



The patchwork: Health reform, American style

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American health care rightly has been characterized as a “paradox of excess and deprivation” (Enthoven & Kronick, 1989, p. 29). The United States spends more on medical care than any country in the world—over \$2.5 trillion or 17% of its gross domestic product as of 2009. At the same time, the U.S. is the only rich democracy where a substantial portion of its residents lacks health insurance coverage. Fifty-one million Americans (nearly 17% of the population) go without health insurance at any given time (Denavas-Walt, Proctor, & Smith, 2010). Another twenty-five million American adults are “underinsured,” covered by insurance policies that inadequately protect them against the high costs of medical care (Schoen, Collins, Kriss, & Doty, 2008).

Serious problems in access to and the costs of American medical care are nothing new, but meaningful health reform has long been elusive. During the twentieth century, reformers repeatedly failed to secure enactment of universal health insurance (Morone & Blumenthal, 2009; Starr, 1982). The U.S. last adopted a major expansion of health care coverage in 1965. Consequently, the nation’s uninsured rate has marched upward in recent decades. The enactment of the 2010 Patient Protection and Affordable Care Act thus stands as a historic milestone and a break from the stalemated past (Kaiser Family Foundation, 2010; Oberlander, 2010).

This essay aims to illuminate the 2009–2010 struggle over health reform and evaluate what type of reform that struggle produced. We begin by highlighting the considerable obstacles that President Obama and Democrats faced in pursuing major health care legislation and the political strategies they developed to overcome those obstacles. We then turn to the legislative result, a patchwork of

reforms that builds upon the existing patchwork system of American health insurance. We conclude with a comparative perspective on U.S. reform.

The politics of health reform

Barack Obama won the 2008 presidential election with 53% of the popular vote and 365 out of 538 electoral college votes. Obama’s Democratic party won decisive majorities of 59–41 in the Senate and 257–178 in the House of Representatives. Yet the new president was not guaranteed success in his pursuit of health reform. As previous presidents have discovered, the struggle over moving the United States towards universal coverage occurs in a political environment resistant to sweeping change (Marmor, 1994; Morone, 1992; Oberlander, 2003; Steinmo & Watts, 1995; Vladeck, 2003).

American political institutions are fragmented and disperse power across many actors. There is no assurance that a president will have a majority of his or her own party in both houses of Congress; divided government, in that sense, is a regular feature of American political life. Even if a president’s party does have such majorities, that does not mean that Congress will adopt the president’s agenda. Party loyalty among U.S. lawmakers is weaker than in most parliamentary democracies and members of Congress, representing divergent views and constituencies, can and often do defy presidential wishes. After President George W. Bush’s 2004 re-election, for example, a Republican Congress refused to adopt his major two domestic policy goals, immigration and Social Security reform. Even when their party controls Congress, presidents must piece together policy majorities and build legislative coalitions issue by issue.

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The rules of the Senate present an especially difficult institutional challenge. A super-majority of 60 votes (out of 100 Senators) is required to close off debate and move to vote on legislation. In recent decades, the use of the filibuster (where Senators prolong debate to avoid a vote) has increased dramatically (Sinclair, 2009). As a result, controversial legislation now commonly requires a super-majority to pass the Senate. And because Democrats and Republicans in Congress are increasingly polarized along ideological lines, assembling a bipartisan supermajority is a difficult task.

In addition, any bill the Senate adopts must be reconciled with a different version passed by the House, and the two bodies often clash over policy and spending issues. The House and Senate are also divided into numerous committees that have domain over health policy, and the chairs of those committees often do not share the legislative vision of the president, or of other chairs.

These institutional features have had a crucial impact on American health politics. Multiple presidents who sought health reform held party majorities in Congress only to see their proposals nonetheless die in the “Congressional graveyard” (Peterson, 2005). If the U.S. instead had a Westminster-style parliamentary system, it is likely that America would have adopted national health insurance over 60 years ago when President Harry Truman proposed it.

Other significant obstacles to health reform exist. There is a long history in the U.S. of opposition to reform from interest groups representing doctors, insurance companies, and businesses. After all, national health expenditures equal income for the health care industry. Historically, any plan that appeared to threaten the flow of money to that industry triggered fierce resistance (Barer & Evans, 1992; Marmor, 1983). Groups representing health care stakeholders are organized, well funded, and politically influential. Meanwhile, health care consumers, and especially the uninsured, lack funds, organization, and political connections. Health reform battles throughout the twentieth century were one-sided affairs dominated, for the most part, by defenders of the status quo (Oberlander, 2003; Quadagno, 2005; Starr, 1982).

Interest groups, particularly those representing physicians, of course opposed national health insurance in other industrialized democracies. What makes health care politics in the U.S. distinct is that pressure groups can exploit numerous “veto points” in a fragmented political system to block change (Immergut, 1992).

One familiar weapon in the arsenal of interest groups fighting health reform legislation is fear. Since Americans began debating national health insurance in the early-twentieth century, opponents have repeatedly (mis)cast reform as “un-American,” “socialized medicine,” and “big government” (Gordon, 2003; Quadagno, 2005; Starr, 1982). Those attacks worked in part because of a prominent anti-government strain in American politics. Fear and distrust of centralized government is a long-running theme in U.S. health policymaking (Morone, 1990). It has forced reformers to narrow their ambitions, embrace incremental strategies, and defend their plans against the stigma of “socialized medicine.”

To be sure, America is hardly a homogenous anti-state polity. The U.S. has major national social programs, including Social Security and Medicare that are broadly popular with the public (Cook & Barrett, 1992). And when surveyed, most Americans say that health care should be a right. Yet there is no doubt that U.S. debates over health reform are ideologically divisive, raising fundamental questions about moral principles and the role of governments and markets. In that context, American reformers must cope with a political culture that is deeply ambivalent about government power (Jacobs, 1993).

Learning from failure

The Obama administration recognized these longstanding barriers but believed they had a strategy to surmount them. The

administration’s plan was shaped crucially by the Clinton administration’s failed effort to adopt universal health insurance during 1993–1994 (Marmor & Oberlander, 2009; Oberlander, 2010). The conventional wisdom was that the Clinton plan failed because of a series of mistakes and political missteps (Barer, Marmor, & Morrison, 1995; Brown, 1994; Hacker, 1997; Johnson & Broder, 1996; Oberlander, 2007; Skocpol, 1996). The administration moved too slowly to enact reform and spent too much time designing its own plan without input from Congressional Democrats (who were divided over different reform options). It fought an unsuccessful battle against the insurance industry and business community, and alienated insured Americans by proposing too many changes that appeared to disrupt existing coverage. And it overreached in trying simultaneously to secure universal insurance, impose robust controls on health care spending, and transform the health care delivery system.

Barack Obama and his advisers were determined not to repeat the mistakes of 1993–1994 (Daschle, Greenberger, & Lambrew, 2008). As a result, the administration’s fundamental strategic premise was simply to do the opposite of what Clinton did. The Obama administration tried to move legislation quickly through the House and Senate while the president’s political capital remained high. It did not release a detailed health plan and instead left key decisions about reform to Congress. Obama’s reform plan built on the existing health system and emphasized that insured Americans could keep their coverage. The administration moderated the ambitions of health reform by pursuing “near” universal coverage and avoiding centralized cost control measures, while also seeking to maintain support for reform among health industry groups (Marmor & Oberlander, 2009; Oberlander, 2010).

Democrats in Congress drew similar conclusions from 1993 to 1994. Rather than work independently, the chairs of the three major committees responsible for health reform developed a Tri-committee plan, a remarkable level of coordination in a legislative system usually prone to fragmentation.

In key respects, the administration’s strategy echoed the choices that the architects of Medicare—a federal program for elderly and disabled Americans—made in the 1950s. Then, as now, the goal was to minimize controversy over reform by drafting a plan designed to attract public support and a majority in Congress while neutralizing interest group opposition (Marmor, 1973). But minimizing controversy in an area as controversial as health policy is easier said than done.

The Senate and other challenges

Despite carefully calibrated strategies, the Obama administration’s health reform plan ran into most of the same problems that had frustrated prior reform efforts (Oberlander, 2010). Old fears of “rationing medicine” turned into new paranoia about “death panels” that would “pull the plug on grandma.” The public, not surprisingly, remained deeply divided over reform. Health reform became enmeshed in controversial social issues about abortion and immigration. Democrats struggled to find a politically acceptable way to raise taxes and pay for the cost of expanding coverage. The timetable for passing legislation was repeatedly pushed back. Congressional leaders strained to manage tensions between conservative and liberal Democrats about the appropriate scope and direction of reform. Many on the political left became disenchanted with the concessions made to produce a bill. Despite the moderating of health reform’s goals, Republicans offered virtually a universal front of opposition to the Democrats’ plan. And the administration had trouble responding to partisan attacks, partly because Democrats’ reform plan, built on the complicated status quo, offered no clear conception of how Americans would benefit from reform.

The administration's greatest challenge was getting legislation through the Senate. When Barack Obama took office in January 2009, Democrats held 59 Senate seats, one shy of the supermajority often necessary to move controversial legislation. The administration and Senator Max Baucus, chair of the influential finance committee, sought to win over several moderate Republicans to get over the threshold of 60 and also give reform a bipartisan imprimatur. Even after Republican Senator Arlen Specter of Pennsylvania announced in April 2009 that he was switching parties to become a Democrat, Baucus persisted in his pursuit of Republican support. The resulting delay in the health reform process gave opponents time to attack the plan and undermine public support. Baucus did win over a single Republican, Olympia Snowe of Maine, in his committee. But when the Senate passed health care legislation in December 2009 (the House had already voted for legislation earlier that November) not a single Republican voted for it.

There is no greater testament to the institutional fragility of health policymaking in the U.S. than the spectacle of health reform nearly collapsing *after* health reform legislation passed the House and Senate. Democratic leaders were apparently weeks away from agreeing to a final health care deal in January 2010. Then, Republican Scott Brown unexpectedly won a special Senate election in Massachusetts to fill the seat formerly held by Senator Edward Kennedy, who had died in August 2009. Brown's surprise victory meant that Democrats majority went back down to 59, and more than the loss of a supermajority, it shook many Democrats' confidence. For a time, it appeared that the health care legislation passed by the Senate and House was dead, and that Democrats would instead adopt more limited reforms such as expanding insurance coverage for children. But the leadership of House Speaker Nancy Pelosi and President Obama, both of whom insisted that the party should not retreat from broader reform, helped Democrats regain their political will (Oberlander, 2010). The House and Senate eventually agreed on a final bill (with the Senate relying on a parliamentary rule, "budget reconciliation" that only required a simple majority to pass legislation).

Patchwork reform

From the beginning, the health reform plans championed by the Obama administration and Congressional Democratic leadership during 2009–2010 were convoluted. Rather than create a new health system, Democrats sought to build on the status quo by patching-up the existing patchwork of public and private insurance (Oberlander & Marmor, 2010). The U.S. health insurance system has three major foundations: employer-sponsored insurance for Americans under age 65, a federal Medicare program for elderly and disabled persons, and state-administered Medicaid for low-income Americans who fit certain demographic categories (such as children and pregnant women). Democratic reform proposals retained these core institutions while aiming to increase the access of uninsured Americans to private insurance and Medicaid.

In contrast, the idea of Canadian-style national health insurance, where all Americans would be covered by a single government insurance program, was never seriously considered. Such a plan was presumed to be too disruptive to the existing system, too controversial for the public, too unacceptable to the health care industry, and too radical to win a majority in Congress.

Instead, liberal Democrats began with a second-best option. Private insurance would be retained but uninsured Americans would also gain access to a new, Medicare-like public insurance program. The public option, advocates argued, would help control medical care spending through the government's lower administrative costs and competition with private insurers. But this plan drew strong opposition from conservatives and the insurance

industry. Moreover, the Obama administration signaled early on that it was willing to abandon the public option if that is what it took to pass legislation. While a public plan passed the House, liberals could not muster the supermajority necessary to get it through the Senate. A proposed expansion of Medicare for Americans aged 55–64 (the federal health insurance program now covers persons 65 and over) also failed to pass the Senate.

In truth, any new public insurance plan would have been so circumscribed in size and power that its impact was likely exaggerated by both proponents and opponents. Yet its defeat underscored a longer-term historical trend in U.S. health politics: a shift to increasingly conservative conceptions of what constitutes reform. During the 1940s, Democrats' reform model was government-sponsored national health insurance for all. In the 1960s, that model was applied to the elderly with the adoption of Medicare. The presumption was one of piecemeal expansions of a social insurance program until universal coverage was reached. In the 1970s, national health insurance remained a prominent part of the debate. In the 1980s and 1990s, it receded. And during 2009–2010, not only was national health insurance not a prominent part of the debate, but even a limited public option and expansion of Medicare could not become law.

The reform plan that Congress passed instead relied on regulated private insurance. It was modeled not on American or Canadian Medicare, but on 2006 legislation adopted by the state of Massachusetts. The primary goal of the 2010 Patient Protection and Affordable Care Act is to expand insurance coverage (Oberlander & Marmor, 2010). To that end, the law creates new state health insurance exchanges, regulated marketplaces where the uninsured and small businesses can purchase coverage, with tax credits available on a sliding-scale to subsidize coverage. It also imposes new rules and regulations on private insurance companies so they cannot, for example, charge higher premiums to sicker persons.

In addition the law expands the Medicaid program to all Americans making under about \$14,000 a year regardless of family circumstance. It also mandates that most Americans must obtain health insurance and most businesses must offer their workers coverage or pay a tax penalty (smaller businesses are exempt from this requirement). The plan is financed largely through tax increases on higher-income Americans and reductions in projected Medicare payments to hospitals and private insurers that contract with the programs.

Health reform, American style

In conclusion, we want to emphasize four points about health reform in the United States. First, the institutional constraints of American politics had enormous influence on the 2009–2010 health reform debate and the legislative outcome. Those constraints help explain why reformers relied on a patchwork plan and why the Obama administration had so much trouble enacting reform even though Democrats had sizable Congressional majorities. Given those constraints, and other formidable barriers to adopting a substantial expansion of health care coverage, enacting the 2010 Patient Protection and Affordable Care Act stands as an extraordinary legislative accomplishment for both President Obama and the Congressional Democratic leadership.

Second, compared to other OECD health systems, this law offers a thin form of solidarity. While over 30 million Americans are expected to gain health insurance coverage under its provisions, the Congressional Budget Office estimates that another 23 million U.S. residents will remain uninsured. Moreover, the law has benefit limitations and out of pocket costs that will leave many Americans paying considerable amounts for their medical care. Indeed, the number of American workers paying high deductibles for private

health insurance has grown substantially in recent years, a trend that health reform may not reverse (Altman, 2010).

Third, the U.S. health reform debate was marked by inattention to international experience with and comparative lessons about health reform. There was virtually no consideration of what the U.S. can learn from Canada, Britain, France, Germany, Japan and other industrialized democracies. This provincialism was particularly evident in discussions regarding cost control. The new health reform law has nothing like the system-wide fee schedules, global budgets, and all-payer or single payer systems that other nations use to limit medical care spending (White, 1995). Instead, it relies extensively on a series of delivery system reforms—electronic medical records, primary care medical homes, pay for performance—that are politically appealing but unlikely to make much of a contribution to controlling health care spending (Marmor, Oberlander, & White, 2009). Reliable cost control remains, like universal coverage, an elusive goal for the United States.

Finally, while the U.S. enacted legislation passed in 2010, the health reform fight is not over. No sooner had the Patient Protection and Affordable Care Act passed than Republican Congressional leaders announced a campaign to “repeal and replace” the law. Republicans have mounted both legal and political challenges to health reform and with Republicans having made sizable gains in the 2010 elections, including winning majority control of the House, conservative challenges to the PPACA will intensify in coming years. Republicans could try, for example, to limit the funds available to the Obama administration to implement the law.

Outright repeal of health reform has little chance of success while Barack Obama remains president. But the major provisions expanding insurance coverage do not take effect until 2014. If a Republican is elected president in 2012, and has a Republican majority in Congress, it could set off a major battle over reform.

The 2010 Patient Protection and Affordable Care Act is a major step forward for the American health care system. But whether the U.S. continues to move forward or instead takes a step back remains to be seen.

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patchwork health. 4. style. 1. reform. 1. american. 1. patchwork. 1. Altmetric Statistics. Show full details. 1 Total Shares. 1 Blogs. 1 Citations. Member Articles. Continuous-wave pumping of multiexciton bands in the photoluminescence spectrum of a single CdTe-CdSe core-shell colloidal quantum dot. Please type a message to the paper's authors to explain your need for the paper. Paper: The patchwork: Health reform, American style. To: Theodore Marmor, Jonathan Oberlander. From (Name): E-mail: Only shared with authors of paper. Please enter a personalized message to the authors. More detailed explanations for your need are more likely to get a response. Send Request. «The patchwork: Health reform, American style» by T Marmor - ©2011. Negativities Edit. The patchwork quilt evokes images of warmth, love, home and hearth, hot cocoa, a crackling fire at a cabin in the woods. In contrast, the patchwork U.S. health insurance system is more likely to evoke images of frustration, hassle, red tape, paperwork, and annoying voice-automated telephone response systems. [Huizhong Zhou - 2001]. See related: Mencius Moldbug; Xenogothic. Health Reform, American Style by Hobson Carroll. to make a decision on what the universal standards will be "incorporating a dynamic that anticipates continuous improvement" and then require all relevant parties to meet those standards in very short order and with no exceptions. There are no acceptable excuses for why America can't revamp its health care system to harness the tremendous productivity and quality improvement that is available through the application of appropriate technology.