Predicting the Potential for National Health Care Reform in an Obama Administration: A Look Back on the Lessons of the Clinton Era

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Introduction

Though health care has long been an important issue in both American politics and the private lives of American citizens, attempts to reform the health care system in the U.S. on a national level have been unsuccessful so far. Though "the health care system is in crisis" is a common expression, what that means to Americans and what can be done about it are far more uncertain. The most recent and serious attempt at enacting universal health care reform came during the Clinton administration. Though attempts to achieve comprehensive health care reform in 1993 and 1994 were ultimately unsuccessful, there is still a great deal to be learned from their failure.

Skocpol (1995) argues that "history teaches us that reformers cannot go back to square one and try again with different tactics, because the institutional and political context for further policy struggles has been transformed by attempt and defeat" (486). What can we learn from the failure of the Clinton era reforms—but more importantly, can we apply any of that knowledge to health care reform today? Looking at the failure of the Clinton era reforms is important because it can offer some broad lessons about health care reform in general. These lessons are especially relevant today, as we are facing many of the same challenges and political circumstances as a nation. This paper will use the Multiple Streams framework of agenda setting and policy making to analyze the events of the Clinton era reform attempts, look at the scholarship examining the factors and conditions in the political climate during the Clinton Administration that either helped or hindered reform, and compare those conditions to the current political environment today. The purpose of this analysis is to provide a context for understanding the factors affecting reform; what does the Clinton era health reform debacle teach us about which factors should be

looked at optimistically, and which should inspire wariness? Is the current political environment is more or less favorable to universal health care reform?

This paper provides a valuable contribution to the scholarship on health care reform, both in the context of the early nineties and today. Though there has been a great deal of literature examining the failure of health care reform in the early nineties, this paper is innovative in that it provides a comprehensive analysis of the failure of reforms using the multiple streams model. Prior to this, the multiple streams model has been used only rarely to look at Clinton's health reform attempts.[1] Additionally, though this paper does not claim the ability to predict the future, it does offer some broad strategic insights to those who are currently supportive of health care reform.

During the Clinton era attempts at health care reform, events in the problem stream pushed health care forward onto the agenda, developments in the policy stream interfered with the progress of reforms, and while early events in the problem stream initially aided reforms, later events served to hinder and ultimately end the window of opportunity—the policy window—open for health care reform. The problems of cost and coverage facing the health care system in the United States have grown statistically worse over the past two decades. Changes that occur in the problem stream of health care, such as increases in cost and the number of the uninsured are important, but not all that significant in determining the overall likelihood of successful, comprehensive health care reform during the Obama Administration. The factors that brought about the failure of health care reform between 1993 and 1994 indicate that current events in the problem stream are probably significant enough to force health care reform onto the

1 Blankenau (2001) and Kingdon himself, in the 2003 edition of his book.

governmental agenda, but it will take an increase in consensus in the diverse field of health care policy and changes in the political arena—Congress, non-government interest groups, and the national mood—for health care reform to have a true chance at success.

Methodology

Predicting the Future of Health Care Reform

After his review of the literature on why the Clinton era health care reforms failed, Hacker (2001) argues that no one reason is adequate to explain why the failure occurred. Political outcomes are inherently subject to uncertainty, characterized by "contingency, imperfect information, the existence of multiple equilibria, probabilistic causal relations and human free will" (Hacker 2001, 85). Hacker discusses the way in which these five causes were excluded by scholars as they attempted to isolate a single overarching reason that the Clinton era health care reforms failed. He concludes that the greatest trap political analysts tend to fall into is retrospective certainty, the idea that because a certain sequence of events transpired, only one definite outcome was possible (92). Because the analysis of major motivating factors in past events has proved to be so uncertain, Hacker argues that in the future, political scientists should exercise more "humility and caution" in their predictions, and go to greater lengths to provide an analysis of the uncertainty inherent to any outcomes they may predict (Hacker 2001, 91).

In line with such reasoning, it would be beyond the scope of this paper to assert certainty over why reforms failed in the early nineties. Instead, this paper uses the three streams model to build a narrative of reform efforts in the early nineties and encompass a variety of factors that helped or hindered reform efforts. Additionally, it would be unwise to use an analysis of those

failures to assert certainty with regards to health care reform in the present day. There is, obviously, no reliable model for actually predicting the future, and scholars such as Hacker (2001) are wise to caution against such assertions of absolute certainty. However, as Kingdon (2003) states, the multiple streams model looks at patterns that recur in the agenda-setting and policy-making process, under the presumption that the recurrent patterns that characterize the dynamics of the streams and certain constraints therein give the model meaning and limit randomness (206-207). Though there are no "absolutes," the multiple streams model is able to appraise the likelihood of certain relationships and events, "adhering to such formulations as 'the chances are improved or lessened' and 'these events are more likely than others'" (208). This paper follows a similarly cautious formula, looking for similarities and differences in the streams between the early nineties and today that might indicate a recurrence of, or departure from, previous patterns.

The Multiple Streams Model

This paper patterns its analysis on the multiple streams model of agenda-setting and policy making as outlined by James Kingdon (2003) in his pivotal book, *Agendas, Alternatives, and Public Policies,* first published in 1984. The multiple streams model is a tool for understanding "what makes an idea's time come," how issues get the government's attention, and why some issues get subjected to sudden sweeping political and policy change while other ideas are just as abruptly forgotten (Kingdon 2003, 1). In this particular case, why did the issue of health care reform, which received so much political and public attention in the time span between 1992 and 1994, not only fail to yield a congressional vote on health policy reform, but

end with health dropping off the government's agenda almost entirely for the ensuing decade?

The multiple streams model is helpful in the examination of the Clinton health care reform attempts because it creates a framework for analyzing the myriad of factors that influenced the failure of reform. As Kingdon (2003) states, “an item can be prominently on the agenda...without subsequent passage of legislation” (3). The Kingdon model is useful for uncovering both factors that push an item forward on a policy agenda and factors that hold it back. Kingdon's (2003) model theorizes that there are three separate but parallel streams of action—the problem stream, the policy stream, and the political stream. Issues, such as health care or transportation, which Kindgon examined specifically in the interviews he used to create his book, each have a subset of these streams that change or stagnate over time and determine an issue's place on the public agenda.

The problem stream examines how issues and conditions in society come to be perceived as “problems.” For the general public, this occurs when people decide that something is actionable, needs improvement, or conflicts with their personal value system (Kingdon 2003, 19). For government officials, this usually occurs when the “problem” is subject to a routine examination of effectiveness, a sudden crisis that focuses public attention, or public feedback (Kingdon 2003, 113). Indicators come from routine monitoring—agencies both inside and outside of the government are constantly keeping a close watch on different activities and occurrences, looking for factors such as the cost and effectiveness of programs or the overall unemployment rate (90-91). A report indicating a sudden spike in car crashes might inspire government officials to take a closer look at automobile safety regulations, or in the case of health care reform, a rise in the number of the uninsured or the cost of maintaining government

welfare programs such as Medicare and Medicaid.

The policy stream examines how policy ideas or proposals “are generated, debated, redrafted, and accepted for serious consideration,” in a process typically starting with many different ideas that are eventually boiled down to a few plausible solutions that are given more serious consideration (Kingdon 2003, 143). Kingdon (2003) writes that the policy community can be characterized as a “primeval soup” where ideas are “softened up” over time; ideas float around, confront one another, and recombine in various ways (117). To survive over time, Kingdon (2003) argues that there are three essential criteria a policy proposal must meet: technically feasibility, (whether or not the policy plan could be realistically, successfully administered), value acceptability (whether it is compatible with values and ideologies), and anticipation of future constraints (the plan's long-term survival and acceptance by the public) (131-139).

Kingdon's (2003) definition of “politics” in the political stream is the “colloquial Washington definition,” encompassing the more tangible activities and factors that influence and comprise governance, elections, and partisan ideologies and strategies, rather than the more broad political science definition of “any activity related to the authoritative allocation of values, or to the distribution of benefits and costs” (145). One of the most important changes that can occur in the political stream is the turnover of key government personnel, for each new official often brings with her a different set of priorities and a different idea of what belongs on the agenda (Kingdon 2003, 153). The most significant and far-reaching turnover is that of a new presidential administration (21-22). The combination of the President's power to influence the agenda and the change in goals associated with a new administration create a ripe opportunity for

the opening of a policy window, giving "groups, legislators, and agencies their opportunity...to push positions and proposals they did not have the opportunity to push with previous administrations" (Kingdon 2003, 168).

The politics stream also encompasses the "national mood" on a particular issue. The national mood describes "the notion that a rather large number of people out in the country are thinking along certain common lines, that this national mood changes from one time to another in discernible ways, and that these changes in mood...have important impacts on policy agendas and policy outcomes" (Kingdon 2003, 146). Most policymakers and government officials feel they are accurately aware of the character of the national mood, and use the perception of shifts in the national mood to push issues up or down on their agenda (Kingdon 2003, 147).

Each stream moves independently, but on occasion, the three streams will couple, creating the opportunity for sudden, comprehensive change in policy "when the conditions to push a given subject higher on the policy agenda are right" (Kingdon 2003, 88). Kingdon (2003) is not looking at small changes or incremental reform; he is looking at opportunities for broad, sweeping policy changes that occur during the opening of what he calls a "policy window." Policy windows, "the opportunities for action on given initiatives, present themselves and stay open only for short periods" (Kingdon 2003, 166). The opportunities for sudden policy change are inconstant and dependent on other factors—if an actor fails to or for whatever ever reason cannot take advantage of the opening of one policy window, he must wait for another (166).

Essential to the success of a policy is the presence of a policy entrepreneur willing to advocate for a particular policy. A "policy entrepreneur" is someone who is willing to invest time and resources to promote a certain policy position, either because of serious concern over a

problem or anticipation of future gain (Kingdon 2003, 179). Through their policy advocacy, policy entrepreneurs very important in joining the three streams and creating an opportunity for reform. Kingdon (2003) calls the joining of a policy solution with a particular, relevant problem "coupling" (172). Coupling is an area where the streams meet to push a policy through a policy window, but this can only occur with the advocacy of the "right entrepreneur at the right time" to align the policy in question with the problem (Kingdon 2003, 205). Policy entrepreneurs show up in many different places in the three streams, "coupling solutions to problems, problems to political forces, and political forces to proposals" (205). An effective policy entrepreneur is able to push problems up on the agenda, advocate for particular solutions, and utilize the policy window created by their efforts to push through a favored proposal.

Other Methods of Analysis

To gain a comprehensive understanding of health care reform in the early nineties, I conducted a literature review of the numerous scholarly works exploring and analyzing Clinton's reform attempts. From these sources, I looked at the factors scholars most frequently cited as prohibitive to the success of reform, and integrated the different accounts of health reform between 1991 and 1994 into the multiple streams model. Additionally, I supplemented my literature review with an examination of U.S. Census reports on health insurance and newspaper coverage of health care cost, coverage, and politics between 1992 and 1994.

In the second half of this paper, I explore the state of health care reform in the current political environment, also structured according to the multiple streams model. To understand the health care problem, I again looked at Census Bureau reports on the uninsured, as well as policy

institute analysis of health care cost changes over the past 20 years.

In order to get a better idea of the nature of the current health policy community, I interviewed experts in the field. Interviewees were either academics in the health policy field or policy directors at various think tanks in Washington, DC, from both sides of the ideological, political spectrum. A majority of these interviews were conducted over the phone, but some were conducted in person, and others were conducted over e-mail correspondence. One respondent directed me towards a series of essays he had written on health policy rather than answer my questions directly in an interview. The questions I asked related to incremental versus comprehensive reform strategies, characterization of expert opinion, health care and the current economic recession, and policy plans in Congress.

My analysis of the current state of the politics stream relied on media coverage of relevant political elements, such as interest group behavior, and actions of Congress and the White House. To understand the national mood on health care reform, I utilized recent polling data from the Kaiser Family Foundation; information about current popular trust in the government came from further literature review. I also studied fragmentation of the health care issue in Congress by imitating a previous study by Baumgartner and Talbert (1995), looking at health care issue jurisdiction among congressional committees between 1995 and 2008. Baumgartner and Talbert (1995) cited data from the CIS, Congressional Information Service. Current CIS data is available on the Lexis-Nexis Congressional database. My replication of their original study (conducted between 1980 and 1991) yielded slightly different results, but minor variations can be accounted for by the exclusion of Joint Committee hearings from both datasets and the prevalence of committee hearings that were double counted—when one hearing was

replicated in two committees.

The Problem Stream

One of the things that makes looking at the failure of the health care reform in the Clinton era so interesting is the fact that there was tremendous momentum, or at least the widespread perception of momentum, driving health care forward on the government agenda, but it ultimately yielded no passage of legislation. The momentum from the health care debate was so strong in the early days of the Clinton Administration, many saw change as inevitable. This momentum originated from the problem stream—health care was widely perceived to be "in crisis," and something needed to be done. As Kingdon (2003) asserted in a later edition of his book, the government agenda during the Clinton Era health care reform debate was driven mostly by the problem stream (217).

Indicators

There were a number of indicators that the United States' health care system was in trouble in the early 90s. For most Americans, the problem had two major aspects—coverage and cost. Between late 1991 and early 1993, the media made frequent reference to the approximately 35 million Americans without health insurance, while the number climbed to about 37 million over the next year and a half.[2] These estimates were typically drawn from a variety of sources. The U.S. Census Bureau estimated that 39.7 million, or 15.3 percent of people in the United States were without health insurance during 1993 (U.S. Census Bureau 1994, 1). This shows a steady increase from previous years, with approximately 15 percent uninsured in 1992 and 14.4

2 See Appendix: Table 1.

percent in 1991 (U.S. Census Bureau 1994, 3). Even for those with health care coverage, the employer-based coverage system made health care insurance inherently unstable for many Americans. Some studies indicated that only about 18.1 million people were continually without health insurance during 1992, though this number is subject to severe continuity gaps in an employer based health system (Bennefield 1995, 1). Between 1991 and 1993, only 73.5 percent of Americans had continuous health care coverage, meaning that somewhere in the realm of 64 million people were without health care coverage for some duration during that period (Bennefield 1995, 1).

Rising health care costs in the U.S. affected everyone. They strained state and government budgets, forced working families to struggle to pay their bills, slowed down the already lagging economy (Kingdon 2003, 217). According to the Organization for Economic Co-operation and Development, the U.S. health care system was seen as "unsustainable" or at least unsatisfactory and was experiencing the fastest rate of inflation for health care costs of any industrialized nation (Blankenau 2001, 45-46). Between 1965 and 1991, the United States went from spending 5.9 percent to 13 percent of its total GDP on health care (Skocpol 1996, 22). Total GDP spending on health care reached 14.4 percent in 1993, more than any other industrialized nation, while the U.S. still had higher mortality rates than other industrialized nation (Langbert and Murphy 1995, 639). For the average family, the increase in health insurance premiums from the previous year was about 8.5 percent, significantly outstripping the increase in workers' earnings, which only rose about three percent and were slightly below the overall rate of inflation (Kaiser Family Foundation 2007). The rate of increase in health insurance premiums in 1993 was actually less than in 1990 (14 percent) and 1991 (approximately 12 percent), but still placed a

large burden on family budgets (Kaiser Family Foundation 2007). Middle class Americans worried about cost and security of their health care coverage, wanted it high on the agenda (Blendon and Brodie 1995). Nothing emphasized this point more in the early 1990s than the special election of Harris Wofford.

Feedback

Somewhat similar to problem indicators is problem feedback, which government officials get specifically from monitoring previously existing government programs, as officials "monitor expenditures, have experience with administering programs, evaluate and oversee implementation, and receive complaints" (Kingdon 2003, 100). For feedback to be indicative of a problem, government officials must perceive that a program has lost sight of its original legislative intent, failed to meet previously specified goals, become too costly to manage and maintain, or draw a great deal of negative public feedback (Kingdon 2003, 102-103). Since the 1980s, the cost of funding federal health care programs such as Medicare and Medicaid had been rising quickly, and earlier attempts to reform Medicare, most notably, the Medicare Catastrophic Coverage Act of 1988, had met with failure and public outrage (Quadagno 2004, 35-36). According to a Commerce Department Report, spending on Medicaid alone increased 29 percent, or 67.8 billion dollars, during the 1992 fiscal year, imposing a huge financial burden on state budgets (Pear 1993, A10). The cost of maintaining Medicare and Medicaid was continually an issue for all those striving to reduce the federal budget deficit (Swenson and Greer 2002, 611).

Focusing Event: Wofford and the Political Earthquake[3]

However, feedback or routine indicators alone are not always enough to incite government action on an issue. Often underlying indications of a problem must be accompanied by a sudden event or crisis that incites a new or renewed dialogue. For Kingdon (2003), a focusing event is a sudden crisis, such as a plane crash or the financial collapse of the transportation behemoth Penn Central railroad in the 1970s, that focuses both government and public attention on a certain issue (94-96). The Wofford election was a relatively unique phenomenon for health care. As Kingdon (2003) points out, health care is less likely to draw attention via a sudden crisis or focusing event, but rather through a series of indicators (95). As was seen in the example of health care reform in the early 1990s, a focusing event does not have to be a disaster, it can also come from a "powerful symbol" or the impact that a certain issue has had on a lawmaker personally—for example, former President Ronald Reagan's battle with Alzheimer's disease (Kingdon 2003, 96).

Many scholars point to Harris Wofford's victory in a special election in November 1991 as a powerful symbolic or signaling event for the importance of health care reform, one which heavily precipitated Bill Clinton's focus on health care in his 1992 Presidential campaign (Kingdon 2003, Ellison and Mullin 2001, Blankenau 2001, Hacker 2001, Quadagno 2004). When Republican Senator John Heinz of Pennsylvania was killed in a plane crash, Wofford, a Democrat, was appointed to take his place and subsequently managed to maintain his seat against experienced Republican challenger Dick Thornburg in 1991 (Kingdon 2003, 218).

3 Though political elections are technically an aspect of the politics stream in Kingdon's model, in this case, the scholarship generally supports the notion that Wofford's election fits the definition of a focusing event.

Inspired by his own campaign's issue polling inside Pennsylvania, Wofford gained a great deal of success in his campaign by emphasizing the importance of health care reform (Blankenau 2001, 46). Wofford came from a place of both personal experience—his wife had a chronic health condition—and excellent rhetoric, as he declared on the campaign trail that so long as every criminal was entitled to a lawyer, every sick person in America should be entitled to a doctor (Quadagno 2005, 184).

The results of the special election triggered a "political earthquake" as media attention swiftly focused on health care reform[4], exit polls from the special election revealed that a majority of Pennsylvania voters had considered health care to be one of their top issues in deciding how to vote, and Wofford's campaign manager, James Carville, went to work for Clinton's presidential campaign (Hackey 1993, 236). According to a Kaiser/Commonwealth Institute survey taken less than a year later, a majority of Americans listed health care reform as their top priority (Blankenau 2001, 45). In his examination of health care reform, Hackey (1993) wrote that "health care reform received more media attention during the 1992 presidential campaign than at any time since the early 1970" (236). As Kingdon (2003) argues, a sudden crisis or symbol must often be accompanied by previous underlying problem indicators, such as the rising rates of uninsured Americans and health care costs, in order for an issue to move from "the back of people's minds" to a prominent place on the policy agenda (98). Though there were many indicators that the health system was in trouble, it was the focusing event of Wofford's election that really pushed health care forward onto the agenda.

The Policy Stream

4 See Appendix A: Table 2.

In 1992, after the “political earthquake” associated with Wofford's election, President Bush decided to take action on health care as well. In February 1992, the Bush Administration announced a health care plan, but in early September of that same year—an election year—the plan was voted down by Congress, an act that the Bush Administration blamed on Democrats (Pear 1992, A26). Angered Republicans pointed to a transcript of a meeting of the House Democratic caucus on July 24th, in which they discussed the “risk of doing nothing on health care,” how important it was that President not get credit for health reform, how they could get the most political gain from the health care issue (Pear 1992, A26). The meeting also revealed that Democrats were ideologically divided on how to solve the problem (Pear 1992, A26). The Bush plan was not the only health care plan in Congress that year. With little consensus on policy, “in 1992, more than three dozen health reform proposals were made in Congress” (Langbert and Murphy 1995, 642).

The Primeval Soup

In his original interviews of health policy actors, conducted between 1976 and 1979, Kingdon cites repeated references to the “big three” issues in health care reform, cost, coverage—sometimes referred to as access—and quality (120). Over time, these three issues became central to the language and formulation of all modes of the health care discourse, spanning all levels of expertise in the health policy community and beyond (120). While there was a general agreement that cost and coverage were the priorities in health care reform in the early nineties, there was widespread disagreement over what policy strategy would be the most effective in limiting cost and expanding coverage for all Americans. The lack of consensus in the

policy stream was a large problem for pushing through health care reform legislation in 1993 and 1994 (Hackey 1993, Blendon et al, 1995, Peterson 1995, Baumgartner and Talbert 1995, Blankenau 2001, Kingdon 2003, Ruger 2007). Though many plans were proposed in Congress in 1993 and 1994, none were able to gain significant momentum.

None of the plans in the 102nd, or even the 103rd Congress were completely new or original ideas, they had already been circulating in the health policy community before 1991. Though there was not significant public attention given to health care before 1991, the health policy community was aware of the problems facing the U.S. health care system, and policy experts were working to come up with a solution for the problem (Skocpol 1996, 30).

In 1992, there were three general categories of health policy proposal: incremental, market-based coverage expansion, a government-run single payer system financed by taxes, or a "hybrid" approach called "pay or play" (Skocpol 1996, 30). The market-oriented approach was favored by Republicans and the health industry; many bills introduced in the 102nd Congress, included "limits on malpractice liability, tax subsidies or credits to help low-income people buy insurance, and new rules for the insurance market," such as mandating coverage for individuals with preexisting conditions (Skocpol 1996, 31). The 1992 Bush plan falls under the umbrella of incremental, market-oriented reform. Bush wanted to encourage the spread of managed care to control costs with market-based competition, suggesting vouchers for the poor to purchase insurance, purchasing pools for small business, and some insurance industry oversight (Skocpol 1996, 31). The single-payer approach was advocated by many health policy experts and generated interest in the House and Senate, but no one who was "serious" about health reform endorsed single payer, for fear that it would upset stakeholders in the health insurance industry,

force payroll taxation for employers, and necessitate raising taxes, which was seen to be a huge political blunder (Skocpol 1996, 32-33).

Early in the campaign, Clinton endorsed the "pay or play" system, but was still criticized for not having a definite enough position on health care reform. In August, the *New York Times* asserted that Clinton "hasn't even proposed a coherent plan, only oratory better calculated to appease important Congressional Democrats than to create sound policy" (NYT Aug 31, 1992). Clinton's "pay or play" required employers to either provide coverage for their employees or pay taxes to subsidize a government health program (Skocpol 1996, 33-34). This approach was criticized by health policy experts who believed it would not control cost and might lead to employees being "dumped" into a second-rate program and Republicans who believed it was a slippery slope towards a single payer system (Skocpol 1996, 34). Clinton eventually turned away from "pay or play" because of the fear that it would label him a "taxer," a designation that had proved to be a political liability in past races, and turned to managed competition (Skocpol 1996, 40-41).

Managed Competition

Managed competition was the brainchild of Standford University economist Alan Enthoven, who made the idea public in a series of New England Journal of Medicine articles in 1989 (Broder and Johnson 1997, 72). Enthoven further explored the idea of managed competition in regular meetings with academics and businesspeople in Jackson Hole, Wyoming, leading to managed competition eventually earning the moniker the "Jackson Hole Plan" (Broder and Johnson 1997, 72-73). Managed competition relied on market forces to regulate cost.

Employers would pay for part, but not necessarily all of their employees' health care coverage, and limited government intervention would establish minimum standards for health care coverage (Broder and Johnson 1997, 73). Managed competition would organize small businesses and individuals into regional purchasing alliances, and competition among insurance providers for these alliances would lower cost (Broder and Johnson 1997, 73). In exchange for insuring high-risk individuals, insurers would receive a standardized "community rated" premium from all beneficiaries (Broder and Johnson 1997, 74).

Left leaning policy experts Walter Zelman, Paul Starr, and John Garamandi, the Insurance Commissioner of California, adopted many aspects of the managed competition plan advocated by Enthoven, with some alterations (Skocpol 1997, 43). Though they generally supported the Jackson Hole plan, they were still concerned that the plan was untested, and there was no guarantee that costs would not spiral out of control when the plan was implemented (Broder and Johnson 1997, 74). To combat this, Garamandi, Zelman, and Starr proposed either "global budgets," which would establish a ceiling on what a nation or state could spend on health care per year, or "premium caps," which would place price controls on insurance policies (Broder and Johnson 1997, 72). Clinton was quickly drawn to this version of managed competition—rather than raising the specter of tax increases, he could advocate for a plan financed by "new federal regulations and mandates on employers" (Skocpol 1997, 44). On September 24th, just over a month away from election night 1992, Clinton introduced this version of managed competition at a speech at Merck Pharmaceuticals (Skocpol 1997, 44). Clinton promised that his plan would not require new taxes, and that it would involve "personal choice, private care, private insurance, private management...a national system to put a lid on costs, to require insurance reforms, to

facilitate partnerships between business, government, and health care providers" and "a national budget ceiling" (Skocpol 1997, 45). In September, nine months after entering office, Clinton announced the specifics of his plan. In addition to adopting Garamandi, Zelman, and Starr's global budget caps, Clinton's plan,

> ...the Health Security Act, was an employer mandate model, based on a managed competition framework. It relied on government regulation rather than market forces alone to control costs. It created a system of regional purchasing monopolies and placed price controls on health-plan premiums. It also set up a National Health Board to oversee health care quality (Ruger 2007, 73).

Coupling

According to the *New York Times,* on January 26, 1993, six days into his presidency, Bill Clinton named First Lady Hillary Clinton to head the "President's Task Force on National Health Reform" (Friedman 1993). Corrigan (2000) argues that this act served as Clinton's first official confirmation of the importance of health care on his agenda as President (151). In this early phase, the goal of the Task Force was to assemble a plan for a health reform package. The specifics of the plan were of course unknown, but the Task Force was expected to address the key problems facing the health care system in the United States: controlling cost and expanding coverage (Friedman 1993). Key members of the committee included White House "domestic policy advisors" Ira Magaziner and Carol Rasco, the health care policy leader of Clinton's Transition Team, Judith Feder, and Health and Human Services Secretary Donna Shalala (Friedman 1993).

Though Clinton attempted to move quickly on health care upon entering office, he did not have a solidly defined plan to immediately propose to Congress. Though he promised to deliver a plan to Congress within his first 100 days in office, other issues interfered and his

Health Task Force, assembled in January, took until September to come out with a definite plan (Quadagno 2004, 37). In the meantime, other issues took precedence, and pulled public and governmental attention away from the health care reform debate. Among others, the Clinton Administration had to deal with the controversy over the nomination of Zoë Baird for Attorney General, conflict over gay rights in the armed forces, a crisis in Somalia, the 1993 Bombing of the World Trade Center, and a Congressional battle over the North American Free Trade Agreement (Quadagno 2004, 37; Hamilton 2007). Such delays presented serious problems for the future viability of the Clinton plan.

Hillary Clinton, Ira Magaziner, and President Clinton himself could all be considered policy entrepreneurs for the Clinton plan, though Mrs. Clinton most accurately fits the definition. Mrs. Clinton and Magaziner were both key figures in the creation of the Health Security Act, and both served on the President's Task Force on Health Care Reform, but Mrs. Clinton was in change of the Task Force and later took the lead in advocating for the plan, both before Congress and to the public. Given the vital importance of the role of policy entrepreneur, it is understandable that Mrs. Clinton is often scapegoated for the failure of reform. Both she and Ira Magaziner were accused of hindering reform through their temperament, by being arrogant and unwilling to compromise (Skocpol 1996, 10). However, others have argued the contrary. In her early appearances defending the Health Security Plan before Congress, Mrs. Clinton endured intense media scrutiny and received excellent reviews for her positive demeanor and keen understanding of the policy she was advocating (Corrigan 2000, 156).

Despite heated ideological conflicts and partisan tension, the biggest error of the Clinton Administration and Mrs. Clinton in her role as a policy entrepreneur was most likely simply

waiting too long to come out with a health care plan. Kingdon (2003) writes that policy entrepreneurs "must be ready...must develop their ideas, expertise and proposals well in advance of the time the window opens...without that early consideration and softening up, they cannot take advantage of the window when it opens" (181). Clinton had an idea of what he wanted to do with health care during the 1992 campaign; he did not have a definite plan. Instead of pushing through a plan immediately upon entering office, he was forced to wait for the plan to be created. Kingdon (2003) states "waiting to develop one's proposals until the window opens is waiting too long" (182).

Prior to her appointment to the Task Force, Mrs. Clinton was not publicly perceived as an expert on health care issues (Kingdon 2003, 220). Though she obviously supported the principles put forth by President Clinton in his campaign, she was not widely known for advocating any particular health policy proposals. Because the Health Security Act was not even written until after Bill Clinton entered office, it was impossible for Mrs. Clinton to act as an entrepreneur for the plan for any significant amount of time. Policy entrepreneurs "aim to soften up the mass public, specialized publics, and the policy community itself...the process takes years of effort" (Kingdon 2003, 205). Hillary Clinton did not have adequate time to advocate for the plan and encourage "softening up," as the plan was thrust into the national spotlight immediately after its conception, and after the policy window for health care reform had opened. On top of that, managed competition itself had been conceived relatively recently, an important distinction in a policy battle that stretches back over 70 years. Clinton's spin on managed competition, including global budget caps, was even newer and disapproved of by the original architect of managed competition, Enthoven (Broder and Johnson 1997, 74). These delays and other time

constraints combined to make Mrs. Clinton an ineffective entrepreneur. Corrigan (2000) writes that “most studies...have assumed that Congress did not act on the Clinton reform plan because the administration was unable to persuade the public that the plan was needed” (150). Mrs. Clinton was unable to couple her proposed solution, the Health Security Act, with the problem of health care as it was perceived by the public. Given the importance of the policy entrepreneur in joining the streams and pushing proposals through open policy windows, it is likely that the lack of an effective policy entrepreneur was a huge blow to the success of the Clinton era reforms.

Criteria for Policy Survival

The complexity of the Clinton plan made it difficult to communicate to the public, and many of those who did understand it doubted its technical feasibility. Clinton's plan struggled from all sides on the issue of technical feasibility. Some opponents claimed the Clinton plan altogether lacked technical feasibility, pointing to “inefficiencies and bureaucratic problems they surmised the plan would create” (Ruger 2007, 73). Clinton's plan had a huge scope—he was trying to restructure one-seventh of the economy in one piece of legislation, and leaving many confused as to policy specifics such as what would happen to private insurers under his plan (Blankenau 2001, 47). Still, the Health Task Force's intense concentration on making sure the plan *would* work successfully also ended up hurting the Clinton plan. “The health reformers gathered sprawling expert task forces; they worked so hard on the details that they lost track of political time (causing fatal delays); and in the end, they produced a proposal that was complex, unfamiliar, and impossible to explain” (Morone 1995, 392). The complexity and unfamiliarity of the plan made it easy for opponents to attach labels such as “Tax and Spend, Big Government,

Federal Bureaucracy Run Amok" to it (Morone 1995, 392). Morone (1995) concludes that managed competition is a "political orphan...its only natural allies were a managerial cadre already immersed in the arcania of systems analysis...managed competition was simply not ready for the real world of politics" (396).

Republicans had severe issues with the value acceptability of the plan. Polling from across the United States showed that Republicans favored health coverage through tax credits, rather than employer mandates "by an almost two-to-one ratio (58 percent to 32 percent)" (Blendon et al. 1995, 9). Generally, only about 44 percent of Republicans thought the health care system was in need of comprehensive reform, versus about 60 percent of Democrats and Independents (Blendon et al. 1995, 9). Republican Senator Bob Bennett, summarized the Clinton plan by calling it "incredibly bloated, complex, unresponsive, incomprehensible" and symbolic of everything people hated about "Big Government" (Broder and Johnson 1997, 234). The association with big government concept implied that the middle class was going to be hurt, and they directed their fears towards Clinton and the Democrats (Broder and Johnson 1997, 234-235). However, Clinton did anticipate some of this from the outset; he believed that through managed competition, he was creating a value acceptable plan for everyone, knowing that extremes such as single payer, (favored by those farther to the left politically) was off the table from the beginning (Rockman 1995). On the other hand, "government-supplied health insurance can be viewed as a social welfare issue, resulting in greater support for its provision among Democrats and liberals" (Koch 1998, 218).

In anticipating future constraints, whether or not a plan is going to stay within budget is very important. The Congressional Budget Office predicted that Clinton's plan would fail to

maintain budget neutrality, as they argued that the price of extending health care coverage to all Americans would quickly eat up any money saved by exerting cost controls on health spending (Blankenau 2001, 47). Another constraint is whether or not the plan will be accepted by the public. Clinton believed he was creating a plan with public appeal, invoking New Deal politics and the idea that accompanies Social Security—this is a universal reform that gives deserved benefits, and not a "welfare handout" (Skocpol 1996, 2). As will be discussed below, opponents of reform were far more successful than Clinton at tapping into the national mood on health care and framing the Clinton plan according to their desires.

The Politics Stream

Clinton was well aware that the issue of health care reform was important to voters and made it a significant part of his campaign. In 1992, approximately 75 percent of voters considered health care to be a "very important issue in the presidential campaign," and viewed Clinton more favorably than Bush on the issue of health care by about three to one (Glied 1997, 2). In November of 1992, Clinton won the presidential election by a narrow margin of victory, only 43 percent of the popular vote in comparison to Bush's 38 percent and third-party candidate Ross Perot's 19 percent, which was the largest percent of votes acquired by a third-party candidate since Teddy Roosevelt in 1912 (Apple 1992, A1). Clinton promised to make health care a priority in his new administration. According to a *New York Times* article from early January of 1993, before Clinton took office, "Mr. Clinton has said that, within 100 days of taking office on January 20, he will propose legislation to slow the rise in health costs and to guarantee insurance for all Americans" (Pear A1, 1993).

Events in the problem stream focused attention on health care reform, and a very significant event in the politics stream—presidential turnover—served to indicate the opening of a policy window. As Clinton entered the White House, health care was high on the agenda of both the President and the American people. Confidence was high as well—many saw reform as inevitable. Given the strong commitment to the issue of health care reform in Congress and in the White House, Peterson (1994) argued that "bold" reform was likely within the year (205). As Clinton entered the White House in January of 1993, there was tremendous momentum behind health care reform.

The National Mood

Beneath the Wofford election and the sudden rise to prominence of the health care issue was an economic recession that was hurting middle class families. Though it was the poor who were uninsured at a far higher rate than working and middle class families, the view of health care reform among the middle class was the most significant in the way the health care crisis was perceived by the American public between 1993 and 1994. Between about 1980 and 1991, health care was not considered a major issue. Despite the rapid inflation of health care costs in the 1980s and Democratic presidential challenger Michael Dukakis' brief attempt to make health care reform an issue during the 1988 election, health care was simply not considered a priority for the government or the voting public (Skocpol 1996, 23). The economic recession damaged George W. Bush's presidential approval ratings in 1991; he was considered to be very strong on issues of defense and foreign policy, but less so with domestic issues such as health care (Skocpol 1996, 24-25). As unemployment rose, there was an increase in corporate downsizing,

an atypically high level of white collar workers were losing their jobs (Skocpol 1996, 25). In the American system, where a majority of health care coverage is employer based, the worsening economy and rising unemployment fueled fears of losing health care coverage among both white and blue collar workers (Skocpol 1996, 25). In late 1991, 60 percent of Americans were concerned that they would not be "adequately insured in the future" (Skocpol 1996, 25). Additionally, in 1992, many Americans listed cost as their number one concern in health care reform (Blankenau 2001, 45). Wofford's election, cited by so many scholars as indicative of the health care problem and its rise to prominence on the agenda, was driven by middle class attitudes toward health care. Those same values later helped to propel Clinton into the White House.

Cost and coverage, the two essential paradigms of the health care debate, were seen in a very specific way by middle class Americans. Cost was the cost they were paying to cover themselves and their families, not part of a larger concern about the health care marketplace in general. Coverage was their own coverage, not coverage for the millions of uninsured Americans. For Americans, the health care debate contained a substantial amount of self-interest. Though Americans wanted reform, they wanted reform that would benefit them personally (Blendon et al. 1995, 12).

> Support for reform plummeted if Americans heard that reform would limit their choice of doctors or hospitals, would require rationing, would reduce the quality of care most persons now receive, or would require more than a modest tax increase...when given a list of goals for health care reform, Americans chose making health care affordable for themselves and their families (34 percent) by nearly a two-to-one margin over controlling the total cost of health care (19 percent) (Blendon et al. 1995, 12).

Blendon and Benson (2001) suggest that Americans wanted health care reform in 1993 and 1994, and many were supportive of national reform, there was simply no "underlying

consensus among the American public over the preferred type of national health plan" (36). Americans were often confused about policy specifics. When pollsters asked about a particular policy plan, a majority of Americans expressed support for the plan, however, when asked to chose among several plans, support suddenly splintered and distributed evenly among plans (Blendon and Benson 2001, 36). For example, between 1993 and 1994, 57 percent of people supported employer mandates, 59 percent of people approved a government run, national health system that was funded by taxes, and almost 80 supported a medical savings accounts. (Blendon and Brodie 1995, 403). In 1992, "among the employer mandate, single-payer, and tax credit strategies, Americans were nearly equally divided with 28 percent, 32 percent, and 33 percent public support" (Ruger 2007, 73). This confusion and lack of consensus among the American people allowed opponents of reform to step in and sway public opinion away from the Clinton plan.

Blendon and Brodie (1995) argue that the public sent three specific but divergent messages out during the health care debate between 1993 and 1994. They were concerned about cost and the security of their health care coverage and wanted major reform, they wanted government action but were not sure what kind of action the government should take, and they were increasingly afraid that any plan enacted by Congress would negatively effect their personal health care plan (Blendon and Brodie 1995, 403). As the debate progressed, peoples' underlying idea of what they wanted from health reform did not change, but their perception of the Clinton plan altered radically, quickly skewing in a negative direction. There was strong support for the Clinton plan in 1993 when he first announced the specifics of the Health Security Act, but in two months, support tanked for the plan itself while opinion remained the same on support for "cost

containment and universal coverage" (Rockman 1995, 401). By the time deterioration of public support for the Clinton plan reached its height in mid-1994, a majority of Americans believed the Clinton plan was either actively "unfair" to them personally, or would hurt them (Jacobs and Shapiro 1995, 420; Blendon and Brodie 1995, 406).

Congress

Brady and Buckley (1995) argue that the Clinton plan failed because it was not ideologically centrist enough to appeal to median voters in the House and Senate (448). Though Clinton is criticized for not reaching out adequately to Republicans during the health reform debate, he faced an extremely partisan environment in the U.S. Congress (Hacker 2001, 71). A few Republicans wanted to compromise and achieve some kind of health care reform in 1993, but a majority of others were concerned that any health reform passed in the 103rd Congress would give the Clinton Administration too much political credit and hurt the Republicans in the 1994 midterm elections (Broder and Johnson 1997, 37). Newt Gingrich, one of the architects of the Republican takeover of Congress in 1994, worried that the Left was going to overtake the issue of health reform and "socialize" health care, a concern he held as early as 1991 (Broder and Johnson 1997, 39-40). During the 103rd Congress, Gingrich worked to maintain a tight coalition of Republicans who would deny support to the Clinton health plan (Broder and Johnson 1997, 40). Senate Republican floor leader Bob Dole announced a willingness to negotiate with the Clinton administration on health care early on, but by the time the Clinton plan had been released to the public, almost all Republicans were opposed to the plan (Rockman 1995, 400).

Even for members of Congress who were open to the possibility of endorsing Clinton's

plan, there was a perception that the political risk associated with supporting Clinton's plan was getting too high (Blendon and Brodie 1995, 408). As public opinion shifted away from supporting the Clinton plan and towards fear that the Clinton plan would force them to pay more, receive poorer quality care, and restrict their choice of physician, members of Congress perceived that "delaying decision making and action on health care was acceptable to an increasing portion of the public" (Blendon and Brodie 1995, 408). While public opinion was not the only factor contributing to Congressional gridlock and the perception that health care was not necessary for re-election in 1994, it was a very significant factor (Blendon and Brodie 1995, 409). Jacobs and Shapiro (1995) suggest that public opinion did not cause congressional gridlock in 1994, arguing that policy makers will take positions based on their personal beliefs regardless of public opinion polls, and then use polls to justify their positions (Jacobs and Shapiro 1995, 418). According to this argument, the Clinton reforms were doomed on two separate but related fronts: Republican ideological opposition to the Clinton plan and public fears of large bureaucratic government.

The Executive Branch

Many scholars blame the Clinton administration for the failure of reforms, arguing that they made key strategic mistakes that alienated the very people they should have been working with to achieve compromise (Blendon et al 1995, Morone 1995, Brady and Buckley 1995). Martin (1995) writes that the Clinton administration was very loyalist, not good at building necessary broad coalitions. Moderates in Congress were further alienated by what was perceived as a refusal to negotiate on the part of the Clinton Administration. During his State of the Union

Address in January 1994, Clinton wielded his first veto threat, warning, “if you send me legislation that does not guarantee every American private health insurance that can never be taken away, you will force me to take this pen ...veto the legislation and we’ll come back here and start all over again” (Alliance for Health Reform 2008). Republicans and Democrats who were uncertain about Clinton's plan were alarmed by this statement, interpreting it as an indication that Clinton would be unwilling to compromise on legislation (Alliance for Health Reform 2008).

Another strategic mistake on the part of the Clinton administration was the perceived “secrecy” of the President's Task Force on Health Care. Broder and Johnson (1997) argue that his choices regarding the task force may have been his “biggest mistake of all” (112). The secrecy policy was originally imposed so as not to draw public attention from the debate over the budget, but turned out to be a huge strategic mistake (Broder and Johnson 1997, 140). The “secret task force operating for months behind closed doors, unwilling to meet publicly with physician groups and lacking any visible private-sector leaders” served to fuel public fears about big government (Blendon et al. 1995, 15). The public was exposed to small amounts of task force data that were leaked to the media, and called for alarming things such as hundreds of billions of dollars in new taxes (Broder and Johnson 1997, 141). Entirely excluded from the process of policy planning, the media was already struggling to convert what little information they had about the complex Clinton policy into something fit for mass public consumption, and instead ended up focusing on who was “winning” the policy debate in Washington (Peterson 1995, Broder and Johnson 1997). Additionally, the task force was sued by a group of conservative physicians for “violating federal open meeting laws” because Hillary Clinton was not a

government employee and, though she continued in her role as a health policy entrepreneur, Mrs. Clinton was barred from future task force meetings (Broder and Johnson 1997, 111-112).

Health Industry Stakeholders

In the United States, the health care debate has stretched over a majority of the past century, and even when the public and government officials are ignoring health care, there have consistently been a number of organized interests concerned with the health care over the years. According to Kingdon, interest groups, such as the ones fighting health reform in 1993 and 1994, are frequently successful at blocking legislation. Interest groups play an important role in setting the government agenda, but because they do not exercise formal decision-making power in the government, they often play a larger role in blocking rather than promoting legislation (Kingdon 2003, 48-49). Quadagno (2005) argues that stakeholders in the health care industry have been so successful in continually frustrating reforms that large health reform programs such as Medicare and Medicaid were only able to pass because they cover the poor and the elderly, populations that private insurers find too expensive to cover (6).

Long before other groups were interested in health care, organized labor was promoting the idea of nationalized health care (Kingdon 2003, 48). In 1993, the labor lobby was distracted from their task of fighting on Clinton's side of the health care debate because of concern over NAFTA (Quadagno 2004, 37). Historically, physicians have opposed organized labor's stance on health reform, and have been the most adamant opponents to health care reform since the New Deal era. However, in the Clinton era health care reform debate, the two most important organized interests were the health insurance industry and small businesses, represented by the

Health Insurance Association of American (HIAA) and the National Federation of Independent Businesses (NFIB). In comparison to previous years, the medical lobby played a fairly minimal role in 1993 and 1994. Langbert and Murphy (1995) and Quadagno (2004) argue that the far less influential role played by the medical lobby, particularly the AMA, occurred because physicians have undermined their own authority in the political debate over health care by throwing their support behind the now juggernaut insurance industry prior to the 1990s (642-643; 29-30).

The Clinton Administration and the HIAA were unable to come to any sort of compromise on policy, and for the most part, Mrs. Clinton continued to denounce the practices of the health insurance industry (Broder and Johnson 1997, 202-203). The HIAA decided to fight against the Clinton plan. The same group of "insurers, corporations, and small-business groups" that had mobilized in the 1980s to fight health reform again surfaced when Bill Clinton first proposed a universal coverage plan (Quadagno 2005, 11). To do so, this "coalition funded a public relations campaign against the Clinton plan, hired lobbying firms, and stepped up their campaign contributions, with the largest contributions going to members of committees that had jurisdiction over health care reform" (Quadagno 2005, 11). The most famous ads to come out of this campaign were the "Harry and Louise ads," in which a middle class couple sits at their kitchen table and laments that the government has taken away all their health care choices with bureaucracy, and that they are paying more now than they were before[5] (youtube.com). These ads ran from October of 1993, only a month after Clinton had announced his plan, to the summer of 1994 (Corrigan 2000, 152).

Another reason for the failure of the Clinton reforms frequently cited by scholars is the

5 http://www.youtube.com/watch?v=Dt31nhleeCg

deterioration of public support for the Clinton plan, driven by underlying fears of big government that were exploited by organized interests (Hackey 1993, Blendon et al. 1995, Rockman 1995, Morone 1995, Peterson 1995. Barer 1995). Corrigan (2000) argues that by 'going public,' and leaving critical support for his policy plan in the hands of public opinion, opponents of Clinton's plan were able to undermine him and sway the public to a state of uncertainty and hostility towards government bureaucracy with issue advertising (151-152). Blendon et al. (1995) suggest that early support for the Clinton reforms was high because many Americans felt that the state of health care coverage in America constituted a legitimate crisis, but support for reform quickly eroded in the face of concern over self-interest and a distrust of big government (12).

The HIAA ad campaign had a profound impact on the American public. Langbert and Murphy (1995) argue that there are two major themes in health care reform that stretch back over almost a hundred years of attempted reform and failure: “the ability of vested interests to frustrate reform proposals” and “their use of direct ideological appeals in doing so” (640). Ads such as Harry and Louise are a perfect example of this phenomenon. Though the ads sponsored by the HIAA were later declared to be “unfair, misleading or false,” they were still highly effective at playing up public fears (Peterson 1995, 428). The HIAA ads were able to understand public attitudes and “zero in, like a laser-guided smart bomb, on the fears of ordinary people” (Jacobs and Shapiro 1995, 418). Elites opposed to reform used ad campaigns and rhetoric to convince Americans that the Clinton plan “jeopardized health insurance for those currently possessing it, brought dangerous government intrusion into a sphere of citizens' lives in which it had no business, limited the freedom of individuals to choose the providers of their health care,

and would result in ever escalating taxes" (Koch 1998, 214). "Americans' preferences on national health insurance changed substantially, first becoming more supportive of an expanded role for government in 1992 and then reversing field in 1994, endorsing a smaller government role" (Koch 1998, 228).

In 1993 and 1994, trust in government reached nearly 40 year low, with the number of Americans claiming to trust the government "always" or "most of the time" at about 20 percent (Skocpol 1996, 109). Despite significant government achievements in civil rights, technology, environmental regulation, and public health improvements over the past decade, the public had a very negative perception of government that was sustained by media coverage highlighting scandals and corruption (Broder and Johnson 1997, 206-207). In the 1992 election, Clinton ran on a platform of distancing himself from government and denouncing the "brain-dead politics of Washington" (Broder and Johnson 1997, 206). Barer (1995) argues that in comprehensive health care reform, some will need to lose something so that the entire system can become manageable. Though this was not extensively talked about openly by the Clinton administration, it served as a very effective theoretical foundation for interest groups to utilize in undermining reform (Barer 1995). Republicans in Congress also utilized these public attitudes to object to the Clinton plan, ultimately winning both the battle over "imagery and symbols" and the "battle over legislative tactics" (Rockman 1995, 400).

Business and Corporate Interests

Big business developed an interest in the rising costs of health care during the 1980s, at a time when health care reform received very little government attention. American corporations

were losing profits because of rapidly inflating health care costs, and knew that the United States was going to have to reform its health care system if they were going to remain competitive in the global marketplace (Martin 1995, 431). The Health Insurance Association of America and the National Federation of Independent Businesses first joined forces to frustrate health reform in the 1980s. The HIAA feared that the proposed plan, which would create home care benefits for the disabled, would threaten the "fledgling long-term care insurance market," and the small business owners in the NFIB worried that the plan would require a tax increase (Quadagno 2005, 11).

The Health Insurance Association of America expressed initial interest in supporting the Clinton plan, but asserted that there were several policy points they could not accept (Broder and Johnson 1997, 201). The HIAA was unhappy with any idea that they believed would lead to government bureaucracies dictating prices to them, one of which was "premium caps," which established spending ceilings, and the other was "community rating," which called for a flat rate for all insured people (Broder and Johnson 1997, 201-202). Lambert and Murphy (1995) write that "small business lobbies feared additional cost shifting due to employer mandates. Also, small health insurance companies resisted managed competition" (646). As Kingdon (2003) states, "interest groups often seek to preserve prerogatives and benefits they are currently enjoying, blocking initiatives they believe would reduce those benefits" (49). The health industry was concerned about the effect that the Clinton reforms would have on their business.

Business lobby opposition is another frequently cited reason for the failure of health care reform (Martin 1995, Langbert and Murphy 1995, Blankenau 2001, Swenson and Greer 1995, Quadangno 2004). Swenson and Greer (2002) argue that some big business leaders initially supported the Clinton plan when it was announced, hoping it would more equitably distribute the

burden of health care costs. However, this support disintegrated when the rate of health premiums dropped between 1993 and 1994, as big business leaders assumed it was proof that the insurance industry was slowly moving towards cost containing reforms under its own steam (Langbert and Murphy 1995, 640; Swenson and Greer 2002, 605; Blendon and Brodie 1995, 407). Between 1991 and 1994, the "rate of increase in private employer health insurance premiums decreased" from 11.5 percent to about 4.8 percent (Blendon and Brodie 1995, 407). Martin (1995) argues that though big corporations wanted to cut health care costs to remain internationally competitive, many business leaders were hesitant to relinquish power to a liberal government and endorse the Clinton plan (432). Any willingness to cooperate with Clinton was further undercut by hostile factions, such as the insurance and pharmaceutical industries, within the business lobby and the fact that though Clinton tried to create a plan that would appeal to big business, they were excluded from the actual policy planning (Martin 1995, 432-433). Those business leaders who did endorse the Clinton plan were met with discouragement, and in some cases, outrage, from Congressional Republicans (Martin 1995, 434-435).

Conclusion: The Defenestration of Health Reform

Kingdon (2003) writes that policy windows open either because of changes in the politics or problem stream (168). The issue of health care reform in the early 1990s saw several events that could incite the opening of a policy window. These factors made up the necessary conditions for reform, but were not sufficient to guarantee the successful passage of health reform. The national mood shifted towards health care because of rising economic uncertainty, the election of Harris Wofford provided a focusing event for this change in public attitude, and the election of

Clinton—and the subsequent turnover in Presidential administration, are adequate conditions for the opening of a policy window. However, the policy window is not immediately indicative of a solution to the problem, “none of these...specifies in detail what is to be done...all of them set general themes that need to be filled out with specific proposals” (Kingdon 2003, 168). In 1993, Americans had achieved consensus about the need for health care reform, but had failed to agree on what kind of reform was necessary (Ruger 2007, 68). Baumgarter and Talbert (1995) state that there was a mistaken idea that massive public pressure would force Congressional compromise, but in truth Congressional decisions can only be made when “particular solutions are attached to that problem” (443).

Officially, health reform was “declared dead” by Senate Majority Leader George Mitchell in late September of 1994 (Broder and Johnson 1997, 528). A couple weeks later, the Senate adjourned without making any significant movement on health care, and a little over a month later, Republicans swept the midterm elections. Newt Gingrich's “Contract with America,” a sort of policy platform for Republicans during the midterm elections completely excluded the issue of health care (Skocpol 1996, 6). The window of opportunity for reform can close for several reasons; policymakers feel that they have adequately dealt with the problem, they get discouraged because of the lack of action, the events that prompted the window to open pass from the scene, or there is an overturn in personnel (Kingdon 2003, 169). In 1994, the Republicans overturned the Democratic majority, Clinton's “honeymoon” period in office ended with other issues having edged health care off the agenda for nine months, business interests felt that they were going to solve the problem of heath care costs with the market, and the public pressure that had forced attention to the health care issue in the first place had been warped into a

state of fear over self-interest.

There were many different places in the three streams in which health care fell short. The problem stream was mostly a driving force behind health care reform—costs were rising, quality and coverage were falling, and many Americans were concerned over their own health care. The policy stream suffered from a lack of consensus in both Congress and the expert community, with no clear policy plan emerging as a victor. No plan was able to successfully couple with the problem of health care as it was perceived in the 1993 and 1994. This included the Clinton plan, as Hillary Clinton was unable to be an effective policy entrepreneur for a proposal that was still very new and took too long to be formulated and released after the policy window had been opened. The politics stream saw issues with the designing of the Clinton plan, self-interest and fear of big government entrenched in the national mood, partisan conflict, and organized interest opposition to the Clinton plan in an increasingly fragmented federal system. Organized interests were able to exploit underlying attitudes in the national mood to turn the public against the Clinton plan, while congressional Republicans were able to ride these public attitudes to re-election and the demise of comprehensive health reform for the next 15 years.

Scholars give many reasons for the failure of health reform in the early 1990s. To choose just one particular factor as the death knell for reform efforts is difficult, and ultimately probably a mistake. The events in the problem, policy, and politics stream for health care in the early nineties were all intensely complex. Looking at the Clinton reform efforts through the lens of the multiple streams model is a good strategy for analyzing and understanding health reform in the Clinton era, but to assert that any model could paint a precise picture of the implications of everything that occurred between 1991 and 1994 in the health care issue is probably

overreaching.

The Problem Stream

Hackey correctly predicted doom for the Clinton reform efforts in 1993, insightfully pointing to many of the factors that other scholars agreed doomed reform efforts even before the efforts had failed, citing "ideological fissures in Congress, an overabundance of reform proposals, intense conflicts over what a new health care system should look like, and wavering support from the mass public" (Hackey 1993, 233). He argues that the mere presence of these factors is enough to potentially cripple reform efforts, and uses his article to show these factors are present. He stated that those who did believe reform was inevitable cited factors such as increased public and governmental attention to health care, public frustration with the health care system, the perception that the health care system is in "crisis," constant media portrayals of "scary numbers," and a growing interest group consensus about reform (235-239).

We have just as many "scary numbers" today. The health care in the United States is facing many of the same problems that it faced in the early 1990s. The main difference is many of the problems with health care cost and coverage have grown worse. With some variation, the number of uninsured people in the United States has increased continually since 1994, with the U.S. Census Bureau estimating that about 45.7 million people were uninsured in 2007 (DeNavas-Walt et al. 2008, 19). Though the number of uninsured was down slightly in 2007 from the 2006 level of 47 million, this drop has been attributed to increased enrollment in government sponsored health programs (19). Underinsurance is also a perpetual problem—in the absence of reform of the U.S. health care system, coverage tends to be unstable. Families USA estimates

that 86.7 million, or approximately one-third, of all Americans under the age of 65 went without health insurance for some extent of time between 2007 to 2008 (Bailey 2009, 2). Of those, "nearly three-quarters (74.5 percent) were uninsured for six months or more," many of whom were from working class families (Bailey 2009, 2). On average, the percent of workers who do not have health insurance has risen from 16.1 percent in 1994 to 18.4 percent in 2007 (Robert Wood Johnson Foundation 2009, 5).

The cost of health care continues to rise for both employers and employees. The average family now pays about 76.4 percent more for employer-sponsored health insurance than in 1994, while their average income level has risen only 9.5 percent (Robert Wood Johnson Foundation 2009, 9-10). The employer contribution to sponsored health insurance have also risen dramatically, by almost 80 percent since 1994 (Robert Wood Johnson Foundation 2009, 9). The problem is expected to get worse. The Center for Medicare and Medicaid Services "projects that by 2016 (nine years from now) health care spending will be over $4.1 trillion, or $12,782 per resident, and account for 19.6% of GDP" (Kaiser Family Foundation 2007). Currently, health care consumes about 15 percent of the U.S. GDP, far more than that of other industrialized nations (New America Foundation 2008, 11).

Though the health care problem is in many ways worse than in the early nineties, this does not mean health reform is inevitable. In the Kingdon model, these numbers are merely indicators of the health care crisis, and indicators are not always enough to force government attention to an issue. Though the problem of health care is growing worse, health care in general is not prone to highly visible events. In the absence of a somewhat anomalous focusing event like the Wofford election, attention to the health care problem would rely on the "aggregation of

disasters," where the continual deaths caused by the lack of health care coverage become so great in number, "it can be called a crisis" (Kingdon 2003, 100). Over the past several years, health care has been increasingly in the national spotlight, with a significant increase in media attention since 2007[6]. This most likely accounts for the sustained interest in health care in the 2008 presidential election.

Though there may be some theoretical tipping point at which the health care problems of cost and coverage become so extreme that reform becomes absolutely necessary, there is no indication that the incremental increases in cost and the deterioration of coverage have placed us any closer to that point in 2009 than we were in 1993. The Clinton reform failure demonstrates that worsening factors in the problem stream can push health reform onto the agenda and even cement its place there for a time, but are not enough to force legislative action or policy consensus. As Blendon and Brodie (1995) argue, public concern is not enough to force legislative action if there is no policy consensus (408). Therefore, growing indication of the problem of health care in the U.S. is merely a necessary condition for reform, but as seen in the Clinton era, it is not sufficient to guarantee comprehensive—or any—kind of reform.

Issue Framing

The rise in agenda prominence of health care can be attributed to events in the problem stream, but this does not account for how the problem was framed. This is an area where the streams, especially the problem and the politics stream, can join together. Issue framing played a huge role in the 1993-1994 failure of health care reform. The economic downturn in the early nineties and the rise of unemployment created a certain perception of health care in the American

6 See Appendix A: Table 2.

people: it was an economic problem, and issue of cost, and an issue that concerned them in a mostly self-interested fashion. Republicans and organized interests were able to exploit both the way that the health care problem was perceived by the public and underlying fears that the public had about the government. If the Clinton administration had a better understanding of the way the health care crisis had been framed by the public—namely, that it was an issue of self-interest and economic security rather than an altruistic desire to cover everyone, they might have had better luck fighting off entrenched interests[7]. In the conclusion to their piece about public support for the Clinton plan, Blendon, Brodie, and Benson (1995) assert that if policymakers intend to push through comprehensive legislation during a "window of opportunity" in the future, they must aim for legislation that has a moderate reach and account for middle class fears and cynicism toward government (21).

In 1993, the health care crisis was driven by the economy—the economic crisis meant that people were losing jobs and losing coverage. Those fears drove health care to public prominence through the Wofford election, and kept it going through 1993 and 1994. Rather than framing health care as a part of the economic crisis, Clinton framed health care as a part of New Deal era style security—something everyone deserves. He did not link it to the economic crisis, rather, he endured a lengthy battle with Congress over the economy and the federal budget deficit many months before he was able to present a health care plan and start advocating it. Clinton chose to move on the federal budget deficit first, he did not link them together as one whole issue. Nor did the public; in 1992 and 1993, they did "not view rising health care costs as a growing threat to the government or the economy" (Hackey 1993, 243).

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7 However, this is not to say that the Clinton administration was completely ignorant—when they first introduced the HSA, Clinton pushed the idea that health care coverage was supposed to be universal, for all hardworking people, and did not mention poor or vulnerable populations (Skocpol 1996).

Today, the state of the economy is even worse than in the early nineties. The unemployment rate in 1992 was 7.5 percent (Oberlander 2007, 1678). Today, the unemployment rate is 8.1 percent (Bureau of Labor Statistics, 2009). Health care costs consume a significant part of the United States' economy, and hurt the United States' ability to stay competitive with foreign businesses. Instead of trying to solve the economic crisis "first" or address it independently, the Obama administration is framing them as part of the same problem, something which Clinton failed to do. Stone (1989) states that issues do not have inherent properties, they have narratives or "causal stories" created and imposed on them by political actors. At the White House Summit, Obama argued that the "exploding costs of health care" are a "danger to the foundation of our economy" and the economic crisis means that "the same soaring costs that are straining families budgets are sinking our businesses and eating up our government's budget too." In this way, Obama is creating a narrative where health care is a part of solving the severe economic recession facing the United States. A majority of Americans seem to endorse this framing of the health care issue—since October of 2008 to February of 2009, between 61 and 62 percent professed to believe that the economic crisis makes it "more important than ever to take on health care reform now" (Kaiser Poll, 2009). Obama is also linking health care reform with Medicaid and Medicare, stating that these programs "cannot be fixed without addressing larger underlying problems with growing health care costs."

In linking health care and the economy, Obama has created an excellent strategy for encouraging health reform, but he has also created a very thin line to walk on. Obama is asking people to think of health care as a fiscal and economic problem, which is not a huge leap—approximately 81 percent of Americans are already "very" or "somewhat" worried that their

income levels will not keep up with rising health care prices (Kaiser Poll, 2009). However, he is also making overt references to the moral issues associated with health reform, such as making sure all Americans are covered, without significantly engaging people in a dialogue about the morality of health reform. All conversation is predominantly directed toward fiscal concerns. Though Obama has argued that health care reform is both a moral and fiscal imperative, getting a majority of people to restructure the moral framework through which they think about health care is a monumental task. Ruger (2007) argues that "though Americans have expressed concern for others and have indicated general support for a right to health care, they have yet to clarify and internalize the underlying values that relate to health reform and the health system" (80). Ruger (2007) warns that "to truly address the nation's public health problems would likely require norms and values to be restructured, as has happened during other social movements, such as the civil rights movement" (80). Quadagno (2005) writes "until we view health care as a social right, not a consumer product, we will never receive the health care coverage we need" (6).

Spillover

While linking health care and the economy is not "coupling" in the traditional sense, it does provide the opportunity for spillover. Spillover is the potential for one policy window to cause another similar window to open, in response to a new precedent set by legislation from the first window (Kingdon 2003, 190-191). Spillover can also occur between "adjacent" issue areas; this occurs when "politicians find there is a reward for riding the same horse that brought benefit before" (Kingdon 2003, 192-195). In this case, the issues are health care and the economy.

During the 2008 Presidential election, the economy started to go into a recession, and that recession only got worse as the months progressed. A significant part of Obama's eventual electoral victory came from the economy; Obama, like many Democrats, was perceived to be more capable of handling the economic crisis than his Republican challenger John McCain, and a majority of voters in 2008 listed the economy as their top concern when voting (Agiesta and Cohen 2008). The Democratic majority, Obama included, was carried into office in large part because of the assumption that they were going to act on the economic crisis. Congress has already taken initial action to fix the economy, through the American Recovery and Reinvestment Act of 2009, also known as the economic "stimulus" bill. Significantly, the stimulus package actually did contain early steps toward health system reform, investing about 1.1 billion dollars in comparative effectiveness research and the health information technology such as electronic medical record keeping (Pear 2/15/2009). Though there is debate over whether or not this bill is going to be effective, and many Republicans are questioning if it is a wise use of tax dollars, what is most important is the fact that it shows the government is taking action on the economic crisis. In this time of economic recession, policymakers may want to keep that momentum going—if health care can be adequately framed as an aspect of economic recovery—spillover from the economy into health care may occur.

The Policy Stream

Because the worsening of the health care problem is not going to significantly increase the likelihood that reform will be successful, it is important to look at developments in the other two streams since the early nineties. Considering that the lack of policy consensus was a problem

for health reform in the Clinton, a less divided policy community would facilitate reform in the current day.

Policy Consensus

When asked about consensus in the health care policy community, some experts agreed that there were certain issues upon which most people agreed, and certain issues that were still hotly contested. Of course, which issues had been agreed upon were also, ironically, a source of disagreement. The most definite area of consensus was the idea that the increasing health care costs should be brought under control, and reforming the health care system is an important policy goal. Len Nichols, of the New America Foundation, asserted that there was a growing consensus on the need for insurance market reform, but a debate over creating a public, government sponsored health plan (Personal Interview, 3/23/09). Dr. John Rother, of the AARP, warned that there was conflict over how health care reform should be financed, saying that approximately 1.5 trillion dollars would be needed over a 10 year period, and Obama has only come up with 634 billion dollars so far (Personal Interview, 3/12/09).

Dr. Judy Feder, one of the architects of the original Clinton health plan, argued that consensus in the policy community was an "overstatement"; though experts focus on policy, most of their divisions are driven by facts, ideologies, and values (Personal Interview, 3/17/09). Joe Antos, of the American Enterprise Institute, stated that there was more consensus among Democrats than Republicans about the proper way to go about health reform, though Democrats still disagreed on policy specifics (Personal Interview, 3/17/09). Dr. Johnathan Oberlander expressed a similar point, saying that Democrats are leaning towards the type of plan expressed by Obama in his Presidential campaign, while conservative analysts disagree (Personal

Correspondence, 3/02/09). Nichols asserted that Republicans have yet to choose a strategy for the upcoming health care debate (Personal Interview, 3/23/09).

Generally, health care experts disagreed on whether or not there is an increased consensus in the health policy community. The idea that the policy community has grown any more streamlined in the past 15 years seems unlikely, though it does not seem to have grown significantly more fractured either. At the time of the Clinton era reform debate, the idea of managed competition was still relatively new, but this point in time, the same general ideas have been circulating in the policy "primeval soup" for awhile now. A less divided community would have been a positive facilitator of health care reform, as it would have decreased the number of plans competing to be labeled the "solution" to the health care problem.

Policy Formulation

When evaluating the actions of Clinton's Presidential Task Force on Health Care, Skocpol (1996) highlights two retrospective suggestions offered by critics. Some, like former House Ways and Means Chairman Dan Rostenkowski, argue that Clinton should have "used a small group to outline broad principles for health care reform, and then let Congress work out the details," while others, who tend to prioritize big business support as the key to successful health reform, argue that "the President should have convened a prestigious national commission to hammer out the details of a health reform plan that could have garnered backing from key interest groups, including business, as well as bi-partisan support in Congress" (Skocpol 1996, 51).

The Obama Administration has made steps towards both of these strategies. Though

Obama espoused his own health reform plan during the Presidential campaign, he has since changed his approach significantly, now endorsing eight "principles" that should guide health reform, and leaving specific policy formation up to Congress. The principles advocate protecting families' financial health, making health coverage affordable, aiming for an eventual goal of universal coverage, providing portability of coverage, guaranteeing coverage of preexisting conditions, guaranteeing choice of health plans, physicians, and the option of keeping employer-based health plans, investing in prevention, improving patient safety and quality care, and promoting long-term fiscal sustainability (Politico Staff, 2009). The prioritizing of "protecting families' financial health" seems to be a calculated throwback to the Clinton era; for Americans to support health reform, history shows that they must first believe it is going to help, and not harm them. Additionally, Obama has called for policymakers to "aim" for universal coverage, rather than demanding universal coverage under threat of an executive veto, as Clinton did. This leaves the door open for both comprehensive and incremental reform.

On March 6, 2009, Obama convened the White House Summit on Health Care Reform. The Summit "There are no sacred cows," said the President during the meeting. He urged policymakers to keep an open mind—every policy should be on the table. The White House Summit was attended by, among others, doctors, hospitals, small business interests, health care insurers, public health advocates, policy experts, and members of Congress (healthreform.gov). The set-up of the White House Summit on health care is a complete divergence from the Health Care Task Force of the Clinton era. Rather than closed door meetings that raise the specter of big government, exacerbate partisan tension, and anger vested interests, the forum allows for an open exchange of ideas. The White House Summit did not actually yield any substantive policy

proposals, but it did do the important task of creating a perception of openness and willingness to cooperate on the part of the Administration, something that was missing from the early policy planning stages of the Clinton health reform efforts.

Congress and Policy Entrepreneurs

Many experts believe that the policy solution with the most momentum is going to be the plan that Senator Baucus, Chair of the Finance Committee, and Senator Kennedy, Chair of the HELP Committee, create and endorse together. Baucus has already laid the groundwork for this through releasing a White Paper calling for health care reform. Antos suggested that whether or not the Senate can agree to a plan will be the deciding factor in health care reform this year, and whatever they decide, the House is likely to eventually drift towards supporting (Personal Interview, 3/17/09). Rother has stated that when Baucus and Kennedy come out with a plan, that is "going to be it" in the upcoming health care reform debate (Personal Interview, 3/12/09). Though Baucus' paper is not a specific policy plan, it does provide a loose framework of policy principles that Baucus believes should be incorporated into a successful health policy plan. Baucus calls for the creation of a national Health Insurance Exchange in which people and small businesses can purchase insurance without being denied coverage for pre-existing conditions (Baucus 2008, iv). He says that those who are satisfied with their current insurance plan should be able to keep it, and advocates for the use of comparative effectiveness research and health information technology to improve care delivery and efficiency (Baucus 2008, iv-v).

As Chairman of the Senate Finance Committee, Baucus is in a an excellent position to become a policy entrepreneur for health care. Baucus's willingness to move forward on health

care reform is also a strong contrast to both his own actions in the past and the actions of the Senate Finance Committee Chairmen in 1993, Lloyd Bentsen of Texas, who openly professed that he did not want to move forward with legislation during the Clinton reform attempts (Skocpol 1996, 34-35). In 1993 and 1994, Baucus pledged support to small business owners in his home state of Montana and the NFIB, one of the organizations who lobbied most fiercely against reform (Broder and Johnson 1997, 221).

Obama himself is also a candidate for policy entrepreneurship, but this capacity may have been diminished by the fact that he has abandoned his own plan for health reform and encouraged a broad coalition of interests and ideologies to come up with a new one. However, Obama is a very trusted voice on health care. Polls show that 46 percent of people would trust his recommendations on health care a great deal—more than twice that of any other group, including their own doctors and congressional Democrats, while 26 percent would trust him a fair amount (Kaiser Poll, 2009). If Obama were to endorse a policy plan issued by Baucus and Kennedy together, it is fair to say that would have the most momentum on the upcoming debate. Recently, Baucus and Kennedy announced their intention to come out with compatible health care reform proposals that would be ready for mark-up in June (Reuters 2009).

State Health Reform

Another potential source of health reform solutions comes from policies that have been enacted in individual states, the most famous being Massachusetts. In his analysis of Canadian health reform, Blankenau (2001) argues that spillover was "an important piece of the puzzle" in achieving comprehensive health care reform (48). The fact that numerous Canadian provinces

were able to enact functional, comprehensive health reform created spillover into the national government, and they too came out with a comprehensive health plan (Blankenau 2001, 48).

In the early nineties, no state had attempted to enact comprehensive health reforms, so there were no significant role model states for health policy experts or the general public to view as a general example. Today, however, many states and even some cities have moved forward with their own health insurance reform plans. Massachusetts and Vermont have both enacted comprehensive coverage strategies, and Massachusetts now reports that 97.4 percent of its residents are covered (Napel et al. 2009, 5). Minnesota, Iowa, and New Jersey also passed health reform legislation, implementing initiatives to cut cost, cover more children, encourage preventative care, and improve health delivery (Napel et al. 2009, 5). These examples provide solid evidence for policymakers to point to when considering the best policy options for health care reform. John Rother argues that many experts in the current health policy community believe in the policies of the Massachusetts model, including compulsive coverage, competition among private plans, and offering subsidies to low income people so they can afford to fulfill the individual mandates to purchase insurance (Personal Interview, 3/12/09).

The Politics Stream

Once again, we have a Democratic Presidential administration and Democratic majority in Congress. Compared to Clinton's narrow majority in 1992, Obama practically swept the elections with 53 percent of the popular vote and 365 electoral votes (CNN.com). Many years of health care reform attempts—all the way back to FDR—reveal that Democratic majorities in the U.S. government are not enough to guarantee that comprehensive health care legislation will

pass (Hackey 1993, 237). Still, such majorities do undoubtedly serve as a facilitator of reform for a Democratic President already seeking to put forth health care legislation. Citing the agenda setting models of both Baumgartner and Jones (1999) and Kingdon (2003), Eshbaugh-Soha and Peake (2004) argue that no one has more power than the president to set the agenda (184). Given this, and Obama's proclamation that "health care reform cannot wait, it must not wait, and it will not wait another year" is a fairly clear indicator that there is a policy window open for health care legislation (healthreform.gov).

Fragmented Jurisdiction and Institutions

Many scholars argue that it is in fact the U.S. system of government that has frustrated health care reform for so long (Morone 1995, Rockman 1995, Blendon and Brodie 1995, Martin 1995, Baumgartner and Talbert 1995, Brady and Buckley 1995, Barer 1995, Blankenau 1995). The decentralization of power that is inherent to a federal system of government creates numerous points of access for opponents of reform to step into the system and block legislation. Blankenau (1995) compares health reform in the United States and Canada, using Kingdon's model for analysis, but adding the extra dimension of institutional structure, a factor which many critics feel is overlooked by the multiple streams model (39-40). In Parliamentary systems such as Canada's, a single political party is able to exert more control over the government during its time in power (Blankenau 2001, 39). Blankenau (2001) argues that "a presidential system is generally less responsive to quick, drastic policy changes because of its several veto points...a parliamentary system with a fusion of legislative-executive relations, is more tenable to quick, significant change" (40). Despite the fact that Clinton went into the executive office as a

Democrat and there was a Democratic majority in Congress, Clinton did not have absolute power to enact his agenda. The nature of the U.S. federal system gives the opposing party and organized interests more opportunity to oppose Clinton's policies.[8]

Baumgartner and Talbert (1995) argue that it was the fragmented jurisdiction of health care among an increasing number of both interest groups and congressional committees, coupled with decentralization in the U.S. federal system of government, served to first draw attention to health care then hinder progress on reform (437). The punctuated equilibrium model of agenda setting, an alternative to the multiple streams model, argues that factors that encouraged attention to an agenda issue can subsequently transform to hinder or aid decision-making progress (True et al. 1999). Kingdon (2003) acknowledges the importance of institutions, but cautions scholars against the over or under emphasis of institutions, and encourages the examination of the autonomy of government structure and government actors on a case-by-case basis (229).

In the early nineties, increasing interest in health care left nearly all congressional committees "clamoring for a piece of the pie" (Baumgartner and Talbert 1995, 440-441). By 1990, Congress was holding hundreds of hearings on health care per year—more committees were holding hearings on some aspect of health care than on any other issue (Baumgartner and Talbert 1995, 440-441). The level of fragmented jurisdiction on health care gave opponents of reform many opportunities to "generate opposition to a bill or simply to delay its consideration" (Baumgartner and Talbert 1995, 442). Also, more committees talking about health care meant more opportunities to introduce health policy proposals and more squabbling over floor votes in conference, so that ultimately, "fragmented jurisdiction made it almost impossible to generate

8 Interestingly, Congressional Democrats are currently contemplating the use of a Parliamentary procedural rule, budget reconciliation, to push a health care bill through Congress with 51 votes, bypassing the 60 votes needed to break a filibuster (Barrett and Walsh 2009).

support for a single proposal" (Baumgartner and Talbert 1995, 442). Despite a number of health care reform bills generated by members of Congress from all points on the political spectrum, the combination of interest group pressure and partisan disagreement made it so that no bill, even the more moderate proposals, could get enough votes to pass (Langbert and Murphy 1995, 645).

The spread of the health care issue over congressional committees in the past 13 years has grown more pronounced in the House, but less pronounced in the Senate. For the most part, the committees that were holding the most hearings on health care in between 1980 and 1991 were still holding a majority of the hearings between 1995 and 2008. In the House, the committees on Energy and Commerce, Veterans Affairs, Ways and Means, and Government Oversight held a total of 50.9 percent of the hearings on health care between 1980 and 1991 and 68.3 percent between 1995 and 2008. A notable skew in these numbers comes from the dissolution of the House Select Committee on Aging, which held 23.9 percent of the hearings on health care between 1980 and 1991. In the Senate, the top committees during both time periods were Health, Education, Labor, and Pensions, the Finance Committee, Select Aging, and Veterans Affairs. From 1980 to 1991, these four committees held 79.6 percent of all hearings on health care, and 64.5 percent of all hearings between 1995 and 20098

Between 1980 and 1991, the HELP (at the time, Labor and Human Resources) Committee and the Finance Committee were holding the most hearings on health care in the Senate, but between 1995 and 2008, they were overtaken by the Select Aging Committee and the Veterans Affairs Committee. Part of this may be attributable to the baby boom generation—as the majority of aging people in the United States has risen, the intersection between aging and health has become an increasing concern for Congressmen and their constituents. Additionally, the wars

in Iraq and Afghanistan may have increased concern over health for combat veterans, as America has been engaged in a lengthy battle in the Middle East between 2003 and the present. However, both aging and veterans' health are very specific issues that probably do not have quite as much impact on the idea of comprehensive health reform in general, especially in the context of a health plan that would extend most of the U.S. population. Therefore, despite the fact that health care is spread out over many congressional committees, a majority of the hearings are currently held in the Senate Finance Committee (17.1 percent) and the HELP Committee (15.7 percent). Assuming that the size of the share of hearings on health care indicates interest and influence over the issue of health care, if these two committees issued a health plan together, the plan would definitely carry a great deal of influence. This does not preclude other congressional committees vying for a piece of the pie in health care reform—jurisdiction of health care is still very spread out—but experts believe that policymaking power is going to be more centralized in the HELP and Finance Committees than in the early nineties, and the evidence seems to support that claim.

Opponents of Reform

At the White House Summit on Health Care Reform forum, numerous groups pledged their support to Obama in achieving health care reform, including representatives from American's Health Insurance Plans and the National Federation of Independent Businesses. The White House forum also served to demonstrate the extreme complexity and sheer breadth of the problems and issues facing health care today. Some groups are primarily concerned over quality, others coverage, and still others cost.

Though the Clinton administration was accused of excluding and alienating special interests, no amount of good feeling is likely to make an organized interest group support a plan that it believes will be harmful. Just because an organized interest group pledges support early in the game, does not mean they will stay supportive. In a *New York Times* article from early December of 1992, one group that later proved to play a very significant role in blocking reform—the Health Insurance Association of America—stated their intent to cooperate with Clinton in his reform efforts, as they "previously opposed overhauling the health care system but now say they see major changes as inevitable and want to help shape the results to their liking" (Pear 1992, A1). When Clinton actually released his plan, the HIAA turned against the Clinton administration very quickly and effectively. The lessons of the Clinton era indicate that it is too early to tell how strong the opposition from special interests will be, especially in light of the fact that no policy specifics have been decided. Though the early indications of support for reform are promising, they absolutely do not represent a significant break from the past. In fact, one might argue that they demonstrate the repetition of past patterns.

The National Mood

How the public prioritizes health care is very similar to the early nineties: 71 percent of people think that the current economic crisis should be a top issue for the president, followed by 49 percent, who believe that fixing budget deficits and stabilizing Medicare and Social Security should be the most important, 42 prioritize fighting terror, and 39 percent prioritize health care reform (Kaiser Poll, 2009). People still prioritize cost over coverage in health reform in general, and many are concerned about paying their own health care costs. As of early January, 80 percent

of people believed that "making health care and health insurance more affordable" was "very important," while 69 percent felt the same way about providing health care coverage to "most" Americans (Kaiser/Harvard Poll, 2009). 53 percent of Americans are concerned that their income will not keep up with rising medical prices, and 38 percent are worried that they will not be able to afford necessary medical care (Kaiser Poll, 2009). In a series of health reform dialogues encouraged by the administration, 55 percent of people said that cost was the most pressing issue facing health care (healthreform.gov). Once again, many Americans feel that health care reform can be accomplished without raising taxes or spending money (58 percent) or forcing them to personally change their health plans (56 percent) (Kaiser Poll, 2009).

People are uncertain as to whether or not health care will benefit them personally, and tend to view health reform as something that will contribute to the greater good. 43 percent of Americans believe that health insurance reform would not make a difference for themselves or their family, while 38 percent believe they would be better off if reforms pass (Kaiser Poll, 2009). In contrast, 59 percent of Americans believe the country as a whole would be better off, only 19 percent think health care reforms would not make much of a difference for the country as a whole (Kaiser Poll, 2009). By mid-1994, when public opposition to the Clinton health reform plan had nearly reached its height, almost 63 percent of Americans believed that the Clinton plan would actively hurt them or limit their freedom in some way (Blendon et al. 1995). Currently, only 11 percent of people believe that health reform will harm them (Kaiser Poll, 2009). Still, public fear of the Clinton plan was not immediate, it was cultivated. Support for health reform in the early nineties was high when the Clinton plan was still in its abstract phases, but plummeted when the public was confronted with actual policy options. Given that underlying public

attitudes on health are very similar to 1993 and 1994, the administration has a very real opportunity to capitalize on the lessons of the Clinton era health reform—focus on lowering cost, and keep people engaged in such a way that they feel health reform will help them personally.

Trust in the Government

In their study of federalism and public attitudes, Kincaid and Cole (2008) look at public opinion data on the trust people in the U.S. have for their state, local, and federal government. Kincaid and Cole (2008) found similar overall trends as those reported by Skocpol (1996), but with variations in the way polling questions were phrased and the actual numbers. In 1987, most Americans expressed a high level of trust of all three levels of government, but over the next 20 years, that trust continued to deteriorate (Kincaid and Cole 2008, 477). Levels of trust in state and local governments have stayed far more stable than levels of trust in the federal government, which has continued to decline at a faster rate (Kincaid and Cole 2008, 477-478). The exception to this occurred in 2002, where trust for the federal government suddenly jumped to a 20 year high—68 percent of Americans expressed "a great deal" or "a fair amount" of trust in the government. The authors attribute this phenomenon to public support for President Bush's response to the terrorist attacks on September 11th (Kincaid and Cole 2008, 478).

Kincaid and Cole (2008) assert that trust in the federal government has grown significantly worse in 2007, as the number of people expressing no trust at all in the federal government has gone up to 15 percent, up from only 4 percent in 1987 (477-478). However, this number is not necessarily indicative of a general low in government trust; it could instead indicate a polarization of feelings. In 1992, 13 percent of people expressed no trust in the federal

government, but 41 percent of people expressed “not very much” trust, while in 2007, 15 percent expressed no trust and only 29 percent expressed “not very much” trust (Kincaid and Cole 2008, 477). This means that in 1992, there was a 20 year low in overall distrust in the federal government, with 54 percent of people stating that trusted the government very little or not at all, while in 2007, only 44 percent having little or no trust (Kincaid and Cole 2008, 477). Only 42 percent of people expressed a “great deal” or a “fair amount” of trust in the federal government in 1992, while in 2006 and 2007, 54 percent of people expressed a “great deal” or a “fair amount” of trust (Kincaid and Cole 2008, 477). Those who expressed a great deal of trust in the federal government was 15 percent in 2007, compared to only 4 percent in 1992 (Kincaid and Cole 2008, 477).

Trust in the federal government fluctuated between 1987 and 2007; it declined sharply between 1987 and 1992, increased more steadily between 1992 and 2002, and then once again began to decline between 2002 and 2007 (Kincaid and Cole 2008, 477). Though the level of trust in the federal government is once more in a state of decline, trust seems to be slightly higher than in the early nineties. In fact, this study seems to uphold the idea that the early nineties saw an unusually, almost anomalously low level of trust in the government. However, it was not the low levels of trust in government that defeated the Clinton health care reform attempts, rather it was those who already opposed reform—organized interests and to some extent, Congressional Republicans—who tapped into these underlying attitudes to frame health reform as something the public should fear and group together with anti-government sentiment. Though public trust in the government is still relatively low, it has not grown worse than it was in the early nineties. The potential to continue the historical pattern of organized interests opposing reform by appealing to

public values therefore still exists, but changes in public sentiment have not given opponents of reform an advantage in this regard.

Conclusion

No change in the factors that influenced the Clinton era reform efforts is going to be adequate to force reform through. Turnover in presidential administration and worsening issues with cost and coverage in the problem stream indicate that a policy window for health care reform is probably open once more, but these conditions are not sufficient to force reform. Many conditions have changed very little over the past 15 years. The way that people think about the health care problem is very similar to the early nineties—it is a problem of personal cost to a greater extent than it is of coverage. The policy community does not seem to have come to any sort of broad consensus on what reform should look like, but only that it is necessary. Organized interests have expressed a desire to aid in reform, but have not expressed a commitment to any substantive principles of what reform should constitute. Fragmentation in health care throughout congressional committees is also about the same. One could say that all the necessary conditions for health reform are in place, but not the sufficient conditions for reform.

Some factors have changed, but only incrementally. Trust in the federal government may be slightly less pronounced than between 1992 and 1994, when it seems to have reached an odd 50 year low point. State health reform efforts have illustrated the practical application of policy ideas and thus created examples of reform for the public and policymakers. The issue of health care has been fairly successfully linked to the failing state of the economy. The most visible changes have occurred in the politics stream. Given that the necessary conditions for health care

reform are in place, the sufficient conditions for reform are most likely going to depend on strategic moves on behalf of the Obama administration.

This paper originated as a general look at the potential for comprehensive health reform in the Obama administration (which was purely theoretical at the inception of this paper) based on the lessons of the Clinton era health reforms. The purpose was to theorize whether or not Obama would find the current environment more or less favorable to health reform than the environment Clinton experienced during the early years of his administration. However, since taking office, the Obama administration has not only expressed a strong interest in health care, but has demonstrated an understanding of the lessons of the Clinton era in a series of early strategic moves designed to bolster health care reform. Obama has a greater electoral mandate than Clinton, and though he is facing very similar conditions to Clinton, he is applying a radically different strategy. Among other things, he is showing much greater flexibility. While Clinton focused health policy making power inside the White House and gave the impression of excluding others, today, the White House has pushed power outward, towards Congress. Rather than internal squabbling within Congress against the White House, Congress has been given the power to craft the health policy for the upcoming reform debate. Current institutional momentum has concentrated power in the Senate, in particular, the Finance Committee and the HELP committee, so fragmented jurisdiction of health care, the classic problem for health care reform in a federal system of government, might be less of a problem this time around.

Just because Obama has corrected many of the mistakes of the Clinton administration does not mean he is invulnerable to new mistakes, or the arising of unforeseen problems. The potential for opponents of reform to undermine middle class support for health insurance by

emphasizing self-interest is still very much alive, and public distrust in government is still high, though not at the extreme levels of the early nineties. The idea of helping the economy and bringing down costs could make it possible to enact broad legislation reforming the health care delivery and payment system, but any bill that goes too far in emphasizing the moral dimensions of health care and the need for universal coverage is likely to be met by public distrust and an effective push-back by Republicans and health industry stakeholders. Linking health care to the economy in the framing of the health care problem may stymie comprehensive reform simply because the focus on cost reduction is going to play into the hands of those advocating more incremental reform strategies.

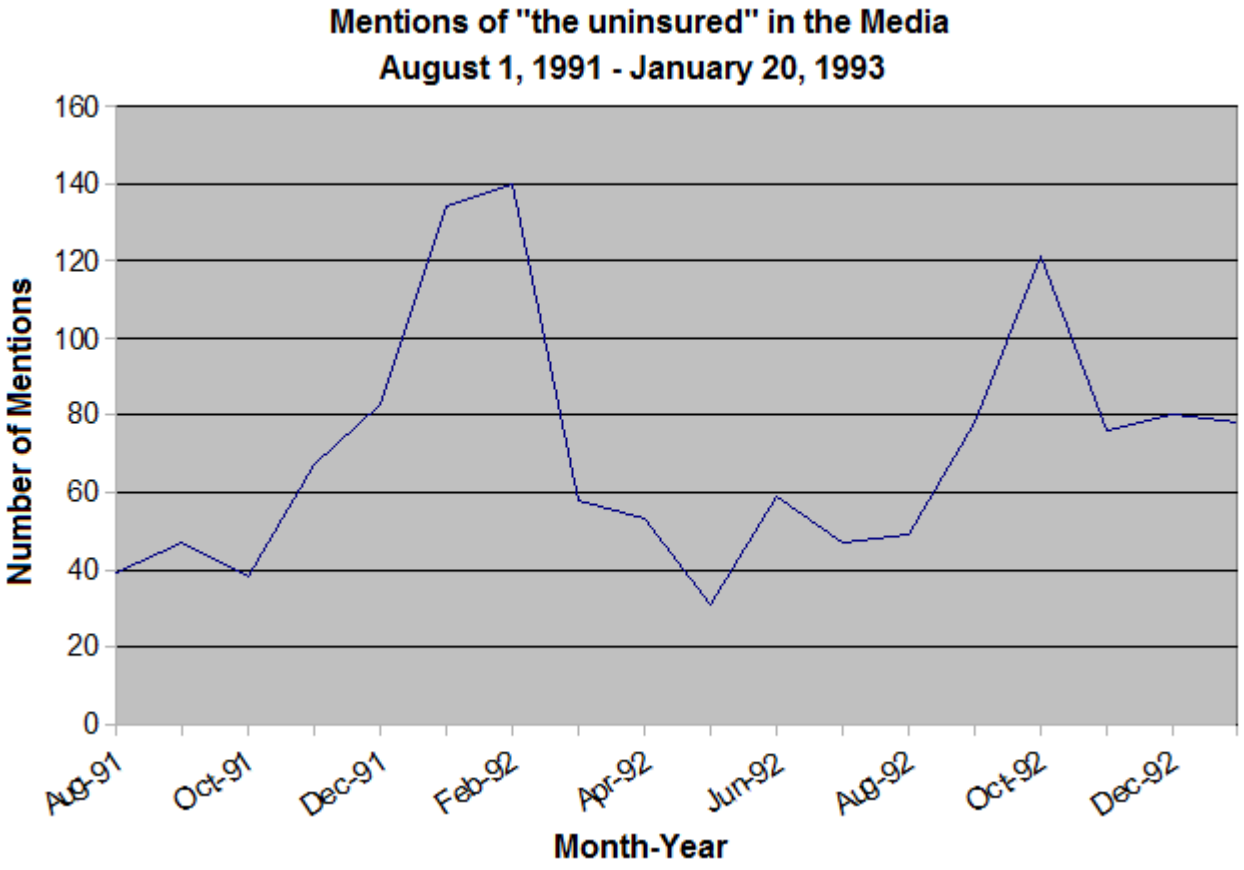
Policymakers supporting health care reform should be wary of the fact that people still perceive health care as an issue of cost and self-interest rather than the common good, fairness, or morality. As Ruger (2007) and Quadagno (2005) argue, Americans have yet to achieve a higher level understanding of the moral principles underlying health care reform. It will probably take a monumental effort to successfully engage the public on this complex issue, but for comprehensive health care reform to have a chance at success, health care must be addressed as an issue of collective good rather than simply of fiscal sustainability.

The multiple streams model allows for the exploration of a diversity of factors within a particular policy area. In this case, Kingdon's model does an excellent job of providing a context for understanding both the failure of the Clinton reform efforts, and the factors that pushed the item forward on the agenda in the first place. Kingdon's model functions by identifying patterns within the three streams it describes, thus making it ideal for spotting the recurrence of patterns over time. In comparing health care reform in the early nineties to health care reform today, the

multiple streams model makes explicit key similarities and differences that health care policymakers and advocates would do well to consider if they intend to break the United States' historical pattern of failed comprehensive health care reform.

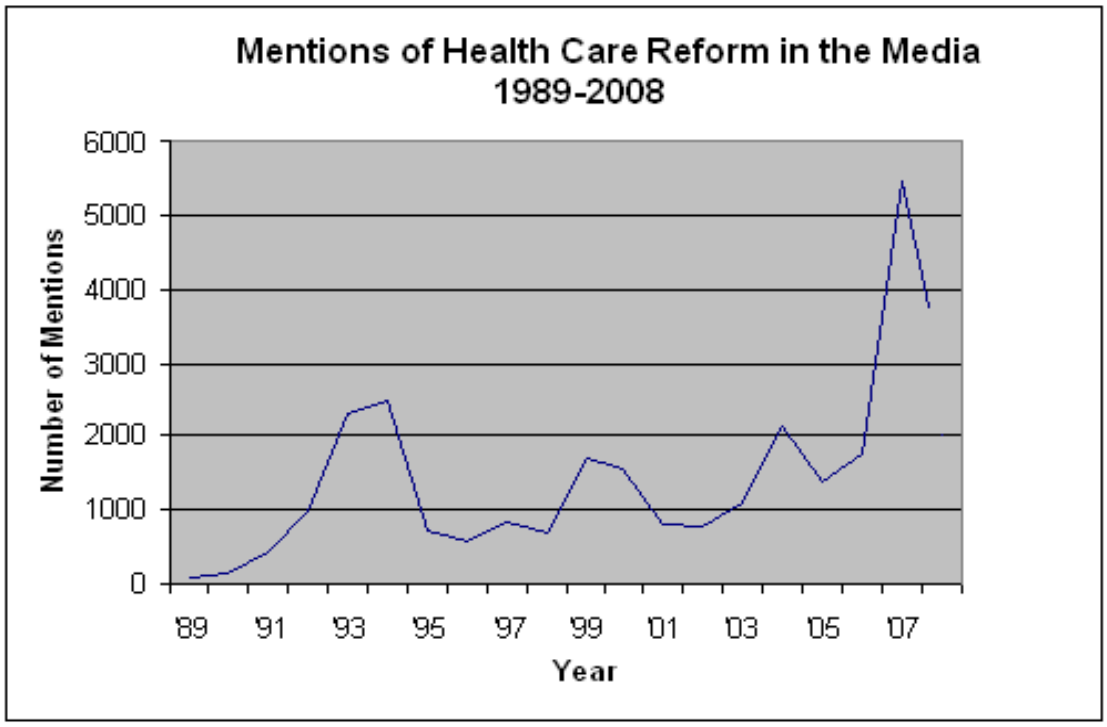
Appendix A

Table 1



From: Lexis Nexus Academic database. Search: "million health insurance uninsured" Accessed April 14, 2009. http://www.lexisnexis.com/

Table 2



From: Lexis Nexus Academic database. Search: "health care reform problem uninsured" Accessed April 16, 2009. http://www.lexisnexis.com/

Table 3

Baumgartner and Talbert

Committee 1980-1991		
House	#	%
Select Aging	239	23.9
Energy and Commerce	207	20.7
Veterans Affairs	132	13.2
Ways and Means	122	12.2
Govt. Operations	48	4.8
Science, Space & Tech.	45	4.6
Appropriations	44	4.2
Small Business	29	2.9
Budget	25	2.6
Armed Services	16	1.6
Education and Labor	14	1.4
Judiciary	14	1.4
District of Columbia	11	1.1
7 Other	52	5.2
Total	998	100
Senate	#	%
Labor and Human Res.	139	26.9
Finance	113	21.9
Select Aging	104	20.2
Veterans Affairs	54	10.6
Appropriations	29	5.6
Govt. Affairs	25	4.9
Judiciary	14	2.7
Budget	8	1.5
Small Business	6	1.1
Agriculture	6	1.1
6 Other	18	3.5
Total	516	100

Hughes

Committee 1995-2008		
House	#	%
Energy and Commerce	165	19.4
Veterans Affairs	174	20.5
Ways and Means	121	14.3
Govt. Oversight	120	14.1
Science and Tech.	6	0.7
Appropriations	90	10.6
Small Business	50	5.9
Budget	15	1.8
Armed Services	23	2.7
Education and Labor	36	4.2
Judiciary	24	2.83
7 Other	26	3.1
Total	849	
Senate	#	%
HELP	86	15.7
Finance	94	17.1
Select Aging	101	18.4
Veterans Affairs	73	13.3
Appropriations	48	8.7
Govt. Affairs	31	5.7
Judiciary	21	3.8
Budget	16	2.9
Small Business	5	0.9
Agriculture	2	0.4
2 Others	5	0.9
Armed Services	18	3.3
Indian Affairs	39	7.1
Total	549	

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