

American Medicine's Transformation (or not): A Quarter-Century's Perspective  
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Anyone who writes a book has to be grateful if it is merely remembered 25 years later, and even more grateful if it is still the subject of serious discussion. As it happens, this is also the 15th anniversary of something else that I had a hand in writing--the 1993 Clinton health plan. So far as I know, there are no planned commemorations--just the usual recriminations will have to suffice. But the two anniversaries invite reflection about transformations that happened and one that didn't, and about the interplay of broad social and political forces and the contingent circumstances and specific choices at moments of decision. That is what I would like to talk about this afternoon.

These two experiences--of first writing about the history of American health care, and then becoming centrally involved in an effort by a new president to change it--give me a somewhat unusual perspective. Like most historians and social scientists, I would have loved to have had a front-row seat in the inner circles of government to observe how decisions were reached at crucial moments in the past. In 1993, I had that seat, in the Roosevelt Room and the Cabinet Room, presenting decision memos to the president and taking part in the formulation of policy. Has that experience led me to change my understanding of history in general or the history of health-care policy in particular? Does it put *The Social Transformation of American Medicine*, particularly its concluding passages, in a different light?

One of the central dilemmas of all historical analysis--and this especially applies to policy history--is how to resolve the tension between political contingency and general models of change. Lean too far in the direction of political happenstance, and history is just one damn thing after another. See it all as the working out of a general model of change, and history becomes too schematic--indeed, why bother studying history at all? The challenge, as I see it, is to get the balance right, to put theory and history into productive tension with one another, casting light on how general processes play out, or

fail to play out, in particular cases, and possibly contributing to new concepts and better theories as a result.

There is also a third element to the tension that is peculiar to the literary form of a book. No less than a novel, a work of history needs to have a narrative arc, with a beginning and an end that give a shape and a sense of unity to a particular story, even though history itself has no neat divisions. Narrative is how we make sense of the flow of events, but it's important to distinguish literary artifice from historical and theoretical argument. That a book's narrative, for example, may have phases of rising and falling action does not imply adherence to a cyclical theory of history, any more than a narrative of the rise of an individual protagonist—or for that matter, a class, institution, or political regime--implies a theory of ineluctable progress.

Now, the tension between political contingency and general models of change is one that I've confronted in all my historical work, not just in *The Social Transformation of American Medicine*, but also in my two other historical studies, *The Creation of the Media*, which is an account of the political development of communications in western Europe and the United States from the early 17th to the mid-20th century, and my most recent book *Freedom's Power*, which is a history as well as a defense of modern liberalism, chiefly though not exclusively in Britain and the United States.

Without pretending to be exhaustive, I want to highlight two ideas that come out of this work. In *The Creation of the Media*, I emphasize the importance of “constitutive choices”—that is, choices about the basic social and material framework of an institutional field, in this case, of communications--which affect its long-run path of development in a particular society. A path-dependent view of institutions implies that there have been critical points along the way where the path might have taken more than one direction. These moments of decision, often about fundamental questions of law and policy, are some of history's crucial hinges, and here the policy historian can make a central contribution by illuminating the particular configuration of forces, the role of leadership, and other factors that may have been decisive at that time.

A second idea is the concept of conjunctures--the intersection of change at different levels of action. So, for example, there may be a conjuncture between national politics and specific institutions, as when a major ideological and political shift in a

society takes place and unleashes reforms at one particular moment rather than another in an institution's development. Or there may be a conjuncture between international developments and national policy-making, as when wars and other international conflicts unexpectedly intersect the history of domestic social policy at a particular moment in different ways in different countries.

In *Freedom's Power*, for example, I trace the comparative development at the turn of the twentieth century of the New Liberalism in Britain and Progressivism in the United States--two reform movements with strong similarities and interconnections, but with different effects on policy, in part because of how they intersected with both domestic politics and war. In *Freedom's Power*, the international dimension of domestic policy--of social insurance, of education, of civil rights--receives special emphasis.

Much traditional historical sociology posits long-term processes such as professionalization, industrialization, state expansion, and so forth--most of them useful ideas, as long as one takes them only as rough approximations to actual patterns of change. How such developments work out in particular societies may depend on variables like path-determining constitutive choices and historical conjunctures that fall outside such models.

### ***Social Transformation in Retrospect***

With those thoughts in mind, let me turn to *The Social Transformation of American Medicine* and briefly outline the argument.

*Social Transformation* is divided into a Book One and a Book Two, each one conceived with a particular narrative arc. Book One runs from the colonial era to just after the beginning of the twentieth century, and it tells the story of the rise of the medical profession and its role in shaping the health care system. In the early American republic, the social status of physicians was insecure, their earnings were modest, and the organized profession was divided and weak. Amid Jacksonian antimonopoly sentiment, states eliminated medical licensing laws in the 1830s, only to restore and increasing licensing requirements later in the century. By the Progressive era, not only were the medical profession's status and income on the rise. Physicians were also able to protect

their independence by constraining the development of other health-care institutions, such as hospitals and public health, and by limiting efforts by government or private organizations to control their work. Changes in knowledge and technology that transformed everyday life were crucial in bolstering the cultural authority of science and the professions, and it was partly on that basis--that is, on the basis of the belief that medical authority served wider social interests--that physicians were able to gain stronger licensing laws and other means of controlling the market for their services and increasing their economic power. The final chapter of Book One is called "Escape from the Corporation" and discusses the success that physicians enjoyed during the early 20th century in limiting the corporate practice of medicine and preserving their own independence.

Book Two, which runs from the early 1900s to the early 1980s, then describes the transformation of health care into an industry and the eventual waning of the physicians' professional sovereignty. The story here is the interplay of politics and the structure of health care--of critical moments of decision, and non-decision, and their consequences for the structure of organizations and markets. At first, the medical profession retained its power to mold public policy to fit its interests, although the very definition of those interests was itself a matter of contention. Before World War I, many physicians were sympathetic to proposals for compulsory health insurance for workers, but as the economic position of physicians improved, their organized representatives turned against any form of tax-financed health care. Repeated attempts to pass such programs then foundered when physicians, in coalition with other interest groups, were able to mobilize sufficient opposition to defeat reform.

As a result, during the middle decades of the 20th century, instead of health insurance as part of Social Security, the United States developed a system of employer-sponsored private insurance, at first mostly in partnership with the Blue Cross plans that hospitals created. Or to put it in different terms, "instead of an insurance system founded originally to relieve the economic problems of workers, America developed an insurance system originally concerned with improving the access of middle-class patients to hospitals and of hospitals to middle-class patients." In the same period, Congress enacted a series of government programs to expand the supply of health care resources: the Hill-

Burton Act for hospital construction; the National Institutes of Health for medical research; and other measures to expand the supply of health professionals. Even when Medicare and Medicaid were adopted in 1965, they did not interfere with the fee-for-service medical practice, preserved cost-based hospital reimbursement, and generally amplified the health care system instead of restructuring it.

The outcome of these decisions was a sharp rise in health care expenditures to far higher levels than in other Western countries. The early 1970s saw the adoption of a series of regulatory and planning measures intended to control costs, but they soon proved toothless in the face of concerted industry resistance and by the early Reagan years were being dismantled.

My conclusion in 1983 was that if there were no rationalization under public auspices, there would be rationalization in the private sector. This was the subject of the book's final chapter, "The Coming of the Corporation." Physicians, I argued, were losing their sovereignty over health care, not to government, as many doctors feared, but to a new corporate system. At that point, in the early 1980s, the new corporate organizations were hospital chains and other health care companies doing business under fee-for-service payment and cost-based reimbursement. Health maintenance organizations had established a foothold, but their growth had stalled. Thus the initial coming of the corporation, as I saw it in 1982, was not centrally focused on what later came to be called "managed care." But the dynamic I was describing – the growth of costs, the inability of existing government policies to control those costs, and the growing restlessness of private payers – all anticipated the shifts toward managed care and much else that emerged later in the 1980s.

So ran the argument of *Social Transformation*. If I were to revise those last pages with the benefit of hindsight, one prominent theme would have to be that the private-sector rationalization I expected 25 years ago failed as well. By private-sector rationalization, I meant a movement toward greater efficiency, effectiveness, and cost containment that I expected would be brought about chiefly by private employers and through the mechanisms of the market. Certainly there have been efforts in that direction during the past quarter-century. In that sense, I suppose I had it right: The next great wave of developments did, in fact, involve employer-driven initiatives and market-based

reforms. But the realistic assessment is that these developments have failed to slow the growth of health costs or to achieve promised gains in allocative efficiency. And, what is just as important, these developments have failed to arrest the deep sources of dissatisfaction that have generated demands for change.

Which brings me to 1993 and the Clinton health plan.

## **The Transformation That Wasn't**

The idea that America is on the verge of enacting national health insurance has proved to be a recurrent illusion--in *Social Transformation*, I called it "The Mirage of Reform." Before World War I, during the New Deal, again during the late 40s, and once more in the 1970s, astute observers were convinced that reform was on the horizon. But each time it vanished into the mist.

Of course, no matter how familiar you are with that history, if you believe that health-care reform is necessary, you're not inclined to dismiss a new political opening as a mere illusion because this time it may, in fact, be for real. At least, that was how I saw it in 1992, when after advising some Democratic senators, including Harris Wofford, who won a special election in 1991 largely on the strength of health care reform, I found my way into the Clinton campaign and then the White House.

Before turning to the question of structure and contingency in the battle over the Clinton health plan, I'd like to try to straighten out one point--which Clinton, Bill or Hillary, made the decisions about the 1993 health plan. If journalism is the first draft of history, this is a case where the impression created by an erroneous first draft has taken on a life of its own and where it may be impossible for historians ever to correct that mistake. But last October, writing in *The American Prospect*, I tried, and here is part of what I wrote:

The mythology of "Hillarycare," as the Republicans like to call it, is only partly the result of right-wing misrepresentations of the plan as a "government takeover" and malicious personal attacks on Hillary. The press never got the story right in the first place, and recent biographies and articles about Sen. Clinton have added to the misconceptions.

By the time Hillary became involved in health-care reform in late January 1993, Bill Clinton's thinking about the problem was already well advanced. The previous September during his campaign, he had settled on the basic model for

reform—a plan for universal coverage based on consumer choice among competing private health plans, operating under a cap on total spending (an approach known, in the shorthand of health policy, as “managed competition within a budget”). Though the media scarcely registered it at the time, Clinton had described this approach in a speech and referred to it in the presidential debates. Moreover, he saw health-care reform through the prism of economic policy, believed that reducing the long-term growth in health costs was a national imperative, and insisted that even while making coverage universal, health-care reform had to bring down future costs below current projections for both the government and the private economy. Among Clinton’s close advisors, Ira Magaziner championed the view that these aims were achievable. When he became the director of the health-reform effort and Hillary the chair, their job was not to choose a policy, but to develop the one that the president had already adopted.

Despite all the attention it received, however, the President’s Task Force—consisting of members of the cabinet and several other senior officials—proved to be useless for reaching decisions and drafting the plan. It immediately became the subject of litigation and dissolved at the end of May without making any recommendations. Bill Clinton actually never gave up control of the policy-making process, and the work fell to a small team of advisors and analysts that Magaziner directed. Beginning in March and continuing in a stop-and-go fashion until September, the decision meetings about the plan took place outside the formal structure of the task force, usually in the Roosevelt Room of the White House, and the president ran the meetings himself.

My knowledge of this process is first-hand. Magaziner first brought me into the internal discussions of health policy during the 1992 campaign after reading the manuscript of a book I had written, *The Logic of Health Care Reform*, which developed the idea of managed competition within a budget. As a senior White House health-policy advisor working under Magaziner, I took part in the decision meetings and presented some of the issues to the president. The first lady was an active force in these discussions, but there was never any question that the president was in charge. We took our guidance from him. That, of course, was how it should have been (who else but the president ought to make such decisions?), except that many reporters and the public thought that Bill Clinton had handed over the policy to Hillary and that she would report back to him, which was not the case.

One of the ironies about the so-called “secretive” Task Force chaired by Hillary is that it was totally irrelevant and the policy was decided on in the usual way—in confidential, that is, secret meetings between the president and a small group of advisors.

Although most of the discussions of the 1993 Clinton health plan focus on why it failed--and there are plenty of legitimate suspects--the prior question is why Clinton undertook it in the first place: Why did he make health care a priority, and why did he

decide to pursue universal coverage under a regimen of cost containment that included both managed competition and a budget cap.

Structural reasons explain why health-care reform persistently emerges as a political issue, particularly in the Democratic Party. Long-term trends toward rising medical costs and eroding private insurance coverage have become a principal, chronic source of economic insecurity in America--and that chronic problem becomes acute when unemployment rises, as it did during the recession leading up to the 1992 election. For Democrats running for president, broad plans for health reform make political sense, particularly during the primaries.

On the other hand, because the United States, unlike other advanced countries, did not introduce universal coverage when health care was a small share of the economy, the obstacles to change have grown far greater in this country than they were elsewhere when those countries acted. Instead of representing just 3 or 4 percent of GDP, health care made up one-seventh of the economy by the early 1990s and now represents one-sixth. It's not just harder to finance coverage expansion because the costs are greater. The basic tautology of health economics is that health care spending equals health-care incomes, and any serious proposal to control spending is, by its nature, a proposal to limit the incomes drawn out of health care. There is no way to change health-care finance without putting immense interests at risk.

A purely opportunistic Democratic politician would, therefore, rationally float bold proposals for reform during the primaries and once elected find reasons to scale them back or postpone action. Bill Clinton, however, did the reverse, and the explanation, I believe, lies in the peculiar circumstances between the election and inauguration and the political calculations that Clinton made at that time.

During the 1992 campaign, Clinton had not given health-care reform top billing—his primary issue was the economy, and he probably talked more about welfare reform than about health care. But higher deficit forecasts that fall, due largely to projected health costs, led him to change his priorities soon after the election. Abandoning his promise of a middle-class tax cut and retrenching on other measures, Clinton opted for deficit reduction in the hope that it would lead to lower interest rates and higher economic growth. The deficit forecasts also highlighted how critical it was to control the cost of health care. If health costs kept gobbling up revenue, they would make long-term deficit reduction impossible and sharply circumscribe what the new administration could



accomplish in other areas. Comprehensive health-care reform therefore held more than one attraction. If reform contained health costs, it would contribute to the success of Clinton's economic program. And at a time when he was downgrading other progressive commitments, a high-profile commitment to universal health insurance would bolster his popular support, particularly among Democrats. At one of the Roosevelt Room meetings on the health plan, Clinton remarked that in 1936 the Depression had not ended, but Franklin D. Roosevelt had won reelection because he had passed Social Security and other measures. Perhaps, he mused, health security could do the same for him in 1996 even if his economic program did not bring results by then. Both health-care reform and the economic programs were gambles, he suggested, but he was comfortable with the odds on both of them, and he could win if either one paid off.

As it turned out, his gamble on health care failed, but his gamble on economic policy succeeded, and he did win reelection.

Clinton's insistence on stringent cost containment in the health plan explains a great deal about the health plan and its defeat. Several of those who've written about the failure of reform--such as Jacob Hacker, whose cruelly titled book *The Road to Nowhere* has an excellent account of the origins of the Clinton health plan--argue that the proposal failed because it was the work of policy wonks and lacked a political strategy. But there was a political strategy, and the person who made all the big decisions about the plan was preeminently a politician--Bill Clinton. The strategy consisted of three phases. The first, a move toward the center, which took place during the campaign, was Clinton's embrace of managed competition--a move that, we had reason to hope, would win the support of business and moderate Democrats and split the insurance industry. The second move, which came with the release of the administration plan, was to tack left by announcing a generous universal plan with a broad benefit package to build popular enthusiasm. The third move, a shift back to the right, which was supposed to come in Congress, was to negotiate the plan down with the Republicans.

So why didn't the plan succeed? Remember, first of all, the immense structural obstacles opposed to change, and then add the following contextual factors. By the time the Clinton health plan reached Congress, the president had asked members of his party to cast difficult votes for tax increases, budget cuts, gun control, and other measures that many of them knew might doom their reelection chances. Once Democrats voted for one

set of tax increases, persuading them to vote for an employer mandate or any other method of financing expanded health coverage was going to be difficult, if not impossible.

Moreover, the whole political climate became toxic; Clinton could not get a single Republican vote for his 1993 budget, Whitewater broke at the beginning of 1994, and the White House was enveloped in what seemed an unending scandal. All the elements of the conservative coalition, from the anti-taxers to the social conservatives, mobilized against the health plan and the Clintons personally. The strong identification of the plan with the president and his wife then became a severe liability. Newt Gingrich, Grover Norquist, Bill Kristol, and other figures in the conservative movement saw health reform as an ideological threat because if it succeeded, it might renew New Deal beliefs in the efficacy of government, whereas a defeat of the health plan could set liberalism back for years. Tom DeLay pressed business organizations such as the U.S. Chambers of Commerce, which had been edging toward a deal, to reverse course. Soon Republicans were backpedaling from their own health-reform proposals. The Republican Senate minority leader, Bob Dole, withdrew his first bill and substituted a more limited one and then withdrew that one, too. It was not just the Clinton plan that was stymied; every effort in Congress to find a compromise failed. While George Mitchell, the Senate majority leader, was drawing up a compromise plan in the summer of 1994, Kristol wrote a memo to Republicans advising, “Sight unseen reject it.” Near the end, Sen. Bob Packwood told his Republican colleagues that after killing health-care reform, they had to make sure their fingerprints weren’t on the corpse. As I wrote in my postmortem shortly afterward, “The Republicans enjoyed a double triumph, killing reform and then watching jurors find the president guilty. It was the political equivalent of the perfect crime.”

The lesson here is not the structural impediments to reform will always be too great. But the political context of reform—the particular configuration of forces at the moment—is going to have to be a lot more favorable for universal coverage to pass. Could something have passed if Clinton had made different choices in 1993? Something smaller, such as an expansion of Medicaid or the later SCHIP program, might well have fit into the 1993 budget and passed as part of it. But if the program hadn’t controlled costs—and most likely it wouldn’t have—the erosion of private coverage would have continued, and the basic problem of economic insecurity would have remained.

## Conclusion

So did the Clinton experience change my view of history? Not really.

Structural economic and demographic forces, social structure, cultural patterns, the international state system -- all of these may create tendencies, pressures, and even probabilities of specific changes in policy. But between those structural factors and the outcomes lies the arena of conflict, contingency, and choice. If we could rerun history thousands of times with different people in different decisionmaking roles, we might find there were high probabilities of particular outcomes. That is why economic and sociological explanations may work especially well for crecive changes--that is, for changes built up out of large numbers of decisions. But when we are dealing with enacted rather than crecive change—when the path of development hinges on singular political events—the models of general processes may take us only so far. This is where history bends, and where individual leaders bend it. For some social scientists, that may be deeply unsatisfactory. But for the policy historian, it ought to be an invitation to get to work.