...And the pursuit of national health: the incremental strategy toward national health insurance in the United States of America

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CONCLUSION: THE PROMISE OF INCREMENTALISM

In 1994, speaking at the American Legion Annual Conference, first lady Hillary Rodham Clinton asked a familiar question. “How can we, as the richest country in the world, be the only one of our industrialized competitors who has not figured out how to provide health care to every one of its citizens?”1 In other words, why did America never enact a government health insurance program that could achieve universal coverage? The absence of such a comprehensive national health insurance program on federal level in the United States of America is often perceived as an example of American exceptionalism. All other western welfare states have enacted some form of national health insurance, thus making the United States an exception to the rule. As Martin Seymour Lipset has stated in his study on American exceptionalism, “Alone in the developed world, [the United States of America] has not moved toward comprehensive health care under the sponsorship of the government.”2 Subsequently, scholars have questioned which factors make the American experience exceptional. Answers are found in the American political system, the relatively slow formation of a centralized state, the relatively weak American labor movement, and cultural values such as individualism, self-reliance, and anti-statism. In addition, the long history of opposition to national health insurance by the American Medical Association (AMA) is often pointed out as a decisive factor in the outcome of American health care policy.

The assumption that the United States has not moved toward some form of “comprehensive health care under the sponsorship of the government” cannot be sustained. Even though a universal national health insurance program was never established, meaning a government program that guarantees coverage to all citizens, the federal government has had a strong influence on American health care policy and is, perhaps most important, its largest single sponsor. The American federal government has been influential in the decision to support the extension of medical care over the extension of health insurance coverage. In addition, limited national health insurance programs – Medicare and Medicaid – were established to provide coverage for the elderly and the welfare poor.

The rhetoric of American exceptionalism has played an important, yet not a decisive part in the debate on national health insurance. American health policy cannot be explained by cultural values as individualism and self-reliance alone. Even though the rhetorical content of the national health insurance debate in the United States is without a doubt exceptionally American, that does not mean that the outcome of the debate is exceptionally American as

well. American exceptionalism should be perceived as an influence rather than an explanation of the health insurance system in the United States. Instead of questioning a vacancy, we should study the policy that has been enacted. More important, an American form of national health insurance does exist, even if it does not guarantee universal coverage. The American system is based on private, employer-based health insurance for the working population and government health insurance for non-working groups such as the elderly, the disabled, and the welfare poor. Such a combination of private and government health insurance is not exceptionally American, as other western welfare states have also combined private health insurance with government programs.

In this study, I have examined the incremental development of government health insurance in the United States of America. During two decisive moments in the history of American health care policy, the social security policymakers and the responsible politicians made important decisions that shaped the future of health insurance in the United States. The first moment occurred during the formation of the Social Security Act in 1935. As the Social Security Act is the foundation of the American welfare state on federal level, the exclusion of national health insurance had dire consequences. In addition, a growing consensus supporting the preference for the extension of medical care undermined the movement for a national health insurance program. The second moment occurred around 1951 when the social security policymakers reluctantly agreed to shift the focus from a health insurance program for the working population to a program of hospital insurance for the elderly. Based on the incremental character of the social security program, the policymakers believed that universal coverage would eventually be achieved. These two moments are crucial in the history of national health insurance in the United States, as they introduced and reinforced the patchwork character of the American system of health care.

THE AMERICAN IDEOLOGY AND THE EUROPEAN EXPERIENCE

Compared to other western welfare states, the national health insurance debate in the United States took place on a far more ideological level. As Richard Hofstadter has stated, “It has been our fate as a nation not to have ideologies, but to be one.” In other words, America does not have ideologies, but is an ideology in itself. While other western nations are based on a common history, the American nation is based on Americanism, an -ism in a similar way as socialism is an ideology. In the case of national health insurance, both the

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opponents and the advocates have tried to place their particular objective within this American ideology. Sacvan Bercovitch points out that the presence of such an American ideology also makes America seemingly without any ideology. "Having precluded alternative systems, the American Way became simply the common-sense way to get things done. Socialism was an ideology; Americanism was the way of reason and nature." This enables the contradiction that opponents and advocates of national health insurance both were able to claim that their objective was the true American Way.

Throughout the first three decades of the century, the European experience (the experience in Germany in particular) with national health insurance was perceived as a model to be followed for American health insurance. Subsequently, the social security policymakers focused on targeting the lower-income working population in the industrial areas. The social security policymakers realized and emphasized that America was the exception. "Nearly every large and industrial country of the world except the United States has applied the principle of insurance to the economic risks of health care," reads the Report to the President, published by the Committee on Economic Security in 1935. Even after, in 1951, the focus shifted from national health insurance for the American workers to hospital insurance for the elderly, the exceptional position of the United States continued to be emphasized. As President John F. Kennedy exclaimed at the Medicare rally in Madison Square Garden: "We are behind every country, pretty nearly, in Europe, in this matter of medical care of our citizens." More recently, President Bill Clinton reminded the public that "the United States is the only advanced country in the world without a national health-care plan." The opponents to national health insurance used the European experience to denounce such a program as an un-American menace to the public health. After the Russian Revolution of 1917 and the American involvement in World War I, national health insurance was easily perceived as a tool of totalitarian regimes to control the population. Opponents of national health insurance cited a statement allegedly made by the Russian political leader Lenin: "Compulsory Medicine is the keystone to the arch of Socialism." After the establishment of the British National

7 Lenin probably never made this statement. The archivist of the Library of Congress was not able to locate the quotation in Lenin’s work. See Max J. Skidmore, Medicare and the American Rhetoric of Reconciliation (University, Alabama: University of Alabama Press, 1970), 119.
Health Service in 1948, Great Britain became the most common comparison. Whether or not the European systems were realistically represented did not matter. More important was the perception of the European welfare states in American eyes. The European welfare states and later Canada functioned as “mirror countries” – an image in the negative, an image of what America was not. “When a British Government agency is called upon to defend the British National Health Service it does so not in order to sell the service to other countries; but only to correct misrepresentations deliberately put about,” as the British Information Services in the United States announced in 1962. Although the agency did not want to get involved in the American Medicare debate, it could not let the AMA’s misrepresentation of the British National Health Service be unanswered. “No one quarrels with ... objective studies: but falsehoods and half-truths about ‘NHS’ are sometimes spread abroad by people who are campaigning against any governmental intervention in the medical and hospital services of their own countries.”

While the opponents to national health insurance could easily point at Europe to claim that national health insurance was un-American, the social security policymakers faced a dilemma. On the one hand, they referred to Europe to point out that the United States of America was the exception to the rule and could not continue to stay behind. On the other, to counter the claims of un-Americanism, they needed to show that the American form of national health insurance was uniquely American. The social security policymakers did so by stressing that the social insurance principle was the American solution to economic insecurity. Even though most European systems were also based on social insurance, the argument was effective as it emphasized that the American workers would earn their right to protection, instead of merely receiving handouts. The same could be said for national health insurance. Preparing a speech for President Franklin D. Roosevelt, I.S. Falk wrote the following draft:

Now, our opponents tell us it’s bad for the American people to have socialized medicine. Sure, they say, people need to be insured against medical and hospital costs. But do it through voluntary insurance, not through compulsory insurance. Voluntary insurance, they tell you is the American way; compulsory insurance, they tell you is the socialist way. Old-age survivors insurance is compulsory insurance. Unemployment insurance is compulsory insurance. And both are “Americanism,” and don’t let anybody get away with anything that contradicts it.


9 Draft speech material written by I.S. Falk supposedly written for President Franklin D. Roosevelt, January 1939, Falk Papers, box 45, folder 281, Yale Library.
Conclusion: The Promise of Incrementalism

After the shift of focus from national health insurance for the working population to hospital insurance for the elderly, the social security policymakers emphasized that the shift made the program more American. Although they continued to favor universal coverage, the difference with other western welfare states needed to be stressed. In 1962, social security commissioner Robert Ball told Senator Clinton P. Anderson, one of Medicare’s co-sponsors, that a study of foreign national health insurance systems would be unwise, as it could lead to charges that “we are trying to import foreign health systems.” As Anderson was told by his assistant, “From a political standpoint, [Robert Ball] feels that the best thing to do is continue to say that the Administration seeks to relieve a special problem for a special segment of the population and this bears no resemblance to plans of other countries where comprehensive care for the entire population is generally the rule.”

One cannot conclude, however, that the opponents to national health insurance could more easily use the arguments of Americanism than the advocates could. As Max Skidmore’s analysis of the Medicare debates in Congress shows, an argument could be used both ways. Throughout the public national health insurance debate, the AMA had used the term “socialized medicine” to denounce Medicare as a socialist measure. Interestingly enough, during the debates in Congress, the advocates of Medicare used the term “socialized medicine” more often than the opponents did, in an attempt to show that Medicare was everything but “socialized medicine.” In fact, throughout the national health insurance debate, opponents and advocates have used the same American values of individual freedom and self-reliance to strengthen their argument. While the opponents argued that national health insurance would take the individual freedom away and increase the American worker’s dependency, the advocates argued that national health insurance could guarantee the freedom of the individual and secure independence. In essence, the arguments of the opponents were not more or less “American” than the arguments of the advocates. They shared the emphasis on all-American high-quality personal health care opposed to the assumed low-quality public health care in the rest of the world.

The Extension of Medical Care

One of the most important roles in American health care policy have been played by lay reformers and social security policymakers, a group of intellectuals and professionals who have dominated the American national health insurance debate throughout the century. From the 1915 model bill of


11 Skidmore, Medicare and the American Rhetoric of Reconciliation, Chapter VI, 147-167.
the American Association for Labor Legislation, describing a health insurance program on state level, up to the enactment of Medicare and Medicaid in 1965, a close-knit group of social security experts had been working together to study national health insurance and design policy. These experts believed that the issue of national health insurance was a scientific one. Before the New Deal, the experts had studied national health insurance on state level, paid by private research foundations such as the Rosenwald Fund and the Milbank Memorial Fund. Their efforts were combined in the five-year studies by the Committee on the Costs of Medical Care. Although they made policy suggestions, their work was limited to studying the issue of national health insurance. With the election of President Franklin D. Roosevelt in 1932, the experts came to Washington, DC, and were able to design policy on federal level. When in 1935 the Social Security Board was established, the social security policymakers, including Arthur Altmeyer, I.S. Falk, and Wilbur Cohen, were able to actively promote the extension of the social security system on a seemingly nonpartisan, objective, and scientific basis.

American social policy has been based on incrementalism, which can be defined as a step-by-step strategy of building upon already existing programs. When the Social Security Act was created in 1935, existing social programs on state level were incorporated within the system. Although the policymakers had emphasized the American character of social insurance, the Social Security Act also included programs based on public assistance. The distinction between social insurance and public assistance is important. While social insurance programs provide protection to prevent economic insecurity, public assistance programs provide protection at the time when one is already economic insecure. The early American “maternalist” welfare state (which differed by individual state) was predominantly based on public assistance programs. In principle, public assistance was only given to the “deserving poor,” such as the elderly, widows, and children. The Social Security Act introduced the “paternalist” welfare state in America, providing benefits as a right. In the case of old-age pensions, the social security beneficiaries would earn their right by contributing into the system during their working years. Ideally, as the social security policymakers believed, social insurance would eventually replace public assistance.

The exclusion of national health insurance from the Social Security Act has often been explained as the result of the opposition by the American Medical Association (AMA). Afraid to jeopardize the entire Social Security Act, the Roosevelt administration decided to exclude national health insurance in an attempt to silence the opposition. Although the AMA’s opposition did undermine the position of national health insurance in the studies of the Committee of Economic Security, it can be questioned if the AMA’s role was decisive in President Roosevelt’s decision to exclude national health insurance. From the start, Roosevelt had favored unemployment insurance and old-age pensions, though he supported national health insurance in principle. Not
intimidated by the AMA's pressures, Roosevelt was far more worried about the growing opposition to the New Deal in Congress. Whether or not national health insurance was included, the Social Security Act would be controversial. Moreover, neither business nor the labor movement actively supported national health insurance. There were no pressing reasons for President Roosevelt to go beyond unemployment insurance, old-age pensions, and public assistance programs. In addition, the incremental character of the Social Security Act enabled the inclusion of national health insurance in the future, a possibility that was studied by the Social Security Board.

One of the biggest obstacles for national health insurance in the United States of America was the lack of medical facilities, particularly in the rural areas of the poorer states. Why introduce a system of health insurance when no adequate medical care could be provided? Moreover, similar to the other social security programs, a national health insurance system could more effectively be introduced in industrial rather than agricultural states. National health insurance would aggravate the social inequalities between the Northern and Southern states. Even though the social security policymakers believed that the extension of medical care should complement national health insurance, to many politicians the extension of medical care provided an alternative. This perspective received support from medical specialists working in hospitals and medical schools. While the AMA was unwilling to cooperate with the federal government, the American Hospital Association worked together with the Public Health Service in the extension of medical care. Subsequently, proposals for national health insurance failed in Congress, while federal programs to subsidize medical research and construct hospitals were enacted.

Throughout the 1930s and 1940s, omnibus bills including national health insurance (the Wagner bill of 1939 and the Wagner-Murray-Dingell bills of the 1940s) were introduced in Congress, but they never received the full support of President Roosevelt. In spite of the lack of presidential support, the social security policymakers worked together with the labor movement in the designing of the national health insurance proposals. The exclusion of national health insurance from the Social Security Act had paved the way for private insurance, an industry that greatly expanded during the 1940s and 1950s. Through collective bargaining, the industrial labor unions were able to obtain health insurance benefits for their members, encouraged by the wartime policy of the War Labor Board and the Internal Revenue Service, making employer-based health insurance dominant in American health care. The social security policymakers had envisioned a national health insurance system which was in principle intended to cover the working-class population, but in which the coverage of the elderly, the unemployed, and the poor could easily be included. Under private insurance, however, universal access could not be guaranteed.

Even though the Wagner-Murray-Dingell bills had no chance of getting through Congress, the AMA actively and publicly opposed national health insurance. President Harry S. Truman openly fought the AMA, especially
during the campaigns for congressional and presidential elections. According to Truman, the "medical lobby" was "a reactionary faction within that tightly held national leadership of the American Medical Association." As the president stated: "The lobby is not the great bulk of the devoted doctors in this country, though it plays freely on their fears and extorts its money out of them. The lobby is, in reality, just a few men and an advertising agency." In spite of the rhetoric, neither President Roosevelt nor President Truman actively supported national health insurance once legislation was introduced in Congress. Part of this reluctance was based on the inactive role of Congress. As long as the chances for legislative action in Congress remained slim, the presidents remained reluctant.

Even though the social security policymakers did not always agree on the strategy to be pursued, they did share the ultimate goal of universal coverage. Whether or not through a program of national health insurance, the social security policymakers believed that eventually health insurance coverage for all Americans would be a reality. Histories of American health care policy have suggested that the move toward hospital insurance for the elderly had been the result of the AMA's opposition. This view was shared by the social security policymakers. According to Wilbur Cohen, the change of strategy was "very Hegelian." As he explained, "The state and federal proposals for compulsory health insurance were the thesis, the AMA's violent opposition was the antithesis, and Medicare is the synthesis."

HOSPITAL INSURANCE FOR THE ELDERLY

When in 1951 the federal security administrator Oscar Ewing suggested to design a hospital insurance for the elderly program, the social security policymakers were not enthusiastic. Limiting the program to hospital care alone had unsuccessfully been tried in the early 1940s. However, Ewing's persistence, with the support of President Harry S. Truman, led to a proposal that was introduced in Congress, though without receiving much attention. By then, the social security policymakers realized that a government hospital insurance for the elderly made sense. Although this change of strategy was prompted by the continuous political failure of the Wagner-Murray-Dingell bills and President Truman's National Health Plan, other developments proved to be decisive. By 1950, the social security system was fully accepted by the American public and gained bipartisan support. Adding a health insurance program to the system had become more logical, as more and more Americans were covered by the system. In addition, the success of private, employer-based


health insurance decreased the need for government national health insurance targeted at the working population. Subsequently, the federal government targeted its health insurance programs at those groups of the population which were the least likely to be insured, namely the elderly, the unemployed, and the welfare poor. In this way, the problem of inadequate access to medical care was no longer a collective social problem, but instead a minority social problem, merely (directly) affecting the low-income marginalized groups in society.

One of the most attractive elements of the new program was its scope; hospital insurance for the elderly would be easier to implement. Moreover, politicians weary of a grand government health insurance scheme could be more willing to accept a relatively small program. Starting with a small group of the population is not exceptionally American in itself. The national health insurance programs in most other western welfare states started with a small group of the population as well. However, while the programs in other western welfare states were targeted at the male, lower-income, industrial workers, the American program was targeted at the retired workers. In addition, the elderly as group were more ideologically acceptable, as they were "deserving" by definition. Although the hospital insurance for the elderly program, that would later become known as Medicare, was based on the social insurance principle, it shared the character of the public assistance programs of only providing benefits to those who were no longer "able-bodied" to work.

The election of President Dwight Eisenhower led to the undermining of the power of the social security policymakers to extend the social security program. Arthur Altmeyer and I.S. Falk were forced to resign, while Wilbur Cohen was demoted. Even though the drive for Medicare had come to a hold, important steps toward a government program were made: the inclusion of federal public assistance for medical care in 1950, the inclusion of the disability freeze in 1952, and the enactment of disability insurance in 1956. The incremental character of the Social Security Act was working in favor of national health insurance. Step-by-step, programs that dealt with medical issues were included within the social security system. By 1957, after disability insurance had been enacted and Wilbur Cohen had left the federal service to become a university professor and independent social security advisor, the time had come to take on hospital insurance for the elderly again.

The enactment of the Kerr-Mills program of 1960, signed into law by President Eisenhower, should also been seen as part of the strategy of incrementalism. Even though the advocates of Medicare perceived the joint federal-state public assistance program for the medically needy elderly as an empty promise, social security policymaker Wilbur Cohen had supported (and partially designed) the program. Realizing that the American system was still based on a combination of social insurance and public assistance, Cohen knew that the eventual enactment of Medicare would still leave many Americans uninsured. Establishing a public assistance program for the medically needy, even if it only provided coverage for the elderly poor, was a step toward a
And the Pursuit of National Health

general medical public assistance program. In addition, negative experiences with Kerr-Mills could add credibility to the need for Medicare.

To promote Medicare, the advocates presented the image of an average American elderly couple, enjoying their well-deserved retirement after a long life of working hard. Then one of them became ill and needed to be hospitalized. As their life-long savings were not sufficient to cover the medical bills, the elderly couple became dependent on their grown children, thereby jeopardizing the college education of their grandchildren. Medicare could correct this injustice. Instead of undermining the freedom of the American elderly, Medicare would enable them to remain self-reliant. They would no longer need to be dependent on the generosity of their children or on the charity of the state. With Medicare, all Americans could grow old with dignity and in freedom.

While the election of President Eisenhower had undermined the power of the social security policymakers, the election of President John F. Kennedy led to the triumphant return of Wilbur Cohen to the center of federal policymaking. Kennedy had turned Medicare into an important campaign issue, though, once in office, his interest in Medicare decreased. Even though the Kennedy administration continuously suggested that the AMA’s opposition obstructed the enactment of Medicare, the real obstruction took place in Congress. Especially the House Committee on Ways and Means, chaired by Wilbur Mills, proved to be a large obstacle. The Kennedy administration was divided on which strategy to pursue: either trying to negotiate with Mills, or starting a big rallying campaign to promote a grass roots movement in favor of Medicare. The two strategies turned out to complement each other. While public support for Medicare was growing, Wilbur Cohen was increasing the pressure on the House Committee on Ways and Means. However, a clear political mandate for Medicare did not exist until the elections of 1964. Pushed by President Lyndon B. Johnson himself, Medicare was added to the Social Security Act in 1965, consisting of a compulsory hospital insurance program and a voluntary insurance program covering physicians’ services. In addition, the Kerr-Mills program was replaced by Medicaid, a joint federal-state medical public assistance program for the welfare poor.

In the end, Medicare proved to be a truly “American” program. Even though Medicare was a government program, in practice the federal government merely financed privately administrated health insurance. The hospital administrations and the insurance organizations (in most cases the nonprofit, provider-controlled Blue Cross for hospital insurance and Blue Shield for physicians’ services) maintained their professional autonomy in the execution of the program, including the power to determine the level of remuneration. Initially both the American Hospital Association and Blue Cross/Blue Shield had been reluctant to support Medicare. Especially Blue Cross and Blue Shield preferred the private market to government intervention. As the National Association of Blue Shield Plans had argued in 1964, the
maintenance of the private market within the health care system made American health care uniquely American:

Blue Shield and Blue Cross have brought the economy of medicine into line with our free economy by adapting to medicine the consumer credit mechanisms that have made possible our unequalled standard of living in America. Blue Shield and Blue Cross have no exact counterparts anywhere else in the world. The movement is in fact the envy of physicians and hospital administrators in many parts of the free world where daily these people must contend with the whims and exigencies of political overlords. A uniquely American contribution to social engineering, [it] is not too much to say that Blue Shield and Blue Cross have become one of America's best hopes for the future of her free society.  

By giving in to the demands of the AHA and Blue Cross/Blue Shield, organizations controlled by the providers of medical care, the federal government maintained an American tradition of having private organizations executing a public program, thereby limiting the role of the state to the subsidizer of a privately-run industry.

In an attempt to explain the absence of a national health insurance program in the United States, scholars have emphasized, among other explanations, the relatively weak labor movement, at least in the comparison to other western industrialized nations. Such an explanation implies that in general a strong labor movement would automatically lead to national health insurance, and that if the American labor movement had been stronger, the implementation of a national health insurance program would have been more feasible. However, the American labor movement has played an important role in American health care policy. First, through collective bargaining, the labor unions were decisive in the establishment of private, employer-based health insurance. Second, the labor union AFL-CIO was actively involved in drafting the Medicare bill and was also responsible for organizing the National Council of Senior Citizens, the "grass roots" movement for Medicare. The eventual success of Medicare suggest that the labor movement did not "fail" to get national health insurance established, but instead shared the preference for private, employer-based health insurance for the working population and government health insurance for the non-working population.

SOCIAL INSURANCE VERSUS PUBLIC ASSISTANCE

Contrary to their own public claims that Medicare would not lead to a system of national health insurance, the social security policymakers clearly intended to expand the programs to include those of the population who were not insured through private, employer-based health insurance. In this way, as the

policymakers believed, universal coverage would eventually be achieved. By extending either Medicare or Medicaid, the remaining uninsured population could be included. Again, incrementalism was considered the right strategy. Possible groups to be included were children, the disabled, and single parents with dependent children. However, the distinction between social insurance and public assistance continued to complicate the extension of the programs. Even though the social security policymakers favored the extension of Medicare, a social insurance program, the extension of Medicaid, a public assistance program, appeared to be more feasible.

The main difference between the universal health insurance programs in European welfare states and Medicare lies in the particular segment of the population at which government health insurance was initially targeted. By focusing on the elderly instead of the lower-income workers, the policymakers were able to erase "class" from the national health insurance debate in the United States. As a result, Medicare became a true "universal" program, equally beneficial to all Americans over 65, regardless of class, race, or gender. However, in spite of Medicare's universal character, the inclusion of the remaining uninsured Americans would mean a shift in ideology. The elderly were "deserving" by definition, as they had worked hard all their lives and thus deserved coverage. To make Medicare truly universal, extension of the system meant that able-bodied Americans between the ages of 21 and 65 should be included as well, even if they were considered to be "undeserving." In other words, to extend Medicare, the distinction between social insurance and public assistance needed to be resolved.

Another possibility to achieve universal coverage was to extend Medicaid, the medical public assistance program for the welfare poor. Even though Medicaid's eligibility rules already enabled the individual states to include medically needy able-bodied individuals between the ages of 21 and 65, none of the states made use of that possibility. When the proposed New York State Medicaid program suggested that a large group of able-bodied individuals would be included, objections arose in Congress. As was generally agreed in Congress, it had never been the intention to provide health insurance coverage for the lower-income workers. The inclusion of the non-poor working Americans would undermine Medicaid's public assistance character of providing aid to the deserving needy. As a result, the social security policymakers focused on extending Medicare and Medicaid to include those who were considered deserving, namely children, the disabled, and single mothers with dependent children.

The distinction between social insurance and public assistance is also reflected in the rhetoric used in the Medicare and Medicaid debates. While Medicare is perceived as a program to provide the elderly with the security to grow old in freedom, Medicaid is regarded as a last resort for the most needy. "Probably the average American would agree that health care is an important social good, that people who need it ought to have it, that those who lack health
insurance should have coverage, and so on,” as Lawrence D. Brown has pointed out. “But the average American probably also believes that those who lack health coverage can go to the emergency room of their community hospital and get care that is reasonably good and timely. With such safety valves in place, why get government into the act?”\(^{15}\) The public opinion turns out to be ambiguous. Throughout the national health insurance debate, polls have shown that the American people favor national health insurance in principle, but that they do not want the quality of medical care to be jeopardized. In spite of the “public wisdom” that Americans do not approve of their welfare state, studies have shown that in fact the American public supports the American welfare state. Particularly programs such as social security, Medicare, and Medicaid continue to be popular.\(^{16}\)

Initially, the social security policymakers had planned that by 1975 universal coverage would be achieved, as the remaining uninsured Americans would be included within the Medicare and Medicaid programs. However, the rising health care costs made extension unlikely. Already in 1967, two years after the enactment of Medicare and Medicaid, the strategy of incrementalism faltered. Medicaid ran into serious financial trouble, as Congress cut the program’s budget. In addition, the centralized power of the federal government was seriously questioned. Medicare was the largest federal effort toward universal coverage so far, but due to its reimbursement policy of “reasonable and customary costs” (thus leaving the financial control up to the medical profession and insurance industry) and due to its use of private insurers such as Blue Cross as intermediaries, Medicare also caused the costs of health care to rise even more. Medicare and Medicaid were no longer seen as a solution but rather as a part of the problem.

The rising health care costs continued to plague Medicare and Medicaid. Health care reform was no longer primarily focused on the extension of medical care or increasing public access to medical care, but on cost containment. The federal government tried to influence the organization of medical care by promoting group practice and managed care in the form of Health Maintenance Organizations (HMOs). Congress also introduced programs to determine professional standards and rate setting. Moreover, as Edward D. Berkowitz has pointed out, “What began as a moral issue in the 1930s eventually became a technical issue in the 1970s.”\(^{17}\) The health care industry had become extremely complex, dealing with many different, and

\(^{15}\) Lawrence D. Brown, “Why Americans Are Different,” in Robert P. Huefner and Margaret P. Battin (editors), Changing To National Health Care: Ethical and Policy Issues (Salt Lake City: University of Utah Press, 1992), 133.


And the Pursuit of National Health

often contradicting, interests of powerful lobby groups. While the original social security policymakers had been social economists from Wisconsin and reformers from New York City, they had been replaced by fiscal analysts and economists who were much more focused on issues as cost containment than on extending the access to medical care.

FREEDOM OF CHOICE

The role of the AMA’s opposition continues to dominate the history of both Medicare and the national health insurance debate in the United States. This perspective of conflict is understandable, as the participants in the debate have repeatedly singled out the AMA as the main obstructionist in the policymaking of American government health insurance. Although the AMA’s opposition cannot be ignored, its influence should not be overemphasized. The AMA’s active propaganda campaign against national health insurance (from the late 1940s to the enactment of Medicare) has contributed to the AMA’s reputation as being the main obstructionist in the national health insurance debate. The AMA’s visibility, however, has distorted the historical picture, as conflict overshadows consensus.

Although the advocates of national health insurance argued that the AMA’s position was based on economic self-interest, the medical profession was more concerned that a national health program would reorganize the delivery of medical care. The conflict between the lay reformers and conservative physicians as was presented in the final report of the Committee on the Costs of Medical Care in 1932 did not deal with national health insurance but with group practice. The conservative physicians, who dominated the AMA, feared that the modernization of medical care would mean the end of the private practitioner, placing all professional power in the hands of the hospital administrations and medical schools. The AMA’s fear was justified. Starting in the late 1930s, hospitals and medical schools were cooperating with the federal government to encourage the federal subsiding of the extension of medical care and the construction of hospitals. While national health insurance remained politically not feasible, a consensus on the extension of medical care was established. From the 1940s on, the federal subsidizing of medical research, the construction of hospitals, and medical education continued to increase. For the AMA, openly opposing the federal subsidizing was not a realistic option. During the 1960s, the AMA did not only oppose Medicare, but also the Regional Medical Program and the Heart Disease, Cancer, and Stroke bill. However, calling the fight against a serious illness such as cancer “socialized medicine” was of course not possible. Although a comprehensive national health insurance program was not established, the AMA failed to counter the growing power of the hospitals and medical care facilities.

The AMA’s most compelling argument in its campaign against national health insurance was that a government health insurance program would
Conclusion: The Promise of Incrementalism

destroy the personal relationship between the physician and the patient. Moreover, both group practice and government health insurance would mean that patients no longer had the freedom to choose their own doctors. Over the years, the rhetorical “Freedom of Choice” argument remained powerful. In the early 1990s, for example, President George Bush stated the American health care was the best in the world and “I don’t want to see that deluded by socializing our medical treatment and diminishing the choice for individuals about going their own doctor.” However, the Americanism argument worked both ways. When New Republic columnist Mickey Kaus coined the word “HMOphobia” to describe the traditional American fear of bureaucracy and strong centralized government, he seemed to forget that the Health Maintenance Organization (HMO) was initially the American answer to anti-statism. This American system of prepaid group practice sponsored by the federal government was introduced in the early 1970s as a free-market – thus more American – alternative to government-run health services. Instead, HMO had become synonymous for un-American bureaucracy.

Throughout the twentieth century, reformers have repeatedly stressed that their programs – national health insurance through the Social Security Act, Medicare and Medicaid, the Clinton Health Security Plan – were American solutions to the problems of inadequate access to medical care. In the 1930s, reformers argued that the freedom of the American individual could only be secured if access to medical care was guaranteed. Accordingly, President Franklin D. Roosevelt added the “right to adequate medical care” to his Economic Bill of Rights of 1944. The policymakers in the 1960s made a similar argument when they stated that, instead of undermining the freedom of the elderly, Medicare would make the elderly more self-reliant. The American elderly would no longer need to be dependent on the generosity of their children or on the charity of the state. When President Richard Nixon presented his Comprehensive Health Insurance Plan of 1974 to Congress, he stated that “One of the most cherished goals of our democracy is to assure every American an equal opportunity to lead a full and productive life.” As Nixon argued, Americans could only fully participate in the freedom of American society, if the federal government guaranteed basic health insurance coverage. Universal coverage would not endanger the “Freedom of Choice” as long as “doctors [would] work for their patients, not for the Federal Government.”

18 George Bush, “Remarks to the Kiwanis and Rotary Clubs in Ontario, California,” 6 December 1991, Public Papers, 1564.
The strength of the American ideology is also shown by the readiness of Americans to accept the assumption that other western welfare states do not have freedom of choice. While the opponents repeatedly claimed that Europeans and later Canadians had lost their freedom to choose, the advocates did not challenge that belief but instead argued that an American system of national health insurance would be different and protect the freedom of the individual. In reality, basically all western welfare states recognize the individual's right to choose one's own doctor. In stark contrast, accounts of Americans on Medicaid, for example Laurie Kaye Abraham's *Mama Might Be Better Off Dead*, show that less privileged Americans are lucky if they get to see a doctor at all, let alone choose one. Moreover, in all western welfare states, including the United States, the freedom to choose one's own doctor is relative, depending on the availability of medical care and the knowledge of the patient. With the continuing specialization in medical care, the patient is confronted with different physicians for each different illness, making the traditional family doctor a fading image from the past.

**THE CLINTON HEALTH SECURITY PLAN**

Throughout the 1970s and 1980s, health care costs continued to escalate, and the number of uninsured and underinsured Americans rose as well. Due to new developments, especially technical advancement, the costs of medical care had skyrocketed, making cost containment top priority. As Erik Eckholm points out, "By 1993, health care absorbed 14 percent of the gross national product, far more than any other country, and by the end of the decade it was projected to eat up an astounding 19 percent of the economy." Over the years, the American middle-class was confronted with higher medical bills, rising insurance premiums, declining coverage, and uncertain health insurance developments in the future. "There is a new ally in the battle for NHI [national health insurance], the middle class," Rashi Fein wrote in 1992, arguing that middle-class fears would be reflected in political votes. "Their fear of losing jobs, and thereby insurance; their fear of

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21 In France, for example, the Charte médicale of 1927 guaranteed the freedom of patients to choose their own doctor. David Wilsford, *Doctors and the State: The Politics of Health Care in France and the United States* (Durham: Duke University Press, 1991), 119.


cutbacks in benefits; their concerns about their costs and the impact on potential wage increases.\(^{24}\)

Health care reform proved to be an effective campaign issue for Democratic presidential candidate Bill Clinton. His election suggested that the time for an American national health insurance program had finally come. On September 22, 1993, near the end of his first year in office, Clinton presented his Health Security Plan to Congress. Similar to the rhetoric of President John F. Kennedy and President Lyndon B. Johnson, Clinton argued that government health insurance could preserve freedom. After referring to the peace process in the Middle East, the fall of the Berlin wall, and the end of apartheid in South Africa, Clinton announced: “And now it is our turn to strike a blow for freedom in this country. The freedom of Americans to live without fear that their own nation’s health care system won’t be there for them when they need it.”\(^{25}\) The overall response to the Clinton plan was positive. Just one year later, the Clinton plan died in Congress. “The funeral was private; no crowds gathered in mourning,” as Paul Starr, one of the designers of the Clinton plan, remembered. “While opinion surveys continued to show strong support for the ingredients of reform, the complexity of the plans and onslaught of criticism had even left many supporters bewildered and uncertain.”\(^{26}\)

Different explanations of the failure of the Clinton plan have been presented, ranging from the plan’s complexity and the secrecy surrounding the White House Health Care Task Force to the anti-campaign by the health insurance industry and the partisan attack of the House Republicans. Journalists have focused on the personalites and the working-methods of the policymakers, questioning the wisdom of President Clinton’s decision to have his friend Ira Magaziner and his wife Hillary Clinton lead the health care reform effort. Scholars have placed the failure of the Clinton plan within the larger context of American politics and social policy.\(^{27}\) Even

\(^{24}\) Rashi Fein, “National Health Insurance: Telling the Good from the Bad,” Dissent (Spring 1992): 158.


though many of these accounts of why and how the Clinton Health Security Plan failed are fascinating and enlightening, I will not focus on the plan as a failure but instead as a part of the continuing process to incrementally reform American health care. Placed within the context of this study, the fate of the Clinton Health Security Plan foregrounds the tension between the goal of universal coverage and other priorities, such as securing coverage for certain segments of the population and cost containment. Also important, the Clinton Health Security Plan brought national health insurance back in the limelight again. Although both supporters and opponents tended to overrate her role as policymaker, the appointment of Hillary Rodham Clinton to lead the health care reform showed that the issue was a high priority of the Clinton administration.

The ultimate goal of the Clinton Health Security Plan was twofold: the Clinton administration wanted to achieve universal coverage, making health insurance coverage a right for all Americans, while, at the same time, curtailing the skyrocketing health care costs. To combine universal coverage with cost containment, the Clinton administration proposed a system of “managed competition,” also referred to as “competition within a budget.” Building on the experience with HMOs and other forms of group practice, the Clinton Health Security Plan provided a choice of insurance plans through regional health care alliances. All American citizens would be able to receive coverage through their local health care alliance, with the exception of those already covered by Medicare or by the health insurance plans of large corporations. The managed competition proposal was a compromise between the single-payer system (favored by liberals) and market-oriented reforms to promote voluntary health insurance (favored by conservatives). Although rumor had it that Hillary Clinton and Ira Magaziner personally favored a Canadian-style single-payer system, they must have concluded


28 Hillary Clinton predominantly functioned as the main representative of the White House. Even though she was kept posted on all the important issues and attended most meetings, she was hardly involved in the actual policymaking, with one exception: on Ira Magaziner’s “headache list” Hillary Clinton is listed as the one responsible for determining whether or not abortion should be included in the plan’s benefits package. “Headache List,” 12 March 1993, Clinton White House Health Care Task Force Papers, box 3308, National Archives.

that a managed competition proposal would be politically more feasible. The managed competition compromise enabled the Clinton administration to curtail the health care costs through government regulation of the free-market system and simultaneously expand coverage to the entire population. “A lot of people mistake managed competition for a pure free-market proposal,” as Paul Starr explained. “Many observers contrast managed competition with national health insurance, when managed competition is better seen as a strategy for making health insurance as a right of citizenship – which, to me, is the essence of national health insurance.”

The Clinton administration was forced to build upon the existing health care system, less elegantly described by Hillary Clinton as “a patchwork nonsystem.” Early on, the White House Health Care Task Force had decided that Medicare would continue as an independent program. The Medicare compromise, orchestrated by Wilbur Cohen almost thirty years earlier, had enabled the hospitals and the insurance industry to control the reimbursement system. Consequently, Medicare was predominantly based on the fee-for-service principle, making the change into a managed care system more difficult. The Clinton policymakers dismissed the suggestion to enable uninsured, non-elderly Americans to enroll in the Medicare program, as it would encourage the maintenance of the fee-for-service system instead of group practice. As Paul Starr told Ira Magaziner, “Medicare’s history should be a lesson on how not to structure a national health insurance program.”

No longer based on the incremental strategy of expanding the existing social security programs, the Clinton Health Security Plan had to set up a new infrastructure to combine government supervision with private health insurance. Consequently, the plan was extremely complex, as any plan with similar comprehensive objectives would be. Moreover, the combination of universal coverage and cost containment proved to be a difficult one. “Americans dislike federal government regulations not accompanied by generous monetary payoffs,” as Theda Skocpol has explained. “Ironically, precisely because Bill Clinton, the New Democrat, was working so hard to save money, he inadvertently ended up designing a health care reform plan that appeared to promise lots of new regulations without widespread payoffs.”

32 Osborne (editor), The Unique Voice of Hillary Clinton, 153.
President Clinton believed that the entire health care system needed to be reformed at once. As he told journalists Haynes Johnson and David S. Broder, he was “afraid that if we took it on piece by piece, we might solve some problems but we might make others worse.”\(^\text{35}\) Hillary Clinton shared the president’s view. “Technical changes that prevent us from reaching the goal of universal coverage are not acceptable to this administration – nor should they be to economists, academics, or the American people,” as the first lady wrote in the introduction to a special issue of *Health Affairs*. “We will not settle for tinkering, only true health reform.”\(^\text{36}\) By making universal coverage first priority, the Clinton administration expressed that health insurance should be a right for every American citizen. The Clinton plan was based on six principles: security, simplicity, savings, quality, choice, and responsibility.\(^\text{37}\) The ethics group of the Clinton Health Care Task Force also added the values of community, equality, justice, and liberty. Such “American” values were important to justify the reforms. As one of the ethic group leaders explained: “The first audience is policy-makers and legislators, who might seek guidance from moral principles that should shape their work and identify moral parameters for the design of the system. The second audience is the wider American public which needs to have some sense … that this health care reform is a noble undertaking.”\(^\text{38}\) Moreover, the professionals and the general public needed to realize that the Clinton Health Security Plan was an AMERICAN plan. Speaking before the members of the American Medical Association on June 13, 1993, Hillary Clinton exclaimed:

> We have looked at every other system in the world. We have tried to talk to every expert whom we can find to describe how any other country tries to provide health care. And we have concluded that what is needed is an American solution for an American problem by creating an American health care system that works for America. And two of the principals that underlie that American solution are quality and choice.\(^\text{39}\)

By then, the AMA was not the aggressive obstructionist it used to be. The AMA had endorsed the principle of universal coverage. The role of main opponent to national health insurance had been taken over by the Health Insurance Association of America (HIAA). Moreover, as relatively fewer physicians were AMA members,

\(^{35}\) Johnson and Broder, *The System*, 97.


\(^{38}\) Marian Secundy to Ira Magaziner, 1 April 1993, Clinton White House Health Care Task Force Papers, box 3808, National Archives.

\(^{39}\) Osborne (editor), *The Unique Voice of Hillary Clinton*, 149.
the American Medical Association could no longer be considered as the only representative of the medical profession.  

Initially, the broad objectives of the plan — universal coverage and cost containment — received bipartisan support. After President Clinton had presented the plan to Congress on September 22, 1993, the New York Times reported that “THE CLINTON PLAN IS ALIVE ON ARRIVAL.” Once the plan was discussed in more detail, however, any suggestion of consensus disappeared. While the majority of the Republicans in Congress favored a more market-oriented reform to promote voluntary health insurance, liberal Democrats tended to favor a single-payer system instead of Clinton’s Health Security Plan. In addition to the groups, led by the HIAA, that opposed health care reform altogether, lobby groups that favored health care reform, such as the American Association of Retired Persons (AARP), refused to give their full endorsement so that the possibility to compromise on smaller details of the Clinton plan remained open. As the discussion became increasingly complex, the American public no longer knew what to make of the Clinton Health Security Plan.  

Even though the public continued to favor universal coverage, support for the Clinton plan dwindled. As Daniel Yankelovich has pointed out, “What most people mean when they say that they support universal coverage should be paraphrased this way: ... We support the president’s goal of insurance for all that can never be taken away, but only if the nation can afford it and it doesn’t limit choice of doctors or raise taxes or cause employers to cut jobs.” The opposition to the Clinton Health Security Plan recognized the public’s ambiguity. In the famous “Harry and Louise” television commercial, the HIAA addressed the fear of the middle-class Americans. The commercial showed Harry and Louise, an average white American middle-class couple, with health insurance, on the couch in their living-room, contemplating how their personal health care will be effected by the proposed reforms. Flipping through a thick copy of the Clinton report, Louise utters, “This plan forces us to buy our insurance through those new mandatory government health alliances,” prompting Harry to add, “Run by tens of thousands of new bureaucrats.”  

Realizing that Clinton’s Health Security Plan was already in jeopardy, the House Republicans made effectively use of the deadlock and dealt the fatal blow.  

41 As a poll of the Wall Street Journal and NBC News (March 1994) showed, 76% of the persons polled preferred an unidentified description of the Clinton plan. When the Clinton plan was specifically referred to, however, only 37% of the same group replied positively, 45% negatively. Skocpol, Boomerang, 98.  
43 As quoted in Skocpol, Boomerang, 138. For an extensive discussion of the “Harry and Louise” commercial, including the parody by Bill and Hillary Clinton themselves, see Johnson and Broder, The System, 205-213.
Denouncing the Clinton plan as “government-run medicine,” the Republicans almost unanimously (with the exception of one) opposed the Clinton health care bill when it was finally introduced in the House of Representatives.\footnote{Skocpol, Boomerang, 92-95; Hacker, The Road to Nowhere, 149.} Without bipartisan support, the Clinton Health Security Plan was history. President Bill Clinton, however, continued to refuse giving in to the suggestion by his political advisors to compromise on universal coverage. “We made the error of trying too much at once, took too long, and ended up achieving nothing,” as Paul Starr remembered. “Oh, yes, I was thrilled when President Clinton waved his pen before Congress and threatened to veto anything less than universal coverage. Like many others who supported reform, I failed to appreciate the risk of losing everything. We were too confident that reform was inevitable, just as some are now too certain that defeat was inevitable.”\footnote{Starr, “What Happened to Health Care Reform?” 31.}

Writing in early 1994, before the failure of the Clinton plan had been completed, social security expert Henry J. Aaron recognized that, if the legislation would have any result at all, the result would be incremental. “Reform of health care financing will not be achieved by one grand new law enacted in 1994. It will emerge from a succession of laws enacted over many years. The current debate is extremely important, however, because it will determine whether the process of reform begins in 1994 or is delayed indefinitely.”\footnote{Henry J. Aaron, “Sowing The Seeds Of Reform In 1994,” Health Affairs (Spring I, 1994), 57-68.} In the end, President Clinton had to give up the goal of universal coverage in favor of the incremental strategy. While universal coverage continued to receive strong popular support, the Clinton administration realized that the fears of the middle-class of no longer being able to afford adequate medical care were decisive. Already in February 1993, the Council of Economic Advisors had informed Hillary Clinton that any reform effort should include at least the following three elements: “1. Insurers will no longer be able to exclude pre-existing conditions from coverage. 2. Individuals will no longer face a higher price just because they experience an adverse event. 3. Individuals will not be locked into their jobs for fear of losing their health insurance.”\footnote{David Culter and Sherry Glied to Ira Magaziner, 8 February 1993, Clinton White House Health Care Task Force Papers, box 3808, National Archives.} While the Clinton administration had not been able to build consensus on its managed competition plan, receiving criticism from both the political left and right, incremental reform of the health care system could be achieved. Instead of building a new infrastructure of regional health care alliances, the existing health care system was reformed through new governmental regulations. The Health Insurance Portability and Accountability Act, introduced by Democrat Edward Kennedy and Republican Nancy Kassebaum and signed by President Clinton on August 22, 1996, included the
three above-mentioned elements. Unlike the Clinton plan, the new act did not include universal coverage, but merely protected the coverage of those who were already insured. Ironically, relatively little media attention was given to the Kennedy-Kassebaum Act, while in fact it will undoubtedly have a larger direct impact on the future of American health care than the failure of the Clinton plan. The success of the Kennedy-Kassebaum Act, shows that the Clinton Health Security Plan should not merely be received as a failure, but also as a revival of the incremental strategy in American health care reform. However, the universal coverage objective was lost in the process.

In the meantime, the AMA’s old claim that government health insurance would take away the patient’s freedom to choose one’s own doctor survived the test of time. A “Nightmare Before Surgery” get-well card depicts Lorena Bobbitt (the woman who cut off her husband’s penis) as surgeon, Dr. Jack Kevorkian as anesthesiologist, and Hillary Rodham Clinton commenting: “No, you may not choose your own doctor.”

CONCLUSION

Imagine a glossy representation of healthy people of all ages, colors, and shapes, all beautiful and happy, followed by the slogan “What if you didn’t have to worry about health care?” This glossy television commercial is real, presented by Blue Cross/Blue Shield, by now no longer a nonprofit insurer. The patient has become a consumer, challenged to picture a world in which health care is nothing to worry about. In the real world, Americans do worry about health care, about their own coverage and even about those forty million other Americans who do not have any health insurance coverage at all.

American advocates of national health insurance tend to forget that Europeans and Canadians also worry about health care. National health insurance is not a magic cure that provides an ultimate solution to the challenges that western nations face. Technical advancement has greatly expanded the possibilities of modern medicine, but it has also created higher expectations and has accelerated health care costs. The population of the western world is aging and needs more and more medical care. An overemphasis on acute care has led to the negligence of long-term care. All western nations, not only the United States, must deal with the questions of who is going to pay for health care, which care is going to be covered and which not, and how the rising health care costs are going to be curved.

Nevertheless, from a European perspective, the large number of uninsured Americans continues to be an incredible phenomenon. It is therefore quite understandable that scholars question why a national health insurance program was never enacted in the United States of America. Possible explanations based on the notion of American exceptionalism seem plausible and often convincing. However,
as I have stated before, studies that merely focus on policy that was not enacted tend to ignore policy that was enacted. In other cases, for example the GI bill of 1944, social policy is not recognized as such. Consequently, scholars try to explain the absence of policy that may in fact be present. One of the biggest obstacles in the study of the American welfare state from a European perspective is the necessity to convince other European scholars that the American welfare state does exist.

In the case of national health insurance, a distinction needs to be made between “national health insurance” and “universal coverage.” American national health insurance exists: indirectly through private, employer-based health insurance encouraged by the state, and directly through the government health insurance programs Medicare and Medicaid. Using the definitions of Richard Titmuss, we need to look beyond the “visible” social welfare and also include occupational and fiscal welfare. Although national health insurance in my definition does exist in the United States, universal coverage has still not been achieved. One should remember, however, that the initial national health insurance programs in other western welfare states did not provide universal coverage either. In some countries, for example France, universal coverage was achieved relatively late. Nevertheless, as far as universal coverage is concerned, the American experience is exceptional.

Two related factors that could explain this exception are 1) the tension between social insurance and public assistance, and 2) the tension between policy on federal level and policy on state level. In the case of American national health insurance, the social insurance principle has only been applied to Medicare, while in other western welfare states, the national health insurance programs included the working population. In the end, the social security policymakers were not able to include the able-bodied workers between the ages of 21 and 65 within the system. The non-elderly that were included tend to be covered by the public assistance programs. As the public assistance programs are administered on state level, large differences in eligibility and in the scope of benefits exist between the individual states. In practice, there is not one American welfare state, but a cluster of American welfare states.

Instead of focusing on the conflict between the social security policymakers and the medical profession as represented by the AMA, the history of American national health insurance should explore the consensus and the options available. Throughout the national health insurance debate, the option of universal coverage was sacrificed in favor of others. During the formation of the Social Security Act in the 1930s and during the decades that followed, the extension of medical care was preferred to the extension of coverage. In the 1940s and 1950s, private, employer-based health insurance was the preferred option. During the 1950s and 1960s, the coverage of specific segments of the population was favored, with the expectation that universal coverage would eventually be achieved. Most recently, the Clinton administration was forced to abandon universal coverage and opted for the reorganization of the provision of health care that gave extra protection to those who were already insured. Before these preferences can be described as
exceptionally American, however, further study should be done to explore the moments when other western welfare states considered similar options.

One element of the American national health insurance debate is without a doubt exceptionally American, namely its ideological and rhetorical content. Both the opponents and the advocates use self-acclaimed national values as “freedom,” “independence,” and “responsibility” to promote their own objective. From a European perspective, the debate sometimes reaches outrageous rhetorical levels. Both the opponents and the advocates have been able to wrap their arguments in convincing American rhetoric and these rhetorical arguments remain powerfully effective today.

In spite of the hope and expectations of the original social security policymakers, the promise of incrementalism was never fulfilled. Universal coverage has not been achieved. Some advocates of national health insurance will argue that the incremental strategy in itself has blocked universal coverage. In 1983, I.S. Falk asked Wilbur Cohen to comment on the remarks he had heard from “people groaning about Medicare who want to know why you flushed national health insurance down the drain & compromised on Medicare.” Although Falk, who had often disagreed with Cohen’s incremental strategy, did not say so, he clearly sympathized with the critics. In his reply, Cohen gave a straightforward rebuttal:

Regarding the reference to why I flushed national health insurance down the drain and compromised on Medicare: health insurance failed on enactment during 1912-1919; was not getting anywhere in 1932; was not included in the Social Security Act in 1935; failed in 1938-39; failed during 1943-1950, despite Truman’s strong support in 1945. The fact is that after Wagner-Murray-Dingell no high level political leader wanted to advocate national health insurance until the Kennedy-Griffiths bills [of the 1970s]. ... With the development of Blue Cross and Blue Shield by 1950 national health insurance, in my opinion, had very little chance of enactment. Neither Jack Kennedy or LBJ during the 1960s wanted to get beyond Medicare. ... I think the history of Medicare has been distorted in a number of respects but I doubt whether it is possible to put the real story in such shape as to persuade the die-hard national health insurance advocates who sometimes appear to say that national health insurance is just around the corner.⁴⁹
