The Politics Of Health Reform: Why Do Bad Things Happen To Good Plans?

In the United States, the more desirable health care reform is on substantive grounds, the less politically feasible it is.

by Jonathan Oberlander

ABSTRACT: This paper examines political feasibility and its implications for health reform. I discuss the political obstacles to health reform in the United States, disentangling perennial barriers from contemporary constraints. I then explore major reform options and their political prospects. I argue that while incremental reform now appears to be the most feasible option, the political climate may change in a way that permits a bolder vision. Moreover, incremental reform may not be sustainable in the long run, for the same reason that makes it politically popular now: It does not change the status quo in the health system.

Health care reform is back. The number of uninsured Americans is rapidly rising. An economic slowdown is shaking the employer-based foundation of private health insurance, while companies dump retiree health coverage. The middle class is increasingly anxious about losing health insurance. The price of medical care and insurance premiums is skyrocketing, far outpacing the general inflation rate and workers' wages. Labor unions strike to protest health benefit cuts. Businesses decry their rising health insurance bills, while doctors decry their malpractice premiums. States respond to fiscal crisis by cutting Medicaid benefits and enrollment. Safety-net providers are stretched to the breaking point by the swelling ranks of the uninsured. Sensing a window of opportunity, members of Congress introduce competing health reform bills, while policy analysts take to the op-ed pages to push their preferred solutions.[1]

These are the headlines from U.S. health politics in 2003. If they seem familiar, however, you are experiencing what Yogi Berra famously called "déjà vu all over again." Indeed, these headlines could just as easily have been written about the health care system in 1993 or, in many respects, 1973. Simply update the numbers for the uninsured and national health spending, and newspapers could run the same stories. To be sure, there are new plot twists now; witness the spectacle of doctors striking over malpractice premiums. Yet the dominant theme of U.S.

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health politics is surely the sensation of being caught in an endless repeating loop, with vigorous calls for reform periodically energizing the polity, only to fall short of aspirations for universal coverage and comprehensive reform.

That failure is not due to a lack of vision, or at least a lack of would-be visionaries. Since Progressives first introduced national health insurance proposals to the United States in 1912, countless health care reform proposals have been funded, developed, modeled, modified, and debated. Ultimately, however, all have been rejected. That is not a comment on their technical merit. Some of these proposals truly did look very good on paper or even in practice (in other countries). Unfortunately, the U.S. political system has not been impressed, and despite the best-laid plans of advocates and analysts, universal coverage has consistently been felled by one opponent: political feasibility. Designing an ideal health reform plan that assures access, quality, and cost control is, in comparison, the easy part; designing an ideal plan or even a decent one that has a compelling political strategy to survive the legislative process is the difficult task. So far, no plan for universal coverage has passed the test, thus the endless loop in U.S. health policy.

After nearly a century of failure, it should be clear that universal health insurance cannot win simply on substantive qualifications: No appeal premised on improved quality of care, better access, and controlled costs is so politically decisive that a plan will be adopted on the basis of merit alone. Bad things indeed do happen to good health reform plans. Yet political calculations are too often a footnote in health care reform proposals. This paper moves those calculations to the fore. I focus here on political feasibility and its implications for health care reform. I begin by identifying some pitfalls in feasibility analysis. Next, I discuss the political obstacles to reform. Finally, I analyze the political prospects of major reform options and explore the future of health care reform.

Pitfalls In Feasibility Analysis

Political feasibility represents what is doable in the real world, which in the case of national health reform is inhabited by Congress, the president, stakeholders, and public opinion. Feasibility analysis deals not with policy ideals but with what is more or less adoptable given political constraints. It is therefore widely viewed as a healthy dose of realism and objectivity. But the pitfalls involved in conducting feasibility analysis in health policy are substantial.

■ **Feasibility or desirability?** The first major pitfall is to confuse feasibility with desirability and thus not to separate out what is desirable from what is doable. It is, not surprisingly, common to argue that one's favorite reform option also happens to be the most feasible course of action. No political side has a monopoly on this temptation. From the right, Alain Enthoven declared managed competition to be "the only practical solution"; as the Clinton administration painfully discovered, that was not quite the case.[2] From the left, single-payer advocates argue that their model is feasible if only the proper social forces are mobilized or the public is made to un-

derstand what government already spends on medical care, despite three decades of failure to move single payer anywhere close to enactment.[3]

■ **Beltway mentality.** A second pitfall is what can be called "Beltway-itis," the tendency to assume that feasibility is dictated by the stories in this week's *Washington Post.* Solutions du jour are taken to be the only game around and quickly become the subject of group-think; however, just as quickly, as in the case of "play-or-pay" employer coverage proposals in the early 1990s, these policy fads can disappear from the political map not long after having been the toast of the town's political and health policy elite.[4] Implicit in the Beltway mentality is the unstated assumption that judgments on political feasibility are to be made in a very short time horizon, conforming to the impatient cycle of media attention and the congressional clock.[5] But unless contemporary political constraints and alignments can straightforwardly be extrapolated to the future, what is feasible today may not be tomorrow, and vice versa. If not acknowledged, the bias to the present inherent in Beltway-itis may narrow and distort conceptions of feasibility.

■ **Overconfidence.** The final pitfall is simply overconfidence that any given feasibility analysis is right. Any discussion of health reform and feasibility has to acknowledge that policymakers and analysts have often been wrong about what is doable in health policy. These mistakes run the gamut from not predicting that important changes and reforms were coming; to wrongly assuming that other important changes and reforms were imminent; to misreading political constraints and opportunities.[6] How many analysts in the mid-1980s saw that a national debate on universal health insurance was just around the corner? Or predicted that the biggest benefit expansion in Medicare history would pass during the Reagan administration—and then be repealed? Or would have guessed that Richard Nixon would be a stronger supporter of national health insurance than Jimmy Carter? A good deal of humility is clearly in order for anyone seeking to predict the future of health policy.

■ **Active, not passive role.** A final qualification is that feasibility analysis does not merely play a passive role in the political process as an objective judge of what will or can happen. Rather, policy analysis itself can influence the course of events and is often deployed as a political weapon. When Medicare was enacted in 1965, there were relatively few health economists and health policy analysts. In 1993 the Clinton administration encountered a more crowded policy environment, and its political opponents easily found policy analysts to bolster their case that the Clinton health plan had fatal flaws.[7] Had Medicare faced a similar environment, its advocates would no doubt have had to spend more time and political capital rebutting arguments that Medicare would "crowd out" private insurance and lead to industry "capture" of federal regulators.

Political Obstacles To Health Reform

■ **Institutional fragmentation.** Health care reform plans face two distinct sets of political constraints. The first set is perennial constraints that endure over a long

period and are particularly resistant to change. The structure of U.S. political institutions creates a number of barriers to the passage of any legislation, let alone a reform as controversial, ideologically divisive, and threatening to powerful interests as national health insurance.[8] Unlike a British-style parliamentary system, U.S. constitutional arrangements provide no assurance that the president will represent the same party as the congressional majority; divided government is a regular feature of U.S. political life. Moreover, even if the president's own party holds majorities in the House and Senate, Congress may rebuff the president's priorities; partisan majorities do not necessarily produce policy majorities in American politics.

U.S. political parties are weaker than parties elsewhere in the democratic world. Members of Congress commonly run their own campaigns, raise their own funds, and run independently from—and sometimes in opposition to—their own party's platform.[9] Their first political allegiance is not to their party or president but to their congressional district. Also, unlike parliamentary legislators, members of Congress can cast important votes against their party's president without worrying that it will lead to a vote of no confidence that triggers new elections in parliamentary systems. Consequently, presidential sponsorship of major health care legislation, even with a Congress controlled by the president's party, does not assure legislative victory.

The internal organization of Congress further complicates the road to reform. Legislation must clear both the House and the Senate and afterward a conference committee to reach the president's desk. But the labyrinth that must be navigated even before that step is formidable. Congress is organized into a series of committees and subcommittees, often with overlapping jurisdictions, through which health reform legislation must pass before it comes to the House and Senate floors for a vote. There is, then, an institutional bias in U.S. politics favoring the status quo: Traditionally, reformers have had to jump over every legislative hurdle, while opponents have only had to trip them up once to win.[10]

The fragmented structure of Congress creates another barrier to reform: the difficulty in achieving consensus on a single piece of legislation. Congress, measured in terms of its political independence, administrative capacity, and ability to pursue policies that diverge from the executive, may be the most powerful legislature in the world. Members of Congress who head committees and subcommittees have their own platforms from which to introduce health reform bills that differ from those of their parties. Any debate over health care reform consequently produces numerous bills sponsored by enterprising congressional policymakers. This fragmentation provides a sobering lesson for reformers. Even if a congressional majority in favor of universal coverage exists, it does not mean that majority support exists for any one plan.

■ **Unbalanced political arena.** A second critical barrier to the adoption of national health insurance is the structure of U.S. health care politics. Fundamental reform poses a threat to interests invested in maintaining the medical status quo, in-

cluding physicians, hospitals, insurers, pharmaceutical companies, and suppliers of medical technology—the entire medical-industrial complex.[11] National health spending represents these parties' income, and they are opposed to any reform that will slow down the resources society is transferring to them. These groups are well-organized, well-funded, and willing and able to take advantage of fragmented political institutions that provide multiple opportunities to block legislation deemed as hostile to their interests.

On the other side are millions of uninsured Americans (now forty-one million) with a stake in universal health insurance. But the uninsured are a group in statistical terms only. They have little in common—except that they are uninsured. They are a diverse group politically, geographically, and ethnically, with no organization, few financial resources, and little political clout. It is no accident that while the list of medical lobbying groups and trade associations is endless, few prominent national groups advocate for the uninsured. Pitted against the resources and influence of the medical industry, the uninsured are no match, and the result is a profound imbalance in the politics of health reform.

Moreover, it is clear that the most relevant political fact about U.S. health politics is not that 15 percent of the population is uninsured but that 85 percent is insured. The insured are generally satisfied with their own medical care, even if they think poorly of the system as a whole. Consequently, the well-insured are not a reliable constituency for change. Indeed, any reform that threatens to alter their medical care arrangements is likely to provoke public opposition. Our health insurance arrangements consequently reproduce the politics of indifference.

■ **Political culture.** The third perennial obstacle to health reform is political culture. Since the American revolution, U.S. political culture has been ambivalent about public power, an ambivalence enshrined in the Constitution. There is a strong antigovernment streak in U.S. politics that is suspicious of centralized authority and confident of the virtues of individual responsibility and free markets.[12] This has made national health insurance an attractive target for ideological opponents to any expansion of federal authority. It also has led some to conclude that we have the health system, inequality and all, that the American public actually wants; after all, the United States tolerates more income inequality among its citizenry than any other industrial democracy.[13]

Nevertheless, U.S. political culture is often oversimplified into a stereotype of universal devotion to individualism and free markets that does not always fit the facts. There is evidence from opinion polls that health care is different; general ambivalence about government coexists with broad support for public action in health policy. An overwhelming number of Americans have consistently supported the idea that health care should be a right. And for much of the past fifty years, a majority of Americans have favored national health insurance. Yet the depth and stability of public support for health reform have remained both suspect and volatile.[14] Even if U.S. political culture is not homogeneous, the intensity

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and durability of its antigovernment strain is politically crucial. It is difficult to dispute the fact that U.S. reformers have unsuccessfully coped with more ideologically based opposition to national health insurance than reformers abroad have had to face.[15] The American public has been especially vulnerable to the influence of media campaigns organized by interest groups to discredit national health insurance. These campaigns succeed, in part, because suspicions about centralized authority are easily aroused in the United States.

Contemporary Influences On Feasibility

Barriers as formidable as those just discussed do not make health care reform impossible to adopt. Given the right political conditions and strategic decisions, things could turn out differently; particularly during the early 1970s, the United States came tantalizingly close to passing universal health insurance.

Medicare, after all, was adopted in 1965 as a single-payer health insurance program, despite frequent assertions that single payer is culturally taboo in the United States, because Democrats enjoyed massive congressional majorities in the liberal Johnson era of federal activism. If Medicare had been enacted at a different political time, it could well have had a different form. In other words, Medicare's single-payer status was contingent on the prevailing politics of 1965, and its political fortunes rested on much more than its internal characteristics or inherent political attributes.[16] That contingency calls attention to the importance of a second set of forces affecting the feasibility of health reform: contemporary political alignments, socioeconomic conditions, and the public mood.

In contrast to the enduring barriers described previously, these circumstances—including elections, economic performance, and public opinion—are subject to quick, frequent, and unpredictable change. Institutional and constitutional barriers to national health insurance will always be there, but a Congress controlled by Republicans (or Democrats) will not. This instability is crucial: While we know the current policy environment, we cannot know what that environment will look like ten or four or even two years down the road. Political feasibility thus involves a different analytic challenge than that of evaluating whether a particular health reform plan promotes quality of care or controls costs. A plan that has attributes promoting quality will still have those attributes a decade from now. But a plan that is politically out of the question today may be feasible in a decade, so the only reliable judgments about political feasibility are those made for the short term, and those judgments are not reliable guides to the future.

The present political environment—conservative Republican president, conservative Republican majorities in Congress, a public agenda dominated by na-

tional security issues, and fiscal politics marked by growing federal deficits and tax cuts—is not conducive to enacting universal coverage. George W. Bush's chief domestic policy interests have not included the uninsured; indeed, the administration's plan to block-grant Medicaid could contract public coverage. And the Bush administration's own health reform proposals have aimed to insure only about 15 percent of the uninsured. Nor is there now, despite recent activity from Sen. John Breaux (D-LA) and others, any perceptible congressional majority predisposed to comprehensive health reform that would, at least, cover a majority of the uninsured. Beyond 2004, though, the crystal ball gets foggier. The current climate is not unlike the political environment in 1991, with the number of uninsured Americans rising against the backdrop of war, economic stagnation, and sizable federal deficits that quickly gave way by 1993 to a new environment with an activist health policy agenda.

Evaluating The Options

One way to manage the dozens of recent proposals for health care reform is to boil them down to their essentials and think of them as fitting into one of three categories of choices: building on the existing mixed system of employer-based coverage and public insurance, moving to an individual-based insurance system through tax credits, and adopting a national health plan.[17] Within these categories there is substantial variation, and some plans overlap across multiple categories, but the three options largely represent the major choices in health reform.

■ **The illusion of cost control.** There is, however, a fundamental mismatch between the aspirations of reform and what this menu of plans can deliver. Given its primacy as a goal in health reform, it is striking that two of the three major options noted above promise to do nothing whatsoever to control health care spending and indeed, in practice, are much more likely to have the opposite effect.

The option to build on the current mixed system of care (by expanding public coverage in combination with new subsidies for private insurance) would retain our pluralistic health care financing structure and rely on the negotiating leverage exerted separately by organized purchasing groups, including large firms, purchasing cooperatives, and government managers, to control costs. But this is precisely the same strategy and collection of actors that we have relied on in the past to moderate health spending, and they have failed miserably. I see no reason why they would perform better under the most likely current scenarios, unless, as in the Clinton plan's combination of health alliances and premium caps, government plays a far more powerful role in setting spending limits. We have heard much in the past two decades about the capacity of prudent purchasing and business alliances to restrain health spending; so far the rhetoric has far outpaced the reality.

Individual-based health reform options would likely fare no better in taming health care costs. Their vision is of individuals, propelled by tax credits, choosing and purchasing their own health insurance, including "consumer-directed health

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plans" and medical savings accounts (the fact that most Americans do not consider catastrophic insurance adequate health security has not deterred their supporters). Jack Meyer and Sharon Silow-Carroll note that in some incarnations, these plans, with deregulation and insurance market "reform," would actually worsen medically uninsurable people's ability to get coverage.[18] If so, they should be rejected outright on that basis alone as a template for reform, whose first principle should be that it does not make sick people who already have trouble getting health insurance even worse off. Setting aside that disquieting feature, individual-based plans offer no realistic strategy to control costs. According to Meyer and Silow-Carroll, the logic of individual-based health reform is that consumer cost-consciousness can give "people economic incentives to economize on their use of health services."[19] There is, then, the familiar resort to markets, competition, and consumerism as the linchpin of cost containment.

Yet the United States has already traveled far down this road, with precious little to show for it.[20] Historically, the United States has focused on transforming patients into consumers through demand-side cost containment tools, such as higher deductibles and copayments, that attempt to reign in individuals' demand for medical services. Canada and other industrial democracies have, by contrast, embraced supply-side cost containment, with global budgets, fee schedules, and limits on diffusion of technology.[21] These nations have sought to shield patients from the rising costs of medical care, generally imposing no or very low levels of cost sharing. The result: Americans have the highest cost sharing and the highest health care spending in the world. Given that dismal record, it is hard to see on what basis anyone could advance the sort of consumer cost-consciousness embedded in individual-based health reform as a reliable mechanism to control health spending. Indeed, the idea in some plans that individuals would shop around for low-cost providers and negotiate with them for even lower prices is both startling and absurd. What is plausible is that the move to individual-based insurance would unshackle the insurance industry from the leverage that employers now exert, leaving insurers to raise premiums as they see fit.

■ **The politics of cost control.** What are we to make, then, of the fact that two of the three options for health reform lack any serious potential for controlling costs? One reading of both the demise of the Clinton plan and the erosion of managed care is that the public does not want cost containment, at least to the extent that they perceive it as creating barriers to care; they want all the access to high-tech procedures, specialists, and surgery that their insurers can afford. And if we are to cover the uninsured, perhaps the only reform plans that are politically feasible are those that do not control costs, since if they do so in a serious way it threatens the in-

comes of providers and the insurance industry and makes the well-insured nervous that reform will hurt them (alas, there is no Rawlsian "veil of ignorance" operating here that could induce insured Americans to choose a socially just system that would protect their uninsured neighbors). Here is the ultimate paradox of U.S. health politics: Rising health costs put health care reform on the agenda, but the more likely a reform proposal is to control costs, the less likely it is to be politically viable.

Most international systems did not control costs until after they had achieved universal coverage. Indeed, the U.S. experience has been to enact programs that expand access without restraining spending (cost control comes later after the inevitable fiscal strain on public budgets): That is the pleasure-without-pain formula for political success repeated in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), a formula that the Medicare prescription drug benefit promises to follow. Perhaps in this era of medical inflation we need, for political reasons, to pretend that building on the mixed system or moving to individual-based insurance will control costs. If so, we should not expect health care reform to produce much in the way of cost containment.

■ **Issues in expanding coverage.** These plans fare better in the area of access, but in many iterations it is worth noting that they fall far short of universal coverage. In either case, building on the mixed system or building a new system of individual-based insurance cannot get to universal coverage without imposing a mandate on employers or individuals or both. It is obviously far easier in the current environment to imagine incremental versions of these plans that introduce tax credits or expand existing public programs. Labeling anything less than national health insurance or 100 percent universal coverage as incremental is, however, misleading; there is a difference of not simply degree but ambition between a reform plan that seeks to cover five million uninsured people and one that covers thirty-five million. But for the short term (through 2004), legislation is likely to be closer to the short end of the incremental stick. The contemporary political constraints described previously make it difficult to overcome bad memories of the Clinton plan's demise or to assemble a congressional majority to pass an employer mandate (and even then, it would be confronted by a president hostile to the idea). Expanding SCHIP or Medicaid to pick up a portion of the uninsured is consequently a more politically palatable option.

An individual mandate of the sort proposed by Senator Breaux has a relatively better chance of short-term enactment, although those odds are still low.[22] Individual mandates manage to turn health insurance, usually thought of by reformers as a right or entitlement, into a responsibility. That, along with the emphasis on tax credits, has a conservative appeal more in line with current political realities. And as Senator Breaux's enthusiasm for a reform strategy once championed by the late Sen. John Chafee (R-RI) demonstrates, there is more crossover potential to reach Democrats and Republicans than in an employer-mandate plan.[23]

But the first-glance political appeal of cutting taxes and talking about individ-

"Microlevel innovation represents an evasion of the harder policy choices that other countries have made at the macro level."

ual responsibility hides some serious political liabilities. This is still a mandate, a fact that is unlikely to sit well with conservatives who are opposed to federal intrusion into individual liberties, as well as with liberals who see it unsympathetically as an unfunded mandate making it illegal to be uninsured without providing adequate subsidies to purchase insurance. Enacting subsidies that enable the working poor to buy good health insurance and thus truly achieve universal coverage is a costly proposition, and the burgeoning federal deficit and Bush tax cuts make it that much harder to find the necessary public funds. Nor is staking a claim to the middle ground, as individual mandate proposals do, free of risk; the Clinton plan, too, aimed at achieving liberal ends through conservative means, but it failed to cement any such political alliance and instead attracted bipartisan opposition. The effort to reach such a grand compromise is complicated by the disappearance of moderates from both parties' congressional delegations.

Moreover, the transformation of the insurance market imagined by some individual-based insurance proposals is radical. The well-insured could very well be unhappy with the prospect of paying more taxes for the uninsured while in return receiving even less health security than they enjoy now.[24] Individual tax credits would also tempt employers to dump insurance coverage, especially for the working poor. The Breaux legislation has a "maintenance of effort" provision to counter this problem, yet this is essentially a euphemism for an employer mandate that shares its political liabilities. Tax credits, then, are more likely to come in incremental packages than as part of an individual mandate.

■ **National health plans.** That brings us to the perennial bridesmaid in U.S. health politics: national health insurance. The international standard in health policy offers clear evidence that such plans can provide universal coverage while controlling costs. Universalism also creates the opportunity to pursue public health goals. Here at last is an option that meets the criterion of access and cost control, while enabling coordinated efforts at quality improvement.

On substantive grounds, the potential of a national health plan far exceeds that of building on the existing system or moving to individual-based health insurance. Unfortunately, in the United States the more desirable health care reform is on substantive grounds, the less politically feasible it is. Politically, the problem with national health plans is not that they cost too much but rather that they would take money out of the system.

The rejection of national health insurance has led over the years to substantial organizational innovation. The United States has, in fact, developed what amounts to an acronym-based health system (HSAs, CON, HMOs, PPOs, and so on). But that has not kept the costs of medical care and the number of uninsured

people from marching steadily upward, leading to even more innovation. Ultimately, this microlevel innovation represents an evasion of the harder policy choices that other countries have made at the macro level.

There are different models of national health plans, ranging from the centralized and largely government-operated British National Health Service (NHS) to the employer-based, multipayer system exemplified by Germany. U.S. health reformers on the left have historically promoted Canadian single-payer insurance and, indeed, have often created the (mis)impression that the choice in health reform is limited to two options: single-payer or the U.S. status quo. That is unfortunate: It represents an all-or-nothing strategy, and so far single-payer advocates have for all their efforts gotten nothing.

Reformers' focus on Canada is understandable. However, Canada's geographic and cultural proximity obscures the reality that Canadian health care has features that are particularly hard to adapt to the United States, including a strict egalitarianism embodied by a one-tier health system that prohibits the purchase of private health insurance for covered services and a centralized model of health insurance that operates in each province as a public monopoly.[25]

Calling single-payer coverage "Medicare for All" is a step forward politically. It has always been a mystery why single-payer proponents have, in a nation with a strong dose of policy xenophobia, chosen to push for Canadian Medicare rather than expanding the culturally familiar and politically friendlier U.S. Medicare, which operates on the same principles. But given the radical changes that Medicare for All (embodied in the bill sponsored by Rep. John Conyers [D-MI]) would require in the status quo of health care finance and insurance, in the short term it still has the lowest political feasibility of any of the major reform options.

Concluding Comments

The need for comprehensive reform is clearly compelling. Many believe that the status quo is no longer sustainable and that business as usual in health policy is not an option. But the resilience of the status quo in U.S. medical care should not be underestimated. Based on historical precedent, it would be wise not to bet against the house, which has always beat whatever hand health reformers have shown. It is by no means a certainty that the current system will collapse. Perhaps it is significant that health care reform, which historically has appeared in every generation, is moving back onto the national agenda after only a decade. Yet health reformers have time and again discovered new reasons why national health reform would succeed, only to be disappointed: In the early 1970s it was the health care cost crisis; in the early 1990s it was another cost crisis, the support of big business for change, and rising numbers of uninsured people; in the latter 1990s the spread of managed care was expected to alienate patients and providers enough that they would support government health insurance. Now the rise of defined-contribution health plans and the unraveling of the insurance market is ostensibly the cata-

lyst in a health system meltdown.

Yet in each of the prior debates on national health reform, the status quo looked to be on the ropes and ultimately emerged relatively unscathed, with reform turning out to be a mirage. Will it turn out differently this time? Presumably, there is a point at which things get so bad, with dramatic increases in health spending and uninsurance (30 percent uninsured? 35 percent?), that it triggers a successful campaign for universal coverage that could even pave the way for a national health plan. But we cannot know in advance what that breaking point is, or if we are going to get there; there is nothing inevitable about health reform.

The three most overlooked lessons from U.S. health politics are these: (1) Getting reform onto the national agenda does not mean that it is going to pass; (2) consensus that a problem exists implies no agreement whatsoever on solutions; and (3) favorable public opinion does not guarantee legislative victory. The U.S. political system is uniquely predisposed to allow those opposed to national health insurance to block it, and to fragment the coalition for universal coverage while promoting disagreement on the appropriate solution. It is difficult to overstate the importance of institutional barriers to reform: Given the political conditions that existed during 1993–1994—presidential endorsement and partisan majorities on a high-profile public issue—there is probably no other industrialized democracy in the world that would have rejected universal health insurance.

Designing new health care reform plans is unlikely to overcome this dilemma. For all the well-intentioned modeling, plan development, and research by health policy analysts, the reform options generated in 2003, as anyone who dusts off a journal issue from a decade ago will discover, look remarkably like those that were available in 1993 and not unlike those around in 1973.[26] Some options have gained or lost prominence, and some innovations have been added, but at the end of the day the basic menu of options looks much the same. The search for a technical solution to what is fundamentally a political problem is not likely to succeed. The failure of U.S. health policy is not attributable to the absence of good reform plans; rather, the lack of political will and moral courage is responsible, and no amount of policy (re)invention is likely to cure that malady.

In the short term, then, there is a strong chance that if reform passes, it will come as incrementalism, most likely through tax credits—which are the solution du jour in Washington—or expanding existing public programs. But there are two important caveats to the current Beltway consensus that incremental health reform is the most promising, indeed the only, path toward reform. The first is that the political environment could change, as it did in 1932 and 1964, in a way that makes comprehensive health care reform possible. The irony is that while we tend to look inside reform plans in evaluating political feasibility, their chances for adoption are largely determined by political and socioeconomic forces outside the health care system.[27] With a fundamental change in those forces in a direction that favors liberalism, the political fortunes of comprehensive health care reform will

dramatically improve—witness the ambitious reform plans offered by Democratic candidates in the 2004 presidential campaign that aim much higher than the incremental proposals of the past decade.

A second caveat is that a neglected component of feasibility is sustainability. Experience with incrementalism during the past decade does not bode well for its long-term success. For all the good that SCHIP and the Health Insurance Portability and Accountability Act (HIPAA) have done, they have not made much of a dent in the rate of uninsurance, nor did they even attempt to stem medical inflation. Over the long run, incremental reforms may not be sustainable precisely for the same reason they are enacted: Their acceptance of the status quo guarantees that they will fail to control costs or assure universal coverage. If that happens, the United States may finally look to a national health plan to get the job done.

Medicare advocates supported the Kerr-Mills program that gave states aid for low-income seniors in 1960 because it was a step up the ladder and they expected it to fail; five years later they got what they wanted. Perhaps national health insurance advocates can find solace in the knowledge that, if enacted, today's incremental reforms may fail and thereby discredit themselves, making way for universal insurance tomorrow.

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NOTES

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4. National Leadership Commission on Health Care, *For the Health of a Nation* (Ann Arbor, Mich.: Health Administration Press, 1989).
5. This is reinforced by the incentives that many policy analysts working at Washington-based think tanks have to stay relevant so as to avoid losing institutional prestige and political access, which can lead them to propose policies that reflect short-term political constraints.
6. It is hard to know where to start in listing such mistakes: the failure of Medicare advocates to anticipate that the 1964 election outcome would permit broader legislation, ultimately encompassing Part B insur-

ance for physician insurance and Medicaid, or their assumption that Medicare would quickly expand into a full-fledged system of national health insurance for all; the confidence of the Clinton administration that it had assembled the perfect plan to win political acceptance or many analysts' belief that health reform's time had finally arrived in the early 1970s—and again in the early 1990s; or, more recently, the presumption that Medicare+Choice would propel Medicare toward a market model of competition and HMOs.

7. John Creighton Campbell and Naoki Ikegami make a similar point in comparing health policy making in Japan and the United States in *The Art of Balance in Health Policy* (New York: Cambridge University Press, 1998), 35–36.
8. This section draws on J. Oberlander and T. Marmor, "The Path to Universal Health Care," in *The Next Agenda*, ed. R. Boorsage and R. Hickey (Boulder, Colo.: Westview Press, 2001), 93–125.
9. However, as the 1994 electoral victory of the Republican party and congressional agenda orchestrated by Rep. Newt Gingrich (R-GA) demonstrates, more centralized, party-dominated action is possible.
10. Historically, two committees—House Ways and Means and Senate Finance—have served as gateways for health insurance legislation, and failure to get a bill out of these committees doomed it to defeat.
11. T. Marmor, *Political Analysis and American Medical Care* (Cambridge: Cambridge University Press, 1983), 66–72.
12. J. Morone, "American Political Culture and the Search for Lessons from Abroad," *Journal of Health Policy, Politics and Law* (Spring 1990): 129–143.
13. T. Smeeding, "The Gap between Rich and Poor: A Cross-National Perspective" (Paper prepared for the National Institute of Population and Social Security Research, Tokyo, 21 March 2001).
14. While favoring the goal of universal coverage in the abstract, public support drops over time when respondents are asked about specific plans. Polls also reveal reluctance to pay much more in taxes to fund universal coverage and deep distrust of government. On public opinion and health reform, see R.J. Blendon and M. Brodie, "Public Opinion and Health Policy," in *Health Politics and Policy,* 3d ed., ed. T.J. Litman and L.S. Robins (Albany, N.Y.: Delmar, 1997), 201–219; L.R. Jacobs, "Health Reform Impasse: The Politics of American Ambivalence toward Government," *Journal of Health Politics, Policy and Law* (Fall 1993): 629–656; and M. Schlesinger and T. Lee, "Is Health Care Different?" in *The Politics of Health Care Reform,* ed. J.A. Morone and G.S. Belkin (Durham, N.C.: Duke University Press, 1994), 297–374.
15. J. White, "The Horses and the Jumps: Comments on the Health Care Reform Steeplechase," *Journal of Health Politics, Policy and Law* (Summer 1995): 373–383.
16. J. Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003).
17. J.A. Meyer and S. Silow-Carroll, "Options for a Better Health System" (Paper presented at the Carolina Health Summit, in Chapel Hill, North Carolina, 6–8 April 2003).
18. Ibid.
19. Ibid., 12.
20. U.E. Reinhardt, "Reforming the Health Care System: The Universal Dilemma," *American Journal of Law and Medicine* 19, no. 1 (1993): 21–36.
21. J. White, *Competing Solutions* (Washington: Brookings Institution Press, 1995).
22. J. Breaux, "The Breaux Plan: A Radically Centrist Approach to a New Health Care System," 5 March 2003, www.healthaffairs.org/WebExclusives/Breaux_Web_Excl_030503.htm (18 July 2003).
23. R. Cunningham, "Joint Custody: Bipartisan Interest Expands Scope of Tax-Credit Proposals," 18 September 2002, www.healthaffairs.org/WebExclusives/Cunningham_Web_Excl_091802.htm (18 July 2003).
24. L.D. Brown, "Who Shall Pay? Politics, Money, and Health Care Reform," *Health Affairs* (Spring 1994): 175–184.
25. These features are not essential to having a national health system: the multipayer German model provides the opportunity for the wealthy to opt out of the public system and operates with a central role for private insurance in the form of sickness funds, which are regulated by the government.
26. Compare the reform options published by the Economic and Social Research Institute in 2001–2002 and described in J.A. Meyer and E. Wicks, *Covering America: Real Remedies for the Uninsured*, vol. 2, November 2002, www.esresearch.org/covering_america.php#volume1 (18 July 2003), with those in a special issue of the *Journal of the American Medical Association* (15 May 1991) on caring for the uninsured.
27. See C.H. Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada* (New York: Oxford University Press, 1999).