

CHAPTER ONE

Introduction

“Comprehensive health insurance is an idea whose time has come in America,” declared President Richard Nixon in 1974. “Let us act now to assure all Americans financial access to high quality medical care.”¹ President Gerald Ford repeated his predecessor’s exhortation, “Why don’t we write—and I ask this with the greatest spirit of cooperation—a good health bill on the statute books before Congress adjourns?”² Ford’s successor, President Jimmy Carter, agreed, “A universal, comprehensive national health insurance program is one of the major unfinished items on America’s social agenda.”³

The contentious issue of universal health insurance coverage did not, however, originate in the 1970s. Theodore Roosevelt ran on this issue in the Bull Moose Campaign of 1912.⁴ Before his death in April 1945, his cousin, President Franklin Roosevelt, called on Congress to establish an “economic bill of rights” that included a right to medical care.⁵ President Harry S Truman intensified Roosevelt’s demand and claimed, “In a nation as rich as ours, it is a shocking fact that tens of millions lack adequate medical care. We need—and we must have without further delay—a system of prepaid medical insurance.”⁶

Most recently, President Bill Clinton renewed the quest for universal coverage, accompanied by his famous threat to Congress before a nationwide television audience in 1994: “I want to make this very clear. . . . If you send me legislation that does not guarantee every American health insurance that can never be taken away, you will force me to take this pen, veto the legislation, and we’ll come right back here and start all over again.”⁷ According to President Clinton’s press secretary at the time, George Stephanopoulos, “The president was determined . . . to succeed where FDR, Truman, Kennedy, Johnson, Nixon, and Carter had all failed, to be remembered as the president who made basic health care, like a secure retirement, the birthright of every American.”⁸

Few issues carry so much political risk for so little political reward as health care reform. When Clinton introduced his Health Security Act to a joint session of Congress on September 22, 1993, he added his name to a long list of prominent leaders, organizations, and coalitions that have tried to achieve comprehensive reform. Frequently, these groups' efforts have been on behalf of attaining universal health insurance coverage (defined as everyone in society having at least some form of insurance against the costs of medical care).⁹ When their efforts began, change often appeared imminent. However, with but one exception, the enactment of Medicare and Medicaid in 1965, they all failed. What follows is an attempt to explain why universal health insurance, arguably one of the most persistently sought after policy goals in the twentieth century, has proved so elusive in the United States.

Overview

Each country's health care system is unique. Neither the U.S. nor any other country's system is the product of one, logical policy-making experience. They are, instead, the manifestations of many years of historical development. As Ellen Immergut points out, the organizational features of public and private health insurance have been patched together by unconnected pieces of legislation, whose effects have interacted with private initiatives undertaken by a diverse group of actors. Health systems can be described with reference to layers that reflect the political and social circumstances of different historical periods.¹⁰ As debatable as the theory of "American exceptionalism"¹¹ might be, the fact that the United States is the only major Western country without universal coverage lends some measure of support to the theory and attracts the continued interest of scholars and policymakers alike.

The central question of this work is: What explains the absence of universal health insurance coverage in the United States? Despite a tradition of public support for the general notion, and numerous efforts to achieve it—from consideration during the drafting of President Roosevelt's Social Security Act of 1935 to the spectacular demise of Clinton's Health Security Act in 1994—the goal remains unfulfilled. Many will find the following explanation ironic, and social insurance enthusiasts may consider it almost heretical.

In brief, there is no one politics of health care or one explanation for the lack of universal coverage; there are, instead, different patterns of politics at different stages of policy development. There has been a unique and critical relationship, however, between Social Security and the development of health insurance (both private and public). Intimidated by organized medicine in 1935, Roosevelt excluded health insurance coverage from the Social Security Act so that the program could pass in Congress. For the next three decades, the AMA continued to prevent any public, contributory health insurance scheme from passing.

By the mid-1960s, though, Social Security had evolved into the leading, if not sole, vehicle for achieving the goal of universal health insurance coverage

due to its increasing political and economic influence. The program's popularity paved an alternative path for policymakers to finally overcome organized medicine's opposition to public health insurance—with the passage of Medicare in 1965. In the process, they would use Social Security to incrementally achieve the goal of universal coverage.

Policymakers' success with incremental expansion, though, also had detrimental consequences. Specifically, Social Security and Medicare's accumulated costs eventually emerged as a major impediment to the goal. Once the payroll tax was exclusively devoted to the two programs, most policymakers became convinced that they could not raise it for any additional commitments. They chose, instead, to pursue alternative financing proposals for increasing health insurance coverage, including controversial employer mandates. These necessary attempts at forging new paths of policymaking became blocked by the constellation of interests surrounding the old, institutionalized ones: the private path of tax-subsidized, employer-provided health insurance and the public path of different government programs for targeted segments of the population.

Employers, employees, and unions established the dominant private path of health insurance in the early 1950s. Over time the path became entrenched not because it was compulsory, but because the groups continually benefited by and, therefore, reinforced it.

For the public path, Medicare's passage in 1965 was a seminal achievement in social insurance. But as a contributory scheme solely for senior citizens, it also reinforced a fragmented approach of having different health insurance programs and policies for various segments of the population. The development of private health insurance for workers and their dependents and Medicare for senior citizens made subsequent attempts at major comprehensive change (e.g., national health insurance) politically unattractive and financially unfeasible. Each individual political constituency—workers, retirees, veterans, the poor—became loyal to its own health insurance program. As an example of path dependency, the development of health insurance demonstrates how preceding stages can narrow the range of possible policy outcomes and make moving off an established path, while not impossible, progressively more difficult.¹²

E. E. Schattschneider's claim that "new policies create new politics" is affirmed in the area of health care policy as in almost no other arena.¹³ The relationship between Social Security and health insurance—with Social Security coming first—proved crucial. Health insurance was left in a position both secondary and, in time, dependent. Social Security's expansion paved the way for Medicare, which offered public health insurance to the retired and disabled. Yet by reinforcing the pattern of having separate public programs for individual political constituencies, it ultimately became an obstacle on the path to the last crowning step: universal coverage.¹⁴ The irony of this argument is that the more success policymakers had with incremental expansion—made possible only by Social Security's growing popularity—the more unlikely it became that universal coverage would ever come to fruition.

As a strategy, incrementalism gave the appearance that it could eventually result in protection for everyone. But it also led to a more costly and complicated patchwork system of health care, a system less amenable to the kind of change necessary for achieving universal coverage because the costs of adapting to a different system became extremely high. “Incremental policy-making by analogy, then, linked social insurance and health insurance within the parameters of the social security model,” argues Andrew Achenbaum. “This ultimately made it possible for Washington to offer health care to the elderly, but it also rendered a truly universal comprehensive plan difficult if not impossible to develop.”¹⁵

This experience, in which policymaking promoted a configuration of elected leaders and interest groups that militated against any universal health insurance scheme, supports Margaret Weir’s argument that distributional biases in particular policies “feed back” in ways that, over time, progressively block some avenues of policy, if not entirely cutting them off. Decisions at one point in time, Weir adds, can restrict future possibilities by sending policy off onto particular tracks,¹⁶ trajectories,¹⁷ or, as John Ikenberry calls them, “developmental pathways.”¹⁸ Health care is a revealing example. Over time, exiting off established pathways became infeasible, as Clinton’s Health Security proposal demonstrated in 1993-94. In addition to the difficulties associated with the necessary politics of retrenchment, the costs of inherited programs and the numerous constituencies that developed in support of them blocked even the politics of expansion.

Why the Absence of Universal Coverage?

Many scholars of the welfare state attribute the lack of universal coverage in the United States to its being a “welfare laggard.” They argue that the United States has a comparatively meager system of social welfare. This, they claim, is due to a number of general factors: a national ideology of rugged *laissez-faire* individualism; federalism and a weak national government (relative to European counterparts) with a high diffusion of power; the lack of a genuine labor party in national politics; historically weak levels of unionization; and the absence of a paternalistic tradition of public provision.¹⁹ These arguments are credible and help to explain how the balance between the public and private spheres in the United States has developed. But they fail to account for certain attributes of generosity in U.S. policy. Social Security’s public pension program (OASDI), compared to equivalent programs in some European countries, is more generous and universal.²⁰

Most specific explanations for the absence of universal health coverage in the United States have fallen into one of three basic categories: *ideology*,²¹ *interest group activity*,²² or *institutions*.²³ Interest group activity is undeniably a key element to policy outcomes. Yet it is also helpful to move beyond the exclusive “pluralist claim that plural and balanced social pressures are the source of political decisions.”²⁴ By incorporating the political feedback that programs and pol-

icy decisions generate, the historical approach seeks to explain why—during different periods—some interest groups were more successful than others in lobbying for the policy outcomes they wanted (or, as Immergut puts it, “translating membership strength into political results”).²⁵

In brief, institutions and interest groups arguably do play the most crucial policy-making roles. But if they share a common weakness as theoretical explanations, it is their static nature; they tend to exclusively address discrete policy debates in 1934-35, 1949-50, 1964-65, 1974-75, 1979-80, or 1993-94. The original contribution of this study is to include the policy feedback between the dramatic events that fostered a pattern of increasing returns, which locked in specific pathways and patterns of policymaking. The goal is to provide a more comprehensive understanding of why major policy events played out as they did. And it contributes to a growing body of research on how policies are as much an influence on political actors and processes as they are an outcome of them.²⁶

Critical Junctures, Increasing Returns, and Path Dependency

As Barrington Moore, Theda Skocpol, and many others have persuasively demonstrated, history matters.²⁷ What comes first, observes Robert Putnam, even if it was “accidental,” conditions what comes later.²⁸ As a result, says Richard Rose, “policymakers are usually heirs before they are choosers.”²⁹ The historically grounded approach I employ synthesizes the tools and structure of “historical-institutionalism”³⁰ and “analytical narratives,”³¹ in which time provides the key dimension of comparison. Time is enormously consequential, as Dietrich Rueschemeyer, Evelyn Stephens and John Stephens have demonstrated, because “causal analysis is inherently sequence analysis.”³²

Accordingly, my approach emphasizes the influence of critical junctures, the increasing returns that follow them, and the path dependency these returns can engender. This style of analysis provides a more nuanced explanation, Daniel J. Goldhagen notes, by breaking down complex phenomena into their component parts, not only for the sake of clarity, but also for elucidating various aspects of incremental change, its ebbs and flows, and the consequences of critical junctures.³³ In understanding why policymakers pursue a particular strategy (and why they fail or succeed), the decisions of previous actors and the reasons they made them are crucial.

Critical junctures may be defined as periods of significant change that produce distinct legacies.³⁴ “Big historical events have big historical consequences,” notes Jacob Hacker, “as these crucial periods of transition shape processes of political and economic development for decades to come.”³⁵

Increasing returns ordinarily follow critical junctures. They are the normal self-reinforcing effects inherent in any policy that achieves passage and is implemented.³⁶ Each step along a particular path strengthens these increasing returns, which makes the path more attractive for the next round. As Paul Pierson claims, “If such effects begin to accumulate, they generate a powerful (or vi-

cious) cycle of self-reinforcing activity.”³⁷ The basic logic of increasing returns processes can be captured in a simple mathematical illustration.³⁸ Imagine a standard BINGO raffle basket containing two marbles: one blue, one yellow. Blindfold an individual, spin the basket, and then have the individual reach in and randomly remove one of the marbles. Afterward, replace the original marble and add another marble of the same color. Repeat this process until the basket fills up with hundreds or thousands of marbles. Regardless of what the eventual distribution becomes in any given trial, the initial selections are critical. After the first ten, twenty, or thirty selections, the eventual equilibrium of yellow and blue marbles becomes virtually fixed, with later selections in the process altering the equilibrium only minutely, if at all.³⁹

On a more anecdotal level, increasing returns help to explain why most seniors in college who happen to not like their chosen majors refuse to change them prior to graduating, even though they still have the opportunity to do so. The financial costs and additional time needed to change (“exit”) from their current majors to different ones are considerable by the time they are seniors. So they usually continue along the academic paths most of them chose as sophomores. Staying in the academy, the effect of increasing returns constitutes an explanation for why numerous senior professors continue to use typewriters and calculators for the bulk of their writing and grade computing, respectively (along with graduate students if they can manage it), even though they could very well use much quicker word processors and spreadsheets. For many of them, the short-term time requirements or personal costs required to learn a new technology, such as computers, outweigh the potential long-term gains in efficiency.

As applied to the political arena of social policy, Pierson explains, there are three features intrinsically associated with increasing returns:

- 1) *Large set-up or fixed costs.* These create a high payoff for further investments in a given program or policy. When set-up or fixed costs are high, individuals and organizations have a strong incentive to identify and stick with a single option.
- 2) *Learning effects.* Knowledge gained in the operation of complex programs and policy arrangements (public and private) also leads to higher returns from continuing them. With repetition, individuals and organizations learn how to maximize the return on their investments in these complex programs and policy arrangements and are likely to spur further innovations in them.
- 3) *Coordination and adaptive effects.* These occur when the benefits an individual or organization receives from a particular program or policy arrangement increase as others adopt the same choices. This enhanced appeal attracts more users, reinforcing the existing advantage. Individuals and organizations will feel a need to pick the most beneficial program or policy arrangement available, because alternatives that fail to win broad acceptance will have drawbacks later on. So projections about future costs and benefits will lead individuals and organizations to adapt their actions in ways that help to make the paths that are already attractive and advantageous even more so.⁴⁰

The more pronounced increasing return features become, the more likely it is that a particular policy area will become path dependent. Why? Because the benefits of sticking with a specific program or policy arrangement increase, as do the costs of dramatically departing or exiting from them. With the relatively short time horizons involved in public and private decision making, actors will tend to follow the path already established and adjust their behavior at the margins rather than the other way around.⁴¹

Roughly analogous to Charles Darwin's theory of natural selection,⁴² society's institutional landscape progressively changes through the preservation of those policies and programs best adapted to survive the political competition for existence. Policies and programs that political actors choose at all tend to survive, and some thrive because of the immense amount of "sunk costs" surrounding them that make change increasingly unattractive.⁴³ In effect, path dependency is the end product of policymakers having "strong incentives to focus on a single alternative, and to continue moving down a specific path once initial steps are taken in that direction."⁴⁴

It must be noted, however, that not all policy areas bear significant evidence of path dependency. Policy areas become more or less path dependent and some not at all. The condition depends upon a complex combination of factors, including, among others, whether the programs in a given policy area are entitlements or need-based welfare, whether beneficiaries involved are concentrated or diffuse, and how long the policy's time horizon is. Furthermore, determining whether a policy area becomes path dependent is done by means of inductive, not deductive, analysis. In other words, it is only after exhaustively reviewing the historical evolution of a policy that one sees either more or less evidence for path dependency; it is not assumed a priori. Thus, path dependency in any policy area is a condition that can easily evolve if given sufficient time, but does not necessarily do so universally.

Organization

The structure of this work is designed to delineate the different stages of health care policymaking, during which universal coverage became increasingly elusive. The first several chapters cover the initial stage of failure and frustration from the mid-1930s to the early 1960s. Chapter 2 focuses on the passage of Social Security—unquestionably the American welfare state's most critical juncture—and the two development pathways it initiated. The first path, old age pensions, became primarily public and produced the eventual ascendancy of old age and survivors insurance (OASI). Policymakers subordinated health insurance to old age insurance for political reasons, thereby relegating it almost entirely to the private sector.

Critical junctures of Social Security's magnitude are exceedingly rare in history, so their significance is difficult to overestimate. Because the welfare state at this time was in its infancy or formative period, interest group activity was the leading type of policy feedback⁴⁵ (with the AMA dominating). The two

other leading forms of policy feedback, lock-in effects and policy learning, were virtually nonexistent, because nothing was locked in yet, nor was there much opportunity for either positive or negative experiential learning (table 1.1). Policymakers focused their political capital and energy on trying to implement and secure their legislative achievements.

Chapter 3 examines how the succeeding period—the late 1930s to 1950—reaffirmed the original decision in 1935. During this time the two policy areas continued to diverge in keeping with the initial decision: the one, OASI, becoming more solidly public, the other, health insurance, being repeatedly rejected as a public program. By 1950, policymakers had secured the public path for old age insurance, which then had comprehensive coverage and was secure against its welfare-based rival, OAA. At the same time, public health insurance had been decisively rejected due primarily to organized medicine's effective lobbying. Policymakers subsequently shifted their attention to the possibility of a private path for protecting individuals from the costs of medical care.

Roughly akin to a second critical juncture, organized labor turned to collective bargaining in 1949-50, which became the foundation for health insurance's private pathway. The NLRB facilitated this development in 1948, when it ruled that employers could offer health insurance as a fringe benefit to their employees. The NLRB's ruling effectively exempted employer-sponsored health insurance from federal taxation.⁴⁶ With collective bargaining—and the related tax advantage of health insurance defined as a fringe benefit—unions and employers made the private path a positive choice and an institution was created.

Chapter 4 describes the phase of increasing returns associated with both paths from the early 1950s to the early 1960s. The public path, Social Security, became the beneficiary of political actors' successful program building, which greatly enlarged the scheme's scope and generosity. Benefit increases were now enacted routinely. When the Eisenhower administration arrived, critics of Social Security considered the possibility of "exiting" to a new path, but quickly ruled it out as infeasible. By this time, the effects of the 1939 and 1950 amendments made any exit from the program's public path politically unattractive, if not an impossibility. So effective were Social Security's increasing returns (both political and financial) that, even during a Republican administration, disability insurance was enacted in 1956.

Meanwhile, the private path of health insurance became institutionalized mostly through collective bargaining between employers and unions. Blue Cross/Blue Shield and for-profit insurance skyrocketed, but did not attain universality. Employer-financed health insurance left out those people who did not have big and/or unionized employers: the retired, the self-employed, employees of small businesses, and the unemployed. In combination with the vigorous development of OASI (OASDI after the passage of disability insurance in 1956), this shortcoming created the possibility of opening a public path of health insurance as a complement to the established public program and as a remedy for a defect in the private sector.

Chapter 5 explains the partial success policymakers had from the mid-1960s to the early 1970s in attaching a public health insurance program to Social Security. As a product of policy learning, incremental expansion and its gradualist tactics emerged triumphant (table 1.1).⁴⁷ Lyndon Johnson's massive electoral victory in 1964 opened a window of opportunity⁴⁸ for public health insurance advocates, which they took advantage of by piggybacking Medicare onto Social Security, the welfare state's main vehicle. Further steps by policymakers along this path of incrementalism culminated in the extension of Medicare coverage to recipients of disability insurance in 1972.

As Martha Derthick has documented, this is the story of political actors successfully attaching health insurance as an increment to a well-established and then still very popular program, OASDI. The thirty previous years of failure and frustration for health insurance were years of extremely successful program building for Social Security. Health insurance became an heir to that success.⁴⁹ At the same time, path dependency can be seen in how policymakers were forced to coordinate or adapt Medicare's design to existing arrangements in the private sector. As evidence of the path's strong inertia, Medicare's (and to a lesser extent Medicaid's) payment structure largely extended the private system's third-party reimbursement model to senior citizens (and the poor) via public programs. Medicare, in particular, emerged as virtually a public Blue Cross/Blue Shield program for senior citizens, many of whom had been enrolled in Blue Cross/Blue Shield schemes during their years of employment.

Chapters 6 and 7 address the return of failure and frustration for health care reformers from the mid-1970s to the present. Chapter 6 examines how efforts to expand Medicare's coverage, which had been many proponents' unspoken goal since the program's formation,⁵⁰ became eclipsed by the program's rapidly escalating costs. Alternative means for universal coverage—notably propounded in President Nixon's employer mandate plan—failed due to organized labor's refusal to compromise its advocacy of pure social insurance expansion. Further incremental expansion along the path established by Medicare became subordinated to the more urgent goal of cost containment. Finally, the administrative relationship between Medicare and its parent program, Social Security, grew so problematic that Medicare ceased to be an add-on and became a separate program in its own right and with its own administrator, the Health Care Financing Administration (HCFA).

Addressed in chapter 7, Medicare's financial hemorrhaging contributed to the crowding out of universal coverage in the 1980s due to the necessity of rationalizing the program's system for reimbursing hospitals. With the advent of its Prospective Payment System (PPS) in 1983, Congress switched Medicare—as the name suggests—from a retrospective to a prospective scheme of payment.⁵¹ This major transformation had a number of unintended consequences, the most significant of which was the private sector's massive paradigm shift from fee-for-service indemnity insurance to managed care. The shift was largely an effort by employers to blunt the deleterious effects of public-to-private cost-shifting that the PPS engendered.

Table 1.1
Policy Feedback and Stages of Health Care Policymaking

Policy Feedback Type	Failure & Frustration (1935-early 1960s)	Partial Success (mid 1960s-early 1970s)	Failure & Frustration II (mid 1970s-present)
Interest group activity	Substantial impact: AMA dominates*	Substantial impact: labor blocks compromise plan for universal coverage in 1974	Moderate impact: “hyperpluralism” dilutes interest group influence
Policy learning	Negligible impact in the beginning, but increasing over time	Substantial impact: positive and learning effects leading to Medicare’s passage*	Moderate impact: results in Medicare’s PPS in 1983, managed care’s growth in private sector
Lock-in effects	Initially non-existent, but gradually increasing over time	Moderate impact	Substantial impact: policymaking constrained by both locked-in policy paths and the accumulated costs of inherited programs (namely Social Security & Medicare)*
<i>Welfare State</i> Periods:	<i>Formative</i>	<i>Expansion</i>	<i>Rationalization</i>

* Denotes leading form of policy feedback in that stage.

By the 1990s, policy feedback reached critical mass. The traditional path of incrementally expanding existing programs was virtually defunct, but lock-in effects blocked any exit to a new path of policymaking (table 1.1). The entrenched paths of private insurance for workers and public insurance for retirees (and the poor) created a phalanx of political actors that effectively resisted the major systemic change that comprehensive reform required. Evidence of this inability to forge a new way of reaching universal coverage was provided by President Clinton’s ill-fated Health Security Act of 1993-94, which vividly illustrated the futility of trying to reconcile old institutional arrangements with new policy paths. Clinton’s proposal was a logical but politically flawed mix of expansion and cost containment, exposing its sponsors to the twin perils of both. In the end, path dependency rendered the politics of retrenchment politically intractable and the politics of expansion financially unaffordable.⁵²

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How providers deliver medical care, what its costs are, and how individuals obtain insurance coverage are political concerns of the first order. They are, as Martha Derthick observes, issues “of principle that have stirred the passions and mobilized interest groups on a massive scale.”⁵³ The average level of public spending in OECD countries on health care is 8 percent of the gross domestic

product (GDP), with the United States exceeding every other country at 15 percent.⁵⁴ It is all the more peculiar, then, that while the United States devotes far more wealth to health care—in absolute terms and as a percentage of GDP—than any other country, it remains the single major Western nation lacking universal coverage.

This returns us to the initial question: What explains the persistent, puzzling, and unique absence of universal coverage in the United States? The following analysis attempts to answer this question by digging into the archives that record the political motivations and struggles of individual efforts at health care reform,⁵⁵ along with, more important, their ramifications.

Notes

1. “Nixon Sees Passage in ‘74 of Health Insurance Plan,” *New York Times*, February 6, 1974, 16.
2. “Drive for Health Bill This Session Intensifies,” *Washington Post*, August 14, 1974, A8.
3. Jimmy Carter, *Public Papers of the President of the United States*, 1979 (Washington, D.C.: GPO), 1031.
4. See Roy Lubove, *The Struggle for Social Security 1900-1935* (Cambridge, Mass.: Harvard University Press, 1968), 67; and *Congressional Quarterly’s Guide to U.S. Elections*, 3d ed. (Washington, D.C.: Congressional Quarterly Press Inc., 1994), 267.
5. See E. Witte, *Social Security Perspectives* (Madison: University of Wisconsin Press, 1962), 333-36, 375-77.
6. State of the Union Message (January 5, 1949), in Harry S Truman, *The Public Papers of the President of the United States, 1949* (Washington, D.C.: GPO), 5.
7. “Address before a Joint Session of the Congress on the State of the Union, January 25, 1994,” *Weekly Compilation of Presidential Documents* 30 (January 31, 1994).
8. George Stephanopoulos, *All Too Human: A Political Education* (New York: Little, Brown & Co., 1999), 198.
9. Between 15 and 17 percent of the population lack health insurance coverage. See Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured* (Washington, D.C.: January 1994), 36-43.
10. Ellen Immergut, *Health Politics: Interest and Institutions in Western Europe* (Cambridge: Cambridge University Press, 1992), 56.
11. For more on this theory, see Louis Hartz, *The Liberal Tradition in America* (New York: Harcourt, Brace, 1955); and Sven Steinmo, “American Exceptionalism Reconsidered: Culture or Institutions,” in *The Dynamics of American Politics*, ed. L. C. Dodd and C. Jillson (Boulder, Co.: Westview Press, 1994), 106-31.
12. Paul Pierson, “Increasing Returns, Path Dependence, and the Study of Politics,” Program for the Study of Germany and Europe, Working Paper Series 7.7 (Center for European Studies, Harvard University, September 1, 1997), 3. See also, Paul Pierson, *Dismantling the Welfare State? Reagan, Thatcher, and the Politics of Retrenchment* (Cambridge: Cambridge University Press, 1994).

13. E. E. Schattschneider, *Politics, Pressures and the Tariff* (New York: Prentice-Hall, 1935), 288.

14. Peter Flora and Arnold J. Heidenheimer, *The Development of Welfare States in Europe and America* (London: Transaction, 1981), 292: "Once the broad Social Security Act was on the books most subsequent income maintenance and social service programs were added to it, so that . . . the most salient feature of the American welfare state is that almost all measures were passed as amendments to the original Social Security Act. The decision to overcome this bitter resistance to health insurance by also adding the Medicare and Medicaid programs in this way may well have inhibited subsequent attempts to lay the basis for a more universal health insurance program."

15. Andrew Achenbaum, *Social Security: Visions and Revisions* (Cambridge: Cambridge University Press, 1986), 167.

16. Margaret Weir, *Politics and Jobs: The Boundaries of Employment Policy in the United States* (Princeton, N.J.: Princeton University Press, 1992), 18-19. See also, K. Thelen, "Historical Institutionalism in Comparative Politics," 1998 APSA paper (Boston), 39-40; and Annual Review of Political Science 2 (1999): 369-404.

17. See John Zysman, "How Institutions Create Historically Rooted Trajectories of Growth," *Journal of Industrial and Corporate Change* 3 (November 1994): 243-83.

18. John Ikenberry, "History's Heavy Hand: Institutions and Politics of the State," paper presented at the Conference on "New Institutionalism," University of Maryland (October 14-15, 1994), 16ff.

19. See Adam Przeworski, *Capitalism and Social Democracy* (Cambridge: Cambridge University Press, 1985); and John Stephens, *The Transformation From Capitalism to Socialism* (London: Macmillan, 1979).

20. For more on this observation, see Michael Shalev, "When Markets Fail: Social Welfare in Canada and the United States," in *Welfare States in Transition*, ed. G. Esping-Anderson (London: Sage Publications, 1997), 124-25, table 5.5; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge, Mass.: Harvard University Press, 1992); and A. Heidenheimer, H. Hecllo, and T. Adams, eds., *Comparative Public Policy* (New York: St. Martin's Press, 1990), ch. 7.

21. See Anderson 1972, Jacobs 1993, Navarro 1992, 1994, Morone 1995, Rothman 1997. Ideological or cultural theories look for explanations in the values and ideologies to which each nation's citizens adhered as urbanization and industrialization gathered forces. For more on the general theory of ideology (or culture or "national values"), see Samuel Huntington, *The Clash of Civilizations and the Remaking of World Order* (New York: Simon & Schuster, 1996); and Gaston Rimlinger, *Welfare Policy and Industrialization in Europe and America* (New York: Wiley, 1971).

22. See Alford 1975, Laham 1993, Navarro 1976, Poen 1979. Interest group theories resemble those social welfare theories (welfare capitalism and political class struggle) that focus on class conflict. The main unit of analysis is not the political system as a whole or the individuals within, but the social groups, classes, or coalitions that come into conflict. For more on the general theory of interest groups, see Peter Gourevitch, *Politics in Hard Times* (Ithaca, N.Y.: Cornell University Press, 1986); and A. Przeworski and M. Wallerstein, "The Structure of Class Conflict in Democratic Capitalist Societies," *American Political Science Review* 76 (1982): 215-38.

23. See Maioni 1995, Steinmo and Watts 1995. Institutional theories emphasize institutional relationships, both formal and conventional, that bind the components of the state together and structure its relations with society. For more on institutional theory, see Peter Hall, *Governing the Economy* (New York: Oxford University Press, 1986); J.

March and J. P. Olsen, "The New Institutionalism: Organizational Factors in Political Life," *American Political Science Review* 78 (September 1984): 734-49; and S. Steinmo, K. Thelen, and F. Longstreth, *Structuring Politics* (Cambridge: Cambridge University Press, 1992).

24. Immergut, *Health Politics*, 249, fn. 25, and xii: "[P]ublic policies should not be viewed merely as the result of the demands of various groups competing for political influence."

25. Immergut, *Health Politics*, 18.

26. Jacob S. Hacker, "The Historical Logic of National Health Insurance," *Studies in American Political Development* 12 (Spring 1998): 83: "The implication . . . about sequence and timing is that policy design matters. Political scientists generally treat public policy as the result of political processes, leaving to policy analysts the task of exploring the content of policies and their long-term effects. . . . Far from starting with a blank slate, policymakers almost always labor in the shadows of an extensive framework of existing policies that critically shapes the types of problems they perceive, the policy lessons they learn, the political conditions they face, and the types of policy instruments they have at their disposal. This is precisely why studies of policy development must take long-term historical processes into account."

27. B. Moore Jr., *Social Origins of Dictatorship and Democracy* (Harmondsworth: Penguin, 1973); T. Skocpol, *States and Social Revolutions* (Cambridge: Cambridge University Press, 1979); and P. Pierson, "When Effect Becomes Cause: Policy Feedback and Political Change," *World Politics* 45 (July 1993): 595-628.

28. Robert D. Putnam, *Making Democracy Work* (Princeton, N.J.: Princeton University Press, 1993), 8.

29. See Richard Rose and Phillip Davies, *Inheritance in Public Policy: Change without Choice in Britain* (New Haven, Conn.: Yale University Press, 1994).

30. See Bert Rockman, "The New Institutionalism and the Old Institutions," in *New Perspectives on American Politics*, ed. Lawrence C. Dodd and Calvin Jillson (Washington, D.C.: Congressional Quarterly Press Inc., 1994), 146-49: "The historical approach to the role of institutions in policy-making tends to lie outside the orbit of positivist methodologies, which seek to operationalize variables, quantify them, and formalize an explanatory structure through a process of analytic decomposition. By way of contrast, the historical approach seeks not to decompose but to recompose—to intertwine the play of societal forces with institutional structures and processes, rather than dissect them. Policy-making patterns over time suggest to us the range of feasible options for the future." For more on historical-institutionalism, see Skocpol, *Protecting Soldiers and Mothers*; and M. Weir, A. Orloff, and T. Skocpol, eds., *The Politics of Social Policy in the United States* (Princeton, N.J.: Princeton University Press, 1988).

31. See R. Bates, A. Greif, M. Levi, J. L. Rosenthal, and B. Weingast, eds., *Analytic Narratives* (Princeton, N.J.: Princeton University Press, 1999); and Margaret Levi, "Producing an Analytic Narrative," in *Critical Comparisons in Politics and Culture*, ed. John Bowen and Roger Peterson (New York: Cambridge, 2000).

32. Dietrich Rueschemeyer, Evelyne Huber Stephens, and John D. Stephens, *Capitalist Development and Democracy* (Chicago: University of Chicago Press, 1992), 387. See also, Thelen, "Historical Institutionalism in Comparative Politics," 33: These types of analyses "engage in close examination of sequences and processes as they unfold, and perhaps even more importantly, as different processes . . . unfold in relation to one another."

33. Daniel J. Goldhagen, *Hitler's Willing Executioners* (New York: Knopf, 1996).

34. Ruth Berins Collier and David Collier, *Shaping the Political Arena: Critical Junctures, the Labor Movement, and Regime Dynamics in Latin America* (Princeton, N.J.: Princeton University Press, 1991), 29-40.
35. Hacker, "The Historical Logic of National Health Insurance," 78.
36. For more on increasing returns, see Paul M. Romer, "Increasing Returns and Long-Run Growth," *Journal of Political Economy* 94 (1986): 1002-37.
37. Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," Working Paper Series 7.7, 5.
38. Paul Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," *American Political Science Review* 94 (June 2000): 253.
39. Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," *American Political Science Review*, 253. Pierson uses a different mathematical illustration involving a Polya urn process, but the basic logic is the same.
40. Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," *American Political Science Review*, 254-66. See also, Brian W. Arthur, *Increasing Returns and Path Dependence in the Economy* (Ann Arbor: University of Michigan Press, 1994).
41. For more on this dynamic of "collective action," see Mancur Olson, *The Logic of Collective Action* (Cambridge, Mass.: Harvard University Press, 1965).
42. Charles Darwin, *On the Origin of the Species* (London: Cambridge University Press, 1975).
43. See Arthur, *Increasing Returns and Path Dependence in the Economy*; Paul David, "Clio and the Economics of QWERTY," *American Economic Review* 75 (1985): 332-37; Paul Krugman, "History and Industry Location: The Case of the Manufacturing Belt," *American Economic Review* 81 (1991): 80-83; and Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," Working Paper Series 7.7, 7-10: "The increasing returns variant of path dependence arguments has been applied to the development of the QWERTY typewriter keyboard, the triumph of the light-water nuclear reactor in the United States, the battles between Betamax and VHS video recorders, and DOS-based and Macintosh computers, early [car] designs, and competing standards for electric current."
44. Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," Working Paper Series 7.7, 8. See also, Douglass C. North, *Institutions, Institutional Change, and Economic Performance* (New York: Cambridge University Press, 1990), 7; and Stephen Krasner, "Sovereignty: An Institutional Perspective," *Comparative Political Studies* 21 (April 1988): 66-94.
45. Policy elites also played an important role in crafting the proposed legislation for old age insurance (OAI).
46. See Arthur F. McClure, *The Truman Administration and the Problems of Post-war Labor, 1945-48* (Rutherford, N.J.: Fairleigh Dickinson Press, 1969); Harold W. Metz, *Labor Policy of the Federal Government* (Washington, D.C.: The Brookings Institution, 1945); and Harry A. Millis and Emily Clark Brown, *From the Wagner Act to Taft-Hartley: A Study of National Labor Policy and Labor Relations* (Chicago: University of Chicago Press, 1950).
47. For more on the theory of incrementalism, see Richard Rose and B. Guy Peters, *The Juggernaut of Incrementalism: A Comparative Perspective on the Growth of Public Policy* (Glasgow: University of Strathclyde, 1978); and M. Hayes, *Incrementalism and Public Policy* (New York: Longman, 1992).
48. For more on opportunity windows and the related issue of agenda setting, see John Kingdon, *Agendas, Alternatives, and Public Policies* (New York: HarperCollins,

1984), 173-80; Frank R. Baumgartner and Bryan D. Jones, *Agendas and Instability in American Politics* (Chicago: University of Chicago Press, 1993); and Gary Mucciaroni, *Reversals of Fortune: Public Policy and Private Interests* (Washington, D.C.: The Brookings Institution, 1995).

49. For elaboration on this point, see Martha Derthick, *Policymaking for Social Security* (Washington, D.C.: The Brookings Institution, 1979), 316-38.

50. Robert Ball, "Medicare's Roots: What Medicare's Architects Had in Mind," *Generations* 20 (Summer 1996): 13.

51. Prior to 1983, with relatively few limits Medicare retrospectively paid the charges that doctors and hospitals submitted for treating patients. After 1983, Medicare paid doctors and hospitals a predetermined figure for treating patients. If the predetermined figure was more or less than the actual cost of treating the patient, the medical provider pocketed the difference or absorbed the loss, respectively.

52. For more on this issue, see Pierson, *Dismantling the Welfare State?*

53. Derthick, *Policymaking for Social Security*, 337.

54. Organization for Economic Cooperation and Development (OECD), *The Reform of Health Care Systems* (Paris: OECD, 1994), 37-39; and OECD, "Economic Surveys" (Paris: OECD, 1996-98).

55. For more on this style of approach, see Immergut, *Health Politics*, 54-58.