



## Learning from Failure in Health Care Reform

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Since 1994, inaction and incrementalism have governed U.S. health policy, with the predictable result that both health care spending and the number of uninsured Americans have reached

record levels. Indeed, worsening conditions in the health care system have triggered renewed interest in comprehensive health care reform. Signs of change in the health care debate are everywhere — in the formation of coalitions by business and labor groups to pursue reform, the launching of advertising campaigns by the American Cancer Society and the American Medical Association to highlight the plight of the uninsured, the pursuit of ambitious plans by states such as Massachusetts to expand insurance coverage, and the unveiling of an array of health care reform plans by candidates in the Democratic and Republican presidential primaries.

Health care reform is even the subject of an attention-grabbing movie, Michael Moore's *Sicko*.

It is thus tempting to believe that the moment for reform has finally arrived and that we stand on the verge of historic change. Yet before reform advocates get too exuberant, they would do well to remember what happened the last time health care reform topped the national agenda. In the early 1990s, reformers also believed that the conditions were ripe for change<sup>1</sup>; then, as now, soaring health care costs and growth of the uninsured population fueled public dissatisfaction (see table). When President Bill Clinton took office in 1993 with Democratic

majorities in the Senate and House of Representatives, the country appeared inexorably headed toward health care reform. But just a year after its introduction in September 1993, the Clinton Health Security Act (see box) was dead in Congress. What happened to the Clinton plan, and what lessons can today's reformers learn from its failure?

The Clinton plan sought to build on and transform our mixed, public-private system of health care. It called for universal coverage, with all employers required to contribute toward the costs of insurance premiums for their workers. Americans would choose from multiple private insurance plans that would compete for their enrollment, and it was expected that the market would shift further toward managed care. Through regional purchasing pools, the government would

strictly regulate insurance practices (e.g., by ensuring community rating — the practice of charging every subscriber or group the same rate — and prohibiting cherry-picking of healthy patients). It would also impose limits on the growth of insurance premiums to ensure cost control.

The Clinton plan was envisioned as a synthesis of liberal ends (universal coverage) and conservative means (managed competition among private insurers) that could break through the stalemate on health care reform and attract majority support in Congress.<sup>2</sup> Other core elements were designed to maximize its political appeal: the plan built on the familiar system of employer-sponsored insurance, avoided any broad new taxes, retained private insurance, left Medicare intact, and promised

Americans health security and choice.<sup>3</sup> Its architects believed that it embodied a winning political formula. They were wrong.



**Hillary Rodham Clinton Talking to a Patient about Health Care Reform, February 1993.**

Perhaps the Clinton administration's greatest mistake was excessive ambition.<sup>4</sup> The plan attempted simultaneously to secure universal coverage, regulate the private insurance market, change health care financing through an employer mandate, control costs

to levels enforced by a national health board, and transform the delivery system through managed care. Any one of these goals alone would have been difficult to achieve, and although there is a substantive rationale for taking all of them on at once, it was a politically treacherous task. Indeed, each dimension of the Clinton plan galvanized opposition. The National Federation of Independent Business vigorously opposed the employer mandate. The Health Insurance Association of America fought against insurance regulation and federally imposed cost controls. Congressional Republicans denounced the entire plan, including the much-maligned health alliances, as too much "big government." The administration's embrace of managed competition and delivery-system change alienated well-insured, middle-class Americans, who lost confidence in a plan that promised health security but appeared to make their own health care arrangements less secure (an appearance exacerbated by opponents' scare tactics).

The Clinton administration both underestimated the opposition and overestimated the support for reform. The administration failed to mobilize any organized constituency to counter the attacks, and groups they had counted on as allies, such as big business, disappointed them. Congressional Democrats were divided and, rather than endorsing the Clinton plan, pushed their own favored solutions. Moreover, the plan's synthesis of regulation and competition won few political friends in Congress: it was too liberal for moderate Republicans and conservative Democrats and too conservative for liberals to

Comparison of Key Factors Affecting the Demand for Health Care Reform, Early 1990s and Today.*		
Variable	Then	Now
Increase from the previous year in health insurance premiums	14% (1990)	6.1% (2007)
Health care spending as a percentage of the gross domestic product	12.3% (1990)	16% (2005)
Per capita health care spending	\$3,167 (1992)	\$6,401 (2005)
Number of uninsured	35.4 million (1991)	47.0 million (2006)
Increase from the previous year in the number of uninsured	1.3 million (1989–1990)	2.2 million (2005–2006)
Unemployment rate	7.5% (1992)	4.6% (August 2007)
Federal deficit	\$269 billion (1991)	\$248 billion (2006)
Percentage of people who say the system needs to be completely rebuilt or needs fundamental change	90% (1991)	90% (2007)
Percentage of people who identify health as a top issue of concern	19% (1992)	27% (2007)

\* Data are from the Kaiser Family Foundation, the Organization for Economic Cooperation and Development, the U.S. Census Bureau, the Bureau of Labor Statistics, the Congressional Budget Office, and a poll conducted by CBS News and the *New York Times*.

**Key Provisions of the 1993 Clinton Health Security Act.**

Universal coverage and comprehensive benefits

Mandate that all employers pay 80% of the average health insurance premium for their workers, with caps on total employer costs and subsidies for small businesses

Cost control through competition among private health plans and federally determined caps on insurance-premium growth

Establishment of regional purchasing pools (health alliances) through which people would enroll in insurance plans

Financing through employer mandate, savings from cuts in projected Medicare and Medicaid spending, and increase in federal tobacco taxes

rally around with much enthusiasm. Meanwhile, foreign-policy crises and domestic scandal distracted the administration, damaging its efforts to sell reform. And when the Clinton plan ran into political trouble, the administration lacked a fallback strategy. In short, everything that could have gone wrong did.<sup>5</sup>

The Clinton administration's misadventure carries several broader lessons about the politics of health care reform. First, no matter how much momentum it seems to have, no matter how many signs point to change, there is nothing inevitable about health care reform in the United States. In U.S. health policy, the status quo is deeply entrenched and, despite all its failings, the system is remarkably resistant to change, in part because many constituencies profit from it. Thus, although everyone decries the amount of money spent on health care, the political reality is that national health care expenditures represent income to health industry stakeholders, whose interests lie in ensuring even greater spending.

Second, many Americans are satisfied with their own health care arrangements, so reforms that threaten to unsettle those arrange-

ments risk running afoul of the voting public. Health care reformers must thread the needle by persuading the anxious insured that reform is in their best interest and that the uninsured can be covered without disturbing (and ideally, while enhancing) their coverage.

Third, expanding government authority over a health care system that accounts for more than \$2 trillion and one sixth of the economy in a country that is ambivalent about public power is an inherently controversial exercise. No universal coverage plan, no matter how clever, can evade that ideological debate.

Fourth, paying for health care reform remains a formidable challenge. The Clinton plan collapsed largely because the administration could not secure congressional support for an employer mandate, but no obvious financing alternatives have emerged in the ensuing years, and persistent antitax politics and federal deficits constrain the options for reform.

Fifth, U.S. political institutions limit presidential power, foster divisions in Congress, create opportunities for those with vested interests to block change, and generally complicate the adoption of health care reform.

Finally, the window for enacting a comprehensive plan for health care reform never stays open for long, so failure comes at a high price — namely, the loss of political will to do anything meaningful about the uninsured for some time to come.

The Clinton administration made no shortage of political miscalculations and strategic errors that helped to derail its campaign for health security. Yet it is easy to forget that Bill Clinton was not the first president to fail at health care reform: he was following in the footsteps of Franklin Roosevelt, Harry Truman, and Richard Nixon. Ultimately, the demise of the Clinton plan says less about the administration's mistakes than it does about the extraordinary difficulty of adopting comprehensive health care reform in the United States. For today's reformers, that is the most sobering lesson of all.

**An interview with Dr. Oberlander can be heard at [www.nejm.org](http://www.nejm.org).**

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1. Starr P. What happened to health care reform? *The American Prospect*. Vol. 6. No. 20. December 1995:20-31.
2. Zelman WA. The rationale behind the Clinton health care reform plan. *Health Aff (Millwood)* 1994;13(1):9-29.
3. Hacker J. *The road to nowhere: the genesis of President Clinton's plan for health security*. Princeton, NJ: Princeton University Press, 1997.
4. Brown LD. Who shall pay? Politics, money, and health care reform. *Health Aff (Millwood)* 1994;13(2):175-84.
5. Johnson H, Broder DS. *The system: the American way of politics at the breaking point*. Boston: Little, Brown, 1996.

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