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It's the Institutions, Stupid!

Why the United States Can't Pass Comprehensive Health Care Reform

Sven Steinmo and Jon Watts

The United States has once again focused its attention on the need to reform the health care system. It is widely believed that *this time* America will pass meaningful health care reform. After all, we have a President who has made health reform his top legislative agenda, we have Democrats controlling both the House and the Senate, and the majority of Americans clearly believe that something has to be done to solve our "health care crisis."

Unfortunately, President Clinton's health plan will fail. Though Congress may well pass *some kind* of health legislation, it will not pass a bill that both offers universal health insurance coverage and restructures the health care marketplace in a way that will effectively control spiralling costs. In fact, if health reforms are passed (and assuming that Clinton doesn't make good on his threat to use his 'veto pen') they are likely to contribute to the health care crisis in America rather than solve it.

After the plan fails there will be a cacophony of post-mortems from pundits and politicians explaining why we didn't get what the majority of Americans clearly want: Health reform that will slow the skyrocketing costs of medical care and at the same time offer health security to all Americans. We will hear hundreds of experts analyzing the President and his plan in nauseating detail. They will conclude that the proposal failed because of flaws in the plan and/or flaws in this President's strategies. At a superficial level these critiques will seem right. But they will miss the basic over arching point. **President's Clinton's health reforms will fail because the American political system is designed to kill this kind of reform.**

*

engage in a massive uphill struggle. Those who wished to prevent the extension of governmental power or authority, on the other hand, could sit at the top of that hill and roll boulders down on the activists.

Culturalists can, of course, point out that the Founding Fathers had a cultural predisposition against activist governments: just as interest theorists could point out that these actors could have been motivated by economic self-interest when forging these institutions. We will not take up this debate here. The critical issue is that these men left this country with an institutional legacy. No matter how well intentioned -- nor indeed no matter how broadly supported -- public policy activists in the U.S. have had to push for reforms through an institutional maze that was consciously and specifically designed to make reform difficult. In no other country have public policy activists faced a similar institutional bias.

Of course the American political system has not remained stagnant for the past 200 years. There have been a large number of institutional reforms over the years, many of which have been specifically designed to make the system more efficient and manageable. But each of these reform efforts was built within and around the basic institutional context of a system in which political power is limited by the structural fragmentation of public authority. In the twentieth century, for example, Congressional reformers attempted to make both the House and Senate more efficacious by creating the Committee System and instituting the seniority system for committee chairmanships. These reforms, of course, have not had their desired effects. They have instead contributed to the further fragmentation of power in Washington creating a national legislature in which political elites have become independent policy entrepreneurs who have become ever more beholden to the support of increasingly narrow, self-interested, special interest groups.

Even a brief look at history shows quite clearly how the unique political/institutional context of American politics shaped the specific strategies of health care reforms and opponents and the policy outcomes. This analysis will also suggest that it is the institutional context of American politics which should be put under scrutiny by progressive reformers rather than the particular inadequacies or failures of President Clinton and/or his health care plan.

Where was FDR?

Many find it surprising that the great social reformer Franklin D. Roosevelt did not introduce a National Health Insurance plan. Like most of their

progressive counterparts in Europe, members of this administration clearly believed that health security would be an essential part of the kinds of basic social insurance they were putting under governmental authority. But when one looks closely at the politics of the day it becomes clear that FDR did not introduce a health plan for purely political or strategic reasons. Despite the President's huge popularity and the clearly perceived mandate for social reform, Roosevelt and his advisors came to believe that bringing health insurance into their reform package could "spell the defeat of the entire plan." This was a strategic choice based on the fact that in America, Congress writes law -- the President doesn't. The public was clearly in favor of governmental sponsored health protection, but the President and his advisors understood that the Southern Democratic chairmen of key committees were hostile to the entire New Deal agenda. Thus, despite the will to act, widespread popular support and Democratic majorities in both House and Senate, Roosevelt knew that NHI would evoke the ire of the medical industry. He also knew that he could not afford to give the New Deal's opponents one more ally to help them knock it down.

The fact that medical interests opposed NHI was not unique to politics in the United States. These interests opposed government "intervention" in virtually all industrialized states. In a recent study of the development of health care systems in Europe, Ellen Immergut describes the attitudes of French doctors towards NHI in the following way. "The practice of medicine, it was argued, was a highly individual art that required a direct and private relationship between doctors and patients." In language that could have come directly out of the American debate she goes on to tell that doctors insisted that: "First, patients were to be free to choose their own doctor; second, the doctor-patient relationship was to be subject to the strictest secrecy; third, physicians required complete liberty with regard to the choice of medical treatment; and fourth, all financial matters ought to be decided by a 'direct understanding' (entente directe) between doctors and their patients." French doctors were hardly unique. "For the views of Swedish and Swiss physicians, the liberal model of medicine was simply a codification of the defense of doctors' economic autonomy, common to elite physicians throughout Western Europe."

In short, ideological differences on the part of doctors, nationally elected political reformers, or the mass public cannot account for FDR's failure to introduce a national health insurance plan. Rather, it was the enormous political power yielded to economic interest groups and entrenched (Southern) local elites in

House. Under the procedural rules in place in Congress in 1949, national health insurance legislation had to clear the House Ways and Means Committee. Despite the fact that the Democrats held a majority on that committee of fifteen to ten over the Republicans, disputes over Civil Rights assured a frosty reception for Truman's proposal. The committee was at that time chaired by Robert L. Doughton from North Carolina. Also insulating the Ways and Means Committee from Truman's influence was the "closed rule" procedure used by the committee for all tax tariff and transfer bills. This rule meant that no additional amendments or changes could be added to the legislation which had been considered by Ways and Means.

Given the institutional rules in place at the time, if the Committee, (or its chairman) chose to kill legislation, neither the President nor the majority of the Party could force the bill onto the floor. Though extensive committee hearings were held on Truman's NHI bills in 1948 and 1949, the committee did not forward any specific legislation for a full vote. Instead - in a tactic that will sound familiar to modern readers - in order to further confuse and diffuse the issue in the face of widespread public support of NHI, Republicans and Southern Democrats publicly announced their support for alternative versions of health reform. There was no real intent to pass a conservative health care program, but this way voters could be lulled into believing that a diligent Congress was working on a better plan than the one Truman had introduced. In the end, no progress was made towards enacting national health insurance for more than a decade.

One could argue, of course, that ideology or political culture played an important if not dominant factor in determining the outcome of Truman's health policy initiatives in 1949. Clearly, the ideology and values of the southern Democratic Party elites was decisive. But it was the peculiar institutional framework of American politics that allowed these Southern elites to block the programs endorsed by the voting majority of Americans. Our failure to pass national health insurance in the 1940s was a deviation from America's preferences, not an example of those preferences.

The Struggle over Medicare

Almost immediately after the defeat of Truman's proposals, reformers began pushing for a modest hospitalization insurance program for those receiving old age retirement benefits under Social Security. Reformers hoped that by scaling down their proposals, they would mute some of the industry's opposition and at the same time generate more focused support for the plan. This was explicitly considered to be a first step in a new strategy towards the gradual development of health

insurance for the entire population.

By 1958, the strategy of focusing on the aged had begun to pay off. Focusing on a specific and politically active target population -- the aged -- produced a new political dynamic in the health reform debate. Demographic trends demonstrated that the elderly were growing in numbers and would require more specialized services, most importantly health care. Focusing on the elderly was also a ploy to take advantage of legislators' charity, or at least sympathy -- Who could be more deserving than the aged? Still, southern conservative Congressional resistance to the reform efforts was quite strong. It was widely recognized that this strategy was but one small step towards the larger goal of a full program of national health insurance. Conscious of this, Wilbur Mills of Arkansas, chair of the House Ways and Means Committee, was also aware of the ever-growing political appeal of the more focused reform plan. He therefore introduced alternative legislation in his committee which was, once again, designed to derail more comprehensive reform.

Still, the reform agenda could not be stopped. Seizing on the popularity of this issue, Senator John Kennedy decided to make it a prominent issue in his presidential campaign. Kennedy's victory, combined with Democratic majorities in the House of 263 to 174 and in the Senate of 65 to 35, led many to predict that health care financing reform would finally and quickly come to pass. These predictions, however, like those which predicted reform in the 1940s failed to account for the basic fact of American politics... In America the President does not write law, Congress does. Though the individuals were now different than they had been in Truman's day, the problem for the President was the same: Entrenched (southern) committee chairman did not share the reform agenda of the majority of the members of Congress, nor of the President, but committee chairman could and did control the legislative agenda. Wilbur Mills used his position as chair of Ways and Means, to continually foil attempts to pass health reform. Like Truman before him, Kennedy could not overcome the institutional power embedded in a single free-willed and ideologically entrenched Congressman.

The assassination of President Kennedy did much to change the politics in this country. While Kennedy himself only won the presidential election by a slim margin, Lyndon Johnson won by a landslide. American voters sent him to Washington with an overwhelming liberal Democratic majority in both houses of Congress. Health reform, moreover, was now an even bigger issue than it had been before. Not only were the presidential candidates views on the issues important, but

national health insurance.

Certain institutional reforms enacted by Congress in 1974 require consideration when trying to understand why Congress reacted negatively to Carter's health care plans. In the past, the House Ways and Means Committee had held almost complete jurisdiction over health care reform matters. But this situation had changed by the time Carter assumed office. Wishing to undermine the overbearing power of certain committee chairmen (most especially Wilbur Mills), reformers passed the "Subcommittee Bill of Rights" in 1974. This measure expanded participation on key congressional committees and also greatly increased the number of subcommittees. The net result was the further division of institutional authority. Whereas two committees had had responsibility for health reform, now four committees were involved. And, all four were needed to move the plan forward.

Considering this new institutional context, President Carter believed he would face insurmountable obstacles if he began with a comprehensive national insurance plan. The administration therefore decided to first get cost-control legislation through Congress and then move towards broadening the net through a more comprehensive reform. The Administration targeted hospitals. This choice was informed by several political considerations. First, hospital cost increases had outpaced other areas of the medical field for several years. Thus, hospitals were an obvious target for cost control regulations. Second, our political system appeared to make it easier to divide and conquer, rather than taking on the whole of the medical industry. This was especially important since the Administration hoped to employ the plan quickly and make immediate gains in controlling costs. They believed this would facilitate the introduction of a national insurance program.

The proposal ran into immediate trouble. Sensing another "foot in the door," every major medical lobby came out against the plan. Both the American Hospital Association and the AMA launched lobbying campaigns against the President's proposal. Interestingly, the industry did not launch into a massive public education campaign condemning "socialized medicine." Instead, the medical lobby employed a strategy of focusing on the individual legislators. After all, every member of Congress has a hospital in his or her district.

As more and more interests lined up against the Carter plan, the legislature began to give reform a cold shoulder. A key to the frosty reception of Carter's reform legislation was the dissenting opinion of the Chairman of the Senate Finance Committee, Senator Herman Talmadge (D:Ga). He chaired the fourth committee

under which the Administration's proposal fell. Talmadge disliked the short term objectives of Carter's cost containment legislation, preferring his own long term plan which emphasized the preservation of the Medicare system. Like Medicare, which had been blocked by Wilbur Mills who hoped to preserve the integrity of the Social Security program, Carter's cost-containment proposals were opposed by a Senator who wanted to preserve the integrity of the Medicare program. While Talmadge's lack of support for the bill did not constitute a veto of the program, his dissent did fracture support for Carter's initiative. In the new post-reform Congress, no one chairman had the influence to take responsibility for the bill; it required the support of all four. This left the other legislators who sat on the four committees to their own devices. Thus the four committees wrangled over the form the bill should take, and each committee proceeded in its own direction.

The tangle of competing jurisdictions radically complicated the Administration's task in promoting the bill. Despite an impressive list of Congressional co-sponsors, Carter was never able to collect the necessary votes to get the bill out of committee. In the past, efforts at health care reform were frustrated by the strength of the seniority system and the partisan fractures in Congress (i.e. the southern Democrat, Republican Coalition). These two sources of conflict were no longer as relevant in the Congress serving under Carter. However, Carter's legislation had run into a new source of legislative blockage: extreme fragmentation of the 'reformed' Congress.

This set a pattern that would be repeated in each of the following years. The Administration repeatedly tried to push the program through Congress, only to be frustrated by the variety of attempts to reduce the bill's effectiveness in order to bypass the intransigency of the committee deadlock. The AHA and the AMA strenuously lobbied against the bill and eventually won an endorsement of the voluntary cost control effort. This allowed the Congress to make a symbolic declaration in favor of cost controls, without having to actually take any action on the issue. The Congress walked away from the cost-control debacle still looking as though it had taken action, thus, soothing voter concerns. The reality was the cost-containment bill failed in 1977, 1978 and 1979 with no part of the cost-control proposal ever becoming law. By 1981, the voluntary effort by the hospitals was condemned as a failure but no further action on behalf of hospital cost control was taken.

The failure to pass any sort of cost-containment legislation killed any chance for the

As policy activists, we wish him the best of luck. As political analysts, we see little reason to hope that he will be able to enact the ambitious and comprehensive program that he laid out both in his electoral campaign and in his early months in office. He will not get the "disciplined national system to control all health care costs, so that we can get the waste out of the system and the profiteering out of the system," that he has called for. He will, we believe, not even be able to "follow the lead of the other advanced nations of the world and provide basic health care to all Americans and control the costs of the system that we have." Instead, the health care reforms that are likely to pass (assuming that he does not use his "veto pen" as he threatened to do in his 1994 State of the Union Address) will substantially compromise the basic principles and administrative processes that would most likely insure their success. The New American Health Care System will cost more than the current one. Though it may well bring many people who do not have health insurance into the system, it will neither dramatically affect the structure of the health care delivery system, nor will it set in place mechanisms necessary to change the incentive systems which are currently causing the system to spin out of control.

We are willing to make these predictions at this point (rather than wait to announce our foresight after the fact) because we believe that the institutionalist analysis that brings us to these conclusions has important implications for citizens and policy activists alike who are concerned about the health care system in America and/or the very legitimacy of American democratic institutions. By the time this essay is in print, the details of the 1994 health care reform should be clear. It will also be obvious if the remarkable Mr. Clinton has been able to pull another rabbit out of the hat as he has done with his budget, NAFTA and a variety of other initiatives. If, however, the final reform fails to meet the basic requirements of success which he set out early in his Presidency, then we believe that the analysis presented here should be taken seriously. ***The failure of the President's health care reform plan is neither a failure of this president, nor a failure of the specific plan he proposed. It is a failure of American political institutions within which the President has been forced to work, and through which the plan had to be passed.***

Conservatives and the medical lobby will argue that Clinton's plans were "out of step" with American values. They will triumphantly declare that the proposal failed because Americans don't believe in the kind of reform implied by term "comprehensive." For them there

is no reason to "reform" because the system works as it is supposed to -- and to their advantage.

Washington pundits and health reform advocates will have a different analysis. They will detail the specific missteps made by the administration and the bold moves and brilliant strategies made by the medical lobbyists and their friends in Congress. They will grumble that if the plan had been better, or the politicians more savvy, or the timing more propitious, America would have gotten what its citizens want and its economy must have. For these analysts, change is necessary, but they will focus on superficial solutions: Elect a new President; throw the rascals in Congress out; bash the medical industry for its tactics.

The analysis we have presented focuses us on a different problem. America cannot pass major comprehensive health care reform that will control costs and offer complete coverage to all Americans because her political institutions are designed to prevent this kind of reform. To pass truly meaningful reform would require imposing costs on certain groups (factions). Clearly the majority (faction) both want and would benefit from such a reform. But the fragmentation of authority designed into the U.S. Constitution makes it virtually impossible for the majority's will to supersede the minority - at least when that minority is well financed and well organized. To overcome the opposition of the minority faction, the majority must buy off their opposition. The effect, in the case of health care reform at least, is to throw fat onto the inflationary fire.

Clearly, meaningful institutional reform is as unlikely as it is unpopular. Both the Left and the Right justifiably fear that Constitutional reform could get 'out of hand.' They also understand that it is difficult to predict the specific policy consequences of institutional change. We are no better nor more confident than any others in these regards. Nonetheless, we submit the following post-mortem of the Clinton health care reforms: It's the institutions, stupid! It is not the particular policies or the specific politicians that are to blame today any more than they were to blame in the 40's, 50's, 60's or 70's. In short, reformers should focus their efforts on reforming the divided institutions of American government and worry less about designing ever narrower policy solutions or electing ever more charismatic political leaders.

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