

Why the United States Has No National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945–1996*

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The United States is the only western industrialized nation that fails to provide universal coverage and the only nation where health care for the majority of the population is financed by for-profit, minimally regulated private insurance companies. These arrangements leave one-sixth of the population uninsured at any given time, and they leave others at risk of losing insurance as a result of normal life course events. Political theorists of the welfare state usually attribute the failure of national health insurance in the United States to broader forces of American political development, but they ignore the distinctive character of the health care financing arrangements that do exist. Medical sociologists emphasize the way that physicians parlayed their professional expertise into legal, institutional, and economic power but not the way this power was asserted in the political arena. This paper proposes a theory of stakeholder mobilization as the primary obstacle to national health insurance. The evidence supports the argument that powerful stakeholder groups, first the American Medical Association, then organizations of insurance companies and employer groups, have been able to defeat every effort to enact national health insurance across an entire century because they had superior resources and an organizational structure that closely mirrored the federated arrangements of the American state. The exception occurred when the AFL-CIO, with its national leadership, state federations and union locals, mobilized on behalf of Medicare.

The right to health care is recognized in international law and guaranteed in the constitutions of many nations (Jost 2003). With the sole exception of the United States, all industrialized countries—regardless of how they raise funds, organize care or determine eligi-

bility—guarantee comprehensive coverage of primary, secondary, and tertiary services. To the extent that care is rationed, it is done on the basis of clinical need, not ability to pay. (Keen, Light, and May 2001; Dixon and Mossialos 2002). Universal health care has proven to be a major tool for restraining cost increases. Planning avoids widespread duplication that underlies the high percentage of empty beds in the United States; high rates of unnecessary procedures, tests and drugs; and ineffective use of some technologies. Although many nations have flirted with competition, most are wary because the most competitive system, the United States has consistently been least successful in controlling costs (Anderson et al 2003).

Most countries allow, and some encourage, private insurance as an upgrade or second tier to a higher class of service and a fuller array of

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services (Keen, Light, and May 2001; Ruggie 1996). However, the practices of these companies are heavily regulated to prevent them from engaging in the more pernicious forms of risk rating. That is not the case in the United States, where private insurance companies are allowed to use sophisticated forms of medical “underwriting” to set premiums and skim off the more desirable employee groups and individuals (Light 1992). The United States is the only nation that fails to guarantee coverage of medical services, rations extensively by ability to pay, and allows the private insurance industry to serve as a gatekeeper to the health care system (Light 1994; Jost 2003). This arrangement leaves approximately one-sixth of the population uninsured at any given time, and it leaves others at risk of losing insurance as a result of such life course events as divorce, aging, widowhood, or economic downturn (Harrington Meyer and Pavalko 1996). The uninsured are sicker, receive inferior care, and are more likely to die prematurely (Institute of Medicine 2004).

The lack of national health insurance in the United States is the prime example of a larger historic issue captured by the phrase “American exceptionalism.” The question to be answered is not just why every proposal for national health insurance has failed but also how commercial enterprise became the preferred alternative. Neither political sociologists nor medical sociologists have fully explained this puzzling pattern. Political theorists of the welfare state usually attribute the failure of national health insurance in the United States to broader forces of American political development but ignore the distinctive character of the health care financing arrangements that do exist. Medical sociologists emphasize the way that physicians parlayed their professional expertise into legal, institutional, and economic power but not the way this power was asserted in the political arena. What is required is a theory that can locate the political determinants of health reform within the changing context of the transformation of American medicine.

POLITICAL THEORIES OF THE WELFARE STATE

For political theorists of the welfare state, the central question has been why, compared to

other nations, the United States has been slow to develop national social programs and why programs that were enacted have been less generous.

Antistatist Values

According to one answer, the central impediment has been an encompassing political culture based on a master assumption “that the power of the state must be limited” (Hartz 1955:62; Lipset 1996). Because the state is equated with government, and liberty with limited government, “it is easy to regard the welfare state as a threat to liberty” (Marmor, Mashaw, and Harvey 1990:5). The converse is also true: a distrust of government provision of social welfare confers upon the market and voluntary efforts “a central role in social provision” (O’Connor, Orloff, and Shaver 1999:44). Examples of the values thesis abound. Thus, Jacobs (1993) contends that “enduring public ambivalence toward government . . . is the underlying source of America’s impasse” over health care reform (p. 630). Similarly, Marmor (2000) argues that, “no matter how large the public subsidies and how substantial the public interest in the distribution, financing, and quality of services dominated by private sector actors, the American impulse is to disperse authority, finance and control” (p. 101).

Despite its prominence in political theory, the values argument raises some problematic issues. Notably, it cannot explain why some programs that appear to contradict these purportedly core values (i.e., Social Security and Medicare) have been enacted or what mechanisms link antistatist values to policy outcomes (Steinmo and Watts 1995). Values are simply presumed to have some kind of unexplained effect on the policymaking process. As Skocpol (1992) notes, “Many scholars who talk about national values are vague about the processes through which they influence policymaking” (p. 16).

Weak Labor/Power Resources

A second argument attributes the failure of national health insurance in the United States to the lack of a working class movement and labor-based political party (Navarro 1989).

This thesis is derived from “power resource” theory, which views the welfare state in Western, capitalist democracies as a product of trade union mobilization (Korpi 1989; Hicks 1999; Esping-Andersen 1990). According to “power resource” theorists, markets and politics are alternative arenas for the mobilization of resources and the distribution of rewards. In the market, “capital and economic resources form the basis of power,” and private economic interests dominate, while in the political arena, wage earners have a numerical advantage, which they can use to “modify the play of market forces” (Korpi 1989:312–13). In the ideal typical case, workers organize into trade unions, form a labor-based political party, and then use their “power resources” to expand the welfare state (Hicks 1999).

Although power resource theorists aptly capture the political processes involved when labor unions mobilize politically, engage in distributory conflicts, and establish claims for processing benefits independent of market criteria, they are less successful in theorizing the political processes involved when the market remains the locus of distribution (Esping-Andersen 1990). Presumably, when unions fail to mobilize politically, then the state will encourage the market and voluntary efforts for social provision. Left unspecified is whether private economic interests organize as active agents in market preservation or merely serve as passive observers of the status quo. The uniquely American system of health care financing involves social legislation that defers to market principles and federal sponsorship of private sector alternatives to public programs. This structure raises compelling theoretical issues regarding the effect of organized labor on the financing arrangements that emerged in key periods and the influence exerted by business groups on both public and private health insurance programs.

Political Institutions and Policy Legacies

A third argument emphasizes the distinctive characteristics of American political institutions. According to one variant of institutional theory, the main impediment to health care reform in the United States is the diffusion of political authority (Steinmo and Watts 1995; Hacker 1998). At the national level, power is divided among three branches of government,

each with its own independent authority, responsibilities, and bases of support. Within the legislature, power is further divided between the House and the Senate as well as numerous committees and subcommittees where legislative measures can be delayed or blocked. Further, because candidates for office largely depend on raising campaign resources personally, they are vulnerable to appeals by interest groups and lobbying organizations (Lipset 1996). Decentralization thus impedes policy innovation by increasing the number of “veto” points (i.e., the courts, the legislative process, the states) where opponents can block policy reform and by allowing special interests greater access (Maioni 1998).

System-level variables such as “state structures” may appear adequate in explaining cross-national variations in policy outcomes, but they are inadequate when applied to historical variations in policy outcome within the United States. A structural argument cannot explain why Congress enacted (then repealed) the Medicare Catastrophic Coverage Act of 1988 but rejected a national long term care program that same year. Although the American political system with its checks and balances is designed to slow down the policy-making process and prevent major and abrupt shifts, that argument provides little insight into how the existing configuration of public and private health benefits came to be.

Recognizing the weakness of “state structure” arguments, a second generation of institutional theorists has devised an alternative approach that emphasizes the effect of early policy choices on subsequent policy options, a process captured by the phrase “path dependency.” The central premise of “path dependent” theories is that policies are not only a product of politics but also produce their own politics by giving rise to widespread public expectations and vast networks of vested interests (Pierson 1994, 2002). Early policy choices narrow the menu of future options by driving policy down self-reinforcing paths that become increasingly difficult to alter. Thus, according to Hacker (1998, 2002), Social Security succeeded while national health insurance failed because of differences in timing and sequencing. Social Security was created before a private pension system developed and by implication before a network of interests could arise to impede its enactment. By contrast, the private health insurance system

was solidly entrenched by the time reformers began to press for a government solution, “crowding out” the public alternative.

The notion of path dependent social policy is useful in that it highlights the importance of tracing the configuration of interests that develop in response to a policy innovation and thus to account for the long term consequences of alternative choices. However, it does not explain why one path was chosen over another.

THE HEALTH CARE SYSTEM AND POLITICAL POWER

The Theory of Countervailing Powers

While the “American exceptionalism” theories each capture distinctive elements of policymaking dynamics in the United States, none provides a comprehensive framework for understanding how the public/private mix of health care financing arrangements was created. That has been the project of medical sociologists who have addressed the issue from a different theoretical paradigm. In medical sociology the key debates have focused on the way that physicians were able to parlay their professional expertise into social privilege, economic power and political influence; suppress all challenges to their authority; and prevent outsiders from dictating the conditions of medical practice. Their ability to do so required them to gain control over the market for their services and the various organizations that governed medical practice, financing, and policy. Physicians established professional sovereignty and relegated any countervailing power to the margins of medical care through five major structural changes. The first was the emergence of an informal system of social control in medical practice based on physicians’ needs for referrals and hospital privileges. The second was the control of the labor market through various mechanisms to restrict supply, blocking the construction of new medical schools and restricting the number of students admitted. The third was the expulsion of profit-making enterprises that could extract surplus labor from physicians. The fourth was the exclusion of any organized purchasers—the state, corporations or voluntary associations—that could offset the market power of physicians. Finally, the fifth change was the establishment of specific spheres of authority

and the rejection of any policy or plan that failed to respect their professional sovereignty (Starr 1982a).

Although medical sociologists have aptly characterized the devices physicians employed to construct and preserve their professional sovereignty, they do not specify how conflicts over health policy were translated into actual political decisions by elected officials. Further, while they recognize that the enactment of Medicare and Medicaid in 1965 represented a turning point that unleashed these “countervailing powers,” they do not theorize the political consequences of this transformation (Chernew 2001; Light 1995, 2000; Havighurst 2002). Thus, for example, McAdam and Scott (2002) note that following many failed attempts, “legislation was successfully passed in 1965 to provide governmental financing for health care services for the elderly and the indigent” (p. 25). However, their only explanation of how these programs succeeded in overcoming resistance from physicians is the weak assertion that, in addition to the election of a more liberal Congress, “the framing of the issues was also of great importance” (p. 25).

A THEORY OF STAKEHOLDER MOBILIZATION

This paper constructs an alternative model that considers both the broader political opportunity structure and the character of the health care system. The theory of stakeholder mobilization suggests that the health care financing system in the United States was constructed through contentious struggles between reformers and powerful stakeholder groups who mobilized politically against national health insurance or any government programs that might compete with private sector products or lead to government regulation of the market. Stakeholder mobilization involves the same processes that social movement theorists usually associate with the mobilization of politically powerless groups (Jenkins and Perrow 1977). To be effective in the political arena, stakeholders share with the politically powerless a need for leadership, an administrative structure, incentives, some mechanisms for garnering resources and marshalling support, and a setting (whether it be a workplace or a neighbourhood) where grassroots activity can be organized (McAdam, McCarthy, and Zald

1996). Even though dominant groups may have privileged and systematic access to politics and to elected representatives, they require these same resources to exert political influence.

Stakeholder mobilization also involved the use of cultural “schemas” to shape public perceptions of the issues, strategically frame ideas, and establish shared meanings (Sewell 1996; Young 2002). Implicit in this emphasis on symbolic politics is a rejection of the notion that political decisions are made on the basis of objective information and a recognition instead that political enemies, threats, crises, and problems are social constructions that create solidarity between groups and individuals and ultimately determine whose framing of an issue is authoritative (Edelman 1988; Kane 1997; Pedriana and Stryker 1997). How issues are defined can activate new groups to take an interest in the policy, fragment the existing configuration of support and limit potential options for change. As West and Loomis (1999) assert, the ability to define the alternatives is the supreme instrument of power.

From the New Deal of the 1930s to the 1970s, the chief obstacle to national health insurance was organized medicine. However, physicians succeeded because their political objectives meshed with those of other powerful groups, notably employers, insurance companies, and trade unions. Physicians also had political allies in Congress among Republican opponents of the New Deal welfare state and among southern Democrats who controlled the key committees through which all social welfare legislation had to pass and who refused to support any program that might allow federal authorities to intervene in the South’s racially segregated health care system (Quadagno 2004). Across two-thirds of a century, physicians and their allies lobbied legislators, cultivated sympathetic candidates through large campaign contributions, organized petition drives, created grassroots protests, and developed new “products” whenever government action seemed imminent (Gordon 2003).

Then the excesses of the profession produced a counter-reaction from the government, corporations, and insurance companies that were activated to challenge the protected provider markets (Light 1995). Ironically, the most effective challenge came from the private health insurance system that physicians had helped to construct as an alternative to govern-

ment intervention and took the form of billion dollar, for-profit managed care firms. Managed care helped to dismantle physicians’ cultural authority by undermining their claims of specialized knowledge, putting them at financial risk for their medical decisions, and placing decision-making power in the hands of non-physicians (Luft 1999). The arousal of corporations and insurance companies also had consequences for national health insurance. Their political mobilization brought powerful stakeholders into debates about health care reform. While corporations were primarily concerned with containing costs, insurers had a vested interest in preventing the federal government from creating competing products and in structuring any new programs in ways that would preserve the private market.

THE DEFENSE OF PHYSICIAN SOVEREIGNTY

The greatest challenge to physicians’ autonomy came from third party financiers of medical care. Should third parties assume responsibility for financing care, they would need to establish some way to control their financial liability. Controlling costs would invariably mean regulating physicians’ fees and intervening in the conditions of medical practice. During the Progressive Era, physicians fought against a proposal for a state health insurance plan (Hoffman 2001). In the 1930s physicians waged a fierce campaign to prevent federal officials from including national health insurance in the Social Security Act. As a result, the largest expansion of federal authority into the social welfare system in American history, the Social Security Act of 1935, did not include national health insurance (Katz 2001).

Although physicians initially resisted any sort of third party financing at all, the Great Depression had brought hospitals to the brink of financial ruin. Searching for some way to stabilize hospital income without allowing external controls to be imposed, the American Hospital Association (AHA) created Blue Cross, a prepayment system of insurance against the costs of a hospital stay (Law 1976). Under Blue Cross plans subscribers would prepay a small monthly fee in exchange for free hospital care when needed. Hospitals would be paid for whatever services they provided at whatever price they charged. The fledgling

commercial insurance industry, too, provided hospital benefits on an “indemnity” basis (meaning that patients were reimbursed for some of the costs after the fact), imposing no controls whatsoever on doctors or hospitals. Thus, the insurance industry became the servant of the providers of health care, a passive vehicle for the transmission of funds from patients to providers but exerting no oversight (Light 1997).

National health insurance was revived in 1945 under President Harry Truman (Poen 1979). As the Truman administration geared up to promote national health insurance, the American Medical Association (AMA) launched a “National Education Campaign” to prevent its passage *and* to promote private health insurance. The AMA was perfectly organized to conduct an opposition campaign. The basic unit of the AMA was the county medical society. Without membership in the county society, a doctor could not be a member of a state medical society or be granted staff privileges at most hospitals. At the next level was the state medical society, which sent delegates to the AMA’s National House of Delegates, its conservative governing body. With its hierarchical organizational structure, the AMA had the capacity to set an agenda, generate resources, and mobilize a grassroots campaign in nearly every state, city, and small town in America.

AMA national headquarters levied a \$25 fee on all members and told state societies to adopt a resolution against “socialized medicine.” Every county society was organized “into a hard-driving campaign organization” with battle orders going out by “letter, telegraph and telephone.” Each state organization received form speeches from headquarters to “get laymen for medicine in this fight” and were instructed to approach local newspapers to get the “real facts” before the editors.¹ Posters, pamphlets, leaflets, form resolutions, speeches, cartoons, and publicity materials that could be adopted for state use all had a single goal: “to keep public opinion hostile to national health insurance.”² The message to be promoted in every venue evoked the same antistatist theme—that national health insurance was socialized medicine, part of a Communist plot to destroy freedom.³ Patients would surrender liberty and receive in return “low-grade assembly line medicine.”⁴

To achieve its political objective, the AMA

teamed up with some powerful employer and insurer groups: Blue Cross, the American Hospital Association, the Insurance Economic Society (an organization representing over 2,000 insurance companies), pharmaceutical and drug manufacturers, and the Chamber of Commerce all took a public position opposing national health insurance and endorsing private health insurance.⁵ The AMA also actively entered electoral politics, organizing against Democratic candidates who supported national health insurance. In Pennsylvania, just three weeks before the 1950 election, physicians created a “Healing Arts” committee composed of doctors, nurses, dentists, and office assistants who mailed over 190,000 letters, ran newspaper ads, hung more than 500 posters in doctors’ offices, and posted notices in waiting rooms. Physicians also sent personal letters to their patients, explaining that there were “evil forces creeping into this country” (Cunningham 1951:53–54) and asking them to vote for Republican candidates. On election day, spot radio announcements were made every hour on the hour.

In 1950 Wisconsin doctors started a “Physicians for Freedom” campaign to defeat Representative Andrew Biemiller (D-WI), a House sponsor of a national health insurance bill, and Utah doctors mustered forces against Biemiller’s Senate co-sponsor, Elbert Thomas (D-UT). Florida physicians also worked to defeat Senator Claude Pepper (D-FL), another co-sponsor. A prominent Florida urologist wrote his colleagues asking for money and endorsing Pepper’s opponent, George Smathers:

We physicians in Florida have a terrific fight on our hands to defeat Senator Claude Pepper, the outstanding advocate of ‘socialized medicine’ and the ‘welfare state’ in America. In eliminating Pepper from Congress, the first great battle against Socialism in American will have been won.⁶

Physicians also ran half page ads of a photo showing Senator Pepper with the African American singer, Paul Robeson, who was a member of the Communist party.⁷

Racism and the Red Scare provided a potent framework for defaming national health insurance and demonizing its proponents. In 1945, 75 percent of Americans supported national health insurance; by 1949 that figure had declined to only 21 percent.⁸ In the 1950 elec-

tions six Democratic Senators who had supported national health insurance were defeated.

According to some interpretations, the AMA campaign against national health insurance was ineffectual. Thus, Morone (1990) claims that the AMA “tirelessly evoked the twin specters of galloping socialism . . . and Kafkaesque bureaucracies (but) . . . the rhetorical pyrotechnics did not matter” (p. 262). In his view, reform depended on “political will in Congress and the Presidency” (p. 262). However, the evidence indicates that “political will” is not determined independent of these campaigns. During the 1940s the AMA shaped the “political will” in several ways. First, it mobilized economic resources and drew upon its organizational capacity to arouse members, stimulate grassroots activities and reach deep into communities to foment opposition to national health insurance. Second, the AMA succeeded in framing national health insurance as a Communist plot and its supporters as communists. Third, the AMA organized other anti-welfare state groups into a coalition to spread its oppositional message across a range of venues.

How did physicians, merely a professional group, defeat the will of social reformers, powerful politicians, and even presidents for more than half a century? Starr (1982) argues that the key to physicians’ political influence was “the absence of [any] countervailing power” (p. 231), but the historical evidence suggests that the opposite is the case. It was not the absence of a countervailing power that allowed physicians to assert their parochial concerns into the policy making process, but rather the fact that their objectives coincided with those of employer groups, insurance companies, and trade unions (Quadagno 2004). Once these interests diverged, the fragility of physicians’ power base was revealed.

Truman did not run for re-election in 1952 and the Republican candidate, Dwight Eisenhower, campaigned against national health insurance. Under eight subsequent years of Republican rule, national health insurance disappeared from the political agenda. The policy vacuum gave the private health insurance industry the opportunity to establish a preeminent position as the financier of health care. In 1940 fewer than six million people had any kind of insurance against the costs of medical care. Just ten years later more than 75 mil-

lion were privately insured (U.S. Senate 1951:2). The increase in private coverage was a product of wartime wage and price controls and tax policies that encouraged the proliferation of fringe benefits and became organized labor’s primary strategy for recruiting and retaining members in a hostile political climate.

PRIVATIZING ORGANIZED LABOR’S AGENDA

The activities of trade unions in other industrial democracies suggests that organized labor is the prime political constituency with the motivation and capacity to promote a national health insurance program. Consequently, one would not expect the trade unions to be advocates of a private insurance system. Yet in the United States, for the most part the trade unions made no effort to win national health insurance through political means but instead focused on obtaining collectively bargained fringe benefits for their members in employment contracts (Derickson 1994). As Stevens (1988) notes, “the political pressure exerted by the American labor movement was . . . a demand for a private alternative to state-run welfare programs” (p. 125).

The reason why the trade unions chose to bargain for fringe benefits must be understood as a response to an assault by business and conservative forces that sought to sharply curb organized labor’s ambitions in the postwar era and reduce its economic program to a militant interest-group politics. The clash between business and labor culminated in 1947 with passage of the Taft-Hartley Act, which rescinded many of the rights unions had won during the 1930s (Lichtenstein 1989). In the wake of Taft-Hartley, the Congress of Industrial Organizations (CIO) expelled 11 communist-controlled unions, triggering internecine warfare among several large unions. Union feuds also helped defeat Operation Dixie, the CIO’s organizing drive in the South (Griffith 1988). The purge of communist unions from the CIO dramatically narrowed the scope of political debate within the labor movement (Stepan-Norris and Zeitlin 1995; Stepan-Norris and Zeitlin 2002).

To surmount new obstacles to recruitment invoked under Taft-Hartley, the trade unions made bargaining for fringe benefits a top pri-

ority. Collectively-bargained benefits obtained on union terms were viewed as the “virtual equivalent of a closed shop,” that is, a unionized workplace (Brown 1997–1998:653). Although pensions involved more money, health insurance was the benefit for which unions bargained most actively. As a result, between 1946 and 1957 the number of workers covered by collectively bargained health insurance agreements rose from one million to 12 million, plus an additional 20 million dependents (Klein 2003). Thus, during a time when trade unions in other nations were working for national health insurance, American trade unions faced an effective employer assault and a hostile political environment. The conflict removed the organized working class from the struggle over a universal health care program, diverting its resources and political energy toward the pursuit of private health benefits for union members (Gottschalk 2000).

Collectively bargained health insurance plans had one significant gap: They generally excluded retirees. Whenever a union attempted to include health insurance for retirees in a collective bargaining agreement, that drove up costs and resulted in concessions on wages and other issues.⁹ Thus, organized labor had an incentive to support a public health insurance program for the aged. Health insurance for old people appeared to be an achievable political objective, one that could resolve the problem of negotiating retiree health benefits and prove what a recently united labor movement could achieve (Berkowitz 1986).

Beginning in 1956 the AFL-CIO wrote model bills and drummed up legislative sponsors, held annual conferences to educate union members about the issues, and worked to develop a broad base of political support. To win over the public, the AFL-CIO created a separate “grassroots” organization of retired trade unionists, the National Council of Senior Citizens (NCSC). The NCSC staged demonstrations, organized mass protests and rallies, prepared flyers and newsletters, and bombarded elected officials with letters and phone calls. The AFL-CIO also seized the initiative in defining Medicare, using publicity materials to characterize the aged as a deserving group (Quadagno forthcoming).

Hoping to regain control of the national debate, the AMA released its own statistics, contending that the aged were not “universally frail and feeble, constantly ill, and doddering

from one visit to the doctor to the next.”¹⁰ Rather the vast majority were in good health. Only 4 percent of people 65 or older were confined because of chronic illness. Nor were the aged especially needy. When tax obligations and family size were taken into account, aged families had only slightly less income than younger families. Moreover, they had fewer financial obligations. Despite employing “every propaganda tactic it had learned from the bitter battles of the Truman era,” AMA efforts were neutralized by the AFL-CIO (Marmor 2000:38).

Notably, the AFL-CIO not only had an organizational structure that matched that of the AMA, with its national headquarters, state federations, and union locals, but it also employed a similar repertoire of tactics, strategies, and grassroots mobilization. This similarity is striking given that the AFL-CIO represented the working class as a whole, both skilled and unskilled workers, while the AMA was a narrowly-focused organization with its primary goal protecting the professional prerogatives of physicians. The comparison of the activities of the AMA and the AFL-CIO suggests a more general principle of policymaking processes in the United States—that the structure of the state channels political activity in certain directions, regardless of what type of group, challenger or stakeholder, organizes that activity.

When it appeared that a government solution was gaining political support, commercial insurers, who had previously been uninterested in insuring the elderly, began offering policies tailored to older people. In 1957 Continental Casualty created Golden 65, the first hospital insurance program for the aged. The following year, in 1958, Mutual of Omaha developed a Senior Security program. Most commercial policies were woefully inadequate, however, leaving the elderly with many health needs uncovered and many expenses to absorb. Fewer than half of people over 65 purchased health insurance, and many who did either dropped their policies when rates rose or were dropped by the insurer when claims were made (U.S. Senate 1964). As it became apparent that insuring the aged would never be profitable, insurance companies stopped actively opposing Medicare and instead lobbied behind the scenes to carve out a role they could play (Corning 1969).

At the 1964 Democratic national convention

in Atlantic City, NCSC members arrived by the busload. Fourteen thousand senior citizens marched for 10 blocks down the boardwalk to the convention hotel. Then during the months leading up to the election, the NCSC worked to ensure that no Medicare supporters were defeated at the polls. The Democrats won the Senate and the House by a wide margin, and no incumbent, Republican or Democrat, who supported Medicare lost (Zelizer 1998). Medicare was signed into law by President Lyndon Johnson on July 30, 1965. The Medicare bill included "Part A," which provided insurance for hospital care, "Part B," an optional voluntary plan of health insurance for physicians' services. Also included was Medicaid, a new joint federal-state program of health insurance for the poor.

ORGANIZED LABOR'S REVERSAL

Medicare was a victory for reformers but also a victory for providers and insurers. The American Medical Association and the American Hospital Association won concessions guaranteeing that the government would not control doctors' fees or hospital charges and that federal authorities would not administer Medicare directly. Rather, private insurance agencies would handle claims, review billed costs and reimburse providers (Jacobs 1993; Fein 1985). Medicare also left a considerable number of health care needs uncovered, ensuring that private insurers retained a share of the market for "Medigap" policies while shifting the riskier, less predictable costs to the government.

With the federal government pouring virtually unlimited public resources into financing care for the aged and the poor, health care became a profitable enterprise for physicians, hospitals, and insurance companies. In 1965 alone hospital daily charges jumped 16.5 percent, average fees for office visits to general practitioners jumped 25 percent, and fees for internists jumped 40 percent (Marmor 2000). Spiralling costs provided fuel for reformers who argued that the problem could only be solved by entirely revamping the health care system and placing responsibility in the hands of one purchaser, the federal government. However, cost increases also made the reformers' task more complex by diminishing the clarity of the message.

The fight to resurrect national health insurance began in 1968 when Walter Reuther, president of the United Auto Workers (UAW), made a fiery speech before the American Public Health Association. Reuther charged that the only way to remove economic barriers to care and contain health care costs was through a single federal program (Reuther 1969). What triggered the apparent about-face of organized labor was the dilemma of rising health insurance premiums, which were taking a larger share of the total wage package with each new contract.¹¹ Reuther organized the Committee of 100 for National Health Insurance (CNHI), a top-notch team of trade unionists and social activists, including Senator Ted Kennedy, the heir apparent of the Democratic party, who introduced the CNHI plan, dubbed Health Security, in 1971. Modeled after Medicare, Health Security would make the federal government the "single payer" for all health services. Not to be outdone, President Richard Nixon announced his own National Health Insurance Partnership Act a few months later. A regulatory approach that encouraged the private insurance market, Nixon's plan included an employer mandate, a concept that had gained favor with some large employers, and health maintenance organizations, now known widely as simply HMOs (Starr 1982b).

After its bitter defeat over Medicare, the AMA had decided that it was better to help craft a bill friendly to the profession than to scuttle reform. Instead of launching a campaign against Health Security, the AMA unveiled Medigap, an alternative based on vouchers and tax credits. However, the AHA refused to endorse Medigap, preferring to expand Medicare into a national program, and the insurance industry opposed Medigap, fearing that any infusion of federal funds into the industry, even in the form of a subsidy, would invite federal regulation.¹²

By July of 1971, 22 different bills were on the table. At one end of the continuum was the AMA's Medigap; at the other was Kennedy's single payer plan. However, national health insurance failed to win congressional support in 1972, because of the Vietnam war, the OPEC oil crisis and the absence of a grassroots movement supporting the legislation. Although the AFL-CIO endorsed Health Security, the endorsement was qualified by an emphasis on costs.¹³ Even the UAW, in disarray since

Reuther had withdrawn the union from the AFL-CIO in an internecine struggle in 1967, failed to provide a firm base of support (Goldfield 2000). In 1973, a weakened version of Nixon's HMO proposal was enacted instead (Hacker 2002; Gordon 2003).

In his 1974 State of the Union address, Nixon announced a new national health insurance program, a two part plan which would give the private insurance industry a central role, as a way to distract attention from the escalating Watergate scandal and head off a more ambitious Kennedy proposal.¹⁴ On April 2, 1974, with much fanfare, Kennedy announced his own plan that he devised with Ways and Means Committee Chair Wilbur Mills (D-AK) without consultation with the trade unions. Like the earlier Health Security plan, the Kennedy-Mills legislation would replace the current system with a single national health insurance program but would otherwise preserve most aspects of the traditional health economy. It would include co-payments and deductibles, allow private insurers to serve as fiscal intermediaries, and leave room for lucrative supplementary benefits. Not unexpectedly, the AMA decried the "socialist" measure (Dranove 2000: 30). The National Federation of Independent Business called it "nothing more than a first step towards socialized medicine" (Martin 1993:369).

The AFL-CIO, furious at being excluded from the process, deserted Kennedy, denouncing Kennedy-Mills as a surrender of organized labor's fundamental principles. The unions objected to the major role allotted to the health insurance industry and to the co-payments and deductibles, which were anathema to organized labor because of the heavy burden they would place on low-income and middle-income families (Quadagno forthcoming). AFL-CIO leaders told their members to press their elected representatives to delay voting on national health insurance until the following year, when it was presumed a veto-proof Congress would be in office and a more labor-friendly plan could be enacted.

When Nixon was forced to resign on August 9, 1974, his successor, Vice President Gerald Ford, singled out national health insurance as the major piece of domestic legislation Congress should pass that year. The House Ways and Means Committee became an instant target for lobbyists and contributions from spe-

cial interests. AMA lobbyists sat in on the Committee's final meeting and mustered 12 votes for an alternative plan, similar to Mediscredit (Wainess 1999). Insurance industry lobbyist also opposed several aspects of the measure, while labor leaders refused to support any compromise plan (Wolinsky and Brune 1994). With few politicians receiving mail on the issue from constituents, Mills announced that national health insurance would be tabled and that the Committee would not resume consideration in the fall (Quadagno 2005).

As health insurance costs continued to rise inexorably during the 1980s, large corporations began seeking other cost containment measures. One strategy was to bypass insurance companies completely and self-insure (Gabel et al. 1987). Self-insurance was a strategy that allowed corporations to reduce the administrative costs of insurance companies, negotiate better rates with hospitals and physicians, and use surplus funds in health benefit accounts as a source of investment capital. In 1975 only 5 percent of employees were covered by self-insured plans; by 1985 that figure had increased to 42 percent (Weiss 1993). The trend toward self-insurance eroded the economic base of private insurance plans and left them with the less profitable business of processing claims and benefits management (Goldsmith 1984). To compensate for these losses, insurance companies began aggressively seeking new markets (Bodenheimer 1990). They began marketing managed care plans to employers that entangled them in complex negotiations with providers through preferred provider networks, health maintenance organizations, and prepaid products. They also began exploring the untapped, potentially lucrative long-term care market, which had, as Kitchener and Harrington (2004) show in this volume, concentrated on nursing home care rather than alternative arrangements because of medical and business opposition. Long-term care was an attractive product line for insurers, because profits in the commercial insurance industry are generated almost entirely from investment income. Policies that incur benefit expenses monthly, such as health insurance, are less profitable than policies that likely won't pay out benefits for years, such as life insurance or long-term care insurance (Gabel and Monheit 1983; Schwartz 1999). The longer the duration of the policy, the greater

the profits. Yet it appeared that the government might absorb this promising market as a compromise with legislation intended to expand Medicare to cover “catastrophic” expenses.

THE TRIUMPH OF THE INSURANCE INDUSTRY

The Long-term Care Defeat

In 1986 President Ronald Reagan proposed expanding Medicare to include the cost of “catastrophic illness,” purportedly to cultivate the support of the elderly whose health care costs in the form of deductibles, co-pays and medigap insurance now consumed a higher proportion of their income than before Medicare was enacted (Moon 1993). He insisted, however, that any proposal be voluntary, self-supporting, revenue neutral, and that it not encroach on the private market (Thompson 1990). A catastrophic care plan was sent to Congress in February of 1987 with the endorsement of the major provider groups. The American Hospital Association supported the measure as long as reimbursement to hospitals was sufficient. The American Medical Association supported it as long as fee-for-service was not challenged (Street 1993). The insurance industry did not oppose the catastrophic care proposal because it would still leave numerous gaps in coverage, including \$2,000 a year for deductibles and co-payments and treatment for Alzheimer’s disease, which was an emerging market for the private industry (Himelfarb 1995). Further, according to conservative columnist Peter Ferrara, “insurance companies weren’t interested in fighting . . . Medigap just isn’t that profitable” (Thompson 1990:199).

Expanding Medicare to cover catastrophic expenses would be a boon to large firms, which had become increasingly concerned about the costs of retiree health benefits for former employees. Over 70 percent of people 65 and older had some supplemental medigap insurance, and half of these policies were paid for by their former employers. By the 1980s health care inflation coupled with increasing life expectancy and early retirement had made retiree health benefits a significant drain on profit margins (Neilsen 1987). The more mature the firm, the higher the costs. For example, in 1982 Bethlehem Steel had 70,000

active employees and 54,000 retired employees; by 1987 it had only 37,000 active employees and 70,000 retirees (Gottschalk 2000). Expanding Medicare to cover catastrophic health care costs could ease these pressures on corporations and reduce employer’s liability to current retirees by an estimated 30 percent (U.S. Senate 1989).

The one influential organization opposed to Medicare expansion was the Pharmaceutical Manufacturer’s Association (PMA). The PMA was an active participant in a conservative movement to halt the growth of federal entitlement expenditures and immobilize the old age lobby, which appeared to be a growing political force capable of swinging elections and then demanding ever greater benefits (Pratt 1993; Powell, Williamson, and Branco 1996). The PMA opposed a provision in the catastrophic care bill that would permit Medicare to set drug prices or stop paying for entire classes of drugs entirely if costs rose too quickly. To prevent the inclusion of price controls, the PMA spent several million dollars lobbying against the legislation. The PMA also mobilized a grassroots movement among more than 12,000 pharmacists, who wrote letters urging their representatives to support a watered-down version of the drug benefit (Quadagno 2005).

On July 1, 1988 Congress enacted the Medicare Catastrophic Coverage Act with huge bipartisan majorities in both the House and Senate. The PMA endorsed the final compromise bill, which made no reference to cost controls on drugs. The Medicare Catastrophic Coverage Act capped the amount beneficiaries would have to pay for hospital and physician care, provided a prescription drug benefit, mammography screening, hospice care, and caregiver support but did not provide any help for the most pressing expense of the elderly, long-term care (Street 1993). The new benefits would be financed by an increase in Part B premiums, which would rise from \$122 a year to \$511. In addition, Medicare beneficiaries who paid at least \$150 a year in income taxes would have to pay a surcharge up to a maximum of \$800 for a single person and \$1,600 for a couple (Pratt 1993). Although approximately 60 percent of older people would be exempt from the surcharge because their incomes were too low, those who would have to pay were the group most likely to already have catastrophic coverage from medigap

insurance policies. Thus, they would be paying twice for the same coverage.

The Medicare Catastrophic Coverage Act triggered an explosive reaction among the elderly. Angry senior citizens descended on Congress, demanding that the new program be changed or repealed outright (Himelfarb 1995). On October 4, 1989 the House voted to repeal the program it had approved just 16 months earlier. Two days later the Senate voted to repeal the surtax, retaining only the long-term hospital benefits, which subsequently were also eliminated (Crystal 1990; Day 1993).

During the battle over catastrophic care, a long-term care measure was introduced by Representative Claude Pepper (D-FL). Pepper proposed expanding Medicare to pay for home care services, a popular proposal among the elderly whose only option when they needed long-term care was to become sufficiently impoverished to qualify for Medicaid (Grogan and Patashnik 2003). According to a poll conducted by the American Association of Retired Persons, 85 percent of the public supported home care for the disabled.¹⁵ In exchange for a promised vote on his home care bill in the House, Pepper agreed he would not bottle up the catastrophic care bill, which he viewed as inadequate, in the Rules Committee.

The insurance industry was willing to allow the federal government to absorb the cost of catastrophic care, because the medigap market was saturated and never that profitable to begin with. In fact, as soon as the Medicare Catastrophic Coverage Act was signed, insurers began offering new policies to cover the copayments and deductibles that beneficiaries would still have to pay. Insurers opposed the home care bill, however, because it threatened to absorb the market for their newest product. In 1985 no insurance company offered a long-term care policy. By 1987, 72 insurance companies had developed some type of long-term care product. However, these policies provided inadequate protection and were often fraudulently administered. An analysis by the House Select Committee on Aging of 33 long-term care insurance policies offered by 25 insurers found that most provided little protection against the cost of nursing home care, few were indexed to inflation, many would only pay for skilled nursing but not custodial care, and more than half excluded Alzheimer's disease, the main cause of nursing home admis-

sion. Many insurance companies paid agents a commission of as much as 60 percent of first year premiums, giving them an incentive to "churn" clients. Some elderly people owned as many as 11 different policies that paid duplicate benefits (U.S. House of Representatives 1989).

Politically, insurers are consummate insiders. State insurance commissioners and their staff are often former insurance executives, and the federal and state committees that handle insurance matters are dominated by legislators with ties to the industry (Bodenheimer 1990). With assets greater than the largest industrial corporations and insurance lobbyists foremost in nearly every state, the insurance industry proved to be a formidable foe (Renzulli 2000). To fend off the threat of a federal home care program, the Health Insurance Association of America (HIAA) bankrolled a lobbying blitz. HIAA lobbyists wrote every member of Congress proclaiming that "this bill is the wrong medicine for our country, another example of an expensive government solution . . . that would lead to exploding public sector costs."¹⁶ The HIAA also created an umbrella organization, the Coordinating Committee for Long-Term Care, to arouse other stakeholder organizations. Blue Cross/Blue Shield, the Chamber of Commerce, National Small Business United, the American Association of Homes for the Aged, the National Association of Manufacturers, and several other insurer groups worked together to defeat the Pepper bill.¹⁷ The Chamber of Commerce, whose own governing committees were stacked with insurers, warned that the proposed payroll tax increase would hurt small businesses and set a "dangerous precedent" that could lead to the "application of the entire Social Security tax to all wages."¹⁸ The National Federation of Independent Business (NFIB), an organization that represented small businesses, sent members of Congress a list of businesses in their districts that opposed the measure and warned ominously that it would "consider the vote on H.R. 3436 a Key Small Business Vote for the 100th Congress."¹⁹

Home care opponents also waged a public relations campaign, demonizing the aged, who were perceived as an omnivorous political force with the potential to overcome business opposition. The *Wall Street Journal* described the home care bill as "the welfare state on cocaine," supported by "the King Kong known

as the senior citizen lobby. There is something both disingenuous and surreal about today's elderly lobby . . . They always want more-preferably in a federal program others will have to pay for."²⁰ When the home care bill came to a vote in the House, 99 Democrats and 144 Republicans voted against it. Following the defeat, the HIAA sent members of Congress who voted for the bill a letter warning, "we want to take special notice of your vote last week on Rep. Pepper's home care bill."²¹ As an alternative, the HIAA lobbied for and won federal tax incentives to stimulate the private long-term care insurance market.

The battle over home care proved to be a useful learning experience for the insurance industry. Insurers formed a viable coalition with other organizations dedicated to defeating federal health care proposals and devised tactics and strategies that allowed them to crush a measure that had broad public support. That battle prepared the insurance industry for a fiercer struggle that would be waged in the 1990s over national health insurance.

National Health Insurance Revisited

In 1991 national health insurance moved to the forefront of political debates when Senator John Heinz (D-Pa.) died in a plane crash and the governor of Pennsylvania appointed Harris Wofford, the sixty-five-year-old former president of Bryn Mawr College, to replace him. Wofford was only supposed to serve until a special election could be held, but he decided to run for the regular Senate seat. The little-known Wofford was trailing far behind his opponent, Richard Thornburgh, the twice elected, popular former governor and U.S. attorney general until Wofford raised the topic of health insurance. Wofford crushed Thornburgh in the election, and polls subsequently showed that voters identified health care as a key factor (Johnson and Broder 1996).

Other candidates seized the issue, and the Democratic party candidate, Bill Clinton, made it a feature of his campaign (Hacker 1997). After Clinton won the election, he promised to have a health reform bill for Congress within his first 100 days. Instead a crisis in Somalia and a battle over the North American Free Trade Agreement absorbed the president's attention. The NAFTA battle had a

secondary consequence of depriving the Clinton administration of a key ally. Before the election, the president of the AFL-CIO had promised Clinton that the labor movement would be the "storm troopers" for national health insurance. However, labor leaders viewed NAFTA as an effort to shift production to low-wage countries with more lax environmental and labor standards, so instead of working for health care reform, the AFL-CIO became involved in fighting NAFTA (Skocpol 1996).

The president's Health Security plan was finally released in October of 1993. The most comprehensive domestic policy proposal since 1965, it would guarantee universal coverage through an employer mandate and contain inflation through purchasing alliances and a national health budget. The purchasing alliances would be similar to the the corporate purchasing coalitions of the 1980s and dominated by the five largest health insurers: Aetna, Prudential, MetLife, Cigna, and Travelers. However, smaller specialty firms stood to lose 30 to 60 percent of their business, and insurance agents would be put out of business entirely. The plan also called for repeal of the health insurance industry's antitrust exemption under the McCarren-Ferguson Act and made insurers subject to federal anti-trust provisions and consumer protection mandates (Johnson and Broder 1996; Skocpol 1996).

The lengthy planning period provided stakeholder groups the opportunity to develop a strategy and plan an attack. The most vehement opponent of Health Security was the Health Insurance Association of America, which spent more than \$15 million in a multi-faceted advertising campaign. In the summer of 1993, the HIAA created the Coalition for Health Insurance Choices, involving many of the same organizations that had fought the home care bill. Initially, the Coalition sponsored vague commercials about health care reform. One ad said the purchasing alliances might be "the first step to socialized medicine" (Skocpol 1996:137). Another series of ads featured a white, middle-class couple confronting the worrisome possibility of government bureaucrats choosing their health plan. As Health Security won public support, the ads zeroed in on fears people had about how their current insurance coverage would be affected (Jacobs and Shapiro 1995). All the ads invoked an antistatist theme, that Health Security

would create a vast, inefficient, and unresponsive government bureaucracy and thousands of new bureaucrats (Goldsteen et al. 2001; Jacobs and Shapiro 2000).

The Coalition for Health Insurance Choices set up an 800 number to enlist grassroots supporters. The Coalition also formed “swat teams” of supporters to write letters and lobby lawmakers (Center for Public Integrity 1995). Concerned employers received a thick manual spelling out ways to get employees, vendors, and other sympathizers involved in the battle against the Clinton plan. The effort produced more than 450,000 contacts with members of Congress, almost a thousand for each senator and congress person (Johnson and Broder 1996).

Insurance companies and insurance agents’ organizations increased their campaign contributions substantially, with the largest sums going to members of the House Ways and Means Committee and the Senate Finance Committee, both of which had jurisdiction over health reform. Members of two House committees that debated health care bills received contributions averaging four times that of members not on these committees (Center for Public Integrity 1995). Insurance agents also organized their own grassroots effort (Johnson and Broder 1996). A political force in their own right, they were located in every congressional district, active in their communities, and involved in state and local politics (Quadagno 2005).

The HIAA had an ally among small business owners who opposed an employer mandate and any tax increase. The NFIB mobilized its own grassroots effort against Health Security, dispatching streams of faxes and action alerts from its Washington office to tens of thousands of small business owners. Every week the NFIB polled 600,000 members on their attitudes toward the Clinton plan and sent their responses to their congressional representatives. The NFIB also organized groups of activists who attended local meetings whenever their congressional representatives visited their home districts, and it also conducted seminars in states that had members on key congressional committees. The NFIB also worked through the press, using the influential radio talk shows to kindle public opposition (Johnson and Broder 1996). When the first poll was taken on the Clinton plan in September of 1993, 59 percent of the public

favored it. By June of 1994 public support had declined to only 44 percent (West and Loomis 1999).

Interestingly, unlike the 1940s, when the AMA had been the most vocal political opponent of the Truman plan, in the 1990s physicians were nearly invisible in the fracas over Health Security. The AMA initially endorsed the concept of universal coverage but opposed any stringent cost controls or regulations that would give managed care an advantage. Some organizations of specialists endorsed the basic features of the Clinton plan; other physician organizations opposed the same features (Tuohy 1999). These disagreements made it impossible for physicians to convey a clear message about health care reform. Tellingly, the various accounts of Clinton’s failed effort scarcely mention the AMA or the physicians it represented (Johnson and Broder 1996; Skocpol 1996; Hacker 1997).

After the demise of Health Security, health policy making moved toward shoring up the private health insurance system by tightening regulations to make private insurance less insecure. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) narrowed the conditions under which companies could refuse coverage, allowed people who itemized deductions on their income taxes to deduct a portion of long-term care insurance premiums, and made employer contributions toward the cost of group long-term care insurance a tax deductible business expense. After HIPAA long-term care insurance sales increased an average of 21 percent a year, with the biggest increase occurring in group insurance plans offered by employers (Quadagno forthcoming).

The most recent health policy event was enactment of the 2003 Medicare prescription drug benefit. Hailed by the Bush administration as the biggest overhaul of Medicare since its inception, the new program would pick up 75 percent of a beneficiary’s drug costs up to \$2,250 a year (Hacker and Marmor 2003). Then, in a confusing twist, coverage would stop until a beneficiary had spent another \$3,600, creating a so-called “doughnut hole” (Oberlander 2003). After that, Medicare would pay 95 percent of any additional drug costs. Also included were tax incentives to encourage higher income elderly to purchase private health insurance policies as a substitute for Medicare, \$12 billion in subsidies to private

insurance companies to encourage them to offer seniors' policies that compete with Medicare and \$70 billion in subsidies to employers so they wouldn't drop prescription drugs from their retiree health plans (although many analysts doubt that the incentives are sufficient to have that effect). The final caveat was that the federal government was prohibited from negotiating drug prices.

The no-price-negotiation feature came from the Pharmaceutical Research and Manufacturers of America (PhRMA), with its 620 lobbyists. In the first six months of 2003, the PhRMA pumped \$8 million into a lobbying campaign against price controls. The "doughnut hole" was a concession to the American Association of Health Plans which represents managed care firms. The main incentive for the elderly to choose an HMO over the traditional Medicare program was prescription drugs. If Medicare assumed all drug costs, then HMOs would be a less attractive alternative. Increases in physicians' payments sealed the deal. The result was a benefit that paid some of the costs for low spenders and most of the costs for people with catastrophic drug expenditures but preserved the free market for the middle class (Weissert 2003).

CONCLUSION

Medical sociologists have aptly described the shifting configuration of power within the health care system from providers to purchasers but have failed to specify the way that the rise of these "countervailing powers" transformed the political terrain. From the New Deal to the 1970s, the most vehement opponents of national health insurance were physicians. Fearful that government financing of health services would lead to government control of medical practice, they mobilized against this perceived threat to professional sovereignty. Physicians were able to realize their political objectives through the American Medical Association, which then had the organizational capacity to marshal resources, command a response from members, achieve deep penetration into local community politics, shape public opinion through antistatist campaigns, and subsequently influence electoral outcomes. The historical irony is that the private health insurance system that physicians helped to construct became a mechanism for undermin-

ing their sovereign rule, as the abuses of professional authority following the enactment of Medicare and Medicaid roused large firms and the insurance industry to seek redress in the form of managed care. The outcome demonstrates the fragility of physicians' power base.

As physicians' antipathy to national health insurance dwindled—tempered by the benefits of guaranteed payment, splits among various specialty groups, and the loss of allies among other health professionals and employer groups—health insurers moved to the forefront of public debates, determined to prevent passage of national health insurance and defeat any program that might compete with their products. In some cases, traditional lobbying tactics were sufficient to ward off government intervention; in other instances, they formed political coalitions with like-minded organizations—whether they be small business owners, pharmacists, or insurance agents—to create "grassroots" social movement activities and fund public information campaigns designed to convince politicians that the public opposed health care reform. The changing composition of the anti-reform coalition, dominated first by physicians, then by insurers, has obscured the persistence of stakeholder mobilization as the primary impediment to national health insurance.

The ironic outcome of each failed attempt to enact national health insurance was federal action that stimulated the growth of commercial insurance and entrenched a market-based alternative to a public program. In the 1940s the failure of national health insurance provided a stimulus to the private health insurance industry. The enactment of Medicare in 1965 removed a key constituency, the aged, from the political debate while preserving a profitable segment of the market for private insurers. The compromises involved in Medicare also led to health care inflation, creating a dilemma that would jinx all subsequent efforts to enact national health insurance. Health care reformers could never again define the problem solely in terms of improving access to health care for worthy and deserving groups. They now also had to promise to control costs and reform the system. A national health insurance plan proposed in the 1970s was redirected and led instead to federal support for private HMOs. The defeat of home care legislation in the 1980s provided a stimulus to the long-term care insurance market.

The centuries-long struggle for national health insurance illuminates fundamental features of American political development. First, it suggests that while anti-statism is not a causal force in and of itself it does provide a powerful weapon that can be deployed in political struggles over the welfare state. Second, it suggests that labor movements can use their “power resources” in ways that reinforce rather than transform the play of market forces, but also that the trade union movement has the capacity to transform the welfare state without forming a political party. Because the American trade unions viewed national health insurance as an unachievable political goal in the postwar era, they instead concentrated on winning benefits through collective bargaining. Once won, these private health benefits created a conundrum in the form of costly retiree health benefits that encouraged the AFL-CIO to lead a successful campaign for health insurance for the aged. The Medicare victory resulted from a confluence of historical conditions and favorable political opportunity structures that included an internally unified labor movement, Democratic party control of Congress and the Presidency, and a national climate that was sympathetic to initiatives to aid the less privileged. Third, it is apparent that the institutional structure of the state in the United States channels political activities in ways that blur the distinction between the tactics and strategies of less privileged groups and normal political processes. Just as challengers not only engage in grassroots activities but also attempt to gain privileged access to mainstream politics, so, too, do powerful stakeholders with privileged access also manufacture grassroots protests to convince political leaders that their interests represent the public will.

The similarities in tactics and strategies used by opponents and successful reformers suggest that the structure of the state organizes political activity in systematic ways. This insight provides a framework for identifying what might be required to transcend the network of powerful, vested interests to achieve universal coverage. Specifically, it suggests that prospects for reform are enhanced when a coalition is organized in ways that closely mirror the representative arrangements of the American state (Skocpol, Ganz and Munson 2000). In keeping with this argument, any reform movement needs an organizational structure with a federal framework. At the top

there must be a national leadership responsible for mapping out a grand plan to disseminate ideas, recruit members nationwide, and cultivate political insiders (influential congressional committee chairs and civil servants) who can introduce bills and devise ways to attach health care initiatives to less visible budget measures. At the middle level, a reform movement needs intermediate institutions, such as state labor federations whose leaders can coordinate activities, tap into indigenous social networks, and disseminate the organizations’ models and ideas (Nathanson 2003). Finally, a reform movement needs local chapters to funnel money to the higher levels of the federation and provide grassroots activists who can engage in social action to influence politics at the local level. This structure ties leaders to one another, links local groups to larger issues, and affords opportunities for political leverage at the local, state, and national levels. Thus, social movement theorists’ focus on informal, emergent social and political processes needs to be coupled with an analysis of the way the structure of the state systematically organizes political activity (McAdam and Su 2002).

NOTES

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 7. Claude Pepper Oral History, Columbia University Oral History Collection, p. 28.
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 14. Memo for the President from Caspar Weinberger, November 2, 1973, National Archives, College Park, MD, Nixon materials. White House Central Files, Subject Files, HE (Health) Box 2, File: EX HE 8/1/73.
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 18. Letter from Albert Bourland, Vice President for Congressional Relations, Chamber of Commerce, May 23, 1988. Pepper Library, Series 302A, File 42, Box 7.
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