

Universal Health Insurance 2007

Can We Learn from the Past?

Theodore Marmor

Americans are not well served by their current medical care arrangements. Compared to our major trading partners and competitors, we are less likely to be insured for the cost of care, and the care that we receive is almost certain to be more costly. Although U.S. medicine has produced many “miracles,” we are not the undisputed leader in medical innovation, only in the costliness and ubiquity of high-technology medicine. Most Americans “covered” by some form of health insurance still worry about its continuation should we or a close family member become seriously ill. Some of us are locked into employment we would gladly leave but for the potential catastrophic loss of existing insurance coverage.

While most commentators decry our peculiar ability to combine insecurity with high cost, the substantial reform of American medicine at the national level has been enormously difficult to achieve, and comprehensive reform has been impossible. This is not simply a description of the Clinton Health Plan debacle of 1993–1994. On many occasions before and after the Second World War, comprehensive national reform was attempted (and in 1973–1974, appeared imminent). In all those instances, reform fell short of the necessary political majorities. Each of these failures has its own history, and in each there are many contributing causes. One fact remains: Americans have long been dissatisfied with the nation’s medical arrangements, but our political system has been unable to come up with a solution that satisfies enough of the public to overwhelm the institutional and interest group barriers to reform.<sup>1</sup>

There is now once again a remarkable consensus that American medical care, particularly its financing and insurance coverage, needs a major overhaul. The critical unanimity on this point—what Paul Starr once rightly termed a “negative consensus”—bridges almost all the usual cleavages in American politics: between old and young, Democrats and Republicans, management and labor, the well paid and the low paid. The overwhelming majority of Americans (including Fortune 500 executives) tell pollsters that our medical system requires substantial change. That level of public discontent was, in 1993 and now again, good news for medical reformers.<sup>2</sup>

The bad news for reformers then and now is this: for a variety of ideological and institutional reasons, American politics makes it very difficult to coalesce around a solution that reasonably satisfies the requirements for a stable and workable system of financing and delivering modern medical care. Agreement on the seriousness of the nation’s medical ills will not necessarily generate the legislative support required for a substantively adequate and administratively workable program. That is as true in 2007 as it was in 1948, 1971, 1993, and 2000.

Learning from the Past?

At four other moments in twentieth-century American politics (leaving out 1993–1994 for now), reformers and their presidential backers tried to change the rules of medical care. In the Progressive Era, during the New Deal, under Harry S. Truman, and during the early 1970s, advocates thought universal health insurance was imminent and were bitterly disappointed. Now, in 2007, as before, entrenched stakeholders can be counted on to block national health insurance by skillfully manipulating our deepest fears to protect what they regard as their economic interests.

Before an administration and a Congress can meet the challenges of workable reform, they have to resolve—or at least cope with—some of the nastiest ideological and budgetary conflicts in American politics. As did their predecessors, they face the seemingly intractable problems of substance, symbol, and support.

The health reformers of the Progressive Era were convinced that broadened access to health care, financed and administered through social insurance, held the key to improved health, medical progress, and economic security. But theirs was an elite view, helped in the pre–World War I period by the apparent acquiescence of the American Medical Association. It turned out, however, that there was no massive popular consensus on the need for change, and, after the AMA turned against the idea, the reform movement withered. State initiatives were frustrated, only academic discussion remained. An elite consensus on the need for change, it appears, is a necessary but not sufficient condition for the enactment of reform programs.

The agony of the Great Depression opened up enormous opportunities for change in American domestic politics. Franklin D. Roosevelt led the way, commissioning expert group after expert group to consider reforms needed in welfare, unemployment, agricultural failure, banking collapse, and in the institutions of economic security more generally. The opening for universal health insurance came in 1935, with the famous Committee on Economic Security. A cabinet-level special committee, the CES took a year to review the circumstances of welfare, unemployment, child health, and old-age poverty and to arrive at a package of programmatic suggestions. Its members did their work with admirable skill and timeliness, fashioning workable ideas from a far-flung investigation of various ways to resolve these difficult problems. Unemployment and welfare were the most pressing; retirement benefits, though they have loomed much larger in subsequent decades, did not dominate their deliberations. With compulsory health insurance, Roosevelt hesitated, worried that the presumed opposition of the American Medical Association and its ideological allies might jeopardize the success of the bulk of his social insurance package.<sup>3</sup> So it was that the committee refrained from even studying health insurance reform, leaving that to congressional advocates who, in the next decade, would, under the banner of the Murray-Wagner-Dingell bill, try unsuccessfully to generate majority support in the public and in Congress.<sup>4</sup>

From NHI to Medicare Truman's experience was no less frustrating. In the election battle of 1948 he made national health insurance prominent among his proposals for a Fair Deal. But he faced a barrage of ideological criticism that linked national health insurance with socialism, communism, and the Soviet Union. After some years of facing certain defeat in the Congress, Truman turned his advisers in 1951 to a more modest goal: a health insurance program for Social Security recipients that would in time become the Medicare program of 1965.

During Truman's presidency, according to the polls, the general public supported government health insurance. But this support was neither deep nor informed. The label of "socialized medicine" scared many, enough so that no amount of presidential enthusiasm could generate majority support in Congress. What we later came to know as the conservative coalition linked opposition from powerful Southern Democrats and their ideological counterparts among Republicans. This was enough to defeat every attempt at universal coverage— whether for all Americans or just the over-sixtyfives—until 1965.

The fight over Medicare illustrates the rarely achieved conditions sufficient for successful (if partial) reform. Before 1965, the conservative coalition was formidable. The Democratic landslide of 1964 swept away the key conservative bases of institutional power: dilatory tactics by the Rules Committee, control of other key committees, and a Congress as a whole less liberal than John F. Kennedy or Lyndon B. Johnson. The massive electoral shift of 1964 held a lesson for future reformers: a fully sufficient condition for reform was a two-to-one Democratic majority in the House of Representatives, a margin large enough to contain within it a (smaller) majority on Medicare. In retrospect, Medicare might well have emerged a bit later in any case, given its narrow defeats in the early 1960s; the 1964 victory makes it impossible to know for sure whether and how long such a counterfactual development might have taken. By 1970, the debate had shifted back from Medicare to national health insurance once again. Though it is difficult for many to remember, the striking feature of the 1970–1974 years was the intense competition among proponents of different forms of universal health insurance. There was the catastrophic proposal advocated by Senators Russell Long and Abraham Ribicoff. There was the Kennedy-Corman bill that closely followed Canada's national program as of 1971. And there was the Nixon administration's plan for mandated health insurance for employed Americans known then as the Comprehensive Health Insurance Plan, or CHIP.

Reform failed because shifting coalitions defeated every attempt at compromise—cycling negative majorities, we might say in political science jargon. The majority that agreed on the need for reform consisted of factions committed to different proposals. The more modest proposals—such as the Long-Ribicoff catastrophic bill—seemed too limited to those who wanted to translate the negative consensus into universal, broad coverage. The proposal for employer-mandated insurance—similar in financing to what Bill Clinton later proposed—seemed too indirect, incomplete, and incapable of cost control to those favoring more straightforward forms of national health insurance. And even Ted Kennedy, who moved from his more ambitious version of national health insurance to a compromise plan that he and the powerful Wilbur Mills could both accept, was incapable of organizing a coalition of liberal and conservative Democrats.

It is no wonder that so many from that period were so eager to act in the early 1990s and why so many now are pointing to the need for reform. But the caution here is that the lessons of the 1970s are multiple, not simple. Mandated, employment-based coverage may have made sense then, but it need not define the limit of what is possible thirty years later. Indeed, figuring out the impact of decades of frustration with partial reform is the major task facing reformers today.

## The Contemporary Task

What worked once may not, in changed circumstances, work again. What failed may succeed. But some constants in American politics are relevant.

First, compulsory health insurance—whatever the details—is an ideologically controversial matter that involves enormous symbolic, financial, and professional stakes. Such legislation does not usually emerge quietly or with broad bipartisan support, either here or elsewhere. The politics of national health insurance not only expresses ideological and partisan differences; it also gives visible form to what political groupings stand for. Legislative success in this arena normally requires active presidential leadership, the commitment of an administration's political capital, and the exercise of all manner of persuasion and arm twisting. This President Roosevelt was unwilling to do in the New Deal years, and Richard Nixon refrained from doing in the early 1970s. President Clinton gave enormous attention to health reform, but proceeded as if he were negotiating with an Arkansas legislature and could make a sufficient number of private deals to secure a majority. As we know, he famously failed. Johnson was fully willing to use all his legendary legislative energy in 1965, though the composition of the Congress made his task easier. Giving priority to the Medicare bill (with H.R.1 and S.1 as the numerical symbols) signaled Johnson's determination, as did his concentration on Medicare as the centerpiece of his first year's legislative campaign.

Second, the limits of political feasibility are far less distinct than Beltway commentators seem to recognize. Political constraints are real, but they do not submit to estimates as precise as the budgetary work of the Congressional Budget Office. For example, the Johnson administration, wanting to make sure its first step would be overwhelmingly acceptable in 1965, requested hospital benefits under Medicare only. But the oddest thing happened. A combination of liberals who proposed making the Medicare program broader and conservative Democrats who wished to head off step-by-step expansion later on agreed to a wider reform than Johnson requested. Not only was physician insurance added to Medicare by the Ways and Means Committee (what we know as Part B), but Medicaid emerged as part of an unexpected "three-layer cake." No one should assume that the substantive and ideological package sent to the Congress is fixed in stone. And no one should treat such "resultants" as the purposeful work of skillful entrepreneurs. Resultants emerge, and the lesson is not that anything is possible but rather that feasibility estimates must acknowledge considerable uncertainty.

Third, the role of language and emotive symbols in this policy world cannot be overestimated. How the president reaches out to the public, what counts in the evening news and the morning newspapers as the central reform themes, and whether the Congress faces a determined grassroots movement—all shape the legislative outcome and, even more important, determine whether the result is sufficiently coherent and workable to satisfy the expectations for reform. Pressure groups that can prevail in quiet politics are far weaker in contexts of mass attention, as the American Medical Association regretfully learned in the Medicare battle of 1965.

But the central lesson of the past—of both defeats and victories like Medicare—is cautionary in a different sense. It is wise to wait if what is acceptable is not workable. It is foolish to hesitate if

what is workable can be made acceptable. If the central elements of a workable plan are acceptable, the pace of implementation can be staggered. But, American political history in this area shows that the opportunities for substantial reform are few and far between, precious enough to make squandering close to a sin.

## Feasible Reform

We need a truce among the health policy analysts and a serious search for a different strategy. My proposal is first to organize a special commission of seasoned, gifted, but not necessarily expert members. Their major task—as with the Iraq Study Group—would be to fashion a set of proposals for American health financing reform that can command broader support than the failed efforts of the last decades.

A starting point would be to lay out a common set of goals that the most prominent approaches to health reform might plausibly be said to share. Below is my initial list, but I have not elaborated their character in any detail. I will only describe what appears to be common ground and to exclude purposes that fall outside this set.

1. **Universal Coverage:** that is to say, protection for all U.S. citizens and legal residents against the catastrophic expenses of illness and injury.
2. **Coverage of Universally Understood Medical Care:** that is, hospital, physician, and pharmaceutical expenses, ordinarily defined.
3. **No Raid on the National Treasury:** that is, the plan must include features that mitigate any expected explosion of health care outlays as a consequence of reform.
4. **Portable Coverage:** protection for catastrophic expenses outside one's own state and possibly outside the country.
5. **Public Accountability:** a clear way to answer the question of which organization would handle violations of the above standards.

From this starting point, the task of review would be to select (perhaps five) prominent proposals for universal health insurance and sort out the common ground among them. I have in mind as examples of well-known reform ideas the following: (1) tax credit reforms to extend health insurance, a position associated prominently with Mark Pauly; (2) competing health finance institutions with universal financial support, a conception identified broadly with Alain Enthoven; (3) Medicare for All, an extension of the present program, a proposal made, for example, by Representative Pete Stark (D-CA); (4) health savings accounts, with catastrophic backup insurance, a version of which was in the Medicare Modernization legislation of 2003; and (5) extensions of Medicaid and Child Health insurance, which are basically incremental steps from where we are now. Then the next phase is to take up the fears these proposals generate.

## Addressing the Worst Fears

The worst fear each advocate has about the other models of universal coverage is, from the standpoint of building consensus, a critically important topic. Few of the reform proposals of the past thirty years have addressed this matter. If one wants to increase the likelihood of reform, attending to fears is as important as highlighting common ground. But this is not a matter of listing objections or excluding disputed ideas.

Rather, the proposal here is to provide a serious answer to each fear. So, for instance, if the greatest fear of a proposal for extending Medicare to all citizens is that it will produce extraordinary increases in total health expenditures, the commission staff would have to present means by which that could plausibly be avoided. Attending to fears is not meant to produce agreement on what is best. Rather, it is to force attention to problems each reform proposal highlights for critics. And it further suggests means by which the opposition to reforms can be lessened—if the answers given are well informed and organizationally as well as politically feasible. The question of what would count as a well-informed and feasible policy response to fears is precisely the job of the commission and its staff.

The idea of a commission is hardly new in American politics, and it is important to note American frustration with commissions as sources of delay rather than initiative. But the fact of past disappointments does not mean that a useful commission is impossible. The Canadian Royal Commission of 1964–1966 is a model of deliberation, careful research, and the promotion of an operational and feasible form of national health insurance. Chaired by Justice Emmett Hall of the Saskatchewan Supreme Court, the body produced a set of documents that brought together Canada's history of financing medical care and the experience of other rich democracies to craft a bill that passed the national legislature despite the opposition of the Canadian Medical Association and its ideological allies across Canada.

Political judgments about particular reform proposals are products of personal experience, political ideology, and local economic and social conditions. These factors change substantially as one moves about the United States. If change is to be workable and acceptable, it must take into account the real differences between New York and Idaho, Wisconsin and

Louisiana. Moreover, what is operational varies less than what is politically acceptable and financially plausible at any one time. Consider what would happen if we combined high rates of economic growth or recession or near recession with the two different distributions of political and ideological dominance—Democratic or Republican control of the executive and at least one of the legislative bodies. The resulting four scenarios do not exhaust the possibilities. Political stalemate (or, if you prefer, a more balanced power situation) could obviously produce two more possibilities. But the main point should be clear. What is likely to win majority support would not be the same under all four conditions. And the point, therefore, is to have available a version of a plausible health system reform that would command wider support in all four because of its commitment to common ground and answering serious objections. That, at least, is what this policy analyst would urge others to consider.

## The Setting of 2007: A Concluding Note

This article has concentrated on the past, not the present, on lessons to draw, not futures to predict. But the prominent contemporary place of American medical concerns on the national political agenda calls for at least some comment.

The most obvious point is that the presidential competition for 2008 has already recapitulated the run-up to 1992 and 2000. Contenders—particularly among the Democratic hopefuls—either feel compelled to propose plans or are put on the defensive for not doing so. The result so far has been depressingly familiar in a number of ways. Not one candidate has straightforwardly stated the core values health reform should express, though John Edwards has come closest. The enumeration of complaints has dominated, as was to be expected, but one would be hard pressed to find any statement of even the common ground identified earlier in this article. The result is a pattern of problem identification and gestures toward complicated steps to broader health insurance coverage. The differences in values between a plan presented by California's governor, Arnold Schwarzenegger, and any of the Democratic contenders are not easy to identify. None of the plans discussed—whether the expansions of child health insurance mentioned by Hillary Clinton, the appeal to mandated coverage by John Edwards and incorporated in the California and Massachusetts plans, or the Bush administration's embrace of medical savings accounts and changes in the tax code's treatment of employer-arranged health insurance—seriously address persistent medical inflation. Yet it is the contemporary costs (16 percent of national income) and the rate of increase (one and a half to two times the growth of American incomes) that is at the core of the coverage problems we face.

The gap between diagnosis and remedy is not an oversight, however. Candidates understandably are wary of announcing who the losers would be if their favored approach were actually to become programmatic fact. After all, if our medical arrangements are to be more affordable, some of those whose incomes come from health expenditures must get less in the future than they might like. But so far the campaign of 2007 shows no sign of improvement over the Clinton period and has less clarity—about values or program structure—than the campaign of the early 1970s. That is not a healthy sign, but it is a good reason to consider the value of a serious commission.

In late April, as this article was being sent to press, Senator Edward Kennedy (D-MA) and Representative John Dingell (D-MI) unveiled their Medicare for All proposal. This universal reform plan was admirably clear about the social insurance values it expressed: financing from proportional payroll taxes disconnected from the experience of illness; a benefit plan broader than catastrophic coverage; and explicit constraints on costs that went beyond wishful thinking. Neither of the proponents is, of course, a presidential candidate; both are longtime supporters of social insurance approaches to universal health coverage.

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conference in May 2005 and will appear in longer form in a forthcoming book to be published by the Federal Reserve.

1. While substantial change took place in the United States in the decades from 1980 to 2000, most of it was privately generated. What is called the “managed care” movement altered the way most American physicians practice and get paid and had a lot to do with the changing ownership and shape of American hospitals. These changes stand in contrast to the publicly organized reforms in the United Kingdom (internal markets in the 1990s) or Canada (national health insurance in the period 1957–1971). For more on health reforms, especially “nonpublic change,” see Carolyn H. Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (Oxford University Press, 1999).

2. For more on the public desire for substantial change in health care, see Robert J. Blendon and John M. Benson, “American’s Views on Health Policy: A Fifty-Year Historical Perspective,” March/April 2001, *Health Affairs* 20 (2): 33-46. A New York Times/CBS news survey in February 2007 confirmed this historical pattern, with “an overwhelming majority” saying “the healthcare system needs fundamental change or total reorganization.” Robin Toner, “U.S. Guarantee of Care for All, Poll Finds,” *NY Times*, March 2, 2007.

3. See, for elaboration on this episode, Alan Derickson, *Health Security for All: Dreams of Universal Health Care in America* (Johns Hopkins University Press, 2005), pp.52-71.

4. The American development of social insurance—and the character of the legislative initiatives of the 1930s—is illuminatingly (and briefly) discussed by one of Social Security’s most illustrious administrators, Robert Ball, in “The Original Understanding of Social Security: Implications for Later Developments,” in Marmor and Jerry Mashaw, eds., *Social Security: Beyond the Rhetoric of Crisis* (Princeton University Press, 1988), pp. 17-39.