led by the American Medical Association, the organized interests opposing Truman's proposal were unified and powerful, more than a match for the bill's scattered band of supporters. By the 1960s and the debate over Medicare, the interest group community had grown more polarized and its opposing camps more evenly paired, leading one observer to describe the Medicare struggle as a classic illustration of "class-conflict politics" (Marmor 1973: 108). But the crucial shift occurred in the two decades after Medicare's passage, as new "stake challengers" entered the political arena and established stakeholders had increasing difficulty maintaining their traditional alliance. In 1945, the dominant groups in the health policy domain had been for-profit and nonprofit sector associations, with organized labor and citizen groups serving as the main political counterweight. From 1945 to 1985, and especially after 1970, the proportion of citizen groups and mixed for-profit—nonprofit organizations increased, while the proportion of for-profit groups decreased. More important, newer groups were more likely than their older counterparts to endorse increased government support for health care, even in sectors historically antagonistic to government involvement (Peterson 1994: 121–125; see also Walker 1991).

Not only did the composition of interest groups in the health policy domain change in the decades after World War II but the aggregate number of groups also increased. Since the 1960s, the number of interest

groups operating in all federal policy areas has increased dramatically, but in no area more than health. The number of interest groups active in health and social policy rose from 674 in 1960 to nearly 4,000 in 1990, practically a sixfold increase. In comparison, the number of groups in all other policy areas increased by about a factor of four during the same thirty-year period (Baumgartner and Talbert 1995: 438; see also Walker 1991; Salisbury 1990: 203–229; Heinz et al. 1993).

Paralleling the transformation of interests in the health policy domain were dramatic changes in the organization of Congress (Peterson 1994: 125–131). The oligarchic Congress of the Truman era, dominated by conservative committee chairs, soon ran afoul of the liberal tide of the 1960s. In 1964, liberal Democrats tamed the House Rules Committee by reinstating the twenty-one day rule, which prevented the committee from stalling bills for more than three weeks. During the 1960s, congressional staffs expanded considerably, providing members with new independent resources for policy advocacy. And beginning in 1971, the Democratic Caucus instituted a series of rule changes that expanded the number of subcommittees and increased their power relative to full committees (see Shepsle 1989: 238–266; Davidson 1992).

These institutional reforms ushered in a new congressional order, more supportive of legislative entrepreneurship and less conducive to the formation of entrenched policy subsystems than the oligarchy before it. Even rank-and-file members now had the resources and discretion to play a leadership role on policy issues, and many more committees and subcommittees participated in making health policy. In the House, for example, health care issues were divided among no fewer than seven major committees (Baumgartner and Talbert 1995). And for the first time, all but one of the House and Senate committees and subcommittees with a significant jurisdictional interest in health care reform were chaired by members who supported reform (Peterson 1994: 129–130).

The effects of congressional reforms on the prospects for passing national health legislation were not uniformly favorable. Although the reforms broke the legislative stranglehold of baronial committee chairs, and with it the privileged influence of the medical lobby, they also made it difficult for congressional chairs and party leaders to construct coalitions and broker legislative compromise.[13] But the effects of these

13. Anthony King (1978: 371–395) has argued, for instance, that these changes contributed to the "atomization" of the American polity, making leadership more difficult and forcing politicians to build "coalitions in the sand." Even with the growth in the leadership's power in the 1980s, party leaders still find it difficult to act when party members disagree. Indeed, much of

changes on the prospects for *addressing* national health care reform were not so ambiguous. Never before had so many members of Congress been poised to assume a leadership role on the issue or possessed the analytic resources needed to develop serious proposals for reform (Peterson 1992a). By the 1990s, the structure of power in Congress and the interest group community was uniquely hospitable to a renewed legislative campaign for national health care reform.

The Impact of the Pennsylvania Senate Election

I have detailed some of the primary reasons why national health care reform received serious consideration in Congress even before Harris Wofford won in Pennsylvania. These were the underlying and proximate causes of the increased congressional attention to health care reform, the factors that helped bring the issue to the congressional agenda. The Pennsylvania election was the catalyst—the "focusing event," to use Kingdon's felicitous phrase (1984)—that transformed the building momentum toward reform into a whole-scale rush. Without the deeper causes, Wofford's victory would not have had the effect it did. Without Wofford's victory, the deeper causes may not have produced a serious congressional response or may have produced one only after further years of accumulating pressure. Together, the momentum toward reform in Congress and the outcome in the Pennsylvania election pushed health care reform to the top of the national political agenda.

That Wofford's victory precipitated a stunning increase in public and political attention to health care reform is undeniable. The figures presented earlier concerning media coverage, congressional hearings, and legislative introductions all reveal a substantial increase in the agenda status of health care reform at the time of the election. As I will show later, the response of Washington politicians to Wofford's victory was prompt, unambiguous, and consequential. Why the Pennsylvania election was such an important catalyst, however, is less clear. Kingdon (1984: 65–68) argues, for instance, that elections are not a particularly promi-

---

the Democratic leadership's renewed effectiveness stemmed not from a more aggressive use of its leadership powers but from the increasing homogeneity of congressional Democrats. As David Rohde (1991) notes, the pattern of Democratic leadership was not of "leaders initiating retaliation against defecting members" but of "a relatively cohesive membership pressuring reluctant party leaders to threaten and impose a range of sanctions against deviating Democrats" (p. 81). In the absence of cohesion, leadership has proved more elusive.

nent factor in agenda setting; he counts them as important in only 30 percent of his interviews and in seven of his twenty-three case studies. This conclusion seems to accord with the frequent observation that politicians need not worry much about reelection, or at least that they cannot do much about it. After all, nearly all incumbent members of Congress are reelected—more than 95 percent of House members were in the 1980s—and their average margin of victory has increased since the 1960s (Alford and Brady 1993: 141; see also Mayhew 1974ab. It seems unlikely that this advantage could be nullified by an incumbent's position on a single issue, even one as salient as health care reform. Indeed, much of the literature on congressional elections suggests that factors other than candidates' positions, such as national party tides, presidential popularity, and the state of the economy, are the main determinants of electoral outcomes (Jacobson 1987b: 125–139). Given this, why would members of Congress pay much heed to the outcome of a single Senate race?

To begin, the Pennsylvania election had several atypical features that made it especially visible and important. The most critical was its timing. The Pennsylvania election was the only off-year Senate race in 1991, and it occurred in the year leading up to a presidential election. President Bush, who had seemed invincible in the wake of the 1991 Persian Gulf War, was beginning to look more vulnerable on the domestic front, with polls showing a smaller percentage of voters believing he should be reelected than at any time in his presidency (Brodie 1991). Furthermore, Bush and Thornburgh were closely identified with one another: Thornburgh had stepped down from the Bush cabinet to run, he had made his service in the administration a major campaign theme, and he had asked both Bush and Vice President Dan Quayle to campaign for him in Pennsylvania. From the outset, therefore, the Pennsylvania race was viewed as an important harbinger of the 1992 presidential campaign.

Moreover, it is simply not true that the electoral constraints on members of Congress are so diffuse or weak that members can do whatever they please. Gary Jacobson (1987a) has shown that despite the increase in incumbents' winning margins in congressional elections, House members are still as likely to lose their races as they were before the 1960s, because while electoral margins have grown, elections have become more volatile. Not only are incumbent members of Congress who won by large margins in previous elections more vulnerable to challengers than in the past but incumbents are also less affected by national party swings than they once were (Ansolabehere et al. 1992). Increasingly, they rise or fall on their own, rather than with their party or their party's presidential

candidates. The net result is that members of Congress are probably no more certain of their reelection today than they were thirty years ago.

In any case, sizable electoral margins do not necessarily prove that incumbent members of Congress are insulated from electoral pressure. As Kingdon (1973) argues, "Such an argument neglects the possibility that they may be so seemingly secure partly *because* they were careful about catering to their constituencies" (p. 61). Admittedly, this proposition is difficult to test; members of Congress do not deliberately flaunt constituency sentiment. But it does help account for the paradoxical finding that even legislators with apparently safe seats worry constantly about the electoral consequences of their actions (Kingdon 1973; Fiorina 1974; Fenno 1978; Arnold 1990).

The uncertainty surrounding future elections explains why members of Congress appear more cautious than their healthy margins of victory in previous elections would seem to warrant. Critics of Congress routinely bemoan the lack of dispatch with which Congress responds to controversial or complex issues, citing it as evidence that Congress is insufficiently responsive to the wishes of the electorate. In many cases, however, delay or incrementalism may be the most prudent congressional response to an uncertain environment. As Keith Krehbiel (1991) argues, "Other things being equal, legislators would rather select policies whose consequences are known in advance then policies whose consequences are uncertain. Under conditions of certainty, legislators can plan and make the most of credit-claiming. . . . Under conditions of relative uncertainty, however, surprise and the prospect of embarrassment lurk beneath any policy choice" (p. 62).

Krehbiel contends that members of Congress try to reduce the degree of uncertainty inherent in the policy choices they make by agreeing to rules, procedures, and structures that encourage the development of policy-related knowledge. But the uncertainty of the policy process also leads legislators to search for issues with demonstrated public salience. After examining the agenda of the U.S. Senate, for example, Jack Walker (1977) concluded that for a new or previously neglected policy issue to emerge on the Senate agenda, "senators must believe that the proposed legislation will have broad political appeal" (p. 43). This condition is particularly important when a policy issue benefits the unorganized over the likely opposition of the organized, for in these cases members of Congress need some assurance that the unorganized constituencies that stand to benefit from a policy change will reward them at the polls for taking action (or punish them for failing to do so). Once popular attention to a

policy issue is confirmed, however, members of Congress are likely to rush to it to share in the rewards. As one House aide said, "Politicians are terrific at figuring out when it is no longer fruitful to be a hold-out. When the public has come to some judgment about what they think needs to be done, and they think somebody is actually proposing that, then to be opposed to it carries some liabilities" (interview with author, 17 August 1993).[14]

In American politics, elections are a particularly important source of information about which issues and proposals have the greatest potential to elicit popular support. Although scholars question the concept of an electoral mandate (see, for example, Dahl 1990), few politicians seem to share their skepticism. The last ballot is barely cast in an American election before observers and participants begin to proclaim the grand meaning of the results. Perhaps such biennial exercises in political prognostication serve a special purpose in the American political system: When parties are weak and government power is fragmented, election results provide a common basis for priority setting and coordination. As David Mayhew (1974a) notes, "Nothing is more important in Capitol Hill politics than the shared conviction that election returns have proven a point" (p. 71).

But how do such shared convictions form? Marjorie Randon Hershey (1992) argues that the ambiguity of election results creates powerful incentives for journalists, politicians, and other political activists to construct plausible explanations of the vote. Journalists want to offer more complex explanations of election results than is possible with vote totals alone, politicians use election results to plan their political strategies, and a wide range of activists want to promote interpretations of election results that give them a political advantage. The formal campaign is therefore followed by a postelection struggle among "campaigners, consultants, party and group leaders [who wish] to get their explanations of the election results reported as if they were fact" (p. 946). These dueling explanations are then winnowed by the news media to a few chosen explanations that become the "conventional wisdom" about an election.

To see if such a process unfolded after Pennsylvania's 1991 Senate race, I performed an analysis of postelection media coverage similar to the one conducted by Hershey to examine coverage of the 1984 presidential election.[15] My results offer strong support for Hershey's central

14. This aide asked to remain anonymous.

15. Like Hershey, I focused on election coverage in major daily newspapers. Three of the newspapers were from the Northeast (the *Boston Globe*, the *New York Times*, and the *Washington Post*). An additional newspaper was chosen from each remaining region: the South (the

thesis that the number of explanations of an election presented in the news media decreases over time. The number of different interpretations was highest on 7 November, the second day after the election, when thirty-five separate explanations of the vote appeared. This number quickly dwindled to fewer than ten distinct explanations per day, reaching zero several times after the second week. This decrease reflected both a precipitous reduction in the total number of articles mentioning the election and a decline in the total number of explanations offered per article. The day after the election, for example, the average number of explanations per article was more than six; by the end of November, it was about one.[16]

One of the most interesting results is the extent to which news media coverage of the Pennsylvania election focused on Wofford's victory rather than on Thornburgh's defeat (Table 1). This finding is directly contrary to the pattern Hershey found in newspaper coverage of the 1984 presidential election, which focused disproportionately on Walter Mondale's defeat. Part of the explanation for this discrepancy is probably that Wofford's victory in 1991 was much more startling than Ronald Reagan's in 1984. Even so, the sheer imbalance in newspaper coverage is striking. Almost three-quarters of the explanations appearing in the print media after the Pennsylvania election attributed the outcome to Wofford's persona, his positions on key issues, his support coalition, and his campaign strategy. In contrast, only 10 to 11 percent of the explanations focused on Thornburgh and his campaign. Another 4 percent or so of the explanations linked the vote to the Bush administration and its policies, and the remaining 10 percent focused on the mood of the electorate. Only a handful of explanations addressed the electorate's perceptions of the Democratic Party—a major topic in postelection coverage of the 1984 presidential race.

Atlanta Constitution/Journal), the Midwest (the *Chicago Tribune*), and the West (the *Los Angeles Times*). Hershey includes these newspapers plus ten others that are not available on the Nexis database and two "black-oriented" newspapers that I chose not to include. Hershey's study examined coverage appearing during two periods: immediately after the election and in the weeks after the presidential inauguration. As there was no event comparable to a presidential inauguration after the Pennsylvania election, I did not separate the postelection coverage into two discrete periods. Instead, I examined a somewhat longer period after the election than Hershey studied.

16. By "number of explanations" I mean the number of times a given explanation was cited. This is to be contrasted with the "number of different explanations," which is the number of distinct explanations of the election that were cited. The former measure shows which explanations were most prominent in postelection coverage; the latter reveals something about the diversity of explanations.

Table 1 Media Explanations of the Pennsylvania Sennate Election, 6–30 November 1991

Explanation	Number of citations	Percentage of All explanations cited
Characteristics of Electorate	38	10.2
Anti-Washington/ Anti-incumbent Mood	16	4.3
General Anxiety/Anger	12	3.2
Desire for Change	6	1.6
Focus on Domestic Problems	3	0.8
All Other	1	0.3
Characteristics of Wofford (total)	277	74.7
Issues, Policies	215	58
National Health Care Reform	95	25.6
State of Economy	49	13.2
Anti-Washington	11	3
"America First"	10	2.7
General Populism/Progressivism	10	2.7
Taxes/Tax Cuts to Middle Class	8	2.2
Unemployment Benefits	8	2.2
Anti-Bush Administration	6	1.6
Foreigh Trade	6	1.6
General Focus on Domestic Policy	4	1.1
Resentment toward "Undeserving"	2	0.5
All Other	6	1.6
Constituency	36	9.7
Middle Class	23	6.2
Labor	11	3
All Other	2	0.5
Personalistic	19	5.1
"Outsider"	8	2.2
Painted Thronburgh as an "Insider:	7	1.9
Good Character/Credentials	3	0.8
All Other	1	0.3
Strategic	7	1.9
Set/Controlled Campaign Agenda	5	1.3
Effective TV Campaign	2	0.5
Characteristics of Thornburgh (total)	39	10.5
Personalistic	19	5.1
Close Ties to George Bush	5	1.3
"Insider"	5	1.3
Arrogant	3	0.8
Lacked Conviction	3	0.8
Too Liberal	2	0.5
All Other	1	0.3

Table 1 Media Explanations of the Pennsylvania Sennate Election, 6–30 November 1991 (*continued*)

Explanation	Number of citations	Percentage of All explanations cited
Strategic	19	5.1
Bad Campaign Strategy in General	6	1.6
Emphasized Resume	4	1.1
Too Negative	3	0.8
Ceded Initiative in Campaign	2	0.5
Gaffe by Campaign Aide	2	0.5
Not Negative Enough	2	0.5
All Other	1	0.3
Characteristics of Bush Administration (total)	13	3.5
Economic Policies	9	2.4
Focused on Foreign Policy	3	0.8
All Other	1	0.3
Characteristics of the Political Parties (total)	3	0.8
Democrats	3	0.8
No Longer a Special Interest Party	3	0.8
All Other	1	0.3

Because of rounding, not all the categories and subcategories equal the sum of their constituent percentages.

By every measure, the campaign theme most commonly cited in explanations of Wofford's victory was national health care reform. Fully 81 percent of the articles that appeared after the election made some reference to health care reform, if only to note that it was a key issue in the race. Wofford's endorsement of national health insurance was also by far the leading explanation of the Pennsylvania vote, accounting for more than one-quarter of all explanations offered between 5 November and 1 December. In comparison, the next most frequently cited explanation, Wofford's focus on the ailing economy, accounted for about one-half as many explanations, or approximately 13 percent of the total. Furthermore, the argument that Wofford won because he championed national health insurance became increasingly prominent in the weeks after the Pennsylvania election, increasing from about 25 percent of the total number of interpretations offered per day to between 50 and 60 percent by the last week of November. Clearly, therefore, this explanation survived the winnowing process to enter the conventional wisdom about the Pennsylvania race.

Indeed, quickly after the election a stock account of the results emerged that neatly tied together the three leading explanations of the vote: Wofford's support of national health care reform, his focus on the faltering economy, and his ability to connect with the politically crucial middle class. A *Washington Post* editorial on 8 November, for example, described "the middle-class populism of Harris Wofford, who came out for health care and against unemployment" (Krauthammer 1991). On 10 November, the *New York Times* noted that Wofford's successful campaign "had hammered away at related themes: that President Bush's policies had damaged the economy and particularly the middle class, and that the United States badly needs national health insurance" (The Nation: Highlights of Last Week's Elections 1991). And a *Washington Post* article on 19 November quoted a political scientist who argued that "health care was a subset of a much more complex set of motives. . . . [T]his was all about the fear of the middle class that their economic life is falling apart" (quoted in Russakoff 1991). These three explanations, health care reform, the economy, and the middle class, together accounted for nearly one-half of all explanations offered between 5 November and 1 December.

Why were these explanations favored over others? And why, in particular, did Wofford's endorsement of national health insurance come to dominate media accounts of the election? In Hershey's (1992) model, the conventional wisdom emerges through a competitive process in which journalists and political activists construct explanations of "events [that] have no inherent meaning" (p. 945). Yet it is worth questioning whether Hershey's constructivist account attributes too much latitude to those trying to explain election results. After all, it would have been impossible to discuss the Pennsylvania election in any detail without mentioning Wofford's support for national health insurance. Events may have no "inherent meaning" in the positivist sense that they embody some objective truth that need only be discovered, but this does not mean that competing interpretations of events are equally valid or plausible. Rather, we would expect the range of acceptable interpretations to vary with the degree of ambiguity surrounding an event. Election results, because they are generally ambiguous, are particularly open to interpretation. Nonetheless, some explanations of election results may appear so self-evident given the available information that journalists and political activists find them difficult to ignore.

On this score, it is interesting to note the extent to which arguments linking Wofford's win to health care reform and the economy were promoted not by Democratic sources but by key Republicans and the Bush

administration. We might have expected Republican sources outside the Thornburgh camp to lay the blame for his defeat on Thornburgh and his campaign strategy. But one of the primary reasons why these explanations appeared so infrequently in media accounts of the election was that few Republicans offered them. Republican National Committee chair Clayton Yeutter called the Pennsylvania results an "aberration" without elaborating further (quoted in Balz and Edsall 1991). Texas senator Phil Gramm, head of the National Republican Senatorial Campaign Committee, conceded that the election "turned into a referendum on Dick Thornburgh's resume versus [Wofford's] issues, and we lost that referendum" (quoted in Schwartz and Drehle 1991). Several other Republican senators were more explicit than Gramm about the appeal of Wofford's campaign themes. Arlen Specter of Pennsylvania told reporters that the election carried "a very strong message" to the Bush administration about the "many, many domestic issues that have to be faced" (quoted in Shogan 1991). John McCain of Arizona argued that the "election indicated clearly that the American people want the health-care issue addressed" (quoted in Lipman 1991).

Perhaps the most striking example of a Republican casting the Pennsylvania vote as a vindication of Wofford's campaign platform was embodied in the postelection statements made by President Bush. In a news conference held the day after the election, Bush explained that the vote bore a "message" for his administration and for Congress: "When the economy is slow, people are concerned. They're hurting out there. They're concerned about their livelihood. . . . One of the messages in Pennsylvania: try to help people with health care" (quoted in Bush: Voter Anger Comes in Loud, Clear 1991). As if to prove he had heard the message, Bush canceled a planned state visit to Asia and told reporters that his administration was now planning to develop its own health care reform proposal before the presidential election (Here's the Beef 1991).

If newspaper coverage is an accurate guide, then there seems to have been a remarkable degree of consensus among political activists about the meaning of the Pennsylvania vote. Of course, journalists may have screened competing explanations of the election, perhaps in sympathy with Wofford's policy positions. (Hershey [1992] found that Democratic sources were cited more frequently after the 1984 election than were Republican sources.) But the similarity between Republican and Democratic interpretations of the vote suggests that widespread agreement did exist among activists of both parties on the reasons for Wofford's win. Certainly the prevalence of explanations citing Wofford's endorsement of

national health insurance did not reflect careful analysis of survey data. Only five articles of nearly four hundred explicitly mentioned the exit poll that showed national health insurance at the top of Pennsylvanians' voting concerns.[17]

Not only did a wide range of activists put the same spin on the Pennsylvania results but they also acted in accord with this shared interpretation. The day after the Pennsylvania election, a group of Senate Republicans led by John Chafee of Rhode Island and including Minority Leader Robert Dole of Kansas introduced their own proposal for reform, which offered refundable tax credits to purchase private insurance (Senate GOP Task Force Unveils Health Care Plan 1991). In the White House, Bush finally acceded to the inevitable and permitted his health policy staff to develop a plan in earnest. Although it was clear that he would adopt an incremental approach similar to the tax-credit plan favored by Senate Republicans, the fact that the administration was scrambling to introduce a proposal indicated how far the outcome in Pennsylvania had pushed the debate.

For Democrats, a strategy to recapture the White House in the 1992 presidential election had emerged. On the campaign trail, every major Democratic presidential candidate invoked Wofford's victory in declaring his support for national health care reform. Fresh from the Pennsylvania win, James Carville and Paul Begala took top spots in the campaign of Arkansas Governor Bill Clinton, who was searching for policy issues that would set him apart from President Bush while garnering support across class lines. In the Senate, the Democratic leadership launched a new effort to rally Democrats around their comprehensive reform initiative and to coordinate their legislative activities with House leaders. Senate leaders also began to focus more directly on cultivating public support for reform, with Wofford joining Jay Rockefeller and Majority Leader George Mitchell in a five-state campaign to raise public awareness about the topic. In January alone, Democratic members of Congress held nearly three hundred hearings on health care reform in their home districts or states. Even Texas senator Lloyd Bentsen, the cautious Democratic chair of the Finance Committee, became more outspoken in his support for reform, hinting that the public might be pre-

17. Of course, the survey results may have been used by journalists without citation. It is very difficult to test this proposition, just as it is difficult to know whether journalists' views of an election are their own or those of an unattributed source. Hershey (1992) found that exit polls were "a surprisingly underutilized resource" (p. 965) in newspaper analyses of the 1984 election. My findings, however tentative, reinforce that conclusion.

pared for more fundamental change than he had previously envisioned (Kosterlitz 1992).

The response of members of Congress to the Pennsylvania election thus lent additional credence to the dominant interpretation of the vote. Convinced that Wofford's win was linked to his endorsement of national health insurance, politicians rushed to demonstrate their commitment to reform. This in turn reinforced the perception that the Pennsylvania vote reflected widespread public support for reform.[18]

The political bandwagons that form when new causes gain salience and popular support is one reason for the presence of "positive feedback" in American politics (Baumgartner and Jones 1993). Small changes may cascade into larger ones, single events may lead to whole series of events, and policy issues may expand quickly to involve all levels of the political system. Agenda change seems to occur swiftly as politicians lurch from issue to issue, only some of which are ultimately addressed. In many cases, agenda dynamics follow a pattern similar to "the issue-attention cycle" that Anthony Downs (1972) observed in the American public's attention to ecology: Long-standing problems suddenly move to the center of political concern as a result of dramatic events and then, regardless of whether they are addressed, fade from attention as the true cost and complexity of resolving them become apparent.

Lost Opportunities and Future Prospects

Traditional theories of politics portray policy making as the incremental adaptation of existing policies to changing circumstances and political alliances under conditions of general equilibrium (see, for example, Bentley 1908; Truman 1951; Lindblom 1959; Dahl 1961). Agenda-setting theorists do not deny that incrementalism is a dominant characteristic of politics, but they argue that the government agenda is also ruled by forces that are more fluid and unpredictable. An understanding of these forces does not always pinpoint how and when a policy issue will emerge. It

18. This adds a further wrinkle to Hershey's argument. Hershey claims that the force of current political events and the struggle among activists to promote their explanations of election results are separate influences on the process by which the conventional wisdom about an election develops. In most cases, however, we would expect events and interpretations to be interdependent and mutually reinforcing. If certain explanations are favored, and if politicians use these explanations to craft their political strategies, then political events will reflect widely held presumptions about election results. Moreover, if journalists gravitate toward explanations that are relevant to current events, they will further reinforce these dominant explanations. Whatever the source of consensus explanations, therefore, the feedback between media coverage and political action will tend to increase their credence and impact.

does, however, identify recurrent patterns that accompany the opening or closing of "windows of opportunity" for policy change (Kingdon 1984, 1995; Baumgartner and Jones 1993).

The emergence of health care reform as a national political issue does not fit well into an incrementalist model of the political process. Although Congress and the president debated various aspects of health policy during the 1980s, comprehensive health care reform was politically unthinkable well into the decade. Beginning in the late 1980s, however, the subject ascended sharply on the congressional agenda and then burst into prominence with the Pennsylvania election and the 1992 presidential campaign. The attendant increase in public, media, and political attention was sudden, dramatic, and, to many, unexpected.

I must emphasize, however, that my argument is not that the emergence of health care reform was random or fortuitous—a product of a freak event, such as the accident that killed Senator John Heinz and created the opportunity for Wofford's Senate run. Rather, both long- and short-term factors, most fairly predictable, shaped the context within which the Pennsylvania election became the critical symbol that it did. The long-term evolution of Congress and the interest group community increased the opportunities for legislative activism and fragmented the previously unified antireform alliance of business, insurers, and organized medicine. The changes in the medical system that occurred during the 1980s fostered middle-class insecurity and increased the severity of the problems to which policy makers would eventually react. The rising budgetary expense of public health programs, the new aggressiveness of congressional Democratic leaders, and growing interest group demands for reform all helped set the stage for congressional action. And the response of the news media further amplified the effect of these trends by raising public awareness and increasing the political salience of the issue. In this context, the Pennsylvania election became a crucial focusing event, crystallizing the inchoate and contradictory signals to which Congress had been responding into a clear and simple message: The American people want health care reform.

Rather than highlighting contingency and randomness, therefore, an agenda-setting perspective draws out the underlying factors that interact with more or less unpredictable events to push policy issues higher (or lower) on the national political agenda (Kingdon 1994, 1995). This perspective not only makes the Pennsylvania outcome itself more intelligible but also helps explain why the election had such a far-reaching effect. By drawing attention to underlying changes in public opinion, it shows

why Wofford and other Democrats found health care reform politically compelling as a partisan rallying cry and campaign issue. By situating the election historically, it suggests why national politicians interpreted the election as a sign of broad-based public support for health care reform. And by tracing the interactions among the public, media, and national politicians, it highlights the feedback effects that transformed the building momentum toward health care reform into a full-scale rush.

Scholars who study agenda setting have lately grown fond of adopting metaphors from biology and physics to illustrate how the dynamics of agenda setting can lead to rapid agenda change. Agenda setting, according to Frank Baumgartner and Bryan Jones (1993), often resembles the evolutionary model of "punctuated equilibrium" proposed by Niles Eldredge and Stephen Jay Gould (1972). Policies settle into long periods of equilibrium, in which institutional venues and policy participants are relatively fixed, but then experience sudden disruption and perhaps even reversal as they become the subject of heightened attention and contestation. Kingdon (1995) likens agenda-setting theory to chaos theory in the natural sciences: Small changes in initial conditions have large eventual consequences, and interactions among multiple factors lead to cascade effects that, although not random, can be difficult to anticipate or predict. Here we have seen that the news media can create an amplifying effect even when they do not actively set the agenda, and that the consensus explanations that form around important political events have a self-reinforcing quality that can rapidly drive electorally sensitive politicians toward new policy issues. Both these examples are illustrations of the importance of positive feedback.

Finally, although scholars who study agenda setting have generally emphasized the limited influence of the citizenry over the agenda of government (Bachrach and Baratz 1962; Kingdon 1984), the evidence in this case suggests greater congruence between public opinion and the political agenda (Jacobs 1993, 1994: 375–401; see also Page and Shapiro 1983; Monroe 1979). Health care reform would not have become such a defining issue if not for the increase in public dissatisfaction and middle-class insecurity created by the trends of the 1980s. In part, the responsiveness of politicians to this change in public sentiment may have reflected the increasing attention paid by national politicians to polls, focus groups, and other indicators of public opinion (Jacobs and Shapiro 1994a). The most important link, however, was electoral. As R. Douglas Arnold (1990) notes, members of Congress appear to have considerable electoral incentives to respond to public beliefs and preferences when

policy issues are salient or potentially so and leaders are willing to draw attention to public concerns. Moreover, the expansion of congressional staff and policy-analytic resources has allowed more members to test new issues and public appeals through policy advocacy and legislative development.

Nonetheless, public opinion alone does not set the national political agenda. Politicians certainly have cause to care about mass opinion, but they respond more directly to the wispy phenomena that Kingdon and others call "national moods" (Kingdon 1984, 1995; Mayhew 1991; Stimson 1991; see also Huntington 1981; Schlesinger 1986). Although national moods often correspond with public opinion, they are also shaped by such things as election results, dramatic events, communications from constituents and interest groups, media coverage, and grassroots collective action. More important, national moods cannot be easily pinned down; politicians and activists struggle to define and interpret them to achieve their goals. The Pennsylvania election was critical because it gave concrete expression to the evolving character of public opinion and thereby advanced a particular understanding of the national mood. In the wake of the election, politicians', commentators', and journalists' explanations of Wofford's victory converged on the idea that the election signified substantial public support for reform even among middle-class voters otherwise suspicious of government action.

Looking back on the events of 1991, it is easier to understand the heady enthusiasm with which President Clinton and his allies tackled health care reform in the early months of the new administration. By 1992, reformers believed that the opportunities for comprehensive change were greater than they had been at any other time. Public support for national health care reform was at a forty-year high (Blendon and Donelan 1991), health care reform was a top priority of Democratic leaders, major stakeholders in the medical sector seemed receptive to change, and the Pennsylvania election offered members of Congress a powerful electoral reason to support reform. The difficult question is not why Clinton championed national health care reform during the campaign and after taking office but rather why the historic possibilities for reform that appeared to exist in 1991 had vanished like a mirage by 1994.

This question falls beyond the scope of my present argument. Nonetheless, without claiming to offer a comprehensive answer, let me close by highlighting a few of the lessons that my account of health care reform's emergence onto the national political agenda might hold for our understanding of the outcome of the recent debate and the future of reform.

The first set of lessons concerns timing and momentum. Windows of opportunity do not stay open for long in American politics. New problems come to the fore. New interpretations of problems already on the political agenda supplant older ones. As the true complexity and scope of problems become apparent, public and political attention inevitably shifts to other, less-daunting concerns (Downs 1972). If legislative action is to be taken, therefore, it must be taken swiftly, when opponents are on the defensive and problems are in the spotlight. This is all the more true when presidents try to set the policy agenda. Presidents now enter office facing a vicious dual cycle of increasing policy complexity and decreasing political influence. To be effective, they must set clear priorities, take the first available alternative, and worry less about the specific content of domestic initiatives than whether they can pass (Light 1982).

One reason timing is critical in American politics is that so few mechanisms exist to ensure that political actors do not abandon previous policy commitments. American political parties, particularly the Democratic party, rarely discipline members of Congress who fail to toe the party line on important policy issues, if there is a party line at all. Members of Congress are far more likely to hurt their chances for reelection by forsaking the interests of their constituents than by switching positions or breaking party ranks. Moreover, the United States lacks the centralized, corporatist-style bargaining arrangements that allow state officials in some European nations to hammer out enforceable agreements with key societal interests (Katzenstein 1985). Perhaps the most grievous miscalculation President Clinton and his allies made, therefore, was to believe that the Republicans and interest group leaders who had supported reform when reform looked unstoppable would feel compelled to maintain their earlier positions as the debate unfolded.

In addition to institutional constraints, there is another reason why the window of opportunity opened by the Pennsylvania election was fragile and fleeting: It hinged on the perception of overwhelming public support for health care reform. This was problematic for at least two reasons. First, it lulled many reform advocates, most notably the president and his advisers, into believing that public support for reform was there to be had, that a willing public could be unified behind fundamental reform through catchy slogans and vague appeals (Skocpol 1996; Disch 1996). Second, and perhaps more important, the perception of overwhelming public support was a brittle fiction that could be crushed as easily as it had been constructed. As the inherent ambiguity of public opinion came into view, and as interest group and Republican attacks stoked public fears

about government medicine and skyrocketing personal costs, the case for bold legislative action gradually evaporated (Morone 1995; West et al. 1996; Rockman 1995). The strategy behind the advertising campaigns launched by the Health Insurance Association of America and other groups was not just to shape public opinion but also, and more important, to shape congressional and media perceptions of public opinion (Annenberg Public Policy Center 1994). This was also the motive that guided William Kristol's influential memorandums that encouraged Republicans to attack the Democrats' definition of health care reform (Kristol 1993; Skocpol 1995). These challenges to the aura of inevitability surrounding health care reform, along with the genuine evidence of public division and apprehension, shattered the belief that public support for health care reform was so strong and deep that politicians who stood in reform's way would be punished at the polls for their recalcitrance.

Of course, this may have been inevitable (Steinmo and Watts 1995; Brady and Buckley 1995; Hacker, forthcoming). The Downsian issue-attention cycle maps onto American political institutions rather badly. The checks and balances of the American legislative process create ample time for opponents of legislative change to foment public fears and for the inevitable fissures in public opinion to surface. In the last decade, moreover, interest groups have become increasingly sophisticated at manipulating public opinion and creating the appearance, if not the reality, of grassroots enthusiasm for their causes (West et al. 1996). In this institutional and political environment, winning major policy changes such as health care reform will always be difficult. Other countries have national health insurance not because they enjoyed sweeping public support for reform but because they did not need it (Steinmo and Watts 1995).

If the failure of health care reform in 1994 contains a broader lesson for future health care reformers, it is that public support for reform will never be strong enough to force health care reform through the American legislative gauntlet single-handedly. The historical evidence indicates that major policy reforms come about only when grassroots mobilization and public support are joined with skillful political leadership and reform-minded political majorities (Heclo 1996). To be sure, advocates of health care reform must be willing to engage the public in an open process of democratic deliberation and debate (Disch 1996; Skocpol 1994: 57–76). But substantial steps toward comprehensive health care reform will only be possible when political leaders inside government can fashion the kinds of self-reinforcing changes in policy that Republi-

cans have used adeptly to undercut public support for an expansion of government responsibility. This not only means resisting current attempts to turn Medicaid over to the states and to cream off the healthiest and wealthiest Americans from Medicare and the private insurance risk pool. It also means shoring up existing programs and trying to expand health insurance to the remaining uninsured while reaching out to the millions of working- and middle-class Americans whom these efforts could assist.

Although incremental reform is the order of the day, the failure of Congress to enact substantial reform legislation means that all the conditions that first prompted public concern are still with us. Opinion polls indicate that most Americans continue to believe that health care should be a top policy priority.[19] <FN19> The ranks of the uninsured continue to grow, with their numbers now standing at more than 40 million (Bradsher 1995). Insured Americans still face gaps in coverage and the possibility of losing coverage if they change jobs. And although the rapid expansion of managed care has contributed to a slowdown in the growth of employer health spending (Freudenheim 1995), it has also fostered a host of new public concerns. The possibility remains, therefore, that a future economic slump or shift in the political climate could create a new window of opportunity for comprehensive health care reform. It is acting on that opportunity that will be difficult.

References

Aaron, Henry J. 1991. *Serious and Unstable Condition: Financing America's Health Care*. Washington, DC: Brookings.

Alford, John R., and David W. Brady. 1993. Personal and Partisan Advantage in U.S. Congressional Elections, 1846–1990. In *Congress Reconsidered*, 5th ed., ed. Lawrence C. Dodd and Bruce I. Oppenheimer. Washington, DC: Congressional Quarterly Press.

Annenberg Public Policy Center. 1994. The Role of Advertising in the Health Care Debate, Part Three: The Effect of "Harry and Louise" on the Press, the Public and the Political Process. Philadelphia: Annenberg Public Policy Center, August.

Ansolabehere, Stephen, David W. Brady, and Morris P. Fiorina . 1992. The Vanishing Marginals and Electoral Responsiveness. *British Journal of Political Science* 22:21–38.

19. Health care was among the top three issues that Americans thought the 104th Congress should address; the other two were crime and jobs (Berke 1995).

Arnold, R. Douglas. 1990. *The Logic of Congressional Action*. New Haven, CT: Yale University Press.

Bachrach, Peter, and Morton S. Baratz. 1962. The Two Faces of Power. *American Political Science Review* 56:947–952.

Balz, Dan, and Thomas B. Edsall. 1991. In Virginia and Nation, Voters Register Their Discontent. *Washington Post,* 7 November, p. A1.

Baumgartner, Frank R. 1989. *Conflict and Rhetoric in French Policymaking*. Pittsburgh, PA: University of Pittsburgh Press.

Baumgartner, Frank R., and Bryan D. Jones. 1991. Agenda Dynamics in Policy Subsystems. *Journal of Politics* 53:1044–1074.

————. 1993. *Agendas and Instability in American Politics*. Chicago: University of Chicago Press.

Baumgartner, Frank R., Bryan D. Jones, Michael Rosenstiehl, and Ronald Lorenzo. 1994. Committee Jurisdictions in Congress, 1980–91. Paper Prepared for the Annual Meeting of the American Political Science Association, New York.

Baumgartner, Frank R., and Jeffery C. Talbert. 1995. From Setting a National Agenda on Health Care to Making Decisions in Congress. *Journal of Health Politics, Policy and Law* 20(2):437–445.

Bentley, Arthur F. 1908. *The Process of Government*. Chicago: University of Chicago Press.

Bergthold, Linda. 1990. *Purchasing Power in Health: Business, the State, and Health Care Politics*. New Brunswick, NJ: Rutgers University Press.

Berke, Richard L. 1995. Poll Finds Public Doubts Key Parts of G.O.P.'s Agenda. *New York Times*, 28 February, p. A1.

Blendon, Robert J., Drew E. Altman, John M. Benson, Humphrey Taylor, Matt James, and Mark Smith. 1992. The 1991 Pennsylvania Senate Race and National Health Insurance. *American Health Policy* 2:21–24.

Blendon, Robert J., and Karen Donelan. 1991. Public Opinion and Efforts to Reform the U.S. Health Care System: Continuing Issues of Cost-Containment and Access to Care. *Stanford Law and Policy Review* 3:146–154.

Blendon, Robert J., John Martilla, John M. Benson, Mathew C. Shelter, Francis J. Connolly, and Tom Kiley. 1994. The Beliefs and Values Shaping Today's Health Reform Debate. *Health Affairs* 13:274–284.

Bradsher, Keith. 1995. Rise in Uninsured Becomes an Issue in Medicaid Fight. *New York Times*, 27 August, §1, p. 1.

Brady, David W., and Kara M. Buckley. 1995. Health Care Reform in the 103d Congress: A Predictable Failure. *Journal of Health Politics, Policy and Law* 20(2):447–454.

Brodie, Ian. 1991. Bush Calls off Overseas Tour after Poll Blow. *Daily Telegraph*, 7 November, p. 10.

Brown, Lawrence D. 1994. National Health Reform: An Idea Whose Political Time Has Come? *PS: Political Science and Politics* 27:198–202.

Bush: Voter Anger Comes in Loud, Clear; Americans Want Health Care and Economic Relief, He Says; Thornburgh's Pa. Loss Called a Tough Blow. 1991. *Atlanta Constitution/Journal*, 6 November, p. A1.

Cobb, Roger W., and Charles D. Elder. 1983. *Participation in American Politics: The Dynamics of Agenda-Building*, 2d ed. Baltimore, MD: Johns Hopkins University Press.

Congressional Budget Office [CBO]. 1992. *Projections of National Health Expenditures*. Washington, DC: Congressional Budget Office, October.

————. 1993. *Trends in Health Spending: An Update*. Washington, DC: Congressional Budget Office, June.

Cook, Fay Lomax, Tom R. Tyler, Edward G. Goetz, Margaret T. Gordon, David Protess, Donna R. Leff, and Harvey L. Molotch. 1983. Media and Agenda Setting: Effects on the Public, Interest Group Leaders, Policy Makers, and Policy. *Public Opinion Quarterly* 47:16–35.

Dahl, Robert A. 1961. *Who Governs: Democracy and Power in an American City*. New Haven, CT: Yale University Press.

————. 1990. Myth of the Presidential Mandate. *Political Science Quarterly* 105:355–372.

Davidson, Roger H. 1988. The New Centralization on Capitol Hill. *Review of Politics* 50:345–364.

————, ed. 1992. *The Postreform Congress*. New York: St. Martins.

Disch, Lisa. 1996. Publicity-Stunt Participation and Sound Bite Polemics: The Health Care Debate 1993–94. *Journal of Health Politics, Policy and Law* 21(1):3–33.

Dodd, Lawrence C., and Bruce I. Oppenheimer. 1989. Consolidating Power in the House: The Rise of a New Oligarchy. In *Congress Reconsidered*, 4th ed., ed. Lawrence C. Dodd and Bruce I. Oppenheimer. Washington, DC: Congressional Quarterly Press.

Downs, Anthony. 1972. Up and Down with Ecology—The 'Issue-Attention Cycle.' *The Public Interest* 28:38–50.

Eldredge, Niles, and Stephen Jay Gould. 1972. Punctuated Equilibria: An Alternative to Phyletic Gradualism. In *Models in Paleobiology*, ed. Thomas J. M. Schopf. San Francisco: Freeman Cooper.

Employee Benefit Research Institute. 1992. *EBRI Databook on Employee Benefits*, 2d ed. Washington, DC: Employee Benefit Research Institute.

————. 1993. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1992 Current Population Survey*. Washington, DC: Employee Benefit Research Institute.

Fenno, Richard F. Jr. 1978. *Home Style: House Members in Their Districts*. Boston: Little, Brown.

Fiorina, Morris P. 1974. *Representatives, Roll Calls, and Constituencies*. Lexington, MA: Heath.

Freudenheim, Milt. 1995. Health Costs Paid by Employers Drop for First Time in a Decade. *New York Times*, 14 February, p. A1.

Fuchs, Beth C., and John F. Hoadley. 1987. Reflections from inside the Beltway: How Congress and the President Grapple with Health Policy. *PS: Political Science and Politics* 20:212–220.

Gallup, George Jr. 1991. *The Gallup Poll.* Wilmington, DE: Scholarly Resources.

————. 1992. *The Gallup Poll.* Wilmington, DE: Scholarly Resources.

————. 1993. *The Gallup Poll.* Wilmington, DE: Scholarly Resources.
————. 1994. *The Gallup Poll.* Wilmington, DE: Scholarly Resources.
Gans, Herbert J. 1979. *Deciding What's News: A Study of* CBS Evening News, NBC Nightly News, Newsweek, *and* Time. New York: Pantheon Books.
Gillespie, Ed, and Bob Shellhas, eds. 1994. *Contract with America: The Bold Plan by Rep. Newt Gingrich, Rep. Dick Armey and the House Republicans to Change the Nation*. New York: Random House.
Hacker, Jacob. Forthcoming. *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security*. Princeton, NJ: Princeton University Press.
Heclo, Hugh. 1996. Clinton's Health Reform in Historical Perspective. In *The Problem That Won't Go Away: Reforming U.S. Health Care Financing*, ed. Henry J. Aaron. Washington, DC: Brookings.
Heinz, John P., Edward O. Laumann, Robert L. Nelson, and Robert H. Salisbury. 1993. *The Hollow Core: Private Interests in National Policy Making*. Cambridge, MA: Harvard University Press.
Here's the Beef. 1991. *Washington Post*, 7 November, p. A22.
Hershey, Marjorie Randon. 1992. The Constructed Explanation: Interpreting Election Results in the 1984 Presidential Race. *Journal of Politics* 54:943–976.
Huntington, Samuel P. 1981. *American Politics: The Promise of Disharmony*. Cambridge, MA: Harvard University Press.
Iyengar, Shanto, and Donald R. Kinder. 1987. *News That Matters*. Chicago: University of Chicago Press.
Jacobs, Lawrence R. 1993. *The Health of Nations: Public Opinion and the Making of British and American Health Policy*. Ithaca, NY: Cornell University Press.
————. 1994. The Politics of American Ambivalence toward Government. In *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. Morone and Gary S. Belkin. Durham, NC: Duke University Press.
Jacobs, Lawrence R., and Robert Y. Shapiro. 1994a. Disorganized Democracy: The Institutionalization of Polling and Public Opinion Analysis during the Kennedy, Johnson, and Nixon Presidencies. Paper prepared for the Annual Meeting of the American Political Science Association, New York.
————. 1994b. Public Opinion's Tilt against Private Enterprise. *Health Affairs* 13:285–298.
Jacobson, Gary C. 1987a. The Marginals Never Vanished: Incumbency and Competition in Elections to the U.S. House of Representatives, 1952–82. *American Journal of Political Science* 31:126–141.
————. 1987b. *The Politics of Congressional Elections*, 2d ed. Boston: Little, Brown.
Katzenstein, Peter J. 1985. *Small States in World Markets: Industrial Policy in Europe*. Ithaca, NY: Cornell University Press.
King, Anthony. 1978. The American Polity in the Late 1970s: Building Coalitions in the Sand. In *The New American Political System*, ed. Anthony King. Washington, DC: American Enterprise Institute.
Kingdon, John W. 1973. *Congressmen's Voting Decisions*. New York: Harper and Row.

————. 1984. *Agendas, Alternatives, and Public Policies*. New York: HarperCollins.
————. 1995. *Agendas, Alternatives, and Public Policies*, 2d ed. New York: HarperCollins.
Kosterlitz, Julie. 1992. A Sick System. *National Journal* 24(15 February):376.
Krauthammer, Charles. 1991. . . . And the Perils of Populism. *Washington Post*, 8 November, p. A25.
Krehbiel, Keith. 1991. *Information and Legislative Organization*. Ann Arbor: University of Michigan Press.
Kristol, William. 1993. Defeating President Clinton's Health Care Proposal. Washington, DC: Project for a Republican Future, 2 December. Typescript.
Levit, Katherine R., Gary L. Olin, and Suzanne W. Letsch. 1992. Americans' Health Insurance Coverage, 1980–91. *Health Care Financing Review* 14(1):31–57.
Lewis, Pierce. 1992. Anatomy of an Upset. *American Demographics* 14(6):52–56.
Light, Paul C. 1982. *The President's Agenda*. Baltimore, MD: Johns Hopkins University Press.
Lindblom, Charles E. 1959. The Science of Muddling Through. *Public Administration Review* 14(spring):79–88.
Lipman, Larry. 1991. Republicans Unveil Proposal to Widen Health-Care Coverage. *Atlanta Constitution/Journal*, 8 November, p. A4.
Marmor, Theodore R. 1973. *The Politics of Medicare*. Chicago: Aldine.
————. 1994. *Understanding Health Care Reform*. New Haven, CT: Yale University Press.
Mayhew, David R. 1974a. *Congress: The Electoral Connection*. New Haven, CT: Yale University Press.
————. 1974b. Congressional Elections: The Case of the Vanishing Marginals. *Polity* 6:295–317.
————. 1991. *Divided We Govern: Party Control, Lawmaking, and Investigations, 1946–90*. New Haven, CT: Yale University Press.
McCombs, Maxwell E., and Donald L. Shaw. 1972. The Agenda-Setting Function of Mass Media. *Public Opinion Quarterly* 36:176–187.
————. 1993. The Evolution of Agenda-Setting Research: Twenty-Five Years in the Marketplace of Ideas. *Journal of Communications* 43(spring):58–67.
Merlis, Mark. 1993. Health Care Reform: Managed Competition. *CRS Issue Brief* IB93008 (4 June). Washington, DC: Congressional Research Service.
Monroe, Alan D. 1979. Consistency between Public Preferences and National Policy Decisions. *American Politics Quarterly* 7:3–19.
Morone, James A. 1995. Nativism, Hollow Corporations, and Managed Competition: Why the Clinton Health Care Reform Failed. *Journal of Health Politics, Policy and Law* 20(2):391–398.
The Nation: Highlights of Last Week's Elections. 1991. *New York Times*, 10 November, §4, p. 3.
Nelson, Barbara J. 1984. *Making an Issue of Child Abuse*. Chicago: University of Chicago Press.
Page, Benjamin I., and Robert Y. Shapiro. 1983. Effects of Public Opinion on Policy. *American Political Science Review* 77:175–190.

————. 1992. *The Rational Public: 50 Years of Trends in Americans' Policy Preferences*. Chicago: University of Chicago Press.

Peterson, Mark A. 1992a. Health Policy Making in the Information Age: Is Congress Better Informed than the President? Center for American Political Studies Occasional Paper 92-7. Harvard University, Cambridge, MA, August.

————. 1992b. Report from Congress: Momentum toward Health Care Reform in the U.S. Senate. *Journal of Health Politics, Policy and Law* 17(3):553–573.

————. 1994. Congress in the 1990s: The Change from Iron Triangles to Policy Networks. *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. Morone and Gary S. Belkin. Durham, NC: Duke University Press.

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

Reynolds, Larry. 1992. Healthcare Options in an Election Year. *Management Review* 81:10.

Riker, William H. 1986. *The Art of Political Manipulation*. New Haven, CT: Yale University Press.

————, ed. 1993. *Agenda Formation*. Ann Arbor: University of Michigan Press.

Rockman, Bert A. 1995. The Clinton Presidency and Health Care Reform. *Journal of Health Politics, Policy and Law* 20(2):399–402.

Rogers, Everett M., and James W. Dearing. 1988. Agenda-Setting Research: Where Is it Going? In *Communication Yearbook 11*, ed. James A. Anderson. Beverly Hills, CA: Sage.

Rohde, David. 1991. *Parties and Leaders in the Postreform House*. Chicago: University of Chicago Press.

Russakoff, Dale. 1991. The Right to See a Doctor When You're Sick: Wofford's Appeal for Access to Medical Care Creates 'Wildfire' in Senate Race in Pennsylvania. *Washington Post*, 19 November, p. Z9.

————. 1994. A Senate Torchbearer Gets Singed by His Own Flame. *Washington Post National Weekly Edition*, 24–30 October, p. 12.

Salisbury, Robert H. 1990. The Paradox of Interest Groups in Washington—More Groups, Less Clout. In *The New American Political System*, 2d ed., ed. Anthony King. Washington, DC: American Enterprise Institute.

Schlesinger, Arthur M. Jr. 1986. *The Cycles of American History*. Boston: Houghton Mifflin.

Schlesinger, Mark, and Taeku Lee. 1994. Is Health Care Different? Popular Support of Federal Health and Social Policies. In *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. Morone and Gary S. Belkin. Durham, NC: Duke University Press.

Schwartz, Maralee, and David Von Drehle. 1991. After Thornburgh's Defeat, Sen. Gramm Again Shifts View of GOP Senate Prospects. *Washington Post*, 17 November, p. A22.

Senate GOP Task Force Unveils Health Care Plan. 1991. *Houston Chronicle*, 8 November, p. A8.

Shepsle, Kenneth. 1989. The Changing Textbook Congress. In *Can the Government Govern?* ed. John E. Chubb and Paul Peterson. Washington, DC: Brookings.

Shogan, Robert. 1991. Wofford Wins Easily in Pennsylvania Upset. *Los Angeles Times*, 6 November, p. A1.

Sinclair, Barbara. 1986. The Role of Committees in Agenda Setting in the U.S. Congress. *Legislative Studies Quarterly* 11:35–45.

Skocpol, Theda. 1994. Is the Time Finally Ripe? Health Insurance Reforms in the 1990s. In *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James A. Morone and Gary S. Belkin. Durham, NC: Duke University Press.

————. 1995. The Rise and Resounding Demise of the Clinton Plan. *Health Affairs* 14(spring):61–85.

————. 1996. *Boomerang: How the Clinton Health Care Reform Effort Accidentally Gave Rise to a Revolt against Government*. New York: Norton.

Smith, Kim A. 1991. Newspaper Coverage and Public Concern about Community Issues. In *Agenda Setting: Readings on Media, Public Opinion, and Policymaking*, ed. David L. Protess and Maxwell E. McCombs. Hillsdale, NJ: Lawrence Erlbaum and Associates.

Starr, Paul. 1976. The Undelivered Health System. *Public Interest* 42(winter):75.

————. 1991. The Middle Class and National Health Reform. *American Prospect* 6(summer):7–12.

————. 1992. *The Logic of Health Care Reform*. Knoxville, TN: Whittle Direct Books.

Steinmo, Sven, and Jon Watts. 1995. It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America. *Journal of Health Politics, Policy and Law* 20(2):329–372.

Stelzer, Irwin. 1994. What Health-Care Crisis? *Commentary* 97(2):19–24.

Stimson, James A. 1991. *Public Opinion in America: Moods, Cycles, and Swings*. Boulder, CO: Westview Press.

Stone, Deborah A. 1989. Causal Stories and the Formation of Policy Agendas. *Political Science Quarterly* 104:281–300.

————. 1993. AIDS and the Moral Economy of Insurance. *American Prospect* 13(spring):62–73.

Swartz, Katherine. 1994. Counting Uninsured Americans: Background Memorandum. Paper Prepared for the Kaiser Health Reform Project. Henry J. Kaiser Family Foundation, Washington, DC, January.

Thomas, Rosita M. 1992. Health Care in America: An Analysis of Public Opinion. *CRS Report for Congress* 92-769 GOV (26 October). Washington, DC: Congressional Research Service.

Thorpe, Kenneth. 1992. Expanding Employment-Based Health Insurance: Is Small Group Reform the Answer? *Inquiry* 29(summer):128–136.

Todd, James S., S. V. Seekias, J. A. Krichbaum, and L. K. Harvey. 1991. Health Access in America—Strengthening the U.S. Health Care System. *Journal of the American Medical Association* 265(15 May): 2503–2506.

Truman, David B. 1951. *The Governmental Process: Political Interests and Public Opinion*. New York: Knopf.

Uchitelle, Louis. 1990. Data Verify Economy's Malaise: 16 States at or near Recession. *New York Times,* 16 July, p. A1.

Walker, Jack L. 1977. Setting the Agenda in the U.S. Senate: A Theory of Problem Selection. *British Journal of Political Science* 7:423–445.

————. 1991. *Mobilizing Interest Groups in America: Patrons, Professions, and Social Movements*. Ann Arbor: University of Michigan Press.

West, Darrell M., Diane Heith, and Chris Goodwin. 1996. Harry and Louise Go to Washington: Political Advertising and Health Care Reform. *Journal of Health Politics, Policy and Law* 21(1):35–68.

Yankelovich, Daniel. 1991. *Coming to Public Judgment: Making Democracy Work in a Complex World*. Syracuse, NY: Syracuse University Press.