Political analysis and American medical care
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Essays

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For J.S.M.
Contents

Introduction page ix

Part I: The Perspective of Political Science

1 Political Science and Health Services Administration 3
   Theodore R. Marmor, Andrew Dunham

2 Comparative Politics and Health Policies: Notes on
   Benefits, Costs, Limits 45
   Theodore R. Marmor, Amy Bridges, Wayne L. Hoffman

Part II: Politics in the World of Medicine

3 The Politics of Medical Inflation 61
   Theodore R. Marmor, Donald A. Wittman, Thomas C. Heagy

4 Representing Consumer Interests: The Case of
   American Health Planning 76
   James A. Morone, Theodore R. Marmor

5 American Health Planning and the Lessons of
   Comparative Policy Analysis 96
   Theodore R. Marmor, Amy Bridges

6 Doctors, Politics and Pay Disputes: “Pressure Group
   Politics” Revisited 107
   Theodore R. Marmor, David Thomas

7 The Health Programs of the Kennedy-Johnson Years:
   An Overview 131
   Theodore R. Marmor with James A. Morone

Part III: The Politics of National Health Insurance

8 Welfare Medicine: How Success Can Be a Failure 155
   Theodore R. Marmor
## Contents

9   National Health Insurance: Some Lessons from the Canadian Experience  
    *Theodore R. Marmor, Wayne L. Hoffman, Thomas C. Heagy*  
    165

10  Rethinking National Health Insurance  
    *Theodore R. Marmor*  
    187

11  Patient Cost Sharing  
    *Douglas Conrad, Theodore R. Marmor*  
    207

Epilogue

12  Medical Care and Procompetitive Reform  
    *Theodore R. Marmor, Richard Boyer, Julie Greenberg*  
    239

Index  
    262
Introduction

This book is a collection of my essays on political analysis and the world of American medicine. Written during the 1970s, most were products of the latter half of that decade. They range widely in immediate topic and expected audience, method and length, generality and concreteness. The obvious question is why such a collection deserves the format of a book, given that most of the articles have already been published, albeit in a wide variety of journals and books. One reason for any book of essays is convenience. When one makes contributions to a field of inquiry but does so in quite different journals, books, and nations, there is a case for bringing together the pieces that appear enduring and useful. This case is particularly strong for applied work in the social sciences that attends to topics of public policy and diverse disciplinary interests. Such is the case with medical care, its financing, delivery, organization, and politics. No one reads all the journals. The disciplines proliferate their outlets; the interdisciplinary journals and books of public policy and particular policies further expand the range of publications. So if one has had something to say and has written in a variety of publications, there is a case for a book.

That case is further strengthened when the articles range over an intelligible but complicated field of work. This I believe to be the case here. The title, Political Analysis and American Medical Care, was carefully chosen. It is meant to signal both a disciplinary orientation and a common subject. As I turn to the structure of the book and its contents, I will buttress this claim of coherence. But here I want to turn to the claim itself.

The essays reflect training in political science and conviction in the importance of medical care to the modern state. Few need to be reminded that medicine is important politically. The expenditures modern societies commit to it are large (between 6 and 10 percent of gross national product across Organization for Economic Cooperation and Development, OECD, nations) and the relations between the polity and the world of medicine are contentious and often bewildering. The practice of medicine fifty years ago was largely a private matter of doctors, patients, and hospitals. Both private and public health insurance was relatively restricted, almost an infant industry. Today among the OECD nations, medical care finance is dominated by public expenditure.

The political salience of medical care is matched by its academic topicality. Medical schools seek courses to acquaint future doctors with the world of governance they will face; programs in nursing, health administration, and management include health policy and politics in their curricula. There are branches of
Introduction

Medical care studies in the social sciences, especially sociology and economics, and a specialized cadre of philosophers and lawyers address—forbid the expression—
“bioethics” and health law. Health planners and insurance officials seek guidance
about the proper and likely role of government in redistributing access, financing
care, and regulating its practice and quality. Once an infant industry, medical
care is now a growth center, financially, intellectually, and politically. The
proliferation of books, journals, and conferences mirrors, with a lag, the growth
of governmental intervention in this world.

With this growth has come the expected outpouring of work on the politics of
particular parts of the medical world. Public officials publish their views on the
politics of health, exemplified by Enoch Powell’s trenchant book on the British
National Service in the 1960s.1 Journalists cover particularly dramatic confronta-
tions, as with Richard Harris’s book on the Kefauver drug legislation of 1962.2
Legal scholars take up the question of how state medical regulation operates, as
with the classic 1954 Yale Law Journal article on the power of the American
Medical Association (AMA).3 And scholars of American health politics seize on
one topic after another, explaining who got what, where, and when: the advent of
Medicare and Medicaid in 1965, the origins and fate of health planning legisla-
tion, the closures of particular hospitals, the struggles over municipal hospitals,
the regulation of physicians through the Professional Standards Review Organi-
izations (PSROs), the play of state commissions charged with regulating hospital
expansion or reimbursement, and so on. Components of the industry, particular
policy struggles, program implementation, and the pressure group actions of
various organizations—all provide ready subjects for political analysis.4

But the discussion of particular political struggles in medical care can be
misleading. This is so for two reasons. First, particular cases of politics in
medicine do not add up to the politics of medicine. The stakes, contestants, and
forms of policy struggle vary. Conflicts over hospital closures, for instance,
differ greatly from those occasioned by the regulation of the drug industry or the
subsidy of medical care for the poor. The undeniably truthful claim that there are
politics in the world of medical care does not entail that there is a uniform politics
of medical care.

There are, in fact, many ways to regard politics in medicine. One can emphasi-
size the institutional setting of the struggle (Congress, the Department of Health
and Human Services, state government), the players (AMA, state licensing
boards, city councilmen), the topic at issue (budgets, social insurance claims,
professional privileges), the character of the fight (muted or noisy), the nature of
the contest (how much local aid to a particular hospital or the scale of redistribu-
tion in welfare state battles), and so on.

Political scientists group political struggles more generally by their institu-
tional setting, their policy stakes, or forms of dispute. Naming politics “medical”
is but one way of describing politics in the medical care industry. The relevant
considerations in disputes about medical care are the same as those in conflicts
Introduction

about any public policy: the distribution of expected costs and benefits (concentrated vs. dispersed), the geographical location of conflict and the pattern of organized interests (balanced vs. imbalanced political marketplaces), or the type of gains and losses that policies appear to generate (zero sum vs. positive sum).\(^5\) It may well be that, in medicine, there is a distinctive distribution of political conflicts. But that has to be maintained on evidence, not by simply invoking the industry in which the politics occur. This point applies to transportation, agriculture, steel, and education as much as it does to medicine.

Thinking of “a politics of medical care” is misleading in a second respect. Such a view subordinates both constitutional arrangements and the socioeconomic structures that constrain what is thinkable and hence politically possible. Both the modes of political representation and the range of political ideologies shape the fate of a nation’s policies on health. In the United States, a constitutional orientation toward dispersion of authority conditions governmental intervention into any industry.\(^6\) Interest groups adapt to this fragmentation. In federal–state programs like the subsidy of hospital construction, this federalism encourages positive-sum games in which the tax-paying losers and the subsidized winners hardly have to confront one another. Likewise, a culture that idealizes liberal individualism and capitalist modes of economic life shapes the medical care options its polity takes seriously. State ownership of medical care institutions—and direct salaried payment of its medical care providers—continues to be a highly unlikely option in American politics, whatever its appeal in Britain and elsewhere.\(^7\) Such constraining factors affect all American politics. And, for that reason, understanding what shapes politics in American medicine is aided by studies of these national characteristics, even when the illustrations only marginally if at all touch on medical care.

These two points suggest, then, a widened focus for any work on medical care in American politics. First, one begins with the structure of American political life and its implications for particular policy struggles in medical care. Here, the issue is what one learns from political studies generally that bears on American medicine’s political life. Second, using the approaches of political inquiry, one can investigate particularly salient instances of a nation’s medical care politics. Here, the question is both explanatory (why the outcome and what are the prospects?) and illustrative (what is the study a case of?). Depending on one’s concerns, applications of this sort can be used to support generalizations about classes of political conflicts or the generalizations can be brought to bear on the particular instance. That is, the work can function as a window on a nation’s politics or as a case example of one of its recognizable forms of struggle and resolution. Finally, political analysis is part of sensible policy appraisal. The political conflicts over policy options shape their implementability and hence their desirability, as all practitioners understand. Policy analysis without politics is like a hotel without people. The political opposition and support a policy will command is analogous to expenditure and revenue in a budget; political benefits
Introduction

and costs vary, just as fiscal ones do, with the particular formulations of policy options. Moreover, putting policies into effect extends political struggle. And where operational policies sharply diverge from stated ones, appraisals of the latter are misleading substitutes for judgments of the former. Forecasts of implemented policies are the necessary preconditions of realistic policy appraisal.  

The essays that follow are grouped into these three classes. The first part addresses the perspectives of political science and asks how its general findings illuminate our medical care disputes. The second part discusses several instances of political conflict in the world of American medicine. The five applied studies range from problems of inflation to consumer roles in health politics, from paying doctors to an overview of the health programs of the Kennedy and Johnson administrations. Not exhaustive, they nonetheless cover a diverse range. And they do so with historical material, cross-national evidence, and comparisons with analogous concerns in other sectors of American life. In this respect, they illustrate both the substantive range of American medical politics and the use of the different approaches to political analysis itself.

The third group of essays addresses a number of questions about national health insurance. The historical legacy of conflict over government health insurance was the starting point. But any national health insurance program would have to deal with the whole of the medical care industry. So the question was what one could learn from American experience with government health programs and from foreign experience with national health insurance. And that meant asking how these lessons would illuminate the shape of struggles an American national health insurance program would face. All of the third part’s essays share a prospective and prescriptive emphasis; they connect different sorts of political analysis to the appraisal of national health insurance in the contentious 1970s. In the early 1980s, it is obvious that national health insurance has receded as a topical political subject. But the role of government in the medical care industry will continue to be controversial. And so the epilogue discusses the debate over competition in American medicine, the alternative, in the minds of many, to the long-standing dispute over national health insurance.

A word about the origins of these essays. For twenty years, my major interest has been the politics of the welfare state in America. But my initial topic of study was government health insurance, particularly why it was that the United States turned to the aged and the poor as the constituencies for its Great Society initiatives in medical care, the Medicare/Medicaid programs of 1965.  

No doubt that interest in health insurance was stimulated when I became a surgeon’s son-in-law in 1961. And my book on The Politics of Medicare (1973) was in part an attempt to settle some extended family discussions. But that book also set the stage for the essays that follow. It was directed at understanding, not prescribing. It meant to make sense of an important watershed in American politics,
to address retrospectively what led the nation to take the course it did during the Johnson administration. The result, however illuminating, was an insufficient guide to future disputes over the government’s role in American medicine. I wanted to write a book on the debate over this question, the likely options, and, more importantly, the likely effects of these options. So I set for myself an agenda of preparation. I asked what I would need to know to write a useful, prospective book on national health insurance. As it happens, that book, written with a group of collaborators at both the University of Chicago and the Urban Institute, was published in 1980. What this set of essays represents are the intellectual precursors of the 1980 national health insurance book.

The epilogue’s combination of historical summary and political forecasting completed the agenda I set for myself years ago. Students of American politics or health policy will find in these pages diverse essays, but not disconnected themes. It is to the particular essays I now wish to turn.

The first chapter, “Political science and health services administration,” addresses the question of what one might learn about politics in American medicine by reviewing the work of political science. Previously unpublished in this extended form, the essay reflects the tremendous growth of interest in health politics that followed the introduction of Medicare and Medicaid in the mid-1960s. Before then, medical care politics and policy were a specialist’s domain, a small part in the agenda of American politics and political study. As public program after program emerged in the 1960s and 1970s, particular analyses abounded but few general overviews.

This long essay supplies such an overview. Moreover, it was intended as a guide to newcomers—both to politics and to health—and draws out the different modes of interpreting politics in medicine. It reviews the subjects regarded as the domain of politics, the concepts political analysts employ, the main approaches they take, and the conclusions about American domestic politics that illuminate medical care. There have been even fewer other such disciplinary surveys; indeed, Herbert Kaufman’s 1969 monograph for the Public Health Service is the only one I know of with the same scope.

The essay on comparative politics and health policies (chapter 2) begins as well with a methodological and disciplinary subject. It questions both what cross-national political studies can tell one about medical care politics and how medical issues can inform comparative politics, so long an area of institutional emphasis and psephological preoccupation. It deals with the broad topic of comparative policy studies but uses medical care to illustrate the costs, benefits, and limits of such inquiries. As such, the essay provides the intellectual underpinnings for three uses of cross-national evidence in the rest of the book: comparisons that set the context for American disputes, parallel studies of how different politics deal with comparable tasks (like paying doctors), and discussions of how
xiv  

Introduction

the experience of one regime can illuminate the options of another (as with the Canadian national health insurance experience and its lessons for America). The first part, then, provides the disciplinary and methodological models of which the essays that follow are particular instances.

Chapter 3 is a political scientist’s view of the internationally common problem of medical care inflation. It takes as its central focus not the causes of inflation but American government’s special difficulty in coping with them. For, although all industrial nations have experienced inflationary pressures in this sector during the postwar period, America’s troubles since the mid-1960s have been comparatively acute.\textsuperscript{14} Why should this continue to be so, especially when all acknowledge that widespread insurance, restraints on price competition, and fragmented financing institutions are recipes for inflation? Why has agreement on these causes not led to significant amelioration? Chapter 3 argues that the answer lies largely in the very structure of America’s political “market.” With inflation’s benefits relatively concentrated and its costs diffused over many patients, insurance funds, and governmental agencies, the interest in controlling inflation is much less than the concern to shift costs. The theory of concentrated and diffuse interests parsimoniously illuminates America’s comparative difficulties.\textsuperscript{15}

Chapter 4 applies the same theory to a policy fashionable in the late 1960s and the early 1970s: the idea that enhanced consumer representation in the corridors of medical power would right the wrongs of American medicine. The ambitious and conflicting aims of America’s experiment in health planning constitute the essay’s initial focus. The discussion then turns to the varied conceptions of representation that, by comparison, highlight the American form of consumer representation: “mirroring” local communities in the institutions of health system agencies (HSAs) all over the country. And the review of experience since the HSA program’s origins in 1974 illustrates how political structures—imbalanced political markets—doom naive hopes for such planning programs.

Chapter 5 also addresses these dilemmas of American health planning but from the vantage point of comparative experience. By looking at the experiences of other nations—both similar to and different from the United States—it suggests how peculiar our own planning has been and provides guidelines our planners might follow when trying to reshape American medicine in the real world of clashing interests, scarce political resources, and competing incentives.

Chapter 6 moves away from planning but employs the methods of cross-national comparison. It takes up the topic of how governments chose methods of paying physicians and what generalizations the comparative historical evidence supports. Its aim is mainly explanatory: to sketch the factors that explain why physicians are almost always paid by the methods they prefer rather than those reformers insist are best. But the policy implications of such findings are highlighted as well. The politics of paying doctors suggest that modern governments have narrow choices regarding major reforms in the paying of most physicians.
Introduction

This in turn suggests that the administration of payment schemes is crucial and that other measures to achieve the ends of favored methods of payment have to be found.

Chapter 7 surveys the fate of health programs in the Kennedy and Johnson administrations. It employs the conceptual tools of Part I to understand the character and consequences of the quite diverse programs initiated between 1960 and 1968. Its categories are those of politics, not industrial economics. So the discussion centers on the forms of welfare state politics illustrated by Medicare and Medicaid; the pork barrel bargains in programs like health research, hospital construction assistance, and community mental health centers; and the regulatory struggles within different agencies. What the federal government does in medical care is the major topic, but the central point is that the federal government’s policies affect medical care but do not constitute a medical care policy.

Part III shifts the focus from politics in American medicine to a particular cluster of issues; namely, those involving the role of American government in health insurance. Chapter 8 leads off by assessing the historical record, reviewing in particular the different political fates of the two major financing innovations in 1965, Medicare and Medicaid. “Welfare medicine” here means health financing programs for the poor, in particular the federal–state Medicaid program. The puzzle posed by the Medicare/Medicaid comparison is why the two programs, simultaneously launched, should have produced such similar results medically and economically but had such different political fates. Both programs redistributed access in the intended direction (toward the old and the poor, respectively), both contributed substantially to medical inflation, and both put considerable pressure on government budgets at the federal and state levels. Why should Medicaid be regarded as a political scandal and subjected to programmatic instability and Medicare remain so stable and, broadly speaking, legitimate? The answer lies in the political constituencies they affected and the ideological claims they excited. And, more important for national health insurance, their fates reveal the profound political significance of the different welfare state conceptions government health insurance proposals can express.  

Chapter 9 turns to Canada and thus shifts from asking what the past of American government’s role in health insurance means for future changes to what we can learn from Canada’s experience with universal government health insurance. It compares the postwar developments in both countries and then, on the basis of similarities in economic structure, medical arrangements, and social stratification, inquires about the effects and fate of Canada’s experiment in socialized health insurance. As such, the essay differs from the comparative design of chapter 6. Rather than testing a proposition across many regimes—as with doctors’ pay—it treats Canada as a natural experiment for the United States. In that sense, the essay is both an instance of comparative political analysis and a special way to forecast the likely policy effects of a major program untried in the
Introduction

United States. It stands as a check on extrapolating how American politics would deal with national health insurance from how we have historically handled partial government involvement in the health market of the Medicare and Medicaid form.

Chapter 10 reconsiders the 1970s’ debate over national health insurance in the light of these national and international findings. On the one hand, it places the struggle at the center of American contentions about decent forms of social welfare policy. It highlights the special place such divisive issues have in the partisan and ideological composition of the American polity. But it also seeks to contribute to that debate by suggesting how far ideological struggle is likely to distort realistic policy forecasts.

Chapter 11 continues that effort at policy forecasting on a level devoted to patient cost sharing under various national health insurance plans; it takes up the traditionally contentious question of what role ability to pay should play in the receipt of medical attention. But it emphasizes how cost sharing will, in fact, operate rather than its theoretical advantages and disadvantages.

The last chapter, “Medical care and procompetitive reform,” is historical, analytical, and predictive. It reviews the current trends in American medicine and government health programs and foreshadows possible futures. For the purpose of this collection, the epilogue’s distinctive role is partly a detailed analysis of proposals for increased competition in American medicine during the 1980s. But it also suggests how political and economic circumstances condition the fate of proposals like those collected under the procompetitive banner. The essay predicts that procompetitive arguments will politically rationalize the attack on contemporary health regulations without fundamentally reforming the industry.

The publication of a collection of essays provides the occasion for personal acknowledgment as well as summary arguments. A diverse set of people and institutions stimulated, assisted, and encouraged me during the decade in which these essays were written. The universities where I taught—Wisconsin, Minnesota, Chicago, and Yale—all provided an atmosphere in which scholarship was taken seriously and thus stimulated. Particular research centers within these universities, however, gave the most crucial assistance, materially and intellectually. I have a particular debt to the Institute for Research on Poverty at the University of Wisconsin, which, in 1967–1969, supported my work on the politics of Medicare and, by generous aid to me as a visitor in 1971, made full-time writing possible. At the University of Chicago, I was the fortunate recipient of the Center for Health Administration’s (CHAS) scholarly encouragement and financial assistance. Most research centers in American universities are paper organizations in a profound but pathetic sense; their letterheads exhaust their intellectual collegiality and misleadingly suggest a community of scholars. CHAS, as its affectionate admirers call Chicago’s center, was different. Odin
Introduction

Anderson made Chicago a mecca for those writing about medicine and society. His workshops attracted a seemingly unending series of visitors, both from America and abroad, stimulating its fellows and nurturing an environment in which serious work was taken seriously. Now, as the Chairman of Yale’s Center for Health Studies, I know well how hard it is to create and to sustain such an atmosphere. Many of the essays collected here bear the imprint of colleagues from my six years at Chicago. However, it would be wrong to express my gratitude even-handedly. Odin Anderson made a crucial difference to my work, and I want to thank him warmly.

There is a final group that contributed even more to these essays, my coauthors. All too often senior authors claim more credit than candor should permit. The coauthors are all acknowledged on the title pages of the essays they helped write. Many are former students whose research found initial expression in joint papers. However, they must know their contribution was greater than the individual pieces on which they worked. There is an informal, loosely organized, and continuing seminar that links them and extends the range of topics I have been able to address. Andrew Dunham, now of Colorado College, initially learned about politics and American medicine by working on the opening chapter of this book. He was the first of a series of graduate students who became colleagues and in their own right have contributed to the literature of this field. Jim Morone, now of Brown University, was the second of these gifted students. His work on the health programs of the Kennedy–Johnson years set the stage for a thesis on American health planning, parts of which are incorporated here in the chapter on the politics of consumer representation in American medicine. Amy Bridges of Harvard, the third of “the Chicago crew,” made the chapter on America’s peculiar forms of health planning more literate and acute than it would otherwise have been. At Chicago these students helped create an unusually stimulating workshop between 1975 and 1979, a place where articles, books, reviews, and daily exchanges emerged in exciting and seeming disorder. Their contributions are only partly revealed by particular joint articles; they all worked more anonymously on the national health insurance project that culminated in the 1980 book on national health insurance.

Other colleagues participated in the Chicago workshop and contributed substantially to the atmosphere out of which most of these essays emerged. They read drafts, contributed suggestions, and made the place and its writing more lively. All have gone on to productive scholarly careers of their own: Beth Kutza at the University of Chicago, Fay Cook at Northwestern, Will White at the University of Illinois–Chicago Circle, and Doug Conrad—the coauthor of chapter 11—at the University of Washington.

Yale’s Center for Health Studies has been a congenial setting in which to select and to edit these papers. Two of its members have particularly helped to produce this book, Julie Greenberg and Terry Eicher. They manage the flow of
xviii  Introduction

scholarship that now is edited here, The Journal of Health Politics, Policy and Law, and have contributed skillfully to the readability of what I have written. Finally, I want to acknowledge the impact of Ed Lindblom on both the center I chair and the scholarship I have finished at Yale. He is a scholar whose own work on politics and public policy, as one of his readers has put it, “does for the mind, what the can opener does for the can.” Moreover, he made possible at Yale, with the support of the Kaiser Family Foundation, the continuing work of the Center for Health Studies. The center, and its staff, helped turn the essays of the past decade into this book.

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Notes

5 The most widely cited typology of policy conﬂicts—redistributive, regulatory, and distributive—is T. J. Lowi’s The End of Liberalism, 2nd ed. (New York: Norton, 1979). For discussion in this book, see especially chapters 1, 3, 4, and 7.
6 For a discussion of this theme, see chapter 1.
Introduction

7 For America’s peculiarities, see R. Klein’s essay on American health planning, “Ref-
8 For discussion of political feasibility, see E. Bardach, The Implementation Game; J.
9 The peculiarity of America’s path to government health insurance is discussed, in con-
10 Marmor, The Politics of Medicare.
12 Different inducements and audiences attended each of these essays, but the common motivation was understanding politics in the world of medicine to help appraise proposals to shape that world.
15 For a similar argument about the contrast of British and American experience with government’s control of medical inflation, see R. Klein’s essay, “Reflecting on the American Health Care Condition.”
16 The differing conceptions of the welfare state in theory and practice are discussed at length in Flora and Heidenheimer, eds., The Development of Welfare States in Europe and America, especially Chaps. 1–3, 11.
18 The tendency to confuse wishes with forecasts is particularly acute in proposals to enhance “competition” in the medical market place. For a discussion of this problem, see D. Mechanic, “Dilemmas in Health Care Policy,” Health and Society, 59(1): 10–14, 1981.