HEALTH AT RISK

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Health at Risk

America's Ailing Health System — and How to Heal It

EDITED BY JACOB S. HACKER

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HEALTH AT RISK

Preface

JACOB S. HACKER

Major reform of American health insurance has once again risen to the top of the political agenda. For the past fifteen years, large-scale changes to the nation's $2.2 trillion medical complex were considered infeasible—too costly, too politically controversial, and too threatening to existing stakeholders to stand any chance of enactment. But for at least the fifth time since reformers struggled to enact compulsory health plans for workers at the state level in the 1910s, the goal of guaranteeing insurance coverage for working Americans has reignited as a burning issue.[1]

Two concerns dominate the growing public discussion: the dwindling reach and generosity of private insurance coverage, and the rapidly escalating cost of medical care. (A third concern, the uneven quality of American medical care, is rising in prominence as well.) These twin worries frequently come together in a single phrase: "health security"—protection against the potentially ruinous costs of health care and a stable foundation of access to quality medical services. Today, many Americans and their leaders believe that health security in the United States is declining and that substantial government action is required to safeguard and improve it. Yet fierce debate continues about how urgently such action is required and what form it should take.

Much of the debate is dominated by claims and counterclaims with little or no basis in serious research. Partisans on both sides make broad assertions unsupported by the facts, abuse statistical data, and misuse foreign and historical examples. In the heat of political battle, there is understandably little attention to the findings of scholarly investigations, much less careful attempt to weigh competing interpretations of the evidence. Nonetheless, the shrill charges that dominate our public discourse should not be taken to indicate that nothing firm is known about the financing, organization, and delivery of American health care, or how they could be made better. In fact, health policy experts in a range of fields have made enormous progress in understanding how America's health system operates. And they have also carefully outlined ideas both big and small for improving how this system works.

This book is an effort to bring these findings and proposals more fully into public discussion. Sponsored by the Social Science Research Council (SSRC), the world's preeminent organization advancing research in the social sciences, this volume is premised on the notion that all of us are entitled to our own opinions about American health care, but not our own facts. The pages to come carefully examine these facts, as revealed in cutting-edge social science research. Noted experts on health coverage, the quality of care, medical bankruptcy, the history of American health insurance, and the politics of health reform draw on the best existing social science research and their own expertise to speak to the pressing issues that face our nation today.

The contributors to this volume have not checked their opinions at the door. But they have all grounded their arguments in the empirical evidence, and expressed those arguments in clear and straightforward language, without scientific jargon. In doing so, they show that we know a good deal more about how our health system functions—and sometimes malfunctions—than the grandstanding and arguing around us suggest. As President Ronald Reagan once put it, "Facts are stubborn things." The facts about American health care should be at the center of the emerging debate over reform.

This volume grows out of a project hosted by the Social Science Research Council, "The Privatization of Risk." The goal of the project is to consider

the extent to which the distribution, effect, and management of risks has changed over the last generation. Its particular subject is the *economic* risks facing Americans in the early twenty-first century: where they come from, whether and how they differ from those faced in the past, how people think about them, how governments and the private sector deal with them, and how they can better deal with them in the future.

This project is an effort to engage the social sciences constructively in important national policy discussions. Since the Progressive Era in the early twentieth century, social scientists have played a prominent role in the debate over economic security. Many of the early campaigners for public insurance programs (and some of their opponents) were themselves social scientists, or closely allied with the social sciences, especially the emerging economics profession. In calling for change, these social scientists believed they were bringing scientific principles to bear on pressing matters of public policy. In the years since, as economics, political science, sociology, and related disciplines have become more professional and specialized, social scientists have moved away from the front lines. But they have continued to contribute to economic policy discussions in numerous ways, studying the contours of America's distinctive welfare state, estimating the impact of specific government and private interventions, and developing proposals for change both targeted and sweeping.

The phrase "privatization of risk" traces two linked trends in the management of economic risk in the United States. The first is the contemporary celebration of the private sector as the first and best means of dealing with problems of all kinds. This enthusiasm for private-sector solutions is nothing new. Today, however, America's long-standing enthusiasm for the private sector is joined with a sometimes unbridled faith that new technologies and new attitudes have finally "solved" the problems of risk management that once bedeviled commercial insurers and private financial institutions. In this ascendant credo, not only should the private sector manage major risks; it can do it better than it ever has—and, needless to say, better than government ever could.

This brings us to the second trend: the shift of responsibility for managing economic risk from government and employers onto individuals and their families. I have elsewhere called this "the great risk shift," and I believe it is a defining economic (and political) transformation

of our times.[2] The individual management of the economic risks of modern capitalism, whether through private retirement accounts or individual health savings accounts or through personal investments in education and housing, has never been as widespread or as widely celebrated as it is today. Yet with this responsibility has come pressing new questions about the ability of individuals to perceive, plan for, and secure themselves against the most threatening risks to their financial welfare—including the risks posed by declining health coverage and rising medical costs.

Each of the chapters that follow is concerned with one of more dimensions of the privatization of risk in American health care. How has health security changed in the United States? What is driving the change? What are its implications for the quality and cost of medical care received by Americans, or the health coverage they have (or, increasingly, do not have)? And what might be done to improve health security today? Although the authors are recognized experts, they have written their contributions so that they are accessible to interested nonexperts—which, ideally, should include a broad cross-section of Americans, so important is this discussion to us all.

The chapters in this volume do not present a single view on these questions. Nor are they of one mind about what should be done. What unites them is a commitment to grapple with three questions. First, what does social science research tell us about the interrelated problems that have prompted renewed attention to national health reform, most notably, those that are seen to compromise health security? Second, what does this research suggest with regard to how these problems should be addressed? Third, what does this research indicate about the prospects for changes of this sort? Not all of the contributors to this volume have addressed all three of these questions in depth, but each has thought about how his or her own research and the work of other social scientists illuminate the dimensions of contemporary problems as well as inform potential solutions to these problems.

Thus, in the first chapter, "The Transformation of American Health Insurance," Jill Quadagno and Brandon McKelvey, of the Pepper Institute on Aging and Public Policy at Florida State University, trace the

changing ideology and institutions of American health insurance, looking at both the private and the public sectors. They focus on a revealing shift in how health insurance is understood to function: from an emphasis on shared risk, embodied in the traditional practice of "community rating," employed by public programs and some nonprofit insurers that did not charge higher rates to less healthy subscribers, toward an emphasis on individual risk management, embodied in the contemporary private practice of "experience rating," in which subscribers are charged according to their expected medical costs. The apotheosis of this shift, they suggest, are so-called Health Savings Accounts, tax-favored savings accounts that are coupled with a high-deductible "catastrophic" health plan, requiring that people pay most routine medical costs themselves. Although Quadagno and McKelvey are clearly worried about this new entrant into the insurance mix—they argue, based on strong evidence, that it is likely to fragment the market and drive up costs for many by encouraging healthier people to opt out of employment-based insurance—their broader point is that private health insurance is less and less a guarantee of the broad sharing of risk, leaving government and individuals to pick up the slack.

This point is driven home by Katherine Swartz in her chapter, "Uninsured in America: New Realties, New Risks." A Harvard economist, Swartz provides an informative tour of the uneven landscape of American health coverage. She tackles the big questions that should be at the heart of today's policy discussion: Who is most likely to be uninsured, and why? What are the key trends in coverage? And what are the options for creating broad risk-sharing in American health insurance given these trends? Swartz reminds us that the fundamental problems are relatively simple: Health insurance is too costly for middle- and working-class Americans, much less the poor, to finance reliably on their own. At the same time, because medical costs are so high, insurance is essential. The small share of Americans who end up incurring the lion's share of national health costs in any given year must have insurance to finance these expenditures. Yet insurance coverage is dwindling, and will likely to continue to dwindle as long as costs rise and employers see declining reason to offer coverage.

Not only the uninsured are at risk because of rising costs, remind Elizabeth Warren and Deborah Thorne in their chapter, "Get Sick, Go

Broke." So too are those who have coverage, either because they are "underinsured" or because they do not have protection for one big cost of sickness, time out of the workforce. Warren of Harvard Law School and Thorne of the Department of Sociology and Anthropology at Ohio University designed the pioneering Consumer Bankruptcy Project—a study that has used surveys, bankruptcy court records, interviews, and other evidence to look at rates and causes of bankruptcy filings over the past decade and a half. They have found that medical costs and crises are a leading (and probably increasing) cause of bankruptcy filings. Warren and Thorne discuss why medical bankruptcy is so common, affecting as many as 2.2 million Americans (filers and their dependents) in 2001; why it affects even those who have health insurance, who make up a surprising 75 percent of filers; and what can be done to reduce the problem.

Swartz, Warren, and Thorne are mainly interested in health security—whether people have insurance, whether they can afford care, and what happens when they do not and cannot. But the quality of medical care is also a crucial issue in American debates, with many critics of proposals to expand health security arguing that reform will hurt "the best medical care in the world." In the fourth chapter of this volume, noted health policy experts David Meltzer and Elizabeth McGlynn bring their recent research to bear on this topic, asking "Just How Good *Is* American Medical Care?" As a leading quality analyst for the RAND Corporation, McGlynn has led the charge in developing new measures that reveal how big the gap is between what is known to improve health and what is done by doctors and hospitals in the United States. The cornerstone of this research is a comprehensive database of clinical guidelines for the treatment of a range of acute and chronic health conditions—in essence, a yardstick against which the appropriateness of care delivered (or not delivered) to patients can be judged.

McGlynn and Meltzer walk through the findings of this research: American adults receive only half of recommended care, children slightly less, and patients are more likely to be undertreated than overtreated. They then look at the United States in cross-national perspective, concluding that while American health care looks relatively good in comparative relief, it is hardly as exceptional as commonly believed. Despite the American system's very high price tag, for example, the United

States has fewer doctors, hospital beds, and nurses per person than the norm among rich nations. Though less healthy overall than citizens other rich nations, Americans visit doctors and hospitals less frequently and have shorter hospital stays. And the United States lags behind other rich nations in the use of information technology, such as electronic prescription systems, to improve quality and lower costs. Perhaps most surprising, the best care in the United States, according to McGlynn and Meltzer, is actually delivered by the government: through the Veterans Health Administration, which, thanks in part to the innovative use of information technology, provides more than two-thirds of recommended care (vs. the 44–55 percent seen in the U.S. system overall). Their big message is that quality does not naturally follow from greater spending or coverage; it needs to be cultivated with targeted efforts using information technology, practice guidelines, and other strategies for bringing into greater harmony what is known to work and what is actually done.

The cumulative effect of these chapters is to suggest that long-standing problems in American health care are growing worse even though there are known ways to make the situation better. The issue, it seems, is not irresolvable gaps in our knowledge or administrative capacities, but rather political and ideological disagreement about the proper direction of change. Given this evident dissensus, how likely is major action by our elected leaders to address declining health security? This is the question addressed in chapter 5, "The New Push for American Health Security." The goal of the chapter is to situate current political struggles in historical and cross-national relief. This requires knowing why the United States is the only affluent nation without health insurance for all its citizens, and what the answer to that question means for the prospects for reform today. It turns out that the main barrier to reform today is the failure of reform in the past, which has left the United States with a patchwork quilt of public and private coverage that divides the public and political elites and makes many Americans worried about the effect of change on *their* pieces of the quilt. In recent years, however, fundamental political and economic trends have collided to make large-scale reform a real possibility. The unanswered question is whether those favoring reform can learn from the "lessons of the past" and build a political and policy strategy that surmounts the barriers to reform that still loom large, without giving up on the basic aim of universal health security.

These contributions stand on their own. But they share a common conviction: that careful scholarship can and should speak to society directly and clearly on questions about which nonscholars truly care. The past and future of American health security could not be a more appropriate topic for such a discussion.

Every book rests on the contributions, advice, and assistance of many. That is all the more true of edited volumes. Each of the contributors to this book deserves a deep thanks. So too do the many colleagues, research assistants, administrative associates, spouses, friends, and children who directly or indirectly aided in the effort. Among them, Victoria Bilski deserves special gratitude for her diligent work transforming the essays that make up this volume into coherent and polished chapters.

Not only is this book inherently a collective effort, but in addition, it took a good deal of shared work to both envision it and bring it into its current printed form. All credit ultimately goes back to Craig Calhoun, President of the SSRC, who commissioned the "Privatization of Risk" project and envisioned the edited series that came out of it. Generous financial support for the project came from the John D. and Catherine T. MacArthur Foundation, as well as the SSRC itself.

To shepherd the volume to its completion, heartfelt thanks go to Paul Price at the SSRC and all of the hardworking editors and staff at Columbia University Press. They learned that it can be very difficult to contribute to current public debates, at least when that means turning a manuscript into a book in the amount of time that it takes most academic books to come back from reviewers. May the speed and quality of their efforts be a harbinger of the success of the debate that this book aims to influence.

NOTES

1 Previous debates took place during the 1930s, late 1940s, 1970s, and, of course, the early 1990s. I do not in this tally include the 1960s debate over Medicare, a program explicitly limited to the aged (though passed alongside the Medicaid program for the poor and later extended to the disabled). I say "at least five" because there were arguably two major debates over reform in the 1970s—one of which

centered around President Nixon's proposal to mandate that employers provide coverage, the other of which occurred later in the decade and featured competing proposals by President Carter and Senator Kennedy, among others.

2 Jacob S. Hacker, *The Great Risk Shift: The New Economic Insecurity and the Decline of the American Dream,* rev. and exp. ed. (New York: Oxford University Press, 2008; originally published 2006).

CHAPTER FIVE

The New Push for American Health Security

JACOB S. HACKER

In the spring of 1962, as Ray Charles's "Unchain My Heart" was climbing the singles charts, another recording by a noted performer was playing in American living rooms across the country. The words may not have been as catchy as Charles's, but they were no less urgent. The speaker on the vinyl LP warned about a bill before Congress that would bring about "socialized medicine" in the United States, imploring listeners to enlist their friends and neighbors to write in opposition:

> Write those letters now; call your friends, and tell them to write them. If you don't, this program, I promise you, will pass just as surely as the sun will come up tomorrow. And behind it will come federal programs that will invade every area of freedom as we have known it in this country. Until one day . . . we will awake to find that we have socialism. And if you don't do this, and I don't do it, one of these days you and I are going to spend our sunset years telling our children and our children's children what is was like in America when men were free.[1]

The voice, soon to be familiar in American political debates, was Ronald Reagan's. And the program sinisterly poised to steal our freedoms was Medicare—the popular federal health plan for the aged that passed in 1965.

As this little trip down memory lane suggests, Americans have been fighting over health care for a very long time. With pendulum-like regularity, the battle has flared up roughly fifteen years after it last flamed out. Reform efforts came to a halt in 1920, 1935, 1950, 1965 (when, despite Reagan's efforts, Medicare and Medicaid were enacted), 1980, and, of course, upon the crashing failure of the Clinton health plan in 1994.

Each time, well-intentioned reformers armed with the sorts of statistics and concerns so carefully laid out in the previous chapters of this volume have argued that change must finally come. And each time reformers have run headlong into a wall of ideologically charged opposition that has thrown exorbitant resources and energy into convincing political leaders and Americans that they will be made worse off by change.

To be sure, the predictions have not always been as dire as the loss of freedom foreseen by Reagan. Yet the charges have always involved the frightening claim that government involvement will lower the quality and raise the costs of medical care, threatening the wellness and financial security of those who are already insured. In a political culture skeptical of egalitarian government efforts and a political framework designed to make major policy transformation difficult, reform efforts have again and again collapsed under the weight of public concerns and interest-group opposition, leaving reformers short of their ultimate goal of universal health security.

So here we are in 2008, back on schedule to have a major national debate about health care, and with every right to ask: Why should anything be different this time? Is the present moment sufficiently more auspicious than when our leaders last waged battle on this issue? Has the line-up of contenders or the experiences or views of the public changed in fundamental ways? And what are the lessons those leaders should take from the past about the most feasible route to change today—particularly from the high-profile failure of the Clinton health plan in the early 1990s?

As the now-clichéd aphorism of George Santayana has it, those who do not learn from the mistakes of history are doomed to repeat them (or, he might have added, to come up with new mistakes of their own). But the lessons of the past are rarely as simple as we like to assume. Much of the social scientific analysis of health policy has been dominated by economists, whose methodological tools equip them well to examine the economic effects and incentives of existing and potential policies.

Economists have no special disciplinary claim, however, when it comes to political analysis and forecasting—the traditional domain of political scientists. Yet, for a variety of reasons, discussions of the elusive concept of "political feasibility" are today mostly dominated by those trained in economics. (One of these reasons is that surprisingly few political scientists actually study the political formation and effects of public policy.)[2] In what follows, therefore, I bring the insights of political science to bear on the question of whether and under what circumstances major reform of American health care might occur in the relatively near future.

This analysis demonstrates that some of the greatest political barriers to change of the past have weakened: a business community willing to throw in its lot with private bargaining and benefits, whatever the cost; a labor movement torn by its continuing faith in union-negotiated welfare capitalism; and, above all, a robust public confidence that private health insurance will inevitably expand. Alongside these long-term developments, moreover, new strategic thinking is taking place among reformers about how, in light of recent defeats, their long-deferred goal might yet be achieved. Central to this thinking is a recognition that the biggest political challenge is how to deal with America's eroding yet entrenched employment-based framework of insurance in a way that is sensitive to the easily ignited fears of well-insured workers that they will asked to pay more for less.

And yet, the long arc of American political history also reveals newly potent barriers, barriers that guarantee the fight will be bitter, the stakes epic, and the outcome deeply uncertain. The most dramatic of these obstacles, the hyperpolarization of American politics and the erosion of public faith in politics and government, suggest that constructively channeling the debate over health reform into concrete achievements will be one of the greatest tests our democratic process has faced—and one it may not pass.

EXPLAINING THE DISTINCTIVENESS OF U.S. HEALTH POLICY

To start our exploration, it is worth asking a deceptively simple question: Why is the United States the only rich democracy without guaranteed health coverage for all (or virtually all)? Although the health policies found in other affluent nations are often bafflingly complex and

diverse, this complexity and diversity mask substantial similarity across rich democracies' health programs, virtually all of which share two bedrock characteristics: they cover all citizens, and they employ measures to contain costs at a high level of aggregation.[3] Against this "international standard" (as Joseph White nicely calls it), only the United States looks like a conspicuous outlier, its public programs covering less than half the population, its overall spending largely unconstrained.[4]

As Table 5.1 shows, America's distinctive position cannot easily be chalked up to the penuriousness of its government. Yes, public health insurance in the United States covers just over 27 percent of Americans, whereas virtually all other rich nations cover their entire citizenry (column 1). But because American medical costs are so much higher than health costs in other nations (column 2), total U.S. public spending on health care per capita (including tax breaks for coverage and coverage for public employees) is actually the highest in the world (column 3). As the fourth column of the table shows, moreover, U.S. health spending (both public and private) is also growing much more quickly. What is distinctive, however, is that a very large share of the United States' very high spending is financed by voluntary private health insurance, sponsored by employers and heavily (and regressively) subsidized by the federal government through the tax code. (In 2004, the cost of exempting health benefits from taxation in terms of forgone tax revenues was $188.5 billion, with nearly 27 percent of this benefit going to the 16 percent of the population with annual family incomes in excess of $100,000.) This point holds more generally: Private employment-based benefits (mainly health insurance and retirement pensions) play a much larger role in the United States than other rich nations—so much more so that, as the final column of Table 5.1 shows, accounting for these private benefits raises U.S. spending on health and economic security as a share of the economy to something close to the average for advanced industrial democracies.

Nor, as Jill Quadagno and Brandon McKelvey show in their chapter of this book, is it simply the case that proposals for universal health care never made it to the top of the agenda of American politics. On the contrary: Presidents Truman, Nixon, Carter, and, of course, Clinton all made high-profile pushes for national reform. In each case, however, universal insurance for working-age Americans failed to win out. Why?

COUNTRY	SHARE OF POPULATION COVERED BY GOVERNMENT HEALTH PROGRAMS (2004)	TOTAL GOVERNMENT & PRIVATE HEALTH SPENDING PER CAPITA (2004)	GOVERNMENT HEALTH SPENDING PER CAPITA, INCLUDING TAX BREAKS (1998/99)	ANNUAL MEDICAL INFLATION IN EXCESS OF POPULATION GROWTH & AGING (1985–2002)	PUBLIC & PRIVATE SPENDING ON HEALTH & ECONOMIC SECURITY AFTER TAXES AS A SHARE OF GDP (2001)
Australia	100%	$3,120	$1300	.88%	24.0%
Austria	98%	$3,124		.65%	24.8%
Belgium	99%	$3,044		1.1%	26.3%
Canada	100%	$3,165	$1500	.43%	23.3%
Denmark	100%	$2881		-.10%	26.4%
Finland	100%	$2235		-.43%	22.6%
France	99.9%	$3159	$1400	.61%	31.2%
Germany	89.8%	$3043	$1600	.76%	30.8%
Greece	100%	$2162		1.31%	
Iceland	100%	$331		1.52%	21.7%
Ireland	100%	$2596		-.65%	13.9%
Italy	100%	$2467	$1150		25.3%
Japan	100%	$2249	$1200	-.03%	22.1%
Netherlands	62.5%	$3041		.88%	25.0%
New Zealand	100%	$2083			18.2%
Norway	100%	$3966		1.50%	23.6%
Spain		$2094		1.25%	18.9%
Sweden	100%	$2825	$1300	.19%	30.6%
Switzerland	100%	$4077	$2100	1.88%	
United Kingdom	100%	$2508	$1100	1.43%	27.1%
Non-US average	97.3%	$2859	$1405.5	.73%	24.2%
United States	27.3%	$6102	$2500	2%	24.5%

Sources: *OECD Health Data 2007,* "Share of population eligible for a defined set of health care goods and services under public programmes," (Paris: OECD, 2008); Gerard F. Anderson, Bianca K. Frogner, and Uwe E. Reinhardt, "Health Spending in OECD Countries in 2004: An Update," *Health Affairs,* September/October 2007; 26(5): 1481–1489; Steffie Woolhandler and David U. Himmelstein, "Paying for National Health Insurance—and Not Getting It," *Health Affairs,* July/August 2002; 21(4): 88–98; Chapin White, "Health Care Spending Growth: How Different Is the United States from the Rest of the OECD?" *Health Affairs,* January/February 2007; 26(1):154–161; Willem Adema and Maxime Ladaique, "Net Social Expenditure, 2005," OECD Social, Employment, and Migration Working Papers, No. 29 (Paris: OECD, 2005), available online at http://www.oecd.org/dataoecd/56/2/35632106.pdf.

Table 5.1 American health care and social policy in cross-national relief

The beginning of an answer is the observation that political parties have historically differed on the proper role of government in medical care. In cross-national research, a well-supported finding is that rule by parties of the left, particularly during the formative years of welfare state development, is associated with more expansive and generous social programs.[5]

The United States, of course, has one of the weakest traditions of socialism and social democracy of any rich democracy. Unions in the United States have relatively limited scope (and much reduced scope today, when they represent less than 12.5 percent of all workers, and just over 8 percent of private-sector workers). Moreover, true parties of the left have never been able to gain a foothold in America's strong two-party structure, both because of the weakness of organized labor and the difficulties that third parties face in America's winner-take-all electoral system.

Leftist rule is certainly not a necessary condition for universal health care, as it has been adopted under governments of varying partisan stripes. But it does appear strongly associated with the establishment of comprehensive "national health services"—programs in which hospitals are owned by government and doctors receive a government salary. More generally, extended governance by socialist and social democratic parties is associated with a diminished role for private insurance and direct consumer payments, which the left has long viewed as inegalitarian.[6] Again, the United States stands out even among other English-speaking nations as distinctively hostile territory for left parties, and as the affluent nation most reliant on private insurance and out-of-pocket spending.

In all nations, however, the scope for political leaders to achieve their favored goals is heavily constrained by the structure of political institutions, particularly the opportunities for blocking activity that institutions create for powerful opponents of national health programs like the medical profession. As Ellen Immergut has convincingly argued, opponents of large-scale government entry into the health field have generally been advantaged when a polity has a large number of "veto points," such as federalism and a separation of powers between the executive and legislature.[7] This no doubt helps explain why no nation with federalism (partially autonomous subnational governments, like the American states or Canadian provinces) has adopted a national health service; why across nations the share of medical spending financed by government is strongly correlated with the number of institutional veto points; and why Switzerland, with its strong federalism and tradition of the use of popular referenda by organized groups, has long been characterized by the most anemic government role in health policy of all European nations. It is also consistent with the fact that the United States—which, with its separation of legislative and executive powers and federalist structure,

has the most veto-point-ridden polity of any rich democracy—remains the only advanced industrial state that does not have a broad framework of public coverage or cost containment and relies principally on voluntary employment-based coverage.[8]

Still, with the exception of the United States, all advanced industrial democracies have adopted some version of the international standard. This suggests that institutional barriers are better at slowing than halting government's entry into the medical field. The timing and sequence of policy interventions, however, may be highly consequential for the *form* that national health policies ultimately take. Most countries began to intrude into the doctor-patient relationship by subsidizing nongovernmental insurers, rather than financing services. These policies created important vested interests in a pluralist financing structure and reinforced doctors' preferences for fee-for-service payment. How extensive and long-lived these arrangements were thus had crucial effects on the types of systems countries ended up with.[9] Countries in which authoritative government action to consolidate or supplant nongovernmental insurance took longer to achieve generally ended up with more decentralized and costly health financing systems in which private insurance and finance played a more pivotal role—in part because delay allowed the formation and enrichment of a formidable collection of private stakeholders, and in part because sophisticated private care represents such a massive burden for government budgets to assume.

This is a paradigm example of what social scientists call *path dependence,* temporal processes in which early choices create self-reinforcing effects that are inherently difficult to reverse.[10] The United States, again, represents an extreme case: Private insurance has, in effect, come to play the role that public programs do elsewhere, and this role has proved as difficult to dislodge as the public foundations of mature welfare states.[11] At the most basic level, the answer to the question of why the United States lacks national health insurance is that *Americans have come to rely on predominantly private sources of health security.* To be sure, private coverage is contracting, and many who have private coverage are insufficiently protected against ruinous financial losses. It remains the case, however, that private insurance reaches just over three in five nonelderly Americans. And this means, in turn, that proposals for public coverage face singular hurdles—not just the opposition of a huge and resourceful

private medical sector, but also the fears of privately insured Americans about threats to existing protections.

ROOTS OF AMERICAN EXCEPTIONALISM

Now deeply embedded, America's unique reliance on the private sector for health security was hardly foreordained. It emerged from political conflicts in which outcomes could have been different. Nor was it guaranteed by the early defeat of public coverage. Endemically prone to failure, the private insurance market had to be actively constructed by private leadership and public policy, which came together at critical junctures in the early to mid-twentieth century to bolster private institutions as a bulwark against state intervention.

The crucial interlude was the 1940s through the late 1950s—often seen as merely the calm eddy between the two "big bangs" of American welfare-state building: the New Deal and Great Society. The standard narrative about this period highlights the blocking role played by Southern Democrats, who dominated leadership positions in Congress thanks to the lack of effective partisan competition in the South. To limit the reach of the federal government into local arrangements of racial hierarchy and exclusion, many Southern Democrats aligned with Republicans against new social policy initiatives, including national health insurance. Yet important policy departures took place despite the stalemate over national reform, and the success of opponents of national health insurance rested critically on promoting a credible private alternative, frequently with extensive government assistance.

During the debate over national health insurance in the late 1940s, for example, the American Medical Association (AMA) made voluntary health insurance the foundation of its bitter assault. Emphasizing that "[y]ou can't beat something with nothing," the AMA's PR guru declared: "We want everybody in the health insurance field selling insurance as he never sold it before. If we can get ten million more people insured in the next year and ten million more in the next year, the threat of socialized medicine in this country will be over."[12]

Although the AMA was the most prominent group touting the virtues of private insurance, it was hardly alone. Commercial insurers were also on board, of course, and so too was corporate America. Large

employers backed private benefits as a means of buying working goodwill, placating (or heading off) unions, and undercutting Democratic efforts to enact national health insurance. In 1949, *Life* magazine wryly described workplace fringe benefits as "ransom devices to buy off the Welfare State"—a ransom that would become more and more dear as coverage spread and health care costs rose.

Indeed, once the floodgates of private provision opened, even organized labor joined the bandwagon. When, for example, the Eisenhower administration announced it was reviewing the tax treatment of health insurance in 1954, the Congress of Industrial Organizations (CIO) submitted a confidential memo on behalf of "five million wage earners" in support of the tax exemption of insurance.[13] Though the CIO noted the huge new levies on workers with private insurance that would result if health benefits were taxed, its main warning concerned "the harmful effect which a reversal of the present tax ruling would have on the growth of voluntary hospitalization and medical plans."[14] The same CIO that had stated in 1949 that "[t]he voluntary groups are limited by their very nature from providing comprehensive care to everyone" now criticized any action that would "adversely affect the continued growth of voluntary prepayment plans . . . as a mechanism for providing comprehensive health services to the American people."[15]

The spread of private benefits into the workforce had two far-reaching political effects. The first was to displace the battle for national health insurance into the areas where private benefits remained rare: namely, among the aged and the very poor. In this light, Medicare and Medicaid—far from the precedents for universal coverage—were gap-filling measures that lessened pressure for national insurance by dealing with the groups most conspicuously left out of the private system.

This brings us to the second effect of the ascendance of private coverage: to create powerful, enduring hurdles to an expanded public role. Americans came to depend on the private system, and powerful vested interest arose within and around it. Major legislative changes to that system, even changes that would make Americans as a whole better off, increasingly ran headlong into the specific dislocations that reforms threatened. Just as with well-entrenched public programs like Medicare and Social Security, radically transforming established networks of private social provision is a political fool's errand. In this broader historical view,

the failure of the Clinton health plan in the early 1990s was as much a reflection of the inherited barriers created by past policy battles as it was of the distinctive character of U.S. politics in *fin de siècle* America.

THE RISE AND DEMISE OF THE CLINTON HEALTH PLAN

Without too much simplification, American health care debates can be divided into two broad eras: the era of expansion, in which private and public coverage extended to reach ever more Americans, and the era of contraction, dating roughly to the late 1970s, when, as Katherine Swartz documents in her chapter in this book, coverage began its contemporary slide.

The debate over the Clinton health plan was the first to take place in this second era, and to the many who engaged in it, the urgency of the discussion was a direct reflection of worsening conditions on the ground. Surely, now that coverage was eroding, the United States would finally wake from its slumber and end its singular status as the only rich democracy reliant on voluntary, employer-provided health insurance to cover (or not, as the case often was) all but the poorest of its working-age citizens.

It did not work out that way, of course. The Health Security Act—1,342 pages long and based on an intricately complicated theory known as "managed competition within a budget"—was dead on arrival. But it succumbed not to some inexorable law of politics that makes any government attempt to deal with the problems in health insurance an impossible sell. Rather, it was an already-crippled creature dropped into the den of wolves that America's ultraexpensive medical complex had spawned.

First were the self-inflicted wounds. Rather than press for quick action based on broad principles, Clinton's policy team constructed a grandiose process for developing an ideal plan that could bridge all the major ideological and political divides. Rather than build on existing programs, insiders in the process denigrated them as flawed and insufficient. One memo on Medicare by a top architect of the Clinton plan declared, for example, that "Medicare's entire history should be a lesson on how not to structure a national health program," ignoring that Medicare was the only national program the United States had and one that was overwhelmingly popular.[16]

At the root of the problem was the elevation of policy analysis over political analysis, a persistent problem for progressive reformers but one abetted in recent decades by the rise of a much more sophisticated science of policy development. As anyone who attempts to follow health policy discussions knows, health reform has become an arcane arena of dueling statistics and approaches. And as anyone who attempted to follow them in the early 1990s will recall, the Clinton plan was formulated in this hothouse of competing reform "models."[17] Even the unwieldy moniker of Clinton's hybrid approach, "managed competition within a budget," belied the plan's aspiration to bridge the elite divide by synthesizing articulated reform visions (private plan competition, public insurance with a cap on spending) embodying sharply contrasting assumptions but sharing the same commitment to technically minded policy analysis.

All this may seem to make too much of elite discourse. But consider the Clinton administration's missteps in light of the policy-analytic mindset. In the craft of policy design, the plan was a tour de force, envisioning the comprehensive remaking of America's medical-industrial complex. Existing employment-based health plans? Inadequate and destructive of the delicate incentives the plan envisioned. The answer: Let only the largest corporations run their own plans under strict rules, a choice that leading employer representatives decried as "movement toward a government financed and controlled system."[18] No platform for properly incentivized consumer choice? Build it, in the form of so-called Health Alliances, a new nation-spanning administrative infrastructure, and the plans will come. And the plans? HMOs and other tightly managed products were the wave of the future, so make these the centerpiece, regardless of the fears they might provoke. The architect of Medicare, Wilbur Cohen, liked to say that social reform was 1 percent inspiration and 99 percent implementation. The Clinton plan was 99 percent inspiration.

The problem was not that the Clinton reformers did not have a strategy to enact their proposal. The problem was that the strategy was their proposal. As a task force memo by Walter Zelman, a central formulator of the plan, put it in March 1993, "We have found a unique blend of approaches that is better than competing models.... It is not a low-level compromise, a product of political give and take, but a genuinely higher synthesis.... We have something...we can really be proud of—a true political break-

through, and [a] new possibility of achieving the kind of consensus we've never gotten to before."[19] The proposal was the political breakthrough.

It was but a short distance from there to the denigration of existing institutions as flawed and inefficient means of achieving "a genuinely higher synthesis," no matter their familiarity or entrenchment. And it was but a short distance from there to the conceit that coalition building was mostly a matter of policy fine-tuning, of brokering political deals ex ante via the fine points of policy blueprints. But it was a very long distance from there to a proposal that could address public concerns about declining coverage and rising costs without stoking fear or confusion. Premised on resolving elite-level disagreement, the structural details of the proposal were not just incomprehensible to most Americans but frankly threatening, envisioning the near-total eclipse of employment-based insurance and the massive expansion of tightly managed plans. The resulting scheme was so complicated, so intricate, so unwieldy it could be portrayed as anything opponents wanted, and fearsome caricatures of liberty-robbing, big-government monstrosities were soon unleashed—caricatures that could scarcely be dispelled with vague mantras of "choice," "security," "simplicity," and "savings." Not surprisingly, public support for the plan plummeted after Clinton's stirring September 1993 speech describing the proposal.

Hobbled, the plan was then crushed under the weight of interest-group and conservative resistance. It had tried to appease all the major groups. The problem was that all these groups still had plenty of incentive to fight, and plenty of money and other resources to wage that fight. No other nation has tried to transform a medical-industrial complex as large or as a costly as the American system, or to do so as thoroughly. Once the battle heated up, even ordinary Americans sympathetic to the cause grew wary, fearful they would lose their own benefits without something better in return. Born in a policy hothouse, the plan wilted in the cold winds of politics, friendless, misunderstood, and shunned by the very middle-class Americans whose plight had prompted the effort.

IS THE TIME NOW RIPE?

Should we expect a different response this time around? There is no question that health security has eroded since the Clinton health plan's

defeat. Personal bankruptcies caused by medical costs, rampant uninsurance and underinsurance, runaway medical debt, crippling benefit costs—all these problems have grown more prevalent and troubling, and all of them increasingly affect the politically crucial middle class. As Katherine Swartz's chapter in this book vividly demonstrates, the ranks of the uninsured have grown substantially since the early 1990s—among the middle class as well as lower income groups (even though the poorest of Americans have been cushioned by the major expansion of public coverage for low-income groups). Medical bankruptcy, as Elizabeth Warren and Deborah Thorne show, is also a major, troubling, and almost certainly growing problem—one that affects those who have health coverage as well as those without it.

Indeed, if the overriding problem of the 1990s was lack of health insurance—a problem that has, of course, worsened—the looming problem of this decade may well be "underinsurance," the lack of *adequate* health insurance. In the twelve months prior to May 2007, according to a survey by *Consumer Reports,* around three in ten nonelderly adults who had health insurance lacked adequate coverage.[20] Nearly six in ten of the *under*insured postponed needed medical care because of the cost, nearly four in ten had to put off home or car maintenance or repairs due to medical expenses, a third had to dig deep into their savings to pay for medical care, and more than one in five made job-related decisions based mainly on their health care needs. Strikingly, the median family income of the *under*insured is $58,000—almost exactly the same as the median income of those with adequate coverage. The underinsured are just as likely to be white as the well-insured, nearly as well educated, and just as likely to work full-time and in large or medium-sized companies. The only consistent way in which they differ from those who are better protected is that they are at grave, and growing, economic risk.

The main reason for these worrisome trends is simple: As medical costs and health premiums continue to skyrocket, traditional employment-based coverage is declining. Some surveys suggest its reach has plummeted by as much as 9 percentage points between 2000 and 2005, while others indicate a steadier and somewhat smaller drop.[21] What is not in dispute is that Americans are ever less likely to be covered by their employers, and that employers are asking workers to pay a larger share of the cost of their coverage and care. With health premiums growing by

roughly 50 percent in inflation-adjusted terms between 2000 and 2006, over a period in which median family income actually declined, it is little surprise that health care costs and coverage have risen in prominence as stated concerns of Americans in opinion surveys.[22]

What the failure of the Clinton health plan vividly demonstrates, however, is that most Americans—even the underinsured and soon-to-be-uninsured, the potentially uninsurable and the one-illness-from-bankrupt—can be scared into fearing that changing America's inadequate public-private patchwork means higher costs and lower quality. This is the legacy of an insurance structure that lulls many into believing they are secure when they are not, that hides vast costs in quiet deductions from workers' pay, that leaves government paying the tab for the most vulnerable and the least well, and that so fragments the purchase of care that no one can bargain for lower prices or judge the value of what is being bought. Call it the catch-22 of health reform: It is the very failings of our insurance system that make dealing with those failings so devilishly hard.

Historically, advocates of reform have looked at this challenge through a rationalist lens, assuming that the basic problem is showing Americans that their fears of higher costs and lower quality are ungrounded. The evidence for such a demonstration is certainly easy to come by. With regard to costs, the United States not only spends much more than any other nation (either per capita or as a share of the economy), but has also seen its spending grow much more quickly than the norm for other rich democracies since the mid-1980s (refer back to Table 5.1). And one does not need to look abroad to see the cost-control advantages of public insurance: Since the introduction of cost controls in the 1980s, Medicare's expenditures have grown substantially slower than private insurance spending.[23]

If the assertion that greater government involvement inevitably drives up costs crumbles in the face of the cross-national and historical evidence, more plausible is the common claim that America's high level of spending guarantees much better care than seen abroad—care that would be made dramatically worse, or so the argument continues, by increased government involvement. But the growing body of research on health quality and outcomes has not been particularly kind to this claim either.

For starters, the dramatically lower spending seen abroad does not seem to be due mainly to "rationing." Waiting lists do crop up in other

rich nations, but even countries without waiting lists spend much less than we do. The United States has fewer doctors, hospital beds, and nurses per person than the norm, and Americans (while less healthy overall) visit doctors and hospitals less often and have shorter hospital stays. Even the prevalence of high-tech equipment like MRIs does not look exceptionally high. And the United States lags far behind other rich nations in the use of information technology to improve quality.

Instead, the main reason for the United States' higher spending appears to be the high prices charged for our medical goods and services—the same medical goods and services that are delivered abroad. Add to this big price disparity the very high administrative costs of our fragmented system, and it becomes easier to understand how the United States can spend so much more with so little evidence of superior care.24 In 2007, a team at the business consulting firm McKinsey & Company underook a comprehensive cross-national analysis of U.S. health spending. Their conclusion was that the United States spent almost a third more than would be expected based simply on the nation's per capita income—roughly $500 billion in extra spending a year—and that the modestly poorer health of Americans could not explain much of the difference. The principal reasons for the discrepancy, they concludeed, were higher input costs, especially higher drug costs; higher profits and taxes due to the heavy reliance on for-profit providers and insurers; and higher administrative costs. "Despite higher costs," the McKinsey team concluded, "the United States does not deliver objectively better quality and access for U.S. citizens as a whole relative to peer countries."[25]

Indeed, as David Meltzer and Elizabeth McGlynn show in their chapter, on some measures our care looks surprisingly substandard. For example, a recent six-country study concludes that "the U.S. scores particularly poorly on its ability to promote healthy lives, and on the provision of care that is safe and coordinated."[26] Meanwhile, analyses of "amenable mortality"—deaths that could have been prevented with timely care—find that the United States has the highest rate of preventable death before age seventy-five among rich nations, and that it is falling farther and farther behind.[27] To be sure, the United States performs well in some areas of high-tech care, as well as some areas of preventive screening; but given how much the United States spends, it is striking how poor American care often is.

Findings like these, published in highly respected journals of health care, provide firm grounding for believing that expanding health coverage through an increased government role is likely to reduce, rather than accelerate, the growth of costs, and improve, rather than harm, the overall quality of care—not least because of the extension of coverage to tens of millions of people whose insurance is inadequate, episodic, or nonexistent.

Yet advocates of fundamental change should be wary of the conceit that simply "getting the facts out" will spur a groundswell of public support for action or easily defuse the inevitable attacks on reform. Recent political science and behavioral psychology research suggests that when political appeals are highly emotional and personal—as, necessarily, are discussions of health care—voters are swayed by their immediate "gut" responses as much as, if not more than, by cognitive evaluation of the competing merits of alternative positions.[28] This is certainly one reason why initially strong public support for the Clinton health plan eroded, as critics pilloried the plan, often deploying grossly exaggerated or inaccurate claims designed to produce visceral reactions. And it suggests that reformers should be proactive in identifying and protecting the soft underbellies of their cause, as well as in thinking carefully about the nature of the public concerns to which they are responding.

WHAT AMERICANS THINK ABOUT REFORM

Public opinion regarding health care is notoriously tricky to interpret. Most Americans, for example, express satisfaction with their personal health care even as they voice high levels of dissatisfaction with the American "health system" as a whole. (Similarly split responses can be seen in evaluations of public school teachers and public schools as a whole, and members of Congress and Congress as a whole.) Moreover, responses to health care questions, like responses to other survey questions, are highly influenced by question wording, and there are many badly worded questions asked about health policy. Thus, the result of any one survey should be viewed with considerable skepticism; the strongest judgments come from analysis of survey questions that have been asked repeatedly in the same basic way over a fairly lengthy period of time.

The response to these sorts of survey questions suggests four broad conclusions about the public's views of health care reform and their evolution over time:

1. Health care is a leading concern of Americans, consistently at or near the top of private financial worries and less consistently but still quite frequently one of the major problems that Americans say faces the nation. Public concern about health care as a national political issue appears to track elite debate closely, but whether it drives or follows national discussions is not entirely clear. Health care tends to emerge as a leading issue among the public during periods of heightened economic distress. As it rises as a concern, political efforts to address it amplify public identification of the issue as a major national priority, transforming private worries into a top-tier public issue.
2. Americans are generally supportive of covering the uninsured—even if doing so requires additional resources. Although survey questions on this topic that have been asked identically over time are less common than one might think, those repeated questions that do exist suggest that the level of support for government action to universalize coverage is roughly as high as it was in the early 1990s, with two-thirds of the public expressing approval. Support remains strong even when respondents are asked whether they would be willing to pay more to cover everyone, and far exceeds support for extending the tax cuts of 2001 and 2003, among respondents of all partisan leanings.[29] Figures 5.1 and 5.2 summarize the responses to two relevant questions from the General Social Survey: "Should government spend more or less on health care, given spending more implies an increase in your taxes?" and "Is it the responsibility of government or people themselves to pay for doctor and hospital bills?" As can be seen, support for increased spending has risen fairly consistently since the mid-1980s. Support for government help with health care (as opposed to self-reliance) has fluctuated up and down but is higher now than at any point since the early 1970s, with the exception of the spike in support for government assistance in the years leading up to the debate over the Clinton health plan.

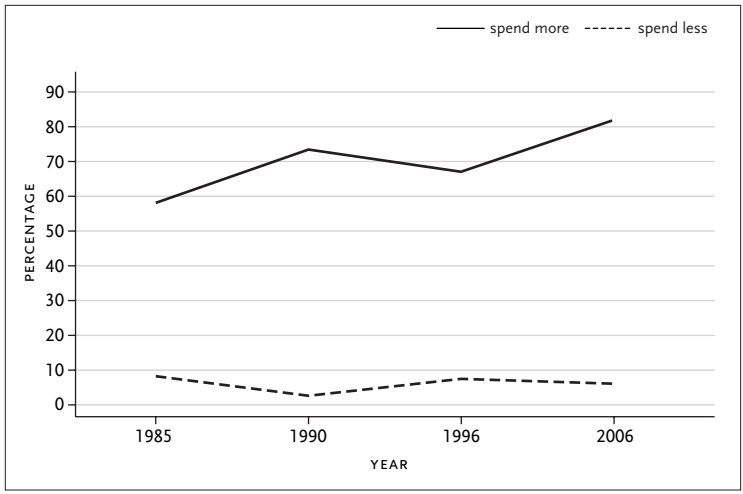

Figure 5.1 Should government spend more or less on health care?

[Source: General Social Survey, Question 1180, "Should government spend more or less on healthcare, given spending more implies an increase in your taxes?]

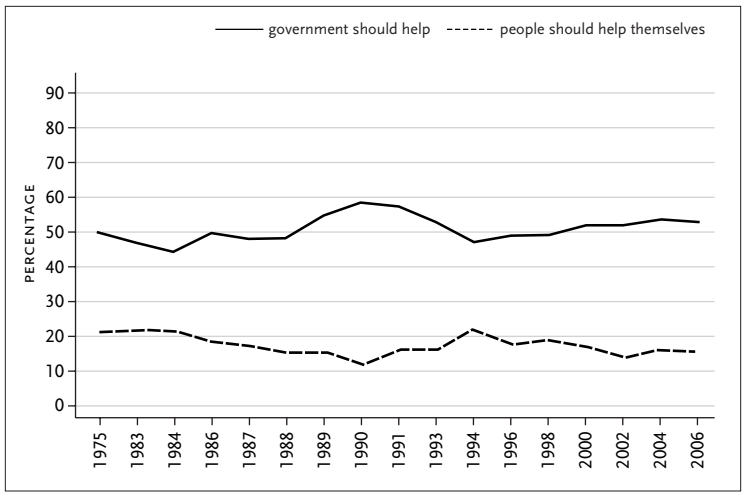

Figure 5.2 Government helps pay for health care or people help themselves?

[Source: General Social Survey, Question 311, "In general, some people think that it is the responsibility of the government in Washington to see to it that people have help in paying for doctors and hospital bills. Others think that these matters are not the responsibility of the federal government and that people should take care of these things themselves. Where would you place yourself on this scale, or haven't you made up your mind on this?" Responses 1 and 2 on the five-point scale are coded as "government should help"; responses 4 and 5 as "people should help themselves." "Agree with both" and no answer excluded.]

3. Public support for government action is coupled with substantial skepticism about the capacity of government, particularly when it comes to safeguarding the quality of medical care. Public trust in government has plummeted in the last generation, reaching a post-World War II nadir in the 1990s, climbing in the wake of the terrorist attacks of September 11, 2001, then falling again to 1990s levels by 2007.[30] Although supportive of government efforts to achieve universal coverage, most Americans express little confidence that government action will reduce their own costs, and the plurality generally state that private insurance would provide better quality care than government insurance. This makes it all the more remarkable how supportive of reform Americans are, but also suggests that public support is highly vulnerable to critics' charge that government involvement will drive up costs and degrade the quality of care.
4. Americans do not have firm opinions regarding the competing reform options about which policy experts so strenuously argue. Given multiple choices, they almost always split relatively evenly among them, and support for different options varies greatly with question wording. Nonetheless, the strongest support can consistently be elicited for measures requiring employers to provide health insurance to their workers. American are more ambivalent about both a national health program in which the federal government pays for care and measures to require individuals to purchase health insurance on their own. Despite decades of rhetoric criticizing government price restrictions and suggesting that patients should be more exposed to health costs, Americans are supportive of government cost controls for prescription drugs and medical services, believe that doctors and hospitals should be limited from charging "too much," and are wary of proposals that would increase out-of-pocket health spending.[31]

In all four of these areas, the relative stability of public opinion is more striking than its evolution. Recent public opinion on health care looks remarkably similar to the contours of opinion in the early 1990s, when health care reform emerged as a leading issue. Today, as then, support

for major policy change is substantial—much higher than it is on many other issue where politicians have obliged by enacting legislative responses. Moreover, there is good reason to think that the dynamics of opinion are even more favorable for change today. The Clinton reform effort was launched amid a relatively conservative era in public opinion—a reality that became clearer when Republicans captured Congress in the wake of the Clinton health plan's failure. Over the last five to seven years, however, indices of public opinion show a significant move in a more liberal and pro-Democratic direction.[32] Americans are more likely to endorse a social safety net and express concern about rising economic inequality than they were when President George W. Bush took office, and much more likely to identify with the Democratic Party.

STRATEGIC SHIFTS IN FAVOR OF REFORM

But American politics is never simply about solving recognized problems, even when they affect a growing share of the middle class. The collapse of America's rickety public-private system has been predicted many times, and each time it has continued to limp along, hemorrhaging dollars, enrollees, and good will, yet still maintaining crucial reservoirs of support. Ultimately, then, three developments at the level of political elites may prove even more pivotal in improving the prospects for change.

The first is that corporate America may well be ready, after years of a promised conversion, to acquiesce to major changes. Although many corporate leaders were favorable toward action in the early 1990s—at least until the Clinton plan came out, medical inflation abetted, and Republican leaders and health industry interests cross-pressured them—even more today seem to recognize that absent action, they will increasingly be caught between the rock of rising costs and the hard place of hurting their workers by dropping coverage or providing bare-bones plans. The last decade has seen large employers pull out every trick in its arsenal for controlling costs, to little avail. Now, the only surefire way to cut expenses is to trim coverage and shift risks onto workers, which is not just unpalatable, but also likely to stoke public interest in reform.

The cause of reform would be greatly advantaged by weakened business resistance, but this outcome is by no means foreordained. In

the early 1990s, a number of large unionized employers vocally supported national action, but their voices were drowned out by the fierce attacks of small employers and the growing wariness of less cost-pressed employers and their national representative organizations. Moreover, as Quadagno and McKelvey point out in their chapter, the next big thing for employers seeking to control health costs may well be "consumer directed health care," and in particular the move toward "defined-contribution" health plans that cap employers' obligations. Although the predicted mass movement in this direction has yet to materialize, surveys of corporations indicate that they believe that greatly increased cost sharing can control costs. As in the early 1990s, when employers opted for managed care as a putative private solution to runaway costs, reformers today may well be in a race against time, seeking to promote a reform vision that will split or placate the business community before a widespread employer turn toward private-sector solutions.

The second important development is a subtle but promising shift in the stance of organized labor. In the early 1990s, leading unions were deeply split over the appropriate course on health care, and a substantial number still clung to the notion that generous union-negotiated benefits could be sustained against the tide of economic transformation and business resistance. Today, there is both greater boldness and greater pragmatism, born of realism about the health of employment-based benefits and of desperation about a shrinking membership. Labor leaders know their movement's future rests on getting health care right, and that means moving beyond the current system.

The most visible figure in this shift is Andrew Stern, head of the Service Employees International Union (SEIU), as well as a leader of Change to Win—a coalition of unions that broke from the AFL-CIO in 2005. Stern is scathing in his denunciation of employment-based health insurance, which is particularly hard to secure for the nearly two million service workers SEIU represents (and even harder to secure for the unorganized service workers SEUI hopes to recruit). Yet Stern has proved willing to join with business leaders to call for intermediate steps toward universal insurance. The most notable alliance brought together Stern and the CEO of the union-disparaged retailer Wal-Mart, H. Lee Scott, who together vowed action on health care in the next five years. If history is any guide, these alliances are unlikely to last once the debate

over reform heats up. But they are indicative of Stern's willingness to join forces with business leaders when he believes it can advance the cause of action. "We're way past the question, 'Can an employer solve this problem?'" Stern said in 2007. "We're at a point where the country has to solve the problem."[33]

The split within labor's ranks, however, suggests the limits of unions' influence. Once covering more than a third of the workforce, American unions now cover less than one tenth of private-sector workers (and around one in eight workers overall). In terms of their ability to spend on political campaigns and lobbying efforts, unions pale in influence compared to the other major players in health care: insurers, pharmaceutical companies, and business. But organized labor has arguably become more politically and organizationally adept since the health reform debate of the early 1990s. As Stern's leadership suggests, unions are less likely than they were in the past to worry about the effect of reform on negotiated private plans. And they clearly recognize that the next health reform debate may be their last real chance to free unions (and employers) from the heavy burden and constant struggle created by private health benefits for an aging unionized workforce.

This brings us to the final promising sign: the evolving strategies of advocates of comprehensive reform, who have returned to their field of dreams with greater sensitivity to some of the political risks they face—particularly the concern of Americans that their current coverage, however substandard, will be hurt or taken away without something better taking its place.

NEW DEBATE, NEW STRATEGIES

As the dismal failure of the Clinton health plan suggests, the two greatest barriers to reform are fear and financing—the fear that good employment-based coverage will be destroyed, and the substantial government financing (and taxes) that will be required to substitute public spending for the private spending that now runs through employers, largely in the hidden form of forgone cash wages. Although Americans are much more supportive of government action to fix health care than conventional wisdom suggests, the Achilles' heel of reform is that most Americans do have some source of insurance most of the time. Against this backdrop, the easiest

way to kill reform is to say, "Oh yes, I support change, but this change will destroy what you have, this change will make you pay more for less."

As we have seen, Americans are much more receptive than the conventional wisdom suggests to an enlarged government role in health care, including new taxes to support it.[34] But this is before the fear-mongering has really begun. Expanding public coverage may be the most promising route to cost control, but public coverage requires money, and money requires taxes, and taxes are politically difficult to enact even under the best of circumstances—not least when they substitute for the much less visible drain on workers' paychecks created by employment-based insurance.

When the rhetoric heats up, reformers will need to be able to fight fear with fear—the fear of government with the fear of losing private coverage, the fear of taxes with the fear of medical bankruptcy and debt. Reformers will also need to be able to fight fear with hope: with a clear, simple, and unthreatening vision that builds on what exists and meets public concerns head on—a vision that may lack the intellectual satisfaction of a fine-tuned policy blueprint, but which provides the political satisfaction of actually having a chance of passage.

There is some evidence that today's reformers have taken this second lesson to heart (though simplicity and clarity still remain elusive). In announcing their reform intentions in 2007, all of the top-tier Democratic candidates for president—Senator Hillary Clinton, former Senator John Edwards, and Senator Barack Obama—eschewed both a "Medicare-For-All" plan and an individualized approach in which Americans would be required to obtain coverage outside of employment with the help of government subsidies and purchasing pools. Instead, they have embraced a messy mix of elements: (1) the creation of a new government insurance "menu" that would allow all Americans without workplace health insurance to choose among a range of regulated private health plans, as well as to enroll in a new public insurance plan modeled after Medicare; (2) a requirement that employers either provide coverage or pay a mandated contribution to help finance their workers' coverage through this new government pool (aka "play-or-pay"); and (3) a requirement—initially, or eventually if necessary—that all Americans show proof of coverage.

From a policy standpoint, this three-pronged approach lacks conceptual purity. But from a political standpoint, it has real virtues. For

one, most workers who now enjoy good employer-provided insurance would continue, at least initially, to receive it at their place of work. For another, because employers would continue to play a major financing role, the federal costs and new taxes needed would be much lower than would be true under a Medicare-For-All plan or a universal individualized framework.

To provide a sense of these virtues, Lewin VHI recently estimated the impact of a health plan that I have developed with the support of the Economic Policy Institute, "Health Care for America." The proposal—a template for Clinton's, Edwards', and Obama's plans—requires employers to cover their workers or contribute 6 percent of payroll to the cost of workers' coverage. Workers whose employers make the contribution will be enrolled in a Medicare-like plan with generous benefits (they can, if desired, purchase regulated private insurance instead).

According to Lewin VHI's estimates, the proposal will cover all but a tiny sliver of the population younger than sixty-five—about half through the new federal system and half through employers. Yet it will actually reduce national health spending, cost the federal government a relatively modest $50 billion a year, and save states and employers substantial money. The reason the plan can cover everyone without driving up costs is that it capitalizes on Medicare's lower service prices, streamlined administration, and ability to get a better deal on drugs. Over time, moreover, this approach will dramatically reduce medical inflation, as public insurance is able to use its enhanced bargaining power to hold down costs.[35]

Finally, all these proposals embody a means of gradually moving away from America's embattled employment-based structure. If, as most expect, public insurance ends up proving capable of controlling costs better than employment-based plans (or if employers simply continue to retreat from coverage), then the public plan will over time come to enroll a larger share of Americans—without the massive disruption entailed by an overnight transformation. This is not an incidental feature of these proposals; it is the core of their strategy for gradually moving away from America's embedded employment-based structure.

But finding a policy design that will minimize public fears is, of course, only part of the battle. The bigger challenge is to build a coalition that can engage Americans constructively in the struggle while press-

ing their leaders to act. And that means coming to grips with the transformed political realities that stymied the Clinton plan.

THE NEW WORLD OF AMERICAN POLITICS

Largely unbeknownst to those who waged battle over President Clinton's proposal, the battle occurred amid—and, indeed, helped complete—a transition between two very different worlds of American politics.

The first world, already crumbling in the years leading up to Clinton's election, was one based on bipartisan compromise, often behind closed doors. It rested on the continuing sway of moderates, who in an era of divided government usually held the cards in high-stakes political fights. It was premised on some degree of insulation of the legislative process from special-interest arm-twisting and party strong-arming. And it required a broadly competitive electoral environment—the myriad fierce campaign fights every two years that ensured, as Reagan-era House Speaker Tip O'Neill famously put it, that "all politics is local."[36]

That world is gone, and it will not be returning soon. Congressional moderates are vanishing; campaign money and corporate lobbying hold greatly increased sway; and party leaders wield vastly more power than they did a generation ago. Even with the shift of Congress to the Democrats, competitive election contests remain few and far between. The result is greater party polarization—something long prized by political scientists enamored of parliamentary systems—but without the consistent electoral discipline that ensures that these polarized parties are accountable to middle-of-the-road voters. In Congress, the two parties are farther apart today than at any point in the last generation, mostly because of the movement of the Republican Party to the right since the 1970s. The motto of this new world was best summed up by Texas Republican Dick Armey, who helped lead the charge against the Clinton plan and then became House Majority Leader: "The first rule of politics is: Never offend your base."[37]

This motto played out vividly in 2008's campaign-driven health care debates. During the primary campaign, all the leading GOP contenders for president explicitly rejected large-scale reforms—and in particular any coverage requirement—even as all the leading Democratic candidates endorsed such changes. Even Reagan's evocative phrase "socialized

medicine," which many thought had met its match when Medicare proved a popular success, returned to the heart of GOP rhetoric. Republicans from President Bush on down used the slogan in denouncing Democrats' attempts to expand publicly funded coverage for children through the State Children's Health Insurance Program (SCHIP). Meanwhile, in late 2007, GOP presidential contenders Rudy Giuliani and Mitt Romney lambasted the relatively cautious health proposals touted by the leading Democratic candidates as emulating "the socialist solution they have in Europe" (Giuliani) with the goal of imposing "a European-style socialized medicine plan" (Romney).

Indeed, many Republicans embraced a set of ideas barely discussed in the early 1990s and diametrically opposed to leading Democratic plans—subsidies for individually purchased insurance and Health Savings Accounts, as outlined by Quadagno and McKelvey in their chapter in this volume. In 1992, President George H. W. Bush put forth a substantial reform plan in response to the growing pressure for action. During the run-up to the 2008 election, no one had any expectation that President George W. Bush—whose major health policy move in 2007 was his successive vetoing of congressional Democrats' attempts to expand SCHIP—would do the same.

Back in 1993 and 1994, the Clinton health policy team seemed flummoxed by the shifting sands they stepped onto. Torn between the old politics and the new, they embraced a cause that cheered the Democratic base, then adopted a proposal that alienated much of it; packed their proposal with special favors for organized labor, then campaigned against organized labor to create NAFTA; expected liberal committee chairs to play their game even as they made clear that congressional moderates were their lodestar. Behind the back-and-forth darting was the assumption that, at some point, somehow, a bipartisan deal would be forged in the back room, as it has been on tax reform in 1986 and Social Security in 1983. But the political preconditions for such a bargain were gone—swept away by growing partisan warfare.

This time, it is clear that the fight will take place on the scorched earth left by these battles. And this means that the fight will require updated strategies: greater willingness to compromise on means yet greater clarity on ends, an attention to coalition building from the very beginning, and hard thinking about procedural reforms that could

reduce minority obstruction, including the threat of a Senate filibuster—the major barrier to change within Congress, now that the filibuster has become an all-purpose tool of minority party obstruction. It will also require serious efforts to bring on board committed reformers who support a universal Medicare plan, and to provide them with the guarantees and arguments they need to embrace a less inspiring but more politically palatable approach. Here, a true commitment to a public insurance option, offered on a level playing field with regulated private plans, could prove crucial.

Given all this, universal health insurance looks likely to happen in the near term—or rather more likely to happen, since the odds are long regardless—only if a Democrat occupies the White House. But even if a Democrat were to occupy the Oval Office and Democrats augmented their standing in Congress in 2008, as most political analysts expect, there remains the difficult task of building a reform coalition in Congress and beyond. In 1993, President Bill Clinton pursued a strategy that ended up alienating both congressional liberals and congressional conservatives. In 2009, any Democratic president will have to do better to have any chance of success.

The main challenge is not to develop an even more detailed health plan, which could and should be left to Congress. In 1993, in part because President Clinton received advice to this effect from congressional Democratic leaders, the Clinton administration set up a massive internal process to refine the plan that had been decided upon during the campaign, a process that took up valuable time and short-circuited congressional and interest-group bargaining. Decades of research on presidential power suggest the limits of presidential policy fine-tuning in the domestic arena. Whatever Democratic leaders say, a new Democratic president should follow the path that President Bush successfully blazed on tax cuts in 2001: Develop the broad outlines, then leave it to Congress to broker the deals. But the challenge will still be enormous to bring advocates of action together around a reform vision that can attract moderate backing, and then to cross-pressure those moderates by mobilizing the support of the public and important allied groups.

Alongside the looming obstacles, there are promising signs for change. Galvanized by the Bush presidency and linked by the Internet, progressive activists have gained some of the passion and grassroots

power that was once seen only on the conservative side. Organized labor is displaying both greater boldness and greater pragmatism. There may be room to run with key segments of the business community, as corporate leaders increasingly realize they are caught between the rock of rising costs and the hard place of hurting workers. And workers clearly are hurting, as medical costs escalate and private insurance declines.

The great unanswered question is whether a public disillusioned about politics can be brought to kindle some faith in their leaders and their government. Americans say they believe in government action to universalize health insurance.[38] They say they want reform to be a top priority. Similar sentiments helped bring health care to the top of the agenda in the early 1990s, and reformers are on the verge of having their moment in the sun again. With the lessons of the past in mind, and fortune on their side, perhaps they can finally seize it.

NOTES

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4 Joseph White, *Competing Solutions: American Health Care Proposals and International Experience* (Washington, DC: Brookings Institution, 1995).

5 See Evelyne Huber and John Stephens, *Development and Crisis of the Welfare State: Parties and Politics in Global Markets* (Chicago: University of Chicago Press, 2001). Using Huber and Stephens's dataset (http://www.lisproject.org/publications/welfaredata) and OECD expenditure data, the correlation between 1945–75 cumulative left-party governance and the 1975 private share of health spending is -0.58.

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12 Frank D. Campion, *The AMA and U.S. Health Policy since 1940* (Chicago: Chicago Review Press, 1984), 162.

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14 Ibid., 19.

15 Ibid., 22. The 1949 quote is from the testimony of James B. Carey to Subcommittee on Health of the Committee on Labor and Public Welfare, *National Health Program, 1949* (Washington, DC: U.S. GPO, 1949), 421.

16 Paul Starr to Ira Magaziner, memorandum, 22 Mar. 1993; quoted in Jacob S. Hacker, *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security* (Princeton, NJ: Princeton University Press, 1997), 128.

17 Paul Starr and Walter L. Zelman, "A Bridge to Compromise: Competition Under a Budget," *Health Affairs* 12, Supplement 1 (1993): 7–23.

18 Robert Patricelli, Chamber of Commerce, to Ira Magaziner, May 10, 1993; quoted in Hacker, *The Road to Nowhere,* 135.

19 Walter Zelman to Bob Boorstin, March 10, 1993; quoted in Hacker, *Road to Nowhere,* 136.

20 *Consumer Reports,* "Health Insurance Survey Reveals 1 in 4 People Insured but Not Adequately Covered," September 2007.

21 The Kaiser Family Foundation, *Employer Health Benefits, 2007 Summary of Findings,* http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf; and Jared Bernstein and Heidi Shierholz, "A Decade of Decline: The Erosion of Employer-Provided Health Care in the United States and California, 1995–2006," *EPI Briefing Paper #209,* April 16, 2008.

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23 Cristina Boccuti and Marilyn Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending over Three Decades," *Health Affairs* 22, no. 22: 2 (2003): 230–37.

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27 Ellen Nolte and C. Martin McKee, "Measuring the Health of Nations: Updating an Earlier Analysis," *Health Affairs* 27, no. 1 (2008): 58–71.

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33 Ylan Q. Mui and Dale Russakoff, "Wal-Mart, Union Join Forces on Health Care; Alliance's Goal Is to Improve Coverage," *Washington Post,* 8 February 2007, D1.

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