Political Influence in the 1990s: From Iron Triangles to Policy Networks

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Abstract To assess the prospects of comprehensive health care reform during the Clinton administration, we must examine the changes that have occurred in the political and structural contexts in which reform is debated. The political context includes the status of the health care system itself as well as public attitudes and voting patterns associated with health care reform; it may be friendlier now to reform than it has been in any previous period, but it cannot on its own produce policy change. The structural context, the representational community of organized interests and government institutions, is the means by which politics is either thwarted or translated into action. Changes in these organized interests and in Congress have transformed the health care reform policy community from an "iron triangle" dominated by an antireform alliance of medicine, insurance, and business to a more loosely bound policy network in which a reform coalition may now be able to prevail, especially under the direction of an activist president like Bill Clinton. I consider three hypotheses: The first claims that, despite the apparent structural changes, the core power relationships will remain the same as in the past, and the antireform alliance either will continue to block policy change or will push through a reform program that protects its constituent interests. According to the second, the structural changes produce an atomization of power, making coalition building in support of reform impossible. The third and most plau-

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sible hypothesis proposes that the structural changes, in combination with the shift in politics and Clinton's election, have generated new opportunities for fundamental reform.

During one of his frequent trips back to South Dakota, Senator Tom Daschle (D-SD) stopped in at the Good Samaritan Nursing Home, in the quiet community of Canistota, located among cornfields in the southeastern corner of the state. A resident of the home asked, with an air of "outside-the-beltway" innocence, "Tom, why can't we have a health care system like the one they have in Canada?" It is a question that comes up frequently in South Dakota, where proximity to our northern neighbor affords residents more than the usual exposure to news about the Canadian experience. It is natural for people there to wonder why the United States is alone among major industrial nations in having a health care system that neither grants everyone access to care nor keeps health care costs under control. It has become an issue that increasingly occupies the minds of people across the United States.

About nine months after the Canistota visit, on 2 April 1992, Senator Daschle, together with Senators Harris Wofford (D-PA) and Paul Simon (D-IL), introduced the American Health Security Plan (S. 2513), a modified single-payer proposal for the comprehensive reform of the American health care financing system. The moment was laden with symbolism, given Wofford's stunning victory over former U.S. Attorney General Richard Thornburgh the previous November, after a campaign that focused heavily on the need for health care reform cast him as the "poster child" of the reform issue.[1] The American Health Security Plan joined the multitude of proposals and options floating around the nation's capital during the 102d Congress, including but not limited to the single-payer approaches introduced by Senator Bob Kerrey and Representative Marty Russo, the "pay-or-play" employer-based mandated benefits approach promoted by the Senate Democratic leadership, and the voucher and tax credit market-based approach advocated by the Heritage Foundation and then President George Bush (see Blendon et al. 1992).

Major health care reform was strikingly back on the nation's agenda, possible solutions were circulating wildly, and the nation's capital was abuzz with meetings, forums, and press conferences, at which the merits of proposals were earnestly debated. Missing, however, was catalytic leadership from the White House. The election in 1992 of Democratic

1. The "poster child" analogy was coined by a member of Senator Wofford's staff.

President Bill Clinton, a proponent of activist government with a campaign commitment to introduce health care reform as one of his first priorities, seems to put a final piece into place. With Clinton in the White House, the momentum toward reform accelerates, even though his adoption of the rhetoric tied to yet another approach—managed competition—complicates the choice about which direction reform might go (see Rosner 1993). But despite all of these activities, the end of divided government, and Clinton's commitment, will the current period of deliberation actually produce reform, unlike all previous periods?

The question posed by the nursing home resident implied two others: First, for all the progress that private insurance and public programs have made in expanding the availability of coverage, what explains the absence to date of a universal health care financing system in the United States? Second, is it reasonable to anticipate that we are now at the brink of enacting such a system? Attempting answers to these questions presents the political scientist with an analytical quandary. Explanations of past actions and predictions of future change are predicated on the presence of variance in observable behaviors and outcomes. But comprehensive reform of the system for financing health care in the United States is of interest precisely because it has not happened before (with the partial exception in 1965 of enacting Medicare for the elderly and Medicaid for the poor—see Marmor 1973; Skidmore 1970).

The idea of comprehensive health care reform is not new: it has appeared on the national agenda in one guise or another roughly six times in this century. Between 1912 and 1917, it was tied to the Progressive movement but waned with the advent of World War I and suspicions of "German" ideas like Bismarck's social insurance (Starr 1982: 243–57). Franklin Roosevelt's Committee on Economic Security in 1935 considered it a complement to plans for social security, but his calculation of the political burdens associated with such a national health care program kept the issue on the back burner (Altmeyer 1968; Hirshfield 1970; Witte 1962). During the latter half of the 1940s, President Harry Truman made national health insurance a highlight of his legislative agenda, but established interests were opposed, the public was skeptical, and Congress, especially when in the hands of the Republican party, was anything but receptive (Campion 1984; Poen 1979). Frustrated by these earlier defeats, strategists shifted in the late 1950s and early 1960s to proposing a government insurance program for the elderly as a foundation for a full-scale program for all citizens (Marmor 1973: chap. 1). After Medicare and Medicaid were enacted, however, the follow-through failed to come

through. In the 1970s, presidents from Nixon to Carter joined the reform debate with congressional proponents of varying degrees of commitment, from Senator Ted Kennedy to Representative Wilbur Mills, but by the end of the decade no action had been taken, and the idea of major reform disappeared into the social policy black hole of the 1980s defined by the prevailing ideological emphasis on market competition (see Brown 1983; Feder et al. 1981; Starr and Marmor 1984).

Now, in the 1990s, the issue of comprehensive reform is with us again. If all we are interested in is the nature of agenda change, then explaining the political rise and decline of the idea of health care reform is well within our grasp. If, however, we want to answer the tougher question posed by the woman from Canistota and determine why in the past enactment has not followed deliberation and then assess whether the 1990s and Clinton's administration will yield a different outcome, the task is far more vexing. There are three possible approaches. The first is to make a comparative analysis across nations, recognizing that other economically advanced democracies have implemented systematic reforms of their health financing systems, sometimes after political struggles that would sound familiar to U.S. reform advocates (note in particular the Canadian case—see Kudrle and Marmor 1981; Taylor 1987). The comparative approach is valuable, indeed essential, but of necessity it highlights what is exceptional about America, including the unique institutional design of the U.S. government (see Immergut 1990, 1992; Wilsford 1991). We can use comparative analysis to generate convincing explanations for why the outcomes of reform debates in the U.S. have in the past been so different from those of most other societies, but we cannot use it to estimate the evolving probability of enacting reform *given* the generic design of the U.S. government and political system.

The second approach is also comparative. It finds the common ground in the many policy domains that figure in the politics of change in America and draws attention to fundamental reforms that have been both deliberated and executed in this country, such as the creation of the Federal Reserve and the establishment of Social Security. Such comparisons furnish invaluable guidance for explorations of health care politics, but because policy outcomes are influenced by the characteristics of the individual policy domains to which they belong and the substantive issues involved, cross-policy investigations may not furnish much insight into the prospects of health care reform. Few, if any, changes in other policy areas match the scope and significance of a truly comprehensive reform of the

now $840 billion health care system (approximately the size of Great Britain's entire economy).

The third approach focuses on the United States and health care policy and emphasizes the attributes of the health policy domain that are both subject to variation and likely to be of consequence to governmental decisions about comprehensive health care reform. The import of these attributes derives from the ways in which they motivate the national policy-making process in the U.S., both individually and in interaction with one another. They provide a framework for assessing the health care debate and the likelihood that President Clinton will prove any more successful as a health care reformer than his predecessors. This is the approach that I adopt in this article.

I review first the politics of health care reform, that is, conditions in the health care system and the role of the public. There is some observable link, however tenuous, between the policy process and conditions confronting society, or more precisely, between policy and the perception that conditions have become problems deserving a collective response. The recognition of conditions as problems depends on how clear they are, how they are interpreted by mediating leaders and institutions, and the breadth and intensity of their impact on the public. But policy proposals and debates about their merits must always refer to objective conditions (see Hall 1986; Heclo 1974; Kingdon 1984).

The public, in expressing its values and opinions, as well as in the actions it takes (or fails to take) as an electorate—determining who has government authority, which partisan coalition is advantaged, whether government is unified or divided—plays a crucial role in framing the constraints on the policy process and the opportunities for substantial policy change. The problems it is responding to may be real or imagined, and political and economic elites may influence its perceptions, but major policy change is unlikely in the face of public opposition or, at least, without its acquiescence. Public sentiment can overpower private interests when its desire for change is unambiguous, when it is clear which policy alternative the public will accept, and when elected officials realize that the issue will affect votes (or when they are voted out of office) (see Bachrach and Baratz 1962; Jacobs 1992; Kingdon 1984, 1989; Marmor 1973; Morone 1990; Page and Shapiro 1992).

After my review of the politics of reform, I turn to institutional structure. I assess changes in the institutional features of the health policy process that potentially turn politics into policy by defining the setting in

which ideas are promoted or blocked, options deliberated, first-order decisions made, and cues to other decision makers formulated. My concern is the evolution of the health care reform policy community. It comprises the "representational community" of organized interests and members of the executive and legislative branches of government who turn proposals into policy or orchestrate vetoes of them. As in any policy domain where the public is concerned, the various members of this policy community seek to influence elected officials by stimulating public opinion and action and interpreting the public's positions to their own advantage. They also generate and share information. Of perhaps greater importance, however, is the character of the representational community: it determines which interests project an effective voice and which do not and affects which ideas and perspectives get emphasized in public debate and so gain the most currency among government officials. The way government is organized determines the vitality of the status quo in the face of innovation, shapes the access of private interests to public authority, and establishes the number and availability of "veto points" (see, for example, Gais et al. 1984; Hammond and Miller 1987; Heclo 1978; Katzenstein 1978; March and Olsen 1989; McCool 1990; Immergut 1990; Johnson 1992; Peterson 1990a, 1990b; Skocpol 1992; Walker 1991a; Weir 1992). Previous policy iterations and the outcomes they produce also affect the process. They redistribute the political influence of private interests, reformulate partisan coalitions, transform relationships among institutions, and alter the government's administrative capacity (see Hall 1986; Heclo 1974; Morone 1990; Skocpol 1992; Skowronek 1982; Starr 1982; Weir 1992).

I propose that by the 1990s politics and structure were radically changed. What is especially significant for the prospects of reform—and the success of President Clinton's agenda in particular—is the transformation of the health care reform policy community from an "iron triangle" to a policy "network." The iron triangle was an autonomous policy community, built on close relations between powerful private interests and an oligarchically organized Congress, which organized medicine and its allies could and did thoroughly dominate. The triangle has yielded to a far more diverse and open system, in which a reform coalition has the opportunity to prevail, especially under the direction of an activist president. Serious challenges certainly remain, but never before have the opportunities for reform been as ripe, even during the 1970s, when the hopes of reform advocates last ran high.

Politics

Politics is the process by which a society converts its values into policy. Those values are related to the distribution of resources among society's members. However, since the availability of resources is rarely a static phenomenon, politics is an ever-evolving process of perceptions, decisions, and adjustments: the conditions that underlie a particular policy area are crucial to the process, as are the public's interpretation of those conditions and its response to them.

Objective Conditions

John Kingdon (1984) in his study of the agenda-setting process is careful to note the difference between conditions and problems. Although even large populations may be disadvantaged, their conditions may not be viewed by the public or by policymakers as problems requiring attention (pp. 115–19). Select elites may even possess enough clout to keep specific problems out of the public domain (Bachrach and Baratz 1962). Conditions alone do not an agenda process make. But objective conditions are a necessary precursor to subjective evaluations of them, which in turn must precede the elevation of conditions to the status of problems inviting attention.

There are myriad objective conditions that could be used to characterize the American health care system at any given point in time. With respect to financing medical services, four broad classes of conditions are of particular importance: access to care, the overall cost of delivering health care services, the allocation of financial resources among services and between services and administration, and the administrative burden imposed on providers and patients.[2] Each condition has a status of its own, but they relate to one another in important ways.

Access to Care. Access to care is frequently discussed in the context of the numbers of people without either private insurance coverage or eligibility for government programs like Medicare and Medicaid. Those lacking insurance, however, may actually obtain care, although usually in the most

2. The quality of care is obviously of central concern, too, and can be affected by the way in which health care services are financed. Because quality of care in the aggregate is not typically cited as a problem with the U.S. health care system and there is not an intrinsic relationship between quality and the financing system (all reform plans seek to address it), I am not including the issue of quality in this discussion of conditions.

expensive settings (emergency rooms) and once their ailments have been seriously aggravated (see Pepper Commission 1990; Long and Rodgers 1989; Spolar 1991). There is also recent evidence that the uninsured, even when treated, are cared for less effectively and are more likely to die than those with private or public insurance (Hadley et al. 1991).

The access problem is as old as the reform debate itself, but because today the U.S. stands with South Africa as the only industrialized nations not to guarantee access to care, it remains the most embarrassing condition of its health care system. Early in the century, when the cause of compulsory health insurance was championed by the Progressive movement, sickness benefits of any kind covered a mere fraction of the population and only the wealthy could be sure of access to the available healing arts (Starr 1982: 242). The idea of social insurance was relatively new even in Europe. Access, defined as possession of insurance benefits, was not yet a norm, violations of which would constitute a recognized social problem. Even by the end of World War II, only 32 million Americans (less than a quarter of the population) were protected by private insurance (Health Insurance Association of America 1990: 23).

By the 1970s, following the rapid diffusion of employment-based insurance in the postwar period and the introduction of large-scale public programs for the elderly and limited categories of the poor in 1965, the access issue had been fully transformed. The vast majority of people possessed either private or public coverage, and the enrolled population grew as a percentage of the population as a whole, so attention was directed at the shrinking minority who continued to fall outside the access standard, as it was now defined.

In some respects, the access issue is similar in the 1990s. Eighty-five percent of U.S. residents have some kind of insurance protection at any given time, although the percentage of uninsured ranges widely by state, from 8 percent to 26 percent (U.S. General Accounting Office 1991a). Most individuals under sixty-five years old possess private insurance, 70 percent through plans offered by their employers (Congressional Budget Office 1991a: 69). But this progress in enrollment is being reversed. The number and percentage of uninsured individuals under sixty-five (of whom 29 percent are children and 54 percent are full-time employed heads of household or their dependents) have actually increased to the highest levels since 1965 (Foley 1991: 7–8; Pear 1991; Pepper Commission 1990: 22–23). Coverage on paper also no longer necessarily yields coverage in fact.

The reasons for the decline in insurance protection are legion. Respond-

ing to everything from the financial pressures of new diseases like AIDS to competitive sales incentives, the private insurance market is unravelling (Stone 1990). Some individuals and families with private insurance are discovering that their insurance benefits are inadequate to protect them against financial ruin in the face of medical catastrophe (Meier 1992). The increasing use of medical underwriting by private insurance companies, excluding those with preexisting medical conditions from coverage, has left myriad individuals without any alternative and has begun to expell the unhealthy from the health insurance market (Kolata 1992). The spread of the HIV virus and the potential for predicting an individual's health through genetic coding will only exacerbate these trends. In addition, employers have been cutting back in their coverage of dependents and, even, of employees and have been supported by the courts in doing so (Freudenheim 1992a). Finally, more physicians are dropping Medicare patients, particularly after the recent implementation of physician payment reform (Freudenheim 1992b).

Cost of the Delivery System. Costs are always a relative matter (and are variously defined; see Marmor et al. 1983). As long as income—personal and national—is on the rise and budgets are flush, a modest escalation in costs can be absorbed without much difficulty or complaint. By the 1970s, however, medical inflation began to hurt both businesses and individuals, with costs rising to almost 10 percent of personal consumption (*Economic Report of the President* 1992: 312; see also Wing 1985–86). The U.S. economy was plagued by the new phenomenon of "stagflation" (high rates of inflation along with slow economic growth and an elevated level of unemployment), expanding federal budget deficits were becoming the norm, and health care costs were outstripping the consumer price index (CPI), often substantially (*Economic Report of the President* 1992: 363; see Marmor et al. 1990: chap. 6).

Despite the considerable attention escalating health care costs received in the 1970s, their impact on policy deliberations was softened by three factors. First, the inflation in the economy and in health costs, in particular, were relatively recent developments. Policymakers could not predict their future course and did not know enough about the full range of mechanisms that could be used to control medical costs. Second, the policies that had been tried, mostly to foster better market incentives—higher cost sharing by patients and expanded availability of managed care, for example—had yet to demonstrate their inadequacy. Third, international comparisons were less illuminating. Throughout most of the 1970s other

industrial nations also saw the percentage of their gross domestic product (GDP) committed to health care grow, and while the percentage of GDP spent by the U.S. on health care was consistently higher than that of other countries, the U.S. was not an obvious outlier (the percentage of GDP devoted to health care in the U.S. was less than 10 percent higher than the next highest country, and that difference was arguably the result of more advanced care).

In the 1990s much has changed. Even though the recession of the early 1980s eliminated most of the inflationary pressures in the economy, medical inflation continues to spiral, at 12 percent or more a year, threatening the viability of personal, business, and government budgets (Congressional Budget Office 1991a: 3, 46; Greenhouse 1992; King and Rimkunas 1991: 5; Pear 1993; Rich 1991). The elderly now see a larger percentage of their after-tax income go to health care than before the implementation of Medicare (Rich 1992). Current international comparisons are also far starker. During the 1980s, other industrialized societies implemented far more effective policies and tamed the escalation of their health care costs, leaving the United States the incontrovertible outlier among nations in the world, spending approximately 40 percent more of its GDP on health care than any other nation (Graig 1991: 25–27). The lessons from abroad have also become harder to ignore. By 1971, Canada, in many respects the nation most culturally and demographically similar to the U.S., had consolidated its experiment with a fully implemented single-payer system. During the 1970s, Canada's national insurance program was not yet a useful point of comparison (see Marmor and Mashaw 1990: 19–20; Marmor et al. 1990: chap. 6; Evans 1984). Today, the Canadian health care system (reinforced by the experiences of other nations) offers an example of a financing mechanism that, while ensuring universal access, is far less costly than the U.S. system, and dramatically highlights the excessive administrative costs of the U.S. system (U.S. General Accounting Office 1991b). More than nine out of ten Canadians view their less expensive system as superior to the one in the U.S., even in light of their system's own problems (Blendon et al. 1991). There is no "right" amount of a nation's resources to be devoted to health care delivery, but far more clearly than before, the international arena in the 1990s—where universal access is the norm—reveals the deficiencies of the U.S. health care financing system. The disparities between us and them and the fact that health care is predicted to absorb increasing shares of our national income receive extensive coverage in the mass media.

Allocation of Resources. During times of plenty and when access is unrestricted, it is far less disconcerting if health care resources are misallocated. There are more political dilemmas when costs are growing, budgets fall increasingly into deficit, and a significant portion of the public goes without private or public coverage. In the early 1990s, with costs seemingly out of control and the very integrity of federal and state budgets threatened by massive growth in Medicare and Medicaid expenditures (in 1991, federal expenditures for these programs grew by 13.9 percent and 31.6 percent, respectively—Rovner 1993: 28), two types of misallocation have begun to draw more notice than ever before. First, while all complex health care delivery and financing systems require an expensive administrative apparatus, the General Accounting Office estimates that the United States spends $67 billion more in administrative costs on its current system than it would with a single-payer system; others suggest that the figure may be markedly higher (U.S. General Accounting Office 1991b; Woolhandler and Himmelstein 1991). Second, the development of increasingly expensive high-technology medical procedures raises questions about the allocation of resources among services. So do recent studies revealing that 30 percent of the treatments patients receive may be ineffective or worse and that the use of particular surgical procedures varies widely and does not correlate with actual differences in medical conditions (Callahan 1990; Brook and Vaiana 1989).

Administrative Burden. Under the current system of multiple payers and fee-for-service reimbursements, lacking overall expenditure budgets, all-payer rate regulation, or managed competition, the individual payer has few options in holding down costs. The payer, whether government or a private insurance company, has to conduct case-by-case utilization reviews and deny some reimbursements. Because payers are so numerous and do not adhere to a single standard for claims processing, and because individual treatment episodes are often financed by multiple forms of coverage, the paperwork associated with paying provider bills is often overwhelming. Both aspects of administering the financing of American health care impose tremendous burdens on patients and providers alike, a situation aggravated as escalating costs increase the pressure to scrutinize each medical decision.

Among these deteriorating conditions, cost has become paramount, both for its own sake and because it affects all the others: access, resource allocation, and administrative burden. The increasing cost of health care

delivery forces previously covered individuals from the insurance market, dissipates the slack capacity with which misallocation of resources can be tolerated, and leads to a Byzantine and onerous regulatory regime.

Public Values and Attitudes

The American public has historically been suspicious of government involvement in most activities, and that skepticism, encouraged by the American Medical Association and other advocates of private and voluntary approaches, has motivated its attitudes and actions (its voting patterns, for example) with respect to public policy in the health field (see Campion 1984; Morone 1990). In the past, the public has been troubled to see millions of fellow citizens go without proper insurance coverage, and most Americans endorsed the concept of Medicare (see Jacobs 1992: 194), but even in the 1970s that altruistic impulse was not sufficient to overcome serious reservations about the suitability and practicality of significant government action and to send elected officials a clear message that reform would be encouraged.

Twenty additional years of unrelenting growth in the cost of health care have not shaken the public's generic contempt for government (see Fuchs 1991: 14), but it has recast the health care debate, especially among the crucial middle class (Starr 1991; see also Knox 1992a; Matthiessen 1990; Rich 1991). Worries about continued access to care, today or in the near future, and frustration over the mounting administrative hassles generated by the current financing system, have made people rethink private health insurance and the role of government in this domain. Middle-class individuals, protected by employer-provided insurance in the past, now find themselves losing benefits and subject to "job lock," that is, being unable to change jobs, for fear they will lose insurance. As Rashi Fein notes, "People with insurance want change because *they* are hurting" (Fein 1992: 158). Surveys and focus groups conducted by the American Association of Retired Persons (AARP) captured the public's view of insurance companies as the embodiment of "efficient greed," while the government represented "bumbling benevolence"; with one pitted against the other, it preferred bumbling benevolence.[3] As Robert Blendon testified before the

3. Based on conversations with AARP lobbyists. See Daniel Yankelovich Group, Inc. 1990. Note, too, that the public misperceives the efficiency of the private market. Administrative overhead for private insurance is far higher than for government programs. Figures reported by the General Accounting Office show that overhead accounts for 12 percent of private insurance costs, but only 3 percent of Medicare's and 1 percent of Canada's provincial programs.

Senate Finance Committee in 1991, we have reached a forty-year high in the level of public support for major government involvement in health care financing (see Blendon and Donelan 1991).

What kind of federal action would be appropriate, however, is far from settled in the minds of most U.S. citizens. Although large majorities agree that fundamental change is required, about as many, for example, favor employer-mandates as favor government as a single payer (*Health Cares* 1992: 85). Some surveys do show that an increasing proportion of the public, up to 66 percent in 1990, express a preference for the Canadian system, even among high-income groups (Blendon et al. 1990: 187; Blendon et al. 1991: 172). Most polls, however, portray a public that is thus far unwilling to commit many additional tax dollars to financing major reform (see Blendon and Donelan 1991). That might be changing. The AARP's most recent studies suggest that in the area of long-term care, when respondents are told the actual trade-offs of different courses of action, people support government involvement and are willing to pay for it, as long as the revenues are earmarked for the program (Daniel Yankelovich Group, Inc. 1990).

These public attitudes toward health care represent significant departures from the 1970s. They found vivid expression in Senator Wofford's 1991 election, where people were "voting their fears" (Fein 1992: 158; see James and Blendon 1991; Petts 1991; Turner 1992) and in the support that Bill Clinton received in 1992 (67 percent versus 19 percent for President Bush) from the significant proportion of voters ranking health care reform as one of the most important problems facing the country (Pertman 1992). For the most influential segment of the voting public, the debate has thus been transformed from one of altruism to the far more powerful motivation of self-interest. The very fact that they have not settled on a preferred solution gives President Clinton and other reform proponents room for maneuver and an opportunity to bring the public to their side.

Structure

Changes in conditions and public attitudes, even if they affect elections, do not have a direct bearing on the course of public policy, especially if the public is not decided on which direction policy should go (see Jacobs 1992). Conditions become perceived as problems, problems attract attention, and popular sentiment motivates adjustments in policy only through mediating institutions, which are, additionally, players in their own right (see March and Olsen 1989). We can demonstrate that health care condi-

tions are conducive to major policy change and that widespread perception of health care problems indicates that the public is ready to engage a serious political discourse on possible solutions, but this is only part of the story. If representational institutions, such as interest groups, reflect primarily the perspectives of those with the most to lose from adjustments in the status quo and if the structure of governmental institutions leaves them dominated by those very interests, no amount of variation in "politics" will result in policy innovation that is more than symbolic, except under extraordinary circumstances (such as a distinct electoral mandate from the public when the government is unified by a strong political party). The second and central part of my story, however, is that as the politics has changed, so has the health policy domain, with respect to both the representation of interests and their access to policymakers. The result is an entirely new type of policy community.

The Health Representational Community

A representational community comprises the organized interests in a particular policy domain. At any given time, one or both of two types of interests may be represented within a policy community: first, the "stakeholders," the interests that benefit by the status quo, or at least are more threatened by revisions in it; second, the "stake-challengers," the interests that want to change the status quo because they either do not benefit from it or are actually harmed by it.

Representational communities vary, both over time and across policy domains, according to the characteristics of these organizational representatives. Stakeholders, for example, may agree on the optimal public policy, creating the conditions for a strong alliance, or they may be divided enough to engender a competitive environment. Stake-challengers may be an effective presence in the representational community, able to compete against the stakeholders' interests, or they may be absent or ineffective.

This simplified view of the variegated world of interests is summarized in Table 1. The different attributes of stakeholders and stake-challengers combine to produce four distinct kinds of representational communities. When stakeholders are allied and stake-challengers are not effectively present, the community is homogeneous and one can label it a *block*. If stake-challengers remain absent but the stakeholders are competitive with one another, the community is made complex, revealing a less uniform and cohesive *amalgam* of interests. On the other hand, effectively orga-

Table 1 Types of Representational Communities

	Stake-Challengers Present	
Characteristics of Stakeholders	No	Yes
Allied	Block (Homogeneous)	Dyad (Polarized)
Competitive	Amalgam (Differentiated)	Network (Heterogeneous)

nized stake-challengers confronting allied stakeholders creates a polarized community, a *dyad* of opposed coalitions. Finally, where stakeholders are competitive with one another and stake-challengers are vigorous, the community is heterogeneous and loosely structured, creating a *network* whose broad boundaries are defined by the shared attentiveness of participants to the same issues in the policy domain.[4]

In most policy domains, representational communities typically begin as blocks, with allied stakeholders unencumbered by stake-challengers. Business interests, for example, organize to secure government protection in certain markets or in response to unwanted government intervention (see Stigler 1971). Membership associations formed early in the development of a policy domain traditionally organize around occupational categories, which may not yet be prone to the kind of specialization that would stimulate meaningful competition over the definition of interests (see McConnell 1966). The interests most readily organized are those for whom the costs (or benefits) they incur from government action are concentrated and thus easily recognized (Wilson 1973: chap. 16). The consequences of government action are often significant enough for an individual stakeholder to attempt political influence on its own, if necessary. The interests of stake-challengers, however, are generally more diffuse and thus less likely to prompt mobilization. An individual stake-challenger cannot justify unitary action, and organized representation is achieved only if barriers to collective action are overcome (Olson 1965; see Walker 1991a: chap. 3).

Early in this century, the health care domain was a block-style rep-

4. This typology, of course, is a major simplification of reality. For example, current stakeholders might eventually lapse into open conflict, losing all cohesiveness. Further, when stake-challengers are effectively present, it makes a difference whether they are competitive with one another and whether a single policy advocacy group emerges with the influence and recognition necessary to lead a cohesive coalition against stakeholders, such as the labor movement can do in European settings.

resentational community. Stakeholders were represented by large peak associations, such as the American Medical Association (formed in 1847) and the American Hospital Association (1898). The numbers of stakeholder organizations began to grow as the medical community grew more specialized (with the foundation of the American College of Surgeons in 1913, the American College of Physicians in 1915, and the American Academy of Family Physicians in 1947); the health insurance industry emerged as a major player; and, after World War II, business became the major purchaser of health insurance. All these stakeholders held very similar views of optimal government policy: Government should protect their interests, including favorable tax policy but not intervene in the delivery and financing of health care (see Starr 1982; for later periods, see Wilsford 1991).

Representational communities, however, are rarely static. Fluctuations in the larger political environment, such as the emergence of patrons of political action supporting underrepresented constituencies, can foster new opportunities for stake-challengers to organize (Walker 1991a: 48–51). By the mid-1970s, business interests were finding themselves increasingly challenged by environmental, consumer, civil rights, and women's groups, creating a redefined polarization in many policy domains (Schlozman and Tierney 1986; Walker 1991a). In the case of health care reform, it was with the battles over Medicare in the 1960s and the return of health care reform to the nation's agenda in the 1970s that the stakeholder alliance began to be confronted by a more forceful and expansive set of stake-challengers. Some organizations had always been advocates of reform (the National Farmers Union, Americans for Democratic Action, and the AFL-CIO, for example), but the 1970s witnessed the development of a broader-based reform coalition. Nevertheless, the close alliance of the stakeholders and the relative weakness and inexperience of the emergent stake-challenger organizations helped to reinforce the political influence of the old powers (see Alford 1975; Wilsford 1991).

The 1990s, Challenges to the Stakeholder Alliance, and the Special Role of Business. The period since the last reform debate has brought new pressures to bear on the alliance of stakeholders (for an analysis of similar patterns at the state level, see Imershein et al. 1992). Changes in health care conditions have compelled all of them to recognize the utility of reform and, in some cases, to lead the call for innovation. Even the American Medical Association now views the status quo as unacceptable and has offered a plan for improving access and holding down costs. In this spirit,

in May 1991, it devoted one issue of all of its publications to consideration of reform needs and options.

However, even though the provider community as a whole recognizes the need for reform, it has lost its cohesiveness and its capacity to dominate health care politics and the course of policy change (Morone 1990: chap. 7). The previously stalwart AMA no longer enjoys autonomy in medical decision making or a political monopoly within the community of practitioners (Morone 1990; see also Campion 1984; Brown 1979). The American College of Physicians and the American Academy of Family Physicians, for example, appear prepared to accept more dramatic reform and government promotion of change than the AMA (see Greenberg et al. 1990; Ginsburg and Prout 1990). The American Hospital Association is split by rifts between the nonprofit and for-profit sectors.

On the purchaser side, the constituency of the Health Insurance Association of America (HIAA) pursues increasingly incompatible interests. Reacting to the gathering momentum of reform, the trade association itself announced at the end of 1992 its support for mandated universal health coverage with a standard benefits package and uniform reimbursement rates (Pear 1992c). This plan, however, is unacceptable to many in the HIAA membership, which is sharply divided between the small firms who profit from the current insurance market distortions, on the one hand, and Blue Cross/Blue Shield and other large carriers, who are more accepting of increased market regulation, on the other, as well as among the large companies, according to their level of participation in the managed care business.

Reflecting this factionalization of the old medical/insurance/business alliance, more and more people and groups with stakes in health care policy have in recent years organized and financed their own lobbies in Washington (Pear 1992a). They are expressing divergent messages. The Louis Harris survey (1991: 35) of stakeholders, commissioned by the Metropolitan Life Insurance Company, exposes some of these differences, such as the 67 percent of major insurers who want to maintain an insurance system offering numerous plans and benefit packages, contending with the 55 percent of hospital CEOs who prefer limiting the set of available policies.

Perhaps more important, however, are the gathering tensions between providers and carriers on one side and the business consumers of health insurance coverage on the other. As long as the cost of providing health benefits remained stable and predictable and insurance practices were not exclusionary, many businesses benefited from collective bargaining with

labor by offering extensive health care coverage and saw little reason to disrupt the status quo. Government intervention in the financing of health care was anathema. When conditions changed, however, the commercial and political calculations of some employers had to adjust as well (see McLaughlin 1991). Around 1975, in the midst of the last reform debate, businesses providing health care coverage to employees began to witness steep inclines in premium payments (U.S. Congress 1978: 56).

During the 1980s, much of business's invigorated participation in health care politics occurred at the state level, as represented by the explosion in the number of business coalitions in just a few years. A primary objective of these coalitions, often working in collaboration with state government, was to control costs by enhancing market forces in the private sector, such as increased reliance on health maintenance organizations and other managed care schemes. This strategy required challenging the autonomy of physicians and hospitals (Bergthold 1987). So too at the national level. Willis Goldbeck, then executive director of the Washington Business Group on Health, stated that "our biggest job is . . . to *break business away* from the *providers*" (quoted in Bergthold 1987: 11; emphasis in the original).

The original concerns of the 1970s have sprouted into full-scale alarm in the 1990s, as costs have escalated, despite the range of competitive market approaches tried in the 1980s. Representatives of businesses large and small have brought their concerns to one congressional committee and subcommittee after another. Companies providing comprehensive insurance coverage for their employees watch as health care costs consume more than 50 percent of their pretax profits and place them at a competitive disadvantage. Insurance is completely unavailable to many smaller firms because of preexisting condition restrictions or skyrocketing premiums that can increase more than threefold in a three-year period, as one small business owner testified to the Senate Finance Committee on 9 April 1991 (see also Edwards et al. 1992). Most large companies and increasing numbers of smaller businesses are turning to self-insurance in an effort to cut costs and avoid state insurance mandates (Freudenheim 1992a). By 1991, 80 percent of both large and small employers reported their belief that the health care system required more than minor modifications in order to perform effectively; nearly a third of small employers agreed that "we need to completely rebuild it" (Edwards et al. 1992: 169).

None of these trends bodes well for the continuation of a mutually supportive, dominating stakeholder alliance among doctors, hospitals, insurance companies, and businesses in favor of maintaining the status quo

(see Ginzberg 1990). Indeed, at the national level businesses are now joining in unusual coalitions: among themselves (e.g., the Alliance of Business for Cost Containment), with unions (e.g., the steelworkers and steel companies task force), and with consumer and other activist groups (e.g., the National Leadership Coalition for Health Care Reform) (Kosterlitz 1991: 66). If business interests were to reach consensus on policy, the impact could be dramatic. As Cathie Jo Martin notes, "When business is unified and clear about its interests, it usually gets what it wants" (Martin 1992: 196; see also Vogel 1989). But the business community is more typically diverse in its outlook and fragmented in organization (Bergthold 1987: 8; Martin 1992: 35). On the issue of health care, it is split along deep internal fault lines. Small businesses, represented by groups like the National Federation of Independent Business, will not accept any form of employer mandates, while the large firms already providing coverage for their employees are more sympathetic; half of them (almost twice the percentage of large firms) could support single-payer national health insurance (Edwards et al. 1992: 169). Whichever direction business ultimately pursues, it will no longer be part of a coherent opposition to change.

The 1990s and the Health Reform Representational Network. At the risk of oversimplifying a complex evolutionary process, one can describe the health care representational community as having traveled through three distinct stages of development. Until the 1940s and probably through the 1950s eras of reform debate, it conformed with the definition of a block community. The 1960s and 1970s saw it become more dyadic, as new stake-challenger groups increasingly polarized health care politics while stakeholders maintained their old alliance. The stresses produced by the 1980s and early 1990s have made the stakeholders more competitive with one another, while time and opportunity have increased the number and resilience of stake-challengers, creating a heterogeneous representational network (see Salisbury 1990).

This pattern of change in the health care representational community is consistent with the findings of Jack Walker's 1985 survey of national voluntary associations concerned about public policy (Walker 1991b). He found that even in 1985 fully 36 percent of national membership organizations in America indicated that they were "very interested" in federal involvement in health and human services; a total of 58 percent were at least "somewhat interested." Given the first- and second-order consequences of redesigning the health care financing system, a considerable

Table 2 Changes in the Representational Community of Groups "Very Interested" in Health and Other Human Services (row percentages)

Year by Which Group Was Founded	*N*	Sectors Represented				
		Profit	Mixed Profit/ Nonprofit	Nonprofit	Citizen	Union
1945	130	30%	3%	37%	19%	11%
1970	226	25%	4%	42%	22%	6%
1985	310	23%	6%	38%	28%	5%

Note. Percentages are rounded and may not sum to 100.
Source. Walker 1991b.

percentage of these organizations is likely to have a significant interest in the issue of health care reform itself.[5]

The surveys from the Walker study also furnish corroborating evidence about how and why the policy orientation of the organized interests concerned with health policy have changed and diversified over time.[6] One can begin by reviewing the distribution of groups according to the sectors they represent (see Walker 1991a: chaps. 3, 4) and assess differences in that distribution based on the periods during which the organizations were founded. Table 2 presents the percentage of groups within each sector that were founded by 1945 (when Truman was beginning his efforts to launch compulsory social health insurance), by 1970 (right before the last flurry over comprehensive reform was played out), and by 1985 (the year of the survey and the latest responses available before the start of the current reform debate). To the extent that the initial imperatives that prompted a group to organize continue to carry weight within the organization and the extent to which these organizational imperatives differ by era, one can identify meaningful changes in this representational community.

Of the groups formed by 1945, 30 percent represented the profit sector of the economy and included most physicians, for-profit facilities,

5. Unfortunately, the most detailed question in the survey about health care includes health with other social services. This categorization casts a broad net, and captures a number of groups that are also very interested in education, civil rights, and housing and urban policy, as well as other concerns (Walker 1991a: 72). One wishes the specific issue of health care reform had been addressed.

6. For a rigorous assessment of long-term change in the representational community, of course, one ideally requires comparable data collected from organized interests in the health domain from several points in time, and the inclusion of lobbying entities that do not have enrolled members, such as law firms, corporate public affairs offices, advocacy centers, and think tanks. Such data do not exist.

pharmaceutical and insurance companies, and other non-health-related businesses. Another 37 percent derived from nonprofit enterprises, including public hospitals and schools of medicine and public health. Very few organizations represented memberships from both the profit and nonprofit sectors. Less than a fifth were citizen groups, associations not organized according to occupational or professional backgrounds but rather around a particular cause. Labor unions, of course, were also present, although they are underrepresented in the data set, due to an especially poor response rate. As one progresses to groups organized by 1970 and then by the mid-1980s, the composition of the representative community shifts. Both profit-making enterprises and labor unions decline in their proportional significance, while the mixed profit-nonprofit organizations double and citizen groups increase by nearly 50 percent as a proportion of national voluntary associations very interested in health and human services. The current array of groups is quite different from what it was in the past. Almost all the unions (93 percent) and over half of the relevant profit sector organizations were founded by 1945 and, by 1970, 80 percent of today's profit and nonprofit sector associations were established. For citizen groups and mixed-sector organizations, on the other hand, four in ten arrived on the scene following 1970, and many of them were not founded until after the last round of reform debate. It is likely that if the survey had been done in 1990 instead of 1985, these trends would be reinforced.

This transformation of the representational community matters, of course, only if there are distinct differences among these various types of groups in how they view federal action in the health domain. As Table 3 shows, the overall set of groups that were active in 1985 shows a majority in favor of "much more" expenditure and provision of services by the federal government in health and human services, compared to the 1985 status quo. Only 40 percent of the groups organized before 1946 held the same position, compared to nearly two-thirds of those established since 1970. Far more important, however, are the shifts within certain sectors of groups and differences among types of groups. Support for the expansion of federal services is substantially higher among nonprofit sector groups founded since 1945 than those established earlier, a pattern repeated for the small number of mixed profit and nonprofit associations. These changes indicate a growing tension in the health domain between nonprofit enterprises, which include some providers, and profit-making providers and other businesses who remain (at least in the mid-1980s) far more antagonistic to government involvement. Here we see how the

Table 3 Group Support for the Expansion of Federal Expenditures/ Services and Regulation in Health and Other Human Services, by Sector and Founding Date

Sector Represented	Year by Which Group Was Founded	*N*	Percentage Favoring "Much More" Federal Expenditure or Service	*N*	Percentage Favoring "Much More or More" Federal Regulation
All	1945	106	40	100	43
	1970	189	51	171	43
	1985	260	53	229	45
Profit	1945	28	21	30	10
	1970	44	30	44	11
	1985	54	26	56	14
Mixed Profit/	1945	2	0	2	50
Nonprofit	1970	6	33	6	66
	1985	13	54	12	50
Nonprofit	1945	40	38	35	43
	1970	80	59	70	39
	1985	101	59	82	38
Citizen	1945	22	64	19	63
	1970	45	62	37	70
	1985	77	64	64	72

Source. Walker 1991b.

interest of the stakeholders has diversified—a trend that undoubtedly has intensified in the 1990s (see also Heinz et al. 1990; Salisbury et al. 1987).

Citizen groups make up another essential element of the transformation of the representational community. No matter when they came into existence, the vast majority of them favor much more federal spending on health and human services and support increases in federal regulation, as measured against the 1985 status quo. They polarize the representational community. Two additional attributes of citizen groups contribute to their importance. First, the groups formed prior to 1946 include various associations promoting disease prevention and cures who traditionally have not been confrontational, unlike the organizations spawned in the 1960s and 1970s. Groups founded since 1970 are about twice as likely as their pre-1945 counterparts to be enmeshed in intense and regular conflict in their policy domain and to view the distinctions between the Demo-

cratic and Republican parties as being relevant to their concerns. Second, because of the emergence of supportive patrons of political action and new communications technologies, these later, cause-oriented organizations found it much easier to overcome collective action problems and grew dramatically in number compared to the other types of groups (see Schlozman and Tierney 1986: 74–82; Walker 1991a: 62–64). These new groups not only disagreed with the status quo favored by the stakeholder alliance, they actively challenged it in an effort to effect policy change (Walker 1991a: chap. 6; see Salisbury et al. 1987).

Access to Government Authority

The transformation of the health care representational community from a block to a network is only one half of the structural equation. If access to government officials, especially elected officials like members of Congress, were tightly restricted, then stakeholders could continue to dominate the influence structure, assuming they retained the capacity to cultivate a policy consensus among themselves. At the very least they could defeat challenges to their essential stakes in the status quo. But government itself, and thus the paths of access to U.S. government authority, changed in some ways as markedly as the representational community, albeit somewhat later. The most significant of these changes occurred in Congress, many of them beginning in the 1970s but not taking full root until after the health care reform debate of that decade had waned without bringing about reforms.

The General Transformation of Congress. In many respects, the Congress of the 1960s would have been recognizable to any congressional scholar or participant whose personal perspective dated back as far as World War I. By then, for example, the House had rebelled against the "Reed Rules" and their application by Reed's successor as Speaker, Joseph Cannon, ending the centralizing power of the Speaker of the House (Galloway 1969: 52–56). That paved the way for an institution dominated by baronial committee chairmen, selected on the basis of seniority on the committee (often favoring Southern Democrats from safe districts), who had a firm grasp of independent sources of influence. In the House in particular, the authority structure was as oligarchical as the external representational community was cohesive.

This convergence of the representational and governmental structures —one of consensual and largely unchallenged stakeholders and the other

of baronial policymakers on Capitol Hill—allowed the relatively impregnable "iron triangle" policy communities to take over a variety of policy domains (see Gais et al. 1984; McConnell 1966; McCool 1990; for an alternate account, see Johnson 1992). The American Medical Association and its allies, in such a constricted policy community, could maintain control of the policy process and stymie efforts at state intervention, even if a single political party—typically the Democrats—maintained control of both the executive and legislative branches of government (see Immergut 1990).

By the late 1960s, congressional committee chairs had grown increasingly out of step with the other members of the House, whose ranks were significantly transformed, in particular by the elections of 1958 and 1964 (Bolling 1966). Starting in 1971, a series of reforms, manifest mostly in rule changes promoted by the Democratic Caucus, challenged the power and autonomy of the sitting committee chairs (see Ornstein 1975; Smith and Deering 1984). A few chairs were eventually actually deposed, but most of the reforms left chairs in place while dispersing their power to newly invigorated subcommittees. Under the new rules of procedure, implemented between 1971 and 1975, members could chair only one subcommittee, subcommittee chairs were to be elected by the full committee caucus, and every committee had to have standing subcommittees with permanent jurisdictions, their own staffs, and their own budgets. Professional staff resources expanded rapidly throughout Capitol Hill, in new institutional settings like the Congressional Budget Office (CBO) and the Office of Technology Assessment (OTA), on the committees and subcommittees reinforcing their independence, and in the members' personal offices, all of which enhanced the entrepreneurial spirit in Congress (Ornstein et al. 1987: 135–49; Malbin 1980; Price 1971). New "sunshine" provisions also opened previously closed-door meetings. The oligarchy had been changed into a remarkably decentralized institution. Some of the reforms of the 1970s and other procedural changes witnessed in the 1980s reinforced certain aspects of control of the House by party leaders (see Davidson 1992; Sinclair 1983; Smith 1989), but Congress as a whole generally became a more permeable and less manageable institution than ever before.[7]

Since in many policy domains, both representational communities and

7. The reforms of the 1970s had a much greater impact on the House than the Senate, largely because the Senate was already an extensively decentralized, if not atomistic, institution. For a discussion of the Senate in particular, and how it has become a more egalitarian and open institution, see Sinclair 1989.

congressional structure evolved, iron triangles had to give way to looser, less stable, less predictable, and more diverse patterns of interaction and decision, eventually yielding "policy networks" (Heclo [1978] uses the term "issue networks"; Walker [1981] discusses "knowledge communities"; see also McCool 1990 and Salisbury 1990). In this setting, policy deliberation and change occur in the context of fluctuating "advocacy coalitions," to use Sabatier's term—variable factions made up of both government officials and organized interests that may or may not have a partisan basis to them (Sabatier 1988). Significant events, such as major electoral shifts or crises, can alter the size, composition, and distribution of these coalitions (Jenkins-Smith et al. 1991).

Health Care Sites Then and Now. The first-order effects of these structural changes can be seen in the health policy domain by examining the four authorizing committees that have a jurisdictional claim over initiatives to reform the health care financing system: in the House, the Ways and Means Committee and the Energy and Commerce Committee (until recently called Interstate and Foreign Commerce); in the Senate, the Finance Committee and the Labor and Human Resources Committee (previously Labor and Public Welfare). Important contrasts are to be found in Congress before and after the congressional reforms of the seventies and between the Congress of the 1970s and the 1990s.

The committees of 1959, the first year of the Bobbs-Merrill *Congressional Staff Directory*, offer a point of departure. What we see is committee oligarchy. The Ways and Means Committee was chaired by Representative Wilbur Mills of Arkansas, who retained full control over the committee, its legislative jurisdiction, and its staff (see Manley 1970). The committee had no real subcommittees, so all issues had to be deliberated, marked up, and voted upon solely in full committee sessions under Mills's supervision. Because the Democrats on Ways and Means also served as the committee-on-committees for making Democratic committee assignments and because Ways and Means had a tradition of securing closed rules from the Rules Committee, Mills possessed unusual influence within the chamber. Health care reform built on the Social Security program or requiring federal revenues would have to go through the Ways and Means Committee, and Mills was deeply skeptical about such a major government health care financing program.

The situation in the Senate was similar. The Finance Committee, chaired by the archconservative Harry Byrd of Virginia, also had no standing subcommittees. And in both cases, although far more for Finance, the

committee members voted more conservatively than their chambers as a whole (Ornstein et al. 1992: 206–11).[8] Both the Interstate and Foreign Commerce Committee in the House and the Labor and Public Welfare Committee in the Senate and their health-related subcommittees were also chaired by Southern Democrats, although the Labor Committee is the only one of the four overall to have an average voting record decidedly less conservative than its parent body and to have a chairman, Lister Hill of Alabama, identifiable as an "economic liberal" (Barone et al. 1977: 10).

Congress in the 1940s and 1950s (especially during periods of Republican control, 1947–48 and 1953–54) was not an institution whose committees took easily to major social programs in health. As powerful "veto points" accessible to the dominant interests of organized medicine and its allies, the committee system afforded the opponents of comprehensive reform a distinct structural advantage.

As the 1970s opened, the committees of Congress would hardly seem any more conducive than before to moving major health care reform legislation. Wilbur Mills remained at the helm of Ways and Means, and wily Russell Long, a Louisiana conservative, rose to chair the Finance Committee, still sans subcommittees. Only the House Interstate and Foreign Commerce Committee and Senate Labor Committee were more inviting. Each now had more liberal chairs (Harley Staggers and Harrison Williams, respectively) and health subcommittee chairs (Paul Rogers, less so, and Ted Kennedy).

Then the institutional reform revolution hit the House of Representatives. By 1975, Al Ullman (D-OR) had replaced Mills as chair of Ways and Means, giving its leadership post a more liberal cast. But other changes occurred as well. The committee was expanded from twenty-five to thirty-seven members, it lost its Democratic committee-on-committees responsibilities, and standing subcommittees with permanent jurisdictions, including health, were imposed upon it (the Senate's Finance Committee also created a Subcommittee on Health in 1973). Renewed debate over major health care reform bills in the 1970s came to a head just as the House committees, in particular, were grappling with the effects of significant institutional dislocations. In the meantime, the representational community was becoming polarized, with nascent stake-challengers confronting the still rather strong alliance among stakeholders in a govern-

8. This assessment of ideology is based on the percentage of times members supported the "conservative coalition" (the voting alignments of a majority of Southern Democrats joining a majority of Republicans against a majority of Northern Democrats) when it was present, with all the attendant problems associated with such measures.

mental setting experiencing considerable flux. Despite the arrival in 1977 of a Democratic president and the continuation of Democratic majorities in Congress, the majority party was divided and unable to bridge the unpredictable institutional fragmentation of Congress in the 1970s. Although committee barons no longer automatically stood in the way of reform, the changes also meant that congressional "whales" no longer existed with whom a president might possibly have negotiated successful coalitions. All the elements of this situation could be exploited by the still relatively united stakeholders against their less numerous and less endowed challengers.

So what is different in the 1990s? Congress remains a highly decentralized institution (Hook 1992). Nevertheless, there have been changes in the last decade and a half. First, committee and subcommittee structures, as well as most power relationships in the legislature, have stabilized. Second, if the 1970s was the decade of subcommittee government, the 1980s brought growth in the leadership's capacity to manage the floor proceedings in the House (Davidson 1988; Smith 1989). Third, the increase in staff has permitted a wider range of members to generate serious proposals for reform. Personal staffs have been responsible for crafting almost every major bill under consideration, even, for the most part, the Senate Democratic leadership plan.[9]

Finally, perhaps most importantly, unlike any time in the past, all of the relevant House and Senate committee and subcommittee chairs, as well as members of the Democratic leadership in each chamber, are committed to some version of comprehensive reform of the U.S. health care financing system, as are a number of their ranking Republican counterparts.[10] They are also individuals with either long or concentrated experience in the health domain: Senate Majority Leader George Mitchell, for example, has chaired the Health Subcommittee on Finance. Daniel Patrick Moynihan, the new chair of Finance, following Lloyd Bentsen's departure, has a long intellectual and practical association with social policy, as well as lengthy service on this committee. Jay Rockefeller, chair of the Finance Subcommittee on Medicare and Long-Term Care, recently led the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Com-

9. The leadership initiative was produced by the personal staffs of Senators Mitchell, Riegle, and Rockefeller, working in cooperation with Kennedy's health policy staff from the Labor Committee.

10. The two Democratic leaders who have been the most cautious on the issue of reform are House Speaker Thomas Foley and Lloyd Bentsen, former chairman of the Senate Finance Committee. Foley, however, will go along with President Clinton's program and the appointment of Bentsen as secretary of Treasury removes him as a serious legislative barrier.

mission) and the National Commission on Children. Ted Kennedy now chairs the full Labor Committee and has abolished its health subcommittee (while retaining its staff as the health policy staff on the committee) so as to maximize his influence on health concerns. In the House, Dan Rostenkowski, former chair of the Health Subcommittee of Ways and Means, is now chair of Ways and Means. Pete Stark, current chair of its subcommittee, joined the health fold more recently, but with no lack of energy and immersion; in the summer of 1992, he accepted Majority Leader Dick Gephardt's charge to forge an interim Democratic consensus bill (Rovner 1992). Over on the Energy and Commerce Committee, the chair, John Dingell of Michigan, is both a supporter of national health insurance and a power to be reckoned with. Henry Waxman has chaired the Energy and Commerce's Health and Environment Subcommittee since 1979. All of these committee and party leaders have either authored their own bills for reforming the health care system or have been active participants in collective bill-writing efforts. Although as a party more reactive and less comprehensive in their approach, Republicans in both houses have sought to meet the Democratic challenge (see Peterson 1992b).

It would be difficult to identify any other period when so many members of Congress in pertinent leadership roles were as intimately associated with the health care reform issue, or when so many relatively junior members could be so involved. The structure of the prereform Congress would not have allowed these activities; the 1970s Congress had not stabilized enough to motivate them. At the same time, the huge influx of new members in 1993—110 in the House and 11 in the Senate, the highest turnover since 1948—may enable new coalitional strategies. The impact on the Ways and Means Committee is particularly pronounced, where 39 percent of its members from the 102d Congress—and over half the ranks of the Health Subcommittee—have departed due to retirement, seeking other offices, or defeat (including Marty Russo, the Democrat from Illinois, who was a major advocate of single-payer reform). Unless the infusion of new members sets in motion significant changes in the legislature's organization and procedures, Congress should not revisit the institutional turmoil of the 1970s. It is also possible that, on average, freshmen members of the House and Senate elected in the "anti-gridlock" atmosphere of 1992 may be more supportive than their predecessors were of both comprehensive health care reform and streamlining congressional procedures to facilitate action.

Moreover, neither the leaders nor new members face the same old dominating stakeholder alliance. Today, a broad spectrum of the represen-

tational community in the health domain enjoys similar levels of access to Congress, at least with respect to the number and quality of reported contacts. In the 1985 Walker survey (Walker 1991b), 49 percent of the profit sector groups very interested in health and other human services acknowledged communicating with five or more congressional subcommittees in the previous year, but so did 41 percent of both nonprofit sector organizations and citizen groups. A slightly higher percentage of citizen groups than for-profit organizations actually reported frequent contact with these subcommittees, 45 percent to 41 percent. Equal percentages revealed that these communications were "normally cooperative" (70 percent); only the nonprofits were higher, at 77 percent. About seven out of ten of all types of groups said that their interactions with congressional subcommittees were both frequent and normally cooperative. Organizations representing the profit sector differed from the others in only one respect: a mere 8 percent indicated that the switch of the Senate to Republican control after the 1980 election decreased the cooperation they received from Congress, compared to a quarter of the nonprofit sector groups and a third of the citizen associations. After the 1986 election returned Democratic majorities to the Senate (affecting relationships two years following the Walker survey), it is possible that citizen groups would now even show some advantage over the profit sector organizations, at least in the context of these measures.

These data and the changes that they reflect—a representational community of both competitive stakeholders and plentiful stake-challengers, a Congress decentralized and more open—indicate that in the health care realm the policy community has all it needs to be a policy network. There are no strict boundaries or barriers. The scope of the community is defined by a shared interest in the subject, but with divergent views, shared information and expertise, and competing stakes in the outcome of the policy process (for a detailed empirical assessment of the structure of health policy networks in the 1980s, see Laumann and Knoke 1987).

The Impact of Structural Change

We can now turn our attention to what impact these structural changes—which replace the iron triangle with a policy network—may have on the prospects for comprehensive health care reform in the 1990s, given concomitant shifts in politics and President Clinton's election. There are three hypotheses: first, that the transformations of the representational community and Congress are of little consequence; second, that they reduce

the likelihood of reform; and third, that they create previously unavailable opportunities for enacting reform.

Hypothesis 1: The Structural Changes Are of Little Consequence. There are strong and weak versions of this hypothesis. Proponents of its strongest formulation would argue that my analysis has left out two of the most important political ingredients. One is campaign financing. Although stake-challengers enjoy some access to government, the stakeholders (by sector and collectively) channel huge sums of money through political action committees (PACs) toward precisely the most central players in Congress. In what might be dubbed the "Common Cause" hypothesis (more precisely, conclusion), major policy change will continue to be stymied by members of Congress who are directly or indirectly bought off by campaign contributions from the insurance industry and the medical community.

A second missing consideration is that the business community, erstwhile ally of organized medicine and the insurance companies, will not change. Employers large and small decry the current financing system and the cost increases it generates and their role in subsidizing care for the uninsured, but as a matter of ideology many will not accept the cost containment provisions most proponents of reform believe are necessary. Senate Democrats, for example, striving during 1992 to craft a consensus reform proposal acceptable to small businesses, grew frustrated by the National Federation of Independent Business and other groups when their representatives insisted on cost controls, but rejected all the mechanisms (enforceable budgets and price regulation) that they themselves agreed stood the best chance of working, because they saw it as government intrusion. In this context, business representatives cannot join in active support of any particular reform initiative and instead may thwart those presented by other participants. So the old politics lives on, only with new clothing.

Is this hypothesis persuasive? The effects of PAC money are certainly to be considered in any evaluation of the policy-making process. But there are counterarguments to be made. First, social science research has uncovered few instances or circumstances in which PAC contributions actually change congressional voting behavior, especially when policy issues are subject to extensive public debate (see, for example, Grenzke 1989; note, however, Hall and Wayman [1990], who argue that "moneyed interests" do influence the levels of legislative involvement by members). Second, contributions have influence mostly because of their capacity to

strengthen campaigns for garnering votes. In the end, politicians are more concerned about votes than dollars. If the two are in conflict, the electorate can overcome well-financed "special" interests (but not necessarily—see Hall and Wayman 1990). For better or worse, the repeal of the Medicare Catastrophic Coverage Act in 1990 had more to do with fears of a block of antagonized voters than with campaign financing (Rutledge 1992). How this set of competing forces will break on the issue of comprehensive reform will depend in part on the clarity and robustness of the public's message to members of Congress and the president in the 1992 (and perhaps subsequent) elections.

The impact of business's philosophical intractability is more difficult to assess. If enacting comprehensive reform requires an active alliance of employers with stake-challengers, then the prospects of reform remain dim. But the fact that business interests themselves lack coherence and that the past alliance of business with other stakeholders is strongly challenged means that for the first time groups advocating change—and their collaborators in government—confront a far less influential coalition of opponents. The parameters of the 1990s are nothing like those of the 1940s and 1970s.

The weaker version of the hypothesis that structural change does not matter, articulated mostly "inside the beltway," is that comprehensive health care reform may be enacted, but the traditional patterns of influence will shape the reform policy to comport with the interests of the stakeholders, just as Medicare's Part A, for hospital care, and Part B, covering physician services, were crafted in ways perfectly compatible with the interests of hospitals and doctors, by preserving their traditional payment practices and autonomy. The political analysis offered by Henry Aaron (1991), an Urban Institute team (Holahan et al. 1991), Families USA (Pollock and Torda 1991), and the Senate Democratic leadership pay-or-play initiative all work on this hypothesis.[11] So does the latest strategy of the AFL-CIO and several of its member unions, promoting employer mandates instead of national health insurance as they had in the 1970s and earlier. Some would suggest that Clinton's embrace of managed competition reveals a similar strategy for achieving reform by avoiding direct attacks on the insurance industry and other interests perceived to be too powerful to defeat. In this scenario, reform can be achieved, but only if the interests of stakeholders—especially private insurance and medical

11. For a description of the process that led to the Democratic leadership initiative sponsored by Senators Mitchell, Kennedy, Riegle, and Rockefeller, see Peterson 1992b.

providers—are well accommodated in the reform. As one senior senator reportedly stated in private, 80 percent of the public would support a different kind of reform than pay-or-play employer mandates, but the other 20 percent have the political influence. Efforts to promote more extensive government involvement are doomed, it is argued, because of the continuing power of the stakeholders and the relative frailty of and lack of consensus among the stake-challengers.

This version of the hypothesis may be born out by subsequent events, but it, too, must be probed and debated. It ignores a few compelling features of the current reform debate. First, while most people respect their physicians, there is no love lost between the public and their insurance companies. Only 29 percent of the public believes health insurance offers good value for the money. Private insurance companies lead the public's list of suspects responsible for the high cost of medical care (Blendon et al. 1991: 172, 174). The increasingly prevalent insurance practices of experiential rating, medical underwriting, and termination of coverage for individuals once they get sick have raised suspicions further about the efficacy of private health insurance. Insurance interests have the weakest base among the public of all past stakeholders. Second, while a unified insurance industry with powerful friends might have the resources and influence to overwhelm any effects of such popular disdain, it is weakened by being deeply divided internally over acceptable strategies of reform. In addition, the whole alliance among stakeholders shows signs of severe strain, between representatives of the profit and nonprofit sectors and especially between business interests and the combination of insurers and providers. Employment-based plans may be especially vulnerable, particularly if opposed by small businesses, the firms most compromised by the imposition of any mandated health insurance coverage. They are numerous and scattered across every state and located in each House district.

Hypothesis 2: Structural Change Has Reduced the Likelihood of Reform. This hypothesis proposes the same conclusion as the strong variant of the first hypothesis, but for a quite different reason. It recognizes the dramatic shifts that have occurred in the representational community and the rearrangement of power in Congress. Both types of change, however, are viewed as contributing to the fragmentation of power and authority in the United States, making it nearly impossible to forge majorities on any policies of any consequence. To use Anthony King's terms, the American system has been "atomized," and as a result, leaders are reduced to

"building coalitions in the sand" (King 1978). Samuel Kernell suggests that we have moved from a system of "institutionalized pluralism" to one of "individualized pluralism," destroying the stable building blocks necessary for coalition formation (Kernell 1986: 10–35). Recent reports about the rapid escalation in the number of lobbyists representing parochial interests in the health policy domain, each committed to protecting its own narrow slice of policy turf, may lend credence to this view (Pear 1992a). No wonder Congress has settled into a policy gridlock, given this fragmentation of authority, stimulating calls for the next generation of institutional reform (Hook 1992). And there is little President Clinton can do about it, according to proponents of this hypothesis, other than watch his initiative succumb to the death of a thousand cuts.

In this context, the decline of organized labor in the U.S. is especially significant (see Goldfield 1987). Labor—with its extensive and active national memberships in associated unions—customarily led the charge for comprehensive health care reform. But, while new potential partners have emerged among stake-challengers and the stakeholder alliance has degenerated, the labor union movement has suffered an organizational crisis. National union membership peaked in the early 1950s at around 25 percent of the entire labor force; today, after a precipitous drop in the 1980s, it is about 16 percent nationally (only 25 percent of manufacturing jobs) and well under half that in the South (Goldfield 1987: 10; U.S. Bureau of the Census 1991: 424–25). The AFL-CIO, viewed now by members of Congress as "just one more PAC," has not been able to claim a single legislative achievement among its priorities in four years (Sammon 1992: 1810).

During the present health care debate, labor's influence has been further eroded by divisions among the AFL-CIO's affiliated unions that prevent labor from extending its full endorsement to any particular reform plan (see Peterson 1992b). Activists in union locals may also have realized that because health care benefits have become so central to collective bargaining and represent such a signal achievement of the labor movement, an entirely publicly funded or even a mandated system of health care financing, whether or not guided by managed competition, might rob the union movement of its raison d'être during this period of evaporating union membership. As yet no other broad-based organization with a coherent reform plan has appeared to fill what was labor's role.

The fragmentation argument is worrisome, but it, too, ignores—or perhaps misinterprets—significant features of American politics. It identifies increasing numbers of actors with increasing numbers of interests

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and, thus, fragmentation. But there is a political structure lying below the numbers that can be exploited. There are "special" interests, to be sure, but substantial numbers of groups have common or at least overlapping interests. Ideological and partisan fault lines cleave the interest group system just as they divide the electorate (Peterson 1992a; Walker 1991a: chaps. 2, 8). These divisions are certainly not European in their depth or consistency, but they provide one basis for coalition building that is available to President Clinton (Peterson 1992a). The more obvious the deficiencies in the health care financing system, the more public the debate over policy change; and the greater the media coverage, the more significant these cleavages become and the harder it is for parochial interests to achieve their objectives behind the scenes in what is now a far more open legislative process.

Hypothesis 3: Structural Change Has Introduced Previously Unavailable Opportunities for Reform. The institutional transformation of the representational community and Congress produces a challenge for any reform coalition, but as long as the structure of American politics and government lent enormous advantage to the original and often unified alliance of medicine, insurance, and business, reform was either impossible or almost entirely dictated by the long-established interests. This hypothesis is the optimistic one for reformers, because it suggests that the previous barriers to comprehensive change have been breached. That provides an opportunity, an opening, for reform where perhaps none ever existed before.

The health care reform policy community, now a policy network, is more complex than ever. Perhaps along the lines suggested by hypothesis 2, the reform effort will consequently collapse under its own weight, aided by the weakening of labor's influence and continuing confusion among the public. But in the current system, new ideas and new players have an entrée and, with them, so do previously unseen alignments of advocates for reform. Not only are leaders of the traditional type active in the reform campaign, but so too are far less senior members, like Jim McDermott in the House, and Tom Daschle, Bob Kerrey, Harris Wofford, and James Jeffords in the Senate (see Kerrey 1991; Peterson 1992b).[12] In combination with conditions in the health system that are increas-

12. As the pool of serious participants expands and includes less senior members, there is also greater risk that influential proponents of reform will become the victims of electoral vagaries, such as occurred with the 1992 defeat of Representative Marty Russo, the result of redistricting, in the Illinois primary.

ingly difficult to ignore and the public's attraction to at least the notion of major reform in the health care area, reform proponents may be able to cultivate enough cohesion in the policy network to obtain a workable majority in Congress. That is where Clinton's election becomes so important. Although even reformist Democrats have substantive disagreements among themselves, all turn to President Clinton to take the lead in mastering a coalition they each can join. They are more willing to compromise with him than with each other.

Entrepreneurs and Leaders

Ironically, the foremost threat to the reform agenda may be the effects of a "perceptual drag" evident in some of the most influential members of the reform coalition, from Senators Mitchell and Kennedy to, possibly, President Clinton (see Peterson 1992c). Just as military officers always find themselves fighting the last war, employing tactics and weapons suited for past campaigns, not the current one, policy leaders tend to fight the battle they just lost, not the one at hand. Originally philosophically linked to single-payer approaches to reform, Senator Kennedy and others, including the major labor unions, have aligned themselves behind the very employment-based schemes they had rejected years before. The reasons are clear and understandable. In the 1970s, national health insurance seemed within reach, but then the opportunity collapsed. Perhaps the advocates pushed too hard, the argument goes, and should have settled on the employment-based plan offered by President Nixon and others in the 1970s. The experiences of that decade, it is thought, proved the folly of bolder reform. The recent politics of managed competition is also consistent with this view. But this line of reasoning assumes that little has changed between the 1970s and 1990s, especially with respect to the coherence and influence of stakeholders, the character of stake-challengers, and the structure of Congress.

The 1990s are, in fact, distinctly different from the 1970s. Following the voluminous scholarship produced by health policy analysts, I have argued that both the health conditions the country faces and the public's attitude about reform have undergone major shifts, all favoring the prospects of reform. Even more importantly, the reform policy community has transformed itself from one of iron triangle entanglements that a unified antireform alliance of medicine, insurance, and business could use to defeat change into a more expansive and open policy network in which reform proponents, especially with presidential leadership, have an un-

precedented opportunity to forge a winning coalition. Much of this change has been accomplished since the 1970s. (For assessments of the remaining barriers to reform and their significance, see Brown 1992; Marmor and Boyum 1992.)

Because coalitions and institutions do not act without direction, what actually happens as a result of these changes in politics and structure—whether reform is enacted or we replay once again the scenario of opportunity denied—will largely rest on the presence, skills, and strategies of three types of leaders (Peterson 1992c). First, there are the policy entrepreneurs, the authors and promoters of particular approaches to reform, who help define the issues of the debate. This leadership is well established and, in the process, those in Congress and elsewhere who are not health specialists are being educated about our problems and the possible solutions. Second, there are the *political* entrepreneurs, who help define perceptions of the political landscape. Their major responsibility is to persuade the major players to see clearly the circumstances of the 1990s and realize that they are indeed not a reprise of the 1970s or earlier configurations of politics and structure in the U.S. The newer players, untainted by the tempering experience of the 1970s, may have to be the ones to play this role.

Finally, there are the major political leaders, those with the resources and influence to mobilize the broad coalitions necessary to enact legislation in a heterogeneous policy network and the larger legislative process. This role is typically borne by presidents. Truman tried, at least symbolically, in the 1940s. Johnson was there for Medicare in the 1960s. Nixon and Carter joined the effort, albeit reluctantly, in the 1970s. Other than LBJ, none enjoyed the overlapping of politics and structure that would permit or at least facilitate comprehensive reform. Such a favorable alignment of factors finally began to happen, however, during a period in which there was no mobilizing leadership from the president. President Bush tepidly offered his tax- and voucher-based plan to counter the Democrats only when political dynamics rendered his failure to participate untenable (President's Program 1992; *New York Times* 1992; Pear 1992b). After the introduction of his plan, he all but disappeared from the scene (Knox 1992b). With President Clinton ensconced in the White House, for the first time in the long history of comprehensive health care reform debates, major attributes of politics, structure, and leadership appear to have come together simultaneously. Clinton's program would probably be defeated if politics and structure had not changed—particularly if the reform policy community had not evolved—and the prospects of reform would be far

more uncertain had Clinton not been elected. It is fair to conclude, therefore, that we are in the midst of the greatest test yet of the proposition that the United States lacks the capacity to secure a major reorientation of its health care financing system.

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