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THE 1993-1994 HEALTH CARE REFORM CAMPAIGN: THE INFLUENCE OF POLITICAL ADVERTISING AND NEWS MEDIA COVERAGE ON PUBLIC OPINION

By

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A DISSERTATION PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
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The following dissertation is dedicated to all of the people who have stood by me throughout the most challenging period of my life so far. A wise person once said that we should judge others by the company that they keep. My family has been a great source of strength and should serve as a model for success. Anything that I accomplish, indeed all that I am, is due to them. And I cannot thank them enough.

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Abstract of Dissertation Presented to the Graduate School
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THE 1993-1994 HEALTH CARE REFORM CAMPAIGN:
THE INFLUENCE OF POLITICAL ADVERTISING AND
NEWS MEDIA COVERAGE ON PUBLIC OPINION

By

Michael David Cohen

August, 1996

Chairman: Dr. Stephen Craig
Major Department: Political Science

The 1993-1994 health care reform effort led by President Bill Clinton was born of, and died due to, public opinion. Although several national leaders had attempted and failed to shepherd national health coverage to law, Clinton attempted to set the agenda by appointing the First Lady to head an unprecedented health care task force. The final report was 1,354 pages and detailed almost every conceivable element of a new system, in which the national government had a substantial role. In September 1993, President Clinton delivered a prime-time health care address to the Congress. Initial public reaction, and press coverage of the Health Security Act of 1993 was strongly favorable. Fifty-nine percent of persons surveyed said that they supported the plan. By the end of summer, the following year, support for the plan dropped to 40 percent, leading Clinton to shelve his plan. Regression and time-series analyses were conducted to determine if the "Harry and Louise" advertising campaign against the Clinton initiative was correlated to, or may have caused, increasingly negative news coverage and a decline in public

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support of the plan. Shifts in news reporting of the Clinton health care plan were found to occur after major ad campaigns. Declining plan support was found to follow increases in negative news coverage. Other variables were found explanatory including lagged indicators of valenced news media content, the economy, and time. As the economy got better, public support for the Clinton plan dropped. As time passed, support fell. The complete model explained over 85 percent of the variance in support for the Health Security Act of 1993.

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CHAPTER 1
INTRODUCTION

Modern health care has enhanced and prolonged life expectancy, providing us with extended liberty and happiness. Reform of the health care insurance and delivery system in the United States challenges each tenet of this uniquely American version of Lockean democratic theory. In 1993 President Bill Clinton set out to reorganize the relationship between patients and doctors to decrease costs and increase the number of citizens with health insurance. After a ten-month "campaign" the administration retreated from its own proposals, encouraging like-minded legislators to take on the battle. Many chose to steer clear, and those who did not failed to bring a bill to the floor of a Congress controlled by Clinton's party.

The following research will review the health care system in the United States, outlining its strengths and deficiencies with an eye to a rationale for reform. I will also provide a glimpse at how other industrialized nations manage to provide care to their citizens. Then, from an historical perspective, this study will discuss previous American attempts at reform, setting the stage for President Bill Clinton's proposed Health Security Act of 1993. Once the details of the Clinton plan are reviewed and important terms defined, I will try to explain how the plan failed to maintain sustained public support.

American Health Care

To date, the United States remains the only industrialized nation without a national system of providing guaranteed health care for its citizens (Moore 1994). The American market-based system has produced cures and treatments for many of the

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world's worst ailments and diseases. It provides approximately 85 percent of its citizens with insurance that helps to cover much of the cost of staying healthy (Cranford 1993). Moreover, the system guarantees individuals the liberty to choose their own insurance carriers (or to be uninsured), doctors, medications, and treatments.

But the system is far from perfect. Nearly 15 percent of the United States population, about 36.6 million persons, were uninsured in 1991 (Cranford 1993). The United States health care system is also highly inflationary and increasingly out of the reach of the middle class. Further, the health care system is quite volatile and disparate as quality varies considerably with the patient's ability to pay. Insurance companies may drop their clients if they switch jobs or restrict coverage to those who have pre-existing medical conditions (Graig 1993). Policymakers in 1993 sought to address these problems.

Other Industrialized Nations

The shortcomings of an unfettered market have led virtually all other industrialized nations to provide some form of health care for its citizens (Center for Public Integrity 1994). Systems vary from total government control in the former Soviet Union to comparably limited public roles such as in Japan (Moore 1994). Although each system is unique, most fund health care through a combination of taxes and government mandates on private businesses (Center for Public Integrity 1994; Graig 1993).

Since the fall of the Soviet Union, England remains the most acute example of a centralized health care system (Moore 1994). The national government effectively controls all aspects of the means of providing care to its citizens (Graig 1993). Every person in Britain is provided care free at the point of service paid for through tax revenue (Center for Public Integrity 1994). Since the government owns most hospitals and employs doctors very little money is exchanged between patients and care givers (Center

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for Public Integrity 1994). Despite universal coverage and effective cost containment, the system produces long waits for many services (Moore 1993).

Canada is an example of a single-payer system, in which the national government is the only organization allowed to sell citizens health insurance. The system provides ready access to high-quality care, and costs are limited by government officials who set limits on fees that hospitals and doctors can charge their patients (Graig 1993). Canada also contains costs by rationing "billing numbers" needed by doctors for service reimbursement (Moore 1993). This effectively limits the number of practicing physicians and helps to keep health care costs for individuals lower (Moore 1993).

In Japan, health insurance is based on employment and is funded through payroll taxes and employer mandates (Center for Public Integrity 1994). The pay-or-play mandate requires companies to either provide health insurance for their employees or pay into a government-run insurance fund, which also covers the unemployed (Moore 1993). The Japanese system allows for private insurance companies to only provide only supplemental insurance to citizens (Center for Public Integrity 1994). Despite mandated insurance coverage, patients get to choose their own physicians. Still, the Japanese government plays a large role in setting rates that employees and employers pay, care-giver fees and drug prices, and the content of health-care insurance packages (Graig 1993).

America Attempts Health Care Reform

President Clinton was not the first American president to propose national health care system reform – he was not even the first in this century. No less than eight presidents, Democratic and Republican, have tried to reform the American health care free market to increase availability and decrease costs. For a variety of reasons, both political and practical, success has been limited (Center for Public Integrity 1994).

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In 1912 Theodore Roosevelt, then a candidate for president under the third party called the Progressives, was the first to suggest that the United States should adopt a national health insurance system that would cover all working people (Wong 1993). Unsuccessfully, he argued that other industrialized nations had enacted successful reform and it was time for America to follow suit (Center for Public Integrity 1994). Roosevelt lost his bid for the White House that year but the issue would be revisited.

Franklin Delano Roosevelt, Theodore Roosevelt's cousin, was the first sitting president to attempt health care reform (Center for Public Integrity 1994). The second Roosevelt effort was connected to a report that the Committee on Economic Security issued in 1935, which resulted in the Social Security Act of 1937. The report called for a national health insurance system (Wong 1993). However, Roosevelt quickly backed off the recommendation in response to strong opposition from the upstart American Medical Association (AMA) interest group. At final passage, Social Security provided some maternal and child services but not universal health care (Center for Public Integrity 1994; Wong 1993).

Harry S. Truman was next to endure the wrath of the AMA lobby. Truman asked Congress to pass national health insurance so that people could be protected from the financial fear of disease (McCullough 1992). Truman proposed to finance the project entirely through payroll taxes and would provide services to all Americans regardless of ability to pay for them (McCullough 1992). The AMA launched a substantial advertising effort in conjunction with inside-the-beltway lobbying (Center for Public Integrity 1994). Derisive language was widely used to describe the plan (McCullough 1992). In the end, congressional Republicans and public opinion soured against the plan, considering it too liberal for the 1940s (Center for Public Integrity 1994; Wong 1993).

But one president beat back health care reform critics and won some substantial gains on the coverage side of the issue. In 1965 President Lyndon B. Johnson signed into law Medicare and Medicaid, two programs that have endured into the 1990s, established

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for the medically indigent. Both programs cover most persons over the age of 65 and pay a percentage of the cost of outpatient fees, hospital care, limited stays in nursing facilities, and some additional medical expenses (Wong 1993). The American Medical Association and other groups again attacked but Johnson, a former legislator, deftly negotiated the compromise (Center for Public Integrity 1994). Today, the program is an entitlement financed through Social Security taxes and, due to rising costs and decreasing mortality rates, has grown to dominate a substantial portion of the national budget (Greenberg and Page 1995). As one of the crown jewels of President Johnson's Great Society effort, it has become a lightning rod for conservative Republican fear and scorn and liberal Democratic defense (Hager 1995a).

After three relatively liberal attempts to reform the health care system, a conservative (for his time) Richard M. Nixon pronounced that the United States faced a "massive crisis" in health care in 1969 (Wong 1993). Nixon viewed the massive increases in costs as the primary reason to engage in reform (Center for Public Integrity 1994). He suggested the expansion of health maintenance organizations (HMOs) and tax incentives for employers to provide health insurance with their jobs (Wong 1993). Nixon failed due to backlash from interests including, again, the AMA and business groups who feared that "mandates" would result in bankruptcies (Center for Public Integrity 1994; Wong 1993).

The last gasp at substantive national reform would occur during the Carter administration. Carter proposed caps on dollar amounts that hospitals could receive from private and government sources (Wong 1993). But by the time Carter suggested his plan in 1979, he was substantially marginalized in the Democratic Congress and was en route to suffering a landslide beating in the electoral college the following year (Wong 1993). Republican presidents Reagan and Bush had no stomach for a nationalization of the health care system. Each marginally cut federal benefits to reduce federal costs, which increased despite their efforts (Wong 1993). Neither reformed the system of private care

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and insurance (Center for Public Integrity 1994; Wong 1993). Prospects for national health care reform appeared dead with Republican dominance of the Oval Office. Moreover, the public appeared to be less and less confident in the efficacy of government to solve problems (Craig 1993).

An Important Election: United States Senate, 1991

The resurgence of the national health care debate began, ironically, with the tragic death of United States Senator John H. Heinz III, R-Pa., in the Spring of 1991. A special election was held to fill the seat and it was widely viewed that President Bush's attorney general, Dick Thornburgh, would succeed Heinz. Opposition was difficult to recruit since Pennsylvania had not elected a Democratic senator since 1962 (Center for Public Integrity 1994). Gov. Robert Casey finally persuaded a friend and member of his cabinet, Harris L. Wofford, to challenge the popular Thornburgh (Center for Public Integrity 1994).

Wofford hired the not-yet famous consulting team of James Carville and Paul Begala to handle his fledgling campaign. Early polling depicted a rather bleak picture of the race demonstrating, at one point, a 47 point advantage for Thornburgh (Center for Public Integrity 1994). After further research, Carville and Begala found that if fair descriptions of each candidate were provided, Wofford closed the gap. The one issue that appeared to strike a chord with citizens of Pennsylvania was national health care reform (Center for Public Integrity 1994). In turn, Wofford defined health care reform as a central issue in the campaign. The unexpected move was not effectively countered by the Dick Thornburgh team. And when the ballots were counted, the Democratic underdog, Harris Wofford, was elected Senator.

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Another Important Election: President, 1992

News of the Pennsylvania upset caught a national audience (Center for Public Integrity 1994). Wide-eyed Democrats began to look at the Carville/Begala/Wofford health-care strategy as a partial means of recapturing the White House after twelve years of Republican presidents (Woodward 1994). One of them was Bill Clinton, governor of Arkansas. Carville and Begala joined the Clinton campaign in December 1991, the opening days of the 1992 presidential primary season. Clinton had worked on the health care issue as chair of the National Governors' Association and through his involvement with the Democratic Leadership Council (Woodward 1994). The political marriage of Clinton and health reform was set to crystallize in 1992.

During the Democratic primaries, Senator Bob Kerry of Nebraska was the first to place national health insurance on the agenda (Center for Public Integrity 1994). Kerry scored some political points by attacking Clinton on the basis that he did not have a plan. In response, Clinton, rejecting Kerry's endorsement of the Canadian single-payer approach, asserted that reform should provide universal coverage without raising taxes (Center for Public Integrity 1994). The Clinton campaign released a New Democrat approach which relied on a private system of employer mandates and some form of managed competition to control costs and increase the number of Americans insured. This approach provided a substantive answer to Clinton's critics and helped to secure him the Democratic nomination (Center for Public Integrity 1994; Woodward 1994).

Health care would remain a major issue in the national election. Bill Clinton continuously attacked incumbent George Bush for not doing anything substantive to reform the health care system (Center for Public Integrity 1994). Although reform registered within the electorate, Clinton campaign officials warned that the issue necessitated some political finesse (Center for Public Integrity 1994). Ira Magaziner detailed the problem in an October memo which asserted that Clinton had to balance

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concepts of free-market and managed competition so as not to offend Americans skeptical of government involvement (Center for Public Integrity 1994).

Clinton, in the end, stayed on-message and was elected with 43 percent of the popular vote in a three-way race. According to exit polls, Americans voted for action on the economy and jobs (43 percent), deficit reduction (21 percent), and health care reform (19 percent), respectively (ABC News et al. 1992). Despite a plurality victory and only modest gains in the Congress, the president-elect began immediately to refine an ambitious plan for the nation's health care system (Woodward 1994).

President Bill Clinton's Turn

To Bill Clinton, 1993 was to be the year that he made his mark on American history. President Clinton was poised to free Americans from the fear of losing their health insurance. No longer would health care be a privilege available only to those who could afford it. No longer would citizens stay in their jobs simply to avoid being uninsured. The nation would take back its health system from what the White House viewed as an oligarchy of physicians and insurance companies who were responsible for staggering cost increases affecting all Americans (Rubin 1993).

On January 25, 1993, President Clinton announced the formation of a task force to assist him in developing health care reform legislation. In an unprecedented move, Clinton appointed First Lady Hillary Rodham Clinton to head the administration's work group (Center for Public Integrity 1994). The 13-member group was comprised entirely of administration officials, including members of the cabinet and domestic policy advisors. The task force was expanded to include 15 "cluster" groups of health care experts charged with examining every aspect of the health care system. Each cluster group set up more than 40 "working groups," which further detailed specific issues

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ranging from types of coverage to cost factors. In all, over 500 people worked for the task force according to the White House (Center for Public Integrity 1994).

President Clinton promised the American people to present a plan to reform the country's health care system within the first one hundred days of his term (Nelson 1993). For a variety of political and practical reasons, this deadline was not reached. It is again important to remember that health care was the stated third priority of exit poll respondents. Upon election, Bill Clinton moved to deal with the first two, the economy and jobs, and the deficit (ABC News et al. 1992; Woodward 1994).

Clinton had promised to "focus like a laser beam" on the economy first and, perhaps because of timing or due to the salience of the issue, the administration focused on that issue first (Cohen 1994). The drafting of his first budget was a nonlinear process which featured different policymakers and consultants vying for control (Woodward 1994). Major provisions of the plan were scrapped or revised during the writing of the administration's budget plan. Internal battles over the budget consumed much of the new president's time and energy (Woodward 1994). The administration thought that the momentum of a victory on the economy would carry health care reform (Woodward 1994; Kerbel 1995). But the final package was passed by narrow margins in both houses of Congress (including a tie-breaker cast by Vice President Gore in the Senate). The administration vowed to learn from its narrow victory with confidence that "nothing was going to stop them" (Woodward 1994, p. 334).

The Clinton goal of providing a health care reform blueprint suffered from some unexpected political missteps and miscalculations, including an attempt to unilaterally lift the ban on gays in the military, troubled executive appointments, and a focus on personal matters such as the infamous haircut fiasco[1] (Cohen 1994). On Capitol Hill, the

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[1] In early January, the newly elected president got into some trouble when a highly-priced hair stylist cut Clinton's hair on Air Force One. The matter was compounded by reports that the transaction held up air traffic at a public airport.

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Democratic Congress viewed the election of Bill Clinton as a signal to pass into law several bills previously vetoed by Republican presidents Reagan and Bush (Abramson et al. 1994, p. 282). During the early days of his presidency, Clinton was quite accommodating, signing the Brady Gun Control and the Family Leave bills into law (Congressional Quarterly 1993). Later in his first year, President Clinton also put the full weight of the White House behind passing the controversial North American Free Trade Agreement, mainly supported by Republicans. All of this legislative activity provided the task force more time, which it needed (Center for Public Integrity 1994).

Despite the size of the task force and the time it took to formulate a plan, some notable sources of information were kept from the process. Interest groups were kept largely out of the loop (Center for Public Integrity 1994). The purpose of the task force was to circumvent special interests and come up with a plan that was based on government experts, not self-interested groups (Rubin 1993). Although interest groups were consulted at times for information, they were not included in the plan generation (Center for Public Integrity 1994). In addition, since the task force met in secret, the press was alienated from the discussion of reforming one-seventh of the national economy (Center for Public Integrity 1994). This, in turn, kept the public out of the debate. Despite allowing input from hundreds of health care professionals, the formal exclusion of these parties would come back to haunt the health care reform task force.

In early fall, the White House judged that the Capitol and the national mood was ready for the unveiling of their health care reform package (Rubin 1993). President Clinton presented the plan before a prime-time joint session of Congress on September 22, 1993. The speech was carried live by network television and represented the first time that the public was to receive the details of how the administration planned to reform American health care. The 1,364-page Health Security Bill addressed almost every conceivable element of the system (Rubin 1993). President Clinton challenged the

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Congress to pass a bill that covered all Americans. If not, he warned that he would use the veto for the first time in his administration.

President Clinton's speech was followed by the generally well-received congressional testimony delivered by task force chief Hillary Rodham Clinton (Center for Public Integrity 1994). Without notes, the First Lady explained and defended the plan to Congress, the press, and the nation. Hillary Clinton demonstrated the various complexities of the plan in masterful form, prompting favorable reaction across the political spectrum (Rubin 1993). This one-two punch provided strong initial public support for the plan. In late September 57 percent of the American people approved of the Clinton reform package while only 31 percent disapproved (Gallup 1993).

Details of the Clinton Health Care Plan

The Health Security Bill of 1993 was a departure from the free-market driven system, replacing it with guarantees of permanent coverage for all Americans (sometimes called "universal coverage") and rearranging the relationship between patients and providers. Clintonites called this new system "managed competition" since it combined market forces with government regulation to increase coverage and cut costs (Center for Public Integrity 1994). The Clinton plan was neither a government takeover of private business nor a version of the centralized British and Canadian systems (Moore 1993).

Instead of buying coverage plans from insurance agents, the government would become the primary link between citizens and health care providers through entities called "regional health alliances," formed in each state (Rubin 1993). Alliances would bargain with local health care providers for low-cost, high-quality service and produce health insurance packages. These plans would be approved by the National Health Board, a new government body appointed by the president to oversee standards and budgets for local alliances. If the local entity exceeded their budget or provided less than

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standard service, the alliance would then explain why to the National Health Board, which, would get the last word in the process.

Under the Clinton plan, all citizens would be covered by law. If they were working, their employers would pay at least 80 percent of the cost for insurance (Rubin 1993). Part-time employees would be covered on a pro-rated scale. Retirees from ages 55 to 65 would have the federal government contribute 80 percent of their insurance payments. Costs not covered by companies or the government would fall upon private citizens.

Despite the expansion of coverage, many government health programs would remain in some form. The health care program for the elderly, Medicare, would continue with little change (Rubin 1993). The national government would also continue to subsidize poor families through Medicaid. However, these patients would buy into regional health alliance plans. Low-income workers and unemployed citizens would receive government assistance to help defray some of the costs of health care insurance.

The Clinton health care system was to be funded through "employer mandates" not unlike Japan's financing mechanism (Moore 1993). While Japan requires all employers to cover all costs for all employees, the Clinton system would require companies to pay only a portion of their employees' health insurance regardless of whether they work full-time or part-time (Moore 1993). For companies with fewer than 50 employees, the national government would provide insurance subsidies (Rubin 1993).

The employer mandate was relatively well received by large companies who could cut back their health coverage and still be in compliance with federal law (Center for Public Integrity 1994). The picture would be considerably less clear for small businesses. The latter would fight hard and early during the debate on the Clinton plan (Center for Public Integrity 1994). And the former would find plenty to quarrel with before long.

Unlike the goal of attaining universal coverage, the Health Security Bill of 1993 contained several provisions that the administration viewed as negotiable. Indeed, Ira

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Magaziner, key member of the First Lady's task force, explained in an interview that the plan was not written in stone. "We are not coming down from the mountain with the tablets," he said (Rubin 1993, p. 7). Highly controversial items such as the employer mandate, cuts in Medicare, and caps on health-care spending and insurance premiums led affected interest groups to enter the debate. Their influence was felt immediately by members of Congress and the administration. Parts of the plan had to be reworked by legislators wary of passing a government take-over of the nation's health care system (Center for Public Integrity 1994). Clinton attempted to steer the debate but ultimately failed.

Interest Groups Respond

Once the Clinton plan was laid on the public table, unhappy interest groups began a campaign against it. Approximately 650 interests descended upon Capitol Hill in an attempt to influence the final product (Center for Public Integrity 1994). In retrospect, this is not surprising since the health care industry generates roughly $800 billion a year in business and represents one-seventh of the national economy (Center for Public Integrity 1994). Veterans of previous health reform battles, including the AMA, weighed in on the Clinton plan. Nurses, surgeons, specialists, hospitals and health care facilities, organized labor, and business interests all lobbied Congress and the administration during the debate (Center for Public Integrity 1994).

One interest group, the Health Insurance Association of America (HIAA), launched a multimillion dollar advertising campaign that took issue with several key components of the Clinton plan (Center for Public Integrity 1994). Heading the lobbying team was former congressman Bill Gradison (R-OH). Upon leaving Congress in 1992, Gradison was offered the job to lead HIAA. Most conspicuous among the HIAA media blitz was a series of television advertisements portraying a fictional couple worrying

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aloud about the details of the president's health reform plan (Kolbert 1993). According to the Center for Public Integrity, "no group has ever blitzed the public policy process with television commercials to this extent" (Center for Public Integrity 1994, p. 27).

Clinton Response

During the 1992 campaign the Clinton "Rapid Response Team" had become legend. Whenever opponents had attacked their candidate, Carville, Begala, and company had a direct and effective response on the air almost immediately. The Clintonites had learned much from the demise of 1988 nominee Michael Dukakis. Without a response, an attack is much more effective. Political science and mass communication research have supported this thesis (Cohen and Weigold 1994; Weigold and Sheer 1993).

But in the early days of the campaign for health care reform, the Clinton White House "rapid response team" was clearly outflanked. The HIAA and others were allocating more dollars toward the effort than supporters of the plan (Center for Public Integrity 1994). The "Harry and Louise" ads, described in greater detail in Chapter 3, provoked direct criticism from President Clinton and the First Lady. Hillary Rodham Clinton's demonization of the health insurance industry was clearly not working (Center for Public Integrity 1994). Moreover, the press had picked up on the skirmish and transformed the conflict into one of the major stories in the debate (Center for Public Integrity 1994). Advertising messages that were originally targeted in key congressional districts and major population centers had been repeated in print media (Center for Public Integrity 1994). Most television network coverage aired the Harry and Louise ads in their stories, providing even greater reach (Kerbel 1996).

In an interview with the Center for Public Integrity, Gradison noted that White House criticism of the ads led to network coverage which may have precipitated a drop in

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public support for the health care plan (Center for Public Integrity 1994, p. 28). The poll numbers certainly appear to support Gradison's claim. During the six-month period when the Clinton administration hoped to build public and congressional support for the plan, polls recorded an 18 point dive to 39 percent in favor and 46 in opposition (Gallup 1994). By the time that Bill Clinton belatedly voiced a formal eulogy of the Health Security Bill in late summer 1994, a large majority of Americans opposed the president's plan (Gallup 1994; Harris 1994).

Congress Responds

Once the Clinton health care plan was officially delivered, Congress assigned the detail work to five committees: Senate Finance, Senate Labor and Human Resources, House Education and Labor, House Ways and Means, and House Energy and Commerce. Many Republicans, including Senate Minority Leader Bob Dole of Kansas, were talking of a compromise reform bill reflecting Clinton's goal of attaining "universal coverage for all Americans" (Center for Public Integrity 1994). The loyal opposition was willing to deal early in the debate. But if momentum was on the White House side of the issue, it did not last. And if both friendly and opposition members of Congress appeared to be amenable to reform, that too was about to change.

As support for the president's initiative continued to slide in early 1994, other Democrats began to propose alternatives and Republicans began to unify against reform. Representative Jim Cooper, D-Tenn., introduced his version, describing it as "Clinton Lite" which offered universal access to health care (the removal of barriers to purchasing health insurance such as pre-existing conditions) instead of universal coverage sought by the administration (Center for Public Integrity 1994). Cooper's plan jettisoned the two most criticized parts of the Health Security Bill: insurance premium caps and employer mandates. Cooper reportedly sought White House support for his alternative but was

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snubbed (Center for Public Integrity 1994). Cooper was not successful in Congress either. His plan never saw the floor of Congress. Moreover, the representative lost a bid for the Senate in November to former Watergate counsel and sometime actor Fred Thompson. Perhaps Cooper was ahead of his time since a bipartisan version of his plan was later introduced by a Senate coalition led by Nancy Kassenbaum (R-KS) and Edward Kennedy (D-MS) (Congressional Quarterly 1996). Similar bills in the House of Representatives also reflect the Cooper formula.

By mid-summer 1994, four congressional committees approved health care legislation in some form (Atler and Waldman 1994). None of the bills completely followed the Clinton formula but two came close. The Senate Labor and Human Services Committee and the House Education and Labor Committee both yielded bills providing universal coverage substantially paid for via employee mandates (Atler and Waldman 1994). However, these bills did not enjoy bipartisan support. One that did was passed by the Senate Finance Committee and its chair Daniel P. Moynihan of New York. The Finance Committee plan eliminated the Clinton employer mandate, instead opting for phased-in cost controls to pay for future universal coverage (Atler and Waldman 1994). The fourth committee, House Energy and Commerce Committee, was hopelessly deadlocked (Atler and Waldman 1994).

Compromise between the three viable plans was not reached perhaps due to Clinton's veto threat or the distinct lack of public support for the administration's initiative. After Clinton finally declared his own plan dead in late summer 1994, he solicited the help of supporter Senate Majority Leader George Mitchell for a last-ditch at health care reform (Newsweek 1994). Mitchell, passing up a nomination to the United States Supreme Court (bad choice), tried to shepherd a reform bill as his final achievement in Congress. He, too, failed to rally bipartisan support or even members in his own party. The 103rd Congress never voted on a plan to reform the nation's health care system (Congressional Quarterly 1994).

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End Game

Despite 40 percent approval for his plan, Clinton promised that the 1994 midterm elections would be a referendum on health care reform and Republican opposition to it (Gallup 1994; Harris 1994; Newsweek 1994). If the election was about Clinton's plan (a dubious claim), he was soundly defeated. On November 8, 1994, Republicans seized control of both houses of Congress for the first time in over 40 years. The agenda had shifted once again. Instead of universal coverage as proposed by the Clinton administration, the new Republican majority spoke of "saving" Medicare and Medicaid by slowing the growth of costs (Congressional Quarterly 1996). Whether or not it will shift back toward reform that would guarantee universal coverage is anyone's guess.

Explanations and Hypotheses

The simple question that this study will investigate is how all of this happened. From historical accounts of the 1993-94 health reform process, it is clear that the downward shift in public support for the Clinton plan affected the actors involved in producing legislation (Kerbel 1995). As Americans turned against the Clinton health care plan it became more difficult to sustain congressional support or compromise on a feasible alternative that would reach the goal of universal coverage (Wright 1995).

Declining public support encouraged congressional Democrats to sidestep the Clinton plan, with some members proposing alternatives while others abandoned the notion of national reform entirely (Wright 1995). Moreover, deepening opposition to the Clinton plan emboldened and united congressional Republicans against any version of reform, especially one that resembled the president's (Pious 1996). This inquiry is based on the notion that the decline of public support slowed and eventually halted the policy process in favor of system-wide health care reform.

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But how did strong public support for the Clinton reform plan turn into strong public opposition against any health care reform (Gallup 1993, 1994)? This more complex question seeks to assign a measure of responsibility to some groups of individuals or interests. By viewing the polling data and historical accounts of the health reform policy process, one finds that support of the Clinton health care plan dropped almost immediately from its high-water mark in late September 1993 (Gallup and Harris polls 1994). With the exception of polls conducted around the president's State of the Union Address in January, measures of support for the plan steadily dropped throughout the fourth quarter of 1993 and into the summer of 1994 (Gallup and Harris polls 1993 and 1994).

Since the drop appears to almost be immediate, one must look for factors that would negatively affect support for the plan around the time it was proposed. Academicians and practitioners agree that most Americans get their political information from the mass media (Ansolabehere, et al. 1993; Patterson 1994). Many media observers also agree that television is the main source that Americans choose from the myriad of choices they have (Kerbel 1995; Kern 1989; Zaller 1992).

Therefore, a plausible question to ask would be, did the content of news media coverage change from predominately a positive to a negative valence against the Clinton Health Care Plan? In addition to news, another plausible question would be, was there another factor on television that influenced public opinion? One likely source for both negative news and other television programming was the multimillion dollar Harry and Louise campaign primarily sponsored by the HIAA (Fallows 1996).

The formal hypotheses follow from the context cited above: that (a) negative interest group advertising had a progressively negative effect on news media reporting of the Clinton health care plan; and (b) news media reporting had a progressively negative effect on public support for the Clinton health care plan. In the chapters to follow, tests

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of these hypotheses will be grounded in academic and popular literature and vigorously tested. But now, let's recap what we know so far.

Summary

Health care in the United States is a market-based system that covers approximately 85 percent of its citizens at a high rate of inflation. Other industrialized nations employ differing forms of a health care system, which provide coverage for all of their citizens while maintaining a lower rate of inflation. However, these systems rely on governments to either fund or closely regulate how health care is delivered and administered. At various times in the 20th century, United States presidents have proposed reforms but with limited success on the coverage end, not the inflationary side.

The election of underdog Harris Wofford (D-PA), a pro-reform candidate, to the United States Senate signaled a resurgence of the health care issue to Democratic presidential hopefuls. Bill Clinton, with the advice from Wofford's campaign team, co-opted the strategy and promised to push for a "managed competition" solution. Exit polls indicated that health care reform was the third priority for Americans in 1992. But with 43 percent of the popular vote and only slight gains in Congress, Clinton nevertheless pushed for reform by appointing a special task force headed by First Lady Hillary Rohdam Clinton.

Initial public opinion of the task force recommendations was quite favorable but it did not last. Interest groups, led by HIAA, launched an effective media campaign against Clinton's Health Security Bill of 1993. The effect of the blitz was to provoke White House responses, which paved the way for more negative news coverage of the reform initiative. As public support for the Clinton health care plan waned so did its support in Congress, encouraging Republicans to jettison their passive-resistance strategy in favor of

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attacks. Congressional Democrats abandoned the plan, leaving the loyal minority unable to compromise and gain enough support to send a bill to the floor of Congress.

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CHAPTER 2
LITERATURE REVIEW

To this point I have discussed the factual history of the Clinton health care plan, placing it within the context of other national systems and other U.S. attempts at reform. Chapter 1 outlined the political lifecycle of the plan from its origins when Clinton was governor of Arkansas, to the naming of Hillary Rodham Clinton as task force chief, to the plan's failure on Capitol Hill. As the details of the Clinton health care plan surfaced, so did targeted opposition. I assert that the magnitude and nature of the response to the plan by interest groups negated initial positive news reaction, thereby souring public opinion.

But the failure of the Clinton effort was more complicated than its simple history. The demise of health care reform was the structural collapse (or rally) of a five-legged stool held up by a conflicting set of political actors, mainly negative political advertising, a skeptical and conflict-seeking press, variable and ambivalent public opinion, and a central but tenuous link between the people's desires and policy outcomes. This chapter will further the argument with support from previous research.

American Representation

Before discussing the various interests vying for the affections of the public, let's first lay the foundation with the theoretical basis for my argument. We must first establish that the people are relevant in the policy process before describing how they were influenced. The responsiveness of government policy to the preferences of the people is a normative democratic issue well-covered by political science (Dahl 1956; Arrow 1963; Sen 1970). Despite the Founders' original intent to construct a system of

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representative democracy where the people are sheltered from direct governance, modern policymakers keep a careful eye on the public pulse (McCombs et al. 1991), some say too careful (Kerbel 1995).

In an update of Miller and Stokes' (1963) classic article on the relationship between constituency behavior and public opinion, Erikson (1978) reexamined the data and found an even more powerful connection. Erikson concluded that representatives respond correctly to perceived constituency opinion. But at the same time people are gaining influence in government, their efforts are blunted by the Founders' careful constructions and modern realities (Erikson et al. 1988). Staggered election cycles, split-ticket voting and divided control, as well as division of power among local, state, and federal governments combine to confuse the electorate, making it difficult to assign responsibility to any in- or out-party for policy success or failure (Fiorina 1992).

As the varying levels of government expanded their role in American society, public opinion has become an even more important component to any policy proposal (McCombs et al. 1991). In response to the 20th Century's Great Depression, New Deal Democrats pulled together a coalition of citizens who felt that the government should provide more help in their daily pursuits (Edwards and Wayne 1994). That coalition had produced stable majorities for forty years for the Democratic party in the House of Representatives until the 1994 Congressional elections. Moreover, even though the Republican party is less apt to campaign on an increased scope of federal government power, government spending still remains on the rise.

Although the federal government is currently in a state of downsizing, at least rhetorically, we see that public support for some programs like Social Security, education, and crime fighting still enjoy strong public support (Bennett and Bennett 1990; Greenberg and Page 1995, p. 161). However, opponents of the welfare state are able to tie their positions into traditional beliefs in limited government and individualism (Feldman and Zaller 1991).

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Political Actors

This dissertation begins with a policy process problem -- How the Clinton Health Security Bill of 1993 did *not* become law. Political science scholars have updated and complicated the traditional grade-school textbook version of how a bill becomes a law. According to this view, people elect representatives who write legislation and then have it approved by the president of the United States.

In Congress, the bill proceeds through various committees until it is refined enough to survive a vote on the floor. After both chambers approve, the bill is then sent to the president for final approval. If the president signs the bill, it becomes law. If not, Congress may override the veto by a two-thirds supermajority in both chambers or send the White House a new version of the bill. The modern equivalent, as one would expect, varies from this relatively clean model of the policy process.

President

Modern presidents are expected to lead despite the expressed intent of the Framers of the United States Constitution for the president to follow the lead of congressional legislative supremacy (Pious 1996). Over the years, foreign engagements, such as World War I and II, expanded the president's policy engagement (Edwards and Wayne 1994). The crystallizing event, however, was clearly a domestic one: Great Depression. Franklin Delano Roosevelt's response to it revolutionized how the American people viewed the presidency as a more proactive and policy-oriented chief executive (Lowi 1985; Pfiffner 1994). Seizing upon constitutional language which permits the chief executive to offer legislation and report to the nation of the State of the Union, the president had become the chief legislator in the 20th century (Rossiter 1987). This balances with public expectations. Clinton White House focus groups found that the president's main

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challenge was to "manage and dominate" his relationship with Congress (Woodward 1994, p. 268).

Adding to this history is the shift in how modern presidents are elected (Hess 1988). Heightened public expectations have coincided with the simultaneous weakening of the political party in the electorate and the rise of candidate-centered campaigns (Wattenberg 1991). Party bosses have been replaced by political consultants hired by individual candidates (Sabato 1981; Salmore and Salmore 1989). Moreover, the press has taken a more active role in screening candidates (Salmore and Salmore 1989; Kerbel 1995). Once nominated through this media gauntlet, would-be presidents' images have become less positive (Goldfarb 1991). Some argue that the process has gotten so bad that the best way to reform it is to shorten the campaign season (Patterson 1994). State party officials have front-loaded many of the important primaries for the 1996 presidential elections (Wayne 1996). The effectiveness of this system remains to be seen, although with the early clinching of the nomination by Senator Robert Dole (R-KS) the strategy worked.

In 1992 the public demanded proactive leadership, in a word, change (Nelson 1993). Bill Clinton made lots of promises to boot. Although he used up much of his honeymoon's political capital with personal and relatively minor public issues (the infamous haircut, appointments, and gays-in-the-military), he did attack the nation's economy as promised early in his first year (Cohen 1994). The Clinton budget barely passed the Democratic Congress, though Senate Republicans successfully filibustered the president's economic stimulus package (Wayne 1996).

Clintonites hoped that the messy and divisive process that characterized the economic debate would provide lessons for their next priority: health care reform (Woodward 1994). The Clinton administration believed that Congress, interest groups, and the news media would be better managed through more efficient use of the White House Office of Communications (OOC), so successful in the Reagan era and for the

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Bush administration during the Gulf War (Maltese 1994). They were wrong. In her days as White House press secretary, Dee Dee Myers argued, without success, that the OOC and its relationship to the press office needed to be restructured so that they would work together more closely (Myers 1996). Whether it would have helped shepherd the Clinton plan to enactment will never be known.

Congress

Until recently, modern Congresses have tended to follow the presidential lead (Katz 1996). The traditional proactive policy role of the Congress was usurped by the dawn of the modern president (Healey 1996). Responding to increased policy responsibilities brought upon by the New Deal, Congress reorganized itself and began an era of committee government through the mid-sixties (Smith and Deering 1990). The Legislative Reorganization Act of 1946 reduced the number of committees in both houses, which centralized power in committee chairs by virtue of their expanded jurisdictions (Smith and Deering 1990). The 1946 Act also expanded unwritten rules including the seniority principle, which further moved Congress toward careerism. It also encouraged specialization, which increased the entrepreneurial tendencies of individual members. Finally, the 1946 Act increased the deference incentive, encouraging more quid pro quo voting (Smith and Deering 1990).

The result of this period was a more powerful committee system and therefore a more powerful Congress (Cox and McCubbins 1993). Committees declined in number but gained influence due to increased jurisdiction and staff allotments (Smith and Deering 1990). While chairs ruled over their jurisdictions as barons (Rohde 1991), subcommittees also proliferated (Smith and Deering 1990).

Iron triangles formed between executive agencies, interest groups, and enterprising committee members (Kingdon 1984; Gross 1992; Goodsell 1994), further

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isolating committee chairs from the congressional leadership and the rank-and-file (Smith and Deering 1990). Iron triangles were problematic because their interests not only dovetailed nicely but they were "alleged to be impenetrable from the outside and uncontrollable by president, political appointees, or legislators, not on the committees in question." (Kingdon 1984, p. 36). The more recent view of iron triangles is less static and is said to be more issue-specific (Cox and McCubbins 1993).

This committee government era was replaced by the early 1970s when junior members and some long-serving liberal Democrats demanded reform on policy grounds (Rohde 1974). These members complained that the committee chairs were, as a group, more conservative than the vast majority of the Democratic caucus (Rohde 1991). Reforms that resulted in the Legislative Reorganization Act of 1970 and other reforms made votes public, limited proxy votes, and allowed a majority of members to call meetings obliterating the deference norm (Rohde 1974). Further limits were placed on the chair/barons including a "Subcommittee Bill of Rights" that affixed guaranteed policy jurisdictions and referrals (Rohde 1991). Empowering individual members of the party caucus (Fiorina 1989) also resulted in a centralization of legislative decisionmaking (Rohde 1991) and increased the probability that the Congress would come to agreement on important issues (Cox and McCubbins 1993). Still, this had not produced a more popular Congress as viewed by the public at large. Since the 1970s, Congress has been a familiar site for negative news stories ranging from legitimate scandal to petty rivalries that sent the institution's approval rating to historical lows (Mann and Ornstein 1994, p. 4).

This was the Congress that Bill Clinton's health plan had to face. Clinton, after all, had supported much of his Democratic party's congressional agenda backlogged by twelve years of Republican dominance of the White House (Cohen 1994). But Clinton won election in 1992 in part due to his running as a "New Democrat," which offended traditionalists in his own party. To defeat his own Congress, it was important to garner

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widespread public support, in effect, to go above members' heads to the people. But his initial stumbles in 1993 combined with the government-centered approach to reform scared off many conservative Democrats from supporting the plan (Kerbel 1995). Therefore, the forces that were to help Clinton in his campaign for health reform would be counterbalanced by a split in the Democratic coalition in Congress. The leadership was on board, but the rank and file would prove more difficult to organize and maintain. Public opinion, was the stick that the White House hoped would get conservative Democrats back on the team to reform the health care system (Rubin 1993).

Interest Groups

The central dilemma regarding interest group participation in the political process was recognized perhaps most clearly by James Madison. As a Constitutional Founder and co-author of the Federalist papers, Madison argued that the causes of factional mischief were unavoidable in a democracy. He maintained, however, that the effects could be mitigated by a large nation with a republican form of government characterized by separation of national power granted by the people in staggered elections (Madison 1787). In short, majorities could maintain control of the national agenda within limits.

Modern scholars have affixed blame to vocal minorities for budget deficits and policy gridlock (Smith 1989). In their view, the majority opinion of, for example, having a balanced budget is being subverted by factional interests who, by their nature, do not serve the national interest. Health care can be viewed as a case study in how the needs of the majority (universal insurance coverage that cannot be taken away) conflicted with the wants of vocal minorities (the right of businesses to refuse to pay for employees' health coverage or the freedom of insurance companies to cover some people and not others at whatever costs the market would bear).

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Much of the current popular and academic literature on interest groups agrees that they are, in some fashion, damaging American politics. Indeed the growth has been staggering. Since the turn of the century the actual number of interest groups has increased by several factors of ten. Roughly 30 percent of groups active today have been founded within the past thirty years (Walker 1994).

But in the early days of the New Deal, pluralists argued that enfranchising interest groups was a positive component of effective policy (Gormley 1989). Some remain convinced that democracy benefits from interest group participation due to their policy monitoring, raising fire alarms, and, in turn, making representatives more responsive to their constituents (McCubbins and Schwartz 1984). After a boom in the growth of groups in the 1960s and 1970s, the actual rate has slowed (Schlozman and Tierney 1986). Perhaps the market for new groups has become increasingly saturated or competition among similar interests has limited the need for more groups (Berry 1989).

Business, which has a financial interest in policymaking, remains the best represented sector of American society (Berry 1989). Many members of these groups are individuals who contribute their time and money to lobby the government for tax breaks or laws amenable to increased sales and profits. Big business interests lobbied Congress to pass NAFTA in 1993 (Kerbel 1995). Small business argued against the Clinton health care reform proposal in 1993 and 1994 (Center for Public Integrity 1994). Some corporations are large enough to employ a permanent staff of lobbyists to look out for their interests. A health care example of this was Philip Morris, who argued against several provisions of the plan supported by the White House (Center for Public Integrity 1994).

Often competing with business are labor unions. Although membership has declined since the mid-1950s, unions remain very well organized and politically active (Wright 1996). Organized labor remains a key component of the Democratic coalition. Labor unions mainly seek to increase jobs, wages, and improve working conditions.

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National organizations, including the AFL-CIO, contested support for NAFTA and supported many of the provisions in the Clinton health care plan with limited effect (Center for Public Integrity 1994).

Public interest groups are not based upon economic benefit (Berry 1989). Instead, these citizen groups tend to focus on issues like drunk driving (Mothers Against Driving Drunk) or gun control (National Rifle Association) or women's rights (National Organization for Women). During the health care debate, several public interest groups weighed in with their opinions, including Planned Parenthood and the Florida Health Care Information Council (Center for Public Integrity 1994). Today, citizen groups are the fastest growing category of political interest groups (Walker 1994).

Activities

Modern interests, and the groups they represent, have become powerful actors in the policy-making process. As the president and Congress have secured roles in the policy process, so have interest groups. According to Berry (1989), interest groups play five main roles in American politics. First, they seek to represent their constituents before their government. The theory of this activity is quite pragmatic: individuals band together so their collective voices are heard louder than independent lobbying. Members of Congress and administration officials naturally give more attention to the AFL-CIO than to individual student graduate assistant organizations, which have fewer members and less political clout.

Berry (1989) also explains that interests serve to educate the American people about issues. Groups commission studies that beget reports that, more often than not, support their views on policy. Lobbyists and other interest group officials then distribute the findings to their members and to officials in charge of various legislation or oversight organizations. Although the information groups disseminate clearly suffers from bias, the

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data provided often serve to increase the public debate over an issue (Smith 1988). When the audience is sympathetic, the data are then used to justify policy alternatives. Opponents commission their version of the issue, prompting the media to arbiter truth. Often, the result is a balance of views providing combatants with tools for policy battle (Kerbel 1995).

Groups also seek opportunities to provide their membership with ways to participate in the political process. Some people are simply more interested in policy than most Americans and want to be politically active. Most interest groups organize meetings, rallies, and letter-writing campaigns (Wright 1996). In addition, many set up political action committees to back friendly candidates with campaign dollars (Berry 1989). Although these organizations remain legally independent, cross-over membership is strong and the philosophies usually are indistinguishable (Berry 1989). Those who bemoan the increase of interest group power usually focus their scorn on the rise of political action committee money in the campaign process (Jacobson 1980) and its influence on public policy (Gross 1992; Will 1992) although some scholars dispute the validity of the latter claim (Sabato 1984; Wright 1985).

Since policymaking takes place between election cycles, interest groups afford extra-interested citizens ways to indirectly or directly lobby for causes at the time important decisions are made (Wright 1996). Although elections provide choices between candidates, they aggregate many alternatives that might not represent all of what a voter prefers (Kingdon 1984). While a plurality of the electorate supported Bill Clinton in 1992, many traditional Democrats (including the congressional leadership) disagreed with their nominee's position on NAFTA (Kerbel 1996). Interest groups provided them a chance to voice their opposition to passing NAFTA outside the voting booth. On health care, many Americans supported the idea of reform but turned against its proponent when details about the plan surfaced the following year.

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Once in place, interest groups often follow up on legislation through program monitoring (McCubbins and Schwartz 1984). When inadequacies of policy arise, groups draw attention to the problems and suggest solutions, often by alerting the media. In the late 1980s, several interest groups began to voice support for health care reform, including both business and labor (Center for Public Integrity 1994). Each conducted research to show that reform was needed but differed on how it should be accomplished. Through effective lobbying and public relations, their findings received attention from both the government and news media (Center for Public Integrity 1994). This produced a public climate for action.

Under favorable conditions, voicing opinions, educating the public, lobbying, and program monitoring often lead to agenda building (Kingdon 1984). This occurs when national attention shifts from one issue to another. Naturally, many interest groups feel that if their issues are on the national agenda then the organization is more likely to gain the benefits they seek. It is much easier to gain the attention of policymakers when those who vote become interested in an issue.

Building support outside government often leads to support inside. Anthony Downs (1972) described this as the "alarmed discovery and euphoric enthusiasm" phase of the policy process where the public realizes that "something must be done" about a problem. Interest groups attempt to set the agenda in this manner through the various roles described above. In some cases groups issue evaluative reports (education and/or program evaluation), lobby members of Congress (representation), or energize their membership to write their congressmen (Wright 1996).

For health care, interest groups spent over $100 million during the 1993-94 fight over reform (Center for Public Integrity 1994). While some of this was spent on traditional lobbying, over half ($60 million) was on advertising alone (Jamieson 1994). Groups in favor of reform (such as the Democratic National Committee) were outspent by those who opposed it (such as HIAA) by more than a 2-to-1 margin on ads (West and

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Francis 1996). Money spent by interest groups, I will argue, had the effect of obstructing the policy process as both classical and contemporary authors profess (Schattschneider 1960; McConnell 1966; Fallows 1996).

Public Opinion

With so much at their disposal and at stake, why do political actors have such a difficult time providing effective representation for the people? For one thing, there are many voices. Each political actor continuously vies to represent the masses in an effort to influence the character and outcome of policy. This happens in real time, meaning that each voice is in competition with the other. Public opinion is measured virtually in real-time through polling. Zaller defined survey responses, or polling answers, as a "marriage of information and predisposition (1992, p. 6)." Interviews provide citizens the opportunity to voice snapshots of attitudes or opinions toward people or policy options. When politicians and activists attempt to set the agenda, many times it precedes public opinion tracked by polls (Downs 1972).

On the individual level, it is clear that attitudes can change (Petty and Cacioppo 1981, 1986a, 1986b; Popkin 1991; Reis and Trout 1986; Zaller 1992). Individuals can reliably resist the arguments to which they are exposed only to the extent that they possess "information" or "common knowledge" about the implications of those arguments for their predispositions (McQuail 1979; Neuman et al. 1992). But individuals seem not to have coherent ideologies (Lane 1962; Hochschild 1981; Kinder and Sears 1985), perhaps due to the irrational amount of effort it would take to compose and maintain them (Downs 1957).

In the aggregate, several factors work against effective representation. Despite the variance in public opinion on specific issues or politicians, national beliefs, traditions, and values have been found to be quite stable over time (Greenberg and Page 1995).

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Freedom, economic liberty, capitalism, equality of opportunity, and democracy all enjoy stable support from the American public (Prothro and Grigg 1960; McClosky and Zaller 1984; Erickson et al. 1991).

On its face, the stability of public opinion would appear to undermine an opinion change study, but it does not. Stable values often conflict on specific issues. This creates ambivalence, or conflicting attitudes toward specific issues (Feldman and Zaller 1992). Instead of making an ideologically clear choice between policy alternatives, the public often accepts both, stressing one over the other in specific situations without rejecting either entirely. On the health care issue, this ambivalence may manifest itself in public opinion supporting universal coverage but rejecting the Clinton health care plan as some polling data suggests (Harris 1994).

Questions

Even a subtle rewriting of survey questions is known to produce, at times, wide variances in responses due to this ambivalence (Johnson and Joslyn 1991). This may produce bias for one response or another such as: Do you like or dislike Bill Clinton? and, Do you support or oppose Bill Clinton? Although both are choices between positives and negatives, one is testing personal affect and the other political backing. Pollsters also know that certain words activate specific attitudes during the question, which may distort answers from reflecting preexisting opinions. The difference between Russia and "former communist nations" is an example. Similarly, changing the order of questioning may distort answers but to a lesser extent (Zaller 1992).

Two-Step Flow

So if polls are the measurement tool by which we track public opinion, what are some of the basic theories behind its aggregate change? One of the long-lasting theories

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of public opinion change is the two-step flow model published in 1944 by the team of Lazarsfeld, Berelson, and Gaudet. Also see Lazarsfeld, Berelson, and McPhee (1954). The theory posited that the impact of the media in opinion change was mediated by community leaders before it reached average citizens. Community leaders, sometimes called opinion leaders, were more interested in politics and public events and therefore took to educating themselves more than their neighbors. Leaders would internalize information from the media and then talk with their friends and colleagues, transmitting a diluted version of what was covered in the news (Nimmo 1978). The result resembles the game of "telephone," in which details of what was said are either passed on inaccurately or omitted entirely.

During the 1993-94 health care debate, initial public support was strong. As details of the plan were presented to the public, negative reaction came from many directions spread by elites in government, interest groups, and the media (Center for Public Integrity 1994). Due to the fact that most Americans are not well-informed on politics in general and ambivalent about the health care issue specifically, and less attentive in non-presidential election years, the elite effect may have been stronger. But diffusion of this negative reaction took some time and had to reach average Americans through some medium. The relative valence of news media stories is one that is measured by this study.

Receive-Accept-Sample Model

Elites are recognized in some fashion by current models of public opinion change (Fishbein and Ajzen 1975; Petty and Cacioppo 1986b; McCombs 1994). One recent model was posited by John Zaller in his book on public opinion published in 1992. The Receive-Accept-Sample model suggests that public opinion tends to shift depending upon the type of information people are exposed to and how they process it. Zaller's model

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outlines a process by which "people *receive* new information, decide whether to *accept* it, and then *sample* at the moment of answering the question" (p. 51). Central to the thesis is that elites play an intermediary role between the initial communication or information before retranslating the message to the mass public. Elites, according to Zaller, lubricate the process by personalizing the transmission of new information, thereby making it easier for people to accept it.

Zaller posits that the system of mass public opinion is, to a large extent, dependent upon political elites who devote themselves full-time to either politics or public affairs (also see Popkin 1991). Some examples of political elites include elected officials and candidates for office, journalists, and policy experts. Although individuals may learn about politics and public affairs from opinion leaders, friends, family, and associates, these leaders actually follow the information originally provided by elites. The relationship between elites and the public may drive mass opinion.

Stories and observations that reach the general public, by their nature, never reflect the entire record of a speech or event. Most people do not watch C-SPAN for information about a particular policy or event. Most citizens do not read congressional bills before they come to a vote. Those who do, mainly political elites, must simplify this data into a form that opinion leaders and the mass public can understand (Popkin 1991). News that follows from this diluting process tends to be oversimplified and incomplete. Yet, as Doris Graber (1984) noted, extended coverage by news organizations tends to be viewed by audiences as "dull, confusing, and unduly detailed . . ." (p. 105).

The speed at which opinions change is mediated by political predispositions, defined by Zaller as the "stable, individual-level traits that regulate the acceptance or non-acceptance of political communications the person receives" (p. 22). These traits include the person's childhood socialization and the direct experience of working, paying the IRS, and living in one area as opposed to another. They are strengthened by political values such as party identification and race -- the most stable mediators. While survey responses

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change, sometimes with severe rapidity, predispositions are less likely to be influenced in the short-term by elite information or news coverage.

Long-term polling suggests that Americans have become increasingly wary of government-centered solutions to public problems (ABC News et al., 1992). Although Democrat Bill Clinton assumed office in 1993, exit polls from November 1992 maintained that the electorate was in no mood for more big government. This predisposition may have worked against the Clinton Health Security Bill, a national government solution to a private insurance problem. The plan suggested the creation of new government bureaucracies to provide universal coverage for all Americans and to limit rising costs (Rubin 1993). The Clinton administration attempted to shape the information about their plan through speeches, press conferences, and reports (Fallows 1996). Opponents were more successful at raising predispositions against a larger government role in the health care system (Stimson 1991; Fallows 1996).

Mass opinion change has accelerated in the modern era of television reaching light-speed in the era of live-satellite coverage, sunshine in the Congress through C-SPAN, Internet access, and all-day newsgathering and reporting via CNN (Greenberg and Page 1995). The instantaneous news story has been followed by the rapid response covered as it happens for political elites and opinion leaders. As the pace of information dissolution hastens, so does opinion change (Erickson et al. 1988). After the president's speech and the First Lady's highly praised testimony to Congress, television advertising and negative news coverage, within days, hit the air and filled newsprint (Center for Public Integrity 1994). This system of accelerated point-counterpoint may have contributed to the initially high approval and rapid decline of public support for the Clinton health care plan.

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Mass Media

In the face of Nazi propaganda in the 1940s, the mass media was viewed as a powerful tool to control the people's thinking (Noelle-Neumann 1984; McLeod et al. 1994). From the end of World War II until the 1970s, the pendulum swung in the other direction with academics asserting that the media had only minimal effects on its audience (Klapper 1960; Kraus and Davis 1976; Iyengar and Lenart 1989). The current view reflects more subtle relationships between the mass media, elites, the public, and the policy-making process (Brody 1991; Page and Shapiro 1992; Zaller 1992). What the media covers often has direct effects on what policymakers do (Protess et al. 1991). This study will focus on two aspects of the media: news and political advertising. I will argue that the latter influenced the former – and both influenced the trend of public support for the administration's health care initiative.

News Coverage

Cited by Zaller (1992) as the "dynamic element" in political preference formation, the mass media have become an increasing presence in American daily life. Cable television, satellite, and other services have expanded the American media diet from broadcast over three networks to narrowcast over many specialty channels. Print media have proliferated as well. Once general magazines and newspapers dominated newsstands, but now lifestyle and topic-oriented periodicals vie for readership. Despite more sources are available to the audience, television news remains the most important source of political information to Americans (Kerbel 1995; Zaller 1992).

The evening news has been a staple of American life since the dawn of television. While the anchors' names have changed from Huntley and Brinkley to Brokaw, Jennings, and Rather, the format has remained relatively constant (Iyengar and Kinder 1987). Anchors read newscopy, either written by other journalists or by themselves, to the

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camera. As technology improved, newscasts broadcast live event coverage. Networks dispatched correspondents to major cities around the globe to cover important stories. These ad hoc trips became bureaus which were maintained year round. The commitment remains an important component of newsgathering and producing the evening newscast. Nightly newscasts used to run for only 15 minutes. Today's broadcasts run 30 minutes, including about 8 minutes of commercial time. In 22 minutes, the anchor and staff of reporters and correspondents deliver what they deem to be the most important stories of that day. The news Americans see every night is therefore substantially diluted from the thousands of stories that networks could have chosen to run.

News can be powerful. Mass opinion on such topics as economic conditions may be influenced both by what individuals experience in daily life and by what originates or is interpreted in media reports (Tims, Fan, and Freeman 1989; MacKuen, Erickson, and Stimson 1992; Blood and Phillips 1995). By covering and then airing some events over others, the program serves to set the agenda for the public. Consistent academic evidence has shown that agenda-setting effect: events covered on news programs play a major role in how people determine what are the important issues of the day (McCombs and Shaw 1972, 1977; McCombs 1994). The media affect the mass audience through their portrayal or "framing" of the issues. Stories on specific ("episodic") events prompted viewers to assign individual responsibility (e.g. the laziness of a poor person), while reports that presented a broad "thematic" context prod viewers to attribute responsibility to societal factors such as widespread economic conditions (Iyengar and Kinder 1987). This may lead to specific attitudes on issues (Page et al. 1987).

Much of the reporting that news organizations do has become more negative, resulting in what Sabato (1981) has termed "attack journalism." Since the 1960s bad news has dominated over good news, increasing by a factor of three (Lichter and Amundson 1994). The decline in trust and efficacy as well as the growth of political malaise may be related to the media's coverage of political issues such as the Vietnam

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War and civil rights abuses (Robinson 1976). In the last decade, ethical lapses have accounted for a fourth of the coverage of Congress, compared to less than a tenth in the previous decade (Lichter and Amundson 1994; Rozell 1994). But despite the negative coverage of politicians due to attack journalism, most candidates make good on the bulk of their campaign promises (Pomper and Lederman 1980; Fishel 1985; Krukones 1984; and Budge and Hofferbert 1990).

Political Advertising

Advertising works. With the proliferation of media, more businesses have become better known to the public through paid spots. More often than not, increased spending on ads blackens the bottom line (Stanley Harris, personal communication, 1996). Candidates and consultants have picked up on this relationship and have increased spending on ads in the hope that their products will garner 50+ percent of the vote on election day. Interest groups and large corporations are following their lead placing ads to improve their image or to argue for a specific cause. Whether in business or in politics, decisionmakers are choosing to buy time or space.

The first to utilize the media in the political arena were political candidates. As the party cue to voting behavior has become less of a factor and voters continue to focus their attention on individuals, the process of communicating information about candidates has become increasingly important. Many contemporary scholars, journalists, politicians, and campaign consultants agree that the manner in which a campaign team utilizes available media often determines its success (Bryant 1992; Hagstrom 1992; Milburn 1991). The most controllable aspect of the media message is the advertisement. And, increasingly, the tone of these messages has turned negative (Jamieson 1992).

The effects of negative political advertising are controversial. Early research in the late 1970s and early 1980s suggested that positive advertisements were more liked by

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viewers (Stewart 1975; Merritt 1984). Others argued, using survey and field study methods, that negative advertising exerts negative evaluations of the sponsor and the target (Garramone 1984) and, in some cases, full-blown "boomerang" effects, defined by Brehm (1966) as a reaction opposite to the persuader's intention. One recent study by Iyengar et al. (1995) suggests that negative advertising may contribute to low voter turnout. Still, one must be reminded that this advertising does not operate in a vacuum. All advertising must compete within the modern "overcommunicated" society (Reis and Trout 1986).

In stark contrast, several authors cite anecdotal, but consistent, evidence that negative ads can work in the intended direction (Boiney and Paletz 1991; Newhagen and Reeves 1991; Sabato 1981; Weigold 1991; Cohen and Weigold 1996). The conventional wisdom in politics reflects Democratic consultant Michael Kaye's lament, "if you try to run a positive, decent campaign, you're dead." Moreover, academics concede that if negative ads didn't work, they would stop tomorrow (Salmore and Salmore 1989, p. 159). If a campaign wants to keep turnout low, negative ads may be of assistance. Recent evidence suggests that they may serve to demobilize the electorate (Ansolabehere et al. 1996).

Campaign operatives use negative ads, and now interest groups have turned to them as well. Political advertising has become a year-round business through the use of issue spots sponsored by interest groups. According to consultants, issue advertising has been a boon for their business, which used to be seasonal. Now between election campaigns, consultants organize message campaigns for interest groups who are attempting to influence the course of legislation. Often they are better organized and funded than electoral campaigns (William Hamilton, personal communication, 1995).

This form of advertising has been on air, in some form, for several years. Large businesses have placed ads to enhance their public image. These "feel good" spots usually place the company square in the middle of a noncontroversial issue, say pollution,

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and claim that they are on the right side. Public image (or institutional) advertising may increase the name recognition of the company in a positive light; most of the time, however, institutional ads do not seek to impact specific public policy (Stanley Harris, personal communication, 1995).

The health care debate changed this benign format. Between September 1993 and late summer 1994, more negative issue advertising was aired than ever before. If health care was not the first campaign against specific legislation, it certainly came of age. The negative issue ad joined the negative election campaign ad as another tactic interest groups use to influence public policy. The notion is not new. According to Godwin (1988) the "direct marketing" of issues is most effective when it shows the reader or viewer a direct threat to their values. Moreover, ads have adopted the format of television news in order to disguise their partisan intentions, and, as Jamieson notes, the emotionally evocative impact of ads has degraded public discourse (1992).

Summary

Representation is at the heart of the American experiment in democracy. The Founders' preference for representative democracy has mutated in practice during the 20th century. Scholars have found supporting evidence to indicate a relationship between public preferences and policy outputs. Since the New Deal, policymakers have accepted their role as providers of public services. Interest groups have defended these public goods through various means of organization and technology. The mass media, through news coverage and political advertising, has personalized these public debates thereby facilitating and accelerating opinion change.

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CHAPTER 3
METHODOLOGY

As Zulkin (1981) notes, the measurement of any specific media effect on attitude change is a perilous task. Ries and Trout provide a useful, yet daunting, perspective for interpreting proposed media effects. Originally published in 1981, Ries and Trout argued that any type of communication is difficult due to the fact that Americans, at $376 per person each year, are the most overadvertised society on the planet (p. 6). Add to that television in commercial, cable, satellite, and pay formats; radio in AM, FM, and now cable; outdoor in posters and billboards; and forms of print including varieties of direct mail, newspapers, and magazines, and the number of messages competing for the mind is staggering.

Positioning

The strongest way to communicate, say Ries and Trout, is through effective positioning, which attempts manipulate attitudes already in the mind, not attempt to change them (1986, p. 5). Therefore, perhaps the best way to attack the Clinton health care plan was not to create new and creative reasons to oppose it. Ries and Trout would argue that the best strategy to kill a plan is to raise attitudes and doubts already present within the target audience. HIAA and other interest groups did this effectively through their framing (Feldman and Zaller 1992) of the issue as a plan to dangerously increase government control over health care. It is possible that the news media picked up on the ensuing debate paying a critical eye to key aspects of the plan. Without continuous and

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effective positioning from the administration, the plan failed to hold its initial level of popular support (Atler and Waldman 1994).

Chapter Outline

This chapter will attempt to describe how to measure a specific effect through a cluttered media environment. So far, this dissertation has dealt with the historical foundations that led to the Clinton health care reform effort, as well as plausible academic theories that may explain why the plan fell out of favor with public opinion. Now it is time to construct a model of how to explain this process. Chapter 3 will seek to integrate history and theory by suggesting ways of testing the connections among the various actors in the national health care debate. First, I begin by laying out two hypotheses and the related model. Next follows a detailed account of the dependent, independent, and control variables that will be used in my analysis. Finally, I will integrate these variables into two testable designs.

Hypotheses

Underlying this dissertation is the notion that the media were powerful in focusing the nation's attention on the health care debate. Most Americans presumably got their information about the issue, as they get most of their political data, from the media (Jeffres and Perloff 1986). But how? The previous review of the literature and preliminary evidence leads to the argument that neither advertising alone nor news coverage alone influenced public opinion against the plan. Instead, this thesis asserts two connected hypotheses:

H1: Negative interest group advertising campaign had a progressively negative effect on news media reporting of the Clinton health care plan.

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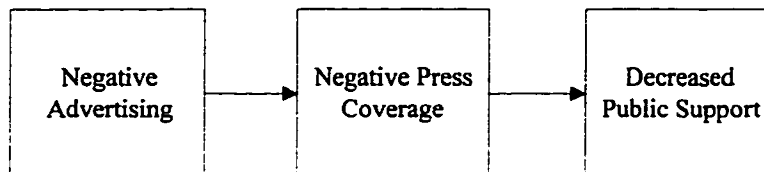
H2: Negative news media reporting had a progressively negative effect on public support for the Clinton health care plan.

The combined model stipulates three connected variables in a time sequence with clear lines of cause and effect. The output of this system was the failure to adopt the Clinton health care plan in Congress.[1]



Dependent Variable

The dependent variable for this study will be public opinion, described by Zaller (1992) as the aggregated responses to questions, such as health care plan support, asked by interviewers in polls. In this next section, I will discuss various academic issues concerning the survey format and the specific polls used. Poll results, measuring decreased public support, are featured in the third box in the model discussed above.

Depending upon your point of view, the United States is either blessed or cursed with several organizations that continuously track public opinion. Some organizations conduct polls internally which may lead to bias. For example the HIAA commissions a poll, staffed by HIAA members, to find out if the public perceives industry members as greedy. The "right" answer of course is no, since HIAA would like to be able to show policymakers and news media types that they are a responsible industry and do not need

[1] This is not meant to exclude the existence of other plausible models. From many press accounts (see Johnson and Broder 1996), the advertising did serve to sway the discussion of the Clinton plan from initially positive to a more critical tone. A direct, but limited, test will be conducted in Chapter 4. In addition, one may argue that negative advertising directly influenced public support as many campaign advertising studies assert or that negative advertising and press coverage may affect each other. As the press covers the advertising, interest groups may be more likely to utilize the medium more often. While plausible, neither of these last two theories will be tested in this thesis.

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expanded regulation to promote fair pricing. If the results turn out not in their favor, HIAA would at least not publicize the data (Wright 1996). Campaign organizations are notorious for this as well (Sabato 1981).

Still, there are plenty of non-affiliated polling organizations who do not suffer this question of validity. A good source for unbiased polling data is the news media. Many outlets are affiliated, or have contracts, with independent polling groups. I consulted several including Newsweek (via Princeton Research Survey Associates) and The New York Times (internal polling operation). But each media outlet provided less than five polls, which averages out to less than one poll over the 8-month debate. Since other available data were more discrete, five polls was judged as not enough information to establish substantial trends over the period.

The Newsweek and Times polls also were deemed unacceptable, defined as exceeding a margin of error of plus or minus five percentage points at .95 confidence. This was possibly due to sub-par sampling techniques but perhaps a more plausible explanation was the relatively small sampling sizes of less than 1,000 respondents (Alpern 1994; Michael Kegey, personal communication, 1995). Large standard errors complicated the interpretation of these polls because in some instances the difference between support and opposition for the Clinton plan was well within the range of standard error (Alpern 1994; Michael Kegey, personal communication, 1995). Further confounding these problems was that Newsweek and the Times did not ask the questions in the same manner every time, which may have led to variation in the results (Alpern 1994; Michael Kegey, personal communication, 1995).

Instead of using Newsweek and Times polls, this investigation will utilize polling information from the George H. Gallup Organization and Harris Polling Group, who asked the same questions every time to over 1,000 people below a margin of error of plus or minus five percentage points within a 95% (or better) confidence interval (Gallup and Harris polls 1993, 1994). Both independent polling organizations, Gallup and Harris,

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questioned more respondents with less margin of error than the news media outlets. Gallup consistently completed over 1,000 telephone interviews while Harris secured over 1,250 interviews each time for measures of support of the Clinton health care plan and the wider measure of presidential job performance (Gallup and Harris polls 1993, 1994). This benefit will allow us to make more reliable comparisons between the two poll variables.

The two polling organizations collected their data over the telephone using trained and professional interviewers. Each sample was derived from the random digit dialing of numbers selected from telephone exchanges in the continental United States (Gallup and Harris polls 1993, 1994). Random digits are used to avoid "listing" bias and by providing a representation of both listed and unlisted numbers (including not-yet-listed). The design of the sample is derived by a random generation of the last two digits of telephone numbers selected on the basis of their area code and telephone exchange (Gallup and Harris polls 1993, 1994).

Both surveys polled adults 18 and older residing in the continental United States (Gallup and Harris polls 1993, 1994). This standard reflects two complicating problems with polling over the telephone. As in the case of the national health care debate, on matters of public policy democratic theory does not provide a seat at the table for those who cannot vote. Therefore it is natural to weed out individuals who do not have the franchise. Polling agencies also usually shy away from interviewing minors due to laws restricting this practice in some states (Gallup 1993).

Following polling industry standards, each organization made at least three attempts to complete an interview at every sampled telephone number (Gallup and Harris polls 1993, 1994). Calls were staggered over times of day and days of the week to maximize the chances of making contact with a potential respondent. If an interview broke off in the middle or was initially refused, potential respondents were re-contacted at

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least once in an attempt to convert them to completed interviews (Gallup 1993; Taylor 1993a).

When a household was initially contacted, interviewers asked to speak with the "youngest male 18 or older who is at home." If there was no eligible man at home, interviewers asked to speak with "the oldest woman 18 or older who lives in the household" (Gallup and Harris polls 1993, 1994). This systematic respondent selection technique, according to the polling organizations, has been shown empirically to generate samples that closely reflect the population in terms of age and gender (Gallup and Harris polls 1993, 1994; Taylor 1993a).

By polling only residents of households, the data are secured from unwittingly counting persons twice if, for example, a person picks up a phone at a friend or relative's residence and then answers it later when he or she returns home. Most Americans do not move residences during a polling period, which is usually one, two, or three days. Another more subtle assumption made by polling organizations is that people are most comfortable discussing their opinions on all subjects at home instead of at work or at a relative's or friend's household. This, pollsters believe, increases completion rates resulting in a more cost-effective service (Kenneth Mease, personal communication, 1995).

While Gallup queried respondents thirteen times, Harris only asked the plan approval question four times. Coincidentally, when each organization asked its plan support question the other did not. The complete time-series will therefore include seventeen distinct reference points. In addition, Gallup asked its questions over two days, while Harris did so over four days. The Harris polling method might allow disproportionate movement in public opinion. As noted earlier, the Harris favorable percentages were consistently six points more favorable than comparable information from Gallup. For this study, the Harris plan support figures will be adjusted downward six percentage points to adjust for this deviation from the Gallup results.

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The main problem with telephone interviewing remains the bias derived from non-responses. This occurs because participation tends to vary for different subgroups of the population. One may argue that on most questions of national interest, including presidential approval ratings and support of the health care plan, answers could vary widely across subgroups likely to be missed by telephone interviewing. To compensate for these known biases, each polling group weights its samples.

Gallup and Harris utilized the same weighting procedures based on information from the Census Bureau's Current Population Survey completed in March 1992. Where necessary, the results were weighted to reflect the age, sex, race, education, and number of adults in each household reflecting their actual proportions in the American population. Gallup and Harris both report their findings under the principles of the National Council on Public Polls.

Another possible explanation for the 6-point difference is that Harris and Gallup did not ask the same plan approval question. Gallup asked: "From everything you have heard or read so far, do you favor or oppose President Clinton's plan to reform health care?" Harris asked: "Overall, do you favor or oppose President Clinton's plan for reforming the health care system?" Adjustments should be considered since the Gallup question frames the question on the recall of what the respondent "heard or read" implying exposure to media sources.

Although very similar, each polling organization allowed respondents different options in answering their queries. Both Gallup and Harris provided respondents with an either/or response to presidential and plan support questions. On presidential support, Gallup tallied responses according to "favor," "oppose," and "no opinion" options while Harris recorded answers with "favor," "oppose," and "neither." From an analysis of the data, there does not appear to be any effect of the different "other" option. In fact there was little variation between the no opinion/neither responses across surveys. "No opinion" and "neither" responses consistently varied in the low single digits and

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comparisons between polls show consistent numbers for most points. Due to this consistency, I will not adjust the data to standardize for different response options.

Independent Variables

As proposed in the model, there are two time-bound hypotheses for change in public opinion toward the Clinton health care plan. First, the political advertising aimed by interest groups at the plan initiated predominantly negative press coverage of health reform. Second, it is hypothesized that the reaction of the news media to the counterdebate and to the administration's rebuttals increased the negative tone of the public debate on the plan. A description of these variables, how they were tabulated, by whom, and according to what principles, follows.

Interest Group Activity

Placing ads was only one component of the larger interest group strategy influencing the health care debate. Activities included all of what Wright (1996) termed Washington contacting and grassroots mobilization in an effort to influence legislators' policy positions. As Krehbiel (1992) noted in his Fenno prize-winning thesis on legislative activity, information is paramount and predictive. Decisions are made on the bases of available data, in many cases provided by interest groups. In agreement, Wright (1996) asserts that direct contact is "one of the most important and effective ways that groups can communicate information to legislators" (p. 70). The Center for Public Integrity (1994), estimates that over 600 groups descended upon Washington in an attempt to shape the congressional health care bill.

How this information makes its way through the process is important in understanding its influence. Often information is presented by former legislators, who have contacts with current government officials (Peters 1993). Their experience and

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connections afford them greater access to present information and, in turn, influence the debate on an issue (Wright 1996). Interest groups also attempt to disseminate the same information throughout their membership in an effort to incite participation through letter-writing, phone calls, or faxes and e-mail to their representatives (Berry 1989).

Although it has been vigorously contested (Berry 1989), there is also the well-documented relationship between interest group political action committee contributions and campaigns and legislation (Grenzke 1989; Wright 1985; Gross 1992). By some estimations, the total dollar amount spent by health care groups during the health care debate exceeded 8 million (Center for Public Integrity 1994). In much the same way as information, these funds do not buy votes directly (Wright 1996). Instead, it is more likely that they afford the group access to the legislator or other elected official (Godwin 1988). With access comes information, which often correlates to support for the group's positions (Berry 1989).

Advertising Spending

Within the realm of interest group activity, advertising is one component that is perhaps well-connected to grassroots mobilization and, more indirectly, to Washington contacting. Interest groups utilize several forms of advertising to move their membership. They send out direct mail, usually detailed information letters. Although expensive, some groups attempt to contact members by telephone (Wright 1996). But some interests have found it economical to advertise via the electronic media or through cable systems. Effectively targeted ads can reach more members and others efficiently, including those not affiliated, than direct mail or over the telephone lines. The dollars spent on communication of this type has been on the rise (Berry 1989; Godwin 1988). If academic literature on campaign advertising is any guide, mass media advertising may be quite effective (Kerbel 1995).

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Several attempts were made to attempt to attain specific time-bound data on interest-group advertising spending. Unfortunately the data, if they do exist, are well-guarded. The best assessment of the total lobbying effort and its ad spending by interest groups during the health care debate was organized by the Center for Public Integrity in a report titled "Well-Healed: Inside Lobbying for Health Care Reform" (Center for Public Integrity 1994). Well-Healed was the final report of a year-long investigation that involved, according to the Center, ". . . hundreds of interviews and reviewing thousands of pages of Federal Election Commission records, House and Senate lobbying and financial disclosure forms, and federal records" (p. 1). However, the report quickly concedes that due to the deficiencies in federal disclosure laws, it is an ". . . insurmountable task to assess with precision the total price tag of any domestic lobbying effort in this country" (p. 9). In short, there is no independent, accurate report of when ads were placed, in what medium, from which interest group.

The contentious game begins when one attempts to assess how much organizations spent on political advertising. One of the things we do know is that the wide majority of it was focused against key components of the president's plan, not to the plan as a whole (Center for Public Integrity 1994). The Center for Public Integrity (CPI) notes that both party committees spent money on air time, as did the National Restaurant Association, the Health Care Reform Project, the American Association of Retired Persons (AARP), Families USA, and the HIAA. CPI argued that, in dollars spent, there were only three "large" advertisers: the Henry J. Kaiser Family Foundation/League of Women Voters, the AARP, and HIAA (Center for Public Integrity 1994).

Well-Healed makes the argument that the well-known "Harry and Louise" television ads sponsored by the HIAA changed the course of the debate in six months (Center for Public Integrity 1994, p. 51). In fact, the ads never mentioned the names of the fictional couple who, in various down-home settings, worried aloud about aspects of the Clinton plan. The interest group campaign chose to pick apart the Clinton plan first

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with snipes at the health care alliances (proposed by the Clinton plan for cost containment) and then at employer mandates (the suggested and preferred method of payment for universal coverage, Clinton's expressed top priority for health care reform).

An interesting aside is how the names "Harry and Louise" entered the popular vernacular. As a part of the public relations campaign, the HIAA distributed copies of the scripts to journalists which showed the actors' real names to cue them to their lines. Some reporters assumed that these were the character names and began to report them in news stories. Harry and Louise ended up being real people, just as HIAA intended (Center for Public Integrity 1994, p. 49).

Considering press accounts and the perceptions of individual members of Congress and the administration, HIAA's negative issue advertising served to raise doubts about the Health Security Bill. Between September 1993 and February 1994, the Well Healed report speculates that ". . . the HIAA campaign was almost single-handedly responsible for a 20-point drop in public opinion regarding the Clinton plan" (p. 2). Kathleen Hall Jamieson, noted communications scholar, argued that the focus of advertising on specific provisions of legislation is a new political development. "If that's happened before, I don't know about it," Jamieson said (Center for Public Integrity 1994, p. 2).

Jamieson estimated that the advertising alone on health reform would exceed $50 million. Several other sources weighed in on the dollars' debate. USA Today reported on April 4, 1994, that the HIAA alone had committed to spending $14 million on an ad-blitz (Center for Public Integrity 1994). Ten days later, the newspaper downgraded that estimate to $10 million. Times Mirror (1994) estimated that HIAA spent about $6.7 million from September 1993 through March 1994. Even if the difference is split, the amount of money spent on the HIAA ad campaign alone is worthy of noting. These estimates still do not take into account direct mail advertising and do not at all address the combined efforts of other organizations (Times Mirror 1995).

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Times Mirror (1993) maintains that Harry-and-Louise-type campaigns' impact has been overblown. Traditional marketing standards require substantial budget, reach, frequency, and schedule length to make a real impact on a broad spectrum of the American public. To reach 80 percent of the American of all U.S. households five times a month costs approximately $1.65 million per month and requires television buys of both entertainment and news formatted programming (Times Mirror 1993).

It should be noted that opinion polls revealed that Americans said they did not find the political advertising believable (Alpern 1994). This is consistent with previous research showing that Americans prefer positive over negative political campaign advertising, and a belief that negative advertising does not affect attitudes or behaviors (Garramone 1984). Research that has followed those initial studies has indicated quite a different picture and has shown consistently that negative ads do affect their viewers' perceptions of issues and candidates (Salmore and Salmore, 1989; Weigold and Sheer 1993; Cohen and Weigold 1996). Therefore, this spending by interest groups on ads should not be discounted initially. Instead, it should be viewed as a potentially important component in the debate.

The Times Mirror Center For the People and the Press, now the Pew Foundation Center for Study of the People and the Press, hypothesize that the real impact of the ad campaigns was to influence opinion leaders and policymakers who read the newspapers and watch specialized newscasts (Zaller 1992). Their analysis indicates that the three top spenders focused their campaigns on the Cable News Network (CNN) and its companion station Headline News (HLN), not on network television in the nation's top markets and targeted to the homes of influential members of Congress (Times Mirror 1993). However, CPI acknowledges that HIAA had the ad field virtually to itself for the first four months of the debate through their initial $3.6 million buy on CNN/HLN and on local TV stations in over 40 markets (Center for Public Integrity 1994).

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News Media Content

My hypothesis is that negative political advertising sponsored by HIAA and others primarily influenced "elites." Empirically, elites are more informed than average citizens and serve to help set mass opinion (Zaller 1992). Such elites, who tend to have a different perspective on issues, can be found in mass media news organizations (Stimson 1991). The stories they produce have an undeniable effect on other elites (such as the leaders of the local Men's and Women's Clubs and the all-knowing barbers and hairdressers) who filter information to their friends and colleagues (Shaw and McCombs 1977). Therefore, one possible source of theory confirmation may be the relative valence of news media content. If news coverage of the Clinton health care plan was relatively positive and then turned negative, this would help to explain the possible effects of the negative advertising campaign.

News coverage may have turned negative for other reasons. First, it is plausible that as beat reporters gained more knowledge about the Clinton plan, they found more fault with it. Second, testimony before Congressional committees provided extensive criticism of the proposed program which resulted in more negative news coverage. Third, reporters began to cover politicians against the plan, skewing the coverage against the plan (cf. Hallin 1984). And finally, news reporters may have contacted experts who provided disapproving analyses of the proposals, resulting in negative reporting.

Columbia Journalism Review (November/December 1994) published a substantial content analysis by Times Mirror in association with the Kaiser Family Foundation. The study, conducted in three stages, included news media coverage from September 1993 through November 1994 (Times Mirror 1995). For this study, the Kaiser Foundation provided the original data, sorted by date, providing this study over 270 days of content analysis points.

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The Times Mirror Center tracked seventeen news media sources encompassing both broadcast and print. On paper, the study covered national newspapers (Los Angeles Times, The New York Times, The Wall Street Journal, The Washington Post, and USA Today), regional newspapers (The Dallas Morning News, The Des Moines Register, The Miami Herald, The Seattle Times, El Diario, and the Amsterdam News), and magazine newsweeklies (Newsweek, Time, and U.S. News & World Report). On the air, the Times Mirror Center and company weeded through video tapes of the following news programs: ABC World News Tonight, CBS Evening News, CNN Prime News, NBC Nightly News, and the PBS MacNeill/Lehrer NewsHour (Times Mirror 1993, 1994, 1995).

In total 5,490 news stories were coded by research associates at the Times Mirror Center (Times Mirror 1995). Although impressive, the present study is concerned with mass level changes in public opinion. To maintain a standardized unit of analysis, it is therefore prudent to utilize only news media with a national following. To maintain the internal integrity of the following analysis, only content analyses of news media throughout the three periods will be utilized since some sources did were not evaluated throughout the entire period. Therefore, this study will focus attention on a substantially more targeted version of the data. In all, the subset will include 4,039 stories. From the above list, this sample will exempt all regional newspaper coverage and all morning news programs because their content was not tracked for the duration of the health care debate.

The Times Mirror study not only tracked, but dissected the news coverage of the health care debate. Among the data, the Times Mirror provided some particularly useful tracking information for my thesis concerning the relative tone of news media toward the president, the Clinton health care plan, and its prospects of becoming law. One of the central arguments of this thesis is that the president was closely associated with his plan as portrayed by the mass media, and perhaps in the mass collective mind of public opinion as well. Therefore, the relatively positive, negative, or neutral news coverage of

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the president should be particularly relevant to how public opinion turned against the Clintons' plan.

Again, the Times Mirror Center data provide clear guidance. Each story about health reform was categorized as positive, negative, or neutral by quantifying and evaluating the positive and negative comments, interpretations, and innuendoes offered by the journalist or presented as quotes from other sources (Times Mirror 1993). The Times Mirror Center not only categorized coverage of the debate and the plan's prospects for approval but also included the relative slant of news coverage of President Clinton (Times Mirror 1993, 1994, 1995).

Times Mirror coders designated a story as either positive or negative if the ratio of the data was 2:1 either way. Those stories with a positive:negative ratio of less than 2:1 were deemed neutral (Times Mirror 1995). This qualifying scheme provides journalists plenty of room to somewhat skew the debate one way or another since valenced content is judged only if stories are scored either doubly positive or negative. However, the 2:1 rule also provides a clear and conservative delineation between positive and negative press and therefore has been deemed acceptable. Intercoder reliability for each story was found well within acceptable limits from a low of .87 to a high of .94 (Lee Ann Brady, personal communication, 1995).

One may posit additionally that the media valence concerning the plan's prospects, as well as its vital components, would influence mass public opinion. If these variables collectively skew negative, it might explain the decrease in support and increase in mass opposition to the Clinton health care plan. The Times Mirror utilized the same 2:1 ratio to determine the level of positive versus negative coverage of the plan's likelihood of implementation (Lee Ann Brady, personal communication, 1995). If the data support the notion that while the plan was supported by a majority of Americans, reporting about its possibilities for adoption were good, then an optimistic spin should be recorded. If the media instead influences rather than reflects the popular will, then one

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would expect that a negative spin trend would precede a drop in public support of the plan.

Some scholars have argued that this bandwagon effect can be especially harmful to voter turnout during the reporting of exit poll results on presidential election nights (Jeffres and Perloff 1986). Theoretically, results demonstrating a lead by one candidate as the polls close on the east coast of the United States might induce some voters on the west coast either to stay home and not vote or influence the choice that some would make (Patterson 1994).

The methodology employed by the Times Mirror Center reflects standard operating procedures found in most mass communication content analyses published within the past several years (Wimmer and Dominick 1991). First, each newspaper, magazine, and broadcast was reviewed in its entirety. The Times Mirror Center determined that a story was fit for this study if one-third or more of a news story was related to health care reform (Times Mirror 1993). Also consistent with conventional content analyses were the following exceptions: for print, articles less than 100 words were omitted; for broadcast, anchor lead-ins of less than 35 seconds were grouped with the corresponding report, as were discussions among experts and/or partisans, moderated by an anchor or correspondent (Wimmer and Dominick 1991). The Times Mirror Center omitted these stories "... too brief to be meaningful or ones not truly the product of a news organization" (Times Mirror 1993, p. 1).

Controls

Although the above variables may have influenced public opinion of the Clinton health care plan, other plausible explanations remain. These variables will be factored into the regression analysis and tracked along in the time-series to give a more complete version of what factors might have influenced the public debate. Three alternatives are

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explained in this section: unemployment rate, index of leading economic indicators, and three health care cost indices. Economic variables were used in light of the shifting focus in the debate from the Clinton strategy of attaining universal coverage to the opposition's view of how much reform would cost Americans. As cost fears increased, it is possible that economic variables may have played a more important positioning role in killing the Clinton plan.

Unemployment Rate

This study proposes that the unemployment rate influenced the health care debate. If a person was out of work, one can reasonably argue that President Clinton's assurance of universal health care might have increased positive opinion toward the plan. On the other hand, those with jobs may have viewed the plan as something that would hurt their chances of remaining employed. In short, the individual-level effects of unemployment on support for the Clinton plan are a matter for debate beyond the scope of this dissertation. Still, the prudent approach to take would be to include this aggregate-level variable in the regression analysis. Therefore, the standard monthly unemployment figures from the United States' Bureau of Labor Statistics will be used. The range of the data reflects a downward trend from 6.7 in September 1993 to a low of 6.1 percent in July 1994. Due to the small variation in unemployment rates, other economic indicators will be added to the overall model.

Leading Economic Indicators

The Bureau of Labor Statistics (1994) provides a wider measure of national economic performance. The Index of Leading Economic Indicators uses the year 1987 as its baseline and sets it equal to 100 and includes eleven distinct measures. Similarly, individual components measured in dollars also are based on that year. These

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components are: the money supply, contracts and orders for plant and equipment, manufacturers' new orders for consumer goods, and the change in manufacturers' unfilled orders of durable goods. Other contributors to the index include the change in sensitive materials prices, average workweek, average weekly initial claims for state unemployment insurance, vendor performance, building permits, index of consumer expectations, and stock prices. During the time period investigated by this study, the range of the monthly Leading Indicators index was from 99.6 to 101.7 relative to 1987 = 100 (United States Bureau of Labor Statistics 1994).

Health Care Spending Index

One may theorize that if health care costs were growing at dramatic rates, people would be more likely to support President Clinton's health care reform plan. The Bureau of Labor Statistics, in conjunction with the United States Health Care Financing Administration (1994), tracks medical costs in several ways. Three indices will be used: the general medical care index, medical services, and prescription drugs. The general medical care index includes all costs of health care commodities and services. The medical services index covers the costs of hospital, general physician, nurse, and dental providers' time. A more targeted version of the index was tracked for prescription drug costs. Each index was adjusted for seasonal factors and was compiled monthly.

Variable Considerations

Substantial attention will be paid to issues of time, level of analysis, and multiple data sources. Each data point needs to reflect the same time period. The level of analysis must not be confused. Moreover, a secondary analysis study should attempt to gather information from multiple data sources. Combined, these components are included in this study. They are discussed individually in the following section.

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Time

The essence of this study is time: How the Clinton health care plan fell from 59 percent support in September 1993 to 40 percent in July 1994. Another reason to take care with time is to minimize challenges to internal validity, which is defined as "the degree to which a research design allows the investigator to rule out alternative explanations" (Bingham and Felbinger, 1989, p. 247). Campbell and Stanley (1963) note that, among other factors, "history" can undermine the internal validity of the test. Individual (but unmeasured) events may have increased the public support or opposition to the Clinton health care plan. Including time as a control variable in the analysis addresses this internal validity concern of history by taking possible variation out of the mix.

Level of Analysis

Unlike traditional media-effects research that focuses on individuals, this study requires, and therefore will utilize, mass-level data (Jeffres and Perloff 1986). For both theoretical and practical reasons, the research question demands a focus on aggregate changes in public opinion determined by the valence in mass media content during the health care debate, the latter as influenced by mass interest group advertising. If this study is to stick to its stated goals, aggregate-level data must be employed. The question is not one of how individual citizens made individual decisions that affected the health care debate. Public officials do not make their decisions that way. Instead, they tend to react to aggregate-level movements (McCombs et al. 1991).

In a perfect environment, a study would follow a randomly-selected sample of individuals through the debate, scoring their attitude changes against a comparable group not exposed to any information on reform except the content of Clinton's plan. Practically, this information either does not exist or is not readily available. Aggregate

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level data that includes different individual's preferences, however, are available, and in this case, preferable. The main research question looks at mass movements in public opinion and news media coverage, not changes in some media coverage and individual attitudes.

Multiple Data Sources

Since this study will not employ an analysis of individual responses in opinion surveys, perhaps the only way to ensure validity is to secure multiple sources of data. Although many current studies faithfully and, some argue reliably, utilize only one source of polling information (usually Gallup data), I will include the work of multiple polling firms and nonpartisan organizations to ensure the highest possible quality of information. By consulting a number of different sources, this study should effectively avoid substantial bias. Each variable should be inspected for its validity and reliability.

Design

Now that the individual variables and unifying considerations have been addressed, it is now time to detail how they fit into my methodology. There are two basic designs utilized for this study. First, a regression model will be constructed to find correlations between variables, as well as to explain variance in level of plan support. Second, the time-series design will shed some direct light on issues of cause and effect.

Regression Analysis

Level of public support for the Clinton health care plan will serve as the dependent variable for the regression analysis. As discussed above, this allows for 17 points in time for comparison with negative news coverage of the plan. If the changes in opinion are found to be strongly related to changes in news media valence, then we will

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have additional conclusions to offer. If the news valence change is judged not significantly related to shifts in opinion, then questions of causality become moot to the extent that they do not occur at the same time or perhaps at all. This would result in a rejection of the second hypothesis.

Although they do not prove cause and effect, correlation studies show how one condition might be related to another (Babbie 1992). While a trend analysis will place the plots of negative media versus public opinion showing this relationship visually, it does not measure the existence or strength of a relationship between the variables (Babbie 1992). For this study, negative news media is hypothesized to be related to the downward trend in public support for the Clinton health care plan.

A regression analysis will be performed to ferret out this possible relationship and its strength of association. The equation will reflect the standard $Y = a + b_1 x_1 + b_2 x_2 + e$ form where *Y* is the dependent variable, *a* is the intercept point at which the regression line crosses the *Y* axis, the *b*'s are the regression coefficients attached to the *x*'s which are the independent variables, connected to the *e*'s which stand for the random measurement error. The *e*'s will also represent in subsequent analyses the confounding and control variables that may serve to complicate or explain the changes in the dependent variable, public support of the Clinton health care plan.

Independent Variable

Negatively-valenced news media will serve as the principal independent variable for the regression analysis. As noted earlier, the data come in the best of formats in that daily assessments of positive versus negative news coverage were made by The Times Mirror Center (1993, 1994, 1995). I will run regressions with a variable that is compared to the dependent variable to test for lag effects. In a study of the effects of public opinion on policy, Page and Shapiro (1983) found changes in policy following a one-year lag in

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opinion changes. A lag effect would appear in this study if, for example, the valenced news media coverage three days before a poll was taken were related to a subsequent change in the support for the Clinton plan.

There are no clear guidelines based on previous research as to where the cut-off for lag-time is or should be (Wimmer and Dominick 1991; McCombs et al. 1991). With the highly salient nature of health care, it is possible that weeks of lag might become days. Page and Shapiro (1983) argued that increased salience is related to policy change, so one might also conjecture that there will be a time lag before a change in public opinion is generated due to interpersonal communication lag effects compounding media agenda-setting effects. It is also plausible that the lag effect may vary as the debate lingered into the summer of 1994 but this study will track the average lag over time. The data will demonstrate which hypothesis, if either, is supported.

Control Variables

Whenever a regression equation is constructed, the researcher should look for other events that might influence or confound the results (Babbie 1992). In true experiments, the researcher does not need to do this because random assignment of subjects to experimental and control groups randomly distributes this variance among both groups (Bingham and Felbinger 1989). Although there might be more, at this stage there appear to be three variables that might influence the health care debate. The regression analyses will seek to control for unemployment, the relative health of the economy, and health care expenditures. Any of these economic indicators may affect public opinion on health care.

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Confounding Variables

At this stage it is not clear whether support for Bill Clinton influences or is influenced by support for the health care plan. However in September 1993, Gallup cited the general increase of public support for Bill Clinton as a product of his health care plan's positive appeal. This effect has been found in academic settings as well. Previous studies stipulate that when a policy is highly approved by the public, a halo effect pervades evaluations of performance on specific policy considerations (see Taylor 1993a).

It is also possible that the effect works in the opposite direction when a popular president announces a policy initiative, i.e., that public support for the issue is enhanced (Edwards and Wayne 1994). Therefore, it is highly likely that presidential approval might be highly correlated with approval of the health care plan. From a preliminary look at the data it appears that presidential approval lags, not precedes, movements in plan support. Reciprocal analyses will be conducted to see if this is in fact the case.

Time-Series

The 270-plus days of valenced news media content will serve as one part of the stream of time-series data. The other series will be the 17 polls that tracked public support of the Clinton health plan. If the two lines match or are closely related, then we may suggest that the two are directly related. If shifts in media content precede changes similar shifts in public opinion, then this study's second hypothesis holds. However, if changes in public opinion precede changes in media content, then the plausible conclusions are either that the two data lines are unrelated or that the media are perhaps reacting to public opinion (Bingham and Felbinger 1989).

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Alternative Media

More difficult to measure but still significant is the influence of opposition media. The partisan press has been resurrected with substantial albeit unclear impact. Magazines, call-in broadcast shows, newsletters, and other media have also served to influence the tide of public opinion. In a recent paper delivered at the annual meeting of the American Political Science Association, Page and Tanenbaum (1995) argued that call-in talk shows were at least partially responsible for the failure of Bill Clinton's Zoë Baird attorney general nomination.

Preliminary arguments suggest that not only do these sources influence public opinion directly, but they also may help to shape conventional media coverage. For this study, however, the possible impact of alternative media (alternative press → conventional media coverage) will not be included in the model. It is highly likely that opposition media added to the clamor against the Clinton health care plan. Opposition media may have also contributed to the decline of the plan's public support. But the status of the research is still in its infancy and access to alternative media sources is not easily secured. Moreover, the unit of analysis is mass public opinion. Most call-in shows are not nationally broadcast and many newsletters and magazines do not enjoy network-level readership. Instead, this dissertation will take the more conventional approach of studying the effects of national media on public opinion while acknowledging other sources of influence.

Interruption

In concert with this thesis' main hypothesis, the theorized results should resemble what Cook and Campbell (1979) describe as an abrupt but temporary impact with a residual effect. It is believed that the initial wave of interest group negative advertising turned the relatively neutral or positive coverage of the Clinton plan to neutral or

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negative. If this were to be true, the results would show a relative positive valence of news stories before the advertising hit the airwaves and a substantial drop close to the campaign's insertion into the debate. Moreover, it would show a residual downward trend in positive health plan coverage that would, in turn, result in a decline in public support.

Once the series is laid out, the findings will show trends that either support or question this study's hypotheses. As mentioned earlier, scholars tend to choose the time-series design because it often helps to demonstrate that the treatment or interruption is responsible for a shift in the natural trend in the data stream. The more data points available before and after the interruption, the less likely that the design will reflect a bias in the shifting trend (Bingham and Felbinger 1989).

Unfortunately for this study, the introduction of the interest group negative advertising campaign into the political mix was almost immediate. According to the best figures available, the Center for Public Integrity (1994) reports that HIAA's spending was concentrated in the first few weeks after President Clinton unveiled the Health Security Bill in late September. The true interruption point will likely fall some time after the introduction of the negative advertising campaign when positive coverage of the Clinton plan turns from mainly positive to neutral or negative.

In any trend analysis there exists the issue of noise (Bingham and Felbinger 1989). Because measures are not perfect, trends are more likely to resemble waves and not straight-lines (Babbie 1992). If the research design takes into account other confounding factors, then all that remains is "white noise" or normal variation around average changes (Bingham and Felbinger 1989). This non-tested movement may result from the polling data's natural fluctuation within three points in a 95 percent degree of confidence. For analyses of content, the noise could result from weak intercoder reliability, which has been assured to be in fact strong (Babbie 1992). Therefore, we expect some minor variation in the trend results within the stated reliability of each variable.

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Summary

This investigation posits a negative relationship between use of political advertising by interest groups and public support for the Clinton health care plan. In addition, this study will argue that press coverage of the administration's initiative was directly related to its declining support in the public arena. The dependent variable for the following analysis will be the combined 17 points of time that Gallup and Harris polls asked their respondents if they supported or opposed the Clinton health care plan. The main independent variable will be the relative valence of news reporting of the Clinton 1993 Health Security Bill. Alternative explanations for the decline of public support including change in unemployment, health care costs, and the economy will be factored into regression and time-series analyses. Each variable will be standardized for time while maintaining a macro-level of analysis.

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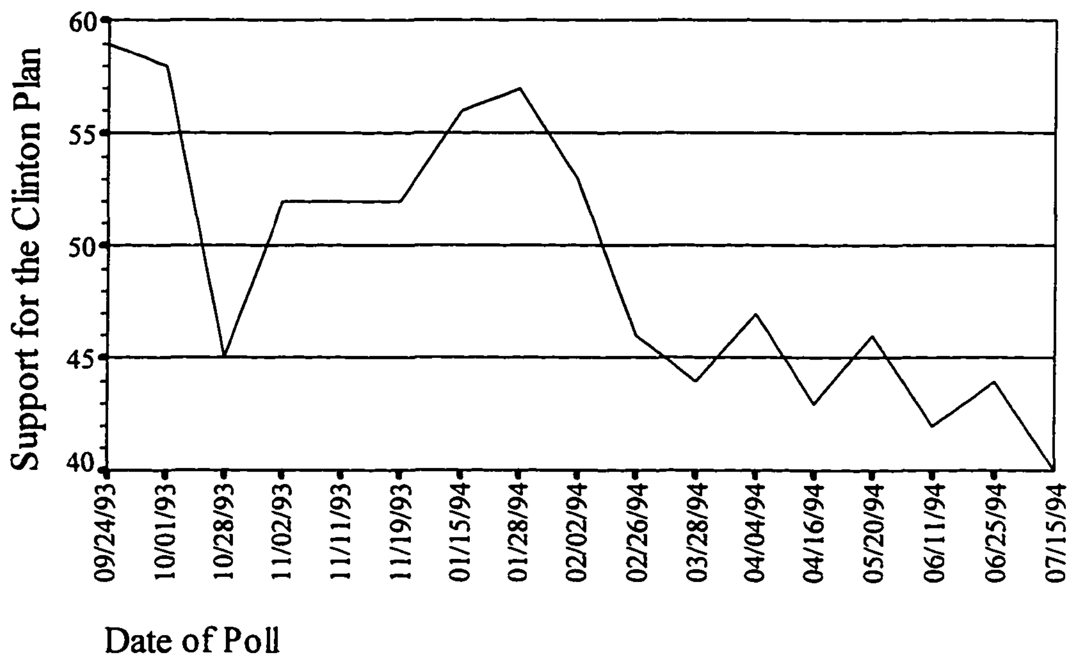
CHAPTER 4
FINDINGS

Overall, public support for the Clinton health care plan exhibited a clear downward trend from its introduction to its virtual death, late in the summer of 1994. As discussed in Chapter Three, two polling organizations tracked it best: Gallup and Harris. Over a nine-month period, a total of 17 surveys were completed, 13 and 4, respectively. This section will discuss how the time, sample, and reliability factors were taken into account to smooth over differences between polling techniques. Figure 4.1 demonstrates the downward trend in public support for the Clinton Health Security Bill.

Figure 4.1 – Plot of Support for the Clinton Health Care Plan (Gallup & Harris Polls)



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Time

In a perfect world, each polling organization would have provided daily measures of public support for the Clinton health care plan. Unfortunately, the combined work of Gallup and Harris only yielded 17 distinct data points between September 24, 1993 and July 15, 1994, with varying time intervals between them. For each observation in the following analyses, TIME represents the number of days that had elapsed between September 24, 1993 (the date of the first poll) and that observation. Thus, for the first observation, shortly after President Clinton delivered the final version of his plan, TIME is set to 0. The second poll was taken on October 1, 1993, seven days after the first poll, so TIME has a value of seven for that observation. The last observation included in this study was taken on July 15, 1994, or 265 days after the first poll. A fully ordered chart for variable TIME is included in Table 4.1, with an indication of which organization conducted each poll.

Sample

Since the surveys used in this study involved national samples of respondents, the sample was restricted to national media sources. The five national newspapers, three newsweeklies, and all five nightly television newscasts were included in the analysis. Each newspaper had a national daily edition, the three newsweeklies were published every week of the study and, moreover, each network broadcast their newscasts nightly. In all, the sample of valenced news media content was comprised of 1190 news stories broken down into 935 print (894 daily, 41 weekly) and 255 broadcast (all daily). A complete tally for each individual media source can be found in Table 4.2.

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Table 4.1 – Polls adjusted for time differences.

Date	*Poll*	*TIME*
September 24, 1993	Gallup	0
October 1	Harris	7
October 28	Gallup	34
November 2	Gallup	39
November 11	Harris	48
November 19	Gallup	56
January 15, 1994	Gallup	83
January 28	Gallup	96
February 2	Harris	101
February 26	Gallup	125
March 28	Gallup	156
April 4	Harris	163
April 16	Gallup	175
May 20	Gallup	209
June 11	Gallup	231
June 25	Gallup	245
July 15	Gallup	265

Table 4.2 – Media sample sizes.

Media source	*# of stories*
Print	
Los Angeles Times	233
The New York Times	228
The Wall Street Journal	163
The Washington Post	270
USA Today	194
Newsweek	26
Time	15
U.S. News & World Report	16
Broadcast	
Evening News	
ABC World News Tonight	51
CBS Evening News	74
CNN Prime News	70
NBC Nightly News	60
PBS MacNeil/Lehrer	34
Total	**1190**

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Reliability

In an article about bridging the gap between political science and mass communication, Jamieson and Cappella (1996) discussed some central issues of validity. External validity refers to how representative and generalizable the results of a study are. Common issues include: How similar are the participants to the general populations of voters or citizens? Do the tasks parallel ones in the real world? Are the activities carried out in realistic contexts? Since this study employed the two best polls with the largest sample sizes, the results should not suffer from representative bias. Gaining information about public opinion is normally done through polling, so the tasks performed by Gallup and Harris parallel those in the "real world" and in realistic contexts.

Still, the question of generalizability to other issues certainly remains. I would argue that the health care debate of 1993-94 was unique yet generally applicable to other national policy discussions. Certainly, replication of this study with a future president and issue would provide interesting results and comparisons. This study looks at an issue of great public focus over a long duration. If the results here are to be generalized, one should take heed that the future political environment and media attention be similar to the conditions of the current study. Moreover, I believe it would be unwise to generalize the following results in the context of a public debate of less salience to the public at large. In short, the findings in this study are generalizable to the extent that the proposed debate is salient to the public, the press, and political actors involved over a substantial period of time. In Chapter 5, I will speculate further as to which issues might be appropriate tests of generalizability.

Analyses of Independent Variables

In this section, I will show the bivariate effects of each of the independent variables on the dependent variable, public support for the Clinton health care plan. I

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expect to show that increased media criticism was one of the prime factors in the decline of public support for the president's health security bill. In addition, I expect that other factors, including medical costs and economic factors, also will be found correlated with decreased public support. Each independent variable will be tested as well as several lag effects.

Each of the variables presented in Chapter 3 was vigorously tested to determine causality and correlation. As anticipated, the relative valence of news media content was found related to, and had a measurable effect upon, public support of the Clinton health care plan. Counter to prediction, however, was the individual effect of macro indicators of health care costs and employment. Finally, the economy was a strong predictor of public support for the Clinton initiative. Lagged effects were also investigated. I will begin with a discussion of bivariate analyses, followed by a discussion of multivariate relationships.

But first, a note about coding and my reporting. The Times Mirror Center coders scored a news story as 0 for positive, 1 for neutral, and 2 for negative. As the story was more critical, the coded value increased. Therefore, a negative coefficient means that as media criticism goes up, public support for the plan goes down. For purposes of discussing lag effects, MEDIAn means media criticism n days before the poll was taken. In addition, the end of this section will include Pearson R coefficients for each independent and control variable as it relates to the dependent variable, plan support.

News Media Content

Perhaps the most important finding of this study is the strong bivariate relationship between the valence of news media reporting on health care and public support for the Clinton plan. The problem was that the media covered the Clinton plan

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every day while polls were taken intermittently. The task was to match polls up with previous days' media coverage.

The general tone of President Clinton's press coverage was predominantly negative, except for a month of positive news during the North American Free Trade Agreement debate (Center for Media and Public Affairs 1993, 1994). To capture the overall direction of media coverage since each previous poll, averaged results will be compared.

As mentioned earlier, I anticipate some type of lag effect for media criticism's effect on plan support. It is reasonable to propose that immediate shifts in media criticism will not greatly influence public support for the plan despite its high salience. Instead, public support for the Clinton plan may have dropped a few days after the shift in media criticism occurred. It may be that a two-step flow of communication, or a multi-step variant, is at work[1]. Another possible theoretical rationale may be Zaller's (1992) Receive-Accept-Sample (RAS) model of public opinion, which requires time to develop changes[2].

On the day of the poll (MEDIA0), the news balance ($F(1,15) = 2.14$, $p < .164$) yielded a slightly positive R-square value but still very insignificant at .067. The F-value was 2.14 within a standard error of 5.87, which does not allow for much explanation of the relationship between media criticism and plan support. However, the unstandardized beta was again found to be negative at -6.82. The beta value suggests the predicted thesis

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[1] The two-step flow of communication refers to the notion that media effects are indirect. Often informed people, called opinion leaders, tell others of what they learned from media sources. Therefore the person who is not "connected to" the media directly, still receives the media effect. However the mediation from the opinion leader modifies the original media effect, in some cases distorting the original message (Berelson et al. 1954).

[2] Zaller posits that the RAS model varies from person-to-person based upon how deeply one holds certain beliefs about issues. A person who is staunchly pro-choice on abortion will not change his or her mind as quickly as one who believes that the issue is of little importance.

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of a connection between news and public opinion. But the p-value is not within .10. Therefore, I cannot argue the news/public opinion connection with any acceptable degree of confidence.

On the day before the poll was taken (MEDIA1), the relative valence of news balance ($F(1, 15) = .49$, $p < .497$) was not found correlated with support for the Clinton health care plan. The adjusted R-square was actually negative (-.033) and the F-value was well within the standard error for the model (6.18). The unstandardized beta was -3.44, suggesting a negative relationship between plan support and MEDIA1. As news of the debate was more negative, public support dropped. But again, the data do not suggest significance for this relationship.

As days are increased before the poll, the relationship becomes slightly more significant and comes closer to breaking out of the boundaries of standard error. Two days before a poll was taken (MEDIA2), the relative media criticism ($F(1,15) = 1.86$, $p < .193$) was again weak in terms of adjusted R-square at .051. Consistent with the two previous measures, the beta was negative (-8.13) but the significance level was not sufficient by academic standards (.193).

When the leap is made from two to three days before the poll (MEDIA3), the media criticism of the Clinton plan ($F(1,15) = 6.96$, $p < .019$) becomes useful by itself. The F-value (6.96) falls outside the standard error (5.18) within the .05 alpha-level (.019). Again, the unstandardized beta (-14.18) relationship between the media criticism and plan support suggests that they are related, as expected. While the adjusted R-square value still does not yield an accepted degree of confidence (.271), the emerging trend suggests that another day-move away from the poll might be more significant. However, it is just as likely that the effect would tail off as well.

The next period we tested was four days before the poll (MEDIA4). News coverage of the plan ($F(1, 15) = 8.22$, $p < .012$) at this time when crossed with plan support again yielded significant results just outside the .01 level (.012). As with the four

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previous attempts, as news became more negative, public support for the Clinton health care plan dropped more substantially (unadjusted beta = -18.28). The F-value (8.22) fell outside the boundaries of the standard error (5.04), which allows for some degree of explanation. In short, this is the best model of the lot so far but still less than the worst of the economic or health cost indices.

A fair question to ask is why not track media content ad infinitum? The answer is a practical one: at some point media criticism will cease to give us an improved lag effect. Variable MEDIA5 actually yields the exact same results as MEDIA4. In other words, the increasing lag effect for media criticism found from MEDIA0 to MEDIA4 went absolutely flat when tested with MEDIA5. From MEDIA6-9 the strength of the effect decreased, or tailed off. Therefore, the best lag effect for media criticism was found utilizing MEDIA4, four days before each poll was taken.

Health Care Costs

Contrary to what was predicted, health care costs alone were not a significant explanation for why people either favored or opposed the Clinton health care plan. Due to the fact the debate centered around the costs of health care, it was believed that price increases would prompt public opinion to be more in favor of the administration's proposal. However, the results indicate that individual cost indices were not sufficient to explain the variability in plan support.

Bivariate correlation results for the combined Gallup/Harris timeline were strong and in the expected direction. For the general index of medical prices ($F(1, 15) = 21.489$, $p < .0003$) the unstandardized beta was found at -1.92. The adjusted R-square was .561 and standard error at 4.02. These results indicate that as medical prices decreased, plan support increased. When lagged by one month, the general index of prices ($F(1,15) =$

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20.099, $p < .0004$) the unstandardized beta was identical at -1.92 but the adjusted R-square was weaker at .544 with a standard error of 4.10.

On more specialized indices, the results were similar. Within .0003 significance, the unstandardized beta for medical care services ($F(1, 15) = 22.10$, $p < .0003$) only was -1.78. This index alone registered .569 adjusted R-square and a standard error figure of 3.99. Results for medical care services demonstrate that as costs increased, plan support decreased. For the lagged version of medical care services ($F(1, 15) = 20.15$, $p < .0004$) the unstandardized beta was -1.76 with the adjusted R-square of .545 at a standard error level of 4.10.

Consistent again with expectations, prescription drug costs ($F(1, 15) = 20.41$, $p < .0004$) exhibited an unstandardized beta of -2.13 at the .0004 level. The adjusted R-square was .548 and a standard error of 4.08. In step with the other two health care price indices, as the cost of prescription drugs increased, support for the plan decreased. The unstandardized beta for the lagged indicator of prescription drug costs ($F(1, 15) = 19.79$, $p < .0005$) was slightly stronger at -2.18 with a slightly less impressive .540 R-square at a standard error of 4.12.

Unemployment Rate

Another reason to reform the health care system cited by reformers was that unemployed workers went without insurance. Bill Clinton's bottom line, remember, was that any bill passed by Congress must include a provision to deliver insurance to all Americans, called universal coverage.

In theory, if unemployment rose, then public opinion would be more likely to register in favor of the Clinton health care plan. Unemployment rates ($F(1, 15) = 17.89$, $p < .0007$) behaved as expected when placed in a regression model as the only independent variable against the dependent variable plan support. As unemployment increased, so did

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plan support. The beta for the relationship was 19.34, well outside the standard error of 4.24 and within a strong .0007 significance level.

State of the Economy

In contrast to health care costs and unemployment, the relative state of the national economy, as measured by the Department of Labor's index of leading economic indicators, described less than half of the variance in public support for the administration's health care proposal. The 1992 presidential election was widely hailed as a contest over the state of the economy. The 1993-94 health care debate was believed to be directly connected to the relative fitness of the economy as well. But results were neither significant nor substantial in the predicted direction.

For the same month of the poll, the index of leading economic indicators ($F(1, 15) = 4.16$, $p < .0593$) was a poor individual predictor of support for the Clinton health care plan. It is noteworthy that the bivariate match of the current index with plan support did not muster significance within the .05 level. The significance of beta -2.32 was only .059.

The leading economic indicators index performed marginally better when lagged one month ($F(1,15) = 6.09$, $p < .0261$) with an adjusted R-square figure of .241. This is still quite inadequate to describe the variance in plan support and less useful than the health care index results. The beta value, although not significant, was found negative at -2.59, indicating that as the economy fared worse, support for the Clinton health care plan increased.

Combined Versus Gallup Only

Before outlining the results of multivariate regressions and time-series analyses, let's pause briefly and discuss the relationship between using Gallup and Harris data

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points or using the former only. Remember, the Gallup polls only yielded 13 usable answer periods so four more were added from the Harris organization. To ensure that the combined time period is valid, I need to demonstrate that the addition of the four Harris polls does not change the character of the results cited above. Perhaps the best way to do this is to provide a comparison table. The following table lists the Pearson-R correlation coefficients for each variable as compared to plan support. Coefficients are paired with their corresponding probabilities.

Table 4.3 – Pearson Correlation Coefficients (Plan Support)

Variable	Gallup & Harris (n=17)	Gallup Only (n=13)
Media Criticism of Plan Day of Poll	-.3534 (p= .164)	-.3896 (p= .188)
Media Criticism of Plan Day Before Poll	-.1770 (p= .497)	-.3228 (p= .282)
Media Criticism of Plan Two Days Before Poll	-.3322 (p= .193)	-.2431 (p= .424)
Media Criticism of Plan Three Days Before Poll	-.5630 (p= .019)	-.4713 (p= .104)
Media Criticism of Plan Four Days Before Poll	-.5950 (p= .012)	-.5413 (p= .056)
Media Criticism of Plan Five Days Before Poll	-.5950 (p= .012)	-.5950 (p= .019)
Media Criticism of Plan Six Days Before Poll	-.4170 (p= .096)	-.3341 (p= .265)
Media Criticism of Plan Seven Days Before Poll	-.3127 (p= .222)	-.2194 (p= .471)
Media Criticism of Plan Eight Days Before Poll	-.3114 (p= .224)	-.2236 (p= .463)
Media Criticism of Plan Nine Days Before Poll	-.2469 (p= .339)	-.1428 (p= .642)
Medical Price Index Month of Poll	-.7674 (p= .000)	-.7453 (p= .003)
Medical Price Index Month Before Poll	-.7564 (p= .000)	-.7296 (p= .005)
Medical Services Price Index Month of Poll	-.7718 (p= .000)	-.7503 (p= .003)
Medical Services Price Index Month Before Poll	-.7571 (p= .000)	-.7293 (p= .005)
Prescription Drug Price Index Month of Poll	-.7592 (p= .000)	-.7311 (p= .005)
Prescription Drug Price Index Month Before Poll	-.7542 (p= .000)	-.7279 (p= .005)
State of the Economy Month of Poll	-.4661 (p= .059)	-.3545 (p= .235)
State of the Economy Month Before Poll	-.5373 (p= .026)	-.5423 (p= .056)
Unemployment Rate Month of Poll	.7374 (p= .001)	.7040 (p= .007)
Time Adjusted by Days Between Polls	-.8024 (p= .000)	-.7683 (p= .002)

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The chart clearly demonstrates that using Gallup and Harris data combined does not skew the results from positive to negative. Every coefficient that was found negative for the combined data was found negative in the Gallup Only column. As expected, using the combined polling information instead of Gallup alone decreased the p-values almost universally. In addition, the table shows that the media criticism effect increases on the day before the poll until the fourth day, maintaining on the fifth, and dissipating through the ninth day. The table also shows that each of the medical price index's effects on plan support during the month of the poll was stronger than when lagged one month. However, the state of the economy was found stronger one month prior to the poll.

First Hypothesis

H1: Negative interest group advertising campaign had a progressively negative effect on news media reporting of the Clinton health care plan.

The first hypothesis tests whether there was a relationship between interest group advertising and news media reporting, termed media criticism. Due to the fact that information was not available about when advertising was bought, we must rely on news reports of the buying strategies of the most conspicuous example: HIAA. Almost immediately upon delivery to Congress, interest groups (including HIAA) began the massive television advertising attack on the plan (Center for Public Integrity 1994; Fowler 1996; Kerbel 1996).

The first ad buy occurred almost immediately after Clinton presented the health reform package to Congress (Johnson and Broder 1996). Note that media criticism increased after this point. The next major advertising blitz was launched after the president's State of the Union address to the nation. Again, media criticism increased. Overall, it appears that the advertising became more effective as the debate wore on. The size of the shift in media criticism from the presentation to the first poll was less than the

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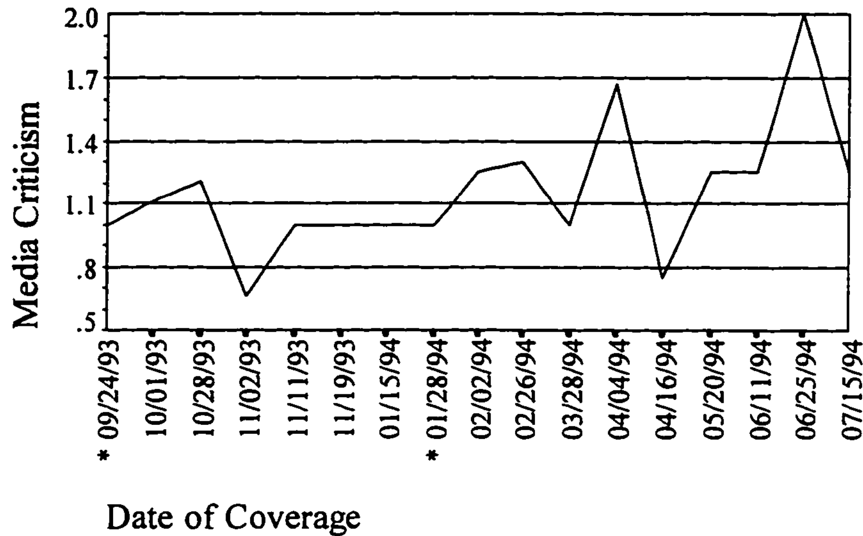
second wave of advertising. To this cursory extent, H1 is supported. The trend is mapped out it Figure 4.2.

Figure 4.2 – Plot of Media Criticism of the Clinton Health Care Plan.



To perform a regression analysis with two data points is very difficult and not highly desirable. However, to test H1 with the data available, a dummy variable (ADBUY) was inserted into the 17-point timeline. An ADBUY value of one indicated the two major waves of negative advertising (after each of Clinton's speeches) launched by HIAA. An ADBUY score of zero indicated that HIAA did not deploy the Harry and Louise ads en masse.

The best four-way model for H1 (MEDIA0) included TIME, dummy variable for major purchases of negative advertising ADBUY, and one-month lagged ECONOMY1. Table 4.4 demonstrates that the HIAA negative advertising did not have a negative effect as predicted. At an adjusted R-square .164, the model ($F(4, 12) = 2.04$, $p < .1574$) explained over almost none of the variance in plan support at .29 standard error. Each of the independent variables was not found significant within .10. The closest that came to significance was the TIME at .1210, while ADBUY performed rather badly at .3255, and

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ECONOMY1 worse at .6369. The overall model's significance was .28. In short, the test failed to explain the variance in news coverage of the Clinton health care plan.

Table 4.4 – Regression Analysis of Media Criticism Day of Poll (Gallup/Harris)

Variables	B	SE B	Beta	T	Sig. T
TIME	.002778	.001764	.750970	1.659	.1210
ADBUY	.241410	.236346	.254874	1.022	.3255
ECONOMY1	-.053149	.109976	-.212885	-.483	.6369
(Constant)	6.126490	10.844420		.565	.5817

$R^2 = .321$, N = 17

Second Hypothesis

To assess the results of the second hypothesis, I will utilize both time-series and regression analysis. The first hypothesis predicted that the negative political advertising supported by several interest groups, most conspicuously by HIAA, would affect reporting of the Clinton health care plan. This was supported by analyzing the time-series and placing the concentration of the ad campaign at two points. As expected, after these two points, a distinct increase in negative reporting was found that turned progressively negative. For H2, the strategy is similar. First, let's recap the text of the second hypothesis:

> H2: Negative news media reporting decreased public support for the Clinton health care plan.

If this were to be correct, the time-series model would show that media criticism preceded a sustained drop-off in public support for the Clinton bill. This will be determined in the same manner as H1 was conducted, by matching the peaks and valleys of negative news before falling support. The regression models pairing MEDIA4 with plan support should be found highly correlated. As discussed earlier, MEDIA4

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performed relatively well, compared to the four other indices measuring media criticism. But MEDIA4 was still found to explain very little of the variance in plan support. Therefore, other indices should be included as independent variables to raise the R-square value to the point where useful explanations can be made with relevant data.

Regression

The regression models may explain the weaknesses in some of the time-series analysis. Regression measures the overall strength of a combination of independent variables on a dependent variable. In this case, the dependent variable is level of support for the Clinton plan. For this section, I will seek combinations of the following variables to explain the variance in plan support: health care costs, unemployment, economy, media content.

From the bivariate analyses outlined earlier in this chapter, we already have clues as to which variables will perform better than others. For example, it is highly likely that MEDIA4 will yield a more substantial R-square than MEDIA0, or any other version of valenced news for that matter. Similarly, I suggest that ECONOMY1, the lagged version of the index of Leading Economic Indicators, would perform better in a model than either the index taken at the same time as the poll or the unemployment rate. As promised earlier, all models will include the variable TIME, so that time differences between polls are effectively standardized. Another way to find out which variables to eliminate is to check the colinearity between pairs. These tests were conducted and will help to explain the why certain variables were dropped entirely from the final model.

Four-variable Models

Armed with the knowledge that some variables are, perhaps, more useful than others, let's look at the permutations of time, valenced news, the lagged economic

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figures, and the three health cost indices. The model TIME, MEDIA4, ECONOMY1, and the most inclusive measure of health costs (MEDPRICE) was found at $F(4,12) = 24.52$, $p < .0000$. The model's .8545 R-square says that we can explain over 85 percent of the variance in plan support using these four variables. TIME, MEDIA4, and ECONOMY1 were all judged significant at the .05 level with the latter two at .01. However, MEDPRICE is far from significant at .335, falling outside an acceptable probability level. Therefore, the search for a better model continued.

Table 4.5 – Regression Analysis of Plan Support (Gallup/Harris)

Variables	B	SE B	Beta	T	Sig. T
TIME	-.141933	.056385	-1.987606	-2.517	.0270
MEDIA4	-14.213289	3.413415	-.462558	-4.164	.0013
ECONOMY1	3.125758	.929334	.648566	3.363	.0056
MEDPRICE	2.052454	2.043030	.821692	1.005	.3349
(Constant)	-656.142773	398.736277		-1.646	.1258

$R^2 = .855$, N = 17

Placing the more targeted medical services index (MEDSVCS) in the mix with TIME, MEDIA4, and ECONOMY1 did not further the quest for an acceptable model of plan support. MEDSVCS was also insignificant, this time at the .400 level. The search was going in the wrong direction so an attempt was made to substitute prescription drug costs (PREDRUGS) for MEDSVCS. Although better than MEDSVCS, PREDRUGS was only marginally more significant than MEDPRICE at .309. This was still not within the bounds of acceptability of a liberal .10.

Three-variable Models

At this point, I looked to see if the medical cost indices could be dropped. By comparing bivariate pairs of variables, judged significant and already in the model, I was able to drop medical costs from the mix. ECONOMY1 and MEDPRICE were highly correlated at .842, $p = .000$. ECONOMY1 and MEDSVCS was also a good match at

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.848, p = .000. Finally, ECONOMY1 and PREDRUGS was only slightly less related at .834, p = .000. This set of results led me to use ECONOMY1 as a surrogate for the less model-friendly medical cost indices.

The final model (TIME, MEDIA4, ECONOMY1) was found at $F(3,13) = 32.345$, $p < .0000$. Each variable was significant within the .01 level. TIME and MEDIA4 were found significant within .001 while ECONOMY1 at .002. The adjusted R-square was impressive at .855, which suggests that the model accurately explains over 85 percent of the variance in public support for the Clinton health care plan. The complete results of the model are listed in Table 4.6.

Table 4.6 – Regression Analysis of Plan Support (Gallup/Harris)

Variables	B	SE B	Beta	T	Sig. T
TIME	-.086668	.012379	-1.213687	-7.001	.0000
MEDIA4	-14.901880	3.345077	-.484968	-4.455	.0006
ECONOMY1	3.413557	.884391	.708281	3.860	.0020
(Constant)	-265.036286	86.215835		-3.074	.0089

$R^2 = .855$, N = 17

Just as the Gallup/Harris results were compared to Gallup alone, it is especially prudent at this time to revisit the final model without the Harris data points. As expected, the results were very similar but the adjusted R-square was found to be marginally less impressive at .829. Still, without four data points, the model for Gallup only ($F(3, 9) = 20.44$, $p < .0002$) explains about 83 percent of the variance in plan support. The standard error for the model was 2.59, well outside the F-value. Each variable in the Gallup Only model was judged significant at the .05 level. Each sign in the Gallup/Harris model corresponds with its Gallup Only mirror. In sum, the strength of the relationships between the variables TIME, MEDIA4, and ECONOMY1, were increased by including the Harris data points but their nature were not changed. Therefore, the results strongly support H2.

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Table 4.7 – Regression Analysis of Plan Support (Gallup Only)

Variables	B	SE B	Beta	T	Sig. T
TIME	-.097886	.017369	-1.380447	-5.636	.0003
MEDIA4	-16.006775	4.095827	-.515471	-3.908	.0036
ECONOMY1	4.306693	1.2844573	.862286	3.353	.0085
(Constant)	-351.541832	125.239451		-2.807	.0205

R^2 = .829, N = 13

Time-series

If MEDIA4 were to move public support, what would it look like? Since MEDIA4 is already a lagged indicator, we would expect that the upward and downward spikes to be closely related to movements in public opinion. Ideally, the time-series graphs would look equivalent. This would be a perfect effect, which would demonstrate that as the valence of news coverage shifted, public support followed in lock-step. For this study, with only 17 data points, the condition could be satisfied with less perfection.

Perhaps the best way to demonstrate the series is to map out the changes of media criticism and plan support in a table. Table 4.8 shows the direction of the changes from T1 to T2, T2 to T3, and so on. When the media was putting a spin on the Clinton health care plan, the News column indicates either "positive" or "negative." When public support either increased or decreased, the table will show "gain" or "drop" respectively. The reader should note that Table 4.8 indicates changes, therefore, September 24, 1993 is not listed. Italicized pairs show when the match was perfect, meaning the direction of change was the same on both sides.

Table 4.8 demonstrates that the movement was uniform a little more than half of the time, especially more toward the end of the health care debate. For these nine points, I would suggest that the media had a hand in moving the public opinion. However, the other seven did not follow as expected. Positives are supposed to beget gains and negatives drops. Why did half follow suit and the other half not? The period between

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September 24 and October 1, 1993 was the honeymoon period for the Clinton plan. As I have stated throughout, the initial reaction to the plan was quite positive – 59 percent approval. Although the news was initially positive, it was obvious that the honeymoon, like that for presidents, would not last. On the first poll after the presentation, support held close to its highest point.

Table 4.8 – Media Criticism & Plan Support

	News	Support
10/1	positive	drop
10/28	*negative*	*drop*
11/2	*positive*	*gain*
11/11	stable	negative
11/19	stable	negative
1/15	*positive*	*gain*
1/28	negative	gain
2/2	stable	drop
2/26	*negative*	*drop*
3/28	*negative*	*drop*
4/4	positive	drop
4/16	negative	gain
5/20	*positive*	*gain*
6/11	*negative*	*drop*
6/25	*positive*	*gain*
7/15	*negative*	*drop*

The mid- and late-November polls demonstrated a stable support period for the Clinton plan at about the mid-fifties despite the news becoming negative. Looking at the charts, however, explains how weak the change was in the valence of health care news coverage. At both points, the change was less than .1. It is possible that the variance in news was imperceptible to the average viewer and may not have affected plan support very much. In short, I would argue that these two points were, realistically, perceived as equivalent by most media consumer/poll respondents.

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The November results may help to explain the lack of parity in the January figures. From the change from the State of the Union Address (January 15, 1994) to the following poll (January 28), there was again very little movement on either end of the debate. Media criticism was virtually flat, as was the change in public opinion. Again, it is entirely possible that the change in news coverage was less apparent than in other, more dramatic, instances.

Summary

Results provided by this chapter have demonstrated that both H1 and H2 were supported through time-series and regression analysis for both the combined data set of Gallup and Harris polls and Gallup as a stand-alone group. Time-series analyses indicated that the insertion of negative political advertising by interest groups changed the predominate valence of news coverage toward the Clinton health care plan. The time-series also demonstrated that the valence changes in news coverage preceded changes in public support for the plan. For the regression models, health care indices performed relatively well with plan support, but they were not found significant when placed in regression models with other variables. Health care costs were found to be highly correlated with the relative valence of the news media coverage of the debate so the final regression models utilized the latter in place of the former. The final combined model (TIME, MEDIA4, ECONOMY1) explained over 85 percent of the variance in support for the Clinton health care plan.

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CHAPTER 5
DISCUSSION

This final chapter is one for reflection. Chapter Four described what variables were significant in the downfall of public support for the Clinton health care plan. Here, I outline the study's limitations and implications for presidential public policy proposals of high public salience. At the very least, the findings suggest three sources for the Clinton defeat on health care: interest group political advertising, negative news, and the economy. Chapter Five will conclude with some thoughts on what directions researchers may want to take in light of these findings.

Study Limitations

Despite the strong results outlined in Chapter 4, now is the time for some honesty. By virtue of the type of data and how it was manipulated, this study has some inherent limitations. Validity refers to the extent to which a measures adequately reflects the *real meaning* of a concept, while reliability questions whether a particular technique, applied repeatedly to the same object, would yield the same result every time (Babbie 1992). In the next section I will defend the measures used in this study on questions of validity and reliability.

Validity

Generally, to challenge this study's validity, one must take issue with the measures used. To what extent did the opinion polls conducted by Gallup and Harris accurately gauge public support for the Clinton health care plan? Similarly, how accurate

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are the United States Labor Department indices for health care costs, unemployment, and the index of leading economic indicators? Finally, one must judge if the content analyses accurately depicted positive, neutral, or negative news content reflecting the reality of the coverage.

More specifically, Carmines and Zeller (1979) define three types of validity: face, criterion, and content. Face validity refers to how measures may or may not agree with the conventional wisdom (Babbie 1992). An example of compromised face validity would be if actual public support for the Clinton initiative was strong when polls indicated that it was falling. Due to the strong sample sizes and use of polling conventions, I am reasonably certain that the polling conducted by Gallup and Harris accurately reflection mass public opinion within their published standard error. In addition, we can reasonably take measures on their face from the United States Department of Labor, which includes health cost indices, unemployment, and index of leading economic indicators. The Labor Department has been tracking these measures for several years and they are widely reported in press accounts and cited by business leaders as accurate. Moreover, the non-profit Times-Mirror Center content analyses employed a rather conservative coding scheme that allowed for a positive or negative slant only when the ratio was 2:1. Stories that did not meet this strict requirement were deemed neutral.

Criterion-related validity, or predictive validity, is based on some external measurement (Babbie 1992). For example scholastic aptitude tests should accurately predict how well a student will do in college. The external criterion in this case may be the student's first-year grades. Such hard proof of validity is difficult for social scientists, especially in this case. How should we measure the criterion validity of polls, Labor indices, or news content? The answer Babbie admits is "sometimes difficult" (p. 132). Indeed, to find support for criterion validity we might have to resort to unconventional means such as finding tangible results for polls (demonstrations against the plan?), Labor

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statistics (recording the length of lines at unemployment agencies), or news valence (affective responses by viewers).

Content validity "refers to the degree to which a measure covers the range of meanings included within the concept (Babbie 1992, p. 133)." Was the wording in the public support polls for the Clinton plan inclusive enough to be understood but not prejudiced? One would expect large and non-significant degrees of standard error (more than .05) if the questions were value-laden or obscured the true intentions. Gallup and Harris results were found within plus or minus 4 and 3 points respectively. Times Mirror coders were fully briefed on what constituted positive and negative news content. The Department of Labor statistics are very careful about claiming what they measure. Health costs were defined in this study by the Labor Department as a complete index (MEDPRICE), medical services (MEDSVCS), and prescription drug costs (PREDRUGS). The meaning of these indices are reasonably unambiguous and value-free in definition for analysis.

Reliability

How reliable are the measures listed in Chapter Four? The simple answer is that they are as reliable together as their weakest link. In a less cryptic manner, the regression models are about as reliable as the measurement with the most standard error. Each model also has its own measurement of reliability: the significance level. By this standard, the results found here are quite reliable. However, Babbie (1992) illustrates four alternatives to my simplicity: test-retest method, split-half method, research-worker reliability, and using established measures.

Since I did not collect original data, one must place faith in Gallup, Harris, Times Mirror, and the Labor Department. Each of these sources are examples of established measures. Gallup and Harris polling firms are tops in their industry. Times Mirror has

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tracked news content for several years under established criteria. And the United States Labor Department is well-respected as a source of unbiased economic information widely used by news outlets and business leaders alike.

Other precautions were taken by the data sources for this study. Gallup and Harris routinely call back a subsample of respondents from their completed surveys to check that the results were recorded accurately. Times Mirror also employed two other methods of attaining reliability: test-retest and research-worker methods. News content was not conducted by coders acting alone. Each person who tracked media content was paired with others and their results were averaged producing intercoder reliability above 85 percent, meaning that they disagreed less than 15 percent of the time. Times Mirror also took care to properly train and require practice before conducting their media tracking.

Study Implications

Despite these limits and concerns, this study did find some interesting results that, viewed in perspective, may provide some explanations as to why the Health Security Bill of 1993 lost its high approval with the American public. Further, it is likely that the political climate of active interest group media participation and negative press will continue, which may set the stage for difficulties in passing presidential initiatives in the future (Fallows 1996). Each variable will be discussed individually.

Time

From the overall trend it is clear that the longer the Clinton health care plan was debated, the less public support was maintained. Overall, the plan's support dropped from 59 percent in September 1993 to about 40 percent in July 1994. On its face, this suggests the war for health care reform was one of attrition. Of the 16 changes between time periods, eight showed waning public support, while five recorded increased support

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and three reflected no change. Support for the Clinton health care plan never equaled or exceeded its initial support rating and the final poll journalized the lowest score overall.

The TIME variable may be taking into account other things that were not directly measured. It is possible that, from the very first day, the plan was overvalued. Initial support may have been due to a type of "honeymoon effect" that increases most presidents' approval ratings during their first few months of office (Pfiffner 1994). Also, it is important to note that strategic thinking did change during the health care debate. As tested earlier, advertising blitzes were not a constant feature of the debate, they were more targeted around presidential speeches. In addition Robert Dole (R-KS), then Senate Minority Leader, was in favor of passing some health care reform legislation early in the debate but shifted against as the political winds that were carrying the plan were beginning to fade. Other legislators, including many Democrats, jumped from the president's ship as the plan became less palatable to the public. Moreover, the strength of conservative voices was increasing as the debate wore on within the Republican congressional conference, making it less likely for the loyal opposition to let any reform package to be passed (Johnson and Broder 1996).

News Media Content

The results are similarly powerful for the relationship between news media content and public opinion. Overall, as time passed, the news became more negative about the Clinton proposal — in step with the downward trend of plan support over time. Valenced news media coverage had a virtually immediate effect on public support for the Clinton health care plan. As the news content variable was lagged over two, three, then four days, the results became increasingly more significant. This suggests that news tone may take some time to register in people's minds as it connects to opinions on issues or may be slowed by a two-step flow of communication.

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The implications of these results are quite important. This study demonstrated a negative reaction to policy (lessening public support as recorded by polls), in part due to predominantly negative press coverage. This goes beyond "agenda-setting" (Iyengar and Kinder 1987) and "framing" (Iyengar 1991). It appears that the news actually had a valenced effect on public opinion when lagged by four days. From this perspective, objectivity in news reporting should not only be a goal, but a requirement as to allow individuals to form their own opinions without slant from the media.

What does this say about the responsibility of the media? As analyzed here, media criticism was not the only factor in the weakening of public support for the Clinton health care initiative. However, media criticism certainly played a role in the plan's demise. The findings in this study suggest that, to some extent, negative media coverage of the Clinton plan may have caused a drop in its public support. Not only can the news set the agenda to raise awareness of an issue, but the results of this study indicate that media criticism influences public support for a proposal to address the problem.

An alternative theory of media responsibility may be that it is not the tone of the news but rather the type of reporting that influences public opinion. James Fallows (1996) argued that an emphasis on "horserace" over issue-centered reporting is damaging the political system. Others have come to the same conclusions, most notably Shanto Iyengar (1991), who found that people assign responsibility differently for society's ills according to how news stories frame issues[1]. The Times Mirror study included some information to substantiate the theory that media coverage during the health care debate became more game-oriented than issue-focused. It is possible that as the focus shifted from the plan to its prospects (and to coverage of its opponents), public support dropped.

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[1] Iyengar's findings showed that people who viewed "thematic" news stories, which emphasize systematic problems, tended to assign responsibility for the problem to the government. On the other hand, people who viewed "episodic" stories, which focus on one person's story (or a few people), tended to assign responsibility for the problem to the individual(s) in the news report.

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Still another explanation for the negative content of news reporting toward the Clinton plan reflects the principals involved in that process. In his research on the media and the Vietnam War, Daniel Hallin (1984) found that media criticism did not diverge from journalistic norms such as objectivity and citing sources. Instead, Hallin argued that the level of media criticism was determined as an objective response to the degree of consensus or dissensus that prevailed, particularly among political elites.

Does this mean that the new elites are political advertising sponsors and the opposition party? Criticism of the Clinton health care plan primarily originated from those quarters of the debate. Hallin might argue that the increased media criticism as the debate wore on reflected the prevailing pattern of political debate: when consensus was strong, the media tended to stay within the limits of political discussion thereby defined – but when consensus began to break down, coverage became increasingly critical and diverse in the viewpoints it represented, and increasingly difficult for officials to control (p. 23). To Clinton's health care team, this statement probably sounds all too real.

Health Care Costs

Quick, how much have health care costs increased or decreased in the last month. How about the last two? Most people simply do not know the results from the Labor Department's monthly calculations of costs related to health care. These statistics are not followed very closely by the popular media and therefore it would be unrealistic to assume that they have a direct effect on mass public opinion. For this study, the results confirm the notion. An alternative explanation may be that people refer to personal experiences with changes or absolute costs to themselves or to someone they know. Despite the fact that cost increases were found correlated with increased plan support, each of the health care indices were insignificant when placed in regression models.

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On the highly-salient issue of health care during 1993 and 1994, the mass media may not have done an adequate job of publicizing the fact that costs for health care were increasing each month, outstripping inflation. Other studies have found that the news media followed the "horse race" in campaign fashion, instead of focusing attention on the factual issues involved in health care reform (Times Mirror 1994). The apparent failure to spotlight monthly increases in health care costs as well as other substantive issues may have contributed to the decrease in popular support for the plan.

As interest groups spent millions to argue that employer mandates were wrong, the news media covered that portion of the debate (Times Mirror 1994). Often, reaction from White House sources appeared lame in comparison. Many times, the administration's explanations were laden with complex statistics and name-calling. Moreover, advertising in support for the plan was not as well-funded or as effective (Center for Public Integrity 1994). The voices against employer mandates clearly won over the voices of increasing costs.

It is also possible that even if people were aware of their health care costs, they may not have supported the Clinton health care plan. A common complaint against the plan was that it would cost too much (Moore 1994), failing to contain rising prices as the administration claimed. Some citizens may have believed that no government initiative, especially a Clinton one, could do it. In short, it is possible that a causal relationship between costs and plan support was not valid.

Unemployment Rate

It appears that public opinion did not react to monthly changes in the national unemployment rate either. As a correlated measure, the unemployment rate was found significantly related to plan support. When the unemployment rate went up, support for the Clinton health care plan also increased. But despite a measure that is far more

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personal than rising health care costs, people did not change their minds due to incremental increases or decreases in the Department of Labor's unemployment figure. This conclusion stems from the fact that unemployment (UNEMP) was not found significant when placed in any regression model within .001, .01, .05, or even .10.

Cumulatively, the unemployment rate doesn't seem to register directly with the American people although it is traditionally reported every month by many news sources. The impersonal nature of the monthly percent change in the rate may not provoke a change in public opinion like the story of a friend or loved one losing a job. Moreover, Americans have been feeling less secure about their jobs despite the overall trend of decreasing mass unemployment (Roberts 1996; Samuelson 1996; Sloan 1996). In short, the measure itself may not be an accurate depiction of perceived unemployment. The fears by those who have jobs of losing them may be more powerful.

There are still yet other explanations. Perhaps respondents did not directly connect unemployment to support for the Clinton health care plan when viewed in conjunction with other factors. The initiative had several planks included in the 1,300-plus-page plan, and securing health insurance was only one of them. Universal coverage, Clinton's bottom-line goal, could have been interpreted by the public as a "gift" to the 15 percent who did not have insurance. Issues of portability and pre-existing conditions may have been too complicated for the average person to place in perspective. Finally, we may posit that the 85 percent with insurance had reason to believe that their coverage was somewhat secure.

State of the Economy

The index of leading economic indicators was not found to be a strong indicator of plan support by itself for the month of each poll. When lagged, the index performed marginally better, reaching significance at the .05 level ($p < .03$). So as a direct

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correlative indicator, the state of the economy was not as powerful as we would have expected. Still, the index did indicate that as the economy went south, support for the Clinton health care plan increased. It was expected that as people felt the effects of a poor economy, they would be more likely to support the Clinton health care reform effort. The results show that the thinking was more complex.

In conjunction with other variables (TIME and MEDIA4 most notably), the state of the economy was a highly significant measure of plan support in the expected direction. The index of leading economic indicators was even more powerful one month before the poll was taken (ECONOMY1) at the .002 significance level. It is plausible that the information was connected to the plan over a period of time, not immediately. It is also possible that the effects of a sagging economy take some time to become relevant to people and their opinions.

The implications of this finding suggest that policymakers should keep a close eye on the state of the economy when proposing major changes in policy that effect the public's pocketbook. The results also warn those who wish to propose major policy changes in health care to keep an eye on broader indicators of economic activity instead of targeted economic or cost figures. It might be more likely that people will connect policy to their general gut feeling about the economy instead of specific costs or small variations in mass unemployment. The index of leading economic indicators may not be an accurate measure of that intuition. Instead, the index may be a broad enough measure to take into account the variances in enough segments of the national economy to not only reflect mood (which it may not) but (more likely) its actual state.

Future Health Care Reform?

Two years have passed since the demise of the Clinton administration's Health Security Bill. In that time, Republicans captured both houses of Congress for the first

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time in 40 years. Capitol Hill fixtures including Speaker Thomas Foley (beaten in 1994) and Chairman Daniel Rostenkowski (resigned in 1994) have been replaced by former professors Newt Gingrich (Speaker) and Richard Armey (Majority Leader). Instead of attempting to expand health insurance to all Americans, Republicans have sought to "save" Medicare through cuts in future spending. Other proposals being talked about by Republican presidential candidates include supplementing the program with medical savings accounts (Lee 1996; Steve Forbes at the Arizona primary debate on videotape). In short, the goal of attaining Clintonesque "universal coverage" appears to be off the table as of this writing.

However, the 104th Congress did take some action on health care in bipartisan fashion. A coalition led by Senators Nancy L. Kassebaum (R-KS) and Edward M. Kennedy (D-MA) kept health reform alive through a comparably modest reform bill that would "generally require group health insurance plans to offer coverage to all employers and their employees and dependents, regardless of pre-existing conditions or medical history. It also would require insurers to issue individual policies for many workers ineligible for group coverage when they leave their jobs" (Langdon 1996a, p. 616). It passed the Senate 100-0 on April 23, 1996 (Clymer 1996). Close to a month earlier, on March 28, the House of Representatives passed a similar bill 267 to 151, which would provide the type of "portability" outlined in the Senate legislation (Langdon 1996b, p. 617; Lee 1996b).

Momentum appeared in Spring 1996 to be carrying limited health care reform to floor action in Congress, but there were signs of trouble ahead. Despite an endorsement from the nation's largest health insurance association (Independent Insurance Agents of America) other industry officials worried about how portability was to be accomplished (Blitzer 1996). Again HIAA led the assault, saying that premiums for individuals may rise as much as 30 percent over the next few years if the bill was passed (Lee 1996b). Moreover, some Republican conservatives, including House Speaker Newt Gingrich,

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wanted to attach controversial medical savings account and tax break provisions to force a stand-off with the president (Lee 1996a).

Their concerns had actually stalled the progress of the bill, convincing the Senate leadership to place a "hold" on the bill, meaning it could not come to the floor for consideration. But President Clinton's endorsement of the Kassebaum-Kennedy bill in his 1996 State of the Union Address and press coverage about the hold prompted the Republican leadership to lift the hold and schedule floor time between April 15 and May 3 (Langdon 1996a). Without the hold, other interest groups, including the U.S. Chamber of Commerce and the National Association of Manufacturers, have warned that if the scope of the bill expands on the floor, they will pull their support (Langdon 1996a).

Whether this means a new round of "Harry and Louise" campaigns or an increase in negative news coverage against the Kassebaum-Kennedy bill remains to be seen. It is my view that the ads, if aired, will be less effective this time since the final bill is viewed as a moderate and bipartisan alternative to the bureaucratic Clinton health care plan that failed in 1994. In addition, the high-profile support of other insurance interest groups may just be enough to carry the day. Moreover, HIAA's main beef with the Clinton plan, employer mandates, are much less conspicuous in the 1996 bill. At this point, the more conservative House of Representatives has passed a version of Kassebaum-Kennedy (Lee 1996b) so it is likely that President Clinton will have some version of health care reform to sign this year.

The Clinton experience with sweeping health care reform and its subsequent advertising reaction by interest groups effectively limit such ventures in the future. Pundits roundly credit the media campaign for grounding the initiative (Ansolabehere and Iyengar 1995; Fallows 1996). As media scholars Ansolabehere and Iyengar note, "The prospect of interest group attacks can have a chilling effect on public policy" (1995, p. 133). As evidence, I would cite the Republican leadership hold on Kassebaum-Kennedy.

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If the bill fails to reach the president's desk, or is further diluted in conference, this may suggest a chilling effect as well.

Future Research

Generalizability is the extent to which findings in one study may be extended to a population, or alternatively, whether a study represents an "n" of 1. In medicine, drugs successfully tested on a group of individuals are hoped to extend to the entire population of human beings. For this study, there are several issues that can address the question of generalizability. I would suggest that researchers consider such factors as whether a particular proposal is (a) widely salient in the media and to citizens generally, (b) supported or opposed by the president, (c) either distributive or redistributive in nature, and (d) challenged by interest groups through the media.[2]

Kassebaum-Kennedy

Perhaps one of the most obvious ways to assess generalizability is to compare the Kassebaum-Kennedy health care reform bill to the Clinton plan. The former is less salient to the public and represents a more targeted attempt at reform. This may be due to the limited attention given to it by the press when compared to President Clinton's Health Security Bill of 1993 (Lee 1996a). However, some of the same interest groups will be against Kassebaum-Kennedy, such as HIAA. When asked about the Kassebaum-Kennedy bill, HIAA president Bill Gradison has consistently voiced his opposition (Lee 1996a, 1996b). Will press scrutiny be comparable to that during the Great Health Care

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[2] By distributive, I mean a "good or service" that can be used by almost all citizens such as roads and public parks. Redistributive policies are those that shift wealth from one group to another. Examples of redistributive policies include welfare and Medicare programs, which shift tax dollars to target specific groups of people who need help.

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Debate of 1993-94? Will public approval for the plan drop precipitously as the bill moves to the floor? Is anyone measuring either variable at this time?

The Kassebaum-Kennedy health reform bill, to be sure, is less salient to the people and the press than the Clinton health care plan. Health care is not a top-tier issue as it was when Clinton was touting systemic reform. It is probably not one of the top three concerns that Americans cite as the "most important" to them. Far less media attention has been paid to the Kassebaum-Kennedy legislation than the Clinton plan. This may be caused by the fact that the plan before Congress today is not the president's plan. Another explanation for this lack of media focus may be because interest groups, such as HIAA, have not launched massive advertising campaigns against the Kassebaum-Kennedy bill. Instead, interest groups have chosen more traditional methods of persuasion such as contacting members directly. Moreover, supporters of the Kassebaum-Kennedy reform bill have been sensitive to tout publicly the support of business and insurance groups.

Surely there are some substantive differences between Clinton and Kassebaum-Kennedy. Instead of originating at the president's desk, the latter is a congressional creation. To use a mass communication analogy, Clinton's Health Security Bill was an act of broadcast, while the 1996 bill is an attempt at reform narrowcasting. The Clinton plan had only Democratic sponsors, whereas its successor has widespread bipartisan support. Will these differences doom a comparison between the two reform plans? Perhaps. Still, a tale of two health bills would prove to be at least an interesting case study of how interest groups, press, and the public react differently to health care system proposals.

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Clinton Issues

Another angle to consider on the question of generalizability relates to other issues that were salient during the Clinton presidency. After the virtual defeat of his health care plan in Congress, Bill Clinton said that the November 1994 election would be a referendum on legislative, particularly Republican, gridlock. In the wake of the Republican takeover of Congress, the issue shifted from health insurance for all to the "saving" of Medicare and Medicaid. Republican leaders pushed for a slowdown in the rate of increase of these entitlements while the president proposed less of a decrease.

The fight over Medicare and Medicaid was highly salient to the press and the American people. President Clinton and the Republican Congress clearly had differences of opinion. The semantics of the negotiations articulate the differences between the two sides. Clinton argued that Republicans were bent on "cutting" the funds while Congressional leaders were saying that they were slowing the increase. The debate was distributive in nature, since younger generations support the system. Just as the Clinton health care reform effort failed, the cuts/slowing increases did not become law. Moreover, the Democratic National Committee, and others, sponsored advertising campaigns against the Republican plan.

The Medicare/Medicaid debate was a good example of an issue that was widely salient and it is reasonable to assume that a content analysis can be conducted to tract media attention. It is also possible that the major polling organizations tracked public support for the Republican Congressional plan and Clinton's alternative. However, it will be difficult to support the validity of these findings since the Republican's first offer was quite different from their most recent. Clinton's proposals also changed throughout the debate, further complicating validity. Some interest groups (and both political parties) sponsored advertising that took issue with both plans. These campaigns may be difficult to track making it very challenging to retest my first hypothesis. In short, while

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Medicare and Medicaid were hot issues for the people and the press, it is unclear whether either was effectively tracked for analysis. In addition, the president and Congress staked out positions on Medicare and Medicaid but they shifted during the debate whereas Clinton was clear on his bottom line for health care reform: universal coverage. And finally, interest group spent far less on advertising campaigns to influence the Medicare/Medicaid debate with perhaps less effect.

Another issue that might prove to enhance the generalizability of this research is the 1996 battle over the minimum wage. Congressional Democrats, with President Clinton's support, proposed a 90-cent increase in the wage that all employers in the United States must offer to their employees. Republicans initially balked at the notion but appear to have moderated their stance. The salience of the issue to the people and the press perhaps was, once again, heightened by an expensive advertising blitz, this time sponsored by organized labor. Political combatants on both sides of the issue agreed that the issue was redistributive in nature. Those in support argued that the wage had not been increased by employers despite the latter's having made record profits in recent years according to the AFL-CIO (Gruenwald and Wells 1996). Opponents argued that raising the minimum wage would actually displace some workers because their employers could no longer afford to pay them.

With the president's support of an increase in the minimum wage in his State of the Union address, the issue became a hot topic for the media. Polls showed that the proposal was widely popular with the public, just as the Clinton health care plan was when it was presented. However, instead of Republicans gaining momentum to shut down the proposal as they did during the health care debate, they faltered. Organized labor's media campaign *for* the minimum wage increase stands in contrast to the HIAA blitz *against* the Clinton health care plan. Both appear to have been successful, influencing citizens and media criticism. Data on advertising spending in support of the minimum wage increase by the AFL-CIO may be more accessible to researchers than the

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limited information gained from HIAA for this study since labor unions operate under different sets of laws.

Previous Presidential Issues

Another direction future research may wish to take would be to examine issues from other presidencies. Under previous Republican administrations, tax issues were often highly salient. President Reagan's 1981 tax cut package and President Bush's 1988 tax hike were examples of an engaged public and press. Tax issues are, by nature, redistributive. The Clinton health care plan was redistributive too, utilizing taxes that all Americans pay to cover the 15 percent who do not have health coverage. Reagan and Bush's stances on taxes were widely salient to the press and the public since each of them took clear positions. Reagan's tax cuts were borne out of his presidential campaign. Bush broke his promise to the voters not to agree to tax increases. What is unclear, however, is the role of interest groups in these two debates.

On the heels of a landslide election, Ronald Reagan set out to "relieve" the average family of high taxes. The final package, which was passed though a Democratic Congress, enjoyed high profile attention from the people and the press. However, oppositional advertising campaigns were not launched en-masse during the tax debate but during the 1984 presidential election campaign. Democrats argued that the effect of the 1981 tax "reform" was to create a large budget deficit and increase the public debt.

Reagan's plan to cut taxes, like Clinton's promise to provide health care for all Americans, was initially popular. Reagan used that popularity to swiftly pass his program while Clinton's plan staggered through the legislative sieve until it died almost one year later. In each case, the press and the American people were attentive but it is likely that Reagan's tax plan enjoyed more favorable media coverage. I would argue that time also played a factor. Reagan's plan was presented very early in his presidency while Clinton

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waged other policy battles before he got to health care reform. Moreover, as mentioned earlier, interest groups did not launch media blitzes against Reagan's plan as they did against Clinton's health care proposal.

An interesting comparison to the Reagan tax cuts may be the Bush tax increases. To move toward reducing the budget deficit left by his predecessor, George Bush went back on his pledge not to raise taxes. Unlike Clinton and Reagan, Bush's (and Congress') plan was a total reversal from campaign rhetoric. In contrast to the Clinton and Reagan plans was that the Bush tax increase did not originate from the White House, instead it was the result of a summit between Bush and the Democratic Congressional leadership. And, the move came two years after President Bush's election while Clinton's and Reagan's proposals were delivered in the first year of their respective presidencies.

The 1988 budget deal struck with the Democratic leadership increased taxes and was widely covered by the news media and was an issue in the 1992 presidential campaign. Unlike the Reagan and Clinton plans, the move was widely unpopular with the public. Perhaps because the deal was bipartisan or timed quickly, interest groups may have had less influence on the plan than during the Clinton health care plan debate. It is unclear what type of influence interests groups had, if any. Negative advertising did not hit the airwaves until the election, when one Clinton ad depicted President Bush asserting his famous line "Read my lips, no new taxes" and then showing how much taxes were raised by the 1988 budget deal. By the time the ads hit, the tax increase had already become law.

Conclusion

Three variables — time, the valence of news coverage lagged by four days, and the state of the economy lagged by one month — combined to explain over 85 percent of

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the variance in public support for the Clinton health care plan. When compared, health care cost indices and the Labor Department's unemployment rate were found to be related to plan support. As costs rose, so did support for the Clinton initiative. As unemployment dropped, so did plan support.

For health care policymakers, this suggests an interactive problem. Prospects for public support rest, in part, upon the combined effect of how the news covers the issue, the relative strength of the economy, and the time it takes to get the plan to the floor of Congress. Good relations with the press may result in residual public support. In a relatively strong economy, the public may be less likely to support health care reform. On the one variable that legislative leaders certainly can control, time, it is suggested that they expedite the process in the quickest manner possible. Time was a counteractive force against health care reform.

Any direction that health care legislation or research takes will likely find some connection to the questions, if not the findings, raised through this investigation. Presidents will continue to propose policy changes, perhaps to a lesser degree – but perhaps not. Members of Congress will probably continue to serve their own interests over the interests of their party leadership or their president. Interest groups will not sit back while their preferences are being overlooked. It is also quite unlikely that the activist, or attack, journalism community will pass over issues of widespread public interest. Therefore, we are left with a similar situation future activist presidents and their policies will somehow have to manage. Presidents beware.

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APPENDIX

Variable	Source/Explanation
ADBUY	Times Mirror Center for the People and the Press. Used two best estimates of HIAA advertising blitz.
ECONOMYn	Bureau of Economic Analysis. The Index of Leading Economic Indicators.
MEDIAn	Times Mirror Center for the People and the Press. Relative news media criticism of the Clinton health care plan. It was coded as 0 for positive, 1 for neutral, and 2 for negative. Each day's stories were averaged to gain a composite score for the media criticism. The "n" represents the media criticism figure for "n" days before the poll.
MEDPRICEn	United States Department of Labor. Index of overall medical prices. The "n" represents medical prices "n" months before the poll.
MEDSVSn	United States Department of Labor. Index of medical services prices. The "n" represents medical prices "n" months before the poll.
PLANSUP	Gallup Polling Organization and Harris Polls. Support for the Clinton health care plan. The "n" represents medical prices "n" months before the poll.
PREDRUGSn	United States Department of Labor. Monthly index of prescription drug prices. The "n" represents medical prices "n" months before the poll.
TIME	Hand tallied with Dr. Wayne Francis, University of Florida. The number of days after the first poll was taken.
UNEMP	Bureau of Labor Statistics. Standard monthly unemployment rate.

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BIOGRAPHICAL SKETCH

Michael David Cohen is currently a field representative for the Republican Party of Florida. Before that, he focused on attaining his collegiate education graduating twice from the University of Florida with Bachelor's and Master's degrees in telecommunication and political campaigning where he was president of the Graduate Student Council and inducted to the Hall of Fame. His professional experience includes teaching American Federal Government, presenting a paper to the American Political Science Association, and serving on a panel at the Florida Political Science Association. Cohen is the son of Philip and Linda Cohen. He resides in Hudson, Florida.

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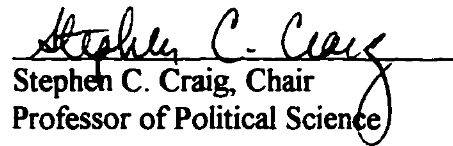

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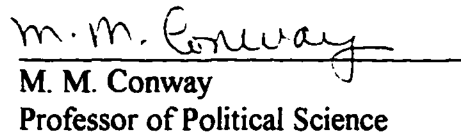

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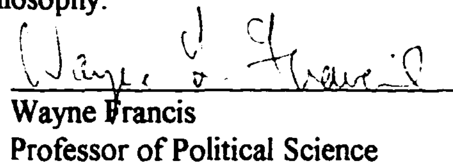

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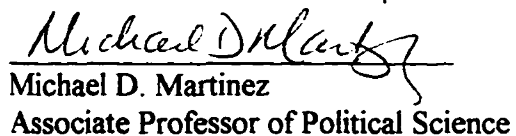

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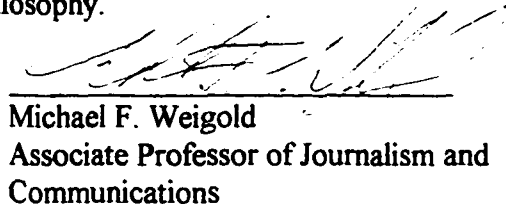

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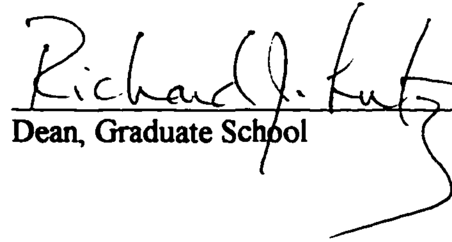
This dissertation was submitted to the Graduate Faculty of the Department of Political Science in the College of Liberal Arts and Sciences and to the Graduate School and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

August, 1996



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