
The Politics of Medicare and Health Reform, Then and Now

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INTRODUCTION

It is not difficult to characterize Medicare as an element of public policy. The program launched and legitimated a major role for the Federal Government in funding health care for part of the population—a role that had been highly controversial before. It has spared millions of vulnerable citizens economic anxiety, avoidable pain, and premature death. It has encouraged major innovations in health care policy. The Federal enthusiasm for health maintenance organizations, for instance, began with Medicare savings in mind, and the later adoption of the prospective payment system and the resource-based relative value scale fee schedule not only protected the Federal treasury but also let providers know that concentrated purchasers would be working to slow the flow of dollars into health services. Meanwhile, Medicare has kept the acceptance and affection of much of the population, bearing increasingly lonely witness to the possibility of government as a force for good though two and a half punishing decades. Lyndon Johnson's words, inscribed on a wall of the Johnson Library in Austin, Texas, capture with eloquent simplicity the essence of Medicare: "Health care is guaranteed to every American over 65. With the passage of this act, the threat of financial doom is lifted from senior citizens and also from the sons and daughters who might otherwise have been burdened with the responsibility for their parents' care."

Depicting Medicare as a political construct is, however, not easy at all. Some see the program as a belated but more or less inevitable extension of the New Deal agenda. Having enacted such pillars of the welfare state as Social Security, unemployment compensation, and income support for the poor, the Federal Government was bound eventually to add national health insurance to the portfolio. (In similar vein, would-be expanders of Medicare after 1965 believed that "salami tactics"—extension of public benefits to one group after another over time—would culminate in universal coverage.) An alternative view reads Medicare not as the product of a relentless incrementalism that finally pushed over the goal line but rather as an incidental consequence of political convergences and coalitions so rare that they dominate U.S. politics for perhaps 10 years in a century, and are neither directly producible nor predictable.

This article explores the points at issue between these two distinct political images by addressing three questions. What were the political circumstances in which Medicare passed in 1965? What has changed so that neither an expansion of Medicare nor any other approach to affordable universal coverage proved to be feasible in the early 1990s, and, indeed so that Medicare itself faced significant political challenges? Can the social insurance strategy, of which Medicare and Social Security are the major U.S. examples, retain its legitimacy and point toward further policy breakthroughs in due course?

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HEALTH POLITICS, 1965

The enactment of Medicare in 1965 coincided with several favorable political and economic conditions. This proposition states a correlation: To contend that Medicare passed *because* these factors converged would be too strong and essentially unprovable. But (as a Marxist might say) it was “surely no accident” that these circumstances—conveniently, 10 in number—were in place.

- In 1965, the Nation had a strong activist president working with a House and Senate that were controlled by his (Democratic) party and, more important, were ideologically sympathetic to his policy goals. Such legislative-executive likemindedness had not been seen since Franklin Roosevelt’s New Deal and has not reappeared since Johnson’s tenure ended in 1968. This atypically placid flow of national power meant, among other things, that the president and congressional leaders could control the inclination of would-be reformers to float their own proposals and then refuse to compromise with the obviously inferior alternatives promoted by others.
 - The economy was very strong and the Federal budget in surplus. Those most visibly left out of the general economic progress were the poor and minorities, not beleaguered “average” working and middle class Americans. Moreover, the analytical tools for gauging the budgetary costs of large new public programs were relatively crude.
 - Liberals, newly abundant and powerful in office, used one of the Nation’s occasional spasms of concern for social justice to promote a universalist program—one that addressed a major “functional” need of a broad slice of the population—built on social insurance financing.
- Universalist programs thus funded were an important legacy of the New Deal philosophy, then still fresh and favorable in much of the national memory.
- Strong organizational allies—most notably organized labor and the elderly—lent formidable political muscle to the push to enact Medicare.
 - Opposition to Medicare was grounded in a lethargic and “reactionary” conservatism that was still reeling from the shock of the Kennedy assassination (“Let us continue” was Johnson’s motto upon assuming the presidency) and the electorate’s repudiation of Barry Goldwater, Republican presidential candidate against Johnson in 1964.
 - Health care costs were not so high that the mind boggled at spending more on health services. And taxes were not so hot a political issue that one dared not discuss raising them by acceptable means for desirable ends.
 - Policy analysts were not so steeped in systems thinking that they would deprecate the values of a segmental intervention like Medicare. Activists were not so frustrated by deadlock that “merely” covering another population group seemed evidence of deficient zeal and energy. And most analysts and activists assumed that one could finance care without having to “manage” it too.
 - The Nation’s civic discourse was not suffused with anti-governmental rhetoric. Medicare passed a scant 20 years after the national government had successfully led the Nation through the Depression and World War II. Few supposed that government was an intrinsically incompetent vehicle of collective action.
 - People with a sharp sense of the politically passable crafted Medicare knowing that the perfect could be the enemy of the good. Wilbur Cohen and his allies in the executive doubtless would have preferred

national health insurance but gauged what they could get and went after it.

- In 1965 the “social issue”—a sense of us versus them sustained by tensions over crime, immigration, race conflicts, drugs, and more—had not yet crystallized and so did not (yet) stifle political conversation about the merits of new redistributive public programs to benefit the vulnerable.

Simply to list these favorable factors of the mid-1960s is to see why health reform is so elusive in the mid-1990s—and why Medicare is under mounting political stress today.

- In 1993, health reform was proposed by a president who had won office with 43 percent of the popular vote, who had partisan but not ideological majorities in the Congress, and who would soon (in November 1994) see both houses of Congress acquire conservative Republican majorities. The weakness of presidential, party, and purposive integration encouraged proponents of miscellaneous reform schemes to decline compromise on any one plan, which (predictably) fragmented the reform “movement.”
- The Nation faced a big budget deficit, and many workers and taxpayers lamented that a generally sound and growing economy did not bring rising real wages their way. Twenty years of elaboration of techniques of budgetary estimation coupled with legislative improvisations designed to balance the budget left the public confused and fretful about the “true” costs of reform. Both raising taxes to offset new spending and reallocating dollars within the health care system were politically perilous, and many policy makers inferred that the Nation “could not afford” universal coverage.
- By 1993, 25 years of rightward drift in national politics had left liberals on the defensive. Those few still willing to

carry the liberal banner were widely identified with policies catering to myriad particular disadvantaged groups. Universalism, social insurance, and kindred mainstays of New Deal public philosophy were increasingly viewed as quaint curiosities from begone days. The current conventional political wisdom held that the only electable Democrats were “new” ones—a status defined mainly by resolve never to talk like an “old” Democrat. Fitting comprehensive health reform to this mold created considerable cognitive dissonance.

- In the recent struggle for reform, organized labor was both a less ardent and less influential advocate than it had been in 1965; the elderly, though supportive of reform, pushed universal coverage with the nonchalance of those who already had “theirs.” No other strong interest groups were prepared patiently to negotiate the details of a system of shared sacrifices and trade-offs that would achieve this (supposedly) common good. Health reform had the macabre character of a national “movement” unfolding without major organizational support.
- Articulate, aggressive conservatives pitched their anti-governmental certitudes under the imprimatur of policy and economic “science.” (Government compulsively throws money at problems, the public sector is inherently less innovative and efficient than the private sector, redistributive measures sink all boats instead of lifting them, and on and on.) Moreover, today’s conservatives complement their critiques of government’s chronic misdeeds with a host of “constructive” policy options—health maintenance organizations, managed care and competition, medical savings accounts—that might save Medicare and guide broader health reform.

- Health care costs have come to be perceived as a national crisis. Analysts (including Bill Clinton) argue that the “bloated” system already contains enough money to cover everyone without spending more on it. The public wants the funds for broader coverage to come from constraints on profits reaped by greedy physicians, hospitals, insurers, and drug firms. And the words “new taxes” cannot pass chaste (and chastened) political lips. This view may make good theoretical sense, but it lets the politics of reform degenerate into a series of “squeezes” inflicted by winners on losers.
- The prevailing policy mindset in the early 1990s held that the problems of the U.S. health care system required systematic solutions. Merely adding new coverage for another subset of the citizenry was myopic. Indeed achieving universal coverage itself would not work unless the system were simultaneously redesigned to control costs. Managing care and expanding coverage now seemed to go hand in hand. Moreover, activists had grown so frustrated with delayed “progress” that many dismissed incrementalism as a strategy for sissies. Beholding the opening of a once-in-a-generation window of opportunity for reform, they determined to do it now, do it right, do it all. In similar vein, policy makers in Washington accept that “saving” Medicare demands an overhaul of the delivery system it employs.
- By 1990 or so politicians perceived that anti-governmental appeals were a natural and perhaps infinitely renewable strategic resource. A Federal Government that in 1965 had been at least grudgingly trusted to keep foreign and domestic affairs in decent repair had, by 1993, staggered under the weight of Vietnam, Watergate, American hostages in Iran,

lines at gas stations, and high rates of inflation, consumer credit, and unemployment. It was not hard to persuade the public, as did Ronald Reagan, that the public sector could do no right. Three little words—“too much government”—were sufficient to kill Clinton’s national health reform plan.

- The recent reform proposals were crafted by people with grand goals, big ideas, and expansive systems-visions, but also with little (or no) political experience, limited feel for what could fly legislatively, and not much taste for listening to and learning from Congress. Polls had become the main means of communication from public to president; television had become the main means of communication from president to public. Republican overreaching on Medicare “reform” in 1995 bears further witness to a paradox: How can policymakers and pollsters know so much about public opinion and yet understand it so little? Nor did would-be reformers see the need for a “Wilbur Cohen type” to fill these gaps and disconnects.
- By 1993 the Nation had suffered 25 years of growing bitterness over “the social issue.” Intergroup antagonisms left little public enthusiasm for universalistic affirmations of “the citizen’s right” to health coverage or the cross-subsidies it implied. Federal social programs were increasingly thought to tear up the playing field, not level it.

WHAT NEXT?

In the quest to reshape the health care system, the sphere “of purposive social action” is much smaller than reformers admit. Many forces that inhibit health reform operate outside the health system per se and have little directly to do with it. Presidents are stronger or weaker, and enjoy

larger or smaller partisan and ideological majorities, for reasons that lie well beyond health affairs, the priority of which tends to gyrate wildly on the scoreboards of popular opinion. Likewise such variables as the size of the budget deficit; the state of the economy; the philosophies and tactical skills of liberals versus conservatives; the electorate's attitudes about taxes and social policy; and diffuse sentiments about government in general and the administration and Congress in particular all condition the political climate, and thus the prospects for health reform, but also resist manipulation by activists.

Political factors that are in some sense health specific—for instance, whether health spending is viewed as a big problem, how people feel about additions or redistributions of health care dollars, and the strength of sentiment for comprehensive versus incremental reforms—are doubtless important but mean little if their larger and largely untouchable political context is unreceptive to reform. The fate of major health reform measures turns on accident and incident, on the alignment of poorly-charted political stars. If Kennedy had not been killed in 1963 and the Republicans had not nominated Goldwater in 1964, perhaps Medicare would have emerged, as Ted Marmor conjectures, as 60 days of hospital coverage plus hopes that the next increment would come soon.

That the health system obeys no laws of inevitable progress toward reform is not a rationale for passivity. If and when windows of opportunity happen to open, what (if anything) goes through them will depend on the convergence of political interests with intellectual currents, and the latter derive partly from expertise and entrepreneurial skill. Like Wilbur Cohen, however, reformers should settle in for 30 year intervals—1935, 1965, 1995—or even longer between breakthroughs. Moreover,

the failure to pass universal coverage in the mid 1990s makes one wonder whether 25 years of severe and persistent negative feedback about the uses of government is reversible.

Of the many worrisome patterns that separate 1965 from 1995, one holds special significance because it speaks directly to the translation of egalitarian values into durable allocative structures and strategies. This trend is the eclipse of social insurance as a vibrant force in thinking about U.S. social policy. Throughout much of this century American policy makers have viewed social insurance not merely as a means of financing programs but also as a public philosophy anchored by moral underpinnings that, though often implicit, were solid and secure politically. Social insurance is a way to socialize, and thus insure against, major risks by pooling resources and crafting cross-subsidies within the population. Its “social security” is a practical expression of social solidarity. Dedicated trust funds give social insurance programs the stability and insulation from budgetary oscillations that befit a social contract among contributor-beneficiaries and the state. Links to the workplace confer popular legitimacy in a society that likes to condition public benefits on moral desert. And although these programs are compulsory, government's role is mainly to set the rules of the game—a “game” of public-private partnerships that command a broad middle ground between *laissez-faire* and socialism.

Today the social insurance strategy faces increasing stress in North America and Europe. Relatively fewer workers must help fund broadened benefits for growing numbers of retirees and beneficiaries, thereby spotlighting and straining payroll taxes. Cross-subsidies, crucial to equity, become more difficult to sustain and recast as social solidarity erodes. The mythology of social insurance—that one gets back what

one puts in, whereas in fact benefits tend greatly to exceed contributions and must be funded in sizable measure by current workers—was acceptable when it seemed to stretch infinitely over the ages, but faces attack as a public sector shell game now that today's workers fear that they will be lucky to get their money back, let alone well-subsidized benefits, when they retire. Critics charge that heavy tax extractions to fund social insurance programs inhibit economic entrepreneurship and the formation of new jobs. Others contend that a social insurance model has grown poorly suited to the peculiarities of health care. Unlike its parent program, Social Security, Medicare faces costs that are driven by (among other variables) technological innovation, discretionary use of expensive personal services, and the demands of providers for fair pay, all of which must be actively managed. These problems and perceptions presumably explain why, when U.S. health reform came recently into vogue, a Nation famous

for incrementalism briskly dismissed Medicare for all (or for the uninsured) as a model inferior to the single-payer approach favored by many on the Left and to the strategies based on managed care and managed competition that appealed to much of the Right.

Can social insurance surmount these challenges and renew its appeals as a public philosophy? By the year 2020, say, will anyone know or care what social insurance once meant as a strand of social thought and how its vision infused public policy? Will reformers in the next century revisit the philosophical roots of social insurance in search of sturdy, albeit rusty, policy principles that deserve cultural renovation? If not, what will those who seek to end the threat of financial doom for vulnerable citizens do for an encore?

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