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Colin Gordon: Dead on Arrival

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Introduction

Why No National Health Insurance in the United States?

WHY, alone among its democratic capitalist peers, does the United States not have national health insurance? This question, or variations of it, has invited a range of replies, some focusing on specific historical episodes, others invoking broad political or cultural or economic explanations for the peculiar trajectory of American social policy. At the same time, the explanatory laundry list is profoundly unsatisfying. Historical accounts often have trouble climbing from narrative to explanation; little of the episodic scholarship on the failure of health reform contributes to our larger sense of the American welfare state and its limits. And theoretical accounts often stumble on the descent to historical context; the debate between state-centered and economic explanations, for example, rests largely on abstractions (capitalism, industrialism, democracy) that are neither unique to the American setting nor offered in such a way that they make sense in specific historical contexts.¹ In explaining this hole in the American welfare state, we must consider both the relative success of other American social programs during the years in which health insurance was beating at the door and, at least implicitly, the relative success of health insurance in other national settings. Our understanding of the politics of American health care must explain both the exceptional character of the American welfare state and the distinct trajectory of health policy within it. And we must consider the absence of national health insurance in light of public support for reform. As one observer asks: “In effect a powerful army sits before an undefended goal but fails to move. Why?”²

The answer rests on the privileged status enjoyed by economic interests in American politics. In health politics, the nature and the alignment of economic or class interests defy easy theoretical categorization. In some respects, the health debate reflects the larger confrontation between labor and capital: employers and insurers have drawn on their control over private investment and economic growth and their com-

¹ Ira Katznelson, “Rethinking the Silences of Social and Economic Policy,” *Political Science Quarterly* 101:2 (1986): 307–325.

² Daniel Greenberg, “National Health Insurance—Forever Imminent?” *NEJM* 293:9 (28 August 1975): 461.

mand of day-to-day political resources to shape public policy. At the same time, the uneasy relationship between health provision and private production has often confounded expectations and found labor clamoring for private coverage or employers looking to public solutions. In turn, doctors—the most prominent “health interest”—derive their status less from control over “production” than from their social origins, professional training, professional organization, and impressive command of political resources. And attention to conventional class forces tends to obscure the reasons why the United States is alone among its democratic capitalist peers in resisting national health care. For these reasons, I trace the influence of doctors, employers, insurers, and others less as *structural* interests whose mere presence discourages reform than as *instrumental* interests whose political stakes and political clout (vis-à-vis the state or each other) are unique to the American setting.³

The clout of private interests has been magnified in health politics—the only arena of social provision in which private providers, private consumers, and private intermediaries were well ensconced before national reforms were contemplated. This circumstance exaggerated the influence of economic interests and their stakes in reform. The ability and willingness of economic interests to shape health policy eroded an already fragile sense of universal social provision and encouraged the growth of private, employment-based benefits as an alternative. Such alternatives, in turn, reflected and reinforced long-standing patterns of racial and sexual discrimination in such a way that, over time, even reformers rarely challenged the family-wage or Jim Crow premises of private and public social policy. I am interested, in this sense, both in the influence of health interests over the course of the twentieth century and in the consequences of that influence in public and private patterns of health provision, the politics and political culture of health policy, and the broader limits and dilemmas of the American welfare state.

Competing Explanations

Some explanations for American health policy tackle the “why no health insurance” question head on; others collapse health policy into the larger development of the American welfare state; still others offer essentially descriptive explanations in the course of narrating a particular epi-

³ Robert Alford, *Health Care Politics: Ideological and Interest Group Barriers to Reform* (Chicago, 1976), 13–17; John Myles and Adnan Turegun, “Comparative Studies in Class Structure,” *Annual Review of Sociology* 20 (1994): 110–11; Vicente Navarro, *Medicine under Capitalism* (New York, 1976), 138–43.

sode or debate. These explanations, in turn, employ a variety of comparative, narrative, and theoretical approaches: some draw loosely on the theoretical literature in order to make sense of historical events; others draw loosely on the historical literature in order to advance theoretical claims about American political development. My own interests and purposes lie somewhere in between. I recognize the importance of building theoretical bridges between academic disciplines and across national boundaries, but I also recognize the difficulty of fitting a past reconstructed from primary sources into neat theoretical boxes. In exploring this scholarship, I am less interested in building up and knocking down straw figures than in scavenging for insights and suggesting the constraints and limits of other explanations. Broadly speaking, these explanations fall into three categories, each of which—in its own way—touches upon the particular absence of health insurance and the broader exceptionalism of the American experience.

The Liberal or Pluralist View

Perhaps the most persistent explanation for health care exceptionalism is the liberal or pluralist view. In this view, the welfare state is a response to the demographic, economic, and political demands of industrialization—reflecting not the demands of labor or capital, but a brokered consensus. This view attributes the failures of health reform in the United States to a popular or cultural faith in private solutions and a corresponding distrust of “radical” political solutions. The United States lacks national health insurance, as Eli Ginzburg argues, because such a policy “runs counter to long-standing American attitudes towards government and deep-seated beliefs . . . in the efficacy of market solutions to social problems.” In contrast to Britain and Canada and others, the United States boasts “a more fragmented polity, a fluid class structure, and a narrower range of ideological debate.” Such explanations generally assume that the American people were naturally receptive to the arguments made by opponents and naturally leery of those made by reformers. As Daniel Fox argues, the latter undermined their chances by refusing to compromise on “practical” or piecemeal reforms and polarizing the debate in such a way that “arguments about proper policy were conducted as holy wars.”⁴ And such explanations generally dismiss

⁴James Morone, *The Democratic Wish: Popular Participation and the Limits of American Government* (New York, 1990), 257–65; Paul Starr, *The Social Transformation of American Medicine* (New York, 1982); Monte Poen, *Harry Truman versus the Medical Lobby* (Columbia, Mo., 1979); Daniel M. Fox, *Health Policies, Health Politics: The British and American Experi-*

the “why no national health insurance” question as irrelevant or ahistorical, preferring instead to focus on the incremental reforms enacted in its place.⁵

There are a number of problems with this view. It often takes for granted the causal importance of ideas and language. Although charges of socialized medicine and the like shaped and chilled social policy debates, scholars too often exaggerate the sincerity of such ideas, underplay the ways in which they were contested, and ignore the ways in which opponents of reform were able to turn liberal politics to conservative ends.⁶ Indeed, the American welfare state has been constructed on quite elastic cultural grounds: much of our current policy would be considered beyond the pale by nineteenth-century standards, just as the contemporary backlash might seem an unusual retreat from the vantage of 1948 or 1968. Reliance on “liberal values” to explain the absence of national health insurance cannot account for either the parallel success of other social programs or the failure of health insurance despite persistent popular support.⁷ Finally, this view is largely indifferent to the material advantages and political institutions that privilege some ideas over others. Other countries with professional medical associations and liberal political cultures, after all, emerged from the middle years of the twentieth century with some form of national health insurance. The influence of the American Medical Association (AMA) and others in the American setting reflected not the natural resonance of their message but the immense resources that they brought to bear on politics and public debate.⁸

ence, 1911–1965 (Princeton, N.J., 1986), 11–14, 47–51, 79–83, 89–93 (quoted at 3–4, 51). For a critical summary of this view, see Walter Korpi, “Power, Politics, and State Autonomy in the Development of Social Citizenship: Social Rights during Sickness in Eighteen OECD Countries since 1930,” *American Sociological Review* 54 (1989): 311–12; Ginzberg quoted in Vicente Navarro, “Why Some Countries Have National Health Insurance, Others Have National Health Services, and the United States Has Neither,” *IJHS* 28 (1989): 383–84.

⁵ Daniel M. Fox, “The Decline of Historicism: The Case of Compulsory Health Insurance in the United States,” *BHM* 57 (1983): 609.

⁶ Robert Westbrook, “Fighting for the American Family: Private Interests and Political Obligation in World War II,” in *Power as Culture*, ed. T. J. Jackson Lears and Richard Wightman Fox (New York, 1993): 135–60; Gary Gerstle, “The Protean Character of American Liberalism,” *American Historical Review* 99:4 (1994): 1045–47.

⁷ Katznelson, “Rethinking the Silences of Social Policy,” 310; Sven Steinmo and Jon Watts, “It’s the Institutions Stupid! Why Comprehensive National Health Insurance Always Fails in America,” *JHPPL* 20:2 (1995): 331–32; Navarro, “Why Some Countries Have National Health Insurance,” 383–35.

⁸ Navarro, “Why Some Countries Have National Health Insurance,” 384; David Wilsford, *Doctors and the State: The Politics of Health Care in France and the United States* (Durham, N.C., 1991): 84–117, 181–220.

The Institutional View

A state-centered or institutional account has recast our understanding of American exceptionalism by focusing on the autonomy and capacity of the state. Recognizing that American welfare policy diverged from that of its democratic peers *despite* common intellectual traditions and the shared experience of industrialization, the institutional account turns its attention to differences in political structure—arguing, most broadly, that the weakness of national political institutions and the absence of programmatic party competition after 1896 made it impossible for reformers to transform a relatively generous Civil War pension system into a lasting welfare state. This institutional vacuum invited private alternatives and enabled conservatives to use both a fragmented state and its attendant political culture to frustrate reform. Although this scholarship has focused on programs other than health policy, its implications for our understanding of the latter are clear: institutions matter, and the trajectory of social reform will usually reflect the capacity of those institutions to accommodate new demands. National health insurance, in this view, made little headway because “American political institutions are structurally biased against this kind of comprehensive reform.”⁹

This view too has a number of problems. Most important, it dismisses or distorts the influence of economic interests. In part, this reflects an explanatory strategy that combines a devastating critique of crude Marxist state theory with an uncritical deference to traditional political history.¹⁰ In part, this reflects an assumption that elements of political or institutional weakness are static background conditions—and not themselves consequences of the efforts of economic interests to shape or limit state power. And in part, this reflects an eagerness to interpret frustration

⁹ Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of American Social Policy* (Cambridge, Mass., 1992); Ann Orloff, “The Political Origins of America’s Belated Welfare State,” in *The Politics of Social Policy in the United States*, ed. Margaret Weir, Ann Orloff, and Theda Skocpol (Princeton, N.J., 1988), 37–80; Theda Skocpol and John Ikenberry, “The Political Formation of the American Welfare State in Historical and Comparative Perspective,” *Comparative Social Research* 6 (1983): 91; Ann Orloff and Theda Skocpol, “Why Not Equal Protection? Explaining the Politics of Public Social Spending in Britain, 1900–1911, and the United States, 1880s–1920s,” *American Sociological Review* 49 (1984): 728–29; Steinmo and Watts, “It’s the Institutions Stupid!” 330–68 (quoted at 330); Theda Skocpol, “Is the Time Finally Ripe? Health Insurance Reforms in the 1990s,” *JHPPL* 18 (1993): 536–37.

¹⁰ Theda Skocpol, “Political Response to Capitalist Crisis: Neo-Marxist Theories of the State and the Case of the New Deal,” *Politics and Society* 10 (1982): 155–201.

with political outcomes as evidence of the independence or autonomy of the state—rather than as a reflection of the diverse and often contradictory political demands made by different economic interests. Eagerness to “bring the state back in” is often accompanied by a tendency to usher all other factors out—a tactic that confuses the insight that “institutions matter” with the implausibility that “only institutions matter.”¹¹ Institutionalists have accordingly retreated from a state-centered focus on administrative capacities to a broader, polity-centered consideration of the capacities of both state institutions and political interests.¹² But such assessments typically consider economic interests alongside all other potential political actors without any allowance for their disproportionate stake in political outcomes or their disproportionate command of political resources.

In turn, the institutionalist account underplays the influence of race and gender, and accommodates only their institutional reflections (the relative clout of women’s organizations or the unusual congressional clout of southern Democrats, for example). Generally, this view acknowledges the important fact that some women worked for, and others were the target of, maternal health programs, but overlooks the ways in which private and public family-wage assumptions shaped the form and function and legitimacy of all aspects of social provision. Distinctions between deserving and undeserving recipients fragmented any sense of universalism even as they sought to create an entering wedge for state welfare. And the confinement of health care to either private consumption or workplace provision marked less an institutional distinction between public and private responsibility than the prevailing assumption that dependency on the state was a temporary interruption of, or unhappy alternative to, dependence on men.¹³ Similarly, racial assumptions and interests were far more pervasive than the influence of southerners in Congress or the Democratic Party. While Southerners ensured that federal social policy not trespass on the deeply racialized political economy

¹¹ Jill Quadagno, “Theories of the Welfare State,” *Annual Review of Sociology* 13 (1987): 118–25; Linda Gordon, “Gender, State, and Society: A Debate with Theda Skocpol,” *Contention* 2:3 (Spring 1993): 143; Frances Fox Piven and Richard Cloward, *Regulating the Poor: The Functions of Public Welfare*, rev. ed. (New York, 1993): 433–40.

¹² Skocpol, *Protecting Soldiers and Mothers*, 47–54.

¹³ Gordon, “Gender, State, and Society,” 143–55; William Forbath, *Law and the Shaping of the American Labor Movement* (Cambridge, Mass., 1991): 25–29; Nancy Fraser and Linda Gordon, “Contract vs. Charity: Why Is There No Social Citizenship in the United States?” *Socialist Review* (1992): 45–46, 47, 52–53; Gwendolyn Mink, “The Lady and the Tramp: Gender, Race, and the Origins of the American Welfare State,” in *Women, the State, and Welfare*, ed. Linda Gordon (Madison, Wis., 1990): 92–93, 99; Carol Pateman, “The Patriarchal Welfare State,” in *Democracy and the Welfare State*, ed. Amy Gutmann (Princeton, N.J., 1988): 238–50.

of the South, the construction of the “deserving citizen” as a white male industrial worker was rooted in ideas and practices reaching far beyond sectional politics.¹⁴

Finally, the institutional account is peculiarly ill equipped to explain the divergent paths of health insurance and the other Social Security programs. In terms of raw administrative capacity (especially between 1935 and 1950), the employment-based programs that succeeded (pensions and unemployment insurance) effectively started from scratch, while the program that failed (health insurance) rested on a substantial and diverse foundation of private and public expenditures and programs (including the Veterans’ Administration, the Children’s Bureau, and extensive public health programs). Economic interests were willing to accommodate the socialization of pensions and unemployment insurance in 1935 but proved unwilling, largely because both private provision and private financing were at stake, to do the same for health insurance. The absence of national health insurance, in short, is precisely opposite the result one would expect from state-centered explanation of the late bloom of American social policy.

The Radical View

Radical scholars have explained American health policy (or its absence) as a reflection of class politics, stressing both the influence of economic interests and the relative weakness of the working class. In some versions, health policy simply reflects the instrumental or structural interests of capital, pressing medicine into a for-profit market mold or responding in a Bismarckian fashion to social unrest. In other versions, the United States is portrayed as a social democratic laggard, and the absence of national health insurance as yet another facet of the failure of socialism in the American setting. Such accounts typically incorporate a particularly damning portrait of both the AMA and the repressive liberalism of American political culture. In sharp contrast to the liberal view, radical scholars argue that politics have frustrated, rather than reflected, popular aspirations and values.¹⁵

¹⁴ Eileen Boris, “The Racialized Gendered State: Constructions of Citizenship in the United States,” *Social Politics* (Summer 1995); Robert Lieberman, “Race, State, and Inequality in the United States, Great Britain, and France” (unpublished, ms., 1999); Robert Lieberman, *Shifting the Color Line: Race and the American Welfare State* (Cambridge, Mass., 1998); Michael Brown, *Race, Money, and the American Welfare State* (Ithaca, N.Y., 1999).

¹⁵ Korpi, “Power, Politics, and State Autonomy in the Development of Social Citizenship,” 311–12; David Himmelstein and Steffie Woolhandler, “The Corporate Compromise: A Marxist Interpretation of the American Health Care System,” *Monthly Review* (May 1990): 22–23; Navarro, “Why Some Countries Have National Health Insurance,” 383–404.

There is much to recommend this view. It is appropriately dismissive of claims about a liberal consensus or the conservatism of American workers, and it is attentive to the economic incentives and interests underlying both health politics and the institutional setting in which they have played out. But this view, like others, has its shortcomings. Such accounts are maddeningly vague as historical explanations, often relying upon functional or teleological assumptions about the behavior of capital or the goals of social policy.¹⁶ Such accounts cannot explain why the American experience departs so markedly from that of its capitalist peers, except by falling back on an exceptionalist argument based on often-dubious causal and comparative premises.¹⁷ And this view tends to collapse the politics of race and gender into the larger riddle of class politics, assuming that “natural” solidarities cut across historical divisions within the working class and obscuring the ways in which some workers proved the fiercest defenders of both the family wage and white privilege. Finally, this view underestimates the importance of diverse and often contradictory class interests. The driving force behind American health politics is not so much the political advantages enjoyed by health interests but the political disarray of those interests—especially when political solutions divided important constituencies or threatened to satisfy one at the expense of another.¹⁸ Health interests shared a general contempt for state intervention and a common language for responding to its threat, but the state was also an arena in which they competed fiercely for political advantage and a tool they would not hesitate to use when it suited their purposes.

Speculations and Considerations

Although none of these explanations are entirely sufficient or satisfactory, this bathwater contains its share of babies and it makes little sense to discard it all. Ideas matter. Political choices are shaped, and often whittled away, by the ideological or linguistic tools at hand. Institutions matter. Political choices are often shaped, and in some cases created, by the political setting within which they play out. And interests matter.

¹⁶ Skocpol, “Political Response,” 155–67.

¹⁷ Alan Dawley, “Farewell to American Exceptionalism: A Comment,” in *Why Is There No Socialism in the United States?* ed. Jean Heffer and Jeanine Rovet (Paris, 1988): 311; Michael Zuckerman, “The Dodo and the Phoenix: A Fable of American Exceptionalism,” in *American Exceptionalism? U.S. Working Class Formation in International Context*, ed. Rick Halpern and Jonathan Morris (New York, 1997): 14–35.

¹⁸ Colin Gordon, “Why No Corporatism in the United States? Business Disorganization and Its Consequences,” *Business and Economic History* 27:1 (1998): 29–46.

Political choices are peculiarly responsive to, and sometimes made directly by, those who command the lion's share of political and material resources. The question is not which of these explanations is the right one, but how they relate to one another. How can we construct an explanation in which causes can be distinguished from consequences and vice versa? How can we weave together a multicausal or multilayered account without overdetermining the outcome—without rendering the historical goal of national health insurance not only elusive but implausible? In the chapters that follow, I explore the twentieth-century health debate through a series of thematic narratives. This explanatory strategy is intended not only to draw out the importance of particular issues, arguments, and constraints over time but to avoid the tendency of chronological narratives to offer discrete and contingent explanations. I sketch the history of the health debate in chapter 1, an overview that serves as both a summary account of modern American health politics and a narrative baseline for the thematic chapters that follow.

The most direct and tangible consequence of interest-driven health policy, as I trace in chapter 2, was the growth of private benefits. The establishment of a private welfare state reflected the ability of employers to shape social policy and encouraged workers to turn from national political solutions to the promise of the bargaining table. I trace the rise (and fall) of the private welfare state and suggest the ways in which workplace benefits distracted, shaped, and trumped public programs. My goal here is to assess the experience of private social policy, plumb the motives of business and labor as they bargained over the terms and scope of private social provision, and suggest the ways in which private benefits not only filled a gap in the famously backward American welfare state but also undermined the pursuit of universal benefits and directed social policy away from those who needed it the most.

As private benefits emerged as a surrogate for public policy, health policy was distorted and distracted by the emergence of a peculiarly American system of social insurance. As I argue in chapter 3, reformers and opponents alike tried to fit health insurance into a social insurance mold despite the fact that health care was not simply an extension of the employment relationship, and could not be plausibly organized around the idea of "contributory" entitlement. In turn, the boundaries of social policy debated through the early decades of the century—some reflecting the efforts of reformers to get a foot in the door, some reflecting the efforts of conservatives to close the door—gradually hardened into distinctions between deserving and undeserving citizens, and between employment-based contributory programs and stigmatized public assistance. Chapter 4 expands upon this by tracing the broader political culture of the health debate, including the famously hysterical antiradi-

calism of the AMA and others, the ritual demonization of other national health systems, and the profound (if often contradictory) influence of market assumptions on health provision and politics.

Doubts about universal provision and fascination with the contributory principle reflected and reinforced broader limits to the very notion of social citizenship in the United States. Perhaps the most fundamental of these limits, as I suggest in chapter 5, was race. From the earliest considerations of national health policy, race was a central, if often unspoken, consideration. Racial assumptions shaped health policy in part because they shaped local and national understandings of public health. White southerners shaped national health policy by maintaining segregated professions and institutions, and by digging in (in national and state politics) against public programs that threatened to upset Jim Crow. In turn, African Americans and Latinos were largely left behind by job-based social insurance and half-heartedly targeted (and whole-heartedly stigmatized) by penurious and locally administered social assistance programs.

Gender shaped the health insurance debate as well, and although the United States was clearly not exceptional in this regard, the combination of national political weakness and private provision did affect American women and men in exceptional ways—especially in the persistent distinction between private contractual benefits organized around a family-wage ideal and public charitable benefits aimed at women and children. In the former, women are considered dependents, and even working women have claimed only token citizenship in the private welfare state. Such assumptions shaped the ways in which women participated—as reformers and as recipients—in the development of American social policy. I come back to the deeply gendered premises of health provision at a number of points: in chapter 2, I suggest the ways in which private coverage both sorted beneficiaries by gender and incorporated the ideology of the family wage; in chapter 3, I suggest the ways in which the politics of social insurance were imbued with the logic of the family wage, and the ways in which maternalism—as a strategy for identifying “deserving citizens”—served as both an opportunity and an obstacle; in chapter 4, I suggest the ways in which the broader political culture of health care was organized, in part, around the idea that public coverage threatened masculine independence.

In chapter 6, I turn to patterns of influence in health politics, devoting particular attention to the shifting terms of a corporate compromise among employers, doctors, and insurers. Although the motives and relative influence of these interests changed over time, their ability and willingness to shape health policy proved distressingly consistent. This chapter offers both a case study of the close relationship between economic and political power in the United States and an explanation for the limits

of health politics outlined in the other chapters. The flip side of this story, of course, is that reform interests—working through the state, the Democratic Party, professional associations, and the labor movement—were weak and fragmented. In chapter 7, I show how reformers were persistently outmaneuvered and outspent by their opponents, and how this monotonous disadvantage whittled reform initiatives down to a pattern of incremental change and half-hearted compromise. In this respect, the history of health policy underscores the importance of economic interests in American politics, not only for their direct influence in particular reform episodes but for their ability to maintain an institutional setting that invited their influence and discouraged others.

Though teased out separately, these themes—the emergence of a private welfare state, the politics and political culture of social insurance, the intersection of race and social policy, the influence of health interests, the disarray of reform interests—are closely intertwined. The political clout of economic interests reflected both immediate and relative material advantages and their ability, over time, to undermine social democratic organization and the emergence of autonomous state interests. The elaboration of health care's corporate compromise not only drove health provision away from the state and into private bargaining, but also justified that choice by leaning heavily on the political, intellectual, and psychological framework of social insurance. Private bargaining, in turn, was shaped by the influence of race and gender both on labor markets and on the peculiarly American construction of social citizenship. Labor's notorious voluntarism underscored the ability of economic interests to turn the state against labor (and labor against the state), and the invocations to "manly independence" and "whiteness" woven through the history of American trade unionism. And the very necessity of distinguishing between the deserving and the undeserving in a climate of less-than-universal provision reflected the unwillingness or inability of labor and others to pursue broadly social democratic alternatives.