
THE CLINTON HEALTH PLAN: HISTORICAL PERSPECTIVE

by Hugh Heclo

Prologue: *Did the Clinton administration ignore the lessons of history in devising its ambitious plan to reform the health care system, thus dooming the plan to failure from the start? Or did the circumstances of the late twentieth century conspire to kill off a well-meant, if ill-executed, effort? No “cookbook recipe for successful social reform” exists in policy history, writes Hugh Heclo, yet certain patterns can “nudge the probabilities for successful reform efforts in one way or another.” In an attempt to shed light on what happened to the Clinton plan, he places the characteristics of successful past reform efforts into three general categories: (1) the nature of reform objectives; (2) the resources of the political environment; and (3) gestation periods for political learning. Heclo writes, “[T]he interesting question [from a broader historical perspective] is not which particular nail in the horseshoe was faulty, thereby losing the horse, the rider, and the kingdom. The issue is why, in the first place, the kingdom was in a position to be vulnerable to any one or more of these factors.” Heclo is Clarence J. Robinson Professor at George Mason University in Fairfax, Virginia, on sabbatical leave during the spring 1995 semester. He teaches courses in American national politics and social welfare policy. Heclo holds a doctorate in political science from Yale and a master of arts degree from Manchester University in England. He was on the faculty of the University of Essex (England), the Massachusetts Institute of Technology, and Harvard University, and was a research associate and then a senior fellow at The Brookings Institution. The invited comments of Margaret Weir and James Mongan, on both Theda Skocpol’s and Heclo’s papers, follow this essay.*

Did President Bill Clinton and his people make fatal errors in ignoring the lessons of history when devising their health care reform initiative, thereby dooming the plan from the outset? Or did they do the best that could reasonably be expected under the circumstances? After all, reformers have been periodically and consistently failing to achieve comprehensive national health insurance for the past eighty years.

Obviously, we cannot rewind the tape of history and see what, if anything, would have happened if different choices had been made or certain events had not intervened. How should the relevance of past social reform efforts be weighed in relation to the particular circumstances confronting health policy in the early 1990s? Policy history offers no cookbook recipe for successful social reform. Each case is unique, dependent in its politics and outcomes on an immensely complex set of events at a particular time. However, there may be some patterns, central tendencies, contingencies of interaction—call them what you will—that nudge the probabilities for successful reform efforts in one way or another. The working assumption of this paper is that success in reforming social policy generally depends not on hundreds or thousands of detailed circumstances but on certain key background conditions that may be identifiable. If successful past reform efforts have some patterns in common, this may suggest some contingently important conditions that are at least worth considering, in an effort to understand the failure of the Clinton health plan.

The Shadow Of Past Reform Efforts

Successful efforts at big, bold policy reforms are rare in the historical record. Such policy ventures make immense demands on a political environment that is distinctly hostile to the authoritative, coherent use of public power that such innovations imply. By constitutional design, political power in the United States is structurally fragmented. Social policy reformers must struggle in an institutional system that tilts the survival odds in favor of incremental action or inaction and against big new expressions of public authority. More recent developments in our informal, unwritten constitution—declining attachments to political parties, reforms in Congress, proliferating interest groups, widening access to policy litigation in the courts, and so on—have only added to the formal constitutional fragmentation of public power. The result, spread across the historical record, is that major social reform efforts rarely succeed. It is the weaselly, piecemeal adjustments to social policy that make up the bulk of successful reform efforts.

Even so, rarities do exist, and they invite comparison with Clinton's proposed health care reform plan. What is at issue in this discussion is not

whether major social policy reforms were successful in achieving their objectives. The focus here is simply on the success of efforts to enact the reform in question, however misguided that reform's intentions or disappointing its eventual consequences may have been. I concentrate on those rare instances when reformers succeeded in enacting comprehensive national changes in the structure and presumptions of American social policy.

For convenience, I group characteristics associated with successful major reform efforts into three general categories: the nature of reform objectives, the resources of the political environment, and gestation periods.

Nature of reform objectives. The success of major reform efforts should have something to do with the character of the ends being sought. For example, any major proposal is likely to contain an immensely complex series of explicit, implicit, and often crosscutting purposes. But it often helps when these purposes can be encapsulated in a concrete, easily understandable action to express the objective. "Prohibit the sale of alcohol," "guarantee minority voting rights," "prohibit environmental pollution"—such messages, even if vastly oversimplified, can provide a rallying point around which to mobilize reform efforts. By contrast, more ambiguous statements of purpose, such as "cleaning up the welfare mess," may have trouble distilling reform into a simple action message (although "stop welfare for teenage mothers" comes close). At the same time, it can be argued that clear-cut action objectives have also had the effect of mobilizing opposition and that vague reform goals allow appeals to larger, if less single-minded, coalitions. In the end one should probably make only modest claims for the helpfulness of simple, concrete action objectives.

A much stronger case can be made regarding what has been called the "breakthrough" versus the "consolidating" character of reform objectives.¹ Some major reform initiatives deal largely with new subject matter, in the sense that federal public policy is being asked to move for the first time into a relatively unoccupied field. Establishing the first national standards for water and air pollution would be an example. Major reform efforts to break new ground in a relatively open policy field face the formidable initial task of justifying such unprecedented action. However, if the principle behind the action can win acceptance, reformers enjoy considerable latitude in designing the substance of that initiative. Their task is then more technical than political, because few preexisting political interests have to be accommodated. On the other hand, major consolidating reforms are efforts to reformulate a policy area in which a great many program commitments and interests are already in place. The fundamental 1990 revisions to the Clean Air Act fall into this category. Major reform in a well-occupied policy field is bound to encounter resistance from powerful stakeholders already organized around prevailing approaches. Hence, modest, incremental initiatives

are often the order of the day, and big and successful reform efforts with consolidating objectives are especially rare.

Finally, in the category of objectives is another obvious but important point. Successful efforts at major social reform generally have sought policy ends that claim to benefit self-conscious and at least moderately powerful constituencies. There was a time in the nineteenth century when religiously driven moral claims were a vibrant part of social reform movements.² In our more secular time, appeals to social solidarity, altruism, and other noble ends have made little headway unless linked to concrete and politically weighty beneficiary groups. Vast numbers of Americans, for example, have been potential beneficiaries of environmental protection, but federal Clean Air and Clean Water initiatives depended more directly on pressures from a mobilizing if nascent environmental movement, from mayors and governors eager for federal grants, and from businesses fearing the growth of diverse state standards.

Environmental resources. Successful efforts to enact major social reforms may or may not build political credit for the future, but they inevitably make heavy demands on political assets that have been accumulated up to the present. Thus, such efforts are often characterized by a movement-based brand of politics, in the sense that the concrete objective in question has put significant numbers of people in many places “on the move” from neutrality or passive support to active and sustained advocacy. For such people, elections are merely part of a larger policy campaign to win on “their” issue. While reform movements are sometimes confined largely to elites (as seems to be the case with social insurance before 1935), those that are successful most often appear to combine elite and mass levels. The drawn-out campaigns for child labor, civil rights, and pure food and drug legislation are only a few prominent examples.³

Additional advantages seem to accrue to those reform movements that have their assets in the form of what might be called “federated” support for their cause. By this I mean a reform movement organized parallel to the formal state and local structure of our federal system.⁴ This has allowed piecemeal victories at the state level to build momentum for national action; it also has permitted a close articulation between the reform movement activists and the geographical bases of congressional power. The temperance movement is a dramatic example. The Prohibitionists’ federated power was so well articulated that the supporters of repeal wisely prescribed ratification of the Twenty-First Amendment through special state conventions rather than state legislatures, the only time this constitutional provision has been used.

Observers frequently have noted a pendulum swing in the political environment’s resources for reform.⁵ At some times but not others social

reform is said to be “in the air.” In such periods public sentiments are thought to favor a tempo of faster change, more energetic innovation, and greater activism in dealing with the public’s problems. However, such assessments of the public psyche need to be tempered with an appreciation of *realpolitik*. The historical record suggests that major social reform efforts have not prospered simply because a mood of change and reform has been prevalent. The rare periods of fundamental policy reform typically have been associated with the appearance of powerfully unified party majorities in Congress and the White House. More than mere numerical majorities, these have been party formations unified on the heels of an election repudiating what has been portrayed as a regime of the status quo.⁶

The contrast with Democratic victories in 1948 and 1960 is informative. On both of these occasions reform and activism were said to be in the air, and Presidents Harry S. Truman and John F. Kennedy enjoyed numerical majorities in Congress. But these were far from proreform, activist philosophical majorities. Truman’s promised comprehensive national health insurance reform ran afoul of a Democratic party in Congress that was deeply divided over Truman’s liberal civil rights position, among other things. Kennedy faced a similar problem with the conservative Democrats in Congress. Having run as an “activist,” Kennedy proposed and bargained for major social reforms that had grown to be part of the Democratic Party agenda. But he was willing to see most of those reform proposals blocked (Medicare, federal aid for education, Youth Conservation Corps, and so on) or deferred (civil rights enforcement, fair employment practices, and so on) rather than risking defeat in major public battles with Congress. As Kennedy explained, “There is no sense in raising hell . . . in putting the office of the Presidency on the line on an issue and then being defeated.” He allegedly went on to quote Thomas Jefferson that “great innovations should not be forced on slender majorities.”⁷

The breakthrough to successful major reform enactments occurred only with the remarkable events of 1963–1964. A presidential assassination, the uniquely (for Americans) ideological challenge from a disunited Republican party, and overwhelming Democratic majorities in 1964 all combined to produce a rare political environment. Forthcoming were groundbreaking reforms in civil rights, federal education funding, health care, and environmental and antipoverty programs. The peculiarity of that situation was already becoming clear by the end of 1966, as the single-minded Democratic majority unraveled under the impact of racial tensions and Vietnam.

More typical was the experience with major social reform efforts in the Nixon and Carter years. With weak or nonexistent majorities in Congress, both administrations unsuccessfully sought major changes in the welfare system and health care policy. For Jimmy Carter the problems were exacer-

bated by a more fragmented, "reformed" Congress and its ability to frustrate efforts to assemble political resources behind any given reform plan.

A final environmental issue concerns economics. The 1970s marked the closing of a period when the costs of major social reform efforts seemed irrelevant or easily manageable. Successful reform proposals to that point had often carried meager spending implications, depending as they did on new legal and regulatory stipulations. But by the 1970s the residue of past reform successes was itself becoming a dense regulatory thicket of competing purposes. Moreover, postwar reforms with major budgetary implications (such as Medicare and federal aid to elementary and secondary education) had enjoyed a favorable political environment of easy financing through rapid economic growth, declining relative defense spending, and unindexed tax brackets. By the late 1970s concerns about pressures from spending and inflation on the budget were mounting, economic growth and tax revenues were lagging, and signs of taxpayer resistance were appearing on the political landscape. Social reform efforts were entering a political environment that brought not good news about painless possibilities of engineering social progress, but bad news about zero-sum conflicts. Not surprisingly, Carter's health care reform strategists sensed the need to enact new cost control reforms before expanding health insurance coverage as promised in the 1976 campaign. No less surprisingly, such reform proved to be a political orphan, given the diffuse, latent constituency that would benefit from cost controls, the well-organized medical interests that would bear the costs of restraint, and the multiple veto points available in Congress.

Gestation periods. At the risk of straining the language, one might say that successful major reform efforts have been characterized by a sustained, multicentered gestation process. By this I do not mean simply that reforms typically have a long history or that in our complicated political system reformers will not at first succeed and must try, try, and try again. All that is true, but gestation suggests something more. It means a gradual working through and ripening of arguments surrounding an issue. Because they are so important, major reform efforts can profit from the extensive, if messy, deliberative process through which the complex political system achieves not so much a consensus but a clarification of the lines of dissent. Through this process, factual claims are tested and countered, the "problem" is defined and redefined, and alternatives are advanced and attacked. Thus, for example, the warrant for major federal reforms in the 1960s was gradually built in the 1950s through the ongoing interactions and arguments of policy activists in Congress, interest groups, and the executive branch. There, and in the press, major new reform proposals were politically tested and reworked on issues having to do with the environment, civil rights, education, and health care for the elderly, among other things.⁸

Such a gestation process plays an important role in preparing the political ground for successful reform. The very ability to sustain the policy argument over time helps persuade people that there is a real problem that will not go away until something is done. In time, opportunities can present themselves for reformers to split the opposition between those who deny the need for reform and those who acknowledge the problem but reject the reformers' specific proposals. Particular circumstances dictate whether some participants coalesce into a larger reform coalition, but the gestation process draws out the political opportunities for that to happen. As health care reformers endured year after year of delay, "progress" toward the major 1965 Medicare reform was occurring indirectly as congressional opponents inched forward with ineffective half-measures (such as the 1956 Old Age Assistance program and the 1960 Kerr-Mills package).⁹

These then seem to be some of the background conditions associated with successful major efforts to reform national social policy commitments. How, we may ask, does the Clinton experience measure up?

The Clinton Reform Effort

Participants in the 1993–1994 health care debate have offered a variety of reasons for the failure of President Clinton's reform proposal. Some claim that the plan was too complex and bureaucratic and that the planning process was too secretive, too partisan, and too long delayed. Reform backers have contended that the Clinton initiative succumbed to massive spending by the health insurance industry, relentless Republican obstructionism in Congress, and a public campaign of misinformation.

From a broader historical perspective, the interesting question is not which particular nail in the horseshoe was faulty, thereby losing the horse, the rider, and the kingdom. The issue is why, in the first place, the kingdom was in a position to be vulnerable to any one or more of these factors. Making retrospective judgments would be a cheap shot. The purpose here is simply to assess the background conditions that pushed the probabilities for success in one direction or another.

Nature of the objective. 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. Far from encapsulating a simple message, the action to be taken pointed variously toward controlling runaway health costs, to covering the thirty-seven million uninsured Americans, and to securing uninterrupted and adequate coverage for persons already insured. Over time the Clinton reform effort cycled among these appeals, ending in the summer of 1994 on

the theme of security: "Health Care That's Always There."

On substantive grounds, a good case could be made that these were mutually supportive objectives. Without cost controls, universal coverage would be too expensive, and without universal coverage, the control of overall costs would be very difficult. However, the fact of life in the public arena was that these overlapping objectives did not translate into an easily understandable call to action. By the 1990s "health care reform," like "welfare reform," inevitably represented an ambiguous rallying cry. 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.

The second consideration concerning reform objectives deserves greater weight. When reformers revisited national health insurance in the 1990s, there could be no question that the ends in view were what we have referred to above as "consolidating" rather than "breakthrough" in nature. Reference to the Clinton plan as affecting "one-seventh of the economy" was really a shorthand way of saying that an enormous array of existing arrangements now crowded the policy landscape. On the one hand, this meant that Clinton had the advantage of not having to make and win a "breakthrough" policy argument with the general public (or courts). By 1992 a major federal government role in the health care system was widely accepted on all sides as legitimate. On the other hand, it also meant that the president had embarked on a campaign for sweeping reform in a field full of powerful groups with an immense stake in the status quo. Here was a preexisting condition in health care with profound political implications.

To be sure, most of the components of the Clinton plan were familiar from past policy debates. What was new—and what places the Clinton initiative in that rarest category of "big and bold" consolidating reforms—was the aim of incorporating all health industry interests into a single, federally designed structure of regulation. The implication was clear: The fundamental work of health reform would be a thoroughgoing struggle of political power, not the technical design of good policy or negotiation about incremental changes.

At the same time, such comprehensive reform aimed to benefit most directly a quite diffuse constituency: the uninsured, workers fearful of losing coverage, and those hard-pressed to pay escalating private insurance premiums. Without doubt this constituency represented a large number of Americans, but it posed the classic problem of collective action by a poorly organized, nonaffluent body of people. Reformers could hope for collateral support by adding sweeteners to the plan for the elderly and others. Also, the financial interests of businesses already insuring their workers could offer some additional, though low-intensity, support to the reform cause.

The fact remained, however, that at its core the reform effort was directed toward a politically weak constituency, who would gain, and a well-organized and well-financed set of interests centered in the insurance industry, who would lose. As far as the objectives of the Clinton health care reform effort are concerned, the structure of the situation firmly nudged the probabilities of success in an unfavorable direction.

Environmental resources. The 1992 election appears to have been one of those times when the pendulum of public sentiments swung toward a proactivist approach to social and economic problems. "Business as usual" was widely perceived to have fallen before the demand for change. To this extent, the political setting seemed generally favorable for the president's reform effort.

At the same time, from a comparative historical perspective, the Clinton reform plan was born into an extraordinarily resource-poor environment. In the first place, there is little evidence that health care reform enjoyed anything like what was termed earlier to be a movement-based politics, much less federated ligaments into the mass body politic. On the contrary, the November 1991 Senate victory of Democrat Harris Wofford in Pennsylvania appeared as a surprising and overinterpreted event precisely because there had been so few signs of grass-roots public interest in health care issues. At best, public opinion polls showed a vague, simple-minded disposition toward cost-free health care reform. Clearly, nothing resembling a serious reform movement existed, except perhaps among policy wonks. Instead, as is typical in the modern era of political consultants, the appearance of grass-roots mobilization was orchestrated well after the partisan policy lines had been drawn in Washington. In the fall of 1993 tens of thousands of "personal" solicitation letters from the president were mailed through the Democratic National Committee. What was envisioned, beyond donations, was a network of citizen groups in all 435 congressional districts (the Democratic Action Network) that would organize speakers' bureaus, rallies, petitions, and ad campaigns on behalf of the Clinton plan. The actual political results appear to have been negligible. Indeed, the major forms of grass-roots power were small-business interests and conservative talk-radio programs opposed to the Clinton plan.

Second, Clinton's major reform effort was launched from an extremely narrow base of presidential political capital. For Clinton, health care reform represented the hope of building a new Democratic majority rather than the consequence of already having a proreform majority behind him. This was reflected in part in the president's meager 43 percent of the popular vote and continued public doubts about the man personally. But in part, too, the Democrats' continued numerical majority in Congress concealed rather than expressed any credible claims for a mandate of transformative

reform from the White House. For all his criticisms of Reaganomics in 1992, candidate Clinton could not launch a thorough, repudiating attack on the prevailing political order commensurate with the public's distaste for that order. This was because the Democratic establishment in Washington was a major part of that received order. It was old Democrats, not Clintonesque "new Democrats," who returned to Congress in 1992. Thus, the wind of reform that blew into town with the new president was not of a strength likely to intimidate opponents of major change, in health care or anything else. While Clinton publicly likened his health plan to the great reforms of Social Security and Medicare in earlier Democratic generations, his political situation resembled that of Kennedy and Carter much more than that of Franklin Roosevelt in 1934 or Lyndon Johnson in 1964.

In fact, President Clinton's command of political resources was actually diminished from the time of either Kennedy or Carter, largely because of long-run trends in public trust and public finances that predated anything Clinton might do. Although it went unrecognized at the time, Kennedy enjoyed the luxury of a large stock of public confidence in the capabilities of government and institutional leadership more generally. His and Johnson's era of reform was also a time of relatively painless choices in taxing and spending, as economic growth drove up revenues and budget deficits had yet to accumulate. Both of these political assets had diminished significantly by the Carter presidency, but Carter's situation was positively rosy compared with the budgetary problems and public distrust of government that prevailed by 1992.¹⁰

On these counts, the resources in the political environment did not bode well for President Clinton's effort at comprehensive health reform.

Gestation periods. No one can claim that national health insurance has gone undebated in the United States. Since Theodore Roosevelt raised the issue in his 1912 presidential campaign, federally supported health insurance has been a recurring, if intermittent, item on the national policy agenda. The question here, however, is not how long the subject has been around but how well the important substantive and political issues were worked through before political capital was put at risk on a major reform effort at a given time.

Compared with other major social reform enactments, the Clinton project falls into the unfortunate category of poorly gestated initiatives envisioned by the textbook presidency. This is not to say that the presidential task force was inadequate in its work, only that for the longer term prior to the task force's work the larger political system had not been particularly involved in thrashing out the political arguments and policy realities underlying such an effort.

The political debate on national health insurance largely disintegrated in

1979 at the end of the Carter administration. For a variety of reasons that need not concern us here, President Carter's health care reform initiatives had stalled in Congress. Sen. Edward M. Kennedy (D-MA), labor's champion on health insurance reform, had launched an internal party challenge to the president's leadership, and mounting concerns about the federal budget only added to the sense of frustration and exhaustion on all sides. Republican control of the White House and mounting deficits in the 1980s added to the sense that major reforms in health insurance were likely to be unattainable, and reformers in Congress settled for cheaper incremental changes such as mandated expansions in state Medicaid coverage.

For all practical purposes, the immediate gestation period for the current round of major health care reform battles began in the hothouse political atmosphere surrounding the 1992 election. Wofford's surprising 1991 Senate victory and subsequent media attention to health issues prompted the Bush White House to hastily frame a proposal for tax credits and deductions that claimed to make health insurance affordable for all Americans. Unveiled in President Bush's February 1992 State of the Union Address, these initiatives were never seriously considered by Congress. Meanwhile, campaign speeches by Democrats in Congress and on the presidential primary trail advanced a variety of health care reform schemes, including single-payer, play-or-pay, and market-based reforms. None of these ideas and their costs could be seriously deliberated in a political system now absorbed with the momentum and staged media events of the presidential campaign.¹¹

For example, early permutations of the Clinton health care reform effort evolved largely in response to immediate campaign needs, especially the need to avoid any discussion of costs and new taxes to pay for reform.¹² In the New Hampshire primary Democratic challengers were countered with a modified play-or-pay proposal. With no new taxes, government coverage of all uninsured Americans would be paid for with savings from cost controls and management efficiencies. The June 1992 manifesto for launching the general election campaign (*Putting People First*) deliberately avoided any mention of whether health care reform would cost or save money. By the fall, Bush's attacks on Clinton as another big-government, tax-and-spend liberal elicited a more detailed plan from the Clinton campaign, again with minimal analysis of financial realities. Universal coverage would be achieved by requiring employers to pay for workers' insurance, by providing government coverage of the unemployed, and by subsidizing insurance premiums for small businesses. Health costs would be held down by managed competition among providers and national limits on overall health spending.

Thus, by the end of 1992 comprehensive health care reform had come to be defined, and explicitly promised, as a purely presidential initiative that

would be fully worked out, presented to Congress in the first 100 days, and passed in the first year of the new administration. And it would all apparently happen with little if any cost to the taxpayer. The danger was that, lacking a more extensive and genuine gestation process—that is, a sustained and fully engaged debate in the political system on the difficult issues of financing and other contentious trade-offs implied by comprehensive change—the real politics of such a reform (both in Washington and in the public's limits of acceptability) remained unknown territory. More even than in the heady 1960s, when Kennedy's and Johnson's reform efforts had profited from gestational scars of the 1950s and the advantage of more abundant political resources, reform in 1993 became a White House deduction about what would work technically and politically.

Heading the health care task force with the First Lady, and managing it through Clinton's personal friend and policy adviser, Ira Magaziner, only made obvious in January 1993 what had been implicit in White House operations since the election: The health care reform effort was to be a continuation of the political campaign to sell a Clinton presidency to the public and rebuild a Democratic majority. As with Johnson's War on Poverty, but without Johnson's political resources, serious reform was now becoming hostage to a president's personal popularity.

While the White House task force consulted widely, its arguments and decisions were made in secret so as to produce a coherent, integrated plan. The plan itself would anticipate and embody the compromises needed to circumvent public fears of big government and higher taxes. This further dimmed prospects for educating Washington and the public about the difficult trade-offs at stake. It also all but prohibited prenegotiated arrangements with those in and around Congress who could be potential allies. From this perspective, any alternatives from congressional Republicans who backed universal coverage or Democrats who advocated a different approach to cost controls could be—and were—seen as a presumptive threat to the political and technical integrity of the Clinton plan. Health care reform was to be a triumph of synoptic policy design and a personal political victory for the president, pointing toward 1996. A number of Republican strategists needed no encouragement to try to turn that partisan challenge into a personal defeat. Eventually negotiators in 1994 would try to produce a single Democratic compromise, but by then it was too late. The great confusion known in the public mind as "health reform" was in full flower.

In sum, conditions were in place firmly to nudge probabilities for a major reform effort toward failure. The enormous challenge of enacting a comprehensive social policy transformation in America's complex political system had been telescoped into an in-house presidential thought experiment as

well as the frenzied footing of a political campaign to sell the resulting brainchild to the public. In the modern history of major social reform efforts, never has a president with so few political resources tried to do so much.

NOTES

1. L.D. Brown, *New Policies, New Politics* (Washington: The Brookings Institution, 1983).
2. T.L. Smith, *Revivalism and Social Reform* (Baltimore: The Johns Hopkins University Press, 1980).
3. M. Keller, *Regulating the New Society: Public Policy and Social Change, 1900–1933* (Cambridge, Mass.: Harvard University Press, 1994).
4. T. Skocpol, *Protecting Soldiers and Mothers* (Cambridge, Mass.: Belknap Press, 1992), 530, 537–538.
5. J.L. Sundquist, *Politics and Policy* (Washington: The Brookings Institution, 1968), 500; and J.W. Kingdon, *Agendas, Alternatives, and Public Policy* (Boston: Little Brown and Company, 1984), 198.
6. S. Skowronek, *The Politics Presidents Make* (Cambridge, Mass.: Belknap Press, 1993).
7. A.M. Schlesinger Jr., *A Thousand Days* (Boston: Houghton Mifflin, 1965), 591.
8. Sundquist, *Politics and Policy*.
9. T.R. Marmor, *The Politics of Medicare* (Chicago: Aldine, 1973).
10. C.E. Steuerle, “Long-Run Fiscal and Budget Issues” (Unpublished paper, The Urban Institute, Washington, D.C., 20 July 1994); and The (Los Angeles) *Times-Mirror* Center, “The New Political Landscape” (Mimeo, Washington, D.C., 1994).
11. For a realistic account of how policy ideas are used and abused in such a situation, see D. Blumenthal, “Health Policy on the High Wire: Thirteen Days with a Presidential Campaign,” *Journal of Health Politics, Policy and Law* (Summer 1992): 353–373.
12. Summary press accounts can be found in R. Pear, “The 1992 Campaign: Issues—Health Care,” *The New York Times*, 12 August 1992, A1; M. McNamee, “Health Reform Hits the Campaign Trail,” *Business Week* (30 August 1993): 34–35; M. Duffy and D. Thompson, “Behind Closed Doors,” *Time* (20 September 1993): 60–63; B. Solomon, “Clinton’s Inscrutable Health Plan,” *National Journal* (18 September 1993): 2260–2261; A. Clymer, R. Pear, and R. Toner, “The Health Care Debate: What Went Wrong,” *The New York Times*, 29 August 1994, A11; and R. Toner, “National Health Program, President’s Grandest Goal, Is Declared Dead in Congress,” *The New York Times*, 27 September 1994, A1.

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