

A Healthcare Reform Postmortem

BY JANE HIEBERT-WHITE

Now that some months have passed since Congress gave up on comprehensive healthcare reform, it may be instructive to look back on it for the lessons we might glean. Not since the demise of the Medicare Catastrophic Care Act has a piece of social policy legislation risen so quickly and fallen so hard. What were the key factors that led to health reform's demise? Is comprehensive social reform even possible in today's political environment?

In this column, I offer insights on these questions from a variety of analysts and healthcare reform players, many of whom participated in a January 23-24, 1995, symposium, "Health Reform: Past and Future," sponsored by the Brookings Institution and *Health Affairs*.

In sorting through what happened last year with healthcare reform, one thing is clear. There is no single factor that led to reform's downfall. Rather, analysts point to a multitude of interconnected factors, which I look at here. I've grouped them under several categories: scope and complexity of the Clinton plan, interest group lobbying, public opinion, cost, and politics.

SCOPE AND COMPLEXITY OF CLINTON PLAN

Many critics blamed the failure of healthcare reform on President Bill Clinton's proposal itself. They cite the plan's complexity and the massive scale of the new bureaucracy it would have created. If only a better plan had been put forward, they say in retrospect.

Scope of Reform Political scientist Hugh Heclo, of George Mason University, Fairfax, VA, observes that the scope of healthcare reform limited its probability of success from the outset. "Successful efforts at big, bold policy reforms are rare in the historical record."¹ Major healthcare reforms have been attempted six times in the past century, and only once did we make a major step forward in covering a significant portion of the population. That was in the mid-1960s, with Medicare and Medicaid.



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On the other hand, major changes have happened and are continuing at full speed in the private-sector arena of healthcare. The growth of managed care and competition among providers has already had a profound effect on healthcare delivery. Thus to say major system changes are not possible does not reflect reality. Perhaps it is government-directed social change that is not possible in today's antigovernment environment.

Complexity A popular criticism of the Clinton plan was its complexity. Yet policy analysts at the Brookings/*Health Affairs* meeting said complexity was inevitable for a reform of this scale. Harvard sociologist Theda Skocpol says: "The plan was intricate and called for daring leaps of innovative organization building."² But she observes that the system the Clinton plan set out to reform is itself already exceedingly complex, with its existing public-private arrangements. Healthcare is something that touches every American and affects one-seventh of the U.S. economy.

Skocpol also points out that the Medicare legislation was complex when it was debated and passed three decades ago. However, she notes that Medicare "had the advantage of being able to build on widespread public understanding of and affection for the well-established Social Security program of contributory retirement insurance. . . . [The Clinton plan] had no relevant analogy to Social Security with regard to how governmental mechanisms in the proposed system would actually work." Thus it wasn't complexity per se, but the inability to calm people's fears about how the complex plan would work, that did in the Clinton reforms.

Heclo agrees that complexity itself was not the issue; understanding was: "Since complexity is inherent in virtually any major social reform, it makes little sense to fault the Clinton plan for its complicated design. However, it does seem fair to say that the president's reform effort did not enjoy the advantage of a single, easily understood objective."

The Clinton administration fluctuated in the messages it sent to the public regarding reform. Sometimes the goal was universal coverage; sometimes it was controlling skyrocketing health costs; at other times it was providing health "security" to middle-class, already insured Americans. Hecla notes: "A good case could be made that these were mutually supportive objectives. . . . However, the fact of life in the public arena was that these overlapping objectives did not translate into an easily understandable call to action." Hecla adds: "Still, since the Carter experience showed that decoupling major cost control from coverage expansion was also no royal road to success, one may not wish to make too much of this point."

In the end, it may well be that the Clinton plan would not have worked in the American system of healthcare and that its ideas needed a more complete road test. Some of the plan's tenets, such as managed competition and health alliances, are now under debate or actual test in several states. Perhaps more experience with these new strategies will make reform in the future more possible. Reformers could then point to definitive examples of how their proposal would work, just as Medicare proponents of the mid-1960s could point to Social Security as its model.

INTEREST GROUP LOBBYING

When one asks the American people why healthcare reform failed, they say interest groups are to blame—or to thank, depending on one's point of view. A September 1994 *New York Times*/CBS poll showed that "respondents pointed most frequently to special interests and lobbyists" as responsible for the reform stalemate.³

The sheer amount of money spent on lobbying healthcare reform is staggering. An estimated \$120 million to \$300 million was spent lobbying against reform, while only \$12 million to \$15 million was spent in favor of the Clinton health plan by the Democratic National Committee.⁴ The National Federation of Independent Business (NFIB) alone devoted \$40 million to killing the employer mandate feature of the Clinton plan.

Large and powerful interest groups—representing business small and large, segments of the healthcare industry, and well-organized consumers such as the elderly—made their voices heard in Washington. But what about the 39 mil-

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lion uninsured? What about the more than 100 million underinsured? Who spoke for the disenfranchised? "Heavy involvement of private interests is a distinguishing characteristic of American democracy, but representative government is supposed to be the arbiter between competing, rival groups, not the patsy of the most powerful," noted *Health Affairs* editor and long-time policy observer John K. Iglehart in an editorial.⁵

Catholic healthcare leaders did vigorously promote universal healthcare coverage with the conviction that the needs of the poor and underserved would best be met in a healthcare system that covered all people in the same way. The Catholic Health Association (CHA) formulated and strongly advocated a major comprehensive reform proposal that brought everyone, including the poor, under the same financing umbrella and in which all people had access to the same basic comprehensive level of healthcare services. But it is much easier to kill proposed legislation—all one needs to do is plant the seeds of uncertainty and fear. This was handily accomplished by NFIB's grassroots mobilization of small businesses and the Health Insurance Association of America's infamous "Harry and Louise" television ads.

To promote change is much more difficult and requires a broad base of public support. Actually, more than simple support is needed—broad social change requires an activist movement at the grassroots level. Such a movement supporting healthcare reform never really materialized, and public support for President Clinton's healthcare reform plan was fickle.

PUBLIC SUPPORT

Both the administration and members of Congress were almost hypersensitive to the whims of public opinion polls on healthcare reform. Early on, polls led reformers to believe that there was a broad base of public support for universal coverage and a major overhaul of the U.S. healthcare system. This support disintegrated remarkably fast, however, as reform opponents handily sowed the seeds of fear and uncertainty. These fears and a lack of understanding played a key role in the public's propensity to change opinion on healthcare reform.

Pollster Daniel Yankelovich does not blame the public for misunderstanding the goals and tenets of healthcare reform, however. He says the problem is the absence of a real debate of the issues

between the public and the nation's leadership class. He places in the leadership category leaders of medicine, religion, industry, education, the legal profession, science, and journalism, as well as national and community leaders. Says Yankelevich:

The nation's elites have little trouble conversing with one another, but when it comes to engaging the public, there is an astonishing lack of dialogue. . . . The plan was the product of experts, and experts alone. Technical experts designed it, special interests argued it, political leaders sold it, journalists more interested in its political ramifications than its contents kibitzed it, advertising attacked it. There was no way for average Americans to understand what it meant for them.⁶

The leadership needs to understand what it is about the healthcare system that worries most Americans—its cost (cited by 73 percent in a 1993 Gallup poll). More important, adds Yankelevich, healthcare leaders need to realize that the public blames the health system for rising costs: In a 1991 *Time/CNN* poll, 83 percent cited hospital costs; also blamed were malpractice suits (75 percent), physician fees (73 percent), fraud and abuse (72 percent), and drug costs (70 percent). "This perspective puts the public on a collision course with the majority of experts. In the experts' view, the two main causes of rising costs are the aging of the population and the explosive costs of new technologies and medical advances," explains Yankelevich.

But even the experts do not agree, says, Princeton economist Uwe E. Reinhardt: "The nation's leadership class was and remains deeply divided over the ethical precepts that should govern the distribution of healthcare."⁷

James J. Mongan, executive director of the Truman Medical Center in Kansas City, MO, adds that the public's ethical values are at odds on healthcare as well. He observes that the current political and social climate "fosters a self-centeredness—a focus more on the individual's needs than on the community's needs."⁸ Some liberals might call it "selfishness," and conservatives might say it's "rugged individualism." "Somewhere in here," concludes Mongan in a conversation, "is where healthcare reform died.

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And I believe until we as a nation make the right diagnosis and begin an honest dialogue about our national values, about the balance between self-interest and community interests, we will not see our nation join almost all others in guaranteeing healthcare coverage to all of its citizens."

This need to foster a dialogue on values between and among the leadership and the electorate is an area where Catholic leaders (both healthcare and religious) and laity can make a major contribution. The CHA began this process with its reform proposal, which was grounded in values, including that public policy must serve the common good, that the needs of the poor have a special priority, and that every person is the subject of human dignity. True public deliberation on healthcare issues, choices, and values must be engaged. For, as Yankelevich says in summing up his view on reform's demise: "Defeats of this sort deepen public cynicism and weaken the fabric of American life. . . . If our society is to continue to function, this kind of failure cannot be repeated too many times."

Cost

Many politicians struggling to sort out the mixed messages of public opinion resorted to the "credible cover" of waiting for cost estimates from the Congressional Budget Office (CBO) to determine their votes on the various healthcare reform bills. The cost of healthcare and its effect on the federal budget became key factors in the downfall of one reform proposal after another.

The reason the cost estimates from CBO came to hold such power in the debate has to do with a set of complicated rules in the Balanced Budget Act of 1985, the Budget Enforcement Act of 1990, and the budget resolutions for fiscal years 1994 and 1995. According to former CBO Director Robert D. Reischauer and deputy assistant director Linda T. Bilheimer: "Those rules placed formidable procedural hurdles in the path of any initiative that would add to the deficit. Ensuring that those constraints were met often shaped policy as much as did considerations of what made programmatic sense or what was workable."⁹

Unfortunately, as cost estimators inside and outside the government agree, the estimates were far from certain, given a host of data problems and time constraints. Differing estimates were put out by CBO, the president's Office of

Management and Budget (OMB), and outside firms such as Lewin-VHI. Former administration estimator Len M. Nichols, who worked for OMB during the reform debate, believes the cost disputes could have been averted. He says, "an opportunity was lost for serious credible analysts to reach a reasonable consensus on the technical feasibility of the administration's goals . . . and losing this opportunity was costly."¹⁰

POLITICS

Finally, politics played a key role in bringing down not only national healthcare reform, but the whole Democratic Party with it. Many Democratic leaders appeared to believe that healthcare reform would be the salvation of the Democratic Party, much as Social Security was back in 1935. Instead, as Theda Skocpol observes, the "decisive defeat of the Clinton plan was a pivotal moment in U.S. politics. . . [that] helped to fuel a massive political upheaval."

A number of moderate Republicans were eager to negotiate with Democrats early in the process when the president's task force was drafting the plan, but came to feel shut out later. By late 1993, after the plan was unveiled, partisan politics became firmly entrenched. And by January 1994 reform was essentially lost, say many observers.

Skocpol notes:

Right-wing Republicans realized that their ideological fortunes within their own party, as well as the Republican partisan interest in weakening the Democrats as a prelude to winning control of Congress and the presidency, could be splendidly served by first demonizing and then totally defeating the Clinton plan. William Kristol of the Project for the Republican Future started to issue a steady stream of strategy memos urging all-out partisan warfare.

On the other side of the partisan issue, some political observers say President Clinton early on received bad advice that led him to believe the votes were there in Congress to pass healthcare reform without bipartisan support. Clearly, the political capital was not there for the president to pull off such a major social reform.

Another blow to bipartisan politics was the indictment of Rep. Dan Rostenkowski, D-IL,

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powerful negotiator and then-chairman of the House Ways and Means Committee. A number in Congress believe that if he had remained on the scene, he could have perhaps brokered an acceptable compromise. Also, the fact that the president's bill had to be navigated through five congressional subcommittees did not help efforts for compromise and consolidation.

Can the hurdle of politics be surmounted? Skocpol believes that "if progressives are actually to achieve universal healthcare coverage in America, it will be because new rationales for the role of government, and new majority political alliances, have been achieved first."

For now, it appears that incremental steps are all that the newly configured Congress is willing to undertake. Next month I will look at some of the proposed incremental reforms circulating around Washington. However, even incremental reforms may fall victim to politics. If the new Congress, now so focused on the Republicans' Contract with America, does not get to healthcare in earnest until fall, the next campaign cycle will soon be upon us. And campaign years, as we have seen, do not lend themselves to bipartisan efforts to improve the lives of Americans. □

NOTES

1. Hugh Heclo, "The Clinton Health Plan: Historical Perspective," *Health Affairs*, Spring 1995.
2. Theda Skocpol, "The Rise and Resounding Demise of the Clinton Plan," *Health Affairs*, Spring 1995.
3. Robin Toner, "Health Impasse Souring Voters, New Poll Finds," *New York Times*, September 13, 1994, p. 1A.
4. Adam Clymer, "Hillary Clinton Says Administration was Misunderstood on Health Care," *New York Times*, October 3, 1994.
5. John K. Iglehart, "Who Spoke for the People?" *Health Affairs*, Fall 1994, pp. 5-6.
6. Daniel Yankelovich, "The Debate that Wasn't: The Public and the Clinton Plan," *Health Affairs*, Spring 1995.
7. Uwe E. Reinhardt, "Turning our Gaze from Bread and Circus Games," *Health Affairs*, Spring 1995.
8. James J. Mongan, "Anatomy and Physiology of Health Reform's Failure," *Health Affairs*, Spring, 1995.
9. Linda T. Bilheimer and Robert D. Reischauer, "Confessions of the Estimators: Numbers and Health Reform," *Health Affairs*, Spring 1995.
10. Len M. Nichols, "Numerical Estimates and the Policy Debate," *Health Affairs*, Spring 1995.